MHCLG Community Champions Programme
Case Study

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Name of scheme:

COVID Health Equity Manchester (CHEM)

Local area(s) covered:

Manchester

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How does this scheme support your local COVID-19 response? Are there other priorities for your champions?

The purpose and remit of the CHEM programme is to reduce the risk of transmission, severe disease and death among groups of people who have been identified from local demographics as most at risk, including: -

- Communities experiencing racial inequalities. Currently, this includes our Pakistani, Bangladeshi, Indian, Caribbean, African, and Gypsy & Traveller communities, where data informs us that COVID impact is highest, but this is subject to ongoing scrutiny.
- People born outside of the UK.
- People in specific occupational groups, including but not limited to, health, care, transport, security and front-line services.
- Disabled people, including people with learning disabilities
- Inclusion health groups, including asylum seekers & refugees and Gypsies & Travellers.

The work of the group is necessarily one of rapid response, community engagement & involvement, learning and building COVID resilience. Our Manchester approach to COVID recovery will be one of investing in our voluntary, community and social enterprise (VCSE) sector, to help build resilience, health literacy and potential for greater economic growth.

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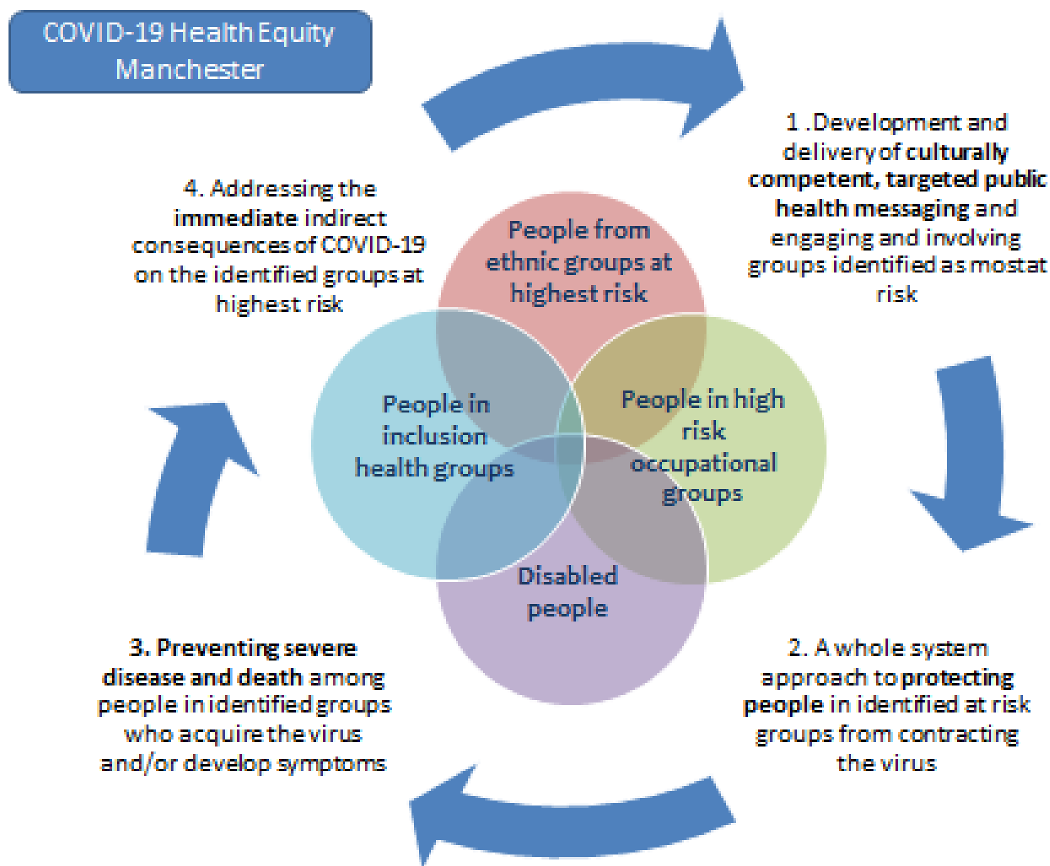

Figure 1. Model for COVID-19 Health Equity Manchester (CHEM)

How did the scheme come about? When did it first come about?

