Public Document Pack

MANCHESTER CITY COUNCIL

Health and Wellbeing Board

Date: Wednesday, 8 July 2020
Time: 10.00 am
Venue: Virtual meeting - Webcast at https://manchester.public-i.tv/core/portal/webcast_interactive/485353

This is a **Supplementary Agenda** containing additional information about the business of the meeting that was not available when the agenda was published.

The Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020.

Under the provisions of these regulations the location where a meeting is held can include reference to more than one place including electronic, digital or virtual locations such as Internet locations, web addresses or conference call telephone numbers.

To attend this meeting it can be watched live as a webcast. The recording of the webcast will also be available for viewing after the meeting has ended.

Membership of the Health and Wellbeing Board

Councillor Richard Leese, Leader of the Council (Chair)
Councillor Craig, Executive Member for Adults (MCC)
Councillor Bridges, Executive Member for Children's Services (MCC)
Dr Ruth Bromley, Chair Manchester Health and Care Commissioning
Dr Denis Colligan, GP Member (North) Manchester Health and Care Commissioning
Dr Murugesan Raja GP Member (Central) Manchester Health and Care Commissioning
Dr Claire Lake Member (South) Manchester Health and Care Commissioning
Kathy Cowell, Chair, Manchester University NHS Foundation Trust
Jim Potter, Chair, Pennine Acute Hospital Trust
Rupert Nichols, Chair, Greater Manchester Mental Health NHS Foundation Trust
Mike Wild, Voluntary and Community Sector representative
Vicky Szulist, Chair, Healthwatch
Dr Tracey Vell, Primary Care representative - Local Medical Committee
Paul Marshall, Strategic Director of Children's Services
David Regan, Director of Public Health
Bernadette Enright, Director of Adult Social Services
Dr Angus Murray-Browne, South Manchester GP federation
Dr Vish Mehra, Central Primary Care Manchester
Dr Amjad Ahmed, Northern Health GP Provider Organisation

Agenda

Information about the Board

The Health and Wellbeing Board brings together those who buy services across the NHS, public health, social care and children's services, elected representatives and representatives from HealthWatch to plan the health and social care services for Manchester. Its role includes:

- encouraging the organisations that arrange for the provision of any health or social care services in Manchester to work in an integrated manner;
- providing advice, assistance or other support in connection with the provision of health or social care services;
- encouraging organisations that arrange for the provision of any health related services to work closely with the Board; and
- encouraging those who arrange for the provision of any health or social care services or any health related services to work closely together.

The Board wants to consult people as fully as possible before making decisions that affect them. Members of the public do not have a right to speak at meetings but may do so if invited by the Chair. If you have a special interest in an item on the agenda and want to speak, tell the committee officer, who will pass on your request to the Chair. Groups of people will usually be asked to nominate a spokesperson. The Council wants its meetings to be as open as possible but occasionally there will be some confidential business. Brief reasons for confidentiality will be shown on the agenda.

The Council welcomes the filming, recording, public broadcast and use of social media to report on the Committee's meetings by members of the public.

Agenda, reports and minutes of all council committees can be found on the Council's website www.manchester.gov.uk

Smoking is not allowed in Council buildings.

Joanne Roney OBE
Chief Executive
Level 3, Town Hall Extension, Albert Square
Manchester, M60 2LA

Further Information

For help, advice and information about this meeting please contact the Committee Officer:

Andrew Woods
Tel: 0161 234 3011
Email: andrew.woods@manchester.gov.uk

This agenda was issued on **Friday 3 July 2020** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 3, Town Hall Extension (Lloyd Street Elevation), Manchester M60 2LA

This page is intentionally left blank

Manchester Health and Wellbeing Board
Report for Resolution

Report to: Manchester Health and Wellbeing Board – 8 July 2020

Subject: Manchester COVID-19 Local Prevention and Response Plan

Report of: Director of Public Health

Summary

The Director of Public Health (DPH) and the Population Health Team have led the development of the Manchester COVID-19 Local Prevention and Response Plan (Outbreak Plan) with local partners.

The Plan is attached to this cover report and the DPH will present a summary of the Plan to the Board.

This report also includes updated Terms of Reference for the COVID-19 Response Group, which will act as the Health Protection Group to oversee the Plan in line with national guidance. It is important to note that the Plan and this cover report refers to the establishment of the Local Outbreak Engagement Board, which is also referred to in the national guidance. Further information on this will be provided at the Board meeting.

Recommendations

The Board is asked to:
1) Endorse the Manchester COVID-19 Local Prevention and Response Plan
2) Approve the updated Terms of Reference for the Manchester COVID-19 Response Group.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	This unprecedented national and international crisis has impacted on all areas of our city and on all of the strategic priorities. The 'Our Manchester' approach has underpinned the planning and delivery of our collective response.
Improving people's mental health and wellbeing	
Bringing people into employment and ensuring good work for all	
Enabling people to keep well and live independently as they grow older	
Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme	
One health and care system – right care, right place, right time	
Self-care	

Contact Officers:

Name: David Regan
Position: Director of Public Health
E-mail: d.regan@manchester.gov.uk

Name: Sarah Doran
Position: Consultant in Public Health
E-mail: s.doran@manchester.gov.uk

Background documents (available for public inspection):

The link to the Plan is:
https://secure.manchester.gov.uk/info/500361/coronavirus/7928/coronavirus/26

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

Manchester COVID-19 Response Group Revised Terms of Reference

1. Introduction

1.1 The Manchester COVID-19 Response Group ("the CRG") (previously called the Manchester COVID-19 Locality Planning Group (MCLPG)) fulfils the role of the Manchester Health Protection Group as set out in national guidance. It has a formal reporting and governance line into the Manchester Health and Wellbeing Board and is chaired by the Director of Public Health.

1.2 The CRG also fulfils the functions of the "Borough Pandemic Co-ordinating Group" set out in the Greater Manchester Resilience Forum Pandemic Strategic Response Plan.

2. Membership

2.1 The core membership of the group is set out below.

2.2 People attending the meeting must have delegated authority from their respective organisations so that decisions can be made quickly. A number of workstreams / sub groups have been established to respond to the various phases of the pandemic

3. Key Responsibilities

3.1 Review and implement appropriate command, control and co-ordination arrangements to ensure effective multi-agency response structures.

3.2 Co-ordinate liaison between the GM arrangements and the City.

3.3 Co-ordinate liaison between the regional NHS Incident Management Centre, local NHS Incident Management Teams and the CRG.

3.4 Support the work of the Local Outbreak Engagement Board (Sub-Group of the Health and Wellbeing Board) to 'warn and inform' the public, supporting the delivery of consistent messages wherever possible and ensure appropriate sign off with Public Health England.

3.5 Support the identification of, communication with, and provision of services to vulnerable groups.

3.6 Consider and act on the emerging evidence that the effects of COVID-19 have traced patterns of inequality, such that the negative impacts of the pandemic have been disproportionately felt across our diverse communities, both from a health perspective and in terms of our public service response

3.7 Lead communication with schools and early years providers, and work within national guidance to support the management of closures if necessary.

3.8 Lead on the work with social care providers and work within national guidance to support and maintain delivery of services.

3.9 Through the Director of Public Health, maintain oversight of population health and ensure that public health expertise and advice is provided to relevant organisations and the public.

3.10 Implement business continuity measures, including the provision of Personal Protection Equipment and other appropriate interventions, to maintain the delivery of services.

3.11 Implement arrangements for the management of excess deaths by working with partners across bereavement services. This work is be led by the Council Resilience Forum.

3.12 Lead on forming and implementing the COVID-19 Prevention and Response Plan (Outbreak Plan).

3.13 Oversight and management of the Manchester Test and Trace Programme.

4. Key Workstreams as at 1 July 2020

a) Schools, Education Settings and Early Years
b) Adult Social Care and Care Homes
c) Homelessness and Street Based Services
d) Communications
e) Community Response
f) Primary Care
g) COVID-19 Health Equity
h) COVID-19 Prevention and Response Plan (Outbreak Plan)
   - Infection Prevention Control
   - PPE
   - Manchester Test and Trace Programme
   - Data collation and modelling

5. Accountability and Reporting

5.1 The CRG will report directly into the Manchester Community Cell on its key workstreams.

5.2 The CRG will also report into the Health and Wellbeing Board on the implementation of the COVID-19 Prevention and Response Plan (Outbreak Plan), as well as any other key workstreams when required.

5.3 The CRG will perform an advisory role to the Local Outbreak Engagement Board (Sub-Group of the Health and Wellbeing Board).

5.4 The CRG will refer any significant consequence management decisions to the MCC Senior Management Team (Gold Control) for approval by statutory officers, using their delegated powers where appropriate.

5.5 The CRG will also, through the Director of Public Health, support the work of the Strategic Care Homes Board and take lead responsibility for the “Controlling the Infection” work programme under the remit of the Board.

6. Frequency of Meetings

6.1 The CRG will meet weekly, however the frequency will be reviewed periodically and may change depending on how the COVID-19 pandemic develops.

7. Review

7.1 These Terms of References will be reviewed periodically, with any significant amendments presented to the Health and Wellbeing Board for approval.

Appendix 1 – CRG Core Membership

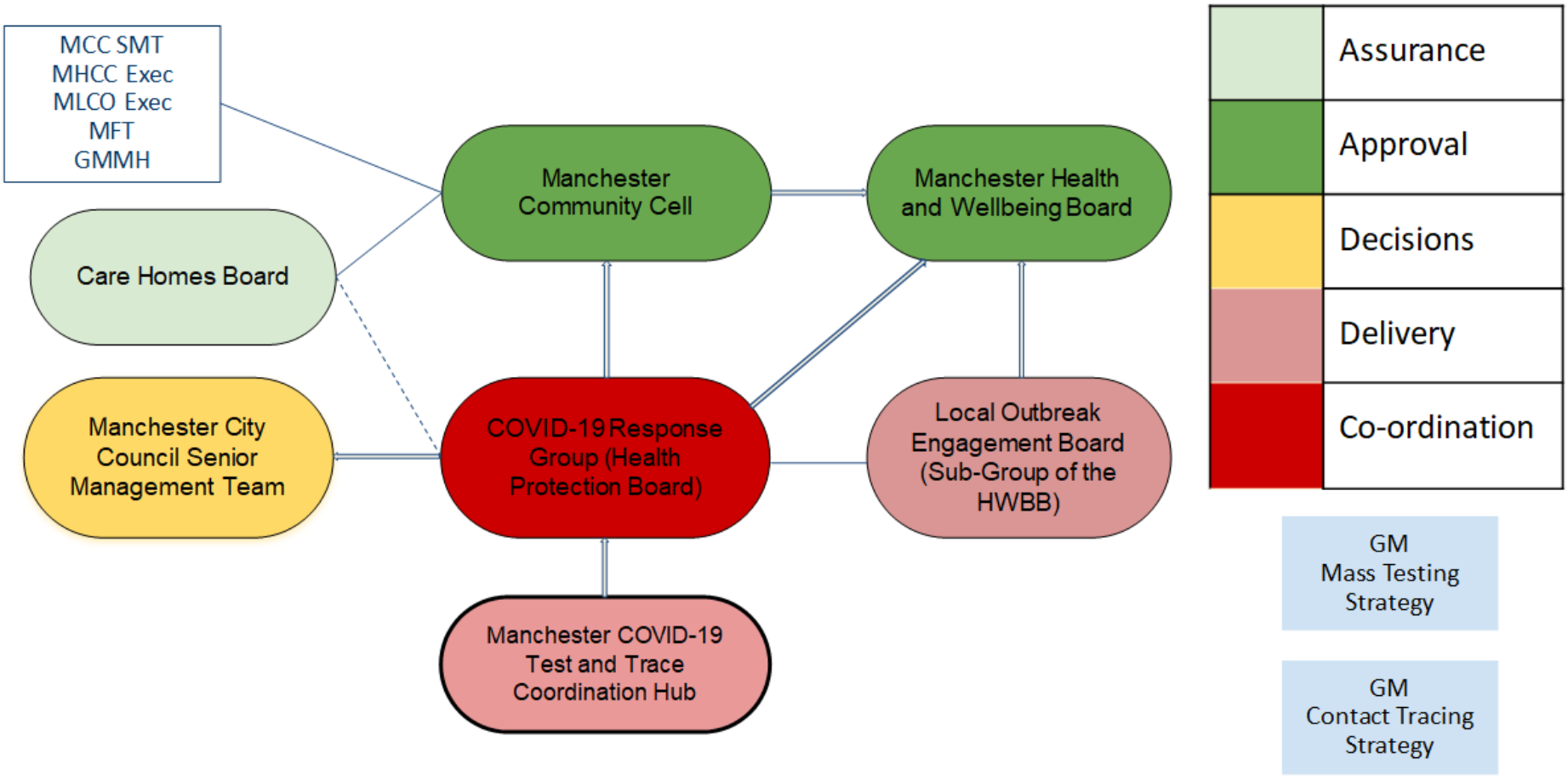
Name	Job Title	Organisation	Named Deputy	Rationale for group membership
David Regan	Director of Public Health	Manchester City Council / Manchester Health and Care Commissioning	Sarah Doran	Secretary of State delegated health protection function to Directors of Public Health
Sarah Doran	Consultant in Public Health	Manchester City Council / Manchester Health and Care Commissioning	Barry Gillespie	Consultant in Public Health statutory role around health protection
Leasa Benson	Clinical Lead Health Protection	Manchester City Council / Manchester Health and Care Commissioning	Helen Fabrizio	Co-ordinating Community Infection Team response to Manchester related queries
Vicky Schofield	Secretary to Director of Public Health	Manchester City Council / Manchester Health and Care Commissioning	Samuel Clarke	Note taking and action log management
Ian Lurcock	Chief Executive, Clinical Scientific Services MCS, MFT	Manchester University NHS Foundation Trust	TBC	
Dr Manisha Kumar	Medical Director	Manchester Health and Care Commissioning	Gordon Reid	Chair and lead of Primary Care sub group

Nick Gomm	Director of Corporate Affairs	Manchester Health and Care Commissioning	Chris Gaffey	Lead for incident management function at MHCC
Sharmila Kar	Director of Workforce and OD	Manchester Health and Care Commissioning	TBC	Representative of the Locality Workforce Transformation Group of all HR/OD Directors in Manchester Trusts/MCC
Ian Trodden	Chief Nurse	Manchester Local Care Organisation (MLCO)	Lorraine Ganley	Executive Director of the MLCO and leads for the Manchester COVID-19 Co-ordination Hub/Service
Bridget Hughes	Strategic Programme Lead	Greater Manchester Mental Health NHS Foundation Trust (GMMH)	TBC	
Mike Wild	Chief Executive	Macc	TBC	Lead for VCSE sub group
Fiona Sharkey	Head of Compliance, Enforcement and Community Safety	Manchester City Council	TBC	Chair of the Council Resilience Forum

Sue Brown	Principal Environmental Health Officer	Manchester City Council	Tim Birch	Senior advisor on environmental health and the Port Health Authority
Alun Ireland	Strategic Head of Comms	Manchester City Council	Penny Shannon	Lead for co-ordination of comms sub group
Karen Crier	Programme Lead	Manchester City Council	Paul Bickerton	Lead for Adult Social Care sub group
Paul Marshall	Director of Education	Manchester City Council	Amanda Corcoran	Director representative of Children's and Education including schools and Early Years
Gareth James	Head of People, Place and Regulation, Legal Services	Manchester City Council	Jonathan Broad	To provide legal advice on emerging legislation and scope for existing legislation to be used to inform local decisions
Robin Lawler	Chief Executive	Northwards Housing	Karen Mitchell	Chief Executive, Southway Housing
Shefali Kapoor	Head of Neighbourhoods	Manchester City Council		Neighbourhoods Lead
Nicola Rea	Strategic Lead, Homelessness Directorate	Manchester City Council	Jane Davies	Homelessness Strategic Lead

Chris Gaffey	Head of Corporate Governance	Manchester Health and Care Commissioning		To provide governance support and advice.
Neil Bendel	Public Health Specialist (Health Intelligence)	Manchester City Council / Manchester Health and Care Commissioning	TBC	Business Intelligence Lead
Jenny Osborne	PPE System Lead Manchester & Trafford	Manchester City Council / Manchester Health and Care Commissioning	TBC	PPE Lead
Dr Cordelle Mbeledogu	Consultant in Public Health Medicine	Manchester City Council / Manchester Health and Care Commissioning	TBC	Testing Lead

Appendix 2 – CRG Governance Structure



Forum	Information	Relationship to COVID-19 Response Group
COVID-19 Response Group	• Chaired by DPH • Fulfils the role of the Health Protection Group for Test and Trace • Provides oversight on the COVID-19 Prevention and Response Plan (Outbreak Plan)	• N/A
Manchester Community Cell	• Chaired by MHCC's CAO • Overall responsibility for the Community COVID-19 Response for the City of Manchester	• COVID-19 Response Group reports directly into the Community Cell on its key workstreams, including Test and Trace
Health & Wellbeing Board	• Statutory Board of the Council (with MHCC membership) • Fulfils the role of the Local Outbreak Engagement Board by establishing a Sub-Group (as detailed below). • Overall responsibility for the COVID-19 Prevention and Response Plan (Outbreak Plan)	• COVID-19 Response Group will submit the COVID-19 Prevention and Response Plan (Outbreak Plan) to the Board for initial approval, as well as any subsequent proposed changes.
Local Outbreak Engagement Board	• Sub-Group of the Health & Wellbeing Board, Chair by MCC's Executive Member for Adult Health and Wellbeing • Focus on communication and engagement with the general public, to develop local support to implementing the steps necessary to reduce the risk of spread of COVID-19.	• COVID-19 Response Group will play an advisory role for the Group.
MCC SMT	• Manchester City Council's Senior Management Team. • Statutory Officers with delegated decision making powers.	• Acts as Gold Command for the COVID-19 Response Group. • COVID-19 Response Group to refer any consequence management decisions for approval by statutory officers, using their delegated powers where appropriate.
COVID-19 Test & Trace Coordination Hub	• Responsible for the oversight and implementation of the Test and Trace Programme Plan	• Reports directly into the COVID-19 Response Group on the Test and Trace Programme.

This page is intentionally left blank

Manchester COVID-19

Local Prevention and Response Plan

June 2020

Our Manchester

Manchester COVID-19

Prevention and Response plan

Contents

Manchester COVID-19

Prevention and Response plan

Foreword

This Plan is designed to ensure that Manchester City Council, working with all key partner organisations in the City can respond effectively to the gradual easing of lockdown measures over the next few months.

It has been developed collaboratively in line with the Our Manchester principles and behaviours and has a strong focus on preventing further transmission of the virus as well as setting out the actions that will be taken should local outbreaks occur.

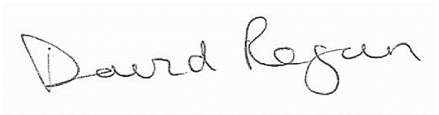
We can be proud of the fact that back in January plans were put in place to respond to the emerging pandemic, which were helped by our previous experiences of dealing with other outbreaks such as SARS, and Swine Flu. From the outset we also worked with and provided support to Manchester's Chinese community, who were being unfairly stigmatised at the time. This focus on community - and also groups who may be more at risk of the virus - is fundamental to our approach and is a key part of this plan, where everyone in the city has a role in keeping one another safe and well.

We would like to acknowledge the excellent work undertaken over the past six months and we can now build on these strong foundations as we continue to respond to the ongoing challenges posed by COVID-19.

Sir Richard Leese
Leader of the Council and Chair of the Manchester Health and Wellbeing Board

Councillor Bev Craig
Executive Member for Adult Health and Wellbeing

Joanne Roney OBE
Chief Executive
Manchester City Council



David Regan
Director of Public Health
Manchester City Council

Manchester COVID-19

Local Prevention and Response Plan

Background

In January 2020 a novel coronavirus, SARS-CoV-2, was identified in samples obtained from a cluster of pneumonia cases in Wuhan City, China. The associated disease, named as COVID-19, spread rapidly across the globe, and was declared a pandemic by the World Health Organisation in March. To date, there have been over 40,000 COVID-19 deaths in the UK.

SARS-CoV-2 is primarily transmitted between people through respiratory droplets and contact routes. COVID-19 presents with a range of symptoms of varying severity. The case definition is a new persistent cough, or fever (over 37.8) or change in sense of smell or taste. It is also possible to be infected with SARS-CoV-2 and have very mild or no symptoms (asymptomatic infection). Asymptomatic infection is common and there is evidence of transmission from such cases.

