The Covid-19 Pandemic in Stockport

Director of Public Health Annual Report 2021-2022

Introduction

Director of Public Health (DPH) annual reports are published in line with the statutory duty of the DPH to write an independent report on the health of the local population, and the corresponding duty of the council to publish it (sections 73B (5) and (6) of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012).

This 2021-22 report has been compiled by the public health team acting independently and represents our assessment, and the assessment of the people we have spoken to, of the experience and impact of the COVID-19 pandemic on our population. It is an honest and open reflection of that experience and impact. It is not intended to represent the views of the corporate body of Stockport Council, or our elected councillors.

This report covers the period from 2021 to 2022 and includes data collected up to the end of 2022 (but not more recently). While an unusual step, we decided to publish a single report covering both these years for two main reasons. Firstly, we were still in the midst of the pandemic at the time when the first years' report would ordinarily have been written, and felt it would be wrong to take away from our response the capacity needed to write an annual report. But secondly, we wanted to write a report that could capture the full impact and lived experience of the pandemic – from start to end – a story that couldn't be told at the start of 2021.

This report tells our borough's story – the Stockport experience of the COVID-19 pandemic. It isn't Stockport Council's formal submission to the national COVID-19 enquiry, but instead gives the underlying narrative of the pandemic period. The report is structured into themes that match its four core purposes; to **record** the Stockport Story, to **celebrate** that we came together in our response and the success we achieved, to **describe** the ongoing impacts, both the good and the bad, and to **learn** from our experience, what worked and what didn't; and make recommendations for the future.

This report will be presented to our Health and Wellbeing Board. Subsequently, it will be published on our website and printed, to be made available in our archives and libraries. We will ask the Health and Wellbeing Board and Health Protection Board to seek assurance on relevant recommendations in the report as part of their ongoing work. Many of the recommendations within this report are already in the process of being implemented, and the Borough Plan, the ONE Health and Care Plan, the Council Plan, and our Portfolio Performance and Resource Agreements (PPRA) each respond to some of these.

Foreword

It was an absolute honour and privilege to step into my role as Director of Public Health and to serve the population of Stockport during a uniquely challenging time for the health of the population. The pandemic of the SARS-COV2 virus has left our population with many challenges – loss, grief, injustice, trauma, illness and exhaustion. It has also shown us that we have huge assets – the kindness and generosity of the people, communities and businesses of Stockport, our ways of collaborating, our flexibility, agility and resilience, and our superb workforce. We have experienced something unprecedented in our lifetime, and it is imperative that we document our learning. This report sets out to achieve that.

The report uses two key areas of analysis to reflect on the experience of the Covid-19 pandemic in Stockport. We have undertaken regular reviews of the data available to us, and provided analysis and commentary on what this means for the health of the population. This process is called a Joint Strategic Needs Assessment (JSNA), and this report draws on and complements our final instalment of our Covid-19 JSNA. This data enables us to see in numbers, what the pandemic has meant for our communities. We have complemented this with stories and case studies, to try and bring this to life with the voices of our population.

The other important piece of work that has contributed to this report is an evaluation of our response as a local system, to the Covid-19 pandemic. The purpose of this aspect of the report is to ensure we do not forget, and that we learn from, the extraordinary efforts of our workforce, who took on roles well outside of the 'day job' and exemplified the point that public health is everyone's business – regardless of if it's explicitly in your job description. We must also ensure that we use this learning to improve our plans ready to respond to the next pandemic.

I hope that you find this report informative and useful. It seeks to celebrate the immense amount of effort, dedication and resilience that was shown by our colleagues and communities. It should give us all food for thought and it should help us all change our services and ways of working to better prepare ourselves and the population for future public health challenges.

Jen Connolly

Director of Public Health, 2019-2023

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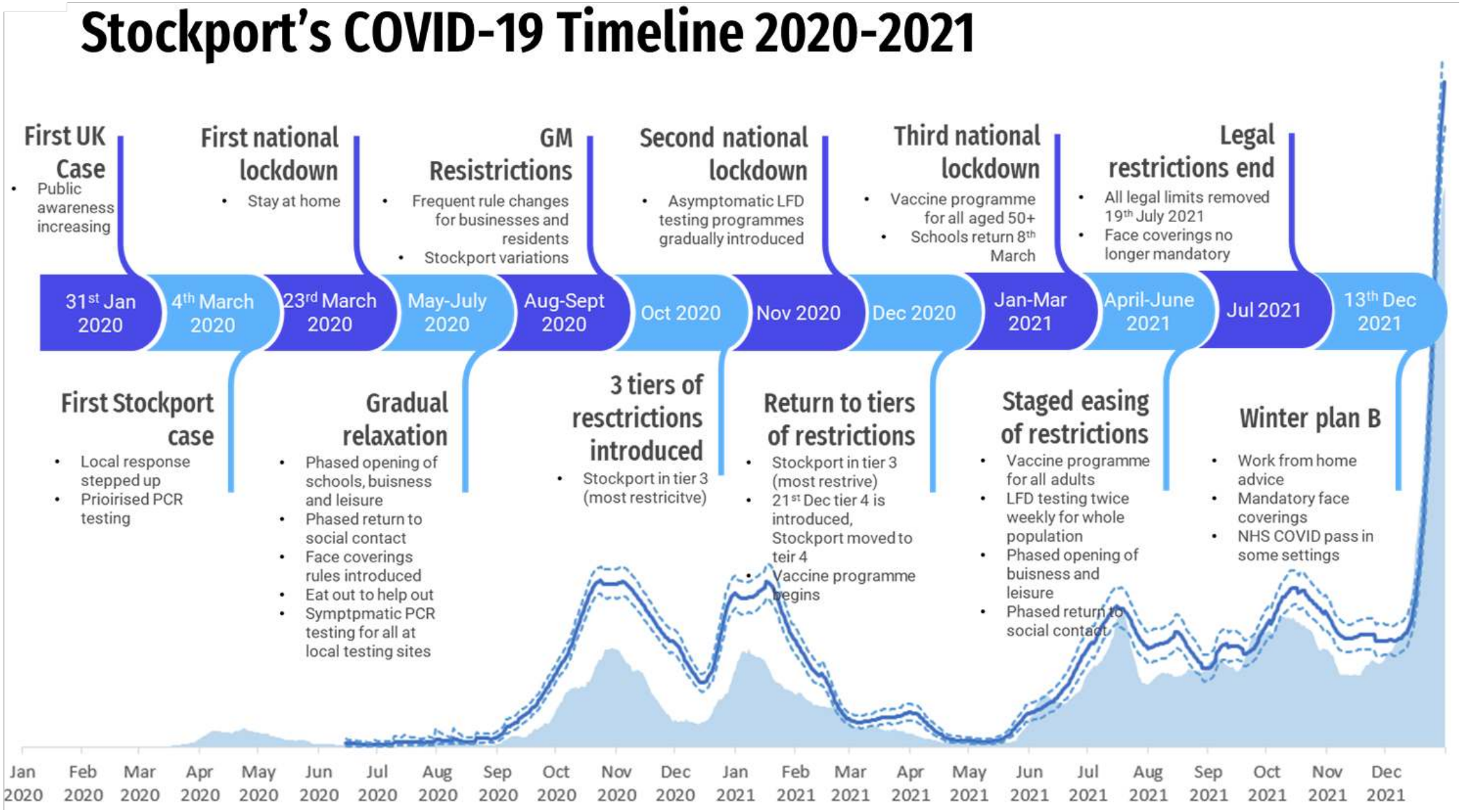

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Stockport's Pandemic in numbers

Cases and health impacts

424,700 estimated CV-19 infections

For Stockport residents 2020-2022

> 100% of the population

111,214 CV-19 cases identified

For Stockport residents 2020-2022

25% of total diagnosed

97.3% adults CV-19 antibodies

By end of 2022

From infection or vaccination

9,650 with long-COVID

5,550 for more than a year

1,750 of whom have day to day activities limited a lot

4,060 hospital admissions

1,050 direct CV-19 deaths

Response

17,900 advised to shield

By mid 2021

7,000 in first lockdown

2.4 million tests reported

1.1 mil PCR, 1.3 mil LFD

8,540 tests a day at peak (Jan 2022)

89,870 cases contract traced

Mainly household contacts found

790,000 vaccine doses given

85.3% adults vaccinated by end Dec 2022

Impact on health & services

26% high levels of anxiety

Up from 18% pre-pandemic

Health behaviours similar

Levels of smoking continue to improve, more non-drinkers but more harmful drinkers

NHS activity recovered

Significant drop in activity in April and May 2020, activity levels recovered but waiting lists up

NHS services changed

63% of GP attended appointments face to face Dec 2022 compared to 88% pre April 2020

School absence rates higher

Inequalities widened

Testing and Contact tracing

Testing for infectious diseases, identifying each person's direct contacts and then reducing harm by providing treatment, vaccination or advice to those contacts are long-established approaches to health protection. People who have had contact with a known case, and those with symptoms, are more likely to be infected than the rest of the population, so if we focus our efforts on these people, it will help reduce overall levels of infection in the population. In theory, this approach has a lower cost for society and the economy than lockdowns.

Testing and contact tracing were employed by PHE at small scale (reaching several hundreds of people nationally) very early in the pandemic, but as numbers rapidly increased, the capacity to deliver this was exhausted, and the population-wide effort was quickly abandoned, with testing re-focussed to priority areas such as hospitals.

After the first lockdown both testing and contact tracing were gradually introduced at the population level, initially with lab-based PCR tests, and then with point-of-care lateral flow antigen tests in the autumn of 2020. Contact tracing was supported through call-centre based approaches and the use of websites and the Test and Trace App. Both arms of the programme involved central government, Public Health England, local councils and private providers.

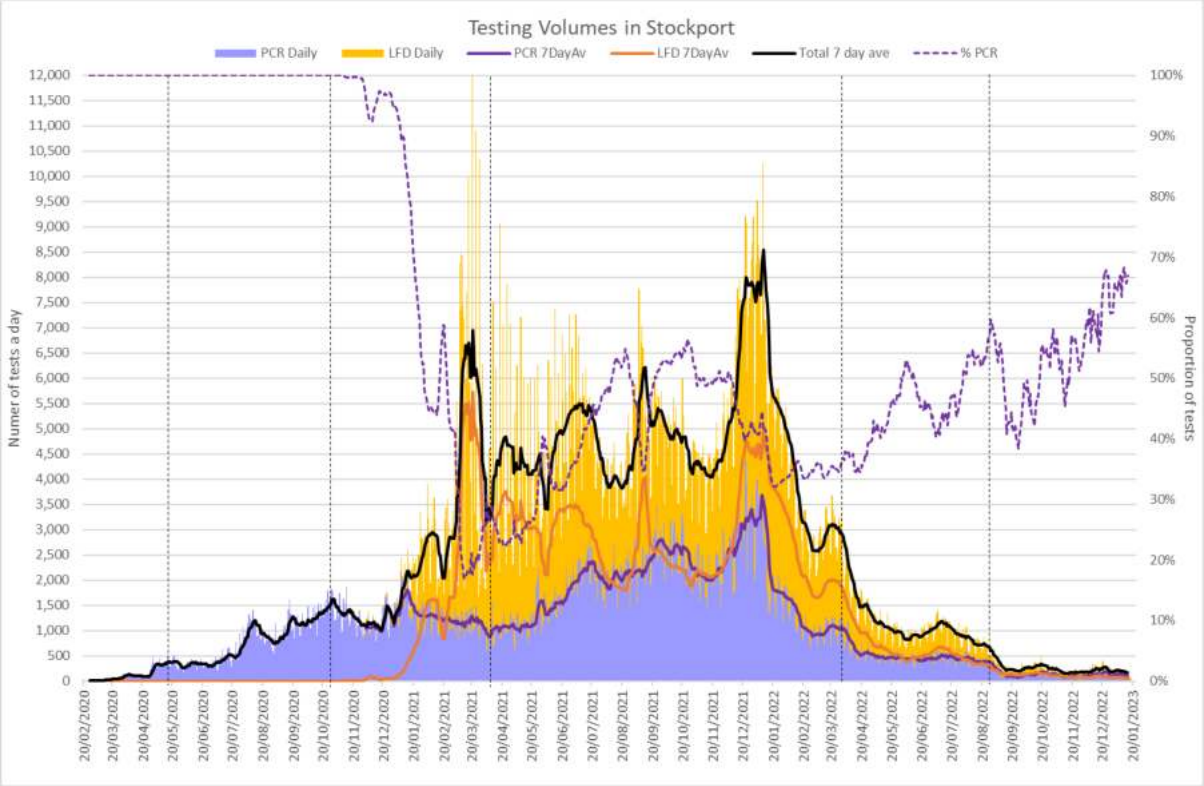
The local role for Stockport was strengthened during summer 2020 when we established a team to support contact tracing, in conjunction with Greater Manchester Health and Care Partnership. We supported schools, businesses and care homes with contact tracing requirements and managing outbreaks. This team developed and over the course of the pandemic went on to establishing local testing centres and mobile offers, community engagement and support and general advice and guidance.

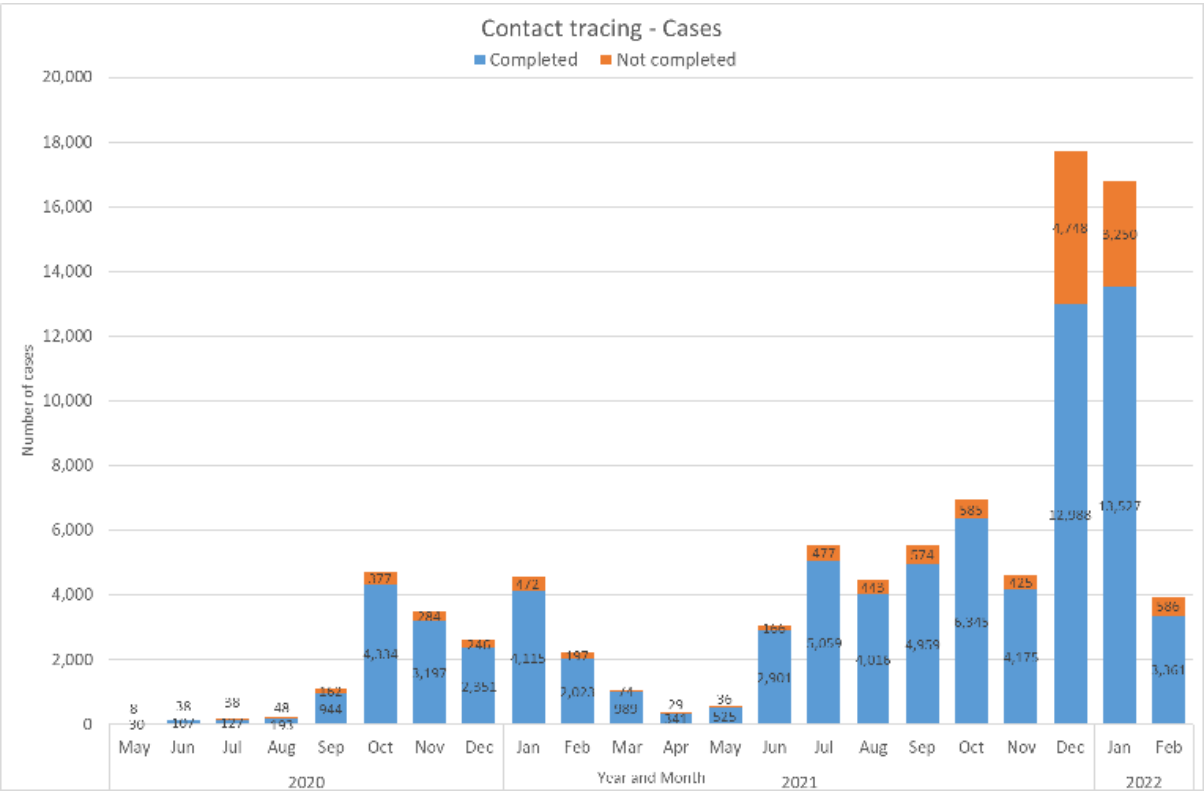
The graphs below show the number of people testing for COVID-19, and the numbers of people identified as contacts at different stages of the pandemic. There is a big gap in the data when testing wasn't widely available coinciding with the first lockdown. We also know that, even when tests were available everywhere and to everyone, we never detected more than about half of cases. Testing by the Office for National Statistics on a representative sample of people in the population has been used to estimate the true numbers of cases.

