Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 1 September 2020

Subject: Recovery of NHS services

Report of: Manchester Health and Care Commissioning
Manchester Foundation Trust
Manchester Local Care Organisation
Greater Manchester Mental Health NHSFT
Greater Manchester Health and Social Care Partnership

Summary

This paper provides an update on the reinstatement of NHS services following changes in service provision as a result of the impact of Covid-19.

Recommendations

Health Scrutiny Committee is asked to note the report.

Wards Affected: All

Environmental Impact Assessment - the impact of the issues addressed in this report on achieving the zero-carbon target for the city
The paper describe the reinstatement of NHS services following the disruption caused by Covid-19. Some of these changes, for example the reduction in transport use as a result of an increased use of digital consultations, will have a positive impact on achieving the zero-carbon target for the city.

Manchester Strategy outcomes	**Summary of how this report aligns to the OMS**
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	Preventing ill health, and improving the health and wellbeing, of Manchester residents is a key element of the city's Our Manchester Strategy. The NHS is the largest employer in the city of Manchester. The expertise required in NHS occupations brings talented people into the city to live and work.
A highly skilled city: world class and home grown talent sustaining the city's economic success	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	

A liveable and low carbon city: a destination of choice to live, visit, work	
A connected city: world class infrastructure and connectivity to drive growth	

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Background documents (available for public inspection):

Not applicable.

1.0 Background / Introduction

1.1 As a response to the emerging Covid-19 pandemic, NHS England and NHS Improvement (NHS E/I) declared a level 4 incident – meaning that the response was to be co-ordinated at a national level.

1.2 Over the following months, NHS organisations have received a number of letters from NHSE/I leaders which have described the required actions for the following phase of the response. These have set the context for the local planning and delivery of health services and include:

- On 2 March, a letter was received which described the organisational arrangements required for the initial response;
- On 17 March, a letter was received describing the next steps of the NHS response with specific asks to:
  - Free up the maximum possible patient and critical care capacity
  - Prepare for, and respond to, the anticipated large numbers of Covid-19 patients who will need respiratory support.
  - Support staff, and maximise their availability
  - Play a full part in the wider population measures announced by the Government
  - Remove 'burdens', so as to facilitate the above
- On 29 April, a letter was received describing Phase 2 of the response, including the re-establishment of urgent non-Covid19 services.

1.3 On 31 July, a letter was received describing Phase 3 of the response, It highlights 3 priorities:

- Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter
- Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.
- Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

1.4 This report summarises how different areas of the NHS are reinstating services which were paused as a result of Covid-19 and in line with the national guidance. It covers:

- Hospital services (including Cancer)
- Community health services
- Mental health services
- Dental services
- GP practices

Representatives for each sector will attend the meeting to take comments and answer questions from Committee members

2.0 Acute Services (including Cancer)

2.1 Manchester Foundation Trust (MFT) has established a COVID 19 Recovery Programme that was activated in April 2020 following the national peak in daily deaths on April 21st and subsequent rolling daily average decline, and steady decline in the number of confirmed daily new coronavirus cases from the 7th April.

2.2 The Trust are currently in the Stabilisation Phase of Recovery, bringing planned services back on stream and transforming them to meet the needs of the post-COVID environment. It is anticipated that this phase will last till the end of August 2020, followed by a period of gradual return to baseline activity in an adapted environment.

2.3 The programme has 17 work streams that take a Trust-wide perspective and cover all aspects service delivery. The aim of the programme is to ensure optimum service delivery, as soon as possible, within a COVID safe environment, ensuring that equalities and inclusion are at the heart of every plan and decision made.

2.4 Each work stream is led by one of the hospital CEOs or an Executive Director, with support from the wider organisation at a clinical and managerial level. A comprehensive recovery plan has been developed to ensure:-

- Alignment with national requirements as outlined in the Phase 3 letter and supporting implementation guidance
- Services return to pre-COVID levels as soon as possible
- We are prepared for winter
- We learn from the experiences of the pandemic and embed changes that are truly transformational

2.5 To date all clinical pathway workstreams (Elective Care, Urgent Care and Flow, Cancer Services and Outpatient Services) have commenced their plans at pace and report progress through the production of highlight reports to the Trust's COVID Recovery Group weekly meeting. Supporting workstreams such as modelling and planning, workforce resilience, infection prevention and control, and digital enablement are also well established and progressing. The most recent workstream to be formed is focussing on Long Term Conditions. This group is in the process of developing their priorities for focus.

2.6 Below is a summary of service area recovery programme aims/objectives and SMART goals:-

Work stream	Problem Statement	Key Aims/Objectives/SMART Goals
Urgent Care &	Activity levels in emergency portals are at	- Development and implementation of an Urgent Care Model by

Work stream	Problem Statement	Key Aims/Objectives/SMART Goals
Flow	risk of returning to pre-COVID levels ensuring that social distancing cannot be achieved increasing the risk of the continued spread of the virus	September 2020 that provides high quality care, meets national and local urgent care standards and can manage capacity and activity in real time against a backdrop of variable demand arising from COVID 19 - Non-life threatening but 'ED appropriate' patients will be assigned an appointment time to attend ED in order to level the demand and achieve social distancing - To deliver the UEC priorities identified by Greater Manchester Combined Authority by the end of Q2 2020 (CAS Development, MDT community-based response model for urgent 2hrs and same day, Streaming and SDEC model, Discharge to Assess) - Completion of measurement and evaluation by end of Q3 2020
Elective Care	The elective care programme faces a backlog of 7000 cancelled operations requiring clinical prioritisation; capacity to undertake the backlog and new referrals is made more challenging due to a greatly reduced level of capacity in theatres with potential for further disruption to staff levels due to ongoing COVID infection	- Validate all waiting lists across MFT to ensure priority patients are identified and prioritised accordingly - Establish robust arrangements with Independent Sector partners to secure additional capacity at pace - Create a single MFT surgical hub to oversee the distribution of priority activity to available theatre capacity - Undertake a baseline theatre capacity exercise identifying theatre capacity and associated resources - Conduct a review of the peri-operative, admission and post op phases of the surgical pathway to account for COVID impact including demand and capacity analysis - Review and agree elective standards to support maximum productivity and ensure best

Work stream	Problem Statement	Key Aims/Objectives/SMART Goals
		practice - Link with Single Service work to accelerate implementation of the Clinical Strategies under the leadership of Joint Medical Director and Deputy CEO
Outpatient Services	Delivering outpatient services at the volumes previously delivered is no longer possible in light of COVID 19 and the requirement to socially distance	- Asses current waiting lists and triage across MFT - Assess demand and capacity for necessary face to face appointments and appraise options for expansion of face to face capacity where shortfalls are identified - Develop and implement the Attend Anywhere offer for virtual appointments - Assess capacity for pharmacy and diagnostics support to outpatient service and model future demand in the new normal - Implement Advice & Guidance initially to priority services and locally across all services - Conduct a proof of concept exercise and agree roll out plan for both e-RS & non e-RS Triage - Review common high-volume pathways and implement a range of pathway specific improvements - Link with Single Service work to accelerate implementation of the Clinical Strategies under the leadership of Joint Medical Director and Deputy CEO
Cancer Services	Within the context of capacity constraints as a result of COVID, cancer services need to move to resumption of all routine and urgent services whilst at the same time improving performance under the Trust's Cancer Excellence Programme	- Recommence Endoscopy Services reviewing current W/L position agreeing clinical prioritisation and principles - Implement phase 1 of the RDC initiative on four cancer sites of Haematology, Gynae, OG and HBP - Commence Best Practice review of pathways and develop a set of improvements based on

Work stream	Problem Statement	Key Aims/Objectives/SMART Goals
		innovation, standardisation and process improvement - Develop Advice & Guidance GP escalation route - Develop KPI dashboard

3. Community health services

Service prioritisation

3.1 As the Committee is aware Manchester Local Care Organisation is responsible for the delivery of community health services and adult social care in Manchester. The following section provides an overview of how its health services are returning to normal following the disruption caused by Covid; it also sets out the process that it is following in re-establishing services.

