GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE

Date: 9 September 2020

Subject: GM Health & Care response to the Covid-19 pandemic

Report of: Sarah Price: Interim Chief Officer, Greater Manchester Health and Social Care Partnership (GMHSCP) and Chair of the GM Community Coordination Cell.

Silas Nicholls: Chief Executive Wrightington, Wigan and Leigh NHS Foundation Trust and Chair GM Gold Command.

PURPOSE OF REPORT:

The purpose of this paper is to provide the Joint Health Scrutiny Committee with an overview of the work done by the Greater Manchester Health and Social Care system in response to the Covid-19 pandemic. It will concentrate on the work done collectively at a Greater Manchester (GM) level however, recognises the primary focus of the response was carried out at a local level within each of our neighbourhoods and districts**.**

The paper will also describe a forward view of what is being put in place to help patients and the health and social care system through the recovery stages from the pandemic.

RECOMMENDATIONS:

The Joint Health Scrutiny Committee is recommended to:

- Note the update, providing challenge and feedback to the team;
- Support the ongoing recovery work into the 2020/21 winter season and beyond.

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1.0 HOSC Paper: Purpose, Structure and Recommendations

1.1 Purpose

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1.2 Recommendations

The Joint Health Scrutiny Committee is recommended to:

- Note the update, providing challenge and feedback to the team;
- Support the ongoing recovery work into the 2020/21 winter season and beyond.

1.3 Structure

1.3.1 The paper begins with a description of the National, Regional and System level response to the announcement of a National Emergency in March 2020, and the resulting governance arrangements and responsibilities implemented across the sectors which are involved in health and care for Greater Manchester citizens.

1.3.2 The paper will then describe the System-level work done to support the response to Covid-19 during the pandemic on a sector-by-sector basis, such as the establishment of NHS Nightingale North West and the increase in virtual Primary Care appointments.

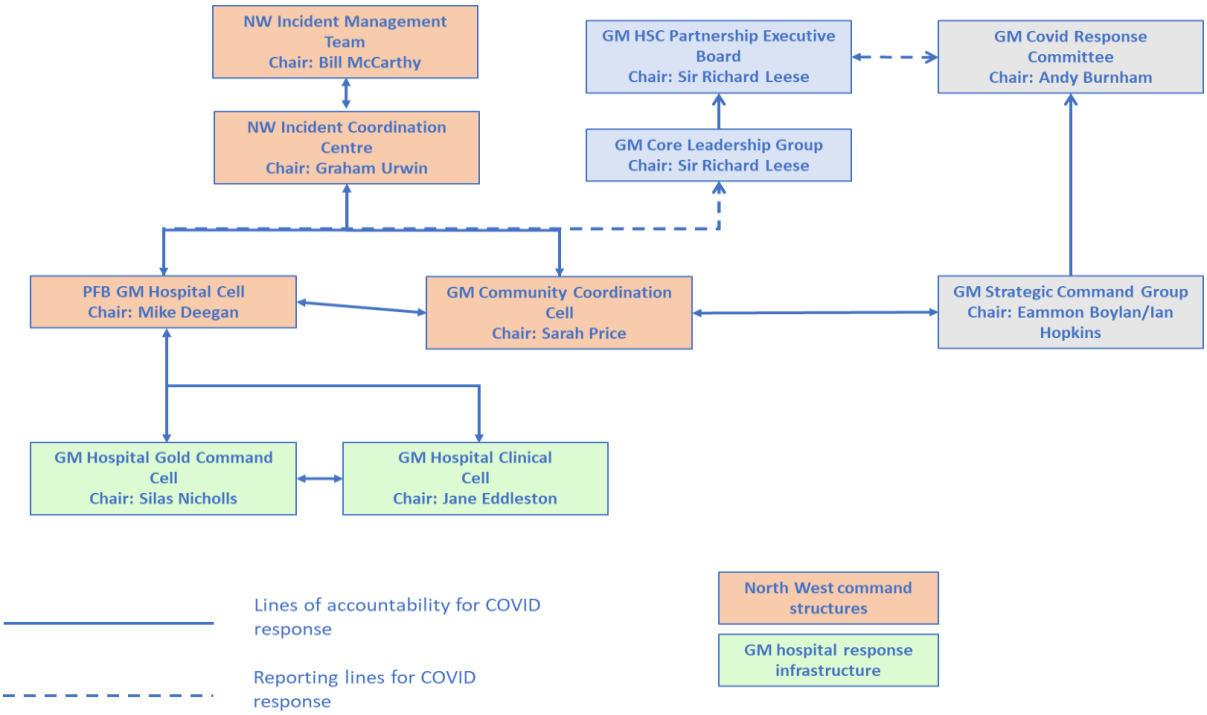
1.3.3 The final part of the paper will focus on our approach to support people, workforce and the system to recover from the impacts of Covid-19 in the short, medium to long term. Care has been taken when planning to implement new ways of working to ensure that they will support the health and social care system to cope with the demands of the next winter season, and to respond effectively to a potential second Covid-19 peak.

1.4 Context

1.4.1 In light of the reported increasing international severity of the pandemic, the NHS announced a Level 4 national incident on 30th January 2020. The GM Covid-19 Emergency Committee, in consultation with the Chair of the Strategic Coordination Group (SCG), agreed to set up GM Command and Control

Structures for key workstreams to support and add value to the work and structures being put in place at a district level.

1.4.2 Similarly, on 24th March, NHS England released a directive to Integrated Care Systems instructing them to form Command and Control Structures. In Greater Manchester, routine health and social care governance was paused and two Covid system response Cells were established: In Hospital Cell and the Community Coordination Cell. A diagram of these governance arrangements is shown below:



GM Covid-19 Governance chart

2.0 CELL FUNCTIONS

2.1 The Hospital Cell

2.1.1 The Hospital Cell is chaired by Sir Mike Deegan, Chief Executive, Manchester University NHS Foundation Trust. The purpose of the Cell is to enable hospitals across Greater Manchester to work as a single hospital system for the duration of the Covid- 19 emergency.
The Cell is responsible for:

- Securing general and ICU bed capacity in NHS hospitals to deal with projected Covid- 19 Numbers;
- Securing overflow bed capacity in other settings;
- Securing workforce capacity needed;
- Securing necessary ventilation and other equipment;
- Co ordinating the use of independent sector capacity;

- Protecting capacity for other urgent services;
- Managing mutual aid arrangements across hospitals within the Integrated Care System in conjunction with the clinical cell who will be managing mutual aid across the
  region;
- Identifying and escalating problems and escalating.

2.1.2 The Hospital Cell is made up of the existing Provider Federation Board (PFB), which brings together the provider trusts in GM and East Cheshire, as well as the Northwest Ambulance Service (NWAS), and GM Gold Command which has overseen the response and, latterly, approach to restoration and recovery, reporting into PFB.