Overall, the efficacy of test and trace against a virus that spread as easily as COVID-19, and routinely spread before symptoms occurred was limited. At periods of high infection rates, large numbers of people were identified as contacts (the "pingdemic"), and self isolation for school children was disproportionate to the risk, especially when entire classes or even year groups were identified as contacts for each case. The harm caused by asking distant contacts of cases to self-isolate may have exceeded the benefit.

Self-isolation was easiest for people who could work from home, and those supported by employers who could maintain their income even while they were isolating. For many people who work face to face in customer facing roles in retail, hospitality, construction and manufacturing, self isolation was either unaffordable, or achieved despite significant personal cost.

Future approaches to testing and contact tracing need to be more granular, and should seek to identify the closest contacts, rather than all possible contacts. The systems and know-how to rapidly scale testing and contact tracing in response to a novel threat should be retained, to avoid the on-off-on nature of the test and trace system experienced during COVID-19.


Testing Volumes in Stockport
PCR Daily
LFD Daily
PCR 7DayAv
LFD 7DayAv
Total 7 day ave
% PCR
Numer of tests a day
Proportion of tests


Contact tracing - Cases
Completed
Not completed
Number of cases
Year and Month
2020
2021
2022

Care homes and social care

One of the major challenges we encountered during the COVID response was managing the outbreak in care homes. Care home residents are amongst the most vulnerable in our community, and we were aware throughout the pandemic that we had to shield and protect them. At the beginning of the pandemic, there were many difficulties to achieving this aim. Firstly, there was limited availability of tests, and even when we were able to access them, the wait for results was long, meaning that we could not always isolate the suspected cases from other residents.

The problem was compounded, when, to free up hospital bed spaces, care home residents who had temporarily been admitted to hospital were discharged back to the homes either without testing, or before their results were available. What happened next was a rapid increase in the number of COVID-19 cases and then large outbreaks in almost all care homes. This was a national problem, but to the regret of everyone involved in the care home sector, Stockport care home residents and their families suffered the consequences of this problem just as much as anywhere else. This wave of infections in care homes occurred during the deadliest part of the pandemic, and led directly to the deaths many Stockport residents, occurring as it did before effective treatments were available. We expect that the national COVID-19 inquiry will examine this in more detail.

It was difficult to manage cases in care homes as older people tended to become more ill with COVID-19, and were more likely to need medical interventions, and require hospital admissions. Another challenge with managing infections in care homes was in trying to keep people apart, in residences that were designed for interaction, with shared living rooms and dining spaces. Isolating residents in their rooms meant enforcing social isolation. This was even more trying with residents with conditions such as dementia or those with disabilities. Those living with dementia often had limited or no understanding of the requirement to isolate, and the change to routine would have been particularly difficult for these people. The management of outbreaks in homes with residents with dementia remained challenging throughout the pandemic.

The dedication and leadership of care home staff throughout the pandemic, with support from Stockport Council made a big difference. Actions that helped included:

- Developing Stockport-specific infection prevention and control advice, which was more practical and user-friendly than the national guidance
- Having good existing relationships between the local authority health protection team, the hospital infection control team, adult social care provider support team and the care home manager network
- Setting up a PPE hub, enabling sharing of access to the limited quantities of personal protective equipment available to us
- Providing helplines, and easy access to professional help and support through webinars, Q&A sessions and written updates
- Distributing additional funding, working closely with care home managers
- Supporting care homes in connection with vaccination, and particularly with the challenges created by the legal requirement for staff to be vaccinated

A key challenge identified by care home managers was the isolation they felt from the usual sources of professional support to meet the needs of their residents, including social workers, the Local Authority (LA) quality team, and General Practitioners (GPs). Many services had moved to virtual working first in line with guidance and had limited contact with the care homes. This was

challenging for managers as they felt like they were left by themselves to deal with every need of residents, a role for which they were ill equipped. They felt like every episode of ill health was classified as COVID-19 and treated as such, even though it was possible that something else was going on. Overall, they felt that they received adequate support from the LA health protection team, but needed more support than they received from central government and other sources.

As the pandemic progressed and vaccinations became available, another challenge for the care homes was staff retention. The Department of Health had imposed a requirement for mandatory vaccinations for staff and this was not acceptable to all. These conditions created added pressures for homes, some of whom were struggling with staffing numbers before the pandemic, as well as losing some staff due to illness or unfortunately death, from the pandemic.

Key statistics

During the pandemic, 4,221 cases of COVID-19 were diagnosed in Stockport care homes. The largest number of diagnosed cases was in January 2022 when over 750 cases were reported, but we know that many cases will have been missed when testing was insufficient in the early phase of the pandemic. 12% of COVID-19 admissions came from care homes. 260 care home residents died with COVID-19 either in care homes or in hospital, representing 25.7% of all COVID-19 deaths. In 2020, 759 deaths were registered as occurring in care homes, which was 80% higher than the 5-year average annual death rate. These figures are similar to those in other areas.

Sarah Turner, Health Protection Lead Nurse

What were you doing when the pandemic arrived?

The team received their first email about a novel coronavirus that had been identified in China in December 2019. This was the first indication that something new could have been on the horizon, but within infectious disease and outbreak management this would not be unusual. This flow of information and activity built throughout early 2020, linked to cases returning from Italy and China, and the need for advice for schools.

At the beginning of March 2020, contact with care homes increased significantly, following individuals being discharged from hospital into care homes.

What happened? - the impact of the pandemic and lockdowns on you and those around you
Prior to lockdown, the Health Protection Team were based in the incident room in the Council's offices, surrounded by colleagues who were also responding to their own various challenges, but they were looking to the Health Protection team and the wider Public Health team to provide them with advice. At this time, there was also a need to provide extra support concerning admissions into care homes, discharges from hospital, symptom recognition (especially in the elderly), symptom management, testing (limited), personal protective equipment (lack of), contact tracing (if any), infection prevention and control guidance, who to contact and when, and outbreak management.

When lockdown happened at the end of March 2020, this all continued, but with fewer people to provide us with support. The council buildings became like a ghost town, if you did see others, social distancing prevented you from having that social contact we all need as humans, so even at work you felt very isolated.

How did you and your organisation respond and adapt to the challenges?
Care homes were my focus, as they are crucial to the healthcare system, but are also the place that residents call home. The pandemic changed visiting and prevented visitors from attending care homes at any time, leading to adapted visiting being introduced such as window virtual, pod and screen visiting. This restriction was hard for everyone, but not least the residents and families directly affected.

Symptomatic staff and residents also needed to be considered, there was limited capacity to undertake any testing at the beginning of the pandemic, with a specialist roving team having to be set up to do this within care homes. It was fabulous to know that there were staff within the department willing to take on clinical work when this was not part of their normal day to day activities.

How has it changed you and your organisation, and how you work?
Living through the pandemic has been an experience that I and the team will not forget quickly. It taught us great personal and professional resilience at a critical time whilst remaining calm under significant pressure, in the knowledge that we had the skills and expertise to manage very difficult situations.

It also cemented relationships that (I hope) will stand myself and the team in good stead for a long time. The team already had strong relationships with social care providers from undertaking infection prevention and control assessments to improve standards and the safety of the

residents prior to the pandemic, however these relationships have strengthened and the skills within the care homes have improved.

It is critical that lessons learned at such a high cost in the premature deaths of residents are not forgotten. We should never again discharge patients with unknown status with respect to a new, rapidly spreading and deadly respiratory disease at scale into care homes. Testing and vaccination are the key tools to avoid this in future pandemics, but we also need to be ready to cohort people discharged from hospital in nominated care settings if these technologies are not available.

The design of care homes also needs to evolve. We need facilities that will still be welcoming and supported environments during outbreaks. En-suite rooms, with enough space for residents to eat and relax as well as sleep in, are critical. The largest care homes with more than 20-30 beds need to be divisible into smaller units, each with their own lounge and dining space. Attention needs to be paid to how linen and food can be moved around without compromising infection control.

The legacy of this pandemic is considerably strengthened relationships between care homes, NHS organisations and the council. We need to build on these to create a stronger, more capable more agile and more resilient care sector.

Mortality

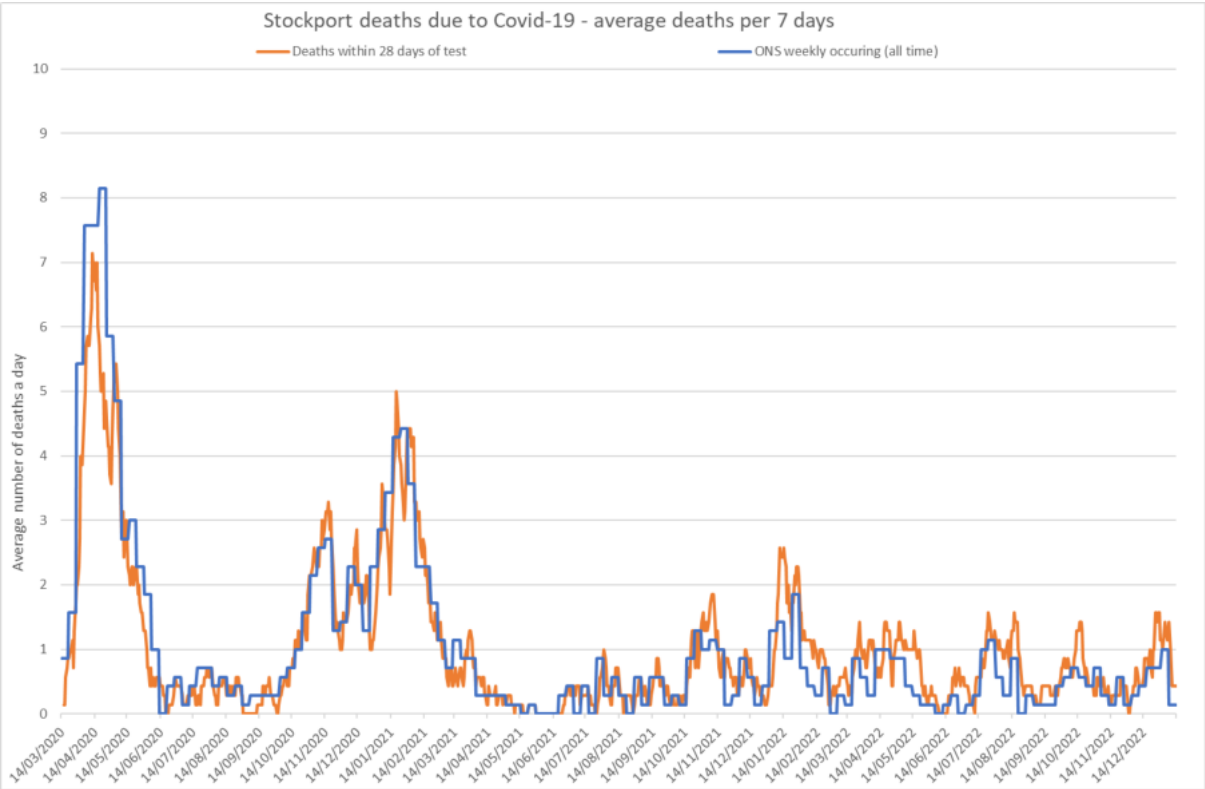
There were around 1,050 deaths due to COVID-19 in Stockport between 2020 and 2022. Significant inequalities are evident in these mortality rates, showing that COVID-19 has disproportionally affected the health of people living in deprived areas.

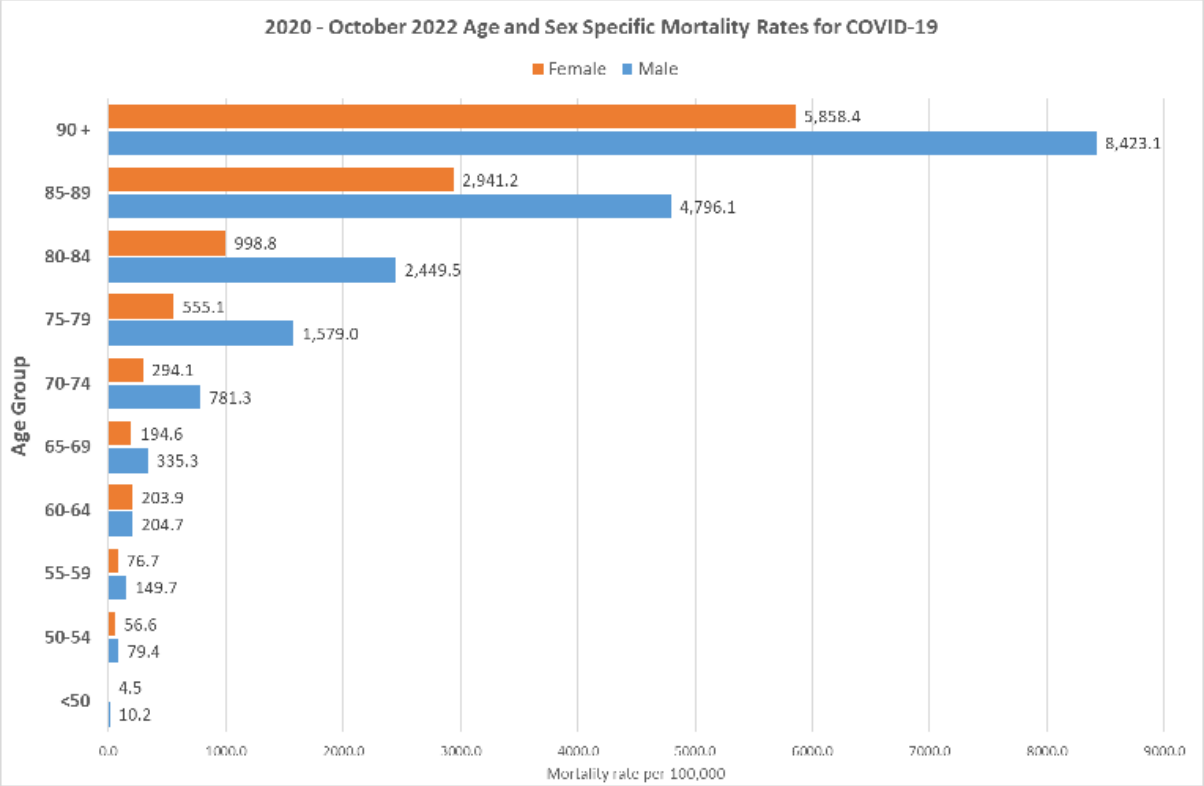
Following national trends, mortality rates for those under 50 are low, and then increase at each age to over 67 per 1,000 residents per year for those age 90+. For age groups 70-84 the mortality rates for males are more double than for females, and for all age groups over 50 there is a significant gender gap.

26% of COVID-19 deaths in Stockport were either care home residents or occurred in care homes.