3.2 In March 2020, and in response to COVID-19, MLCO mobilised two work streams to support a response to the anticipated increase in care required by patients diagnosed with COVID 19.

3.3 In line with guidance provided by NHS England/NHS Improvement (NHSE/I) on 19th March 2020 MLCO were required to prioritise the delivery of its community health services. This guidance set out in detail those services which were required to stop or partially stop with immediate effect. The process that was mobilised in MLCO was clinically led and overseen by the Chief Medical Officer and Chief Nurse.

3.4 For reference and completion, adult social care services adopted a similar process, however its decision making processes were aligned to the delivery of statutory responsibilities of Manchester City Council.

3.5 As a result of the work to prioritise its community health services 755 clinical staff of various disciplines were released from their usual duties in anticipation of the increasing workload across six essential workstreams that had been identified by NHSE/I:

- District nursing
- Palliative care
- Therapy/rehabilitation
- Crisis/Discharge to Assess (D2A)
- Intravenous (IV) therapy
- Safeguarding of adults and children

3.6 The majority of the 755 staff that were released from their normal duties required some retraining/refreshing of clinical skills/knowledge to support the essential services. MLCO held two training days for those individuals who

could be redeployed into adult services; with approximately 600 staff attending the training at different sites across the city between 2 – 4th April 2020.

3.7 As part of the redeployment of staff, MLCO also looked to support the wider system pressures working in close collaboration with colleagues from primary care, secondary care and social care. This enabled MLCO to adopt digital technology to support GPs and care homes staff and others to "make every contact count" and maximise the efficiency of services provided by community staff whilst reducing unnecessary footfall and risk to patients and residents where that was clinically appropriate and safe to do so.

3.8 A comprehensive overview of stop, partially stop, and continue services is set out below in Table 1:

Table 1

STOPPED

COMMUNITY HEALTH
- Podiatry
- AAA screening
- Tier 2 gynaecology
- Falls service
- Orthopaedic outreach
- RU Clear
- Audiology (CYP and adults)
- Orthoptics (CYP and adults)
- Specialist Weight Management
- Womens Health
- ADHD Pathway
- Expert patient programme
- Central Manchester Home Physiotherapy Service

ADULT SOCIAL CARE
- Short beaks - Hall Lane
- Day Services - three day centres
- Non-essential equipment collections and deliveries
- Blue Badges: clinics suspended and issue 12- month badge to all applicants.

Manchester Local Care Organisation

PARTIALLY STOPPED

COMMUNITY HEALTH
- District Nursing including out of hours service
- Manchester Case Management/Active Case Management
- Diabetes specialist nursing
- Bowel and Bladder/Continence service
- Stroke, Neurological and community rehabilitation services
- Leg ulcer service
- Home enteral feeding service & community nutrition team
- Lymphoedema service
- Treatment room
- Cardiac and Heart failure specialist service
- Stoma care
- Community dental
- Sickle cell and thalassemia service
- Learning disability service
- MSK Tier 2
- Nursing home service
- Parkinson's Nurse
- CYP: Health Visiting, School health, Community Paeds, CCNT, SALT, OT Physio, Child health, Newborn hearing screening

CONTINUE

COMMUNITY HEALTH
- Phlebotomy
- Crisis
- D2A
- Home and community rehabilitation
- IV therapy
- Intermediate Care units
- Palliative care
- High risk podiatry
- Complex discharge
- Vulnerable babies service

ADULT SOCIAL CARE – SERVICES CONTINUING IN FULL OR IN PART
- Reablement support to citizens (prioritising citizens risk rated amber / red)
- Community alarm installations and response
- Disability Supported Accommodation Service
- Essential equipment deliveries
- ASC Care Act responsibilities
- Safeguarding enquiries and investigations
- DoLS (revised guidance)
- Mental Health Act assessments (revised guidance)
- Welfare checks (as necessary)
- Complex urgent OT assessments
- Equipment only assessments via telecon
- Provision of minor adaptations - as above

3.9 As a key part of this process, all stop and partial stop services continued to dynamically review their caseloads to ensure that if patients move into 'priority one' (visit/contact required) this was able to be actioned in a timely manner and clinically led. This enabled MLCO to prioritise those residents most in need.

3.10 Where it was necessary to discharge patients from an active caseload, advice was provided to the patient/referrer with a process put in place to ensure that as services return to normal those patient were added back into the caseload.

3.11 This is consistent and in line with national policy and guidance. Other services maintained patients on an active caseload with regular reviews of the clinical needs of the patients with an ability to move them through different priorities if clinical need changes. All services were required to signpost patients to alternative services/advice as appropriate

Leading recovery in the MLCO

3.12 The safety of our staff and the people we support is paramount to the MLCO, as such we are committed to reintroducing services in a structured way that provides assurance that it is safe to do so.

As part of its recovery phase the reestablishment of services is a key priority. This follows a multi-stage process that incorporates the following:

- Reintroduction of services to support the needs of patients and residents in Manchester
- Ensure that services have identified learning through Covid-19 as part of the delivery of any changes upon reintroduction.
- Reintroduce services where national/regional/local guidance dictates. This may also introduce changed delivery models
- Assess the impact on workforce within the service and where staff have been deployed to other teams
- Assess the impact on residents and service users through the use of equality impact assessment methodology
- Assess the impact of returning services to estates. Ensuring risk assessment and service models are adapted where required.
- Ensure that that executive team are sighted/supportive on risks and issues as assessed through the above aims.

3.13 As part of the process that has been mobilised 21 service groupings have been identified to be reviewed across Manchester. By the 1st September 2020, 18 services have been assessed and services will have started in accordance with their implementation plan. The remaining three services will be assessed during September 2020. Therefore, all services will be reinstated by October 2020.

3.14 The 18 services that have been through the process and subsequently restarted are:

1. Abdominal Aortic Aneurysm (AAA) Screening
2. Bladder and Bowel Service
3. Care Navigation
4. Congenital Heart Disease service
5. Community Nutrition team
6. Day Services
7. Diabetes
8. District Nursing including Treatment Rooms
9. Home Enteral Feeding
10. Learning Disabilities
11. Lower limb services
12. Manchester Case Management
13. Manchester Service for Independent Living (MSIL)
14. Physiotherapy Inc. MSK
15. Short breaks
16. Sickle Cell

17. Stoma
18. Tier 2 Gynaecology

3.15 The remaining services to be reviewed in September 2020 are:

- Single Point of Access
- Podiatry
- Expert Patient Programme

3.16 To support this process and to ensure that services can restart safely MLCO have established a Recovery and Programme Board that oversees the processes that support the reestablishment of services. This board is jointly Chaired by the Chief Operating Officer and the Interim Director of Strategy for the MLCO, and it has two principle functions:

Establish processes and assessment for the safe (re) introduction of services across the MLCO and TLCO service

Provide a programme assurance for the delivery of our Operating Plan Transformation programmes. These identified workstreams support our longer-term goals. These are being reviewed considering the pandemic response and our reorganisation of service deliver as defined by our Operational Recovery programme.