2.1.3 On the 17th March 2020, NHS England (NHSE) responded to a sudden surge in cases of Covid-19 by issuing a directive to all provider Trusts to cease all but the most urgent scheduled activity. Shortly after, it moved into a centralised 'command and control' governance approach to manage what was evidently going to be a challenge of unprecedented scale and nature in the history of our health and care service.
To support the NHS with operational planning, NHS England (NHSE) described the national response to Covid-19 in four phases.

- Phase 1 (Mar – Apr) – immediate Covid-19 incident response
- Phase 2 (May – Jul) – continue managing high-level of Covid-19 demand and step-up of critical elective services (e.g. cancer diagnostic pathways)
- Phase 3 (Aug – Mar) – ongoing Covid-19 management and increased step-up of elective services
- Phase 4 – 'New NHS' from April 2021.

During phase 1, GM Gold Command's key focus was on:

- Critical care – ensuring capacity across the system and providing mutual aid where needed in terms of beds and equipment
- PPE – overseeing stock levels and coordinating mutual aid where required
- Development of a coordinated approach to Independent Sector (IS) capacity.
- Deployment of the Nightingale Hospital Northwest.
- Commencement of joint work with Out of Hospital Cell.

During phase 2, GM Gold focused on:

- Initial capacity planning and modelling - bottom-up approach to capacity and demand planning
- Management of the peak of the pandemic – continuing to action mutual aid on critical care beds and PPE where needed
- Consideration of recovery implications

- Innovative approach to recovery and restoration – e.g. Single System Management (SSM) for Endoscopy.
- Collective approach to Seacole centre bids.
- COVID-19 capital – collective prioritisation of bids.

Moving into phase 3, GM Gold is focusing on:

- Coordinating and managing recovery across the system
- Expansion of innovative approaches to recovery and restoration
- Continuation of mutual aid principles and application in local outbreaks
- Targeted and coordinated use of the independent sector with commensurate GM monitoring/assurance arrangements
- Peer review and challenge - particular focus on 52 week wait and cancer access.
- Development of joint working on key programmes with Out of Hospital Cell, e.g. UEC and capacity planning.

2.2 Community Coordination Cell (Formerly Out of Hospital Cell)

2.2.1 This Cell is chaired by Sarah Price, Interim Chief Officer of the Greater Manchester Health and Social Care Partnership. The purpose of the Cell is to coordinate the work of community services, mental health services, primary care and will work with social care in responding to the Covid- 19 emergency.

2.2.2 The Cell was able to support rapid mobilisation of primary, community and social care, ensuring there was capacity in community services during times of peak demand to keep people at home, prevent hospital admission and facilitate early discharge. It quickly oversaw the development of real time situation reporting to manage infection risks, roll out testing for example across care homes, and essential equipment to support staff to do their job safely. This enabled people to work collaboratively, share and provide mutual aid to de-escalate issues before they arose.
The Cell is responsible for:

- Creating capacity in community settings;
- Overseeing the management of hospital discharge process to achieve targets Set;
- Monitoring capacity pressures in community, with, primary care and social Care;
- Identifying problems and escalating to Regional Incident Director;
- Supporting the SCG in particular their vulnerable people and shielding Arrangements.

2.2.3 Both Cells also oversee and endorse the work of several sub cells, which are more operational to plan and manage approaches, for example to cancer as well as coordination of the utilisation of the independent sector hospitals (ISH).

A breakdown of which is shown below:

<table>
<tr><td colspan="6">CELL SUB STRUCTURE
<u>Core Health Leadership Group</u>
<u>Chair: Sir Richard Leese</u></td></tr>
<tr><td colspan="3"><u>Community Coordination Cell</u>
<u>Chair: Sarah Price</u>
Weekly updates to Core Group and SCG
Information flows via Sector Leads and Gold Command</td><td colspan="2"><u>Hospital Cell</u>
<u>Chair: Sir Mike Deegan</u>
Weekly updates to Core Group and SCG</td><td><u>Strategic Command Group (SCG)</u>
<u>Co Chairs: Eamonn Boylan & Ian Hopkins</u>
Weekly updates to core group</td></tr>
<tr><td colspan="3">Community Sub Cells</td><td colspan="2">Hospital Sub Cells</td><td>SCG Sub Cells</td></tr>
<tr><td>Community Based Response and Achieving Discharge Targets
Lead: Steve Dixon</td><td>Adult Social Care
Lead: Jo Chilton</td><td>Primary Care Operations
Lead: Rob Bellingham</td><td colspan="2">GM Gold Command
Chair: Silas Nicholls</td><td rowspan="2">• Management of Deaths
• Military Assistance
• Transport
• Humanitarian Assistance
• Situation Cell
• Blue Light Services Liaison
• Economic and Business Impact
• Communications
• Health
• PPE Procurement
• NW STAC (Scientific Advice)
• LA CEO Group
• Homelessness
• Finance
• DsPH Network
• Emergency Liaison and Licensing
• Data Sharing</td></tr>
<tr><td>Field Hospital Development
Lead: Michael McCourt</td><td>Intelligence Cell
Lead: Matt Hennessey</td><td>Mental Health
Leads: Neil Thwaite & Claire Molloy</td><td>Imaging Cell
Lead: Raj Jain</td><td>Independent Sector coordination
Lead: Darren Banks</td><td>Cancer Hub
Lead: Roger Spencer</td></tr>
</table>

2.2.4 Both Cells report fortnightly to the Core Leadership Group, which was established to provide tactical direction, oversee the actions and coordinate support for localities and organisations.

2.2.5 This paper also recognises that the effects of Covid-19 of inequality and the impacts of the pandemic that have been disproportionately felt across our diverse communities, both from a health perspective and in terms of our public service response. We know that some factors increase the risk and vulnerability of certain groups of people to Covid-19, for example: people from certain ethnic groups, the elderly, people living in more deprived areas, certain occupations and disability. Although the exact reason for this is not known, it is clear the pandemic has put a spotlight on existing health inequalities.

2.2.6 Much of the effort to date has concentrated on engagement and insight collation with diverse communities across GM and links into many LA and NHS, GMHSP groups. There is a wealth of insight including that done by different community groups and Voluntary, Community and Social Enterprise (VCSE) organisations. As a result of gathering insight a number of immediate changes have been implemented including action on mental health, bereavement support for different faith groups, Covid testing, impact assessments and workforce race equality. Additionally, through work called the ‘Safety Siren’ we are beginning to look to see if measures put in to respond to Covid-19 have unintentionally, had a negative

impact on non-Covid groups. This is important as we begin our recovery, to restart NHS services and need to change the way in which some of these are delivered to ensure everyone is treated fairly.

3.0 SUMMARY OF OUR RESPONSE TO COVID-19

3.1 SYSTEM CAPACITY PLANNNING

3.1.2 We have recently moved into phase 3 of the recovery plan. To support this, we are currently engaged in a planning process which projects our anticipated activity and demand by month through to the end of March 2021, subject to the country, and region, being able to maintain the stable level of Covid-19 demand it is currently reporting.