The basic reproductive number (R_0) for the SARS-CoV-2 virus was estimated to be between 2.7 and 3.0 by the Scientific Advisory Group for Emergencies (SAGE) at the start of the outbreak in March. This means that each case would infect nearly 3 people on average in a population with no immunity to the virus. The effective reproduction number (R_e) is the number of people in a population who can be infected by an individual at any specific time.

R_e is affected by the number of people with the infection, levels of immunity in the population and people's behaviour e.g. social distancing. Regional estimates of R_e are updated on a weekly basis. When R_e is above 1, the number of new infections is accelerating. The purpose of outbreak control measures is to keep R_e below 1.

The Greater Manchester (GM) COVID-19 Outbreak Management Plan explains how the city region will collectively manage the spread of the SARS-CoV-2 virus, to minimise the prevalence and impact of the subsequent COVID-19 disease. The Manchester COVID-19 Local Prevention and Response Plan outlines our approach to controlling the spread of SARS-CoV-2, managing local outbreaks, protecting vulnerable people in our communities and co-ordinating efforts across organisations. In conjunction with national measures, these actions will help to reduce R_e and allow people to return to a more normal way of life.

The Director of Public Health (DPH) in Manchester has a statutory lead role for the health protection of the population. The DPH is supported by a Consultant in Public Health lead for health protection and a local Community Infection Control Team (CICT) providing specialist infection prevention and control advice and support. Additional specialist health protection advice is provided by the North West PHE team. In order to respond to the COVID-19 pandemic, capacity to deliver our local health protection function has had to increase significantly.

Manchester COVID-19

Local Prevention and Response Plan

Purpose of the Plan

The purpose of the Manchester COVID-19 Local Prevention and Response Plan is to act as the high-level programme plan for the Manchester COVID-19 Response Group. This document will give assurance that appropriate systems are in place for outbreak management and prevention. Initial plans for the allocation of Manchester's additional COVID-19 response Test and Trace funding are also included.

The detail of how individual outbreaks in specific settings and circumstances are managed will not be described in detail in this document. This plan is not intended to give operational level detail for professionals or advice to the public. This is an iterative plan which will continue to be informed by local circumstances, emerging evidence and ongoing engagement with our communities.

The Manchester COVID-19 Local Prevention and Response Plan has been developed to respond to the specific threat caused by the SARS-CoV-2 virus and should be considered alongside these existing plans:

- Manchester Health Protection Outbreak Plan
- Greater Manchester Multi-agency Outbreak Plan
- Greater Manchester Multi-agency Generic Response Plan
- Greater Manchester COVID-19 Outbreak Management Plan

Guiding Principles

The Association of Directors of Public Health (ADPH) sets out four principles for the design and operation of Local Outbreak Plans.

The prevention and management of the transmission of COVID-19 should:

1. Be rooted in public health systems and leadership
2. Adopt a whole system approach
3. Be delivered through an efficient and locally effective and responsive system including being informed by timely access to data and intelligence
4. Be sufficiently resourced

Outbreak Management

An outbreak is defined as two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days. An outbreak will be declared over when there are no confirmed cases with onset dates in the last 28 days in that setting.

The Manchester Test and Trace Coordination Hub with a single point of contact (SPOC) will respond to outbreaks in specific settings, in conjunction with external partners such as PHE where appropriate. Outbreaks will be risk assessed on an ongoing basis and decisions to manage the outbreaks will be taken at a local level in partnership with the setting affected.

High risk outbreaks, such as those with the potential to cause larger scale impacts, involving high numbers of cases or across a wider range of settings will be escalated to Manchester City Council's (MCC) Strategic Management Team (SMT) as Gold Command. This Gold Command structure will closely monitor all data sources so that any decisions taken are based on the best available evidence of what is happening in a setting, neighbourhood, or wider area.

The Local Outbreak Engagement Board will play a key role in ensuring communities are fully informed about what is happening in relation to high risk outbreaks and provide clear information about actions that can be taken. The respective roles and responsibilities of the various groups and boards are set out under Theme 7 – Local Boards.

Compliance and Enforcement

There may be situations where potentially infectious people cannot or will not agree voluntarily to be tested or self-isolate. The Manchester approach will be to try and persuade the potentially infected person to agree to a test or to self-isolate by the 4 E's - Engage, Explain, Encourage, and last resort Enforce.

- Attempt negotiation directly,
- Advise of consequences (power to direct to attend, offence if they fail to attend, remove with reasonable force)
- Ask for assistance (Trusted person contact, case worker, family member or friend, religious leader, Environmental Health officer, local councillor, police officer to provide assistance)

Where it has not been possible to secure compliance by means of engagement, explanation and encouragement, Schedule 21 of the Coronavirus Act 2020 provides for the detention, isolation and the screening of potentially infectious persons also allowing for the imposition of restrictions and requirements to such persons if they refuse to self-isolate.

Currently there are two designated Public Health Officers (PHOs) in the North West who can impose requirements and restrictions under Schedule 21. Further PHE consultants will be designated. Access to a PHO is via PHE North West.

Manchester COVID-19

Local Prevention and Response Plan

Introduction

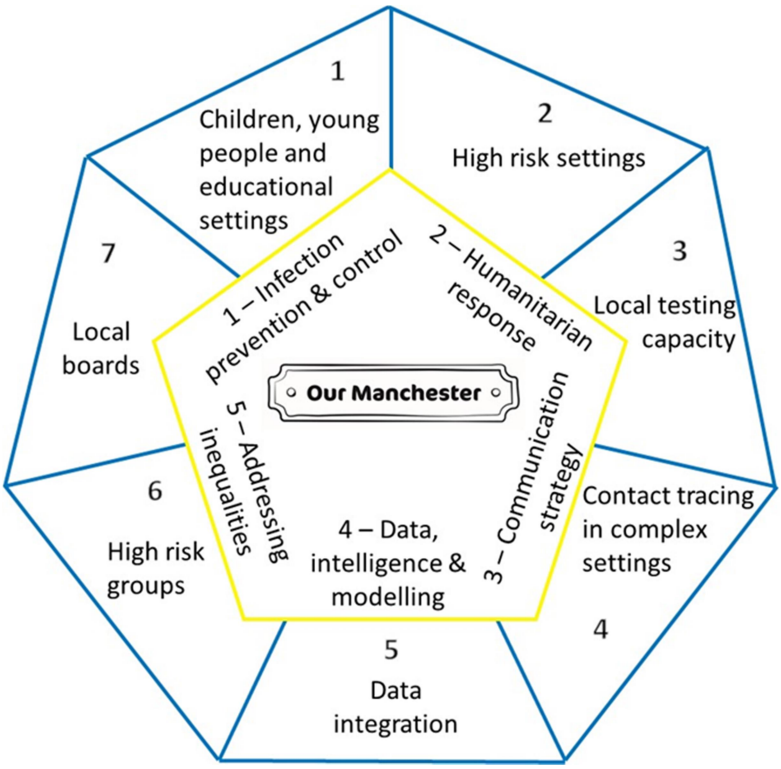
The plan commences with a COVID-19 inequality assessment to give the context for the impact of the outbreak in Manchester. The plan is described in 7 themes and 5 cross-cutting workstreams, covering what is currently in place, what is working well and our next steps. The final section summarises the resource implications and includes costs for planned work.

Themes:

1. Children, young people and educational settings
2. High risk settings
3. Local testing capacity
4. Contact tracing in complex settings
5. Data integration
6. High risk groups in the community
7. Local Boards

Workstreams:

1. Infection prevention and control
2. Humanitarian response
3. Communication strategy
4. Data, Intelligence and Modelling
5. Addressing inequalities



Manchester COVID-19

Local Prevention and Response Plan

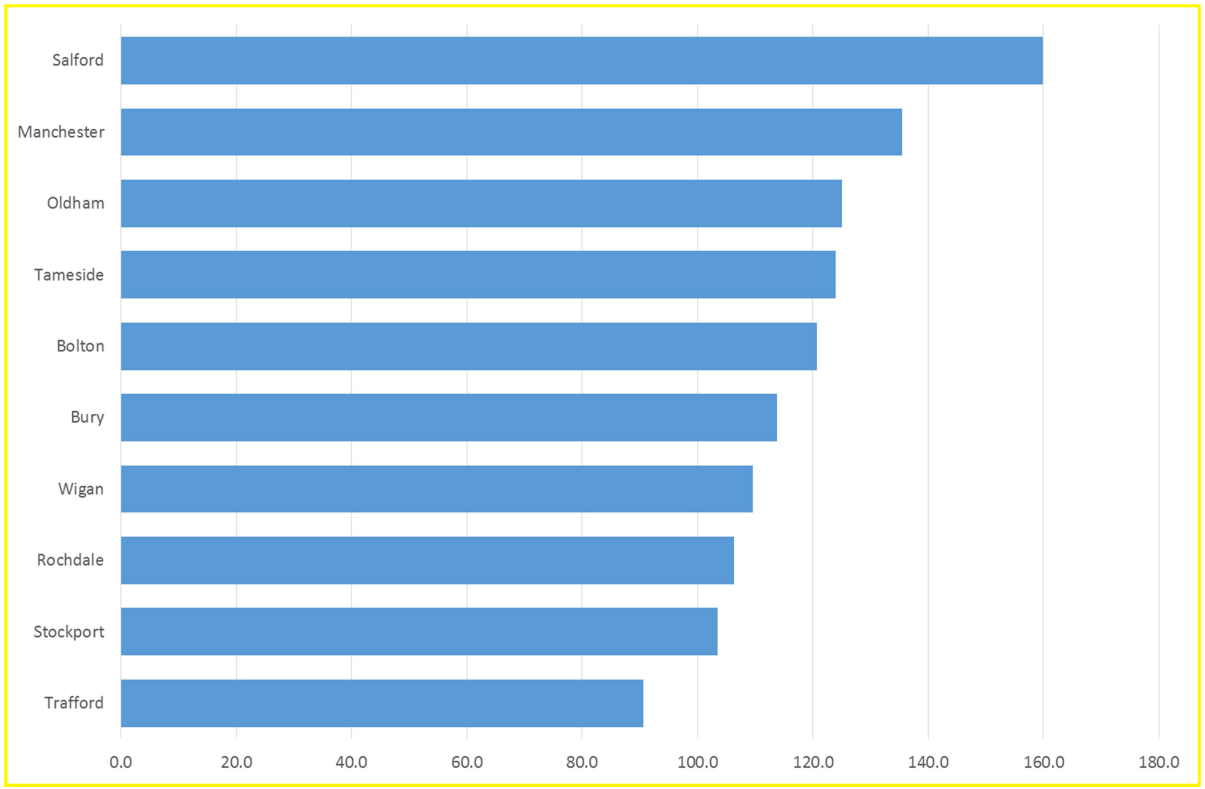
The impact of COVID-19 on the population of Manchester

The impact of COVID-19 in Manchester has been significant. To date (25 June 2020), there have been:

- 1,720 positive cases of COVID-19 identified based on tests carried out in NHS and PHE laboratories[1] (a rate of 314.1 per 100,000 population)
- 383 deaths involving COVID-19 in Manchester residents. This represents just over a fifth 20.9%) of all deaths registered since the beginning of 2020.

In absolute terms, there have been more positive cases identified in Manchester than in any other part of Greater Manchester. However, the rate of positive cases in Manchester is low compared with other parts of the conurbation. The age standardised mortality rate for deaths involving COVID-19 among Manchester residents (based on deaths between March and May 2020) is among the highest in Greater Manchester.

Figure 1 - Age-standardised rates of deaths involving COVID-19 by Local Authority



[1] At the time of writing only data sets relating to Manchester residents tested through the NHS and PHE laboratories (Pillar 1) were publicly available. However, data sets relating to residents tested through regional drive through testing facilities and mobile testing units (Pillar 2) will shortly be in the public domain. This section of the plan will therefore be updated on the website to give a much more comprehensive picture of the Manchester COVID-19 situation.

Inequalities in COVID-19 impact

There are a number of population groups or communities that are known to have experienced a disproportionate impact from COVID-19. These include:

- Men and older people
- People experiencing homelessness
- Black, Asian and minority ethnic groups
- Certain religious groups
- Refugees and asylum seekers
- Certain occupational groups
- People living in deprived areas
- Care home residents
- People with long term illnesses and disabilities

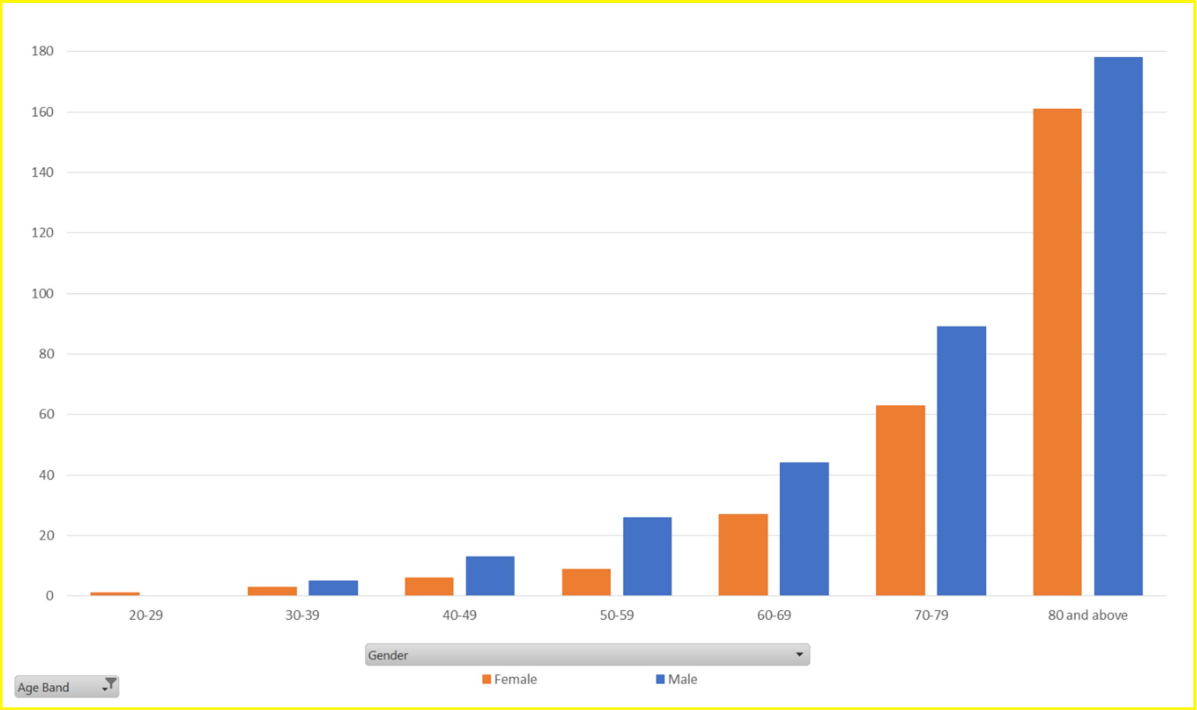
Age and sex

Age and sex are known factors associated with increased risk of death involving COVID-19. The age-standardised mortality rate deaths involving COVID-19 in Manchester in the 3-month period March to May 2020 was significantly higher in males (185.6 deaths per 100,000) than in females (98.8 deaths per 100,000). It is not yet fully clear why there are gender disparities in COVID-19 outcomes. This could be a combination of biological, behavioural and environmental factors.

Nationally, diagnosis rates for COVID-19 increased with age for both males and females. Among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those aged under 40. The chart below shows the number of deaths involving COVID-19 registered in Manchester by age and sex. Overall, 54.2% of all deaths involving COVID-19 were in people aged over 80 and 78.5% were in people over the age 70.

Coronavirus has also had significant social impacts on older people. Data from the Opinions and Lifestyle Survey on the social impact of the COVID-19 pandemic shows that the well-being of older people has been affected by the coronavirus. 70% of older people in Great Britain reported being worried about the future and 54% admitted to feeling stressed or anxious.

Figure 2 - Number of Deaths involving COVID-19 registered in Manchester by age and sex (based on deaths registered up to and including 17 June)



Manchester has a higher proportion of working age people (adults aged 16-64 years) in the city compared with England as a whole and a lower proportion of older people. According to the ONS population estimates for mid-2019, 9.3% of Manchester's population are aged 65+, compared to 18.4% of the population in England.

With the low population of people aged 65 and over it would seem logical to assume health and social care needs are lower than expected for a large city. However, evidence shows that the reverse is true. Many older people living in Manchester are at risk of social isolation and loneliness and the characteristics of Manchester's older residents mean that they are more likely to place high demands on hospital emergency services, mental health services and suffer from long term limiting illnesses at an earlier stage in their life.

People experiencing homelessness

A rapid review of the disparities in the risk and outcomes of COVID-19 undertaken by Public Health England (PHE) found that socially excluded populations, such as people experiencing homelessness, tend to have the poorest health outcomes. Figures presented within the review suggest that between 1.5% and 2.0% of the known population of men and women who experienced rough sleeping in 2019 have had COVID-19. However, there is some uncertainty around these figures and they should be considered an estimate.

The latest publicly available official estimate of people sleeping rough in Manchester indicated 85 people were sleeping rough as of September 2019. However, this is

based on a headcount on one night and may be an underestimate of the true number.

Rough sleeping is only one form of homelessness. People experiencing homelessness may be living in a range of different types of temporary accommodation settings, including in-house temporary accommodation, homeless bed and breakfasts, and Housing Related Support commissioned schemes.

The most recent estimates suggest that approximately 1,074 individuals are residing in hostel-based accommodation settings, with 273 staff at these sites who could potentially be exposed to COVID- 19 in the event of an outbreak.

Black Asian and Minority Ethnic Groups

Ethnic inequalities in health are well known, generally showing a poorer health profile among some ethnic minority groups compared with the overall population.

The disproportionate impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) communities is now well documented. ONS analysis shows that the risk of death involving COVID-19 among some ethnic groups is significantly higher than that of those of White ethnicity. For all ages, the rate of deaths involving COVID-19 for Black men was 3.3 times greater than that for White men of the same age, while the rate for Black women was 2.4 times greater than for White women.

Socio-economic factors explain a substantial part of the raised rate of death experienced by ethnic groups compared with the White ethnic group. After adjusting for region, population density, socio-demographic and household characteristics, the raised risk of death involving COVID-19 for people of Black ethnic background of all ages together was 2.0 times greater for males and 1.4 times greater for females compared with those of White ethnic background. Men from Bangladeshi or Pakistani and Indian ethnic background also had a significantly higher risk of death involving COVID-19 (1.5 and 1.6 times, respectively) than White men, once these characteristics were accounted for. Women from Bangladeshi or Pakistani, Indian, Chinese and Mixed ethnic groups had a similar risk of death involving COVID-19 to White women.

Data from the 2011 Census shows that around 205,000 people in Manchester identified themselves as being from a non-White British ethnic group (including Irish and ‘Other White’ groups). This is equivalent to around 41% of the population of the city as a whole – twice the average for English local authorities as a whole (20%). This data is now 9 years old and we can expect data from next year’s census population (in 2021) to more accurately show a higher BAME population in Manchester compared with the last census.

The reasons why the risk of death involving COVID-19 among some ethnic groups is significantly higher than that of those of White ethnicity are still being explored. However, some of the additional risk is likely to be linked to the fact that people from BAME communities are more likely to live in urban areas, in overcrowded

households and in deprived areas. BAME people are also more likely to have jobs that expose them to higher risk and to have been born abroad, meaning they may face barriers in accessing services. Some comorbidities known to increase the risk of having a poorer outcome from COVID-19 (e.g. Type II diabetes) are also more prevalent in BAME communities.

Religious groups

Provisional analysis by the ONS for the period 2 March to 15 May 2020 has shown variation in the rate of death involving the coronavirus (COVID-19) between self-identified religious groups, as reported in the 2011 Census, including "No religion". The highest age-standardised mortality rates (ASMRs) of deaths involving COVID-19 were in the Muslim religious group with 198.9 deaths per 100,000 males and 98.2 deaths per 100,000 females. People who identified as Jewish, Hindu or Sikh also showed higher mortality rates than other groups.

However, once region, population density, socio-demographic and household characteristics and ethnic background are taken into account, men who identified as Jewish at the time of the 2011 Census were at twice the risk of a death involving COVID-19 compared with the Christian men. The risk of death in Jewish women was 1.2 times higher than that of Christian women.

Data from the 2011 Census showed that 15.8% of the population of Manchester identified as Muslim, 0.5% identified as Jewish, 1.1% as Hindu and 0.5% as Sikh. Given that the census was now nine years ago, the percentage of residents identifying as belonging to these religious groups may now be different.