4. Mental Health services

Beginning of lockdown period

4.1 During the peak of the lockdown, there was a 30-40 per cent reduction in mental health referrals across adult and children mental health services.

4.2 Most mental health services across Manchester continued throughout the lockdown. The main provider of adult mental health services, Greater Manchester Mental Health Trust (GMMH) quickly adapted and focussed its capacity on high priority critical services. These were the inpatient wards, home based treatment services, and the mental health liaison teams based at the three A and E sites in Manchester.

4.3 Those services categorised as medium priority remained opened, such as Community Mental Health Teams, Early Intervention in Psychosis, Perinatal Services and Psychological Therapy services. All these community services saw a significant change from face to face appointments to phone and video appointment.

4.4 However the Memory Assessment and Treatment Service (MATS) closed to new routine referrals. Also the ‘No 93’ Health and Wellbeing Centre in North Manchester was closed.

4.5 GMMH established a Recovery Planning Group to ensure all services are able to continue to deliver safe care in line with national guidance on social distancing and infection prevention control (IPC).

4.6 The specialist child and adolescent mental health service (CAMHS) at Manchester Foundation Trust continued to provide its services throughout the pandemic, without the need to reduce any planned activity. The service was able to quickly adapt by offering more telephone and video appointments. Face to face appointments continued to be offered in line with social distancing measures to the most vulnerable and risky young people.

Additional services in response to COVID

4.7 By working with partners, GMMH were able to quickly set up a number of additional services, such as 24/7 help line, Urgent Care Centres, Resilience Hub, and Homelessness Service.

4.8 A number of clinical staff had been redeployed into these additional services. The Trust utilised staff currently shielding and working from home to support these services.

4.9 GMMH launched a 24 hour, seven day a week telephone helpline to provide advice, guidance and support over the phone to anyone in Manchester. The helpline is able to respond to urgent need and divert people in crisis from A&E. People can now access specialist mental health support via the helpline and the plan is to link the helpline to NHS 111 by March 2021.

4.10 During the pandemic, Mental Health Emergency Centres and Hubs were established in North, Central and South Manchester, to help provide appropriate crisis care for mental health patients. These centres are located out of A&E departments to reduce pressure on acute A&Es.

4.11 Also a Resilience Hub has been implemented at GM level to provide mental health and wellbeing support for wider NHS workforce, especially acute.

New ways of working

4.12 The use of telephone and virtual consultations has allowed the majority of mental health services to continue uninterrupted. All staff working in psychological therapy services for example immediately transferred to telephone and video platforms upon announcement of government lockdown.

4.13 Community Mental Health Teams implemented a hybrid model of working. This permitted safe working practices to be established, allowing a small number of workers to attend the community base on a rota basis to support core work that needed to take place in the community setting, with other staff supported with IT capability to continue their work from home.

4.14 Going forward, GMMH plan to deliver 40% of patient contact face to face, and 60% via telephone or remote video consultation. It is expected that there will

be an increase in productivity as a result of staff delivering services in this way.

4.15 Specialist CAMHS services updated their operational processes for outpatient services to meet IPC and social distancing measures. Also remote appointment guidance was issued to all clinical staff to help facilitate digital interventions.

4.16 Both adult and children mental health services recognise the need to consider a person's preferred communication style and ensure alternatives to virtual are available particularly for people with learning disabilities, older people, those suffering from digital exclusion.

4.17 For inpatient services at GMMH, IPC measures require all hospital staff to wear face masks to reduce the risk of transmission in hospitals. This has meant changes to current practices. The Trust has supplied sufficient supplies of FFP2 masks to services and staff have quickly adhered to these

Recovery phase

4.18 A significant rise in referrals is expected over the coming months, which is forecast to peak in the autumn (30% increase compared to pre COVID level) before stabilising in early 2021 with a predicted 15% increase in demand on services. Specialist CAMHS are expecting a surge in demand following the school holidays when children return to schools. The increase in demand will also be combined with higher levels of acuity.

4.19 Recovery plans are being developed to help mitigate the increase in demand and ensure continued delivery of safe and effective services. As part of this, work is underway to understand the impact of COVID for people with protected characteristics. Both GMMH and Specialist CAMHS are committed to ensuring that people who are more likely to be affected by COVID have access and support from appropriate mental health services.

4.20 CAMHS are developing a worst case scenario traffic light system to ensure service continuity for those groups of children deemed vulnerable to mental health (e.g. those known to the criminal youth justice system) or known priority groups (e.g. eating disorders). This system being developed will be shared with key stakeholders and would only be enacted if surge in demand outstrips capacity/CAMHS resources. Also the service is starting to increase the number of face to face appointments it can offer.

4.21 To mitigate the expected increase in demand on hospital beds. GMMH is working closely with partners to introduce alternatives to admission for adults in crisis. This includes increasing staffing, particular during the night for Home Based Treatment Services, and strengthening the access to overnight crisis beds that are accessible outside office hours. Also the Trust is aiming to release additional bed capacity by focussed work to reducing DTOC levels to the national benchmark of 3.8% and reducing length of stay in hospital.

4.22 The continuation of the additional services set up during the lockdown phase and the implementation of new working practices such as providing 60% of patient contact via telephone or video consultation will help mitigate demand in the community.

4.23 Providers have started implementing the requirements of the phase three guidance, which includes fully restoring Improving Access to Psychological Therapies services and proactively reviewing all patients on community mental health teams' caseloads.

4.24 The MATS which was closed to new referrals during lockdown returned to a fully operational service from mid-June.

4.25 Meeting the expected increase in demand for mental health services will also require partnership working from across the health and care system, and beyond. The pandemic has allowed greater partnership working and more freedom to implement new services quickly such as the 24/7 helpline. Going forward, strengthening the relationship with the voluntary and community sector will prove vital.

4.26 The third sector is already experiencing an increase in demand from people requiring low level psychosocial support such as help with housing, employment, debt and personal relationships. If social issues become entrenched for a large section of the population, there is a risk that low level mental health needs become more serious and more specialist care will be required.

5. Dental Services

Background

5.1 On 25 March 2020, dental practices received national instruction to suspend routine, non-urgent dental care as part of the national response to limit transmission of COVID-19.

5.2 Further to the national guidance by the Chief Dental Officer on 28th May 2020, practices have been recommencing face to face treatment for patients if it is safe to do so. 100% of dental practices across Manchester, indeed across Greater Manchester, have now confirmed that they are delivering face to face treatment for patients.

Current service provision

5.3 Assurance returns have been received from all Greater Manchester dental practices in respect to their ability to resume services in a safe manner. Manchester currently has a higher proportion of practices able to deliver more comprehensive care than comparison position across Greater Manchester. This position is indicated in Table 1.