3.1.3 The simultaneous ongoing management of Covid-19 and phased resumption of services including elective activity has resulted in many practical challenges to overcome. This has principally been caused by the movement of patients and staff from where services are usually delivered – either because the wards and equipment were required to treat Covid-19 patients or the staff themselves had been redeployed from their substantive roles to shield from the virus or to help manage the earlier surge in cases.

3.1.4 Gradually, we've been able to bring people back to their usual places of work and switch services back on – but we are now operating in a new context of social distancing; more thorough hygiene regimes; maintaining separate 'flows' through our sites for Covid-19 positive and negative patients; and ensuring that patients attending for elective procedures have self-isolated appropriately before accessing our services. This has significantly reduced overall productivity and throughput but is necessary to keep our patients and staff safe.

3.1.5 The restart of elective activity commenced in early June. At the same time, NHSE secured capacity at private hospitals for NHS patients; a contract which has recently been extended until the end of March 2021, albeit at slightly reduced capacity after October. Therefore, we have worked with some local private hospitals to shortlist suitable patients to undergo procedures on their sites.

3.1.6 As we begin to restart services again, we are very aware that we will be managing Covid-19 as a live issue for the foreseeable future, which will continue to place some strain on our workforce and site capacity. Therefore, measurement tools and dashboards have been developed to give us some early warning indicators where Covid-19 or non-elective demand (A&E) is starting to stretch our capacity. This information enables us to reconfigure sites or redeploy staff pro-actively.

3.1.7 We have updated our critical care escalation plan in case we need to respond to second surge in Covid-19 cases. Our need to prioritise more urgent cases has inevitably led to other issues arising, such as the increasing number of patients

waiting longer than 52 weeks for a procedure, or some patients spending longer on cancer pathways than in more usual times – in most cases this is because we've found it difficult to give them access to the service they require whilst maintaining a Covid-safe pathway. We are working to address these issues as quickly as possible.

3.1.8 We are clear that even in a post-Covid-19 world, the health and care system will not look exactly like the one which preceded the outbreak of the virus – something which has been recognised by NHSE in their description of a 'new NHS' from April 2021. What this means in reality is that we have seen some technological developments; changes in practice; and efficiency gains that we want to sustain and retain in the future. One such example of this is the more widespread use of the video consultations for patient appointments when appropriate. Whilst this was necessary to help reduce people attending outpatient departments or GP practices, it was also an existing standard over the next few years in the NHS Long Term Plan.

3.1.9 Patients and clinicians have responded positively to the change – and it would be a backward step for us to revert from this model as the threat of the virus eases. Long-term, this will impact on how we use our estates for example, with fewer patients attending the hospital for outpatient appointments. Other changes include how we will use Urgent Care models to stream non-Covid patients away from A&E; and the implementation of appointment booking systems in A&E to align with requirements to reduce the concentration of patients in confined areas.

3.2 URGENT AND EMERGENCY CARE (UEC) response to Covid-19

3.2.1 Discharge to Assess

3.2.2 An early development in the response was to quickly agree a discharge to assess pathway to support the acute hospitals to manage capacity and discharge patients effectively and without unnecessary delay. This set out the process to discharge patients safely to the community, care homes, NHS Nightingale and described the criteria needed to care for them appropriately and was adopted across all localities in GM. Localities are now looking at the longer term sustainability of the changes as part of their recovery and planning work.

3.2.3 GM Clinical Assessment Service

3.2.4 The Covid-19 pandemic has provided the need to accelerate initiatives within the urgent and emergency (UEC) care transformation work. The response to and recovery from COVID 19 has presented a major challenge to GM in the way it makes best use of available skilled clinical resources to support patients accessing care via 999 and NHS 111 to be managed away from A&E and Emergency departments.

3.2.5 The GM Clinical Assessment Service (CAS) has played a vital role in managing the high demand away from 999 and 111 by taking appropriate calls and manging

them effectively by providing a flexible and clinically skilled service as a forerunner to a fully integrated urgent care service for Greater Manchester.

3.2.6 In March 2020 the CAS was extended to manage 150 calls per day as part of the Covid- 19 response. This capacity was subsequently doubled to 300 per day.

3.2.7 In addition, the GM CAS now manages specific mental health demand as part of the GM response to the provision of 24/7 urgent mental health care, providing a single point of contact and clinical assessment of patients experiencing a mental health crisis who had originally called 999, before onward referral to other GM services.

3.2.8 Importantly, the access to senior clinical advice by telephone and referral to more local services has delivered a quicker and more efficient experience for all patients accessing the CAS.

3.2.9 The GM CAS is a core development to transforming the pre-Emergency department part of the UEC pathway to help safely reduce hospital attendances and admissions. This is further enhanced through a number of initiatives described below.

3.2.10 111 First - Urgent care by Appointment

3.2.11 In January 2020, prior to the Covid-19 crisis, the Greater Manchester Urgent and Emergency Care Board were developing a programme of work to improve the way that people receive urgent care, advice or treatment, to make sure they got this in the right place at the right time. As the NHS starts to recover, services resume and we begin our long process of living with Covid-19, this work has become a top priority.

3.2.12 Crowded Emergency Departments (ED) can no longer be the norm due to the risks this poses of spreading the Covid-19 virus. People who do not need to be there should not be, to help those who do need to, be seen as quickly and safely as possible.

3.2.13 During lockdown there was a significant reduction in emergency department attendances. In Greater Manchester this was around 60% lower than for the same period last year. A national analysis of emergency care data during this time has shown that the reduction was largely down to people with minor issues not turning up.

3.2.14 It is unclear if they sought out other NHS services instead, but there are other services available which can support them more safely than ED or, if they do need to visit an ED, an appointment can be booked to save them waiting.

3.2.15 During Autumn time this year we will introduce changes to how patients access urgent and emergency services. We will:

3.2.16 Before hospital:

- **Ask people to be assessed before leaving home, by contacting NHS 111.** This will mean that patients can have their needs assessed quickly and easily without having to leave their home. This assessment can rapidly identify people who need to attend an ED.
- **Connect patients directly with local clinicians to assess their needs.** If the patient does not need to attend an ED straight away, local clinical assessment services will call to complete a more detailed assessment of the patient. The service is staffed by doctors and other health professionals and has access to a wide range of local services to support the patient's needs. The service will be able to offer self-care advice or book the patient into appointments in the community. In some cases, an appointment might be booked to attend ED.

3.2.17 At hospital:

By assessing patients to identify if they need to access ED as soon as they arrive.

3.2.18 People who attend ED will be safely assessed as soon as they arrive. The assessment will guide what services the patient requires. Those that do not require emergency care, may go on for further assessment in a different area of the hospital or be referred back to another service in the community, which might include pharmacy, or a GP.