National data show that mortality rates in the early part of the pandemic were higher for people from Black and Minority Ethnic groups than for those from White groups. The local mortality data doesn't include information about ethnicity, but this national trend mirrors local trends in numbers of cases, which were higher for BAME groups s during autumn 2020, before moving towards the average in later waves.

Deaths were highest in April 2020, at around 8 deaths a day. Rates fell to fewer than 1 death a day in the summer of 2020, before rising again through the alpha waves to an average of 5 a day. Since the vaccine programme began to take effect the number of deaths have been far lower, although waves of mortality followed the case trends through the second part of 2021 and 2022. In 2022 there were an average of 0.76 daily deaths due to COVID-19.



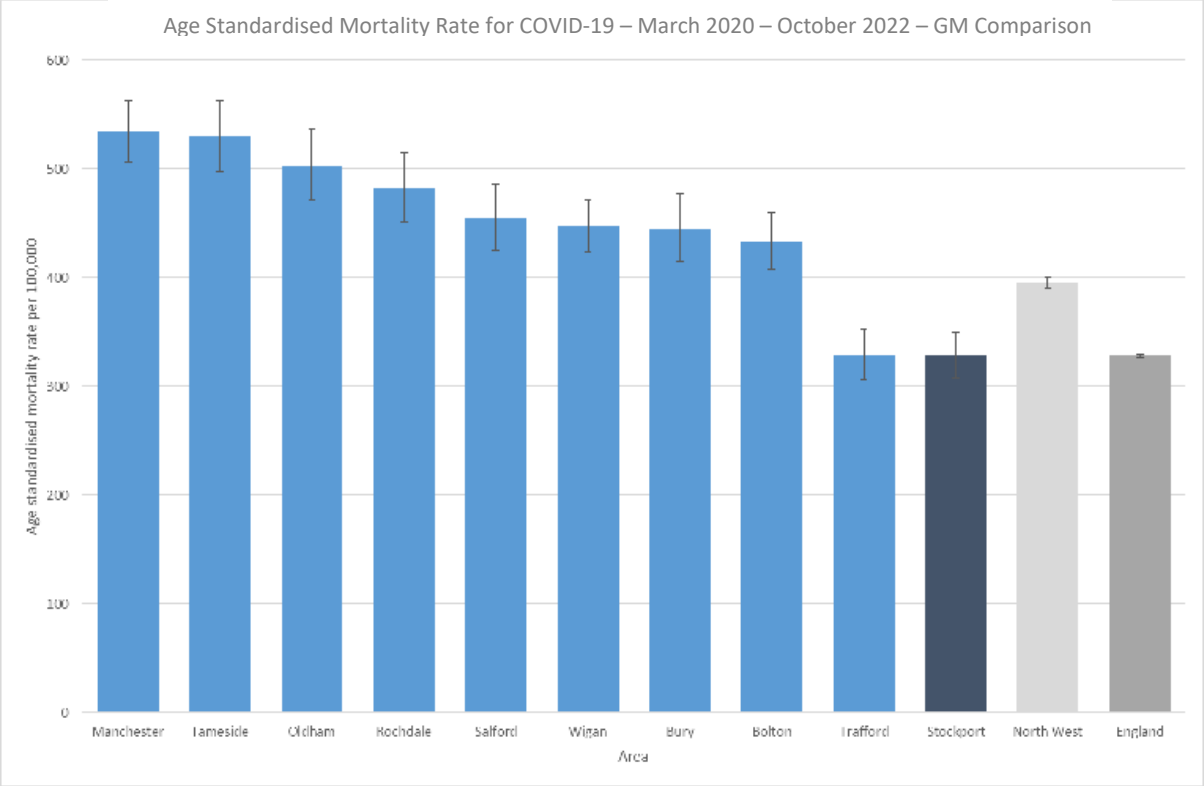


Regional and GM comparisons in mortality from COVID-19

Taking into account the size and age structure of the population, there were 328.3 deaths involving COVID-19 per 100,000 people in England over the period March 2020 to October 2022.

There have been significant regional variations in the mortality rate from COVID-19. The areas with the highest mortality rates across the pandemic so far are those that experienced large case numbers early in the pandemic, since the deaths per case were much higher in the early phase of the pandemic than in later phases. Rates were significantly higher in London (409.9), followed by the North West (395.4), while the South West has experienced the lowest rates so far (190.8).

Mortality rates in Greater Manchester are higher than the national average, but rates for Stockport and Trafford are much lower, and not significantly different to the national average.



Excess mortality (all causes)

In 2020, 3,205 deaths from all causes were registered for Stockport. The 5-year average 2015-2019 for the same period was 2,804; meaning that in 2020 there were 401 excess deaths (14.3%). Across England and Wales in 2020 there were 75,031 excess deaths, a similar proportion to in Stockport at 13.9%. In 2021, the number of total all cause deaths was lower than in 2020 but was still higher than the average between 2015-2019, at 125 excess deaths (4.4%).

Early data for 2022 (to be confirmed) shows the number of total all cause deaths has risen again; there were 341 excess deaths (12.2%). This could suggest that the impact of COVID-19 on the wider health of the population is starting to become apparent.

Impacts on other causes of death for 2020 and 2021

A direct impact of first two years of COVID-19 has been a fall in the mortality rates for heart and respiratory disease and dementia, the causes of death that are most common for older people, as people have instead died of COVID-19. Mortality rates for cancer overall have not changed significantly; but we have seen increases for mortality from breast cancer and colorectal cancer, potentially linked to pauses in screening programmes. We will continue to monitor and report on these statistics, and respond to data as it emerges.

CELEBRATE

Community action

When the first Covid lockdown was imposed in March 2020, the response of voluntary, community, faith and social enterprise (VCFSE) organisations in Stockport was phenomenal. While much of the existing voluntary activity stopped, many people came forward, both existing and new volunteers, wanting to do what they could to help their communities. Mutual Aid Groups (MAGs) sprang up in many communities across Stockport, while existing VCFSE organisations demonstrated the value of their agility, creativity and motivations to find ways to look after those who needed help.

Nationally, the Royal Voluntary Society NHS responders volunteer service was inundated with new volunteers, and over 400,000 active volunteers delivered over 2.2 million tasks between them using the newly develop GoodSAM app, which allocated requests for help to local volunteers. Locally, Healthwatch Stockport took a leading role, providing a central point for volunteers to register their availability, and matching them with organisations who needed help. The Council and Sector 3 worked with Healthwatch, providing a dedicated staff member who was redeployed from the museums team to establish a volunteer hub, working to engage and support volunteers matching them with needs and opportunities to help local organisations in their response. Over 500 people registered within the first months of the pandemic, and many local projects and activities were supported. The volunteer hub was taken over by Sector 3 in autumn of 2021, and continues as a valuable legacy of the early response, a key part of our infrastructure support for VCFSE organisations in Stockport.

In December 2021 Stockport was invited to became one of the 60 nationally funded Community champion programmes, the programme aimed to connect to people who are most at risk from Covid-19 to reduce the impact of the pandemic on themselves and those around them. In January 2023, Sector 3 took over the lead for development of programme in Stockport, aligning the initiative even more closely to the volunteering offer for Stockport.

The legacy of this work is now being used to inform our work with communities and partners at local level, including the development of Family Hubs in neighbourhoods, which will bring together support for families from across the public and VCFSE sectors. Stockport's new seven-year all-age mental health and wellbeing strategy also draws on this work to shape our responses to the impacts of the pandemic, placing lived experience at its heart, and prioritising further development of VCFSE capacity and neighbourhood level collaboration.

The story of Marple's Mutual Aid Group: Zoe Porter

Marple Mutual Aid started in a whirlwind of passion, stress and determination. By mid-March 2020 we were all facing the coming reality of the pandemic and the impact it would have on our lives and those around us. It was the only thing anyone was talking about, on the streets, in the shops, and, of course, on social media. While many people were talking to neighbours and coming together in their streets, a local resident started a Facebook group to begin to organise some of the community response and Marple Mutual Aid was born.

We wanted to be there to support our self-isolating neighbours with the practical and emotional impact of what was to come, and we also wanted to support local businesses. We were clear that we were just neighbours helping neighbours and weren't trying to provide anything that would be more appropriately offered by professionals, or existing services.

Within a few days we had over 1,000 people on the Facebook group and countless offers of help pouring in. For all the pain and damage the virus has caused, it has also brought out the very best in people. But there was no time to reflect on that, we needed to get organised, and quickly!

Some local businesses already had ways to take payment online or over the phone, and even delivery services, while others were now having to adapt under extreme pressure. We thought that we would be able to help with deliveries, by drawing on the kindness of volunteers who weren't self-isolating. We set up a central email account, and a phone number that could be transferred to different people who were willing to take phone calls. We quickly made up a leaflet that listed the details of shops, and our offer of help and we were off!

By the following Monday we were receiving over 20 calls a day, so we asked our community for help. We ended up with a crack team of people from a variety of backgrounds who stayed committed throughout lockdown, taking calls Monday-Saturday. We loved talking to people, and getting to know them, but we were also given a glimpse into how tough things were for some of our neighbours, particularly for those who had lost loved ones, who were having to cope with their grief in isolation.

Local businesses and voluntary organisations worked together with over 200 volunteers to provide and deliver prescriptions, groceries, and in some cases hot meals for people. We also set up 'buddies', which were simply longer-term connections between someone who was self-isolating, and someone who was there to lend a hand, connecting over 40 sets of people up this way. The volunteer might help with dog walking, getting in weekly shops, or just a regular chat on the phone.

Where someone seemed to need more support than you would expect a neighbour to give, we connected to other services. The Council, local GPs and the Stockport voluntary sector hub 'The Prevention Alliance' were really helpful. There are other areas of the country where groups like ours have felt that Councils and others have tried to take control, or even stop them – but our experience has been positive.

The scheme emerged through extraordinary circumstances, but it brought out connections, relationships and generosity that we want to become part of our everyday life. The constant willingness of so many people across our area to offer help and support has been what kept everything going and made it all worthwhile. Now that the Mutual Aid group has stepped back and people have gone back to 'normal life' many of the relationships have sustained, and the memory of being part of something so spontaneous and community-spirited will stay with us forever.

Businesses

The impact on business of the COVID-19 pandemic arrived quite suddenly, with the introductions of lockdowns and subsequent restrictions. Within the space of a week, the majority of businesses moved from normal operations to remote working or complete closure, for an unknown length of time. The Coronavirus Job Retention Scheme (CJRS), or 'furlough' system, established by the government to protect jobs and businesses operated from March 2020 to 30th September 2021. Statistics show that 49,800 (38%) of Stockport's jobs were furloughed at some point between March 2020 and September 2021. By September 2021 5,700 Stockport jobs were still on the furlough scheme.

Between July 2020 and April 2021, more women than men were furloughed, but between May and September 2021 the situation reversed. This reflects decreases in the number of jobs on furlough in sectors such as accommodation and food, which typically have higher numbers of female employees.

For most of the scheme's life, the under 25 age band were the most likely to be put on furlough. As restrictions eased from spring 2021, the level of furlough in this age band decreased faster than other bands. By the end of the scheme, the take-up rate of furlough for employees aged under-25 was the lowest across all age bands at 3%.

The accommodation and food services sector and the arts, entertainment and recreation sectors have had the highest furlough rate with over 90% of jobs in these sectors being furloughed at some point, followed by other service sector and construction (both at over 50%). Over two-fifths of wholesale and retail jobs were furloughed (43%) at some point and 40% of manufacturing jobs. However, not all sectors have seen as high rates of furloughing, with the public administration (1%), finance and insurance (7%), education and health (both 10%) having lowest furlough.

Impact on business: Our Story: Richard Simkim, Director of Operations, Stockport County Football Club

Looking back, I can't really remember exactly what I was doing nor when I realised the severity of the situation unfolding but it was certainly much, much, earlier than the March official lockdown. I

recall seeing news pre-Xmas 2019 around the situation in China but “wrongly” assumed this was just another virus outbreak which wouldn’t affect myself, my family, friends and colleagues – but how wrong that assumption was going to turn out to be. January to February 2020 seemed quite slow and surreal with all the media coverage, and felt like it was getting very serious, but not closing borders appeared to give a false sense of “safety” even though the virus was spreading around the globe and fast…

March 2020 arrived, and we all could tell something major had to happen and it did – on Thursday 23rd March the official first lockdown began and that was when the sense of terror hit home and especially for my partner and our young family (children of 2yrs, 4yrs and 10yrs at the time).
We became custodians of Stockport County in Jan 2020 and so little over 2 months later we found ourselves in lockdown, the season was curtailed (we missed out on play offs on Points Per Game - 2) and we subsequently furloughed all of our players, staff and senior management team. Financially, our owner pledged to support all staff and so navigating through was not too much of a financial burden at all. Sadly there were numerous friends, relations and people not too far away who passed due to the outbreak and many fans also sadly died as a result.

Myself and our facilities manager were kept on to keep the business running, develop and implement our various Covid 19 phased returns; spaced out training/office staff returning, small group training, 11v11 training, behind closed doors games (for the entire 20/21 season) and subsequently the return of fans for the 21/22 season where we won the league and returned back to the EFL after an 11yr absence.

Our organisation has not changed other than the fact we are much more spaced out in our office environments/spaces, training grounds and other key areas (virus’s/colds/flu are constantly around us and also evolving). We have kept all hand sanitisers in situ, which are regularly utilised to this date, and constantly topped up! I feel if anything the outbreak, and subsequent devastating fatalities, taught us all to not take anything for granted and to be more than prepared should anything of this nature happen again.

Our hopes for the future are mainly centred around our team of staff across all the businesses and to constantly monitor how we both perform and behave to develop ourselves in order to deal with any such instances. Whilst it will always be a shock to the system, the latter parts of 2020 will be a stark reminder to all that these outbreaks can and will happen, and to ensure we share our experiences with future generations and keep all records relating to the processes and procedures which we all used to navigate out of the pandemic.

Impact on economy and unemployment

Stockport has developed a new economic plan for the borough, which responds to the significant and lasting impacts of the pandemic. Mobility has been significantly impacted by the pandemic, and the ways we work have changed forever. The local economy lost an estimated £700m as a result of the pandemic in 2020, this is equivalent to 10% of the total output of the local economy. As with furlough, the sectors most acutely affected by lockdown restrictions saw the largest losses, with accommodation and food services in particular being the most significantly affected, losing an estimated £100m in 2020.

The pandemic led to an increase in the number of people who are unemployed and claiming job seekers allowance in Stockport, with the impact most severe in areas of high deprivation. Early career and older workers have been the most significantly impacted by COVID-19.

Stockport Council worked to support businesses through the pandemic by:

- Administering the rapid local distribution of business grant funding support
- Commissioning Stockport Jobs Match, originally as a crisis response to help businesses find workforce at the start of the pandemic but evolved into a longer term support for workforce needs and careers education, advice and guidance https://stockport-jobsmatch.co.uk/ linking unemployed residents with local job opportunities and training courses.
- Commissioning Stockport Economic Resilience Forum as an ongoing support, preparing the borough for opportunities in the green economy, improving the local digital and physical connectivity and supporting 'building back better' http://skeconomicresilience.co.uk/
- Establishing the Pandemic Response Team to support businesses in interpreting and implementing guidance in order to open and work as safely as possible, and identify cases of flagrant rule breaking.

The Stockport Pandemic Response Team: Adam Forbes, Team Manager

The initial Lockdown in March 2020 was a very worrying time for friends and colleagues. Working from home became commonplace and internet shopping a lifeline for many. As the virus morphed and restrictions came and went there was a clear need for clear, direct communication with businesses around the changing regulations. Regrettably this also highlighted a need for enforcement of these regulations as some businesses failed to comply.