Table 1. Manchester Dental practices recovery position (numbers of providers and % of local provision), compared to Greater Manchester position

Checklist Update	Manchester	% of providers		Greater Manchester	% of providers
Level 0	0	0%		0	0%
Level 1	37	51%		226	58%
Level 2	17	24%		84	21%
Level 3	18	25%		83	21%
Number of Providers / Sites	72			393	

Legend:
***Level 0** - Practice is unable to open for any face to face contact*
***Level 1** - Practice able to see own urgent patients and offer some face to face assessment and simple (non AGP) care.*
***Level 2** - Practice able to see some other priority patients – those under treatment or vulnerable groups (still non AGP)*
***Level 3** – Practice able to offer comprehensive service including AGP.*

5.4 Primary dental care services available to patients in Manchester:

- 18 practices can provide the full range of routine dental care including aerosol generating procedures (AGP) e.g. surgical dental extractions and interventions that require a high-speed handpiece and so are not restricted in treatment options.
- 54 practices are delivering face to face treatment but are restricted in providing non-aerosol generating procedures (non-AGP) e.g. prevention, Orthodontics, dentures, simple dental extractions, caries removal with hand instruments or slow handpieces and so currently cannot deliver the full range of treatment options.
- Referral arrangements are in place into 92 Urgent Dental Care (UDC) sites to meet the needs of any patients of practices currently restricted in their delivery.

Specialist dental care

5.5 Similar to primary dental care services, COVID-19 has significantly impacted the capacity of specialist dental care providers. Providers responded during the period by prioritising of patient access for urgent treatment needs, providing advice and support to patients and primary care for other matters.

Progressing improvement

5.6 Key matters preventing providers from being able to deliver full range of treatments appear to fall within three areas:

5.7 *PPE & Fit-test training*

Across GM the Local Resilience Forum and PPE cell have successfully developed responsive support arrangements around the supply of PPE. This has included provision of FFP3 masks to address risks associated with AGP activity. However, the use of FFP3 requires specific fitting for effective use. Initial training for UDCs was delivered by SRFT. However, capacity to deliver the required training for all dental practices has been a limiting factor.

Working with HEE, GM dental commissioners and the LDCs have established a local model based on the national guidance. Delivery of this Fit Test Training for all Dental Practice staff is currently in roll-out across GM. This is supplemented with access to training to become a Fit Test Trainer to ensure sustainable local management of the use of required specialist PPE. This development is in addition to the roll-out of national arrangements.

There have been some reports that independent/private providers of dental services are passing on the cost of PPE to patients through an additional charge. For NHS services, the only charges would be national patient charges levied to fee-paying patients.

5.8 *Identified Staff Risks*

A number of practices have reported limitations on delivery due to identified staff risk and shielding arrangements. All primary care providers are requested to undertake workforce risk assessment, with uptake being reported from dental practices.

Planning and Recovery

5.9 Dental commissioners and Consultants in Dental Public Health are developing a *Roadmap to Recovery*. This plan outlines the stages leading to recovery for dental services across the whole system. The purpose is to standardise the approach across Greater Manchester to strategically plan a range of dental services, to support opportunities for locally responsive transformational change, reducing health inequalities.

5.10 Secondary care providers have reported their own recovery plans for dental services. These are being reviewed and triangulated to provide a whole system picture, including interface and dependencies upon primary and specialist community dental services recovery.
Phase 3 planning requirements for the NHS in response to COVID-19 require both ongoing COVID-19 management and a move to the NHS being open for business.

5.11 The purpose of Phase 3, planned to take place between August 2020 to March 2021, is to:

Ensure capacity is in place for on-going activity

- From 20th July, all dental practices will maintain virtual consultation and risk management and be able to deliver face to face interventions with

a focus on the management of urgent cases and the stabilisation of oral health.
- 100% of practices are open to provide face to face treatment for patients.
- Retain Urgent Dental Centres remain in place across Greater Manchester.
- However it is to be acknowledged that there is a reduction in capacity in light of Infection Control Procedures and PPE constraints. Reduction in capacity to treat patients estimated to be 70%. This will also affect secondary care services.

Return critical services to agreed standards

- All services will be delivered in accordance with national Standard Operating Procedures
- Considerations in relation to Infection Prevention Control for all services
- Work is underway with Dental Managed Clinical Networks and Secondary Care Providers, including the University Dental Hospital, MFT, to re-establish pathways between primary and secondary care.

Address backlog of services

- Commissioners are working with secondary care providers to ensure access is available across systems and ensure restoration does not widen health inequalities.
- Reopening referrals for specialty care, including domiciliary provision.
- Whole systems approach working through Managed Clinical Networks for dental specialties across Greater Manchester.
- Prioritisation will be based on urgent dental care provision by practices, vulnerable patients and those patients part way through treatments (stabilisation); any remaining capacity will include routine care.

Work has been initiated to capture lessons learnt across the North West and capture innovation and beneficial changes within recovery plans for dental services.

Community & Paediatric Dentistry

5.12 A particular focus for recovery of specialist dental services is that of community and paediatric dentistry. The waiting times for paediatric dental treatment under general anaesthetic was a challenge prior to COVID-19 and this position has been further exacerbated during the pandemic period.

5.13 A recovery group for these dental services has been established with an opportunity to consider ‘new normal’ ways of working alongside the resumption of paediatric dental services provided by community and primary care services. This working group will explore operational aspects of service recovery with the aim of having a consistent approach to recovering community and primary care paediatric dental services in Greater Manchester,

developing practical guidance for both for managing patients appropriately post COVID-19 and identifying opportunities for improving patient experience.

5.14 Themes for this recovery group are:

- Reviewing current and planned capacity for face to face service delivery across GM and proposed timescales for recovery.
- Understanding the impact of new ways of working on capacity.
- Management of patient flows – given that operating procedures will significantly change numbers accessing face to face clinical care including dental GA provision:
- Managing patients requiring clinical care
- Improving the patient and local community experience (‘building back better’)

Retain positive changes and innovations from the pandemic

5.15 Primary care has rapidly transformed in response to COVID-19 across all contractor groups, including Dental. There has been a move to remote models of access and care delivery and positive changes to how services operate and are delivered. Many of the innovations are likely to be sustainable and could be expanded where appropriate. It will be necessary to ascertain that these innovations do not adversely impact on some of our patient population and do not contribute to widening health inequalities. Details of innovations which it would be considered beneficial to keep are described in the table below:.

Innovation to be retained	Risks	Barriers to embedding innovation	Mitigation
1. Service Development			
Virtual consultation and triage implemented across all primary and acute dental services to manage patients in urgent need, prioritise patients referred and to treatment plan.	Unable to deliver services to meet population need and address inequalities.	Access to tech by patients and variations across systems limit utility.	Digital Plan across GM to standardise delivery and technical capabilities of staff.
Further development of the Referral management system to triage and direct urgent referrals to the Urgent Care Hubs alongside the development of the Urgent Care DOS	Fail to develop and unable to deliver services to meet population need and address inequalities. Second phase of localised lockdowns.	Capacity within system due to limited availability of sites delivering face to face dentistry. Availability of PPE and FTT.	Recovery plan in development to explore delivery of services across the whole system. Ongoing development of FTT and increasing stability of PPE delivery.
Refresh oral health improvement programme in dental services (Healthy Living Dentistry) to focus on prevention and virtual delivery	Lack of access to training and development will lead to Practices not being able to offer a range of services to patients. Failure of practices to deliver programme due to lack of capacity	Capacity within system due to limited availability of sites delivering face to face dentistry. Availability of PPE and FTT.	Continue to work with the national team and support the LDC and LDNs. Seek clarity on abatement and flexible commissioning. Ongoing development of FTT and increasing stability of PPE delivery.
Community & Paediatric Dentistry (Recovery Cell) focus on improving access to dental services and oral health improvement to children through service development across the whole system	Fail to develop and unable to deliver services to meet population need and address inequalities	Capacity within system due to limited availability of sites delivering face to face dentistry in acute and primary care settings. Availability of PPE and FTT.	Whole systems recovery plan to develop model with training and workforce development that sits within preventive paradigm e.g. child friendly dental practices.