3.2.19 It will be much easier for people to contact 111 first, rather than turn up to ED to be assessed, where they may then be redirected elsewhere or asked to come back another time for an appointment.

3.2.20 The benefits:

The benefits that can be gained from these changes will be:

- People who do need rapid emergency care will be seen and treated more quickly in less crowded EDs.
- There will be a lower risk of spreading infections. By accessing remote assessment patients can be referred to their local ED only when they absolutely need to, who will be ready to receive them at a specific time.
- If the clinical assessment service refers a caller to ED or another service, they will be given a time for an appointment – so the caller can wait at home, and this shortens the time they have to wait at the hospital or other setting.
- People will be able to receive more treatment in their own homes or closer to home.

- Patients may be linked to the right specialists for their condition much more quickly
- Reduced travel across the city region for staff and patients

3.2.21 Whilst this is a Greater Manchester model the emphasis is on developing local-based models that suit the needs of the local population therefore the pace may vary slightly in different localities.

3.3 THE NIGHTINGALE HOSPITAL NORTHWEST

3.3.1 The Nightingale Hospital model involved the development of a new group of temporary hospitals which were to use existing non-NHS infrastructure to rapidly expand the capacity of the health service to care for patients during the pandemic. Anticipating that the majority of surge demand would be for patients requiring mechanical ventilation, multi-organ failure support (in level 3 intensive care settings), or non-invasive ventilatory support (in level 2 high dependency settings), early Nightingale planning focused on providing the NHS with additional capacity for patients requiring ventilatory support.

3.3.2 However, in the Northwest, our modelling suggested that regional intensive care bed capacity was unlikely to be exceeded. Therefore, a new model of supporting our hospitals was proposed. The Nightingale North West Hospital (NNW) was designed to provide additional “step-down” capacity from regional acute trusts, and provide multidisciplinary clinical care, oxygen therapy and, if necessary, continuous positive airway pressure (CPAP) support to patients recovering from Covid-19. It was forecast that, by providing step-down capacity, the Nightingale North-West could alleviate pressure on critical care units and improve patient flow in acute hospital trusts.

3.3.3 Nightingale Hospital Northwest Activity

3.3.4 In addition to seeking to reduce pressure on acute hospital trusts in the region, NNW served to protect the community from Covid-19. Many patients who were clinically well enough for discharge required ongoing precautions to prevent transmission of the virus to their contacts. By ensuring that patients had negative swab results prior to discharge, we were able to protect vulnerable family members, carers, and fellow residents of care homes from onward infection. NNW had a capacity for 630 beds; the patient numbers in the initial weeks of operations were around 6-12 beds and this increased to 52 beds in late May.

3.3.5 Before stand down, Nightingale North West managed 104 admissions, 1183 patient/days with an average length of stay around 7 days. The temporary hospital recruited sufficient staff to operate around 100 beds.

3.3.6 Nightingale Hospital Northwest Stand down to Standby

3.3.7 All Nightingale hospitals were asked to prepare plans for stand down, stand by and reactivation. NNW’s Executive Team completed its plan on 27 May.

Following a continued low level of utilisation from the Northwest region a decision was made to place NNW on standby. The plans to stand down were as follows;

- Close to admissions Thursday 11 June 2020
- Last patient discharged by Friday 26 June 2020 at the latest –this was actually achieved by 17 June
- Stand by options presented to Northwest region and Manchester University FT (MFT) week of 22nd June 2020
- Monday 29 June to Monday 13 July 2020, stand by arrangements finalised
- Week of 6 July 2020 approvals for stand by arrangements secured
- Monday 6 July 2020 NNW Hospital Management Board confirms completion of stand down and commencement of stand by

3.3.8 NNW Current standby status

3.3.9 The degree of standby is based on the national requirement to be able to reactivate within 7 days. Plans for reactivation are based on 1 ward (36 beds) initially. To be able to achieve this, there remains some retained work by the NNW Executive team, continued connections with the Nightingale workforce/NHS Professionals (NHSP), maintained facilities support, and support of the Northwest sub-regional cells.

3.3.10 There are two main monitoring requirements during stand by: readiness to reactivate and maintenance of the estate.

3.3.11 NNW has developed a slimmed down governance structure in its standby role, in which the Executive team produces, on a monthly basis, a collective status report to the MFT Group Chief Executive and the NHSE Region's SRO.

3.4 PRIMARY CARE

3.4.1 Like all sectors the way we deliver primary care has had to change dramatically in order to respond to Covid. We have seen routine services paused, a move to more digital appointments with patients and reduced capacity and space within which to safely see and treat people. Consequently, we have seen many services transformed and innovative ways of working as a result.

3.4.2 In the early days of the pandemic an understanding of our ability to respond and deliver across primary care was essential for the overall GM health and care system. This saw the development of transparent, real time reporting on pressures and the situation across all primary and community care, including care homes. This signalled where local services were significantly challenged and enabled a high level of mutual aid across the sectors, resulting in de-escalation of risk and continuity of service.

3.4.3 Due to safety and infection control procedures capacity in primary care has been dramatically reduced. In response, GP practices are making the most use of digital technology as an essential part of the primary care response plan. This

quickly meant that many face to face consultations are now telephone or video appointments. With 100% of our practices having a solution in place for video and online consultations (August2020). This way of working has been supported by the quick production of GM wide guidance, for example, for the assessment of patients for general practice which has been adopted across practices.

3.4.4 Critical to the primary care response has been providing support to care homes, where the Covid-19 pandemic was posing a significant challenge. GM guidance for community support to care and nursing homes was produced. This built on the fact that many districts already have established services in place. Primary and community care responded by ensuring:

- A named lead clinician for each care home
- Timely access to clinical advice for staff and residents
- Proactive support for people living in care homes
- Residents with suspected or confirmed Covid being appropriately supported

3.4.5 Workforce has been a key consideration for primary care during the pandemic, not least because of the disproportionate effect that Covid -19 has on different communities and cultures, particularly BAME groups. The GM risk assessment guidance and tool has been rolled out across all primary care to ensure risks were identified and appropriate mitigations were enacted to protect those most vulnerable.

3.4.6 To date 95% of general practice staff have had a risk assessment, which is higher than the rest of the Northwest and England as a whole. The remaining risk assessments are for staff members who were shielding and will be completed in the next few weeks. Dental, optometry and pharmacy teams are also working to ensure all teams have had a risk assessment with appropriate measures in place to ensure staff safety.

3.4.7 To support the deployment of the GP workforce across GM during the pandemic and to control the cost of locum usage during this time, a GM GP workforce locum bank was established to provide consistency. This bank is able to complete necessary checks in terms of GP qualifications and fitness to practice as well as matching clinicians' availability to service demands within primary care. The workforce bank will now be extended to include nursing staff.