The programme was set up in April 2020 in response to the pandemic. It is led by a system-wide group, with representation from Manchester City Council (MCC), Manchester Health and Care Commissioning (MHCC), primary care, Manchester Foundation Trust, Manchester Local Care Organisation and VCSE senior leaders across ethnic, migrant, faith and disability sectors. The group is co-chaired by Sharmila Kar, Director of Workforce, OD & Inclusion, MHCC and Dr Cordelle Ofori Consultant in Public Health Medicine MHCC/MCC.

Please briefly describe your local population. Does your scheme target any specific population groups?

Our target groups are detailed as above. Risks related to ethnicity, migrancy, occupation and disability, and their intersectional aspects, form four overarching themes (see fig. 1). We also address and include other protected characteristics in the delivery of this programme where proportionate and sensible to do so, for example specific projects for Muslim communities, Jewish communities, women

who require women only services, and intersectional risks such as LGBTQ asylum seekers and refugees.

Manchester's demographics are complex. We have over 200 languages spoken in the city, are in the region of 50% ethnic make-up other than White, over 22 % disabled people and attract a high level of migrants, asylum seekers and refugees. Our migrant population is the highest in the North West. Our average age of population is younger than most comparable cities. Our ethnic and faith communities are many and varied rather than populated from one or two main continents, with our Pakistani, Chinese and African continent populations being the largest after White British/White Irish. We have the largest Jewish population outside of London and a large Muslim population of around 15%. Our Chinese population is the third largest in Europe and our LGBT population is higher than the national average. We have the third fastest population growth area outside of London.

How does the scheme work? Which organisation or groups are involved?

Accountability is assured by both the regular CHEM group membership and system governance structures. The system governance structure is led by the Manchester COVID-19 Response Group, which fulfils the role of the Manchester Health Protection Group. This is the established group for all health protection issues in Manchester and chaired by David Regan, Director of Public Health. The COVID Health Equity Group is made up of system organisations, including those from the VCSE sector, and reports to and is a key workstream under the response group. The work is co-designed across the system. The governance infrastructure for CHEM and an overview of the local COVID-19 Prevention and Response Plan are included in appendix 1 and 2 respectively.

We utilise local evidence and weekly data drawn from across our systems to determine our urgent and immediate priority focus at any given time. This includes those communities where large gatherings or events may require extra precautions and those communities where we can evidence increasing risk of COVID infection or death rates.

In recognition of gaps in reach, we have co-designed a VSCE sounding board for each 'at risk' community supported by a wider list of community influencers to deliver core public health messages in culturally competent ways across the different communities. These sounding boards and influencers are facilitated by the VSCE sector. Each community delivers core messages in different ways, relevant to the best mediums and approach identified for those communities. They also feedback intelligence to the CHEM Oversight Group in order to scale up/out where results are evidencing, for example, higher vaccine coverage. An example of a recent focus piece for our sounding boards on COVID and travel is included as an

attachment, for further information and to demonstrate how we deliver timely, accessible communication around specific requests.

Our aim is to support the development of these infrastructures to form a strengthened ring of defence around these communities, ensuring they get accurate, timely, accessible advice and information to keep COVID safe and are better informed about what to do if they think they are at risk.

How are champions recruited?

Champions/volunteers will be recruited into the scheme via four key anchor institutions from the following areas; education, faith, youth and the voluntary sector. We have appointed 17 volunteer co-ordinators, who will manage the volunteers across our communities most at risk, supported by a wraparound package from Manchester Adult Education Service. The programme interrelates to digital access support and CAB advice programmes. This is in recognition that issues like vaccine overage may prioritise below other pressing concerns for residents and a rounded support offer is most likely to improve health literacy and protection.