The age distribution of the populations belonging to these religious groups also differed, with 24.6% of those identifying as Jewish being aged 65+ compared to 4.6% of those identifying as Hindu, 3.1% of those identifying as Muslim, and 2.1% of those identifying as Sikh. The overall percentage aged 65+ was 9.4%.

Asylum Seekers and Persons with No Recourse to Public Funds

Some groups of migrants, such as asylum seekers, persons with no recourse to public funds (NRPF), EEA nationals who are ineligible for benefits, unskilled workers or undocumented migrants, may be economically disadvantaged, live in over-crowded conditions, and live and meet socially with other at-risk groups, putting them at increased risk of infection whilst living in the UK. These individuals may be at increased risk from COVID-19 due to language and communication barriers which may impact on their understanding of the virus, measures to mitigate spread, and ways to access support.

Data on people's reasons for migration and their legal status in different local areas are not widely available at the local level but there are some figures for asylum seekers and resettled refugees. Section 95 support is provided to destitute asylum seekers until their claim is determined. Data from the Migration Observatory shows there were 968 asylum seekers in receipt of Section 95 support as of 30 June 2019 (a rate of 1.80 per 1,000 population). Note that these figures do not include people

who are not receiving this destitution allowance (such as people with private incomes) or those whose asylum claims have been determined (with either a positive or negative decision).

The Boaz Trust estimates the numbers of asylum seekers residing in the city to be 6000, with 2000 destitute. The Home Office has recently opened a short-term induction hotel for asylum seekers in Manchester, which has the facility to accommodate 255 individuals.

Those seeking asylum in the UK would normally have entitlement to asylum support (accommodation and subsistence) from the Home Office. However, the system in place to access this support often proves difficult and challenging. Other migrant groups such as those that have overstayed their visa, or on student visa, those who have leave to remain with no recourse to public funds condition, EEA nationals who are ineligible for benefits and mainstream services, can only turn to the local authority for support. The NRPF Network reported that as of mid-May 2020, local authorities have reported that they have accommodated 14,610 people though it is not reported how many of these people are subject to the no recourse to public funds condition or are EEA nationals who are ineligible for benefits.

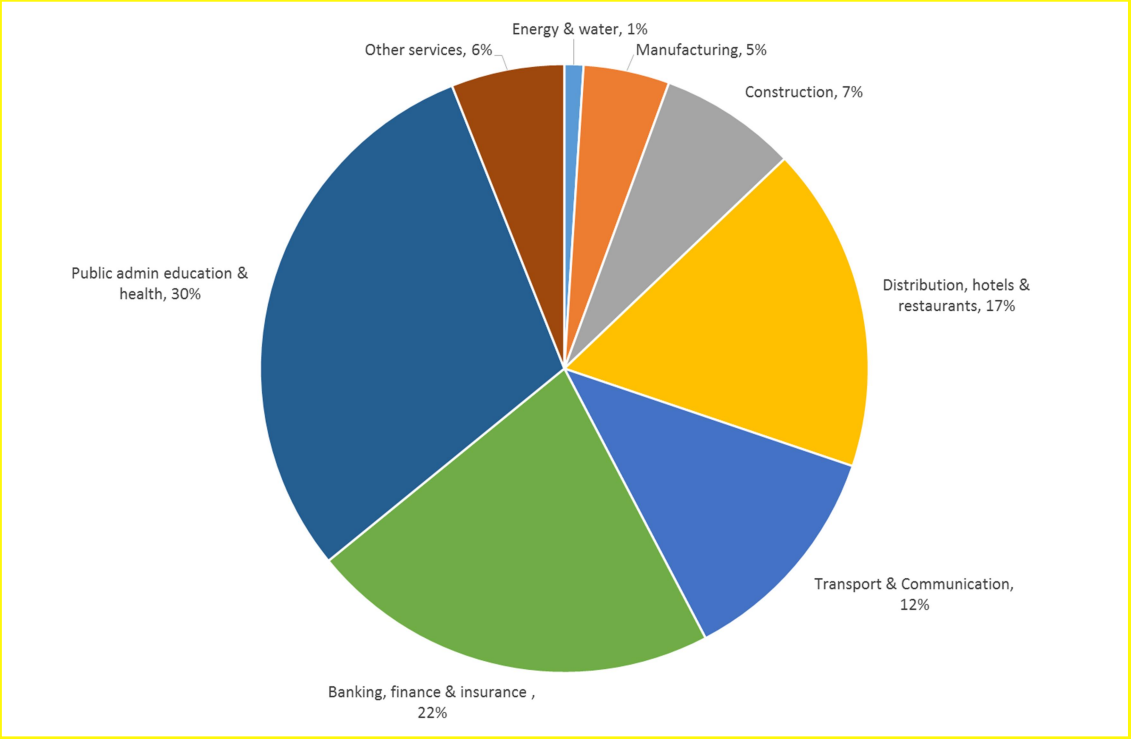
Occupational group

Men working as security guards, taxi drivers and chauffeurs, bus and coach drivers, chefs, sales and retail assistants, lower skilled workers in construction and processing plants, and men and women working in social care had significantly high rates of death from COVID-19.

Manchester has significant numbers of people employed in these occupations. As the chart below shows, just over two-fifths (41%) of people in employment in Manchester work in the manufacturing, construction, distribution, hotels and restaurants, transport and communication sectors of the economy.

There is a strong overlap between the higher risk of death involving COVID-19 in BAME groups and the increased risk among certain occupations. For example, British Bangladeshi and Pakistani residents are much more likely to be employed as drivers while Black African residents are known to be more strongly represented in health and social care professions.

Figure 3 - People in employment by industrial sector, Manchester (ONS Annual Population Survey, July 2018 - June 2019)

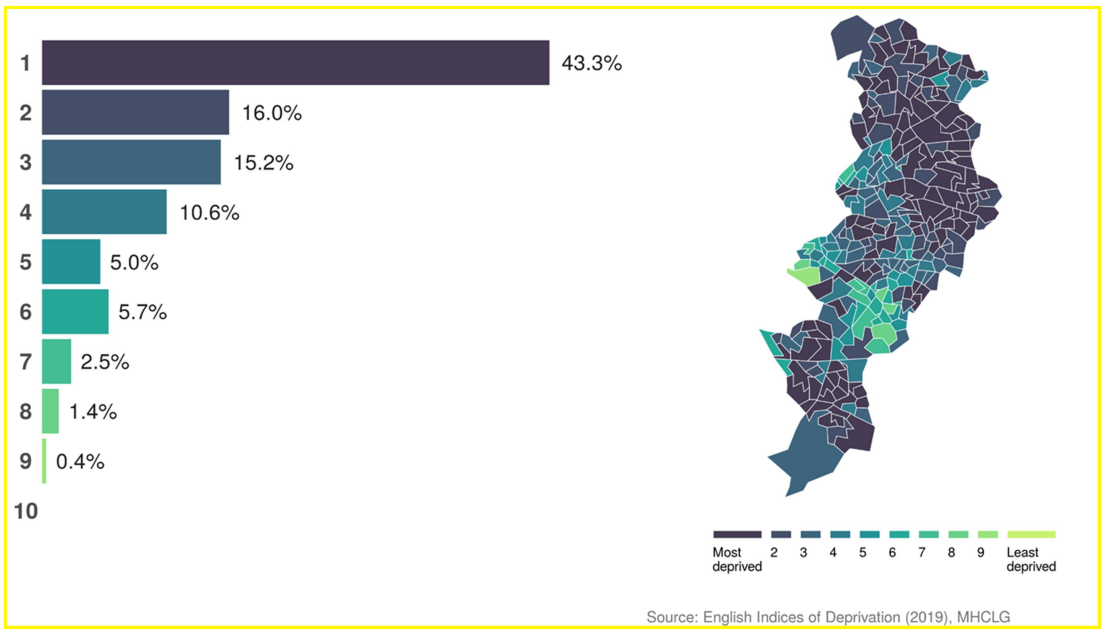


Deprivation

People who live in deprived areas of the country have higher diagnosis and death rates than those living in less deprived parts of England. The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females, and survival among confirmed cases was also lower in the most deprived areas. This is particularly clear amongst people of working age, for whom the risk of death was almost double that of people in the least deprived areas, with male diagnosis rates significantly higher than those for females.

The latest Indices of Deprivation (IMD) 2019 show that Manchester ranks 6 out of 317 local authorities on the overall IMD 2019 when ranked according to the average score of each Lower Layer Super Output Area (LSOA) within its boundary. Within the city, over 43% of LSOAs rank in the most deprived 10% (decile) of LSOAs in England and just over 59% are in the most deprived 20% (quintile). These LSOAs are primarily concentrated in areas in the north and east of the city and in Wythenshawe.

Figure 4 - IMD 2019: Manchester LSOAs in each national deprivation decile



The high and persistent levels of deprivation across Manchester as a whole and in specific parts of the city mean that the our local residents are likely to be at greater risk of being diagnosed with COVID-19 and, when they are, they are more likely to experience a poorer outcome in respect to hospitalisation and death.

Care Home Residents

Care home residents are more susceptible to COVID-19 by virtue of their age and attendant comorbidities. Care homes are also an environment where there is the potential for COVID-19 to be transmitted quickly among their residents.

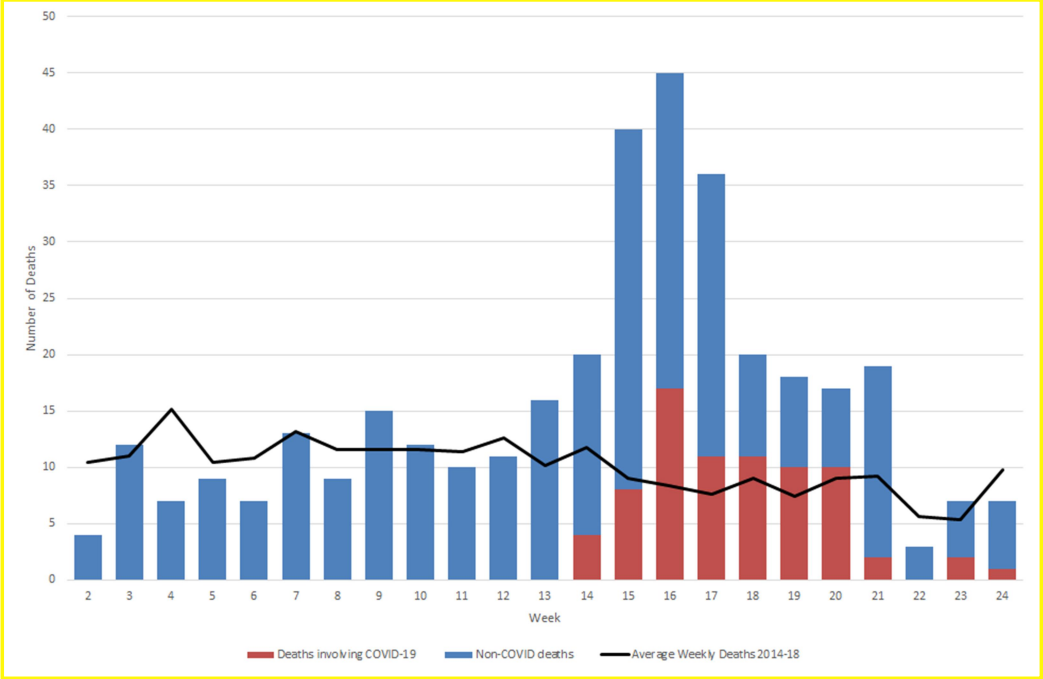
In the period up to and including the week ending 12th May 2020, there have been a total of 370 deaths occurring in care homes in Manchester - 20.2% of all deaths occurring in the city. This figure excludes deaths among care home residents where the person died in hospital or some other setting. Just over a fifth (20.5%) of these deaths involved COVID-19. In this context, a death involving COVID-19 is one where COVID-19 was mentioned anywhere on the death certificate.

The chart below shows the weekly number of COVID-19 and non-COVID-19 related deaths occurring in Care Homes in Manchester in 2020, alongside the average weekly number of deaths in the 5-year period 2024-2018. This provides a means of counting the additional ('excess') number of deaths in care homes over the course of the year.

Manchester COVID-19

Local Prevention and Response Plan

Figure 5 - Total number of COVID and non-COVID related deaths occurring in care homes in Manchester by week, 2020



In the year to date, there have been 130 excess deaths in care homes in Manchester compared with the 5-year average for 2014-2018. The number of excess deaths in care homes peaked between Weeks 15 to 17 (4th April to 24th April). Over that period, there were 121 deaths in care homes - 96 more than the historic average for that period. At this point in time, the number of deaths occurring in care homes in Manchester was 3.8 times (384%) higher than the 'norm' for that point in the year.

People with long term illnesses and disabilities

Males whose activities were "limited a lot" at the 2011 Census had an all ages standardised rate of death involving COVID-19 of 199.7 deaths per 100,000; for females, the rate was 141.1 deaths per 100,000. The equivalent rates for males and females who were not disabled in 2011 were 70.2 and 35.6 deaths per 100,000 respectively. After adjusting for region, population density, socio-demographic and household characteristics, the relative difference in mortality rates between those "limited a lot" and those not disabled was 2.4 times higher for females and 1.9 times higher for males.

Further Sources of Information

Appendix 2 of the Manchester Population Health Plan contains a detailed list of sources of information about the health of the local population, including Public Health England (PHE) profiling tools and the Manchester City Council Intelligence Hub. The Manchester Joint Strategic Needs Assessment (JSNA) also contains a detailed set of reports that contribute to our understanding of the health and wellbeing needs of people in Manchester.

THEMES


1
Children, young people and educational settings
2
High risk settings
3
Local testing capacity
4
Contact tracing in complex settings
5
Data integration
6
High risk groups
7
Local boards
Our Manchester

Manchester COVID-19

Local Prevention and Response Plan

Theme 1 – Children, Young People and Educational Settings

Manchester has a relatively young population, with over 130,000 children and young people aged up to 18 years. Manchester has 2 universities and a large student population, including many international students. There are 184 schools, 4 further education and 6th form colleges, 131 early years settings and 403 registered childminders.

Where are we now?

COVID-19 risk assessments have been completed in schools, early years settings and childminders. Settings have been supported by the Health and Safety (H&S) team with quality assurance and additional advice. Regular updates have been issued to ensure current guidance and best practice is shared.

Schools

Regular group sessions have been held with school Headteachers and advice (developed jointly by the Community Infection Control Team (CICT), Education and Health and Safety) has been provided to schools, providing a step-by-step process for responding to outbreaks. A weekly communication bulletin, including frequently asked questions (FAQs), is updated by Education HR following questions from schools and trade unions. Briefings have been provided to chairs of governors and Headteachers. Weekly meetings are being held with trade unions. There is on call support to Headteachers for COVID-19 related issues. Schools have been provided with a template and guidance for undertaking individual assessments for BAME / vulnerable school staff.

Advice and support provided to schools on management of COVID-19 cases is provided by the CICT. Guidance on how to access emotional and mental health support for children and staff has been shared with schools. Resources for children are shared regularly. Approximately 2500 laptops have been ordered and distributed for disadvantaged children and young people through the Department for Education scheme. Letters have been sent to all year 11 students from the Council. A document to support children with Special Educational Needs and Disability (SEND) has been sent to schools for sharing with families.

PPE

Guidance has been provided to education settings on use of personal protective equipment (PPE) and PPE welfare packs have been issued to all settings and childminders. There is a weekly push of PPE to special schools.

Children and young people with special educational needs/disability

All children with Education, Health and Care plans (EHCP) have been risk assessed to determine if it is safer for them to be in school or at home. Multi agency discussions have taken place with families to agree 'reasonable

endeavours' to meet provision set out in plans. Letters have been sent to all families of children with EHCPs (4900) with key information and sensory bags provided for families of children who are at home. A local newsletter is in place and an offer of virtual drop-ins for parents/carers. We have an educational psychology helpline set up for families and a multi-disciplinary health pathway for special schools.

General

- H&S guidance, risk assessments and support provided to council services.
- Regular updates to council staff reinforcing importance of handwashing and social distancing
- Weekly PPE issued to Children Services Settings
- Coordinated approach to ensuring children's premises are COVID-19 secure
- Provision of emergency PPE across out of hospital settings from MCC/Trafford Metropolitan Borough Council (TMBC) PPE Hub
- Recovery planning group meeting weekly.

What is working well?

Engaging and supporting schools:

- Headteachers have reported appreciating the support and communication provided by the Education Department.
- There are regular updates, templates and guides and follow up support, which have been used by the majority of schools and settings.
- The Education Department is regularly updating guidance and issuing new information that makes it clear which changes have taken place.
- Engaging the Trade Unions so that schools have the confidence that the approach has been consulted at a strategic level.
- Starter packs of PPE have been provided to schools, nurseries and childminders and there are regular deliveries of PPE and sanitiser to special schools.
- The Education Department regularly reviews changes to PHE / DoE guidance. There is close coordination between Education, CICT and H&S to ensure a collaborative approach to supporting schools and other settings.
- There has been a positive response from many parents of children with SEND regarding the support provided. The provision of sensory bags for some children at home were especially well received.
- Children Services have been provided with detailed risk assessments and guidance on working safely, which includes how and where to use PPE (donning and doffing). Adequate supplies of PPE and hand sanitiser have been provided across the services.

What are our next steps?

A key part of our forward planning is preparation for the wider opening of educational settings from September 2020. We will provide support and advice to schools on a risk-based approach. We will support schools and settings to provide additional handwashing facilities and hygiene measures where required.

We will work with the Youth Strategy team, health services and other providers to plan for a summer offer to target both children who have not been in school and key worker children. We will support planning for September opening of schools based on two scenarios: all children in or a blended 50:50 offer.

We will develop minimum standards for a remote learning offer for all schools and sharing learning from schools/Trusts who already have a well-established offer. We will provide an alternative place for children to access remote learning if school/class needs to close and access to learning at home is not possible or suitable.

We will provide clear messaging for parents/carers to support school attendance in September, engage community leaders in supporting this message and develop clear messaging for all front line services to support school attendance (if it is not compulsory in September).

We will develop assumptive plans regarding opening of facilities that schools may use, for example swimming, sports halls, leisure facilities, school trips and provide advice to schools to update business continuity plans so they are fully prepared to close classes/school in response to an outbreak.

We will provide advice, support and services to schools and settings for those children who need additional help due to anxiety, mental health, bereavement, and trauma. We will work with Transport for Greater Manchester regarding use of public transport for pupils and will work with MCC's Travel Coordination Team and special schools to consider options and solutions for home to school travel for eligible children with Special Educational Needs. We will work with Neighbourhoods regarding logistics for drop off and pick up times to prevent crowding outside schools.

We are developing an education offer with schools for children who need to remain at home due to shielding or living with an adult who is high risk and are developing with Manchester Schools Alliance/Teaching Schools and Multi Academy Trusts an evidence base of interventions/approaches available to support children to 'catch up' on learning.

We will ensure that regular meetings of the School Outbreak Prevention Group (including CICT, Education, HROD, H&S) take place and update

signage and hygiene provision in Council premises following changes to COVID-19 secure standards.

We will conduct an ongoing review of guidance to ensure appropriate provision of advice and development of resources in response to new guidance.

We will learn from responses to positive COVID-19 tests in schools to ensure testing and tracing systems are working effectively and updating step-by-step guidance.

We will amend template individual risk assessment for BAME / Vulnerable staff (both for MCC and schools) following PHE advice on risk factors and update COVID-19 secure risk assessment approach following changes around social distancing criteria.

Theme 2 – High Risk Settings

This section covers care homes, homeless hostels, hospitals and primary care as key high-risk settings. Another important local setting is Manchester Airport, which Manchester City Council has responsibility for. Other high-risk settings such as asylum seeker accommodation, prisons, bail hostels, supported living and children's homes will be managed appropriately with input from the Test and Trace Coordination Hub, CICT, Environmental Health, PHE, NHSE, prison healthcare teams and other partner agencies.

Care Homes

Where are we now?

There are 92 care homes in Manchester, of which 47.8% have had outbreaks of two or more cases. There have been 76 deaths involving COVID-19 (e.g. mentioned anywhere on the death certificate) in care home residents as of 12th June 2020. Due to the high level of vulnerability of care home residents, and the potential for spread in these institutional settings, care homes have been a focus for outbreak prevention and management work.