3.4.8 Nationally, NHS dental practices established a remote urgent care service providing telephone triage for patients with urgent needs during usual working hours. However, this response did not meet all urgent dental care needs. In GM we have therefore developed an expanded urgent dentistry model for Greater Manchester with three levels:

Level 1 – delivered by most General Dental Practices;

Level 2 – locality provision – mainly delivered through existing urgent dental care premises;

Level 3 – Covid-19 'hot site' – a single GM site is planned for this.

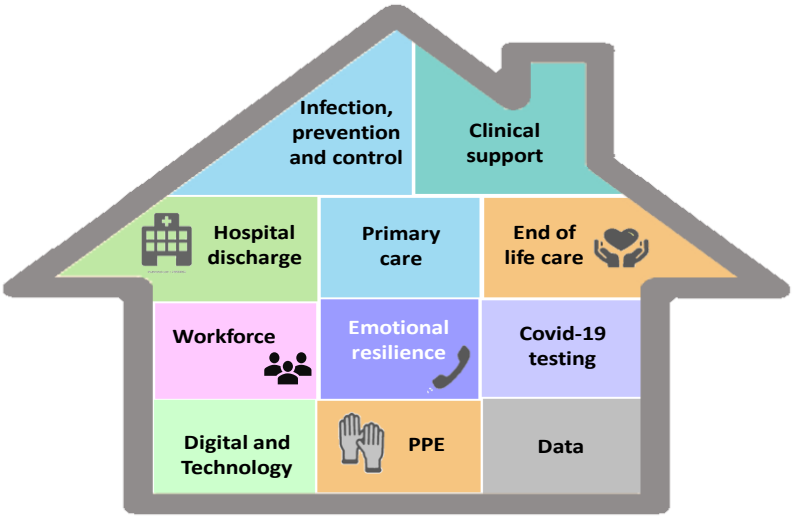
3.4.9 The GM Community Coordination Cell approved the implementation of these arrangements - subject to the availability of appropriate PPE.

3.4.10 Work has commenced in earnest to embed what has worked well during Covid-19, adopt new ways of working as well as resume primary care, ensuring patients can benefit from a full range of integrated services.

3.5 ADULT SOCIAL CARE
Support to people living well at home

3.5.1 In light of national requirements and the GM approach to supporting people to live well at home, wherever that home is, a more joined up approach was required across GM. This ensured best practice is shared, whilst also enabling risks and areas of concern to be escalated. There has been a vast amount work to strengthen the support to care homes, supported housing and home care providers, particularly around Infection Prevention and Control, workforce, and primary care. All of which have seen care providers and hospices become truly part of the local integrated response.

3.5.2 The areas of support are illustrated below:



3.5.3 Infection Control

3.5.4 Within GM, we have been taking a whole system response across health and social care to reduce the rates of Covid-19 transmission within care settings.

3.5.5 An area of significant focus has been on infection prevention control (IPC) in response to the challenge faced by care homes in GM, supported by the national Infection Control Fund.

3.5.6 GM undertook a 9-point Care Home Risk Assessment for infection protection and control with Care Homes against the grant conditions set out nationally, so we could be satisfied that everything possible was and is being done, and identify any support measures that may be needed to mitigate any risks.

3.5.7 This is supplemented by care home and home care real time situation reports developed with our care providers, that provides information and numbers of: infections, staff absence and the supply of personal protective equipment for each provider, to enable rapid response, de-escalation, training, and mutual aid across Greater Manchester.

3.5.8 Testing

3.5.9 Directors of Public Health and Directors of Adult Social Care have been working hard with local NHS Providers and Regional teams to ensure that testing of staff and residents in care settings is more joined up, and that available national capacity is targeted to areas and care homes with greatest need. Greater Manchester worked hard and responded quickly to address testing in care homes. Social care staff were provided with early access to testing, with GM being one of the first regions to prioritise national routes to social care staff, including being part of the home testing pilots. All care home residents were tested for COVID-19 48 hours before discharge from hospital: in some areas this was provided ahead of the national guidance.

3.5.10 More recently whole home testing is being rolled out, for GM authorities the proposal for the whole home testing approach was based upon the following:

- To be undertaken at the homes wherever possible to avoid staff having to make unnecessary journeys, or to use public transport.
- To be offered to staff and residents whether they are symptomatic or not, to identify the introduction of asymptomatic transmission in to home.
- To be followed up with advice about interpretation of test results, advice on self-isolation for those testing positive, and reminders about adhering to PPE and infection control guidance for all.
- To be accompanied with infection prevention and control advice provided by the Infection Control and Public Health team, and adherence to this through the care homes.
- To be accompanied with clinical advice on residents' care, provided by the appropriate GP/Covid service.
- To be accompanied with outbreak management support, provided by the Infection Control and Public Health team, liaising with the care home.
- To be supported by a workforce discussion about any impact of a reduction in workforce as a result of testing and self-isolation.

3.5.11 In addition, Greater Manchester is also supporting the Department of Health and Social Care to pilot antibody testing in care home services in Bury, Manchester and Trafford.

3.6 Primary Care support to care homes

3.6.1 NHS England set out a number of requirements with respect to the Primary Care response for Care Homes which each Clinical Commissioning Group (CCG) were asked to put in place. These were:

- Weekly check ins
- Process for the development of personalised care and support plans
- Clinical Pharmacy support, included structured medication reviews for care home residents
- A named clinical lead

3.6.2 All CCGs in GM have achieved 100% compliance with these requirements which forms part of a wider support package within GM. This includes dental training practices buddying with care homes to support both the oral health and treatment response; NHS Sight tests for care home residents provided by Domiciliary providers of General Optical Services, work with Health Innovation Manchester for care homes to have access to summary care records and input health data regarding residents prompting a pro-active response from primary care; and continued MDT support.

3.6.3 Data, digital and technology

3.6.4 A number of initiatives have been developed to form a digital support package for adult social care providers including:

- **NHS Mail:** Every care home and home care provider has been offered access to a secure NHS email address and Microsoft Teams for online consultations, with 88% of care homes and 60% of home care providers already signed up across GM so far.
- Working with Health Innovation Manchester, care homes to have access to S**ummary Care Records** and be able to input health data regarding residents, prompting a pro-active response from primary care so they can “look through the window” of the care home and contact them if any resident shows signs of deterioration.
- **Use of tablets, Ipads and other technology** to support residents with maintaining contact and personal relationships and also reduce social isolation e.g. Facebook, Zoom, sharing old town photos to spark reminiscence discussions; accessing online quizzes, which tap into people’s hidden skills etc.
- **Situation reporting and OPEL system**: Monitoring of pressure points to support with local and GM responses, including direct support, joint action and

mutual aid. This also provides an early warning of where there are increasing levels of fragility and ultimately informs policy and strategy.