In September 2020, Stockport was placed in Tier 3 restrictions and the Council acted by forming the Pandemic Response Team (PRT). Several of the Council most effective and pragmatic officers were selected to advise and enforce residents and businesses of their responsibilities. Initially this was focused on the hospitality sector – drinks could be served only with meals at socially distanced table. Joint visits were carried out with the Police, advising publicans and licensees of the nuances in the regulations.

All bars were granted exemptions to allow 'off' sales of alcohol which in some cases caused long queues to form outside as thirsty resident took advantage of this concession!

Non-essential retail was ordered to close however some businesses attempted to circumnavigate this by stocking new lines. An example I recall was a (non-essential) card & gift shop started to stock (essential) mops and buckets to seek to remain open. These workaround efforts only helped the virus spread and through conversations we were able to help businesses to become compliant.

One sector that was particularly non-compliant were barbers (not hairdressers), with many choosing to remain open and refusing even the basic measures to prevent transmission such as

face masks. This led to enforcement action, issuance of fixed penalty notices and the prosecution of several business – Some were even found working behind closed shutters!
The work of the PRT concluded in 2022 as the vaccine rollout progressed and restrictions were lifted. I hope we safeguarded the welfare of many of Stockport's residents although it was certainly an experience that no one wishes to revisit.

The impact of COVID-19 on unemployment was less severe than the world banking economic crises of 2010, but still lead to a significant rise in unemployment locally, with a peak of 6,700 (4.7%) people out of work who were looking for employment in the year between July 2020 and June 2021; this was an increase of more than 36% from a year previously (4,900 people, a rate of 3.3%). Levels of unemployment remain higher than pre pandemic and by September 2022 in Stockport were 4.2%. The increase in unemployment was more significant in Stockport than across England as a whole (25% increase).

Vaccination

One of the biggest successes we experienced during the pandemic response was the development of suitable vaccines against COVID-19 and their rapid deployment. Stockport played a key role in the COVID-19 vaccination research and development programme, as the second largest contributing centre to the Novovax trial.

With the availability of a variety of vaccines developed by the pharmaceutical industry, which received unprecedented support from governments and regulators, the UK was able to secure supplies to commence a vaccination programme. The vaccination was first offered to the oldest and most vulnerable people in society, as well as the workers who had most contact with this group in the NHS and social care. We were supported in our efforts by the willingness of people to come forward for vaccinations as well as the availability of both healthcare workers and the many local people who volunteered to deliver the programme. As part of the initial roll out which was led by Stockport's Primary Care Networks (PCNs), the military supported our vaccination programme, as other parts of the UK. The vaccination delivery group was made up of different stakeholders, with leadership and collaboration from Stockport's PCNs, Clinical Commissioning Group, the hospitals, the Council's public health team, community pharmacists and voluntary organisations.

Once we had completed the initial roll out, we offered vaccination to other at-risk groups that had been identified, such as people with pre-existing health challenges that could be made worse with the COVID-19 infection (people with asthma, transplant patients, other respiratory challenges, diabetes etc). Eligibility then expanded in 10-year age bands, eventually reaching everyone aged 5+. We offered vaccinations to all adults in our area, by decreasing age bands. Eventually, when approved, we were also able to support the roll out of the vaccination programme for young adults and school-age children.

The availability of data, broken down by local areas and numbers of people vaccinated was very useful in planning the vaccination programme. We were able to see what areas had the lowest vaccination levels, and in so doing were able to target the vaccination clinics to those places, to hopefully drive-up numbers. The data was shared with our community organisational to support the design of further campaign effort and collaboration on where and how to offer vaccination within specific communities. This data was available because of greater cooperation and collaboration between organisations and departments and this model should be adopted in other vaccine programmes achieve the best possible results.

We were also able to hold on to the skills of the members of the vaccine delivery team, some of whom had been seconded from other parts of the council by creating the flexibility to call on them when we needed to start new vaccination campaigns. By doing this, they were available to offer their expertise during the general booster vaccination campaign as well as the subsequent vaccination programmes for at risk people.

The success of the vaccination programme meant that, even though people were still being infected with COVID-19, a lesser number of people were getting very ill and requiring hospital admissions. This, by extension, reduced the death rates among our residents. The success of the vaccination programme enabled government to lift the lockdown restrictions and allow people to go back to living their lives in similar ways to before the pandemic. Businesses were able to reopen, people were able to see friends and loved ones and offices and schools could reopen.

Overall, the vaccination programme was a game changer in our management of the pandemic. Almost all the other measures can be seen as creating a temporary bridge to minimise harm and keep infection levels under control and until widespread vaccination could be implemented.

What we know about COVID-19 vaccine uptake

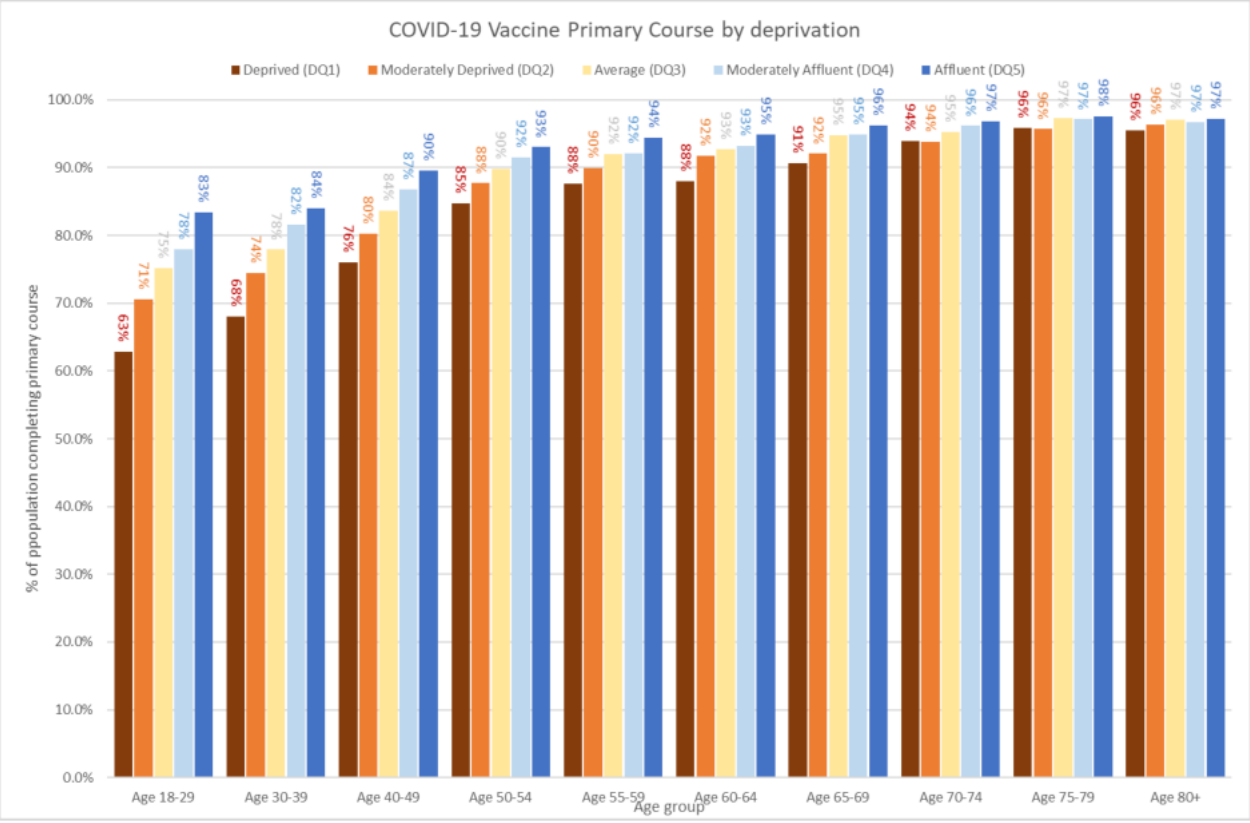
Since the vaccine programme started in late December 2020, over 790,000 doses of the vaccine have been given in the borough, 85.3% of the adult population of Stockport have completed their primary course (2 doses). Uptake of the primary course is especially high in older populations, at 96.3% for people aged 70+, and 93.3% for those aged 50+. Uptake is lower in younger ages, but more than 70% of those aged 18-29 have completed their primary course, and over 50% of 12-17 year olds have had at least 2 doses of the vaccine.

Booster doses were offered in autumn 2021, spring 2022 and autumn 2022; with different eligibility criteria each time. Over 80% of those aged 75+ years have had five doses of the vaccine (primary course plus three boosters)

Vaccine uptake is lower in areas of deprivation and in certain ethnic groups, however this effect was lessened by our success in achieving 75% uptake of the vaccine in adults in every area of Stockport.

Covid-19 vaccine inequalities – deprivation

While the overall primary course uptake for those aged 18+ years in Stockport is 85.3%, this varies by deprivation, with uptake being 91.4% in the least deprived areas and 76.7% in the most deprived areas – a gap of 14.7 percentage points. This gap is similar to that seen nationally and is much greater among younger age groups



Covid-19 vaccine inequalities: Ethnicity

Analysis shows that there are significant differences by ethnic group, following national trends. Uptake of the primary course for those aged 50+ is lowest for people from Arab, Chinese, Black /

Black British Caribbean and Black / Black British African ethnic groups, with uptake between 70% and 79% for those aged 65+. Rates are higher in other Asian / Asian British, but are still lower than the White / White British population. For younger age groups the equity gaps are even more significant and more recent data for booster doses shows that these gaps are persisting.

DESCRIBE

Long covid

Most people with coronavirus (COVID-19) feel better within a few days or weeks of their first symptoms and make a full recovery within 12 weeks. For some people, symptoms last longer. This is called long COVID or post COVID-19 syndrome. Long COVID is a new condition which we continue to learn about but it encompasses a range of symptoms– including extreme tiredness, shortness of breath, muscle aches, memory issues, heart palpitations, depression, anxiety and tinnitus.

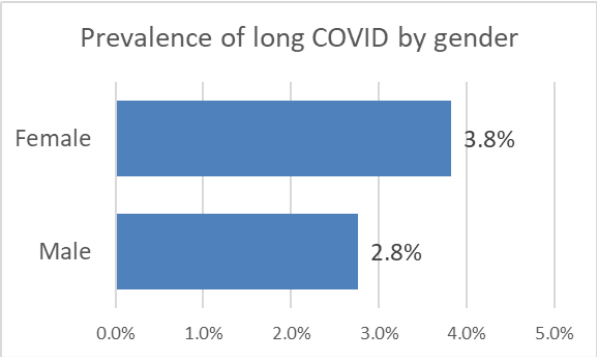
The Office for National Statistics (ONS) uses the Infection Survey to estimate the prevalence of, and risk factors for, long COVID symptoms and health complications following coronavirus (COVID-19) infection. By the end of 2022 around 3.3% of the UK population respondents were experiencing self-reported long COVID, defined as symptoms which continued for more than four weeks after the first confirmed or suspected COVID-19 infection that were not explained by something else. Fatigue is the most common self-reported symptom of long COVID (71%), followed by difficulty concentrating (49%), shortness of breath (47%) and muscle ache (46%).

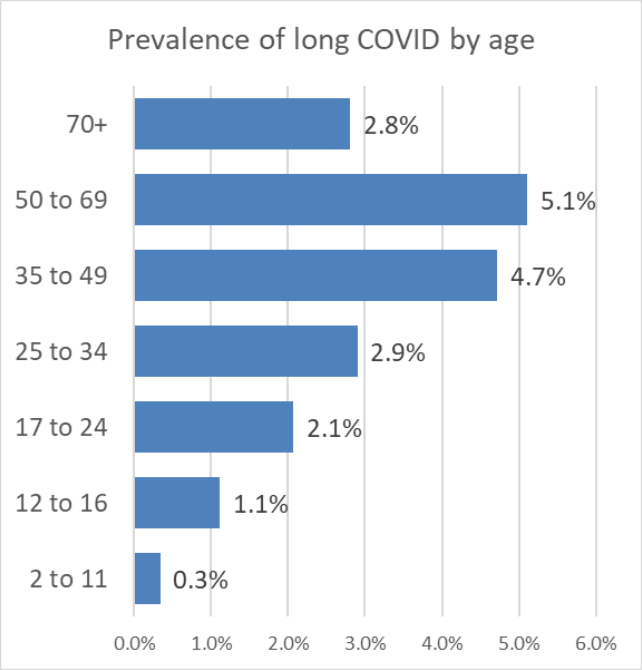
At the end of 2022, around 9,650 people in Stockport were estimated to be experiencing self-reported long COVID. 57% of these people (5,500 in Stockport) are likely to have experienced symptoms for at least a year and 18% of those with long COVID report that their ability to undertake their day-to-day activities had been "limited a lot", estimated at 1,750 people in Stockport.

From February 2021 to November 2022 an estimated 1,260 people in Stockport sought support for long COVID. 65% of these are females and 35% males. The most common ages for seeking support (mirroring the findings from national surveys) are 30-59. Analysis also shows that people from more deprived areas in Stockport are more likely to seek support for long COVID.

As a proportion of the UK population, the prevalence of self-reported long COVID was greatest in:

- people aged 35 to 69 years
- females
- people living in more deprived areas
- those working in social care
- those who were not working and not looking for work
- those with another activity-limiting health condition or disability.

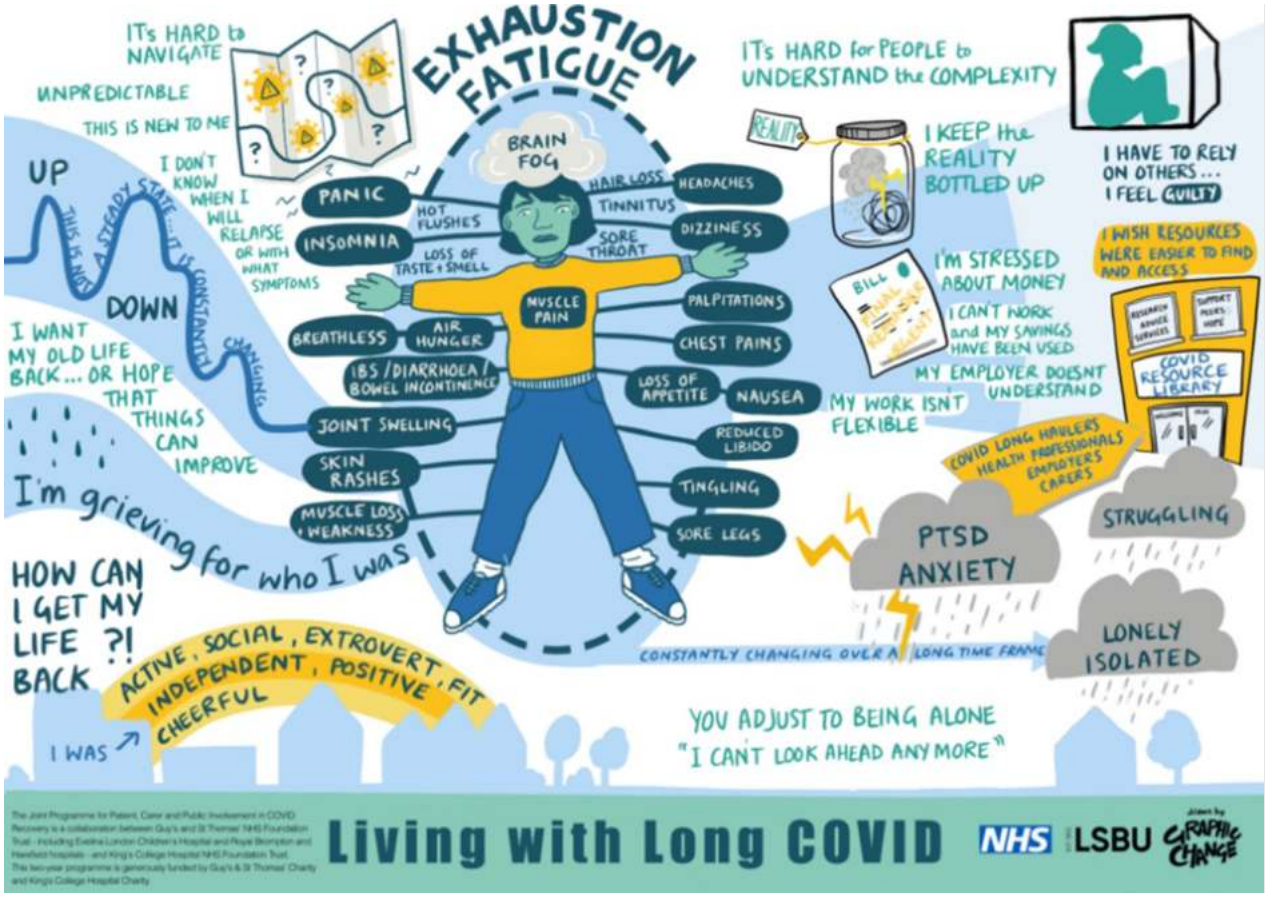




There have been 315 admissions to hospital with a primary or secondary diagnosis of long COVID. 62% of these admissions were for females, and the most common ages were again 30-69 years. Stockport Healthwatch have worked with Stockport's long COVID support group and others to understand the impact of long COVID on our local population. The impact of long COVID has been felt on the following:

- Most of all mental health has been impacted, with 73% of respondents reporting a negative impact
- The ability to carry out daily chores and tasks was an issue for 65% of respondents,
- Maintaining previous working levels was difficult for 38%, with some respondents being off work for significant periods,

Whilst some respondents did not feel comfortable with attending a support group, many found them valuable in knowing they were not alone in experiencing their symptoms and the effects these were having on their life. They found the information shared was useful and helpful.