Innovation to be retained	Risks	Barriers to embedding innovation	Mitigation
Standardised approach to MCNs to step up to recovery plans working with the LDNs. Reviewing membership of groups to include representatives from the whole dental team including FTs, DNs, Therapists, etc	Fail to develop and unable to assure quality of services that to meet population need and address inequalities	Capacity within system due to limited availability of sites delivering face to face dentistry in acute and primary care settings.	Whole systems recovery plan to develop model with training and workforce development
Oral Health improvement Transformation programme use of alternative methods of delivery i.e. tooth brushing packs delivered through VSCO rather than schools	Fail to develop and unable to assure quality of services and address inequalities	Lack of staff due to redeployment	Centralised management and working across systems to ensure capacity within remaining workforce
Nightingale - developed a training pack for acute sector workers to deliver basic oral health care for inpatients	Lack of buy in from acute sector and failure to roll out across acute sector	Capacity within system to deliver due to competing demands	Identified training need and have developed robust well-evaluated online package of training. Opportunity now to embed in recovery plans within acute sector now.
2. Training Development & Research			
In partnership with HEE, PHE and NHSEI compiled a programme of virtual learning for dental teams to support the delivery of urgent dental care during the coronavirus pandemic. Hosted on the GM Training Hub, the remit of the work has expanded to meet the educational needs of the multi-disciplinary primary care team	Lack of continuous support from all sectors to keep the site up to date and relevant.	Lack of funding, lack of staff. Availability and functionality of the digital platform. Technical skills within team to develop.	Continue to meet with the aim to further develop the Hub. Potential Joint funding proposal to support the digital system. Work with MCNs to ensure that they are utilising this platform to promote all training and development.

Innovation to be retained	Risks	Barriers to embedding innovation	Mitigation
delivering oral health improvement activity and bring together NHS organisations, community providers and local authorities on a North West footprint.			
Localised development and delivery of Fit Test Training for ALL Dental Practice staff. Plus, access to training to become a Fit Test Trainer.	Failure to support the GM system by the dental workforce	Limited access to training and development will lead to Practices not being able to offer a range of services to patients	Continue to work with the GM LDC Fed to support the training and ensure it is offered to all.
Collaboration with University of Manchester to evaluate delivery of dental services including urgent dental care, prescribing, patient experience and resilience of dental practices	Failure to implement lessons learned. Research funding bid unsuccessful.	Lack of data to substantiate learning from evaluation,	High-level buy-in to support implementation of lessons now and meaningful outcome focused evaluation. Evaluation built into service development now to support longer-term evaluation (Tableau and activity capture). Develop team skillset to evaluate and implement lessons learned if academic funding unsuccessful.
Package of support for UDC system and dental services in recovery including Practice Level SOPs for UDCs and training videos by Dental staff shared across the system	Fail to develop and continue to deliver services to meet population need and address inequalities	Lack of clarity regarding abatement and contract monitoring for UDCs. National information not clear.	Continue to work with the national team, access the BDA information and support the LDC and LDNs

Innovation to be retained	Risks	Barriers to embedding innovation	Mitigation
1. Service Development			
Virtual consultation and triage implemented across all primary and acute dental services to manage patients in urgent need, prioritise patients referred and to treatment plan.	Unable to deliver services to meet population need and address inequalities.	Access to tech by patients and variations across systems limit utility.	Digital Plan across GM to standardise delivery and technical capabilities of staff.
Further development of the Referral management system to triage and direct urgent referrals to the Urgent Care Hubs alongside the development of the Urgent Care DOS	Fail to develop and unable to deliver services to meet population need and address inequalities. Second phase of localised lockdowns.	Capacity within system due to limited availability of sites delivering face to face dentistry. Availability of PPE and FTT.	Recovery plan in development to explore delivery of services across the whole system. Ongoing development of FTT and increasing stability of PPE delivery.
Refresh oral health improvement programme in dental services (Healthy Living Dentistry) to focus on prevention and virtual delivery	Lack of access to training and development will lead to Practices not being able to offer a range of services to patients. Failure of practices to deliver programme due to lack of capacity	Capacity within system due to limited availability of sites delivering face to face dentistry. Availability of PPE and FTT.	Continue to work with the national team and support the LDC and LDNs. Seek clarity on abatement and flexible commissioning. Ongoing development of FTT and increasing stability of PPE delivery.
Community & Paediatric Dentistry (Recovery Cell) focus on improving access to dental services and oral health improvement to children through service development across the whole system	Fail to develop and unable to deliver services to meet population need and address inequalities	Capacity within system due to limited availability of sites delivering face to face dentistry in acute and primary care settings. Availability of PPE and FTT.	Whole systems recovery plan to develop model with training and workforce development that sits within preventive paradigm e.g. child friendly dental practices.

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6. Primary Care (GP practices)

6.1 Introduction

This Primary Care update is framed by the COVID -19 Pandemic. It is written at a time where we are passing the peak but need to keep vigilant about any potential second wave. The Manchester health system focus is currently on understanding immediate needs, planning our services in relation to "the new normal" and "building back better". We are maintaining the essential objectives around population health and that existed prior to the Covid-19 Pandemic, establishing a clear understanding of the progress made, learning from the challenges that have been encountered and the innovations that have been key to a successful response, as we establish a path for the weeks, months and years ahead.

6.2 Whilst acute health activity has changed during Covid-19, delivery of primary health care services has also changed radically. This period has seen an unprecedented level of pressure being placed on the primary health care system. Primary Care has worked tirelessly to ensure that business continuity has been sustained against a backdrop of Covid-19 concerns, workforce pressures, the need to continue to provide responsive primary care to all patients, in particular vulnerable patients. This has been set against a continually changing regulatory and guidance backdrop.

6.3 Positive collaboration has been happening right across the city to ensure patients are able to continue to access and receive safe, high quality primary care and ensure that primary care remained 'open for business' during the course of the pandemic. Primary care is now experiencing significantly increased demand and operating a 'new normal' way of working

6.4 Whilst it is important that 'Business as Usual' has been achieved in primary care we have also seen rapid transformation. The period between March and August has seen the development and implementation of a number of new services, new pathways, new workforce models and a significant level of progress around ensuring practices are digitally enabled to deliver care differently

6.5 A large proportion of Primary Care activity has moved to a telephone and online consultation model following a move to a nationally mandated 'Triage First' approach within general practice. Further details of this approach can be found in Section 4.