- **SafeSteps**: Captures real time data on residents and their health and wellbeing allowing care homes staff to input information about a residents' Covid-19 related symptoms and track for signs of deterioration more easily, using a national scoring system. Information is shared directly with the resident's GP and NHS community response team to ensure that a swift assessment and response can be put in place. This will also optimise situation reporting.

3.6.5 Workforce

3.6.6 Greater Manchester initiated and supported a number of local and national campaigns to support the social care workforce, some examples are:

- **Care Heroes recruitment campaign:** an additional auxiliary workforce of people with the right values and behaviours to work in social care during the pandemic, helping the sector to keep safe staffing levels by streamlining the recruitment processes and providing significant visibility of available social care roles to the general workforce.
- **GM 'Step into Care' programme:** providing people with the right skills to embark on a career in social care, facilitating the development of people with the right values but who need additional training and education, and building a workforce during and beyond COVID
- The social care workforce have access to **virtual training and other online support, nationally, regionally and locally.** This enables adult social care managers to access the abundance of information more easily and ensures that they are directed to areas of best practice, that support them to recruit and support staff.

3.7 MENTAL HEALTH

3.7.1 Since the beginning of the pandemic mental health providers and the GMHSCP have taken significant steps to ensure continuity of provision whilst working hard to reduce demand on critical urgent care services including A&E's. The priority being to support mental health services to work as effectively as possible, ensuring that those seeking and needing mental health treatment receive the care that they need. This included ensuring frontline workers across the health and care system were supported effectively through enhancing the GM Resilience Hub to meet the mental health and well-being impact of Covid-19.

3.7.2 A brief summary of the response includes:

- GM Mental Health providers moved swiftly to help protect core services and use risk stratification to ensure those in greatest need receive ongoing support.

- They established 24/7 telephone crisis lines and explored other urgent care alternatives to strengthen crisis support and avoid placing pressure on A&E services.
- They rapidly accelerated the provision of digital services including talking therapies.
- Expanded the range of online support for people of all ages.
- Expanded bereavement support services.
- Strengthened support for staff, particularly those supporting critical care.

3.7.3 Mental health input to the GM Clinical Assessment Service

3.7.4 This development saw provision of a mental health crisis support line delivered through Provider Crisis Lines and the Clinical Assessment Service (CAS). This provides a 24/7 integrated all-age, mental health, learning disabilities and autism, substance misuse crisis support line.

3.7.5 The CAS team receives low acuity referrals from 999 and 111, they assess each patient and offer appropriate guidance, signposting via a directory of services or they will direct certain patient groups to a local senior clinician without unnecessary delay. Together with the Mental Health Liaison service they actively seek to divert activity away from accident and emergency departments especially during the peak of the pandemic.

3.7.6 Greater Manchester Mental Health Resilience Hub: Supporting our Key Workers

3.7.7 The offer of the GM Resilience Hub which was set up after the Manchester Arena attack, has been extended so staff, including cleaners, porters, security and other ancillary workers, across health and social care, can access it. This provides:

- Targeted wellbeing screening which takes a proactive approach to help prevent suicide and improve wellbeing.
- Consultation advice to managers and leaders
- Guidance, resources and targeted webinars
- Facilitated peer support
- Targeted family support

3.7.8 Provided through a multi-agency approach, the service initially prioritised front-line workers who were in direct contact with people suffering from Covid, who had saved lives and provided end of life care.

3.7.9 Extended bereavement support

3.7.10 This development created a single GM wide bereavement service, offering telephone support to those struggling with loss, covering all faiths and religions. Those making contact are offered information and guidance on grief, mental health and emotional support; practical related advice such as debt counselling, a

space where they might express their feelings and be heard. The service can be accessed through the online website at

https://greater-manchester-bereavement-service.org.uk/

and will accept calls from the public and a from professionals.

3.7.11 Expanded digital support

3.7.12 Mental Health services across Greater Manchester have considered and rapidly put in place provision of a range of digital options available to assist with continuing care delivery across the 10 districts. The aim being to provide an alternative offer across all age groups and reduce pressure in other parts of the mental health system to protect the availability of core services for those in greatest need. Specific offers are also available for frontline staff and their families to assist with anxiety, resilience and coping strategies.

Some examples include:

SHOUT: 24/7 crisis text service with trained crisis volunteers using recognised techniques via text.

Kooth: an online counselling and emotional wellbeing platform for children and young people.

Living Life to the Full: delivers online course for people affected by low mood, anxiety or depression using cognitive behavioural therapy concepts.

SilverCloud: online programmes for adults (aged 16 years+) to help ease levels of stress, sleep better or to build resilience.

3.7.13 Additional Support Programmes

3.7.14 The mental health response to Covid has been vast, these are just a few examples of the work that has been underway and rapidly implemented, others include from supporting NHS Nightingale and homelessness to perinatal support and mental health in education (support being provided to all schools, colleges and universities across GM).

3.7.15 The VCSE sector have played a critical role in the provision and response and through the VCSE mental health leadership group are engaged across a diverse range of activities for children and young people to faith groups and specific communities of identity.

3.7.16 We are already seeing and anticipate over this next period there will be a significant increase in demand for mental health services, particularly community mental health, child and adolescent mental health services, early intervention in psychosis, perinatal services and IAPT. Alongside these our planning for the next phase includes:

- Restarting memory assessment services
- Rescaling the number of sites providing electroconvulsive therapy
- Reviewing the location and model for mental health urgent care centres

3.8 SUPPORT FOR VULNERABLE PEOPLE

3.8.1 During the pandemic the Humanitarian Assistance Cell has been established, this primarily focussed on support for shielding and socially vulnerable people through the establishment of community hubs but has since picked up the increasingly worrying issue of inequalities caused by Covid-19. Some examples of socially vulnerable groups are:

- 'Troubled' Families'
- Rough Sleepers
- Asylum Seekers
- Poverty – low income/unemployed
- Victims of Domestic Abuse

3.8.2 The Community Hubs themselves provide a variety of services to people who live in the Greater Manchester Localities, which include but are not limited to things such as:

- Voluntary, Community Sector support network
- Food bank networks and provision
- Daily check-ins
- Matchmaking local volunteers
- Link to mutual aid groups
- Provide local information
- Local support infrastructure co-ordination- food, pharmacy, wellbeing advice and comfort calls

3.8.3 Over the course of the pandemic connections have been made and strengthened between the Humanitarian Assistance Cell and Health and Care – in particular, the connection to primary care, pharmacy and health and support to asylum seekers and homeless people.

3.8.4 It is recognised that localities are experiencing large numbers of people who typically would have presented in primary care accessing the system through the local community hubs. It is important that we continue to work in a joined-up way to co-ordinate our approach we move into the recovery phase.

3.8.5 The success and adaptability of the Community Hubs arrangement is partially due to the pre-existing relationships shared across the sectors in GM and is in line with a long history of collaboration shared across the City Region.