1 Experience of Long Covid: Healthwatch and Stockport Long Covid Support Group

What we need to understand more about

Nationally, work is continuing to understand the long-term impacts of COVID-19 on those who have been infected. Research is in place to define long COVID and to understand how it may impact people in the future.

The full impacts of the changes in health service availability and demand have still to be seen in local data about the health and wellbeing of the population in Stockport, monitoring future rates of hospital activity, diagnosis of cancer, depression and mortality rates from other causes over the next few years will be key to understanding the long-term impacts.

Mental Health

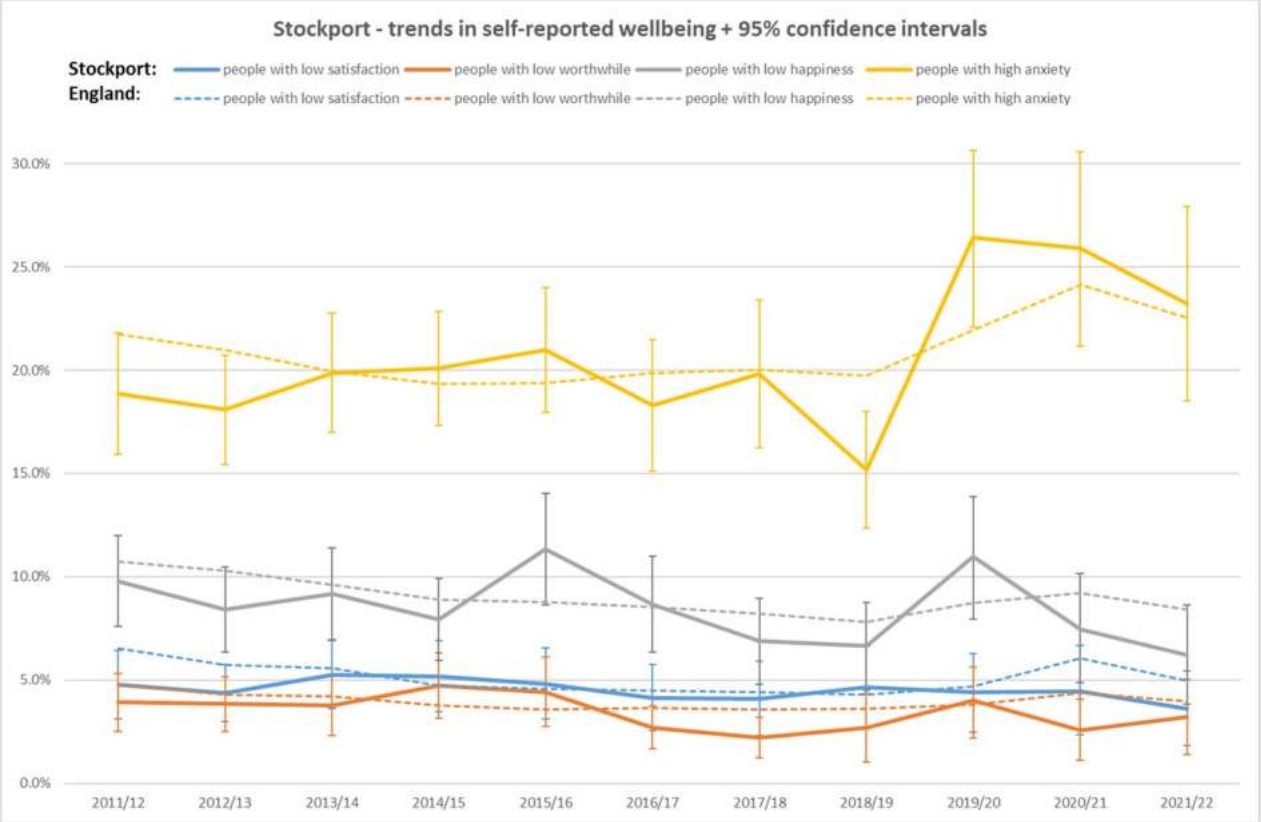
The impacts on people's mental health were significant, if unsurprising. The number of people in Stockport reporting symptoms of severe anxiety increased to more than one in four adults at its peak, while people reporting symptoms of depression peaked in the lockdown of early 2021. While such feelings are natural responses to living through the pandemic, the longer-term effects on mental health and wellbeing remain uncertain. Levels of anxiety and depression overall have reduced from the peak, as life has returned to normal, but it is clear that vulnerable people have been affected more. This includes those with pre-existing mental health or wellbeing problems, those who are clinically vulnerable and children and young people. Rates of probable mental disorders and eating problems among young people remain at elevated levels compared to before the pandemic; amongst 17- to 19-year-olds, the percentage increased to one in four in 2022, up from 1 in 6 in 2021[1].

Wellbeing and anxiety

Good wellbeing describes a person who is feeling good and doing well. From 2011/12, these wellbeing measures had generally shown a reasonably stable trend, given the confidence intervals, partly due to the small survey samples. In most years, Stockport residents reported similar or slightly better levels than the population of England as a whole on these measures.

From 2019/20 to 2021/22 the anxiety measure in particular showed the negative impact of the COVID-19 pandemic. The increase in high anxiety in 2019/20 was especially large in Stockport and with a score of 26.4%, there were more people with high anxiety than the England average. In 2020/21 and 2021/22 whilst the levels of reported anxiety remained high in Stockport, the level across England rose so that they are now similar. Levels may now be reducing further.

[1] *State of the nation 2022: children and young people's wellbeing.* Research report. February 2023. Department for Education



Depression

The pandemic has led to an increase in symptoms of depression. Around 1 in 6 (16%) adults experienced moderate to severe depressive symptoms in Sept-Oct 2022, which is a decrease since the peak during January-March 2021 (21%) but is still significantly higher than levels observed before the coronavirus (COVID-19) pandemic (10%). This suggests levels of depression may be decreasing from the peak, but are still above pre pandemic levels. We do not know how long it will take for symptom levels to reduce back to pre-pandemic levels, and the cost of living crises is likely to prolong the recovery.

Evidence shows that those already vulnerable are more likely to be affected by worsening wellbeing:

- **Younger adults and women were more likely to experience some form of depression,** with over 4 in 10 (43%) of women aged 16 to 29 years experiencing depressive symptoms, compared with 26% of men of the same age in early 2021, and around 1 in 3 (35%) of women aged 16 to 29 years experiencing depressive symptoms, compared with 23% of men of the same age in autumn 2022
- **Disabled adults were more likely to experience some form of depression**. Adults with disabilities (39% early 2021 / 35% autumn 2022) had higher rates than those without disabilities (13% early 2021 / 7% autumn 2022)
- **People who were financially vulnerable were more likely to experience some form of depression and the pandemic had a greater impact on levels of symptoms.** In early 2021, around 1 in 3 (35%) adults who reported being unable to afford an unexpected expense of £850 experienced depressive symptoms in early 2021, compared with 1 in 5 (21%) adults before the pandemic; for adults who were able to afford this expense, rates increased from 5% to 13%. By autumn 2022, around 1 in 4 (24%) of those who reported difficulty paying

their energy bills experienced moderate to severe depressive symptoms, nearly three times higher than those who found it easy to pay their energy bills (9%)

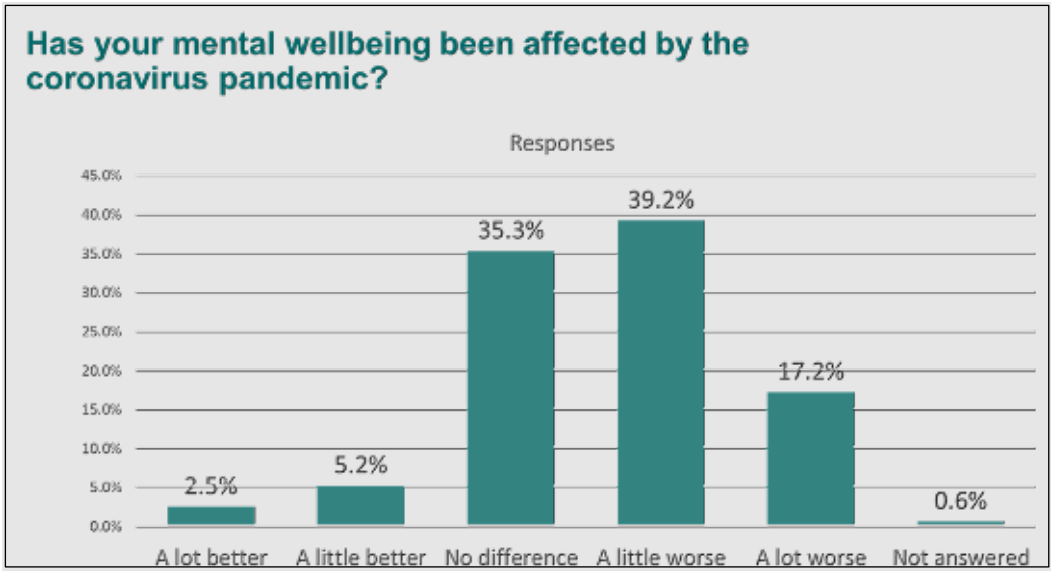
- **People living in deprived areas are more likely to experience some form of depression:** By autumn 2022, around 1 in 4 (25%) adults living in the most deprived areas of England experienced some form of depression; this compared with around 1 in 8 (12%) adults in the least deprived areas of England.

2ONS data Adults with symptoms of depression[2]

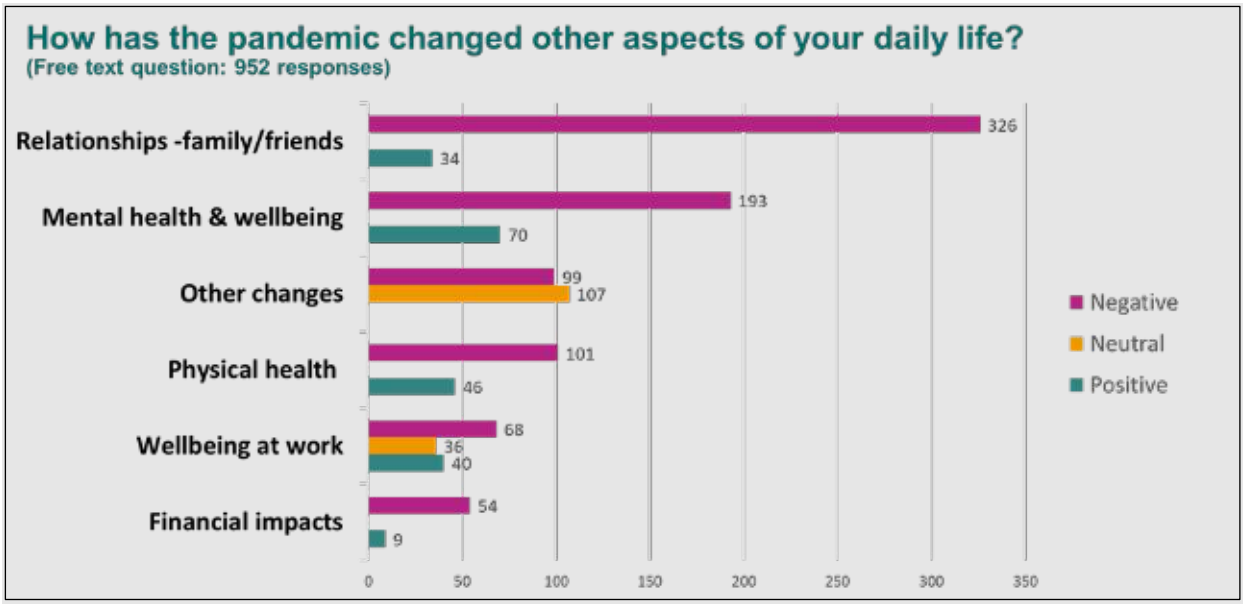
People's experiences of mental health and wellbeing

In early 2022, 1,231 Stockport people responded to a survey about the impact of the of the COVID-19 pandemic on their mental wellbeing, and while for over 40% the pandemic led to improvements or no change, for the majority (56%) it has led to a deterioration; for 17% this was a significant deterioration.

2
https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/coronavirusanddepressioninadultsgreatbritain/januarytomarch2021
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/costoflivinganddepressioninadultsgreatbritain/29septemberto23october2022



People were also given the opportunity to describe how the pandemic has impacted their lives, the most common response was a negative impact on relationships.

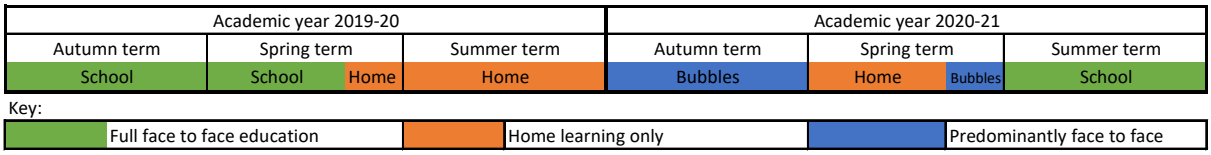


The impact of the COVID-19 pandemic on children and young people's mental health and wellbeing was large, 13.5% of 11–16-year-olds and 23.9% of 17–23-year-olds felt their lives had been made 'much worse' by coronavirus restrictions. In contrast, 4.4% of 11–16-year-olds and 2.3% of 17–23-year-olds felt these had made their lives 'much better'. Children and young people with a probable mental disorder were about twice as likely to report that restrictions made their lives much worse, compared with those unlikely to have a mental disorder.

Education

Lockdowns and other restrictions imposed in response to COVID-19 created unprecedented disruption to the provision of education. From early years provision by childminders and nurseries, through schools, colleges and universities, these closures to all but the children of key workers, plus the long periods of degraded learning due to 'bubbles' and contact tracing had an immediate and long-lived impact on children.