6.6 MHCC has coordinated a number of priority response work streams; supporting vulnerable patients, hot hubs (for people with Covid symptoms) & cold hubs (additional capacity for practices to support resilience), proactive and reactive support to care homes, digital, testing, medicines optimisation, palliative care, workforce, and estates.

Background

6.7 In March 2020 in line with national Covid-19 guidance, a review was quickly undertaken to understand national guidance requirements, and in particular on access requirements and which primary care services should be 'paused' to enable resource to be targeted in response to the Covid 19 pandemic. The position of primary care being available to all needed to be maintained but also allow for a focus on the immediate health crisis and support to the resilience of the NHS as a whole.

6.8 Daily communications to support rapid transformation were initiated.

6.9 To support a change in priorities and funding flow to support the sector and the immediate Covid-19 response - MHCC commissioners launched an initial Covid-19 'standard' in March 2020.

Current position and overview of work streams

6.10 A significant amount of change has been delivered in such a short amount of time. The immediate Covid-19 Standard response is a good example of a rapidly mobilised programme of work, which provided a significant amount of system assurance, and created the conditions for a subsequent strategic medium and long term Covid-19 response by Primary Care.

6.11 MHCC rapidly established the Covid-19 standard which asked practices to undertake a range of urgent work in advance of the expected increase in activity in the event of a Covid-19 peak. Examples of this work included:

- *Business Continuity Planning work*
  This included staff risk assessments, full involvement with Primary Care 'Sit Rep' reporting to ensure issues were flagged to MHCC as quickly as possible, and to ensure that Business Continuity Plans were updated in advance of the Covid peak.
- *Ensure that practices were set up for remote working*
  Every practice was given a supply of laptops so staff can work remotely to ensure social distancing within general practice, and to maximise the number of patients who can have a 'virtual' consultation. A range of remote working applications were quickly commissioned and rolled out to practices.
- *Move to a 'telephone triage first' approach*
  To ensure patient and staff safety all 85 Manchester GP practices moved to a telephone triage first approach, with patients routinely offered same day telephone consultations Urgent patients would continue to be brought into practice for face to face appointments where necessary.
- *Adoption of online and video consultation models*
  MHCC asked all practices to have an online consultation system in place that supports the total triage model. All practices quickly adopted text based online consultation software and rolled them out for patients providing rapid and targeted communication. All practices are now

offering video consultations, and MHCC has commissioned the support of Redmoor Health to accelerate the training and uptake by all clinicians.

- *Making safe adjustments for 'face to face' appointments*
  In addition to the total triage approach highlighted above, MHCC required practices to use PPE in line with national guidance and report any Personal Protective Equipment (PPE) gaps via the Primary Care Sit Rep system. Practices were also required to undertake estates changes to maximise social distancing between staff and patients. Practices were asked to 'zone' their building to allow safe patient flow.
- *Practices encouraged to undertake proactive communications with patients*
  This involved all practices updating websites, undertaking regular social media messaging, and direct patient messaging via the MJOG system where required and commissioned for those practices that did not already have this system in place. Additional assurance checks ensured practices adhered to translation requirements from patients, and that patient communication met Accessible Information Standards. Interpretation and translation services were quickly adapted to enable video consulting for patients whose first language is not English.
- *Practices to contact vulnerable / clinically at risk*
  Practices were required to validate the 'shielded' patient lists and contact patients to identify any additional support needs that they had. The aim of shielding is to protect people who are clinically extremely vulnerable from COVID-19. The definition of high risk is based on Chief Medical Officer clinical criteria and a period of self-isolation was required, initially to the 30 June 2020 and then extended to 1 August 2020.
  In the next phase of Covid-19 response, Primary Care was asked to ensure safe access to healthcare and medications for this group and provide proactive care and support. A collaborative system response allowed patients a holistic approach to managing their health during shielding. We have continued to offer support following changes in national arrangements both in terms of readjustment, access to food and the mental health impact of shielding.

  The shielded group in Manchester as at 19th August 2020

Manchester (total)	20,595
North	7,528
Central	6,695
South	6,372
Children	1,323

- *Practices to increase the number of appointments that practices must make available for direct booking by NHS 111*
  Practices were required to make available a minimum of 1 appointment per 500 patients each day for direct booking from NHS 111.
- *Continue to immunise adults and children where appropriate*
  Practices were asked to follow Covid immunisation guidance circulated including Royal College of Nursing (RCN) guidance for maintaining the National Immunisation Schedule during Covid 19.

- *Continue to make urgent referrals for patients showing symptoms*
  Practices were informed w/c 30th March that routine cervical screening for those patients who are asymptomatic had been paused. MHCC was clear that cervical screening is not a diagnostic test for investigating symptoms, such as irregular bleeding and any urgent referral for these patients must continue to be made.
- *Continue to ensure Safeguarding processes are in place*
  With increased barriers to accessing care it remained paramount to emphasise safeguarding risk and to continue with appropriate safeguarding training.

Continued Covid-19 initiatives during 2020/21

6.12 Following the successful roll out of the Covid Primary Care Standard, Primary Care and clinical leaders across the city developed a comprehensive response structure which led to the agreement and further acceleration of the following key work streams:-

- Information Technology and Information Governance
- Medicines Optimisation
- Care Homes
- Primary Care Situation Reporting (SitRep)
- National and Local Guidance
- COVID-19 Assessment pathway
- Hot Hubs
- Personal Protective Equipment (PPE)
- Workforce
- Communications Support
- The Best Way
- 2020/21 Flu Response Planning
- Manchester Primary Care Standards 2020/21 - including the new Covid-19 standard.

Information Technology and Information Governance

6.13 All of the work, innovation and progress has been achieved as the result of the hard work done in practice (or remotely) by primary care and has only been possible as result of the dedicated and collaborative approach between Primary care as a system and the multiple directorates in Manchester Health and Care Commissioning and colleagues in Manchester Local Care Organisation, Greater Manchester Shared Services, Greater Manchester Health and Social Care Partnership, Health Innovation Manchester and voluntary community and social enterprises (VCSE).

6.14 Professionals and the public have taken to remote working and online communication at scale and the rapid delivery of hardware and software has enabled a significant number of the workforce to work from home, and a great deal of clinical care to be provided without the need for face to face encounters.

6.15 General Practice in Manchester has made rapid progress in relation to the use of digital first approaches in response to the national pandemic. Software deployment that would have been rolled out over a period of months has been taken up very quickly enabling practices to communicate with people in new ways: video, text chat, to share photographs and respond to questionnaires. Using these new methods of contact has reduced the dependency on telephones and reducing queues at the reception desk, in turn to reduce the risk to staff. This approach has also enabled staff to work from home, further reducing social contacts.

6.16 Inclusion is at the heart of Manchester's vision and values. These changes with regards to how services are being delivered have happened at pace and there are, as yet, unrecognised impacts and barriers that will have been created. Our services need to continue to be assessed in relation to the impact of these changes on equality, with specific considerations such as spoken language, disability, digital literacy, literacy and digital poverty.

Agile working

6.17 Covid-19 created the immediate need for agile working at scale, for outreaching the capacity of local commissioning support services both in supply of hardware (Laptops) and the ability to support remote access using software.