Manchester began a 'whole home testing' pilot on 5th May 2020, prior to this becoming available via DHSC pillar 2 testing. As of 16th June 2020, 60 out of 92 care homes in the city (65%) have had applications to the DHSC for whole care home testing processed and approved. Prior to 7th of June, only care homes that were exclusively for people aged over 65 or those with dementia could apply for whole home testing. After applying these criteria, 84% of care homes eligible for whole home testing had applied as at the 3rd June 2020. Since the 7th of June all adult care homes with a CQC registration number are eligible for whole home testing.

Each care home receives a daily phone call from the MCC Performance and Quality Improvement (PQI) team. Care homes are asked for details on:

- Symptomatic residents and staff
- Newly confirmed COVID-19 cases
- PPE requirements
- Ability to manage service delivery
- Vacancies
- Financial viability
- COVID-19 testing processes and results

The data collected from the PQI team supports the CICT data collection. A daily care home update is circulated by the CICT to key stakeholders. Sector specific guidance is shared with care homes via specific COVID-19 emails.

CICT liaise with care homes that have reported cases/outbreaks either directly to them, via the PQI daily calls or from cases notified from PHE or the Test

and Trace Coordination Hub. A risk assessment is undertaken for each setting and infection prevention and control (IPC) advice given. CICT works closely with the Test and Trace Coordination Hub to ensure that guidance on results/interpretation of results is clear and can be communicated to care homes to ensure residents and staff are being cared for and that staff are working safely. Care homes are supported by CICT in contact tracing within their settings following a confirmed case. A care home outbreak will be declared over when there are no confirmed cases with onset dates in the last 28 days in that setting.

Care homes have received IPC advice and training on COVID-19 outbreak management, including the safe use of PPE. An IPC Train the Trainer programme was developed and rolled out to homes by the CCG with CICT input.

What is working well?

Daily contact with care home providers has enabled Manchester to have an early indication of issues for providers and respond accordingly. This contact has been positively received by care home providers.

There are excellent working relationships between CICT and care homes, which has been key in the support and management of cases/outbreaks. Care homes know to contact the team routinely to report any outbreaks; this has meant that cases have been reported early and the team has been enabled to give key IPC management and advice and arrange swabbing.

77% of care homes have said they are confident to swab their own residents and where this is not the case support has been put in place. This has enabled many care homes to carry out whole home testing without the support of the Community Swabbing Team. We have a 28-day rolling programme planned for whole care home testing.

CICT have sent a support questionnaire to providers to ensure that all homes (including those that had not reported cases/outbreaks) have had some contact. The questionnaire asks for key IPC and COVID-19 outbreak preparation information and helps to ensure that providers have procedures and equipment in place to enable them to respond to any future COVID-19 cases/outbreaks.

What are our next steps?

We plan to increase the frequency of whole care home testing to ensure new infections, particularly those where residents are asymptomatic, are identified early. We are exploring the use of salivary testing for SARS-CoV-2 which is less invasive than swabbing and has similar sensitivity and specificity. Our

ambition is to establish daily testing for all care home staff and residents so that testing becomes part of 'business as usual' in these settings.

An ongoing programme of training for care home staff will be developed that takes into account changing guidelines and staff turnover.

CICT and the PQI team will be provided with additional resources to maintain the proactive daily contact and follow-up of COVID-19 cases in these settings.

When a vaccine becomes available, care homes will be a priority setting for delivery and we will mobile a mass vaccination campaign.

We recognise the need to research on COVID-19 in care home settings and will actively engage in research projects in this area.

Homeless hostels

Where are we now?

Manchester has a large number of people experiencing homelessness, almost half of which fall into the COVID-19 'vulnerable' category largely due to the high prevalence of chronic conditions such as lung disease, diabetes, and cardiovascular disease. This can make them more susceptible to contracting and transmitting COVID-19.

In response to the Government's 'Everyone In' policy, emergency accommodation has been provided in hotels and re-purposed hostels for rough sleepers, newly homeless people and those in shared 'A Bed Every Night' (ABEN) facilities. Facilities have been provided for self-isolation following sanitation guidance. However, there are now a cohort of people who have left or been evicted from hotels and are rough sleeping again. The numbers across homeless hostels for single people as of 22nd June are:

Bed and Breakfast - 236 singles
In-house temporary accommodation - 338 singles
Housing-related support - 479 residents
A Bed Every Night (ABEN) - 165 singles
COVID-19 hotel accommodation - 188 singles

Some EU nationals and people with no recourse to public funds are residing in the COVID-19 and ABEN provision.

Monitoring
The Manchester City Council (MCC) Homelessness Team collates information from managers of MCC-commissioned locations and hotels on a weekly basis. Two GMCA officers conduct a daily ring-round of the hotels and pass this information to the MCC Homelessness Team. Data is collected regarding

numbers of individuals who are symptomatic, numbers who are self-isolating, numbers of tests conducted, and positive tests results reported.

Testing & IPC advice

As of the 23rd June, there has been 1 reported death involving COVID-19 in the Manchester homeless population. There have been 114 suspected cases, and 4 confirmed cases, all of whom were tested in hospital. There is no evidence that community testing is being accessed by this population or that IPC advice is routinely being sought from CICT by services in locations with suspected/confirmed cases. It is thought that very few staff working in these settings have been referred for testing and it is not known how many staff have sought testing for themselves via the national testing programme as this data has not been made available to localities. Reminders have been sent to all accommodation schemes about social distancing, infection control, and appropriate use of PPE.

Pathway

NHS England recommends having three types of facilities for the homeless population: COVID Protect, COVID Prevent and COVID Care. There is currently no COVID Care facility in Manchester. Suspected and confirmed cases are asked to self-isolate 'in place'. There is anecdotal evidence that social distancing is not being adhered to in some locations. A dedicated COVID-19 Care facility would allow cohorting of symptomatic individuals and reduce the risk of transmission.

Contact tracing

A joint meeting was held with Public Health and homeless accommodation providers to share information about contract tracing and to start to identify key issues that need to be reflected in a shared process for working in these settings.

What is working well?

To date there have been no reported deaths related to COVID-19 in the Manchester homeless population living in hostel accommodation. Emergency accommodation has been provided for over 1400 people. Staff within hostels and hotel accommodation keep track of people entering and leaving the building, so they can be contacted if necessary. All schemes have good access to PPE.

Homeless accommodation schemes have business continuity plans in place that set out how they are managing COVID-19 and to date there have been very few positive cases in these settings.

Staff are proactively monitoring residents so that any potential infection is identified as early as possible.

What are our next steps?

There is a risk that people from some hostels will gravitate back to the city centre as lockdown eases. Work is needed to identify this group/specific schemes and explore what might be put in place to minimise this - including providing food to people and enforcement options.

A working group has been set up to develop and monitor practice. This group will develop policies and procedures to support contact tracing.

An audit of individual schemes will take place so that we can identify high risk settings, offer tailored advice on infection control and better manage any outbreaks.

A more robust pathway for testing and IPC advice to respond to suspected/confirmed cases in homelessness settings is required. This includes the need for enhanced CICT input into homeless locations, including IPC advice and training, for example upskilling of staff to enable them to be confident in self-swabbing.

We will consider establishing a COVID-19 Care facility to support the hospital discharge of confirmed cases who no longer need clinical input. Targeted communications regarding testing for homelessness staff to ensure that they are aware of the various offers may be required.

We will consider 'whole setting' testing in homeless hostels where there has been a confirmed case and develop a clear pathway for the de-escalation of 'hotel' accommodation.

Hospitals

Where are we now?

Manchester is principally served by Manchester Foundation NHS Trust (MFT) and Greater Manchester Mental Health Trust (GMMH), although residents may also attend acute and mental health providers in neighbouring boroughs. At present COVID-19 cases and outbreaks in acute settings are managed by hospital infection prevention control (IPC) teams. There are no mechanisms in place to discuss hospital-acquired COVID-19 cases who are now in the community.

NHS England has started collecting data on hospital onset COVID-19 infections. Transmission has been reported within hospitals affecting both patients and staff. Due to the high vulnerability of many patients and frequent movement of people between hospitals and care homes, hospitals must also

be considered a high-risk setting.

The current inpatient testing programme is:

- all patients at emergency admission, whether or not they have symptoms;
- those with symptoms of COVID-19 after admission;
- for those who test negative upon admission, a further single re-test should be conducted between 5-7 days after admission;
- test all patients on discharge to other care settings, including to care homes or hospices;
- elective patient testing prior to admission.

SARS-CoV-2 antibody testing for NHS staff has commenced as part of the NIHR SIREN study. The primary objective of the study is determining if prior SARS-CoV-2 infection in healthcare workers confers future immunity to reinfection. Trusts have been asked to support at least 10% of their staff in this study.

As outlined in the inequalities section of this plan, there a number of groups at risk of poorer outcomes from COVID-19. Ensuring appropriate access to acute settings for these groups is a key priority. For example, emerging evidence from the UK Obstetric Surveillance System at Oxford University shows that women from a Black, Asian and minority ethnic background make up more than half (56%) of pregnant women admitted to hospital with COVID-19. The research indicates that Asian women are four times more likely than white women to be admitted to hospital with COVID-19 during pregnancy, while Black women are eight times more likely.

What is working well?

The number of deaths in hospitals involving COVID-19 (e.g. recorded anywhere on the death certificate) for Manchester residents has been reducing in recent weeks, from a peak of 58 in the week ending 17th April to 6 in the week ending 12th June.

What are our next steps?

Health Care Acquired Infections

As of 24th June, all NHS trusts have been asked to do root cause analyses (RCAs) for every probable healthcare associated COVID-19 inpatient infection i.e. patients diagnosed more than 7 days after admission. NHSE has asked that all organisations providing NHS services within an integrated care system meet as a minimum on a weekly basis to discuss your local infection status. These discussions should allow for the sharing of information and best practice across organisations to enable local improvements and engage peer support. Further discussions are required to put plans in place for this in the

local region.

Testing
NHS trusts have been asked to test all their staff for SAR-CoV-2 antibodies by mid late-July.

High Risk Groups
NHS trusts have been asked to take specific actions to minimise the additional risk of COVID-19 for Black, Asian and minority ethnic women and their babies, including co-produced operational policies and tailored communications.

Primary care

Where are we now?

During the COVID-19 outbreak there has been an increase in the barriers to accessing care for example, people with learning disability, language and interpretation challenges. Alongside this are safeguarding and domestic violence considerations. MHCC has coordinated a number of primary care priority response work streams: supporting vulnerable patients, 'hot' hubs (for people with COVID-19 symptoms) and 'cold' hubs, care homes, digital, testing, medicines optimisation, palliative care, workforce and estates.

Delivery of primary care services has moved to a nationally-mandated Total Triage model and has been supported by the provision of clear communications, the distribution of 500,000 PPE items and the production of a primary care Situation Report (SitRep) to ensure that MHCC has awareness of any emerging issues in real time. Weekly demand and capacity modelling allow a shift between 'hot' and 'cold' offers to support patient needs. A range of practice assurance activities have taken place, including equipment audits, Business Continuity Plan checks and risk assessments for key staff groups.

A large proportion of primary care activity has moved to a telephone and online consultation model following a move to a 'Triage First' approach within general practice. MHCC has supported digital access and functionality for practices to enable them to continue working effectively in response to the requirement for remote working. Practices have been supported in a procurement exercise led by GMHSP and NHSE to ensure all practices have a video and triage platform. Between the 85 practices in Manchester, 526 laptops, 461 headsets, 461 webcams and 264 smartcard readers have been deployed, 487 remote connections have been provided and telephone support has been provided to 8 practices. All Manchester practices have implemented AccuRx Video consultation and texting.

'Hot Hubs' have been commissioned to provide face-to-face support for patients who are COVID-19 symptomatic. Improvements have been made to

existing estates, including the zoning of practices into 'hot' and 'cold' areas with 'hot' areas providing additional safety precautions for staff and patients to enable them to be supported safely. An example of this is the planned arrangements to establish Perspex screens at GP receptions, and continued roll out of PPE to now include patients who arrive at practice without face coverings.

Other improvements have been made to ensure that key locations can continue to operate. The flagship Homeless Healthcare service at Urban Village was able to operate physical triage services through the use of a mobile unit outside the practice, enabling non-symptomatic patients not suitable for remote consulting to be seen urgently on site. 'Shelter' structures have been introduced in some locations to enable a form of drive-in consulting to be undertaken in a safe manner. A framework has been developed for emergency practice cleaning to ensure that practices can continue to operate effectively and safely. MHCC has worked closely with landlords to establish 'Building User Groups' to help ensure that all stakeholders are able to contribute to key decisions around their building.

With system wide support, including Manchester's palliative care consultants, the primary care team has developed end of life guidance and medicines stock lists to support Manchester to deliver evidence-based treatment for patients. The team has also commissioned an extra 5 community pharmacies to hold specific end of life stock, bringing the total to 12 across the city. The clinical guidance and community pharmacies can be found on TeamNet.

The Medicines Optimisation Team are working closely with the Manchester Community Response Hub and Manchester Local Care Organisation (MLCO) to develop a system that ensures all patients in Manchester get access to their medicines in the time frame required.

What is working well?

Levels of patient engagement have increased as GP practices have moved to digital delivery of Patient Participation Groups in order to support vulnerable patient groups.

There has been greater unified working between primary care colleagues, (Primary Care Networks (PCNs), GP Federations and community and secondary care, providing opportunities for improved communication between the sectors and shared learning going forward. The relationship between MHCC and its member practices has become more supportive and collaborative in nature. The value of the leadership roles of PCN Clinical Directors has been highlighted with regard to collaborative working

Staff COVID-19 Risk Assessments have been made available for use to

support the management of employees who have relevant health conditions and staff that are deemed to be more at risk, such as those who identify as BAME.

Primary Care SitRep requirements continue to expand, including practice capacity status links to the Directory of Services (DOS) and additional assurance requirements – expanding the support required from the primary care team and the input required at practice level. Practice engagement around this remains high, and this model of good practice has been adopted across all GM CCGs.

A Border Contingency Primary Care Service was mobilised at short notice, providing primary care services to a Quarantine Hub at Manchester Airport for COVID-19 symptomatic travellers with no confirmed onward address. A further service was mobilised at short notice for asylum seekers with longer term care needs and limitations due to COVID-19.

Manchester Health and Care Commissioning (MHCC) has worked together with system partners to rapidly develop an urgent care pathway to meet the needs of care homes. The three existing care home services have been expanded to provide system resilience and ensure delivery against the urgent care pathway.

Manchester locum bank has been established through the Federations, and an additional GM locum bank has been established to work closely with practices regarding non-GP roles.

What are our next steps?

We will undertake an assurance exercise to ensure that COVID-19 Risk Assessments are taking place with primary care staff and that any support required is provided.

The testing processes continue to expand both in relation to those able to access testing and the protocols and range of testing available. A Standard Operating Procedure for Antibody Testing was published by MHCC on 12th June, with a target of offering tests to all practice-based staff by 10th July.

We will undertake careful planning and consideration of the impact of the changing secondary care environment upon the safe reopening of practices to mitigate against the risk of unplanned activity shifting into the primary care sector.

We will support practices in the challenging task of managing the backlog of patients not seen routinely during the COVID-19 period for long term condition

management, medication reviews and urgent referrals. In addition, there will be a recovering cohort of COVID-19 positive patients being discharged from ICU that require ongoing enhanced primary care support.

We will support practices in implementing social distancing rules for patients in waiting room areas and for staff in back office/non-clinical areas, including where community services share premises with primary care.

We will work with practices to implement 'medical distancing' in managing chronically unwell patients, including looking at developing greater mobile/visiting offers and use of Perspex screens. We will provide support, advice and guidance to practices in implementing safe working practices, including the use of 'workforce bubbles' or teams to ensure service continuity.

We will continue to support practices around delivering in the digital environment and manage remote working.

We will work towards the integration of hot clinic activity with urgent care, including refinements to NHS 111 pathways, and implement refinement of walk-in centre provision in line with COVID-19 guidance.

We will share learning from practices that have had issues during the crisis, enabling their experiences to inform how practices 'open up safely'. We will ensure that risk assessments are undertaken in all primary care locations in order that risks are managed and mitigated effectively and that buildings are 'COVID-safe' for staff, patients and visitors.

Manchester Airport

Where are we now?

Manchester City Council is the Port Health Authority for Manchester Airport and the lead role for this sits with Environmental Health. Manchester Airport is a major international airport around eight miles south of the city. It is the third busiest airport in Britain after Gatwick and Heathrow, handling tens of millions of passengers each year with direct flights all over the world. It is jointly owned by the 10 Greater Manchester councils - Manchester council has a 55 per cent stake and the other nine authorities own five per cent each. Since 25 March only Terminal 1 has been in operation. Manchester Airport is set to reopen Terminal 3 on 1st July with social distancing measures as more airlines resume some flights.

What is working well?

Manchester City Council has worked collaboratively with partners, including

Public Health England (PHE) and Manchester Airport Group. The 'Port Health Incidents - Manchester Airport Response Plan' (created by PHE) sets out the roles and responsibilities of each agency.

The Manchester Test and Trace Coordination Hub has a fully integrated approach, including the expertise and support of Environmental Health Officer colleagues, to enable an effective coordinated response to any outbreaks at the Airport.

What are our next steps?

The Director of Public Health for Manchester City Council will convene a national network that will share best practice between Councils with Port Health Authority responsibilities. This network will meet for the first time in mid-July.

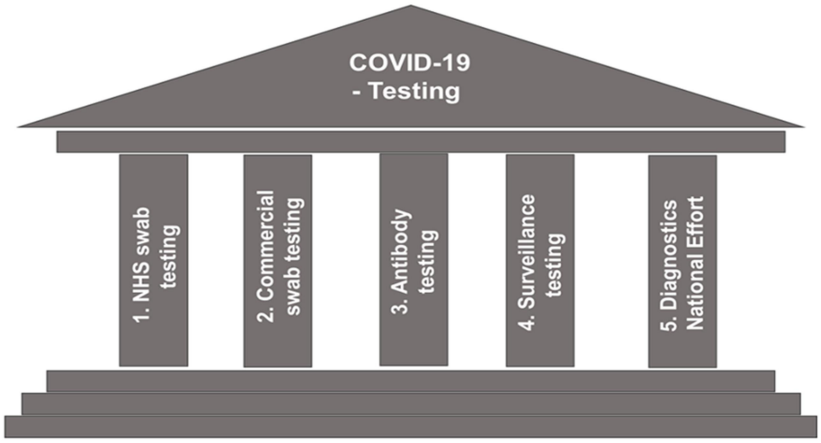
Manchester COVID-19

Local Prevention and Response Plan

Theme 3 – Local testing capacity

mhcc.communitytestinghub@nhs.net

The national approach to COVID-19 testing includes 5 separate Pillars through which testing is delivered. The testing Pillars cover a number of pathways. Broadly, each pathway, irrespective of location, includes the same steps of: Requesting, Testing, Laboratory analysis and Reporting.



The aim of mass testing for COVID-19 in Manchester is to identify cases and support contact tracing. Isolation of cases and contacts is a key public health action to minimise spread and reduce the effective reproduction number (R_e).

Where are we now?

Manchester's COVID-19 Community Testing Plan is delivered by the Manchester Test and Trace Coordination Hub, reporting to the Manchester COVID-19 Response Group and Manchester Community Cell. The Community Testing Plan covers all out-of-hospital testing.

The Testing Plan has 4 strands:

High risk settings: to inform outbreak management. This includes care homes and other high-risk residential settings (e.g. homeless/asylum seeker accommodation). Symptomatic residents are tested via Pillar 1; either by staff or, where this is not possible, the Community Swabbing Team can carry out assisted swabbing. Asymptomatic/symptomatic care home residents and asymptomatic staff have access to Pillar 2 tests (via the DHSC portal).

Essential workers: to protect the health and safety of service users and to enable the return to work of critical staff (including household members) with an initial focus on local priority health and care services. Manchester essential workers have access to two drive-through Regional Testing Centres (at the Etihad Stadium and Manchester Airport) and access to Mobile Testing Units

as part of the GM rolling programme of deployment. Manchester residents with internet access/phone can also request home testing kits. MFT staff have access to a local testing site at Alexandra Park and agreement has been reached to expand this facility to other essential workers.

Residents: to reduce virus transmission with a focus on complex/vulnerable groups. Currently access to testing for residents is through Regional Testing Centres, Mobile Testing Units and home testing kits. Work is underway to enable access to testing for residents who cannot access these testing pathways.

Antibody testing: to inform understanding of the disease through surveillance. This is taking place via national and regional pilots for antibody testing e.g. in-hospital testing, primary care testing for staff and patients, supported by the Test and Trace Coordination Hub.