The timeline below shows the extent of disruption of education. Across two academic years around two complete terms of face to face teaching was lost, with other time during the pandemic severely disrupted by the measures in place:



Education during lockdowns

Once lockdown measures were introduced, our local schools closed to students, except for children of key workers. Families had their children at home and had to find a balance between working from home and supporting their children. It was impossible to follow the normal school curriculum, and learning opportunities were dependent on the availability of parents to provide structure motivation and supervision.

As the pandemic progressed, the government launched the Oak National Academy, offering 180 video lessons each week, across a broad range of subjects for every year group from Reception to Year 10. The BBC also provided educational content across its services. Whilst each of these made a difference for schools and students alike, services were only available virtually (online, or sometimes via television and digital radio), meaning they couldn't be accessed by every child. Online classes would have been very difficult for families with limited IT equipment or an unreliable internet connection. Educational attainment was hit particularly in areas like Stockport, where there were more lockdown measures imposed, for longer periods than other parts of England.

Education during the rest of the pandemic

When lockdown measures were lifted and pupils returned, there was a requirement to control outbreaks in schools. Regular testing was introduced among staff and students as well as creating 'bubbles' of students to reduce mixing. There were thousands of cases of COVID-19 in schools, including localised outbreaks, which prompted control measures. While these were managed by the public health team in collaboration with the schools concerned, they inevitably led to further disruption of studies due to absences of both staff and students.

The disruption to education during the pandemic and pause in the curriculum resulted in the decision to not have formal examinations for the 2020/21 and 2021/22 academic sessions. The government committed some funding to help address these gaps in educational attainment because of the pandemic and this work is still ongoing, but the long-term effects of the pandemic will be felt for years to come.

Case Study: Marple Hall School

Here, Joe Barker, Headteacher of Marple Hall School, talks about how the pandemic has affected education at his school and the experiences to date.

Looking back, most people will see the 23 March 2020 as the start of the pandemic. Although Covid had been in the news for a while before that, the 23 March was the first day of real lockdown and the first day of school closures.

However, for me as the headteacher at Marple Hall School (MHS) the date of Wednesday 18 March will be forever burned into my memory. This was the morning after Boris Johnson had announced the upcoming lockdown, and that morning I found myself standing in front of 300 16-year-old students in our Year 11. I had known them for five years, taught many of them myself, and was due to give the standard messages about working hard and getting ready for the summer exams. Instead, I stood there and told them that 'this is it'. School was over. No exams, no prom, no final day. Looking back now it was both the right and wrong thing to do. Without doubt it helped from a Covid point of view, but it was so sad for the students and definitely gave every member of staff there a real desire to make the best of the pandemic for the 1,250 students still at the school.

So, that's what we've tried to do. Like all school leaders the past 20 months has been a rollercoaster ride as we try to keep school going as normally as possible whilst reacting to an ever-changing situation. Covid measures, face covering wearing, one-way systems, bubbles and the dreaded contact tracing – these features have dominated school life since September 2020. Last school year was the year of the bubble closure, but also the year of teaching staff becoming expert at delivering lessons online. No way on earth would I have thought, before the pandemic, that it would be possible for teachers to teach ¾ of a class of teenagers in a classroom and simultaneously deliver exactly the same lesson to the other students at home. Yet, that is what is happening at MHS and other schools across Stockport.

Since September 2021 welcome elements of school life such as extra-curricular activities have returned. Like the national data, Covid cases have been high but steady and without 'bubbles' school has been more normal than previously. We've run literally thousands of Lateral Flow Tests and supported the rollout of the vaccine for eligible 12–16-year-olds, working with the fantastic school nursing team to vaccinate over 700 young people in November. Indeed, collaboration has been the name of the game during this crisis – whether with other schools, the Local Authority, health professionals or parents, the overwhelming majority of whom have been amazingly supportive. This year has been hard work and my colleagues are busting a gut to keep going, but it's so much better than that feeling from 18 March 2020.

Impacts on children's school attendance, attainment and wellbeing.

In Stockport, our schools stayed open as much as permitted throughout the pandemic, and worked with public health and education colleagues in the council to ensure that "bubble closures" and other restrictions were proportionate and well considered. The strength of the relationships between schools and council colleagues was important in enabling this. Nonetheless, a significant number of children were affected and there were many days when significant numbers of children were unable to access face to face learning. It is only now that we are able to see the full impact of this.

At the time of writing this report, school attendance in Stockport is, as in the rest of the country, yet to return to pre-pandemic levels. We are especially concerned about the attendance of our most vulnerable learners. This picture is particularly concerning for our older children in our high schools, where 59% of children with social workers, 46% of children with an education, health and care plan and 45% of pupils qualifying for free school meals were persistently absent. Increases in challenging behaviour are also being observed by school leaders and are reflected in school exclusion data and records of suspensions from school.

The impact of the pandemic on educational attainment varies by age. The younger the children, the more significant the impact. This analysis focuses on primary school attainment, since data on attainment at secondary school is difficult to interpret due to changes to examination practices.

At the end of primary school, the impact is most prominent for writing and maths. In writing there was a 9% reduction in the proportion of children meeting the expected standard, and in maths this was 6%. Reading, by contrast, improved. In both cases, the disadvantaged learners experienced greater harm – the proportion attaining expected levels of writing at age 11, fell from 67% (2019) to 53% (2022), and in maths the figure fell from 66% to 55%, both marginally below national averages.

For 7 year olds (Year 2), the reduction in attainment since July 2019 in reading was 8%, in writing 11% and in maths 7%. In each subject, disadvantaged children and boys fared worse. In line with the national picture, only 25% of our children who were supported by a social worker achieved the expected standard in all three subjects. Children re-sitting the phonics screen in Year 2 also struggled. There was a 17% reduction in the achievement for this group, who missed out on face-to-face learning in their reception year and were least able to engage with remote learning.

For the very youngest cohort, the impact was slightly smaller, but again we observed a greater fall in achievement for disadvantaged children. The Good Level of Development, the measure used at the Reception, showed a 5% reduction for Stockport. The negative impact was greater for boys and disadvantaged children, with only 45% of disadvantaged children reaching the expected standard in 2022.

Outcomes at age 5 at the expected standard	2019		2022	
	Stockport LA	National	Stockport LA	National
Good Level of Development (all children)	71%	72%	66%	65%
Good Level of Development (Disadvantaged children)	47%	57%	45%	49%

The above data is extremely clear in describing a significant and lasting impact of the pandemic on children. It is not the purpose of this report to reach a conclusion on whether the benefit of school closures exceeded the harm caused, but the extent of harm, particularly for the youngest and most

vulnerable learners, is sufficient to demand that this question must be answered by the current national inquiry into the pandemic.

The impact of the pandemic will be felt for some time in our educational system. Many learners have found it difficult to re-adjust to face-to-face learning and social situations. Equally many children, particularly those who are disadvantaged or vulnerable in some way and our younger boys now have significant gaps in their learning. It requires an urgent response and a very focussed curriculum for these children to reach pre-pandemic levels of attainment and progress. To this end, Stockport has been working on our Intentional Educational Recovery, which started in September 2021, the focus of which is reading, delivering an enriching curriculum and promoting wider opportunities. Our school leaders are all too aware of the impact of the pandemic on their learners and together we will continue to respond to the needs of our children.

In any future pandemic, the harms of school closures must be weighed heavily against any putative benefit of school closures in reducing social contact and infection rates. If restrictions in schools are seen to be warranted, these should be implemented for the shortest possible duration and focussed on the oldest learners, who have both a larger number of contacts within schools and a greater ability to adapt to online learning.

NHS

All NHS services for which we have data saw a significant drop in activity in April and May 2020, as some routine care was paused and the NHS dealt with the impact of the first wave of COVID-19. GP practice appointments rapidly increased to pre-pandemic levels after the initial period, but there has been a lasting shift in the method of appointment with a higher proportion undertaken by telephone rather than face to face. By September 2022, 63% of GP attended appointments were face to face compared to 88% pre-April 2020. Face to face appointments have continued to increase and it is not yet clear what the long-term average will be. Monthly A&E attendances averages were 10% higher, emergency admissions 5% higher and planned admissions 10% lower than they were pre-pandemic. Referral to treatment times have deteriorated greatly since April 2020, with half of all patients (50%) now waiting more than the 18-week standard.

Primary Care

Stockport GP practices remained open throughout the pandemic but changed their appointment booking processes to triage patient enquiries, using clinical prioritisation, and direct patients to the most appropriate person in the primary care team, and mode of interaction. This approach reduced footfall (and infection risk) to keep staff and patients safe at the height of the pandemic, but also enabled practices to work more efficiently while promoting continuity of care and equity of access.

The overall number of attended appointments for both GPs and other health care professionals fell in April and May 2020 but quickly rebounded to previous levels, albeit with a significant shift (particularly for GPs) from face to face to telephone. For other health care professionals, face to face appointments, which accounted for over 90% of attended appointments before April 2020 have now settled at around 80% of all appointments.

The impact felt in Primary Care: Dr James Higgins, Brinnington Health Centre

When the pandemic first arrived, we were watching events in China with some trepidation and wondering what might happen. I remember a meal out with my family and talking with my brother about the impact and potential death toll if data from China were to prove accurate. Were it not for lockdowns & the subsequent vaccination programme, it's very possible that it could have been. The subsequent spread into Italy and then France was a concern, although the quarantining efforts in the beginning felt like they may provide some mitigation. This was short lived, and I remember hearing about the first case in Stockport, which is when it all felt very real. It was not long after this that we lost our incredible colleague, Dr. Alan Gilman, who had worked tirelessly in Brinnington for 30+ years. Thankfully we were able to mourn Alan just before lockdowns were implemented and could later reflect that he would have hated missing the opportunity to work through the pandemic with all the challenges it would bring.

As a GP surgery, the pandemic affected us to a degree, but perhaps not as much as many. We were still coming into work, although we would forego our after-surgery coffee and catch up, and instead would meet over Zoom to engage with each other & debrief. As tighter lockdowns were implemented, we moved to working from home for part of the week and operated a "red doctor" system with 1 or 2 GPs at the surgery for essential face to face appointments. The days at the surgery were strange - traffic was lighter, almost eerily so at times, and you would generally be confined to a single surgery room all day with no-one else for company. I think outside of work, we all felt the lockdown effects to a degree – unable to see friends or family, nowhere to go and nothing to do, but thankfully the weather was good & the kids could play in the garden to stop them going stir crazy. Home schooling was a challenge, and certainly gave me a galvanised respect for our teachers!

As a practice and also as a healthcare system in Stockport we adapted quickly and effectively. All key organisations came together to plan our approach, forging some really strong cross-organisational relationships that weren't really there before and daily meetings were set up to establish testing centres and clinical assessment centres locally, as well as to source better PPE, including safety goggles, masks & scrubs donated & made by patient groups. We helped develop technology to enable remote consultation, templates & guidelines to enable robust clinical assessments & systems to ensure that the people most in need of services could access them as needed. Remote consultation was hard, and the reduction in personal contact affected both patients & practitioners alike. There was then further challenge as the vaccine programme came and we were required to mobilise an entire new service in a way we've never done before, with less than 2-weeks' notice, over Christmas. The response from our practices, patients and volunteers was truly remarkable and a demonstration of human nature at its best.

We still have some signs of the pandemic evident in our present work. As a result of the skills developed, we are more comfortable with having remote consultations as part of our offer. This is great, as due to significant growth of our team to meet rising demand we don't have the space for everyone to work from the surgery building every day. This also provides a flexibility that some patients still want, although thankfully the majority of consultations are back to face-to face. On the downside, we also have the care backlogs in the secondary care system to contend with – long waits for out-patient appointments, operations & follow-ups etc.

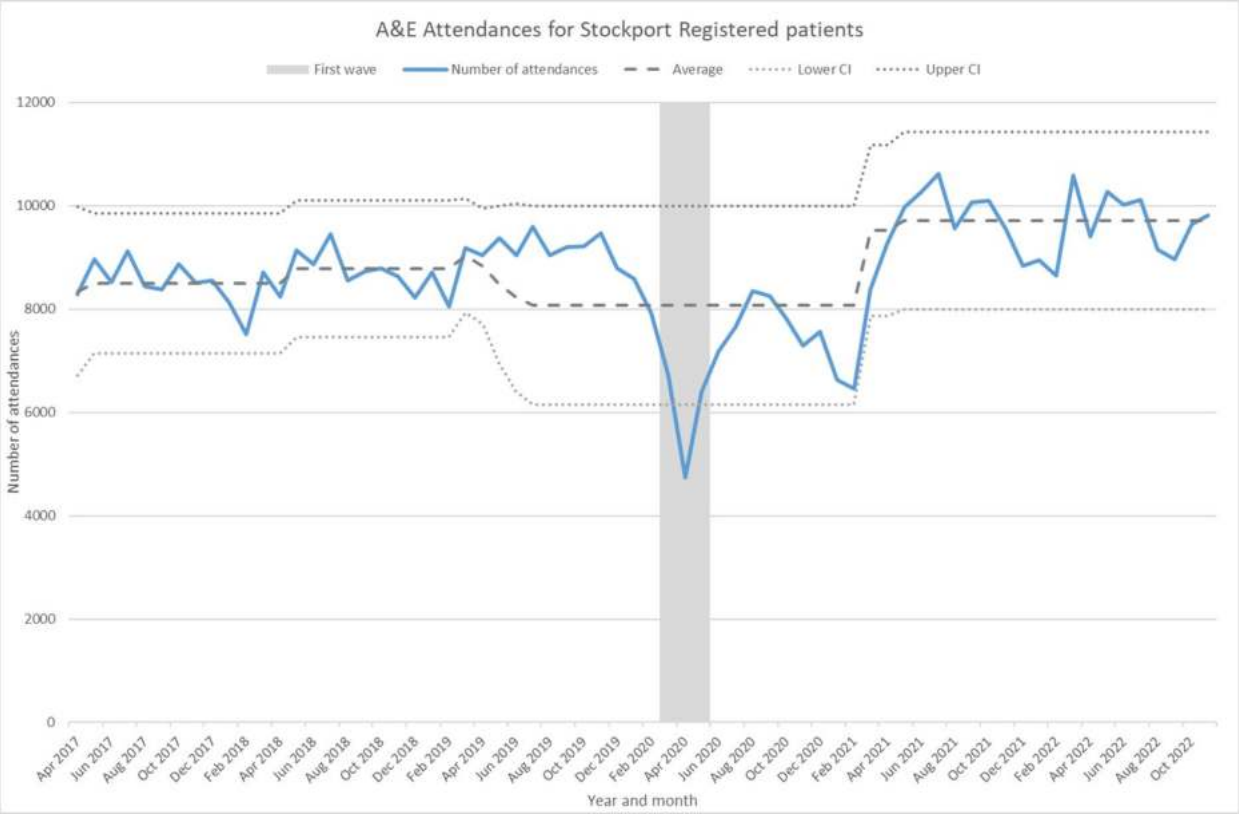
In terms of lesson learnt, on a personal level, I learnt not to take for granted the people around me. You never know when you might want to see them again & not be able to, so see them today, tomorrow, whenever you like, but don't put it off for another day, as that day may not be yours to choose. In work, I learnt that there's no need for rigid organisational boundaries. We can all work

together really well, if given time & the opportunity to innovate and to get stuff done. I also learnt more of the kindness of people – the garden angels, visiting the vulnerable to check they're OK, the volunteers stepping up to collect medication, deliver pulse oximeters, supply food parcels, staff the vaccine clinics.