6.18 Immediate pressures have been met as best as possible with supply of laptops to approximately 25% of the primary care workforce. For others remote access is being provided using their own computers, using software to gain access back to practice computers. Whilst these solutions have provided some limited business continuity, they lack the ability to support the diversity of software that primary care staff needs to perform their jobs as normal.

6.19 To achieve our aim of 100% of staff being able to work in an agile way (including locums) we need to establish a longer term strategy considering potential approaches which could include a gradual replacement of the majority of desktop computers with laptops as part of a the hardware refresh program of work, using cloud based computers, or a mixture of both. This will be captured in the longer-term strategy.

Medicines Optimisation

6.20 *Palliative Care* - With system-wide support, including Manchester's palliative care consultants, the 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.

6.21 Medicines Delivery Services - 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 timeframe required. Currently,

the Medicines Optimisation Team is supporting the review and the coordination of all medicines deliveries sent by the hub. This includes, at the weekend and over the bank holidays to ensure all patients have their medicines in a timely manner.

6.22 Deployment - The Medicines Optimisation team are deployed across the Primary Care Networks (PCNs) to provide medicines optimisation support. Each PCN pharmacy team is working closely with their clinical director to identify and deliver on priority work streams to ensure patients are fully supported with managing their medicines.

Examples of priority areas include:

- Rationalisation of monitoring for high risk medicines
- Increasing uptake of pharmacy nominations and to reduce footfall
- Medicines reviews
- Rapid discharge medicines reconciliation
- Supporting transfer of care

6.23 In the future, the team will be supporting practices to roll out EPS (Electronic Prescription Service) phase 4 including consideration of complicating factors and supporting clinical work streams including advanced care planning, COPD and asthma reviews.

6.24 The Medicines Enquiry Line remains open to support General Practice and the team are also actively developing guidance to ensure primary care is fully informed of new and emerging medicines related evidence.

Care Homes

6.25 In April 2020, Manchester Health and Care Commissioning (MHCC) 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. It is designed to meet the following requirements:

- Single point of access
- Video/Telephone consultation enabled
- Clinical assessment within one hour
- Advanced Care Plans/ReSPECT*/Anticipatory Care

**The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to express their choices.*

The importance of care in Care Homes during Covid has accelerated this work, and the work to identify a clinical lead for each care home and weekly ward round taking place at each home commenced in July 2020, in advance of the original anticipated November 2020 start.

Primary Care SitRep

6.26 In order to support GP Practices across Manchester, MHCC developed an online tool to report on COVID19 related practice issues. The aim of this is to 'take the temperature' of our Primary Care system on a regular basis, to allow us to understand and wherever possible, anticipate pressures on the system as they begin to occur. This allows plans to be quickly implemented and where appropriate, mutual aid arrangements to be put in place.

The tool allows MHCC to more effectively prioritise the areas of most need and respond more effetely to practices needs in a timely manner.

6.27 **National and local guidance**

National and local guidance is reviewed daily to ensure that any key actions or requirements for both MHCC and Manchester practices are shared and actioned. Since 27th March MHCC has responded to 232 national Covid-19 guidance actions. Key information is shared with practices via twice-weekly communications, via online services and where necessary, additional contacting of practices if the information includes urgent requirements.

6.28 **Covid 19 Assessment Pathway**

Manchester's clinical leads worked together to develop a COVID Assessment Pathway that reflects the latest national guidance. The pathway has been reviewed and updated in line with emerging guidance since it was first published on 8 April 2020 and provides clinicians with a succinct narrative summary of the key emergent principles of managing patients of Covid-19 in the community accompanied by clinical guidelines for telephone and video consultations, and for those people requiring face to face consultations.

6.29 **'Hot Hubs'**

In line with national guidance, MHCC and federation partners quickly established development of local 'hot hubs' to ensure accessible pathways to enable the remote triage and a face to face service for ambulatory patients with Covid symptoms or patients living in a household with someone who has Covid symptoms.

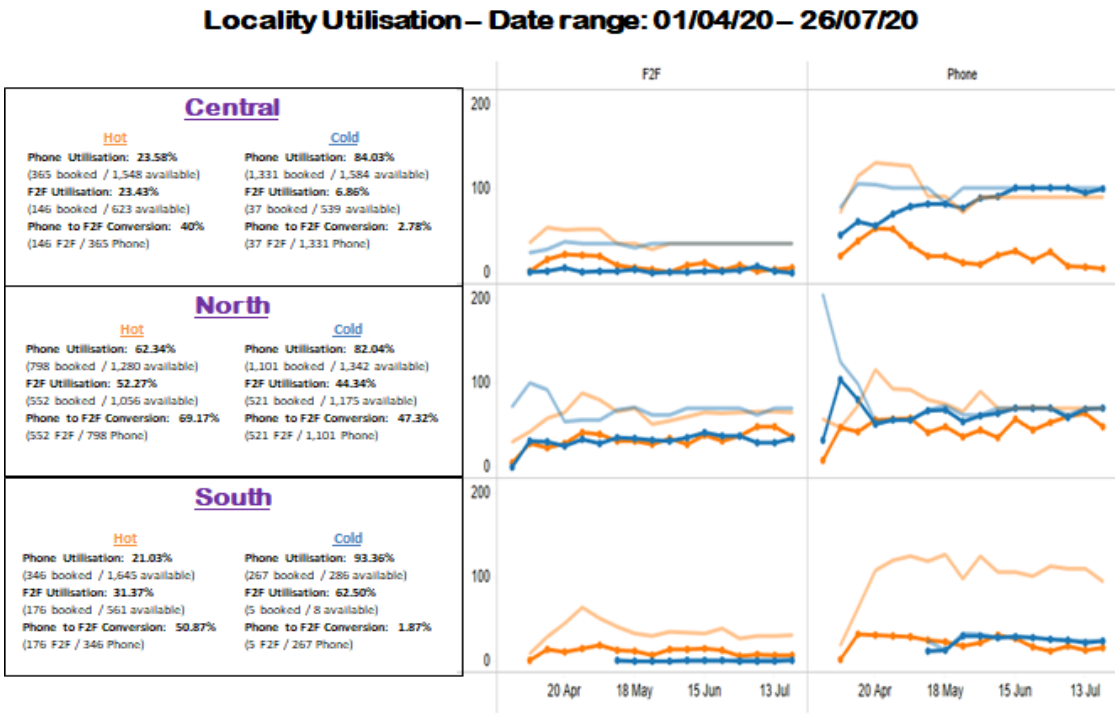
Non-ambulatory patients requiring face to face appointments would be seen by GP practices that rapidly developed home visiting models. A best practice home visiting pathway was developed and shared with primary care to ensure staff and patients were safe.

Five hot hub locations were established across the city, some of which have a sheltered 'drive-thru' facility - provided by the three GP federations. Referrals are accepted from GPs and NHS 111 (CCAS) and the services continually monitored to adapt to primary care capacity.

Additional ‘cold’ provision was commissioned to provide further primary care resilience during this period.

Walk in Centres (WiCs) were reconfigured to a ‘talk before you walk’ access model; the role of walk in centres will continue to be refined in line with the redesign of urgent and emergency care services.