A Hub Coordination Team was mobilised with staff deployed from other services to coordinate testing in high risk settings and queries. The team is led by an Operations Manager.

What is working well?

A multi-agency Testing Coordination Hub was established quickly to respond to the need for testing, providing a seven days-a-week service to coordinate testing referrals, respond to testing queries and communicate information to stakeholders. New team members rapidly assumed new roles, putting in place processes and pathways to provide a consistency of approach. Additional resources were provided from across the system, including communications and data analysis expertise.

The development of Manchester's Community Testing Plan was underpinned by the understanding that Manchester has a diverse population with significant pre-existing health inequalities that have been exacerbated by COVID-19. The Community Testing Plan aims to ensure that all Manchester's residents are able to access testing when needed and are linked to the support that they might need to respond appropriately to a positive result. There is a particular focus on ensuring that vulnerable residents (including those who are clinically vulnerable, those who are otherwise more likely to be adversely affected by COVID-19, or find it difficult to access testing and support) are a priority for the development of local testing models.

As the response to COVID-19 has developed, the Testing Coordination Hub combined with the emerging local complex contact tracing team to form the Manchester Test and Trace Coordination Hub. The Hub has robust links with other key services and teams that support the broader public health response to COVID-19, including adult social care, primary care and the CICT.

The Test and Trace Coordination Hub has developed plans in relation to its responsibility to provide a Single Point of Access (SPOC). This has included a phased approach to moving SPOC functions into a Contact Centre delivered by the GMSS Gateway service.

Strategic and programme leadership and support for testing is being provided by a Consultant in Public Health, two Programme Leads and Project Manager. Two Registrars in Public Health support approaches to testing in high risk settings.

What are our next steps?

We will develop a sustainable local model that will provide testing as part of an ongoing COVID-19 response programme for the next 18-24 months.

We will develop additional local testing capacity to ensure that outbreak management testing is available to the full range of residential settings. Work is underway to expand the scope of the Community Swabbing Team's service to support this, including swabbing high risk individuals who are unable to be tested in other settings and providing a training and support function to support residential staff to develop skills to deliver tests if needed.

In addition, local community testing for essential workers and residents will be developed through:

- Extending walk-in and drive through capacity at the existing Alexandra Park testing site to non-hospital staff (e.g. other essential workers and residents) **(short term)**

- Establishing a network of community testing 'mobile outreach' that can provide reactive testing to targeted settings and groups of individuals, including the Community Swabbing Team **(medium term)**

- Developing a 'business as usual' locally-managed testing network (including community testing 'mobile outreach') to provide testing kits, information and advice, training to a range of health, care and other services to enable them to deliver reactive testing as required **(long term)**

Delivery will require access to additional resources, including: testing kits and laboratory capacity to process tests, a case management IT system, Community Swabbing Team staffing capacity, payments to providers to carry out testing on an activity basis, a courier service for test kits, hire and running costs for short-term testing sites

We will consider what approach is needed on access to testing as part of outbreak prevention and management in other settings (e.g. essential businesses), including how businesses could support this for their staff.

Manchester COVID-19

Local Prevention and Response Plan

Theme 4 – Contact tracing in complex settings

mhcc.communitytestinghub@nhs.net

Where are we now?

The UK Government launched the National Test and Trace service as part of an integrated Test, Trace, Contain and Enable (TTCE) approach to COVID-19. The aim of the national service is to reduce the national R_e number to below 1.0, save lives and allow safe release from lockdown. The national capacity around contact tracing consists of teams of national call handlers (Level 3) and professional contact tracers employed via NHS Professionals (Level 2). More complex issues will be escalated to local areas (Level 1).

Cases that involve added complexity, high risk settings or people who are more vulnerable will be managed with more bespoke support at a local level (Level 1). To enable this across GM, a Contact Tracing Hub has been established to bring additional contact tracing capacity as well as expertise from the Health Protection Team in Public Health England into the system. The GM hub acts as Level 1 in Greater Manchester and will be an interface for those complex cases passed through by the national service.

As part of this system, a Manchester Contact Tracing Team, with a dedicated Single Point of Contact (SPOC) has been established to manage Level 1 cases where input is required from the local authority. The Manchester Contact Tracing Team has three functions:

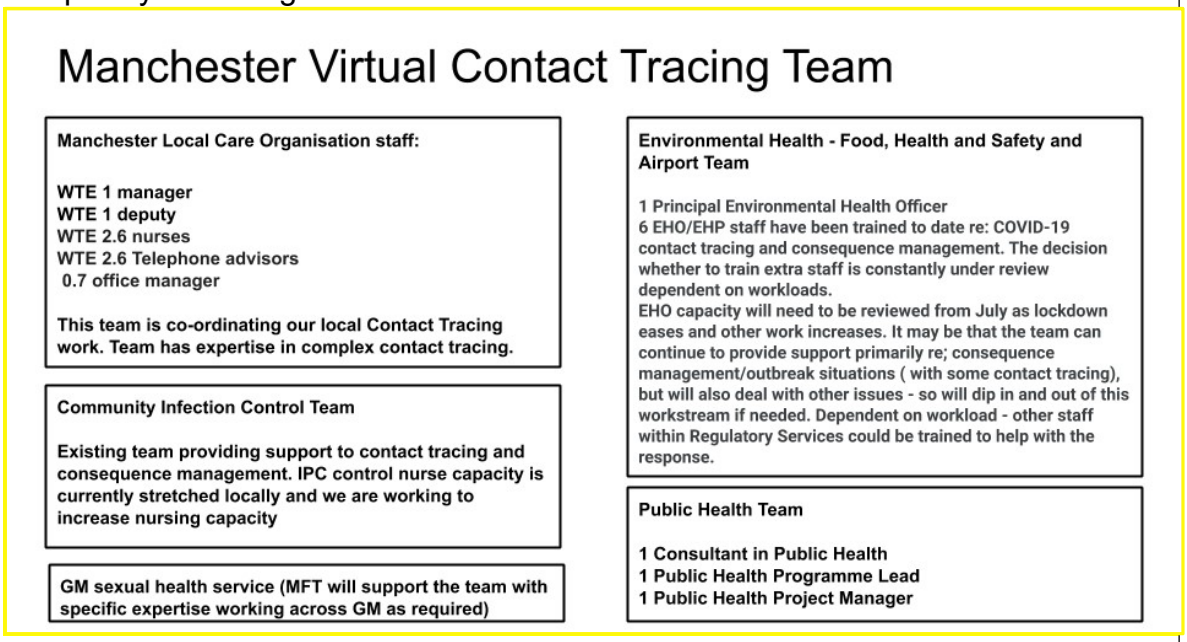
1. Complex contact tracing
2. Supporting individuals to self-isolate
3. Managing high consequence situations

Manchester's virtual contact tracing team has been mobilised from across MCC and MLCO, drawing in expertise from a range of settings, including Population Health, Environmental Health Team, MLCO's Central Coordination Team and CICT. The team is in place and responding to cases both escalated by the GM Hub and cases that are notified locally - these might include high risk settings that are made aware of a positive case and reach the attention of a locality before coming through the national test and trace service.

The capacity of the virtual team is flexible and will respond to changing demand for complex contact tracing and consequence management. For example, within the Environmental Health Team, a number of staff have been trained who will support cases whilst also working on other core business issues depending on demand. The MLCO team has responsibility for coordinating all aspects of our local response and a mixed staff team of eight whole time equivalent staff are available. CICT supports proactive infection prevention and consequence management as part of their core function.

Strategic and programme leadership and support to local contact tracing is being provided by a Consultant in Public Health, Programme Lead and Project Manager. We also have access to expertise in sexual health contact tracing from a GM commissioned service based within MFT.

The team is currently dealing with a small number of cases which are of high complexity. The diagram below summarises the current team structure.



What is working well?

Using population intelligence, we have identified the following complex groups in Manchester:

- Complex settings: special schools, homeless accommodation, domestic violence refuges, day centre provision, supported living sites
- Complex cohorts: People sleeping rough, asylum seekers and people with no recourse to public funds (NRPF), sex workers, traveller communities
- Complex individuals and households: people with a learning disability, with diagnosed mental illness, people sleeping rough, victims of domestic violence and abuse, carers and young carers, sex workers, people with drug and alcohol misuse issues

We are working closely with stakeholders across the public, voluntary and community sector to build a multi-agency support network for contact tracing. This will be highly valuable where an index case may not have a fixed address and their whereabouts are unknown (e.g. people sleeping rough in the city

centre) or where people may be reluctant to disclose contacts or there may be a risk to doing so, for example victims of domestic violence or sex workers.

We have prepared guidance for contact tracers to signpost to support on offer across the City, including:

- The Manchester City Council COVID Helpline, for deliveries of food parcels and medicine and support with fuel bills and social support
- Mental health and wellbeing support, including Every Mind Matters and guides written for LGBT people
- The Greater Manchester Bereavement Service
- Advice for older and vulnerable people on health and dietary needs, staying active and signposting to VCSE groups offering phone friendships and virtual social clubs
- Support available for children and families, including parents of children with SEND, counselling and emotional wellbeing support and support for those who are at risk of suicide
- Physical wellbeing guidance, including strength and balance exercises and eating well while at home.

All contact tracers have been prompted to complete a 20-minute suicide prevention awareness course, which aims to increase levels of confidence in talking about suicide and increasing awareness in what to listen out for when speaking to contacts.

We are working closely with colleagues leading the humanitarian support offer in the City to ensure the needs of people who are self-isolating are being met, while simultaneously reviewing the sustainability and demand on the support itself.

What are our next steps?

We will continue to build an ethos of learning and sharing across the virtual contact tracing team and will establish a weekly learning group to share lessons and build on learning from cases. We will convene a Complex Contact Tracing Review Panel to escalate cases that require additional input.

We will provide suitable technology to the contact tracing team to enable them to call contacts from a single direct number; this will support consistency across the team. We will procure and implement a clinical IT system to support contact tracing. We will monitor demand over time and review the

capacity of the local contact tracing team. Additional staffing resources may be required.

We will work towards implementing an integrated case management system across testing, infection control and contact tracing; an interim measure will be introduced that will be replaced by an integrated system once developed (this may include the system being developed by GM)

We will use the expertise of environmental health when carrying out contact tracing in large employers of essential services e.g. large food manufacturer, hospital caterer.

Theme 5 – Data integration

Where are we now?

Responding to COVID-19 requires integration of multi-source data to support local decision making. There is a collective need to have access to the right data (local and from the national system) to enable the other 6 themes and prevent outbreaks. Nationally a continuous data capture and information loop at each stage of Test and Trace is envisaged, and we are working towards integrating data locally to enable and support the national system.

As an integrated Health and Care system in Manchester, collaboration across teams and organisations has already been implemented and has been an integral part of the COVID-19 response from the earliest stages. This integration is now being expanded further to support outbreak response, for example with the creation of a virtual team to manage contact tracing locally where this is better served by local contact tracing teams (e.g. more complex cases).

Having a virtual team working across different systems is complex but has the benefit of being able to deal with outbreaks at scale across multiple locations and facility types simultaneously. Communication and accurate data integration is key to facilitate this working well, as are shared policies and procedures.

Data on outbreaks in care homes is being managed and shared across Manchester – the data is gathered by the Performance and Quality Improvement Team (PQI) in MHCC, actions are taken by the Community Infection Control Team (CICT), and outputs are reported through the Tableau portal and a weekly report on care home outbreaks for the Executive Member for Adult Health and Wellbeing.

Data on community testing (for example in care homes) is gathered via the Test and Trace Coordination Hub and reported in the same weekly outbreaks report.

Data on Pillar 2 testing has been slow to materialise, however there is now a Tableau dashboard available via the Manchester Tableau portal which means activity for testing can be viewed across the 10 local authorities in Greater Manchester. The data provides a limited picture as at the moment it is not broken down in enough detail to provide a comprehensive picture of who has been tested in Manchester.

Initially, the Test and Trace Coordination Hub was able to manage employee referrals on behalf of organisations; the majority of organisations now access the employer portal themselves, with a small number using the Hub's Contact Centre.

Testing for Manchester University NHS Foundation Trust staff has been delivered locally.

All data that is available is incorporated into a report that is received by the Testing Steering Group which meets every two weeks.

Contact Tracing will be primarily undertaken by the national and GM contact tracing teams, with more complex contact tracing being undertaken by a virtual team across MLCO, MCC and MHCC. Teams are working towards using existing IT systems for case management as an interim measure in the absence of a working GM level system, which is in development. Processes to enable secure information sharing across the virtual team are being finalised.

Key tools to support management of local outbreaks have been developed and will continue to be refined and added to. Data and intelligence linked to COVID-19 is available from the Manchester Health and Care Commissioning Tableau portal. This includes data from at risk populations, confirmed cases, deaths, testing, outbreaks, and service utilisation. Teams across MHCC, MLCO and MCC have contributed to the data within this resource. Some of the dashboards require a Tableau account and password which can be requested via the portal landing page for those with a strategic or operational need to see this data.

What is working well?

Teamwork and communication across the virtual contact tracing team has been exemplary. The team has been able to mobilise at pace with little guidance from the national system in the early stages of the programme. Specialist expertise has been sought to facilitate the collection and recording of data and information, and to ensure data is handled in accordance with GDPR and data protection legislation.

Contact tracing and consequence management have been integrated into outbreak response prior to the national system going live, helping to bring outbreaks under control quickly.

Members of the Population Health Knowledge and Intelligence Team have been working as an integral part of the testing and contact tracing teams, which has added a data analysis and intelligence perspective to the work of the teams and has enabled a speedier response to requests for data analysis and product development.

An example of the contribution of the Population Health Knowledge and Intelligence Team is in the production of a proforma for contact tracing data collection, to standardise the information recorded by the virtual team working across different systems and ensure a smooth transition to an integrated case management platform. This supports the contact tracing programme and

wider work on measuring inequality in relation to COVID-19.

Having an integrated data portal across organisations has enabled strategic data and information to be accessible and encouraged teams to work together on delivery of data projects, reducing duplication of effort. There is evidence that data is being accessed regularly and is therefore useful to teams for planning and operational delivery of the COVID-19 response.

What are our next steps?

A technological solution to case management for testing and contact tracing is required (see above). The cost of this is as yet unclear. This would ensure each part of the system that is supporting testing/tracing/outbreak management has the technology to do this.

A case management system for the Community Infection Control Team is required to enable improvements to case management across the Test, Trace and Isolate programme. This may need to be procured at a cost to the project, or existing systems could be adapted and opened up to the team for which the additional cost may come from the licenses needed for staff.

Further dashboards will be developed to track and monitor local contact tracing and will be linked to any outputs required for reporting back to Greater Manchester or the national track and trace system.

Evidence and research in relation to COVID-19 is developing at pace and a coordinated approach to accessing high quality research findings is under consideration.

Data sharing and data consent policies and procedures regarding contact tracing and consequence management are in the process of being finalised. A data sharing agreement document from Public Health England has been developed, to enable sharing with Local Authorities. As part of the information governance process there are a number of requirements on our part. This is so that PHE is able to demonstrate its compliance with Information Governance, including compliance with GDPR and Caldicott. Initial comments have been made by our Information Governance Team in relation to the Data Sharing Contract and we are soon to confirm in writing that the Local Authority is compliant with each of the above requirements.

An information flow diagram for contact tracing has been drafted, which now needs to be circulated for comment before being signed off via the appropriate channels in the governance structure.

An integrated data early warning system is in development to be able to trigger escalation in the event that data indicates a potential second wave of infection. This will involve adapting existing reporting mechanisms rather than

development of an entirely new product and will be undertaken in close communication with a GM surveillance system which is also under development to ensure the two are complementary rather than overlapping.

Theme 6 – High risk groups in the community

This section contains information on our approach to key high-risk groups in Manchester including older people, Black, Asian and minority ethnic groups (BAME), people experiencing homelessness, asylum seekers, and people with no recourse to public funds (NRPF) and those with existing co-morbidities.

Older people in the community

Where are we now?

There have been a disproportionate number of deaths due to COVID-19 in people over the age of 70. As people get older, they experience increasing inequalities which are specifically linked to older age and ageing.

Older people (aged 70+) tell us that they have been treated as one homogeneous group and that not every older person needs to shield or feels vulnerable. For many older people the view is that age is not a risk factor in its own right unless underlying health conditions are attached. Older people tell us that they are upset to see a retreat to ageist language and attitudes that have pervaded all corners of society. They feel they are framed as vulnerable and in need.

We are seeing a considerable reduction in the uptake of psychological therapies across Manchester. Even during business as usual times the referral and uptake of these kinds of service is markedly lower for older people. The fear is that this will be reflected across other areas across health and care too. Ongoing issues resulting from loneliness, social isolation and anxiety about leaving home are exacerbating this for some.

36% of older residents are income deprived and 59% of older residents live in our most deprived neighbourhoods. In England only 7% of housing is accessible and 20% of homes in England occupied by older people fail the Government's basic standards of decency.

Access to transport is often cited as a key concern for many. This concern is heightened as older people are being told to avoid using public transport but rely upon it heavily to access health and care services, social networks and for shopping.

What is working well?

Manchester City Council's Community Hub response has the ability to reach

many older people in need. Neighbourhood Groups have quickly responded to COVID-19 and adapted their focus, particularly focusing on the most vulnerable older people in their neighbourhoods. Neighbourhood models, including local neighbourhood networks and neighbourhood working arrangements have coordinated their effort. Creative ways of articulating older people's voice have been developed that can inform the city's response to the crisis.

A 'Stay Well at Home' campaign resulted in printed information being delivered to 16,000 households, overcoming the digital exclusion experienced by many older people.

The frequency of the older people's e bulletin has been increased, reaching many more people

What are our next steps?

We will continue to explore more effective and appropriate ways of communicating with older people, many of whom are more comfortable with phone calls and letters rather than texts.

We will ensure that communications with older people reflect the potential and contribution of older people in our communities. We will explore breaking this group down based upon particular circumstances where risk varies; for example, 'shielded & vulnerable', 'isolated' or 'worried and scared'.

In our development of local testing offers, we will take into account access to testing for older people, understanding that many may no longer feel confident driving or do not drive. We understand that a large number of older people are worried and scared about using public transport and taxi costs are considered prohibitive for many.

We will support local groups and communities to provide support to older people who are self-isolating.

We will remodel our approach to tackling health and other inequalities in later life to enable smaller groups and individuals to receive support and access activity and services closer to home.

We will apply an older people's focus on whole population services across design, delivery and commissioning stages that recognises that many older people's needs have changed and how we deliver services post COVID-19 will need to change.

We will expand our Ageing in Place Programme (AiPP) across all 13 neighbourhoods so that people are better supported to stay well in their own

home and in their own neighbourhood.

We will enable older people that have no access to, or experience of using, IT to gain the means and skills to connect digitally to services and social networks so that they can access web-based and digital platforms.

We will support the financial inclusion of older people by supporting benefits maximisation and will support older people to move to a more cashless economy.

Black, Asian and Minority Ethnic groups

Where are we now?

The recently published Public Health England (PHE) report confirms that people from Black, Asian and Minority Ethnic (BAME) backgrounds are being disproportionately affected by COVID-19. On 16 June, PHE published a report summarising stakeholder insights into the factors that may be influencing the impact of COVID-19 on BAME communities and strategies for addressing inequalities alongside a rapid literature review. The report summarises requests for action from stakeholders and points to the areas where commitment, focus, and delivery at scale could make a significant difference in improving the lives and experiences of BAME communities.

What is working well?

MHCC have issued a staff COVID-19 Risk Assessment for use in primary care to support the ongoing management of employees who have relevant health conditions and staff that are deemed to be more at risk, such as those who identify as BAME. MCC, MLCO and MCC risk assess all staff, particularly those who may be at increased risk, including BAME staff. Schools have been provided with a template and guidance for undertaking individual assessments for BAME / vulnerable school staff.

What are our next steps?

We are in the process of establishing an 'Addressing Inequalities' group which will report into the COVID 19 Response Group. The aim of Manchester's 'Addressing Inequalities' workstream is to improve outcomes for communities that experience disproportionate direct and indirect adverse impacts of COVID-19. The group will have a specific focus on Manchester's BAME communities.

We will work to implement the recommendations of the PHE report on the impact of COVID-19 on BAME communities, including:

- Collecting good quality ethnicity data in our COVID-19 testing and contact tracing hub
- Fund, develop and implement culturally competent COVID-19 education and prevention campaigns
- Carry out an equality impact assessment on our local COVID-19 provision
- Provide funding for meaningful approaches to tackling ethnic inequalities

Homeless population

Where are we now?