Going forwards, I want life to get back towards normal, but not necessarily how it was pre-pandemic. I want us to remember the kindness & resilience that we all showed during lockdown, the willingness to check on a neighbour or to pick up the phone & tell someone you love them. The levels of mental distress we see now in surgery are way higher than before or during the pandemic, a reflection of the damage the pandemic has caused, but also, so many false divisions have entered society as a result of the rules – lockdown or anti-lockdown, masker or anti-masker, vaxx or anti-vaxxer. I want people to remember the spirit we had in the Summer of 2020 and that we've far more in common than we have that divides us. If we can bring back that willingness to come together and support each other then the future can be bright...

A&E attendances

The chart below shows the impact that COVID-19 has had on overall A&E Attendances. Attendance levels were lower in 2020/21 than in 2019/20 but rose above this previous average in 21/22; to an average of 9,700 attendances a month, compared to the pre-pandemic level of 8,800. There was a sharp decline in attendances during the first wave and particularly in April 2020, when levels were around 53% of the normal volume, as the NHS dealt with the first wave of COVID-19.



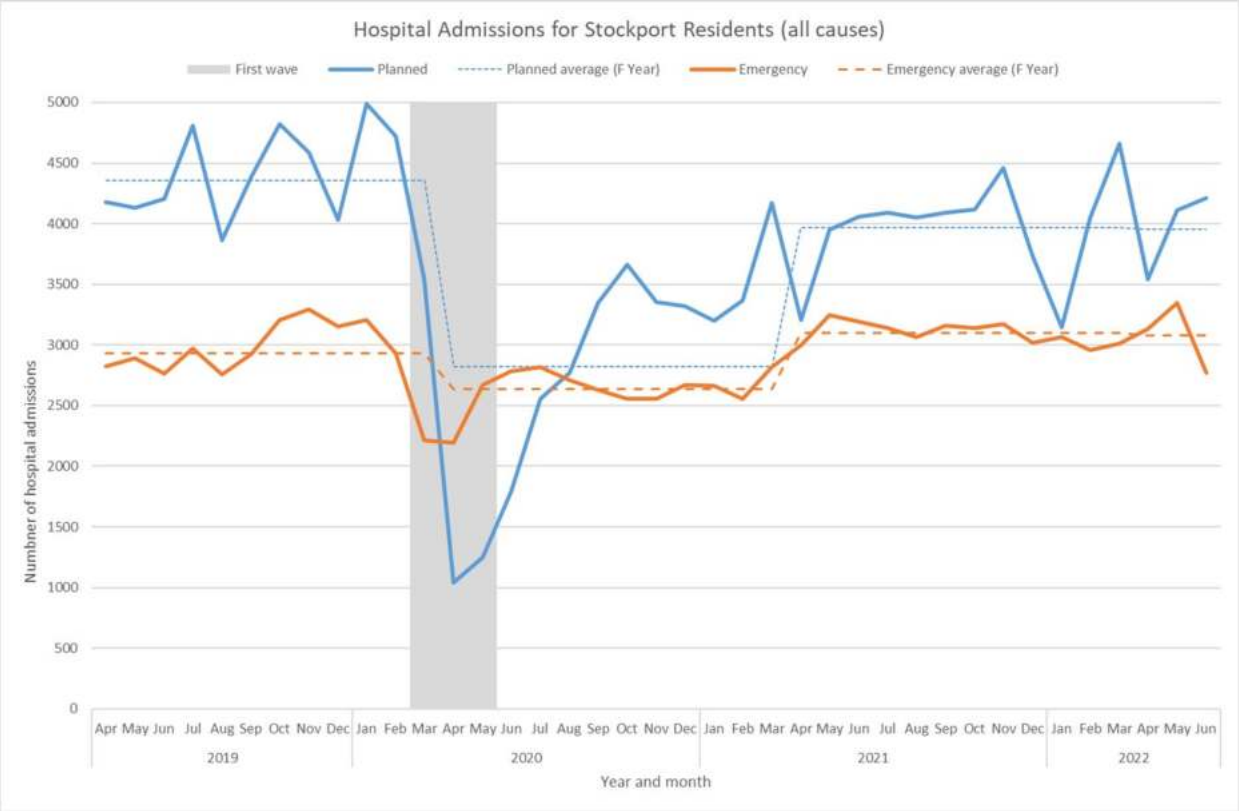
Secondary Care

The chart below shows the impact that COVID-19 has had on general hospital admissions, although at this summary level it is not possible to draw detailed conclusions about the implications of these

trends. Emergency admissions were slightly lower in 2020/21 than in 2019/21 but rose above the previous average in 21/22; this is despite the over 1,300 direct COVID-19 admissions in 2020/21.

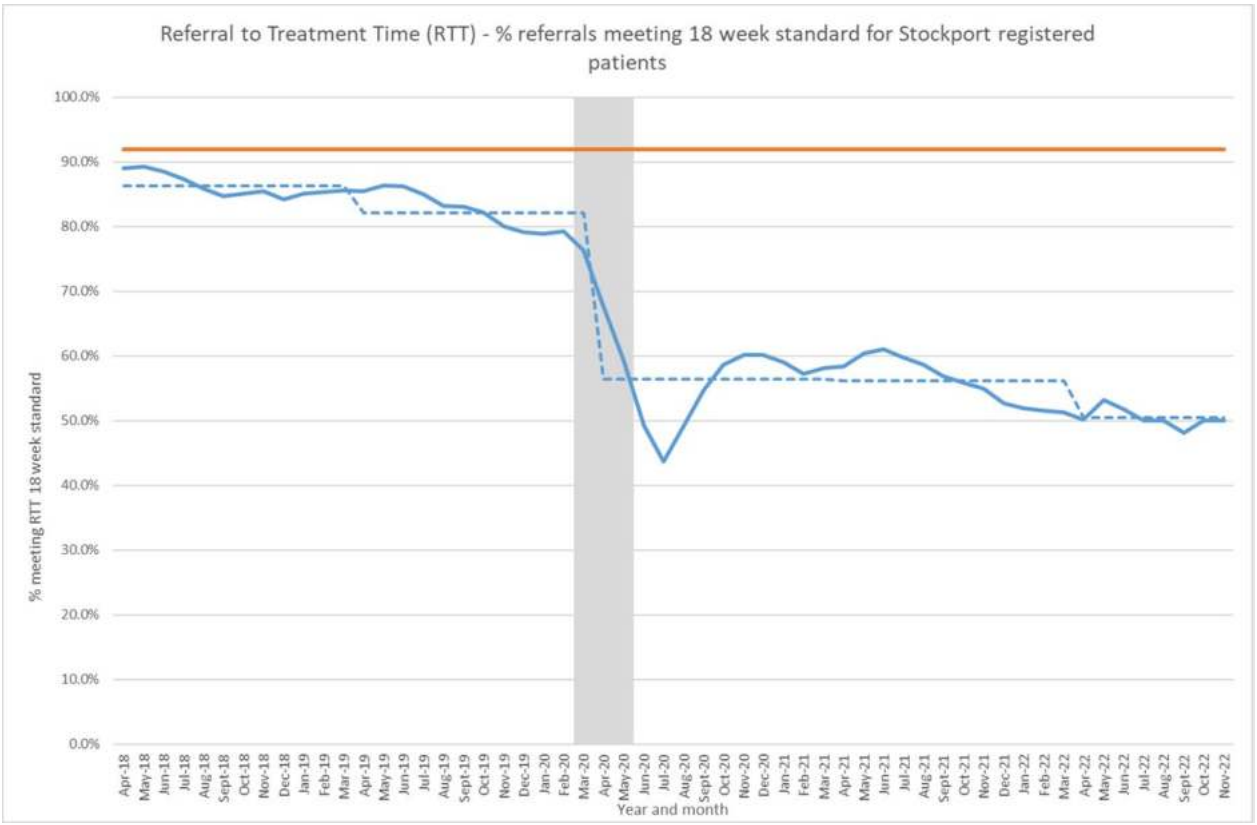
Planned admissions saw a much sharper decline, particularly in April 2020, when levels were around 25% of the normal volume as the NHS dealt with the first wave of COVID-19. From July 2020 onwards the number of planned admissions increased quickly so that by 2021/21 they were 90% of previous volumes.

Admission volumes for cancer and mental health diagnoses were least impacted in 2020/21 and have recovered completely by 2021/22. Respiratory and infectious diseases have seen the largest decrease, most likely as COVID-19 impacted patients susceptible to these illnesses more often.



NHS waiting lists

The NHS aims to treat patients within 18 weeks of their referral to a hospital specialist, with a target that 92% of patients should be treated within this time. Prior to the pandemic, Stockport's performance was below this standard at 82%, and since April 2020 performance has significantly deteriorated with an average of half of referrals now being seen within 18 weeks. In November 2022, there were 41,543 patients on the trust's 18-week referral to treatment waiting list, 50% having waited more than 18 weeks. 5,000 people had been waiting more than a year an increase from 3,800 in in December 2021. While no-one should be forced to wait this long for treatment, the NHS has prioritised cancer treatment and other urgent treatment – where a delay will lead to a reduced likelihood of a good clinical outcome – throughout this time.


Referral to Treatment Time (RTT) - % referrals meeting 18 week standard for Stockport registered patients
% meeting RTT 18 week standard
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sept-18
Oct-18
Nov-18
Dec-18
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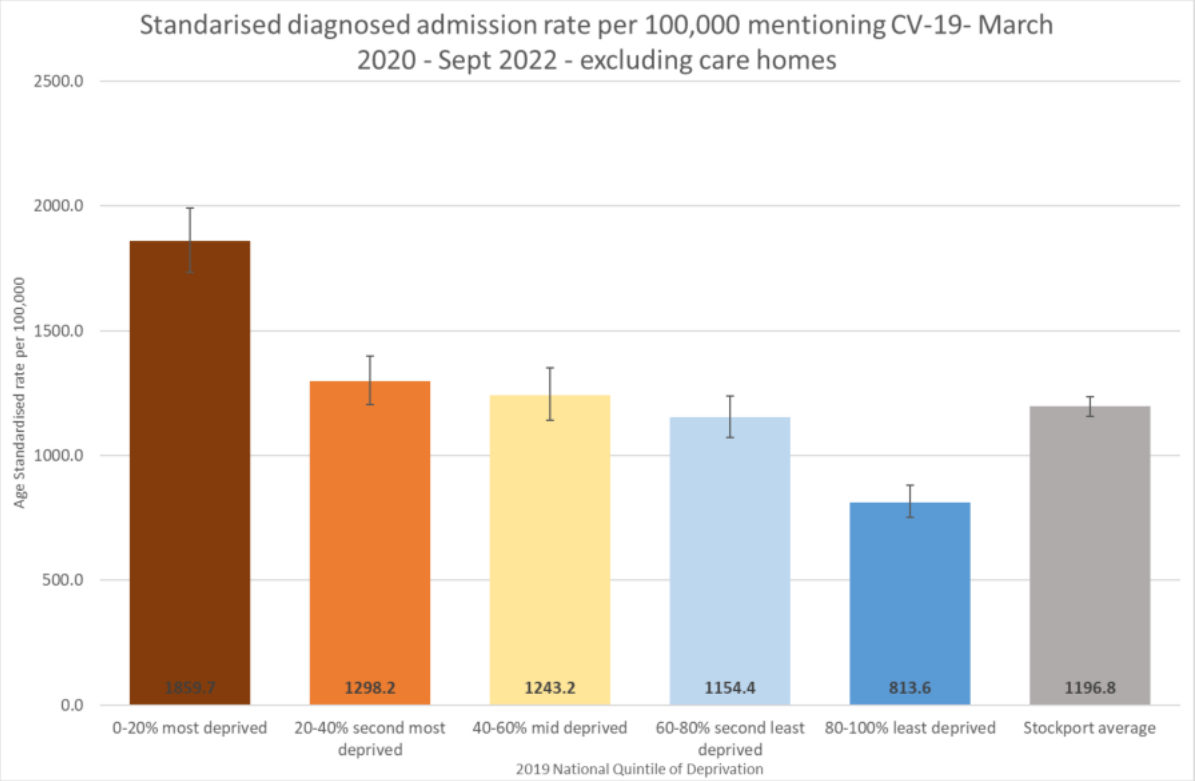
Jul-22
Aug-22
Sept-22
Oct-22
Nov-22
Year and month

Inequality

The pandemic shone a light on the inequalities already present in our society. Both the infection itself, and the impact of the restrictions and changes imposed on society widened inequalities – including inequalities in income, educational outcomes and health outcomes.

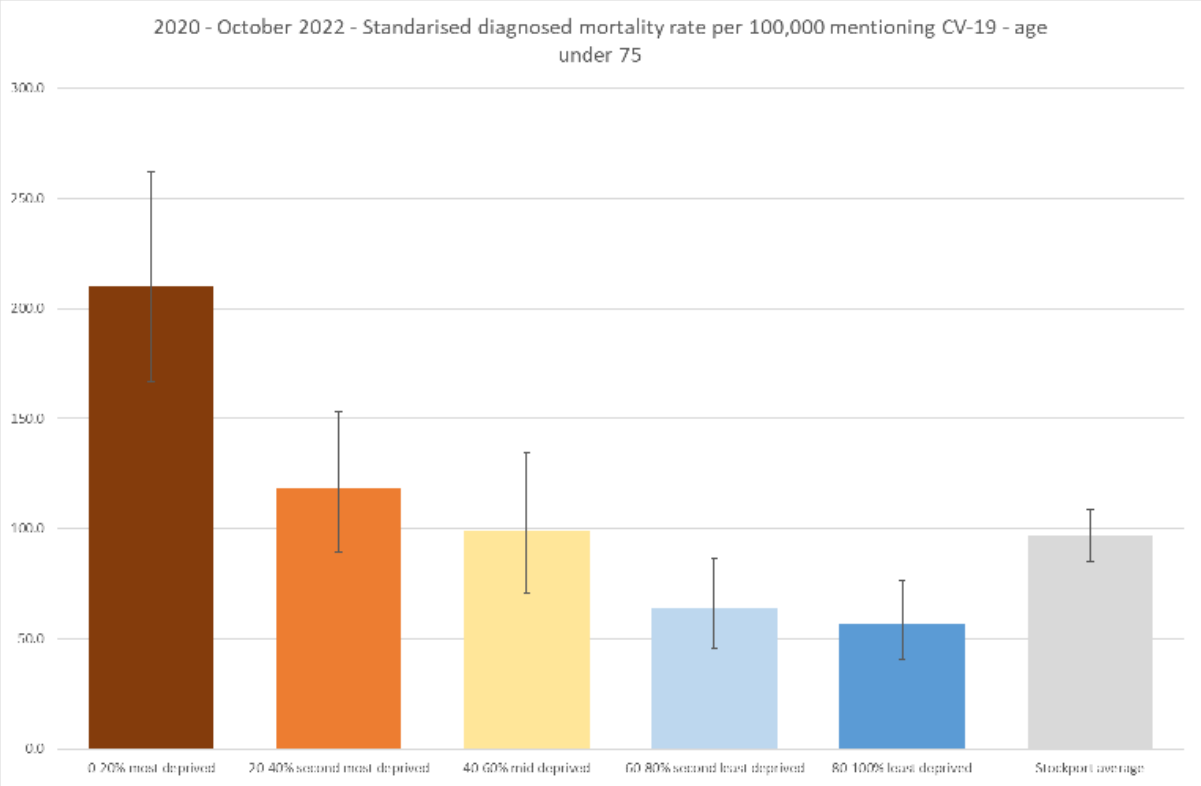
Health inequalities are unfair and avoidable differences in health across the population, and between different groups in society. The conditions in which people are born, grow, live, work and age have an impact on their health and wellbeing. These are referred to as the social determinants of health. Prior to the pandemic, we were concerned about high levels of inequalities across the UK and within Stockport. Since the pandemic, this concern has become a fundamental building block for how we think about meeting people's needs across society.