The diagram below shows Hot and Cold Hub utilisation**:**



6.30 Personal Protective Equipment (PPE)

Working with partners such as the Mutual Aid Supply Hub, Didsbury Gin, Greater Manchester Health and Social Care Partnership (GMHSCP), Manchester Chinese Centre and NHS Personal Protective Equipment (PPE) Leeds, Manchester Health and Care Commissioning (MHCC) has distributed just over 700,000 items of PPE to GP practices reflecting the appropriate national PPE guidance as it has evolved in recent months (i.e. face coverings for patients). Key PPE items include; masks, goggles, full face visors, hand sanitisers, face masks and gloves.

6.31 Primary Care Estates

Initial estates requirements focused on sourcing appropriate estate to deliver hot hub services across the Manchester footprint including ensuring outdoor space requirements such as parking and outdoor waiting and consultation areas.

As per national guidance the move to a ‘digital first’ triage approach means that Practices have had to consider how their site can be managed in different ways to ensure both staff and patient safety.

All Practices have completed a GP Premises Checklist and Risk Assessment for their building, where appropriate these have been completed in conjunction with NHSPS, CHP and other tenants. The GP Checklist reflected on the fact that ways of working, staff risk assessments and national requirements would also determine how a site can be safely used by both staff and patients. Practices were advised to consider zoning of staff and sites as well as considering team bubbles and remote working to ensure Primary Care services continue to be delivered to patients in a Covid secure environment. This piece of work was shared at GM as an example of best practice.

6.32 **Workforce**

In advance of the national mandate, MHCC developed a risk assessment assurance tool to support practices and their staff. Over 2000 risk assessments were completed with all practices engaged in the process and over 700 mitigating actions plans in place to support those staff in higher risk categories. Practices have worked with their staff to adopt new ways of working such as remote working or in low risk work environments to maintain their safety.

A Manchester locum bank has been established through the Federations, and an additional Greater Manchester locum bank has been established to work closely with practices regarding non-GP roles. It is recognised that increased staffing levels, post-COVID and during the stabilisation and recovery phase, will be essential but they will need to be deployed across new ways of working and within new pathways and models of care.

The mental health & wellbeing needs of the primary care workforce need to be factored into recovery planning. Practical issues, such as the impact of staff not taking annual leave during COVID will mean there will potentially be a backlog which will be taken towards the back end of the year

Test and trace guidance brings risk in terms of workforce and staff needing to isolate; it also has the potential to destabilise practices and cause temporary closure. The use of “workforce bubbles” or teams requires further development to ensure service continuity. Practices have had the full support of MHCC to undertake testing where needed, and MHCC made available antibody testing to all GP practice staff during the summer.

6.33 **Communications to GPs**

In order to support the primary care team’s response to Covid, since the start of the pandemic, MHCC’s communications team have produced 87 primary care email updates. These updates contain the latest national and local information and guidance. There have been 1009 documents uploaded onto the CCG’s communication network (GP TeamNet) with over 10,000 views of the COVID Topic Page.

To engage with and support the public MHCC has had a heavy social media presence creating 910 posts across our platforms. Our 590 tweets

have been seen by 823,000 people. Our Facebook content has generated 2.3k reactions and reached 1.78k new users. Our Instagram content reached 114k people. We have shared key messages on several campaigns including – COVID -19, Be Clear on Cancer, Test and Trace, Stroke Awareness, Mental Health, Digital Practices and Domestic Abuse. This communications work has been delivered as part of the wider Covid-19 communications workstream, overseen by the Covid Response Group, chaired by the Director of Population Health

6.34 **2020/21 Flu Planning**

Due to the risk of flu and COVID-19 co-circulating this winter, the flu immunisation programme is vital to protect vulnerable people and support the health and social care system across Manchester. The Health and Care system in Manchester is focused on achieving maximum uptake of the flu vaccine in eligible groups, as they are most at risk from flu or in the case of children transmission to other members of the community. Seasonal Flu alongside Covid-19 creates additional risks for population and health and care system this winter.

Manchester Health and Care Commissioning is committed to:

- A make every contact count approach
- Each neighbourhood will have its own integrated flu plan including the development of new delivery mechanisms and flexible use of the workforce Major communications and engagement strategy at city-wide and local levels
- Comprehensive workforce vaccination across health and care system and wider priority groups
- Systematic focus on equalities and inclusion
- Flu Core Programme Team established to drive system-wide coordination and Manchester Flu Plan
- Start of a three-year plan to make significant shift in city's immunisation rates

6.35 **Roll out of Manchester Primary Care Standards**

The aim of the Manchester Primary Care Standards is to support all Manchester GP practices to ensure that their patients continue to benefit from pro-active, high quality primary care through a consistent population offer. Many of the standards reduce the risks from Covid and patients will benefit from these being focused on immediately as opposed to later in the year. We have done our upmost to ensure the scheme will continue to be achievable should we go into lockdown again at any point during the year.

The areas of focus this year are Inclusion and working within neighbourhoods to understand the local impact of Covid , Learning Disabilities, Cancer recovery , Long term conditions optimisation and safe support , proactively contacting those patients with severe and enduring mental health diagnoses as well as ensuring robust adherence to Safeguarding standards. An

additional standard has also been agreed specifically to support practices to deliver a robust Covid response and to support Covid system recovery.

6.36 **Health Inequalities**

COVID-19 has highlighted the significant inequalities that exist across the nation's health. The virus has had a disproportionate impact on groups already facing the poorest health outcomes. In particular, it has underlined the structural disadvantages experienced by people from Black, Asian and minority ethnic communities (BAME). The economic and social consequences of measures to contain the virus risk worsening these inequalities further.

The impact affects a significant proportion of the Manchester population. Data from the 2011 Census shows that approximately 205,000 people in Manchester identify themselves as being from a BAME group. This is equivalent to approximately 41% of the population of the city, which is twice the average for English local authorities as a whole (20%).

The response will require a sustained population health management approach with local place- based partnerships incorporating NHS, local government, voluntary sector and communities. GP practices will play a key role within this approach.

6.37 **Summary**

Crisis encourages innovation by necessity. The need to work differently and deal with the unprecedented impact of Covid supported innovation – including targeting our most vulnerable communities, supporting working in outside settings with shelters, allowing patients to receive safe and effective care at home with "doorstep observations", self-monitoring, use of wearable technology, working in partnership with patients and focussing on care around a patient rather than care delivered by a system.

The current plateau allows the opportunity to take stock, regain our focus and establish next steps to ensure that we retain best practice, whilst reinstating services and "building back better" – building a cultural change in how we deliver care. However, the following is clear:

- Our priorities as outlined in the Manchester Primary Care Strategy remain relevant. These are: improved patient access, a focus on population health need, multidisciplinary working, long term conditions management, and a focus on digital primary care;
- Significant progress has been made in relation to the priority areas outlined above in a very short space of time; and
- Priorities key to supporting the Primary Care response such as online consultation and agile working are of greater importance now as we establish our new normal.

Manchester is in the process of finalising its recovery plan, which falls largely in line with the GM Primary Care Recovery Plan committed to a series of actions as a collective. These were split down into immediate catch up and recovery, embedding what has worked well during COVID, and accelerating new ways of working.

The timeframes for immediate catch up and recovery and embedding what has worked well were within a six-month period until November 20 with a further six months to accelerate new ways of working.

As we enter Phase 3 Recovery, the focus will be to ensure primary care can restore activity where clinically appropriate whilst managing increased demand, both urgent and routine.