We utilise a range of culturally relevant social media, radio, TV, webinars and face to face engagements. These are advertised through respected and trusted organisations and individuals. Our 3-pronged approach is to deliver the right messages, using the right messengers in the right mediums. Volunteers are not reimbursed for their engagement but will be supported and signposted to employment and other opportunities through, for example, the offer from Manchester Adult Education Service.

How are champions trained and supported?

Champions/volunteers have a full induction and training process, as referenced above, and are supported throughout their engagement by Manchester Adult Education Service. COVID Chat support and support around safeguarding, as well as intelligence and data are provided through our CHEM infrastructure. This includes, for example, public health teams, digital teams and health commissioning, as well as support from VCSE organisations, who are particularly strong in the areas of cultural competency and disability awareness.

How do you engage and communicate with champions?

The programme is monitored and evaluated monthly to ensure we can respond rapidly to any changing circumstances or requirements. The volunteer co-ordinators and sounding boards are provided with weekly data on ethnicity,

migrancy and disability COVID impacts and vaccine coverage, to help them set their weekly priorities. This has enabled us, for example, to respond swiftly to surge testing in areas where is high density of particular populations, in supporting these communities around language or other cultural barriers. Insight and feedback from the sounding boards and volunteers is critical to the success of the strategic direction of the programme and bi-monthly feedback is built into the infrastructure for that purpose. We also support this action with deep dive data, for example where we have evidence of surges within particular populations.

Our engagement activities are undertaken by trusted and familiar people and organisations. For example, a webinar for the Black African and Caribbean communities was hosted by the Caribbean and African Health Network, featuring high profile clinicians from these communities, with attendance exceeded 1000 participants. We have recently held a similar event in British Sign Language for our Deaf communities, hosted by Manchester Deaf Centre and featuring Deaf clinicians and biologists, followed by a pop-up vaccine clinic at the Deaf Centre.

We have learnt that nuanced approaches are required for different communities and different community members in order to allow them to engage more effectively. The same is true for how we engage communities, for example engaging and making service provision available to Muslim communities in gender specific cohorts, working directly though youth and older age organisations, creating safe spaces for asylum seekers and refugees, etc.

Has the scheme been evaluated in any way?

We have developed a theory of change (included as an attachment) to support this programme, which has helped us devise our monitoring and evaluation process. We collect qualitative and quantitative data regularly to support evaluation of our work.

What outcomes has the scheme led to?

We have had a number of outcomes to date, including but not limited to: -

- Improved system working to address all impacts of the pandemic together.
- Building of further trust and engagement with the VCSE sector in relation to black, migrant and disabled groups.
- Improved understanding and embedding of wider concerns for the above within the system
- Improved understanding and address of systemic discrimination in our public bodies.

- Improved understanding and address of pandemic impact on small communities where data is sparse, such as sex workers (60% of whom are members of migrant communities) and Gypsies, Travellers, showmen and other nomadic communities.
- Specific outcomes, such as focused and evidence-based interventions leading to increased vaccine coverage. A recent example of this is the move from low vaccine coverage to a higher than city average coverage in our Bangladeshi communities.

What has been your key learning from the scheme to date?

Key learning has included: -

- Use of data to drive action in a timely, focused and responsive way
  - Deep dives/more granular evidence for particular communities where our data evidences particular disparities to provide a more nuanced and tailored response
  - Intersectional overviews to better understand and address compounded impacts, e.g. men with learning disability or Bangladeshi women.
- Bringing our place based and community-based knowledge together to better understand context and place (e.g. newer African migrant communities in the north of the city have very different requirements from our older established African communities in the south of the city).
- The importance of working in partnership with local communities to create a forum where intelligence and insight can inform a clear decision-making process regarding the impact of COVID-19 on communities at higher risk.

How are you planning to develop your scheme moving forward?