3.9 HOMELESSNESS - ‘Everyone In’ response

3.9.1 In response to Government’s ‘Everyone In’ policy, in March 2020 Greater Manchester Combined Authority (GMCA) approved the rapid implementation of a humanitarian response for people who were homeless or sleeping rough across Greater Manchester. ‘Everyone In’ instructed Local Authorities to meet Public Health social distancing guidance by immediately accommodating people into self-contained accommodation, including into hotels.

3.9.2 Health and support services worked closely with Greater Manchester Health and Social Care Partnership to ensure continued access for those who required it whilst in emergency accommodation. New pathways and access routes into services were developed with providers demonstrating a great deal of flexibility to respond to this changing environment. Significant support was put in place in relation to substance misuse, mental health and physical health.

3.9.3 Substance Misuse Services

3.9.4 Referral pathways were developed with the hotel sites and providers across GM with a collective agreement to assess and treat patients from other providers to prevent unnecessary transfers. SMS providers were able to offer telephone advice, same day assessment and scripting appointments with a focus on getting people into substance misuse treatment and where appropriate, provide rapid access onto Opiate Substitute Therapy (OST). A harm reduction framework was also developed and implemented across all hotel sites.

3.9.5 General Practice

3.9.6 Specialist GP Practices, such as Urban Village Medical Practice in Manchester, proactively worked with hotels to ensure people staying there could access their services. As far as possible access to General Practice was provided remotely by the individuals registered practice and those without a GP were registered with Urban Village. Where required new prescriptions were issued electronically to the pharmacy nearest to the hotel.

3.9.7 Mental Health

3.9.8 Manchester Homeless Mental Health Team provided both face to face outreach and remote access to support to those staying in hotels. They were able to offer assessments, support with care planning, Community Mental Health Team referrals, psychological therapy and dual diagnosis support. Standardised triage processes and pathways were agreed across all mental health providers to provide access to services for people in all self-contained accommodation. A VCSE led ‘Call and Check’ service was commissioned through the central GM mental health response to provide informal advice and support to those in emergency accommodation, delivered by people with lived experience of homelessness. Support with mental health was also been offered to staff on site and resources developed to address common issues and support staff wellbeing.

3.9.9 Management of symptomatic residents

Pathways to national and local Covid-19 testing facilities were established, although there were a very small number of hotel residents who have presented with symptoms of Covid-19. Where residents were symptomatic, supported was provided to self-isolate in hotel rooms. Where necessary a GP was informed to monitor symptoms.

3.9.10 Alongside the main health response, additional elements of support were put in place where appropriate to further support residents and staff on the hotel sites. This included;

- First aid treatment and triage service provided to hotel sites managed by Manchester City Council and GMCA by St John's Ambulance on a weekly basis.
- Development of GM specific Public Health guidance for emergency accommodation sites to ensure infection prevention and control advice, based on guidance published for care homes and supported accommodation. Similar guidance has since been developed for move on accommodation settings.
- Access to emergency dental treatment from specialist dental practice, Revive, offering remote consultation and referral for basic treatment if required.
- Offer of nicotine replacement (e-cigarette) and smoking cessation support.

4.0 GREATER MANCHESTER RECOVERY PHASE

4.1 GM Cancer Plan

4.1.2 Cancer services in GM have moved to Phase 3 of the recovery plan and GM Cancer Alliance will continue to support the system to deliver this. Within GM, Hospital and Community Co-ordination Cells remain in place, and provide a clear command and control structure to cancer services. The Phase 3 recovery, detailing the requirements for Cancer alliance, was issued on the 31st July 2020:

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf

4.1.3 Phase 3 recovery details the need to restore cancer services to pre-pandemic levels. There are 3 clear priorities of the recovery:

- Restoring urgent 2 week wait referrals to pre-pandemic levels;
- Taking immediate action to reduce the number of longer waiters, prioritising those waiting over 104 days
- Ensure there is sufficient diagnostic and treatment capacity in place to meet demand through the autumn/ winter 2020 and beyond.

4.1.4 This will be achieved by continuing to:

- Work with primary care and GPs colleagues on clear communications plans to restore public confidence to increase numbers of patients being appropriately referred with suspected cancer to at least pre-pandemic levels.
- Expand diagnostic capacity by the continued use of independent sector facilities, and the development of Community Diagnostic Hubs and Rapid Diagnostic Centres.
- Increasing endoscopy capacity to normal levels and using CT colonography to substitute where appropriate for colonoscopy.
- Expanding the capacity of surgical hubs to meet demand (phase 2 and phase 3 patients) and ensuring other treatment modalities are also delivered in Covid19-secure environments.
- Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
- Fully restarting all cancer screening programmes. Alliances delivering lung health checks should restart them.

4.1.5 Covid-19 has had a significant impact on cancer services in GM over the last 6 months. This has exacerbated the backlog; led to unsatisfactory cancer performance and increased pressures on diagnostics and treatment services that were evident pre-covid. Therefore, it is essential that the GM Cancer Recovery Plan is accelerated at pace.

4.2 The GM Elective Care Reform Programme
Elective Care Vision

4.2.1 The Greater Manchester Elective Care Reform Programme was established in September 2019 with an overarching aim of improving how services are delivered for people who may need planned care from the point at which they start experiencing symptoms to when they are discharged from NHS care.

4.2.2 The vision for elective care services is as follows:

“Individuals will be cared for primarily in the community, supported by their primary care clinician(s) and with easy access to self-care information and also to virtual specialist advice when required.

When they experience complications or deterioration of their condition, their primary care clinician will access relevant specialist expertise to adapt the patient’s management plan, using a multi-disciplinary team approach and supported by technology. This will include having rapid access to appropriate diagnostics in the community wherever possible.

Only by exception will a patient physically transfer for care into a secondary care setting and only for as long as clinically required, before transferring back for ongoing support by their primary care clinicians in the community.”

4.2.3 Elective Care Transformation

4.2.4 The Covid-19 pandemic has undoubtedly led to unprecedented challenges for the delivery of elective care services; waiting lists for planned care have increased by around 13650 people between February 2020 and June 2020, with waiting times for patient at an unacceptable high level with patients waiting on average around 29 weeks for their appointment and whilst referrals to secondary care have slowed this is indicative of a concerning level of unmet need.

4.2.5 Through the sustainability and recovery phases following the pandemic, there is an opportunity to 'build back better' with an uncompromising focus on reducing health inequalities. We intend to utilise the changes that have taken place during the pandemic to deliver up to 70% 'traditional' outpatient activity differently with rapid access to diagnostics/specialist expertise including via remote consultations enabling more patients to be supported in the community.

4.2.6 This will save patients' time and inconvenience, reduce the risk that is posed by high footfall through the hospital setting and release specialist clinical time to be used more effectively. Patients will have more choice about when and how they will be seen. There will, of course, need to be consideration of approaches to ensure that those without easy digital access are able to access health care in an equal way with, for example, care navigator support or digital access to virtual appointments in the community.