As described in the inequalities and high-risk settings sections of this plan, Manchester has a large population of people experiencing homelessness. The MCC homelessness team estimates there are about 80 people sleeping rough on any one given night at present, and approximately 1400 single people are in emergency accommodation.

For the general population, those over the age of 70 are considered at increased risk. However, given average life expectancy for people sleeping rough is 44 for men and 42 for women, it is recommended that the age limit is reduced to 55 for homeless people to be considered at high risk for COVID-19.

Many people experiencing homelessness have chronic mental and physical conditions, engage in high rates of substance abuse (including sharing of needles), and have often less access to health care, all of which could lead to potential problems with testing, tracing, isolating and treating people who might have COVID-19.

A joint meeting was held with Public Health and Homeless Voluntary Sector providers to share information about contract tracing and to start to identify key issues that need to be reflected in a shared process for working in these settings. Voluntary Sector Providers agreed that they would keep track of people's friends as they entered their buildings in case the individuals themselves could not remember if asked in the future.

What is working well?

All services working with the homeless population follow current guidance around social distancing and infection control. Services have good access to PPE.

A manager in the Outreach In reach Team, Ros Wolfe, will act as a single contact for Contact Tracing for people that are rough sleeping.

Risk assessments will be shared with day centres for people sleeping rough to help them with their plans for ongoing safe service delivery.

Staff will ask people if they think someone looks unwell / has symptoms, so that any potential infection is caught as early as possible.

What are our next steps?

We will continue exploring the offer for people who are currently sleeping rough who may need to self-isolate, but where there is no appropriate facility for them to self-isolate in. Discussions are ongoing about whether a COVID Care facility is needed.

Within our local testing models, we will explore the potential of providing testing at homelessness service locations, to overcome some of the issues associated with testing via the national scheme for this population.

We will continue to develop policies and procedures to support contact tracing for this group.

Asylum Seekers and Persons with No Recourse to Public Funds

Where are we now?

The Home Office have stated that they will embargo all positive decisions to relieve pressure on homeless services and to reduce the amount of population movement. This has meant that all asylum seekers are remaining in their dispersed accommodation. There will be a review of this decision at the end of June.

Due to the numbers of asylum seekers still arriving in the country, the decision not to evict people has created pressure on the asylum accommodation. A significant number of hotels have been opened around the country to manage the demand. One such hotel has been opened in the south of Manchester, accommodating up to 255 people, both small numbers of families and a large number of single males.

Whilst COVID-19 remains a public health risk, local authorities will need to continue to provide accommodation when this is required, alongside identifying longer-term arrangements for those already in emergency accommodation. Despite multiple calls from local government and others for the temporary removal of the no recourse to public funds condition (NRPF) to enable all residents in need to access the support they require, there have

been no changes to this immigration policy, or to the housing and benefit eligibility rules. The Government has recently confirmed that 'the legal position on those with no recourse to public funds has not changed'. The Government has not provided any further guidance to local authorities with regards to how they can achieve sustainable long-term accommodation solutions for people who have been assisted as part of the public health response when no legal duties or powers are engaged to provide ongoing support.

Manchester has a Specialised NRPF Team equipped with providing appropriate support i.e. accommodation and subsistence for these groups should they become destitute.

What is working well?

Asylum Seekers Hotel Accommodation - Both primary care and public health have visited the hotel and are working closely with Serco and the Home Office to ensure people's health needs are met. Environmental Health are working closely with the hotel and Serco to help to ensure that the hotel is being operated in a COVID-19 secure way.

The Manchester NRPF Team continues to respond to requests for financial assistance as a result of hardship due to COVID-19 (loss of employment, delay with getting papers from Home Office, disruption with oversea students getting their funding from oversea sponsors in cases etc) to prevent destitution which impacts on wellbeing of residents and resilience towards the risks of COVID-19.

Assessment to determine eligibility for interim financial support were carried out over the telephone, and required supporting documentation kept to minimum.

NRPF Contingency plan included providing monthly subsistence payments instead of weekly or fortnightly payments either directly into individuals bank accounts or post office vouchers for those without bank accounts. This helps to support the government social distancing policy, reduce contacts and helps residents to plan their essential shopping i.e. food.

In some cases, money for rent is paid directly to residents to appease their private landlords so as to prevent illegal eviction and street homelessness.

Manchester NRPF Team has provided additional hardship payment to residents who are in receipt of interim financial support to help with additional costs due to COVID-19.

Manchester NRPF Team has provided a one-off hardship payment to single homeless residents without benefits who are being accommodated under the Government 'Bring In' Scheme.

Manchester NRPF Team carry out a weekly COVID-19 Safe & Well Checks on residents currently in receipt of interim financial support, this helps to quickly spot any potential COVID-19 issues and take steps to mitigate potential risks.

Those residents who are medium-high risk (i.e. clinically vulnerable or extremely clinically vulnerable) are provided with self-contained accommodation sourced from private providers.

The NRPF Team continues to advocate and negotiate with the Home Office on behalf of residents who are destitute for a positive decision on immigration matters.

What are our next steps?

Asylum Seekers Hotel Accommodation - The Environmental Health team will continue discussions with both the hotel and Serco regarding reviewing their risk assessments. The Public Health team will co-ordinate plans to respond to any outbreak within the hotel, including any contact tracing and outbreak consequence management work.

For people with NRPF, whilst accommodation and or subsistence is being provided on public health grounds, we will use this opportunity to work with individuals to identify and achieve sustainable step-down outcomes. We will work collaboratively and in partnership with the Home Office, Community Legal Services, and charity organisations, to organise support and explore how more sustainable outcomes may be achieved.

Due to COVID-19 pressures, additional funding is required to support to work of the NRPF team.

Existing co-morbidities and shielded groups

Where are we now?

People with existing co-morbidities are more likely to die due to COVID-19. Nationally, between 31 March and 12 May, 5,873 (26%) people dying from COVID-19 suffered from either type 1 or type 2 diabetes. This was the most common comorbidity found, followed by dementia (18%), serious breathing problems (15%) and chronic kidney disease (14%). One in ten (10%) suffered from ischaemic heart disease. After adjusting for region, population density, socio-demographic and household characteristics, mortality rates involving COVID-19 were 2.4 times higher for females and 1.9 times higher for males with an acute limiting long term illness compared with those who were not disabled.

People classified as either high or moderate risk of developing complications from COVID-19 infection were asked to shield for 12 weeks from the start of the outbreak in March. There are over 21,000 people shielding who are registered with Manchester GP practices.

Neighbourhood	Shielding	Registered	% shielding
Ancoats, Clayton and Bradford	2,345	65,752	3.6%
Ardwick and Longsight	1,951	68,691	2.8%
Cheetham and Crumpsall	1,690	57,489	2.9%
Chorlton, Whalley Range and Fallowfield	1,586	57,659	2.8%
Didsbury, Burnage and Chorlton	1,289	43,816	2.9%
Fallowfield (Old Moat) and Withington	1,454	52,219	2.8%
Gorton and Levenshulme	1,876	53,063	3.5%
Higher Blackley, Harpurhey and Charlestown	1,858	47,556	3.9%
Miles Platting, Newton Heath, Moston and City Centre	1,795	56,300	3.2%
Moss Side, Hulme and Rusholme	1,510	83,805	1.8%
Wythenshawe (Baguley, Sharston, Woodhouse Park)	3,006	56,845	5.3%
Wythenshawe (Brooklands) and Northenden	1,253	28,916	4.3%
Total	**21,613**	**672,111**	**3.2%**

The table above shows shielded patients expressed as a percentage of the registered population.

Wythenshawe has both the highest number and (because the registered population is relatively small) the highest proportion of shielded patients in the city. This is likely to be a consequence of age and deprivation leading to a higher number of patients with long term conditions registered with general practices. We know that north east Manchester and Wythenshawe are the most deprived parts of the city but the population in Wythenshawe is generally older than that of east Manchester where the impact of regeneration has led to an influx of younger people to balance out the existing communities in those areas. In contrast, the population in Wythenshawe is more stable leading to more multi-generational deprivation.

Shielding can have negative impacts on psychological wellbeing and increase social isolation. Primary care anticipates increased referrals to self-help and counselling services.

The Shielded Patient List (SPL) remains dynamic, with regular guidance changes and patients being added and removed as clinically appropriate. Practices have in recent weeks seen larger numbers added to their SPL due

to a national delay in the addition of hospital identified patients to GP SPLs. The National Shielding Team currently requires all GPs to continue to perform a clinical review of all additions to the SPL. If the clinical review indicates the person is actually low or moderate risk, then the appropriate code should be added following the guidance and the patient contacted to discuss they are no longer advised to shield.

What is working well?

GPs have followed 9-point guidance/actions to ensure shielded patients are reviewed and supported. Practices have been supported to continue long term conditions management and reviews. Planning for flu vaccinations has started earlier than usual to ensure maximum coverage of shielded groups.

What are our next steps?

The guidance on shielding is now changing. From 6 July, people who are shielding will be able to meet up outdoors, in a group, with up to five others and form 'support bubbles' with other households. From 1 August the government will be advising that shielding will be paused and replaced with strict social distancing. Plans on how we support our shielded patients through recovery are underway.

Theme 7 – Local Boards

Where are we now?

Manchester's Health and Wellbeing Board, chaired by the Leader of the council, brings together NHS, public health, social care and children's services representatives, elected representatives and representatives from Health Watch Manchester to plan health and social care services for Manchester.

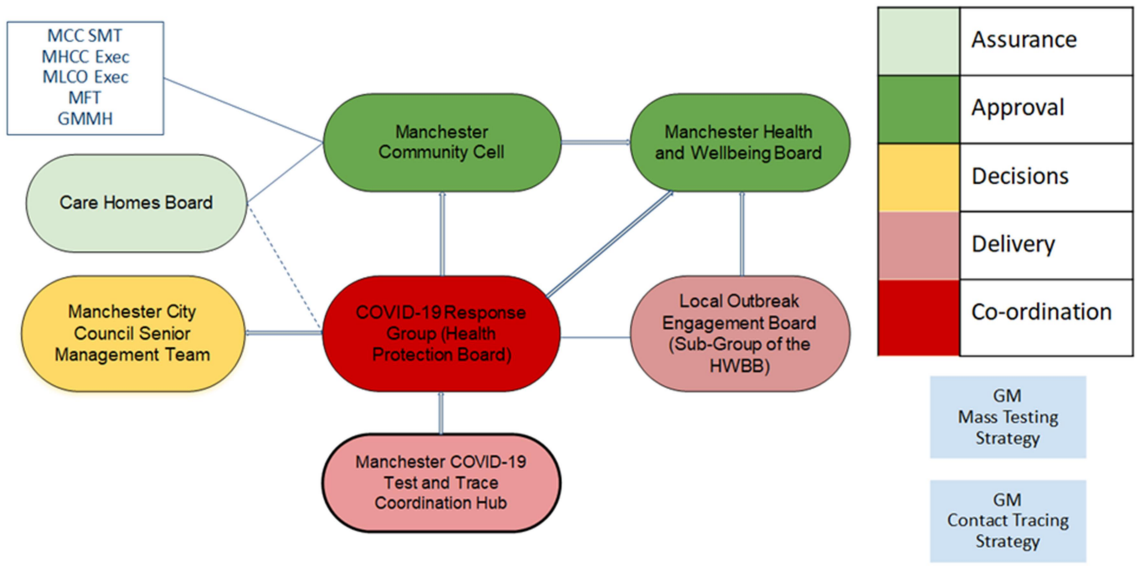
The COVID-19 Response Group (previously called Manchester Locality Planning Group, chaired by the Director of Public Health David Regan) had its Terms of Reference agreed by the Health and Wellbeing Board in March 2020. This group fulfils the functions of the "Borough Pandemic Co-ordinating Group" set out in the Greater Manchester Resilience Forum Pandemic Strategic Response Plan, reports to the GM Strategic Coordination Group (GMSCG) and links to NHS Incident Management Teams and the Council's Resilience Forum. This group fulfils the role of the COVID-19 Health Protection Board for the purpose of the Manchester COVID-19 Outbreak Response and Prevention Plan, having oversight of the plan and all the other existing workstreams to ensure benefits and interdependencies are realised. The COVID-19 Response Group reports to both the Community Cell and the Health and Wellbeing Board.

For complex consequence management decisions, Manchester City Council's Senior Management Team act as the Strategic Coordinating Group (Gold), enabling Manchester to move quickly using delegated powers of statutory officers. NHS Trusts, Greater Manchester Police (GMP) and MHCC/MLCO (primary care) have their own mechanisms to take the consequence management decisions that apply to them.

Forum	Information	Relationship to COVID-19 Response Group
COVID-19 Response Group	• Chaired by DPH • Fulfils the role of the Health Protection Group for Test and Trace • Provides oversight on the COVID-19 Prevention and Response Plan (Outbreak Plan)	• N/A
Manchester Community Cell	• Chaired by MHCC's CAO • Overall responsibility for the Community COVID-19 Response for the City of Manchester	• COVID-19 Response Group reports directly into the Community Cell on its key workstreams, including Test and Trace
Health & Wellbeing Board	• Statutory Board of the Council (with MHCC membership) • Fulfils the role of the Local Outbreak Engagement Board by establishing a formal sub-committee. • Overall responsibility for the COVID-19 Prevention and Response Plan (Outbreak Plan)	• COVID-19 Response Group will submit the COVID-19 Prevention and Response Plan (Outbreak Plan) to the Board for initial approval, as well as any subsequent proposed changes.
Local Outbreak Engagement Board	• Sub-Group of the Health & Wellbeing Board, Chair by MCC's Executive Member for Adult Health and Wellbeing • Focus on communication and engagement with the general public, to develop local support to implementing the steps necessary to reduce the risk of spread of COVID-19.	• COVID-19 Response Group will play an advisory role for the Group.
MCC SMT	• Manchester City Council's Senior Management Team. • Statutory Officers with delegated decision making powers.	• Acts as Gold Command for the COVID-19 Response Group. • COVID-19 Response Group to refer any consequence management decisions for approval by statutory officers, using their delegated powers where appropriate.
COVID-19 Test & Trace Coordination Hub	• Responsible for the oversight and implementation of the Test and Trace Programme Plan	• Reports directly into the COVID-19 Response Group on the Test and Trace Programme.

Manchester COVID-19

Local Prevention and Response Plan



The Manchester Test and Trace Coordination Hub currently has an existing Testing Steering Group, Tracing Steering Group and joint Test and Trace Operations Group.

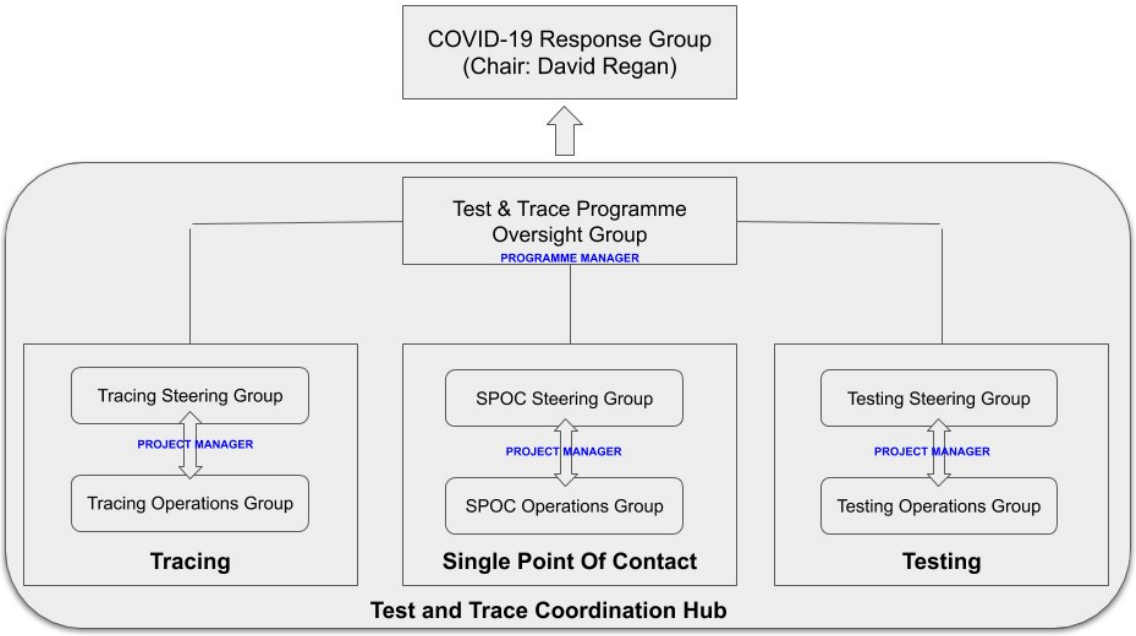
What are our next steps?

A member led Local Engagement and Communications Group will be established as a sub group of the Health and Wellbeing Board. This will be chaired by Cllr Craig (Executive Member for Adult Health and Wellbeing) with other Executive Members and a small number of officers and will be advised by the COVID-19 Response Group.

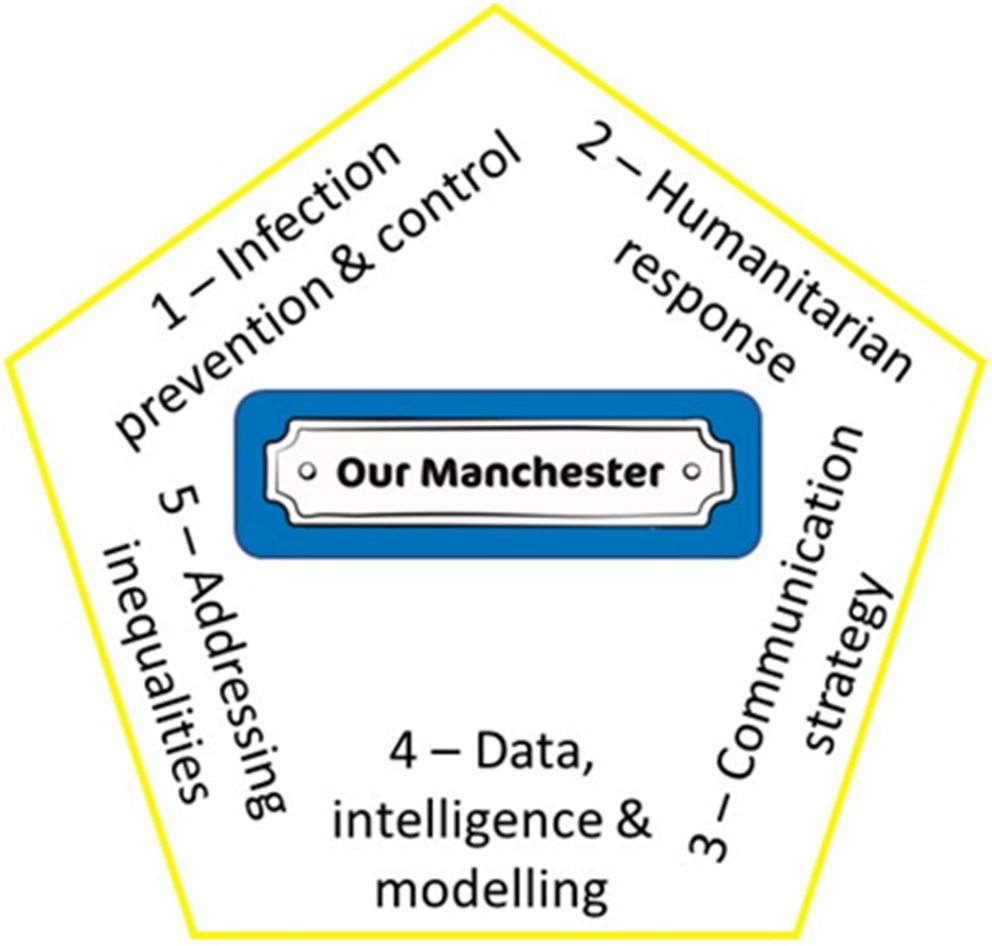
Following a review, the internal governance of the Manchester Test and Trace Coordination will be reformulated to include a Test and Trace Programme Oversight Group. This group will be responsible for the oversight and implementation of the Test and Trace Programme Plan and will report directly to the COVID-19 Response Group:

Manchester COVID-19

Local Prevention and Response Plan



WORKSTREAMS



Manchester COVID-19

Local Prevention and Response Plan

Workstream 1 – Infection Prevention and Control

cict@manchester.gov.uk
ppemutualaid@manchester.gov.uk

Where are we now?