We are seeking further funding to enhance the successful approach we have taken with ethnicity and disability to cover our inclusion health groups, including migrants, asylum seekers, refugees, Gypsies, Travellers, Roma, sex workers, Jewish communities, and Chinese & other East Asian communities.

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Further information

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QA:

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- Lisa Binns-Sykes, Senior Policy Lead, Ministry of Housing, Communities & Local Government

For any further information on this collection of case studies or to make a submission, please contact Tom Mapplethorpe, Programme Support Manager, Public Health England – tom.mapplethorpe@phe.gov.uk.

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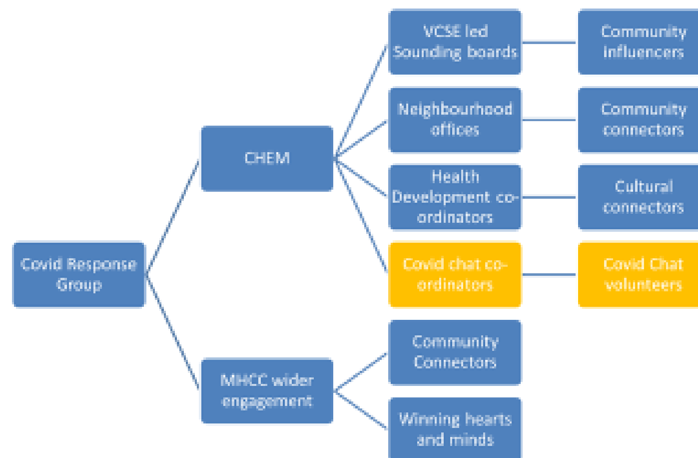
Appendix 1 - Governance infrastructure for COVID Health Equity Manchester (CHEM), including the COVID Chat volunteer programme added using community champions funding from MHCLG.

Who's who? COVID Health Equity Manchester Network



- CHEM Group (overarching programme governance group reporting to Manchester COVID-19 Response Group)
- VCSE led Sounding Boards (engagement forums)
- Community Influencers (messengers – mass media)
- Cultural Connectors (messengers & engagers– place based , lived experience, local and cultural knowledge)
- COVID-Chat volunteers and coordinators – COVID chat volunteer programme as part of Vaccine Inequalities plan (funded by MHCLG*)
- Community Connectors (in the broadest sense rather than a funded or specific role including VCSE, FBOs, Elected Members, GPs, community leaders etc etc)
- Health Development Coordinators
- Neighbourhood Officers
- Winning Hearts and Minds (North Manchester field workers)
- MHCC Engagement team

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Appendix 2 - Manchester COVID-19 Local Prevention and Response Plan, showing local priorities.

Manchester COVID-19 Local Prevention and Response Plan

Manchester COVID-19

Local Outbreak Prevention and Response Plan: March 2021

Our plan addresses the following **themes**:

1) High risk settings and locations
2) High risk, clinically vulnerable and underserved communities
3) Compliance and enforcement
4) Communications and engagement
5) Resourcing
6) Data mobilisation and information sharing

and reflects the approach to the core aspects of the **end-to-end COVID-19 response**:

7) Community testing
8) Contact tracing
9) Support to self-isolate
10) Outbreak management
11) Surveillance

1 High risk settings and locations

2 High risk, clinically vulnerable and underserved communities

3 Compliance and enforcement

4 Communications & engagement

5 Resourcing

6 Data mobilisation and information sharing

7 Community testing

8 Contact tracing

9 Support to self isolate

10 Outbreak management

11 Surveillance

Our Manchester

Our plan now incorporates the following **developments**:

12) Responding to Variants of Concern (VOC)

13) Action on enduring transmission

14) Enhanced Contact Tracing, in partnership with PHE Health Protection Teams

15) The ongoing role of Non-Pharmaceutical Interventions (NPIs)*

16) Interface with vaccine roll out

17) Activities to enable 'living with COVID-19 (COVID secure)

*categories of NPIs taken from SAGE October 2020