4.2.7 An overarching principle is that people should only have to travel to face to face hospital appointments to receive a test or intervention or to receive significant diagnoses. People should be issued with management plans which support them to self-manage and their community teams to manage any expected changes in presentation. Virtual follow up review should be flexible and responsive to unexpected changes in condition or targeted and specific.

4.2.8 This approach will be enabled through standardised approaches to clinical prioritisation and triage. People will be triaged directly to diagnostics when needed, with results reviewed by the specialist and advice provided by letter or by virtual appointment when required. Face to face appointments will be reserved for when absolutely needed and will make maximal use of hospital visits with the potential for multiple interventions to take place in one visit. There will be more coordinated care for those with multiple conditions and more efficient use of theatres.

4.2.9 To ensure we consider the whole pathway of care, we have broken down the care journey into three thematic areas which align to the national strategic direction for elective care:

- supporting self-care;
- rethinking referrals and
- transforming outpatients.

4.2.10 Over the last few months, there has been a significant focus on endoscopy across Greater Manchester due to the scale of the challenge for this service. Endoscopy services see a very high volume of patients and enable diagnoses for patients in the breadth of outpatient provision, including for cancer patients, whilst productivity has been severely impacted as a result of adhering to infection prevention control requirements.

4.2.11 It has therefore been essential to work to increase capacity and productivity in endoscopy services, and a single system support approach has been implemented to ensure that, where appropriate and in the best interests of patents, there will be a shared capacity approach to endoscopy across Greater Manchester to ensure that patients with the highest clinical needs are seen promptly.

4.2.12 Furthermore, work is underway to review if this approach is suitable for other outpatient specialties and groundwork is taking place to obtain a transparency of patients waiting in each locality across Greater Manchester to enable a shared approach to recovery.

4.2.13 Other initiatives underway seek to provide the patient with more control over their care and increasing opportunities to be supported in the community, enhancing the interface between primary and secondary care through a shared care approach and increasing the use of digital technology to support the care pathway.

4.3 GM Imaging

4.3.1 As described earlier in this paper within the structure of the Hospital Cell Gold Command, an imaging cell was established to coordinate the approach to diagnostic services to meet immediate need during the response and, in particular, to model the impact of COVID-19 on imaging capacity in GM.

4.3.2 During the response, the Imaging Cell coordinated national investment to ensure that funds were allocated to areas of greatest need, this included CT, MRI, and Ultrasound equipment.

4.3.3 It developed an adaptable model that identified the size of the loss in capacity due to Covid and how this would impact GM over the course of the year.

4.3.4 Building on the modelling, it has now started work to identify how the gap can be bridged, including through solutions such as; mutual aid, innovative solutions, and new capacity. The Cell is also beginning to take a role in use of the independent sector and optimizing policies so that the available capacity is used.

4.3.5 As in other areas during the response to Covid-19, this work has demonstrated the significant benefit of collaboration across GM, particularly through sharing of knowledge, skills and resources, a better understanding of our capacity and

demand and development of equitable services. As our recovery develops, the expected benefits to patients in GM will include:

- Equitable access to all imaging services;
- Sharing of operational practices, with many services extending their opening times to match comparable services within GM;
- Patients will start treatment earlier due to increased imaging capacity;
- Priority patients will receive their appointments earlier due to increased capacity from additional equipment and resources;
- Patients will have services delivered locally, with scans reported across all of the Greater Manchester;
- Patients will have access to state-of-the-art equipment which reduces scan times and radiation doses.

4.4 GM APPROACH TO RECOVERY

4.4.1 In Greater Manchester we are planning for recovery in 3 phases. We realise however, that these will not be entirely separate from each other, and there will be 'blurring' between timescales and phases.

1. Release of lockdown (0-2months)

2. Living with Covid (0-12months)

3. Building back better (0- beyond 12 months)

4.4.2 The city-region is beginning to move out of the lockdown phase, with businesses, the economy and society re-starting, with appropriate adaptations to accommodate the 'new normal', and recovery planning is already underway across Greater Manchester. It should be noted that as the pandemic is ongoing, the response phase has not finished. Therefore, while recovery planning is underway there will continue to be a 'double running' of response and recovery activity and learning from the initial response phase will continue to share future actions. In the co-design and delivery of Greater Manchester's Living with Covid Plan with all parts of GM society we will continue to listen to our citizens and businesses, responding to issues raised and continually learning as Greater Manchester lives with Covid 19.

4.4.3 To support the restart and Living with Covid phase in Greater Manchester, work is now underway to develop a strong Living with Covid one-year Recovery Plan for our social and economic recovery. This will not only make the most of Greater Manchester's most important asset, its people, but support more sustainable and equitable growth as we build back better to continue to make GM a world-leading city region.

4.4.4 We know that the response phase showed both significant cooperation and accelerated service transformation. In thinking of restoration and recovery, we are keen to ensure that we keep the best of those developments and joint working arrangements. The examples in individual districts will be numerous, even selecting those developments we have worked on together across Greater Manchester, many of which have been described in this paper.

4.4.5 A number of opportunities and priorities in particular stand out in thinking about our recovery work, for 3 key reasons:

- They apply across each of the phases of recovery (short, medium and long term);
- They are relevant to GM as a whole and not the Health and Social Care Partnership alone; and
- They are relevant to GM's representation and influence with national partners.

4.4.6 These priorities include:

- *Tackling Inequality* – as we move through recovery this will be immediately relevant to the restoration of services, the effects of that disruption to the most vulnerable groups and the long-term effects of economic exclusion. It will guide our further work with Sir Michael Marmot and the Institute of Health Equity and apply fresh impetus to the role of healthcare institutions as economic anchors and approaches to community wealth building.
- *Retaining positive service innovation* – there is a strong appetite to retain and build on the progressive developments described in this paper and recognise the extent to which those changes have accelerated the realisation of some of our long-term public service reform ambitions.
- *Contributing to Staying Safe in GM* – As public confidence affects the processes of returning to work, participating in leisure activity and moving around the city region, it also affects the public's considerations in seeking healthcare. Overcoming any public fear associated with accessing healthcare and ensuring all elements of society act to reduce the risk of further infection will be ongoing priorities. At the same time, there is an opportunity to support people's own desire to improve their health and provide greater protection from the virus and its effects.
- *Building a resilient social care market* – whilst not a new finding, the longstanding concerns for the fragility of the care market have been exposed through the crisis. GM has the opportunity to illustrate an alternative future for

social care, building on the first phase of Living Well at Home, and work with Government as part of a national exemplar.

5.0 Recommendations

The Joint Health Scrutiny Committee is recommended to:

- Note the update, providing challenge and feedback to the team;
- Support the ongoing recovery work into the 2020/21 winter season and beyond.