Community Infection Control Team

The Community Infection Control Team (CICT) provide support and guidance to any Manchester facility that may be experiencing human borne disease issues, working closely with a wide range of partners to prevent the spread of infection.

CICT are currently solely working on COVID-19 related issues and are in high demand from numerous sectors to help plan a safe return to service delivery as part of the wider recovery work. The small existing team have been working with Education, Environmental Health and Health & Safety teams to provide practical, bespoke guidance for individual services and premises. This vital function is delivered alongside CICT's existing outbreak response work, which has increased exponentially during the crisis.

The core team consists of one Lead Nurse, one Specialist Nurse, one Specialist Dental Nurse and one Infection Control Officer (all 1 WTE). From the beginning of April, the team were provided with additional support from two Nurses from MHCC's Safeguarding Team & a Nurse based within the Test and Trace Coordination Hub, however some of these additional staff have returned to their substantive posts leaving only 1.2 WTE additional Nurse capacity; this provision will remain until the end of July.

During the crisis, wider Infection Prevention and Control (IPC) and Health Protection work has not been delivered, including mandatory health care acquired infection (HCAI) elements.

CICT are closely involved in managing COVID-specific updates and sharing guidance with care homes. They provide outbreak, case management and infection prevention and control advice to settings. They liaise with homes that have reported cases/outbreaks, undertaking risk assessment. This includes advice around cohorting and managing residents who are difficult to isolate.

The team arranges swabbing of settings via the PHE system or national care home portal, referring where appropriate to the Test and Trace Coordination Hub to facilitate testing by the Community Swabbing Team. The team also arrange sampling for other COVID-related symptoms.

CICT works closely with the Test and Trace Coordination Hub to ensure that results information and guidance on interpretation is clear and can be

communicated to care homes, to ensure residents and staff are being cared for and that staff are working safely.

The team provide regular follow-up calls and advisory emails to care homes during any outbreaks to discuss management or support and help resolve issues. Settings have direct access to via email and team mobiles for advice.

CICT liaises daily with MHCC's PQI team to share relevant information and intelligence and to identify any issues that could affect homes. The team helps interpret complex and sometimes conflicting national and regional guidance for settings, enabling them to apply it correctly in practise.

The team is responsible for notifying PHE of any new cases or outbreaks (COVID and non-COVID), providing minimum data sets. They provide a daily summary of outbreaks to all partner organisations. They raise concerns regarding aspects of care impacted upon by COVID-19 and other infection prevention and control issues to other services as appropriate.

The team contribute to and provide infection prevention and control expert advice and training support for care homes around all aspects of outbreak management, as well as providing consequence management support and advice to settings. CICT is supporting other COVID-19 services such as the PPE Mutual Aid Hub.

Environmental Health

The Food, Health and Safety and Airport Team of Environmental Health deal amongst other matters with outbreaks and work closely with partners such as PHE, CICT, The Food Standards Agency, the Health and Safety Executive.

The team consists of 4 Managers, 12 EHO's, 3 Neighbourhood Officers, 1 Graduate EHO. 2 newly appointed EHOs are due to start within the next few weeks. The team also has an EHO working on an Agency basis.

In relation to outbreaks, the team will investigate potential sources and secure relevant improvements as appropriate where the local authority (LA) is the enforcing authority e.g. for food safety, health and safety, health protection. The team have Primary Authority partnerships with national companies and advise nationally on matters, including in relation to COVID-19. The team therefore has an enormous existing reach into businesses which will be used to supper contact tracing in these settings.

During the current COVID-19 pandemic the team has been busy enforcing coronavirus legislation, regarding businesses that should be closed. Also helping to ensure that businesses that are open are operating in a COVID-19 secure way in relation to coronavirus controls. The team has been heavily involved in supporting the community food provision response and has produced various sets of guidance in relation to e.g. volunteer shoppers doing

this in a safe way, guidance for food banks etc. Members of the team are part of the Manchester City Council Virtual Contact Tracing Team.

PPE Mutual Aid Hub
The Mutual Aid Hub co-ordinates the Manchester and Trafford locality response where there is a need for urgent supply of PPE in order to ensure continued delivery of care to individuals who are not in hospital in accordance with national guidance, including: primary care; nursing, residential, home care, specialist placements, supported living and those in receipt of direct payments or personal health budgets; Local Authority services; VCSE and any other health and care or related service provider who has a need for PPE under national guidance

The Hub is led by Population Health but has operational and strategic support from Manchester and Trafford PMO, audit and procurement colleagues. PPE is stored and delivered from an established base at New Smithfield Market in Openshaw. PPE is ordered via a central route and delivered direct to providers with a rapid turnaround, usually the following working day.

A regional approach to PPE procurement is in the early stages of being development with GMCA, GMHSCP and the GM Local Authorities.

What is working well?

Community Infection Control Team
Excellent existing working relationships between CICT and care homes have been key in the support and management of cases and outbreaks. Settings are clear about the process for contacting the team to report any outbreaks; this has helped in early reporting of cases and given CICT the ability to provide early key infection prevention and control advice, management of cases advice and given settings access to the services of the Community Swabbing Teams.

Settings often contact the CICT for general support or if they are not sure where else to go for information. CICT staff have provided emotional support and a listening ear for care home managers, who might feel that they cannot share feelings of distress with their staff.

Excellent working relationships with other partners and teams have helped to provide a responsive service for care homes. Work Groups have benefited from CICT's contribution in interpreting and clarifying guidance.

As the pandemic has progressed CICT have been responsive in their approach, adapting and developing new documents and tools to enable the team to work smartly and efficiently. Team members have quickly upskilled and developed and worked above their usual grade and in areas which may

not have previously been within their remit. New staff from other services have been redeployed to the team and have been effectively utilised to ensure a more robust service.

CICT have worked proactively, for example creating a questionnaire for care homes to ensure that all have had some contact. The questionnaire, and follow-up one-to-one discussions with care home managers, helped ensure that all settings have procedures and equipment in place to enable them to respond to any future cases and outbreaks. The team received messages of thanks from a number of homes who were grateful for the practical and emotional support.

Environmental Health
Throughout one of the most challenging periods that most staff will experience in their working life, staff have responded to challenges that they have faced in a remarkable way. Multi Agency working has worked really well both across the council and with external partners/agencies. Whilst dealing with all the extra requirements posed by COVID-19 - staff have also dealt with other workstreams including visits to premises when required where it is considered that there is a serious Public Health risk and a visit is necessary. Existing support networks have been valuable in relation to e.g. legal interpretation of new legislation, to ensure consistency of approach.

PPE Mutual Aid Hub
The PPE Hub has been effective in ensuring that emergency provision has been available across all sectors to ensure safe delivery of care. As of mid-June 2020, the Hub has delivered close to 4 million items of PPE and has been featured in the press, including BBC Northwest Tonight.

The Hub has developed robust PPE stock management and usage data, supporting both internal and regional intelligence in future stock requirements.

The Hub has also provided strategic and operational oversight into the supply of PPE specifically related to those outside of hospital in receipt of Aerosol Generating Procedures (AGPs) of which there are very high numbers in Manchester. This has involved extensive work in gathering patient data together with the coordination of staff training, fit testing of face masks and appropriate supply of specialist AGP PPE.

What are our next steps?

Community Infection Control Team
Work is underway to recruit part-time returning retired Nurses to work with CICT for a maximum of three months. They will require support to re-establish their knowledge in order to be able to work as part of this specialist team. Additional resources will help ensure that adequate and effective

infection control and health protection provision can be provided to care homes and other settings and services.

Plans are underway to restructure CICT with more robust nursing & support staffing levels to meet the need of the new COVID-19 safety requirements and to re-establish the wider Infection Prevention & Control and Health Protection work which has not been delivered during the crisis. This will include the mandatory HCAI elements, which have not been delivered in the last 3 months.

The team will explore what post-COVID-19 infection prevention and control support might be required for staff caring for residents in high risk settings, including contributing to the development of training packages and training delivery to settings.

The team will be involved in Implementing a new electronic IPC audit programme for Nursing and Care homes and continue to contribute to contact tracing and the management of COVID-19 test results

CICT will contribute to planning around mass vaccination for COVID-19 when a vaccine is available.

The team will actively participate in research projects with care homes where required and will lead on the implementation in schools of PHEs 'ebug' virtual training programme.

Environmental Health
Will continue to build on the relationships built during the COVID-19 response and work to support the MCC virtual Test and Trace and consequence management team where possible. Staff within the Food, Health and Safety and Airport Team will become increasingly busy with other workstreams as society opens up again.

PPE Mutual Aid Hub
There is an established need for Local Authorities to supply emergency PPE until at least March 2021. Planning is underway and a business case in development to secure the relevant resources required to allow continued operation of the Hub to meet predicted demand.

Manchester COVID-19

Local Prevention and Response Plan

Workstream 2 – Humanitarian response

covidsupport@manchester.gov.uk
Community Response Helpline - 0800 234 6123

Where are we now?

A Community Response Helpline was established at the end of March with a freephone number and email facility for Manchester residents that allows them to access support including help with food, medicine, loneliness, getting online and fuel. The helpline is available to all residents in Manchester who need support as a result of COVID-19 and as of 13th June over 16,000 calls had been made to the helpline.

Letters were sent to all over 70s in receipt of council tax support or housing benefit informing them of the offer and a leaflet was provided with advice on how to stay well at home. Letters sent to the shielded group by GP included information about the support available via the helpline. Phone calls and visits are being made to those that are shielded and have not registered with the national website for support.

Teams around the Neighbourhood have been using data available to ensure that those who are known to services are receiving the right support. 'Safe and well' calls are being conducted and referrals have been made to existing neighbourhood services such as Be Well (social prescribing), Care Navigators, local VCSE support providers and mental health services.

What is working well?

The 'Team around the Neighbourhood' model is working well; this is a multi-agency approach delivered at a neighbourhood footprint, connecting people to local assets. The model is supported by a city-wide target operating model and framework.

An approach to sharing of data in relation to the shielded group and how they interact with other services has been tested successfully in one neighbourhood and is now being rolled out across the city. This approach helps to understand demand and identify individuals who would benefit from targeted support.

A food response system, including food banks, has been now established working with over 40 food providers to help support those who need it.

What are our next steps?

We will build on the Neighbourhood approach by connecting local testing and tracing into the neighbourhood model.

We will continue to provide the helpline, with reduced hours to reflect reduced demand. Callers to the helpline will now be asked if they have been referred from the National Test and Trace Centre.

A key part of our response will be working in partnership with Manchester's 3500+ VCSE organisations to ensure our high risk communities are supported through the COVID-19 response and recovery. Manchester's VCSE organisations are very diverse: larger organisations have management capacity and more organised operating structures and so are progressing with risk assessment and putting measures in place. Smaller groups do not have this capacity and will need support in learning about and operating safely in this new environment.

Many groups have maintained remote support during the lockdown period but are now opening up for regular activities as well – particularly as the summer approaches and the school system shuts down again for the holidays. There are pressures on groups to maintain remote provision as well as physical provision, which will increase pressures on groups – as well as concerns about workforce burnout and long-term sustainability. Being mindful of these challenges, upskilling the alertness of VCSE organisations to risks in communities mobilises them as part of the city's response and outbreak management system.

Our approach therefore is to build on existing knowledge of issues such as first aid and safeguarding and add to established ways of working so that adopting good safe practice is a clear and practical set of messages. We will organise a series of briefings for VCSE organisations on:

- How to assess infection risk within their working environment
- How to minimise risk – what steps they can take
- VCSE workforce support
- How to call in / alert the public health system
- Key messages to share with communities
- Key contact numbers

As part of the wider plan we will engage with VCSE organisations as trusted community groups to help share key coms messages and myth busting within community networks. We have worked closely on provision of information in community languages and accessible formats about the humanitarian response and the MCC Hub and can build on this work. We will need to consider non-digital communications as feedback from VCSE groups shows significant digital exclusion (there is a citywide partnership developing work on this).

Manchester COVID-19

Local Prevention and Response Plan

Workstream 3 – Communication Strategy

Where are we now?
Currently we already have a communications and engagement strategy for COVID-19 Test and Trace work. This strategy will be developed to include and support outbreak response and the prevention plan. Our strategy has its focus on Manchester, but also gives the national and Greater Manchester context for synergy and alignment of messages. It takes each theme of work and breaks it down into key audiences - the public, staff and high risk settings, and people who may be more vulnerable - and calls for action, with a strong emphasis on cascading information through established and trusted community groups and voices. We have also segmented audiences and channels so that we reach the right groups in the right way. In particular we have a rich and diverse multicultural make-up in Manchester, so we have worked with VCSE, community and engagement teams to make sure materials reach people in the right languages. This is particularly important for our Black, Asian and Ethnic Minority communities. We've also put channels in place so that we have versions of materials for people who may be deaf or partially sighted or have learning difficulties.
What is working well?
Within all our communications messages we have put a strong emphasis on prevention - including looking after general physical and mental health. Messaging that has simplified lots of facts has worked well - along with a high visibility of our Director of Public Health via short films and Q and A sessions which have been shared across many sectors - and bring transparency and relatable content to our audiences. For example, a question and answer session with David Regan in the Manchester Evening News was the second highest read article over the course of one weekend on the MEN news site. Integrating public health into all aspects of communications has also been received well. For example, our Welcome Back Manchester campaign, at the start of easing on lockdown on June 15 had public health messages about staying safe and looking after one another at its core. This also included messages around mental health, while still giving a warm and friendly welcome as the city came out of lockdown very gradually.
What are our next steps?
We have joined the Greater Manchester communications meetings on both

test and trace and also outbreak plans. This has allowed us for example to make a recommendation or ask for a bank of materials that all localities can use in the top required languages.

We are now also compiling a piece of work to map all groups who need to be involved in Manchester's work along with the channels and ways to reach them.

We will maintain our stance of doing what is right for our particular audiences and their needs - bearing in mind the insight behind our population health characteristics and the partnerships we already have in place through the city's locality plan.

We will also continue to place both health and social care within all the plans for the city's eventual recovery.

Manchester COVID-19

Local Prevention and Response Plan

Workstream 4 – Data, Intelligence and Modelling

Where are we now?

Data and intelligence linked to COVID-19 is available from the Manchester Health and Care Commissioning Tableau portal. This includes data from at risk populations, confirmed cases, deaths, testing, outbreaks, and service utilisation. Teams across MHCC, MLCO and MCC have contributed to the data within this resource. Some of the dashboards require a Tableau account and password which can be requested via the portal landing page for those with a strategic or operational need to see this data.

We have been closely monitoring the situation in care homes using a number of different sources of data, including information collected from care homes themselves via the Manchester Care Capacity Tracker and the Community Infection Control Team (CICT), alongside data from Public Health England (PHE), the Office for National Statistics (ONS) and the Care Quality Commission (CQC). We have also initiated a daily flow of information on deaths taking place in the city from the local registrar. This is used to produce a weekly report on outbreaks, infections and deaths involving COVID-19 for the Executive Member for Adult Health and Wellbeing.

Data on outbreaks is reported on a weekly basis to monitor changes in the spread of infection across commissioned services settings such as care homes.

In the early stages of the pandemic, modelling of the potential spread of the infection in a “worst case scenario” was undertaken for Manchester to enable planning of services and responses.

Modelled estimates for local contact tracing activity have been calculated to assist in planning and ensure adequate staffing provision.

A local model of the volume of positive cases where access to testing via the existing routes may not be feasible has been calculated. This strengthens the business case for continuing to offer community testing and is one part of the plan to control the spread of the infection going forward.

What is working well?

Data and information has been made available and is being accessed regularly to inform our response and plan prevention work.

Members of the Population Health Knowledge and Intelligence Team have been working as integral parts of the Test and Trace Programme, providing expert advice and support as required.

While models have proven to be inaccurate, they have proven to be useful. As this is a new and complex infection, the world has lacked enough detailed research findings to be able to construct accurate models. Despite this, models have enabled us to plan locally for much larger levels of infection than we have seen – we have mobilised services in response to this and would be able to mobilise again in the event of a second wave of infection.

What are our next steps?

Next steps include development of a local COVID-19 surveillance system to monitor the transmission of disease and identify the early signs of future waves of the pandemic in Manchester. This will need to build on existing dashboards and data flows that have already been established. The output needs to be a system-wide 'early warning system' and dashboard using data from MHCC, MCC and the MLCO. This will likely involve repurposing and re-visualising existing data to meet these requirements.

Further dashboards will be developed to track and monitor local contact tracing once the system is up and running, and will be linked to any outputs required for reporting back to Greater Manchester or the national track and trace system.

We are also working to finalise data sharing and data consent policies and procedures regarding contact tracing and consequence management.

Manchester COVID-19

Local Prevention and Response Plan

Workstream 5 – Addressing Inequalities

Where are we now?

As outlined in the needs assessment, we recognise there are a number of population groups or communities that are known to have experienced a disproportionate impact from COVID-19. An effective approach to preventing the spread of COVID-19 requires a specific focus on the differential impact on different groups and communities.

We are in the process of establishing an 'Addressing Inequalities' group which will report into the COVID 19 Response Group. The aim of Manchester's 'Addressing Inequalities' workstream is to improve outcomes for communities that experience disproportionate direct and indirect adverse impacts of COVID-19. The group will work to work systematically provide review, guidance and assurance that COVID-19 response and recovery:

- Addresses existing inequalities
- Addresses potential to amplify inequalities through our COVID response
- Addresses potential to amplify inequalities through our COVID recovery plans
- Acts to leverage a reduction in existing and future inequalities

The framework for this group will relate to the 7 themes outlined in the Manchester COVID-19 Local Prevention and Response Plan. A high-level equality impact assessment has been prepared for the contact tracing however detailed equality analysis will be completed for testing and tracing and other workstreams.

What are our next steps?

The initial plan for the group is to focus on reducing morbidity and mortality from COVID-19. It is anticipated that this will lay foundations for addressing broader/indirect impacts later on. This work will be delivered in conjunction with the MHCC operational plan which aims to harness positive social change, undertake risk assessments and processes to reduce health inequalities and outcomes arising as additional impacts of COVID-19.

The resource implications for this work have not yet been scoped, but are likely to link to the follow themes and workstream:

- Community engagement – theme 6 high risk groups
- Hyperlocal testing capacity – theme 3 local testing capacity
- Support for contact tracing – theme 4 contact tracing in complex settings
- Enhanced support for communities – theme 2 humanitarian response
- Local intelligence to direct resources – workstream 4 data, intelligence,

modelling
- Culturally appropriate messages – workstream 3 communication

Resource Implications

Local authorities across England have been allocated a share of £300m to support the joint work between NHS Test and Trace, local government, and local partners to stop the spread of the virus. Manchester has received £4.8 million to support the delivery of the local Test and Trace work.

This plan describes essential work that needs to be funded as well as work that will or may be needed over the next 2 years to respond to COVID-19 locally. We recognise that we need to be prepared for a second or more waves of COVID-19 that would significantly impact on local capacity.

There are ongoing discussions to finalise the budget required. Approximately £2.2m has been allocated to staffing to increase capacity in our Manchester Test and Trace team, establish a local Contact Tracing Team (MCC Environmental Health Officers, MLCO Contact Tracing Team), increase capacity in our Community Infection Control Team and contribute to the GM Contact Tracing Team.

The initial staffing costs are summarised below. As stated above it is likely that this resource will be required for a two year period.

Contribution to GM contract Tracing Hub	£287,089
CICT team	£334,000
Manchester test and trace team	£1,509,059
Recovery	£72,000
Total funding allocated	**£2,202,148**

It is anticipated that the remaining funding will be required in full to cover the additional costs associated with testing, data and intelligence and other areas required to support an effective local COVID-19 response. Work is being carried out to finalise the Resourcing Plan. Key funding areas are summarised below:

Testing

- Pillar 1 testing kits
- DHSC pilot for testing people who are homeless
- Rolling programme of testing in care homes
- Establishing hyperlocal testing sites
- Local courier service for testing sites
- Community swabbing team in high risk settings

Data and Intelligence

- IT system for testing and tracing

Other

- Community engagement work including VSCE contribution
- Communications campaign
- PPE
- Training for settings
- Possible COVID care facility
- Additional funding for NRPF team

Appendix 1 – Glossary of acronyms

ABEN	A Bed Every Night
ADPH	Association of Directors of Public Health
AiPP	Ageing in Place Programme
BAME	Black, Asian and Minority Ethnic
CICT	Community infection control team
COVID-19	Disease resulting from infection with the SARS-CoV-2 virus
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
DOS	Directory of services
EHCP	Education, Health and Care plans
GM	Greater Manchester
GMCA	Greater Manchester Combined Authority
GMHSCP	Greater Manchester Health and Social Care Partnership
GMP	Greater Manchester Police
GMSCG	GM Strategic Co-ordination Group
HCAI	Healthcare acquired infection
LSOA	Lower Layer Super Output Area
MCC	Manchester City Council
MFT	Manchester Foundation NHS Trust
MHCC	Manchester Health and Care Commissioning
MLCO	Manchester Local Care Organisation
NHSE	NHS England
NRPF	No recourse to public funds
PCN	Primary Care Network

PHE	Public Health England
PPE	Personal protective equipment
PQI	Performance and quality improvement
R_0	Basic reproductive number
RAG	Red-Amber-Green
R_e	Effective reproductive number
SAGE	Scientific Advisory Group for Emergencies
SARS-CoV-2	The virus which causes COVID-19
SEND	Special Educational Needs and Disability
SitRep	Situation report
SPOC	Single point of contact
TTCE	Test, Trace, Constrain and Enable
VCSE	Voluntary, community and social enterprise

Manchester COVID-19

Local Prevention and Response Plan

Appendix 2 – Mapping of themes to Greater Manchester Plan

Greater Manchester Themes	Manchester Themes
1 Care homes and schools	1 Children, young people and educational settings 2 High risk settings
2 High risk places, locations and communities	2 High risk settings 6 High risk groups in the community
3 Local testing capacity	same
4 Contact tracing in complex settings	same
5 Data integration	same
6 Vulnerable people	6 High risk groups in the community
7 Local boards	same

Manchester Health and Wellbeing Board
Report for resolution

Report to: Manchester Health and Wellbeing Board – 8 July 2020

Subject: Addressing Inequalities

Report of: Director of Workforce and Organisation Development, Manchester Health and Care Commissioning and Director of Policy, Performance and Reform Manchester City Council

---

Summary

Covid-19 has further reminded us of the differential impact of health issues on the communities who live in Manchester. This report describes how the pandemic has affected different communities in the city and the actions we are taking to respond to this.

Recommendations

The Board is asked to:

1. Note progress to date.

2. Encourage respective partner organisations on the Board to continue to prioritise addressing inequalities in health and care both as a system and within own organisations in our response to COVID 19.

Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	
Improving people's mental health and wellbeing	This report outlines the actions in relation to our recovery planning and mitigating risk so as to enhance resilience for the city in relation to addressing inequalities.
Bringing people into employment and ensuring good work for all	
Enabling people to keep well and live independently as they grow older	
Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme	
One health and care system – right care, right place, right time	As Above
Self-care	

Contact Officers:

Name: Sharmila Kar
Position: Director of Workforce & Organisation Development, MHCC
Telephone: 07811 982 287
E-mail: sharmilakar@nhs.net

Name: James Binks
Position: Director of Policy, Performance and Reform, MCC
Telephone: 0161 234 1146
E-mail: j.binks@manchester.gov.uk

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

N/A

1. Introduction

Clear evidence has emerged that Covid 19 is having a disproportionate impact on some communities who already experienced health inequalities in our city. BAME, disabled and people in poverty are more likely to contract Coronavirus and have poorer mortality outcomes. The longer term health impacts are not known yet but it is expected that the socio-economic impacts and impacts of higher mortality rates not directly linked to Covid 19 will also be within these communities, unless we radically change our approach to health and social care. This makes the need to embed inclusion and address inequality even more critical.

1.2 COVID risk factors

Clinical[1]

- If you are in the High clinician risk group (shielded) – disabled people
- If you are in the Moderate clinician risk group – disabled, older, obese and pregnant people
- your age – your risk increases as you get older
- being a man
- where in the country you live – the risk is higher in poorer areas
- being from a Black, Asian or minority ethnic background
- being born outside of the UK or Ireland
- living in a care home
- having certain jobs, such as nurse, taxi driver and security guard

Based on deaths that occurred up to 19 June but were registered up to 27 June there were a total of 1,883 deaths among Manchester residents. Of these, 386 deaths involved COVID-19. A total of 77 deaths involving COVID-19 were recorded as having occurred in a care home. This represents 19.9% of all deaths involving COVID-19. In the most recent week, there were a total of 3 deaths involving COVID-19 among Manchester residents (compared with 9 deaths in the previous week). Just one of these deaths were recorded as having occurred in a care home. There is now a clear downward trend in the number of deaths involving COVID-19, from a peak of 75 deaths occurring in the week ending 17th April.

The age standardised rate of deaths involving COVID-19 in Manchester (59.8 per 100,000) is 63.3% higher than the rate for England as a whole (36.6 per 100,000). The age standardised rate of deaths involving COVID-19 for men in Manchester (90.0 per 100,000) is more than double that for women (38.9 per 100,000).

The risk of death involving COVID-19 among some ethnic groups[2] is significantly higher than that of those of White ethnicity. After taking account of age, other socio-demographic characteristics and measures of self-reported health and disability.

[1] https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/

The risk of a COVID-19-related death for males and females of Black ethnicity is 1.9 times more likely than those of White ethnicity. Males in the Bangladeshi and Pakistani ethnic group were 1.8 times more likely to have a COVID-19-related death than White males. Females in this ethnic group were 1.6 times more likely to have a COVID-19-related death than White females.

The difference in COVID-19 mortality between ethnic groups is partly a result of socio-economic disadvantage and other circumstances. We also know that health and racism are inextricably linked. For many BAME communities this results in unequal access to social and economic opportunities. Quality education, employment, liveable wages, healthy food, stable and affordable housing, and safe and sustainable communities are factors that shape health. When these factors are distributed in unfair and unjust ways, they contribute to racial and ethnic disparities in health.

The PHE report published earlier provides clear evidence that COVID-19 does not affect all population groups equally. The review of disparities in the risk and outcomes of COVID-19 shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with COVID-19. Genetics were not included in the scope of the review.

The report that followed titled *Beyond the data: Understanding the impact of COVID-19 on BAME groups* made a number of recommendations that arose from a range of requests for action from stakeholders and point to the areas where commitment, focus, and delivery at scale could make a significant difference in improving the lives and experiences of BAME communities. It is important to note whilst some of these recommendations are being acted upon many of them need to be further strengthened within our system and organisations, such as data collection, improving access, recognising how we effectively engage and communicate with communities and target our funding to name a few.

Young people and employment

National ONS figures show that 408,000 people in the 18-24 age group are unemployed, while data from the Resolution Foundation research indicates that the crisis could push a further 600,000 young people into unemployment, unless support is provided. Tens of thousands of internships, work experience opportunities and entry-level employment roles could also be cut for those new to the job markets, depending on how employers choose to respond.

Older people and transport

Access to transport is often cited as a key concern for many older people in the City. This concern is heightened as older people, who are disproportionately reliant on public transport, are advised to avoid using public transport or to do so with significant restrictions that see anxieties rise in many older and therefore more at risk

---

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020#toc

people. This serves to effectively sever a lifeline to access health and care services, social networks and for shopping.

Digital exclusion

As the effects of the Covid pandemic continue, so does an increased reliance on electronic means of communication and access to services. This throws up issues of digital exclusion; affordability and access to devices, broadband etc. exacerbate pre-existing economic challenges for some of Manchester's poorest residents. Added to that, even when access to a device is possible, some cohorts (i.e. disabled people, older people, some BAME groups) cannot always access services in an equitable way due to inaccessible website design or communications.

Disabled children and families

Parents and carers of children and young people with SEND managing daily family life whilst meeting the needs of their child/children is challenging. With schools shut for most pupils and access to their usual support services limited these families are facing increased pressure. Short breaks for disabled children offer a much needed break from caring responsibilities and the absence of this provision will cause increased strain on families. Specialist CAMHS services are reporting an increase in calls from families of disabled children - particularly in relation to children's sleep problems and strategies to manage behaviours of children struggling to cope with an enormous change to their daily routine.

Geographic and economic considerations

People who live in deprived areas of the country have higher diagnosis and death rates than those living in less deprived parts of England. The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and females, and survival among confirmed cases was also lower in the most deprived areas. This is particularly clear amongst people of working age, for whom the risk of death was almost double that of people in the least deprived areas with male diagnosis rates were significantly higher than females.

We need to continue to better understand what the local evidence tells us in terms of the impact on Manchester residents, communities and patient and how it compares to some of the national data.

2. Planning ahead for the recovery

Although the response work will continue for some time, there is now a significant focus on planning ahead for the longer term challenges as we emerge from the lockdown period. This forward planning work will help to plan for the city's recovery including its economy, residents and communities, as well as the impact on the Council including its services and finances. This work will be undertaken with key stakeholders in the city in order to develop the best possible joint plans.

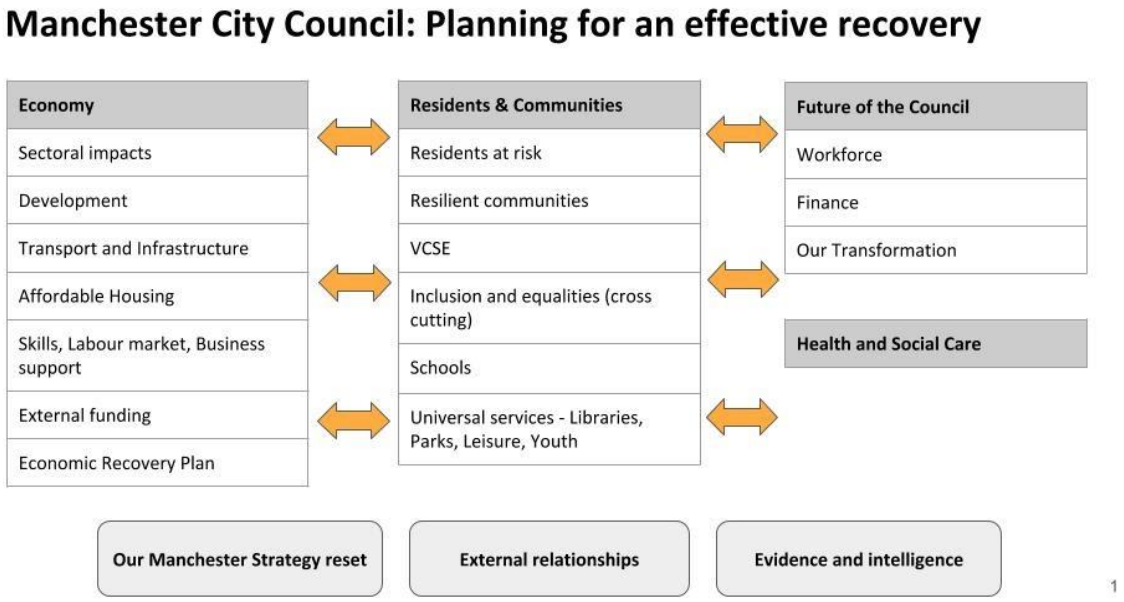
Four workstreams are being progressed in order for the City and the Council to prepare effectively for the recovery. These are highly interdependent, as illustrated

in the diagram below. Each workstream involves a significant portfolio of work, and each is in the process of identifying short, medium and longer term priority actions. The workstreams are:

- Economy
- Residents and Communities
- Future Council / Impact on the Council
- Health and Social Care

Underpinned by:

- Evidence base and impact for each of the above workstreams
- External relationships with a range of key partners
- Reset of the Our Manchester Strategy



Work is being prioritised under the Equalities and Inclusion workstream within MCC to read across various evidence sources to 1) extrapolate the key findings with a focus in the first instance on race, disability, age, poverty and shielded; 2) give an indication of gaps in the data and / or where more depth of understanding is needed, 3) use the gap analysis to inform an approach to specific and targeted engagement with relevant groups (consideration will need to be given here to which groups and forums already exist and where new engagement connections are needed) to address the gaps and / or understand community sentiment in Manchester on particular issues. This high level, strategic analysis will be kept under regular review as new and more detailed data emerges in the coming months, and reported back via the Executive Members Equalities and Inclusion subgroup to inform recovery planning.

Supporting this strategic analysis, an increased use of Equality Impact Assessments against each of the Council's relevant practical recovery actions will provide service-level / more operational consideration of community impact in relation to a given activity.
Across health and care the 'Community Cell' has been set up to lead the out of hospital/care system within the City during the period of Covid-19 response and

recovery. The community cell will seek joint working opportunities with Trafford, and other GM Localities where it makes sense to.

The 3 workstreams for the community cell are listed below. Each will have its own leadership, and coordinating group, to oversee it and report into the Cell.

1. Coordination of the Manchester Covid 19 response
2. Overall capacity and demand planning
3. Care home and home care capacity increase

The Cell will work closely with the Manchester Hospital Cell arrangements and also connect to the wider system response at City and GM level.

The Manchester COVID-19 Response Group ("the CRG") (previously called the Manchester COVID-19 Locality Planning Group (MCLPG)) fulfils the role of the Manchester Health Protection Group, which is the established group for all health protection issues in Manchester. Addressing inequalities/Health Equity is a key workstream under this group. The purpose of this workstream is to improve experiences of and outcomes for, communities that suffer disproportionate adverse impacts from COVID-19.

This will involve reducing the risk of transmission, severe disease and death among groups of people who have been identified as most risk including*;

- Black African, Black Caribbean and Asian people
- People born outside the UK or Ireland
- People in specific occupational groups
- People with learning disabilities
- Inclusion health groups -Asylum Seekers and Refugees, Gypsies & Travellers, Sex Workers, Ex-offenders*

*This will be kept under review based on emerging and evolving understanding of the disease. Note the needs of other at risk/vulnerable groups e.g. people who are homeless, older people, clinically at risk/shielded groups are being addressed through other workstreams.

3. Equality Analysis

MHCC have produced a summary of the requirement to continue to meet the statutory duty under the Equality Act 2010 to consider equality implications when reviewing policies and practices and introducing new ones through an equality impact assessment. This takes account of the easements introduced within the Coronavirus Act of 2020. We have undertaken strategic Equality Analyses in past four months, including Hot clinics, Hot care homes, Testing service, MHCC Bereavement policy and digital primary care. There have been some challenges with sequencing solutions as new pathways are developed and some retrospective analysis and mitigating actions required due to the speed of change. We have now trained twenty MHCC and MLCO colleagues to undertake an Equality Analysis and will continue to support with identifying mitigating actions where we are working in relation to recovery plans.

MCC has issued a Covid-19 specific equality analysis template and guidance which has already been used to good effect on the organisation's response work (i.e. the establishment and operations of the Community Hub) and is now being implemented across a range of recovery workstreams (i.e. in Highways regarding the re-opening of public spaces to boost the City's economic recovery). The requirement for Council services to complete equality analysis against all relevant Covid-recovery work has been restated through the organisation's recovery governance mechanisms. Progress against this requirement is overseen by the Equalities and Inclusion recovery workstream.

4. Evidence base and Governance

The Public Health Intelligence Team and Engagement Teams continue to work together to ensure that we have a full picture of the available quantitative data, analysis and qualitative evidence around the disproportionate impact of Covid-19 on certain communities.

A weekly community and public surveillance report is now being produced and shared across MHCC based on feedback to the Engagement Team from the Patient and Public Advisory Committee and Expert Panel members, Community Explorers, voluntary and community organisations and GP practices. This is effectively a log of all issues being raised by individuals and groups, many of which have equality implications. The report also shows what the Engagement Team has put in place to address the issue. Whilst some of the issues raised are linked to individual enquiries, they will help us to understand what is not working for wider groups of the community and put in place support.

The Our Manchester Disability Plan Board organised an extraordinary meeting on the 14th April and invited a range of VCSE group representatives who support other communities who experience discrimination and inequality to join the meeting. The group shared detailed evidence of the impact of Covid-19 on the communities that they serve.

A piece of rapid research has been undertaken into cohorts of the population whose needs could potentially be missed or ‘slip through the net’ as a result of the response to COVID-19. For example as a result of reduced contact – or reduced opportunities for contact – with public service professionals / carers and associated missed opportunities to identify and respond to need or risks. This includes members of the traveller community, people not registered with a GP and people of all ages at risk of domestic abuse. We continue to work collaboratively with MCC on ensuring that we are reaching people on the ‘at risk’, shielded list, both in terms of the primary care and community hub responses. This work is ingoing as part of our recovery plans.

The Our Manchester Strategy reset will involve targeted engagement with groups and communities that have been disproportionately impacted by Covid-19, as well as universal engagement opportunities for all residents, geographically organised engagement, and engagement with key partners and city-wide Boards. Inclusion and equalities will be a key 'horizontal' theme that cuts across all aspects of the reset of the strategy.

5. Workforce specific measures

Staff risk assessments are being undertaken across MHCC, MCC, MLCO and other partner organisations to address the need to ensure that 'at risk' staff, including BAME staff are protected. The MHCC risk assessment tool has also been shared with primary care. MHCC has worked with the MLCO to develop a risk assessment framework that has been shared with care homes in Manchester.

Manchester University NHS Foundation Trust has already acted to protect colleagues particularly those staff who Public Health England has reported are most at risk of severe illness arising from COVID-19. Over the last few months, as we have continued to learn more about COVID-19, it has also been recognised that some people from Black, Asian or Minority Ethnic (BAME) backgrounds are at greater risk of severe illness from the virus alongside the other vulnerable groups. These include colleagues who are aged over 70 years, those who have an underlying chronic health condition or who are pregnant. In order that the Trust can look after and support colleagues appropriately there are individual risk assessments available. Letters have gone out to all staff encouraging staff to feel confident to speak to their managers about undertaking a risk assessment and to talk to their managers about concerns they have. The risk assessment is part of a broader programme of protect and support staff.

Alongside the development of the standardised risk assessment, the BAME Reference Group and COVID-19 BAME Engagement Group have also supported the development of the self-assessment process which enables staff to consider how their personal circumstances may relate to the risk levels. As part of this work staff have been encouraged to complete the process and speak to their managers if they feel that they require a risk assessment.

There are also links with the BAME Nursing Network and the Caribbean and African Community Group (C&ACG) including specific contact with the C&ACG COVID-19 support work streams. These groups have helped to shape a communications campaign, produce staff focussed materials, provide feedback on documents and suggest new and innovative ways that the Trust can engage with staff.

Following receipt of the letter from NHSE/I, an audit of diverse representation within the MFT and MLCO command and control structures .The outcome of the review was agreed by the COVID-19 Strategic Group and included consideration of the full range of planning and operational groups associated with the management of the COVID-19 Pandemic. The Group agreed a proposal for chairs of command and control groups to formally review Black, Asian and Minority Ethnic (BAME) representation within existing structures.

Greater Manchester Mental Health Trust

In terms of workforce the Trust worked closely with Trade Unions and the BAME Staff Network in the design of a template to ensure staff receiving risk assessments felt assured by them and that they were creating the right conditions to have a meaningful conversation. Best practice guidance issued by the Royal College of Psychiatrists was used as the basis for this document. All risk assessments

completed are reviewed by an HR professional in the first instance to ensure that actions are captured and where there are issues that appear to be unaddressed or gaps in information these are returned back to the relevant manager for clarification or further completion where needed.

Where a BAME worker is in a frontline role and has additional comorbidities then the manager is being contacted to discuss further the rationale for retaining them in a front-line clinical role and occupational health support considered.

At the recent BAME Staff Network event (held on 29th June 2020) specific feedback was asked for in relation to how staff felt about the completed risk assessments so the Trust could understand the perspective based on staff experience. Overall staff stated that they felt the risk assessment was very positive and they had a positive experience when completing them with their manager. Staff welcomed the supportive measures put in place following the completion of the risk assessment. Some commented on the feeling of it being "tick box" and as a result of this the Trust is putting on virtual sessions to discuss with managers how to carry out a quality conversation in relation to assessing risk for vulnerable workers. These sessions will be run in partnership with Trade Union colleagues.

The Trust have provided a sample of redacted completed risk assessments to their lead health and safety trade union representative who will review and provide feedback on themes and issues that may be presenting in relation to the quality of risk assessments. Following this they will amend and send out further guidance for managers and assess the level of support that is needed to ensure the quality of the risk assessment continues to grow. Above all else the Trust wants to ensure transparency in relation to the management of risk assessments. All of the aforementioned actions are being managed via the Trust Covid Working Safely Group, chaired by the Director of HR/Deputy CEO, which reports into the Recovery Board and has trade union involvement.

6. Conclusion

The pandemic has highlighted and amplified inequalities in our society. The sheer scale of the impact on some communities means that we will need to be bold if we are to prevent inequalities from widening. As a system and within our own organisations we must make addressing inequalities a key priority.