With the emergence of COVID-19, the existing inequalities were reflected in higher hospitalisation and death rates among the least affluent communities. On a national scale, there were more COVID-19 cases among people in areas of deprivation, among the ethnic minorities, skilled and unskilled manual workers, and people with underlying health conditions. Along with older people, they seemed have the worst health outcomes and deaths as the pandemic progressed. It is likely that that causes of such inequality are complex, relating to multiple social, economic and cultural factors.



For example, it was not possible for many people in these groups to work from home as their roles required physical contact with others, increasing their risks of infection. In the case of health and care workers, a disproportionate number of ethnic minority colleagues

were infected and died during the pandemic. Some of the risk factors for worse outcomes from a COVID-19 infection were related to people with underlying health conditions such as respiratory illnesses, type 2 diabetes, and cardiovascular disease, which are known to be associated with inequalities. For example, lung cancer and Chronic obstructive pulmonary disease (COPD) are associated with smoking and manual labour, and these are more common in areas of deprivation. It is possible that had more resources been allocated to smoking cessation and a reduction in respiratory illnesses over the years, there would have been less deaths amongst these people during the pandemic. Addressing other social determinants of health such as housing, employment, income could have helped to reduce the impact of COVID-19 infections among people experiencing inequalities as well as improving all other overall health and life outcomes.



Tackling inequalities should be among our greatest priorities as a local area, due to the disproportionate impact on some communities and the need to build resilience in preparation for future pandemics.

Additionally, it is important to acknowledge that the impacts of the pandemic response were felt unequally, as less affluent people were more vulnerable to the effects on the employment, education and other aspects of their lives, including domestic abuse. These included both short and long-term unemployment and reduced income for self-employed people. Additionally, the pandemic has resulted in longer waiting times in the NHS and social care. These have contributed to later diagnoses, delayed assistance for mental health and a knowledge gap for children and students. The current cost-of-living crisis has further added to the pressure felt by those with least resources, and unless we make tackling

inequalities our priority, the legacy of the pandemic will be enduring negative outcomes for the UK and our local area.

Stockport shielded population

People who were identified as 'Clinically extremely vulnerable' (CEV) were advised to take extra precautions during the peak of the pandemic in England, this was known as 'shielding'.

Initially (April 2020) around 7,060 people in Stockport were advised to shield, and this number rose to 11,200 people by September 2020 and 17,900 people by August 2021 as knowledge about COVID-19 increased and definitions improved. By September 2021 data showed that:

- People who were CEV were likely to be older: 44% were aged 18-65 years, 28% aged 65-79 years and 28% were aged 80 years plus.
- There was a strong association with deprivation, with numbers in Brinnington & Central ward being more than three times larger than in Bramhall South & Woodford.

ONS surveys found that of the 2.2 million clinically extremely vulnerable (CEV) people, in May 2020 63% reported completely following shielding guidance[3], but this level of compliance started to fall from June 2020[4]. The government and communities, provided support to enable CEV people to shield; the support mechanism that most people who had not left their home since receiving shielding guidance or in the last seven days found helpful was:

- video or telephone calls with family and friends (74%),
- prescription deliveries (59%)
- food deliveries or food boxes (56%).

In Stockport, humanitarian responses were set up during the first lockdown, including many community-led Mutual Aid Groups (see page 15), and support for food and shopping were the most common requests received by the Council response service.

Clinically extremely vulnerable (CEV) people experienced impacts on their mental health and well-being after they were advised to shield, and these varied by gender and age group. The age group most likely to report a worsening in their mental health was CEV people aged between 50 and 59 years, irrespective of gender and CEV females were more likely to report a worsening in their mental health than CEV males. Approximately half of CEV females aged 20 to 49 years and 50 to 59 years reported a deterioration in their mental health (49% and 52% respectively). CEV people who are currently or have previously received treatment for their mental health were also more likely to report a worsening in their mental health since being advised to shield (68% and 56% respectively).

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3 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronavirusandshieldingofclinicallyextremelyvulnerablepeopleinengland/9juneto18june2020

4 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronavirusandshieldingofclinicallyextremelyvulnerablepeopleinengland/9julyto16july2020

Impacts on people with protected characteristics in Stockport

National analysis following the first year showed that people from all minority ethnic groups, apart from Chinese and 'Mixed', were at greater risk of a coronavirus (COVID-19) infection than the White British population.

Analysis over time shows that in Stockport the proportion of cases from ethnic minority populations was highest during the autumn of 2020, when case numbers were lower but has moved to reflect the population average over time, especially over the most recent waves.

In the summer of 2020, Forward (Stockport LGBT+ Centre) and NEXUS undertook a lockdown experiences survey for Stockport people. The purpose was to explore how the community as a whole and minority groups with certain protected characteristics were affected by the restrictions.

155 people responded to the survey, and while the sample size for some groups was small the results showed that those with a protected characteristic were, on the whole, likely to see a more significant worsening of their physical or mental health as consequence of COVID-19:

Mental Health

- There is greater impact on mental health for those with a disability, Lesbian, Gay, Bisexual and Queer (LGBQ) people, Transgender (T) people and those aged under 35 years - all more than 10% above the average
- Minority ethnic groups (as a whole, due to small sample) and those aged over 55 years reported mental health worsening below the overall average.

Physical Health

- Transgender people and people with disabilities were more likely than average to report impacts on their physical health (18.4% and 9.7% above average respectively).

Access to healthcare

- People with disabilities are most likely to have had difficulties with access to healthcare and medication – 61.3%

A separate survey undertaken by Ebony and Ivory Community Organisation (EaICO), with support from the Stockport Race Equality Partnership, in July-September 2020, investigated the experiences of the pandemic on Stockport's Ethnically Diverse Communities (ECD).

Most of the 56 survey respondents identified as Black African background, and 54% had dependent children. The most commonly reported issues arising from the pandemic were loneliness and isolation, finance, and mental wellbeing, while some also reported an increase in hate crime and racial abuse. Respondents also reported feeling unsupported and that their cultural and religious needs were not understood, while experiencing heightened fear, due to the reported higher impacts of the virus on black and minority ethnic people. The report pointed to lack of culturally appropriate mental health services and argued that ethnically diverse communities remained at the fringes of support service provisions. It suggested that mental health problems often remained hidden as people from ethnically diverse communities remained unsure of what help to ask for and where to go to receive help.

LEARN

Technology and communications

The COVID-19 pandemic felt like nothing before it, because it suddenly prompted the mass adoption of a range of technologies that – while available previously – had never been exploited at scale. Prior to the pandemic, whilst it was possible for some colleagues to have hybrid working arrangements, this certainly was not the case for everyone. However, the implementation of lockdown restrictions in March 2020 changed working patterns for most people in Stockport, the UK, and similar countries. All but essential workers were required to stay and work, if possible, from home. The infrastructure of most organisations was not prepared for this so IT departments were working at capacity to provide staff with equipment and facilities to enable working from home. People were able to connect with colleagues virtually to discuss work items and attend meetings flexibly.

This transformation affected work across much of society, but in each sector it disenfranchised people who didn't have the required internet connection and equipment, and who didn't have the skills or the quiet, private space to use it. As noted in the education section, children in more deprived communities, older adults in care settings and many others felt left behind.

People who were involved in our evaluation of Stockport's pandemic response spoke about the initial teething problems of trying to commence virtual working, from the provision of computers to connectivity issues such as Wi-Fi challenges and even challenges using communication tools such as Microsoft Teams and Zoom. With time, however, issues were resolved, and virtual working got better and more efficient. People commented positively on the ability to reach colleagues to support them in making decisions, often over short periods of time using technology. While it was beneficial, it is important to note that many people still felt that it did not replace the connection of colleagues being together physically.

In the NHS, some aspects of healthcare provision changed over the pandemic. Providers moved to offer some virtual appointments either by telephone or video calls instead of physical ones. This happened across primary and secondary care alike and face to face appointments were offered if deemed necessary after the initial consultation. Healthcare professionals were able to offer flexible appointments to patients to discuss their concerns as well as triage them virtually, some of which was not previously possible, sometimes due to available technology. As the pandemic progressed, we not only resolved the teething difficulties with the technology, but both clinicians and patients learned which appointments were suitable for a virtual consultation, and which ones really benefited from being offered face to face. With this lesson learned, significant use of virtual appointments has continued, and our recent scrutiny review suggested that many clinicians and patients welcome the flexibility they offer.

As COVID-19 infection rates rose across the world, social media enabled professionals to communicate across borders and countries and share their thoughts and understanding on issues. This included information such as rate and mode of transmission, symptoms of

infection, and how to contain the virus. Social media became an important way of sharing scientific and medical knowledge both between professionals and more broadly. It also played a crucial role in enabling local communities to organise local responses, including setting up Mutual Aid Groups through Facebook, and using WhatsApp groups to communicate and organise within local communities, including for responses to requests for help. On the other hand, social media also enabled the spread of misinformation. In our review, one participant commented on how information sharing happened organically on social media, across the world and how some of these assisted in developing a pandemic response.

Overall, technology and communication were a vital tool in the pandemic response. It kept people safe at home, while providing the opportunity for virtual working. The legacy of the pandemic in terms of technology has been establishing hybrid working for many people and fast-tracking a greater use of technology across healthcare, education, business and government.

Decision making, devolution and partnership working

There are many different types of emergencies, ranging from major fire, road accident to a terror attack or a pandemic. In the UK we have a standardised way of commanding, controlling and coordinating the response to them and making decisions. In an emergency, within each organisation, there are three levels of command, termed gold, silver and bronze. Across an area, gold and silver commanders meet with their equivalents from other organisations in strategic and tactical coordinating groups respectively. In an incident spanning more than one area, each area reports into central government via the cabinet office (widely known as COBRA). Scientific advice feeds into these decision-making bodies, via the Science Advisory Group for Emergencies (SAGE) at the national level, and the Science and Technical Advisory Cell (STAC) locally. These generic, top-down, hierarchical arrangements work well for a short lived, dynamic incident with a single locus, but it is not as clear that they are well designed for a long-lived incident like a multi-wave pandemic, which has far reaching economic and social consequences. In a pandemic, partnerships, transparency, mutual understanding, inclusivity, and co-production may be just as important as centralised command, control and coordination.

In Stockport, we used a hybrid approach, with different meetings set up and disbanded as and when needed. We used the command and control systems, but joined these to forums that enabled effective working with some fantastic businesses, community and voluntary organisations that wouldn't have normally been part of an emergency response, and made an enormous difference. Throughout the pandemic, we challenged ourselves to think about the communities living in smaller areas of Stockport and understand health and social needs at a more local level. Doing this was part of what made the vaccine programme successful, and we are building on the successes of this work now by establishing much clearer approaches to working at the neighbourhood level to improve health and wellbeing. In preparation for a future pandemic, we'd like to be better prepared to engage community groups and support action at the most local level, but also to involve people in communities much more in codesign of services and joint decision making.

Prior to the declaration of a pandemic in March 2020, outbreaks of COVID-19 were being managed using the procedures in place for the management of infectious diseases at local, regional, and national levels. This included contact tracing, arranging tests and isolation measures where necessary. This response relied on existing teams in Stockport Council, Public Health England and other organisations, but was determined by centralised guidance.

As the case numbers built up, and the picture from Italy and other nations showed that a much stronger policy response would be needed, there was a period in which national direction was absent, and organisations were anticipating changes and attempting to prepare for these but without knowing what the UK interpretation of a 'lockdown' policy would be. We didn't have specific plans for a lockdown – it wasn't considered as a possible policy response to pandemic influenza, in part because of an assumption that it would be socially and economically unacceptable.

As we moved into the first lockdown, we immediately saw an incredible community response to the pandemic, with people coming together to help their neighbours and people in their wider community. As the government started to address the questions about what we needed to put in place to be able to come out of lockdown, the pandemic response was tightly controlled by central government, including elements such as contact tracing, testing and the provision of Personal Protective Equipment (PPE) for the relevant professionals, such as healthcare workers, care staff and other key workers like the police and other frontline colleagues.

Some of the issues were resolved at the regional and subregional level (such as the GM PPE hub which served as a central hub for the Greater Manchester area, providing the necessary PPE across the local authorities within it) and others at the local level, such as contact tracing of potential cases not reachable by the national teams.

The overwhelming sense from people who led the Stockport local response was that some of the pandemic response would have been better targeted had some of the powers been devolved to allow for more localised decision making. An example of this was the lockdown restrictions imposed in the North West. The North West was under lockdown restrictions for a longer period than most other areas of England. The argument put forward was that if those powers had been devolved, local decision makers would have been better able to target restrictions according to risk levels instead of imposing blanket restrictions. The impact of a longer lockdown in the North West is significant. Individuals and families were not able to meet, businesses stayed shut down for longer, with devastating effects on the local economy as well as a massive impact on health and wellbeing. These could have resulted in a greater need for mental health support as well as longer waiting times for NHS treatment.

Partnership working

In Stockport's evaluation of the pandemic response, people identified their existing relationships as key to their effectiveness throughout the pandemic. These were working relationships both within the council and with organisations such as the CCGs, care homes, schools, hospitals, the third sector and the police, which helped to ensure that activities and communications did not have to start from scratch as the response effort kicked into gear. New partnerships were created as well, in cases where there had previously not been much collaboration and participants recommended that efforts be made to ensure these relationships are maintained. An example is collaborative working with voluntary and community representatives that helped to coordinate cross-sector responses, including the establishment of the volunteer hub. This work also supported efforts to tackle vaccine hesitancy; conversations between members of the community helped to provide reassurance. This partnership working, together with everyone's commitment to achieving the best outcomes possible for Stockport residents, dramatically increased our effectiveness.

Preparing for the next pandemic

The risk of a new pandemic remains one of the highest risks on the National Risk Register, with a potential impact of 5 out of 5, and a likelihood of 4 out of 5. Flu pandemics occur, on average, three times per century, with other pathogens, such as coronaviruses also able to cause a pandemic. The risk of infectious disease spread and predicted frequency of pandemics is increasing due to climate change, and will continue to do so until global temperatures begin to decline.

While there is still some dispute over the genesis of the COVID-19 pandemic within Wuhan, China, good governance, strong biosecurity and global data sharing and cooperation are important in reducing the risk of the next one – and delaying its onset and spread. But whatever we do, there will be another pandemic, so it's vital that we are prepared.

In preparing for and responding to the next pandemic, we need to learn some of the key lessons from this pandemic. These recommendations would be difficult – if not impossible – to implement if they are considered only within local government. Implementing them will need consistent and

coordinated efforts from central government, national agencies like the UK Health Security Agency, NHS Bodies and Local Government.

The National Enquiry into the COVID-19 pandemic will examine many of the topics addressed in this report, and make recommendations. Stockport Council's submissions to that enquiry will reflect the evidence summarised in this report, and the recommendations below. As the recommendations from that enquiry are reviewed by future governments, Stockport's Health Protection Board will seek assurance that lessons are properly learned.

Recommendations for management of future pandemics:

- We need to retain sufficient PCR testing capacity to be able to test everyone discharged from hospital into a care home in the early stages of a future pandemic. This mistake – made at the start of the COVID-19 pandemic – should not be repeated
- We need to appreciate that vaccination may be the only countermeasure that really holds the key to ending a respiratory disease pandemic. Other measures only serve to reduce and modify the harm caused by a pandemic in the period between its emergence and widescale vaccine deployment
- As such, preparedness for rapid development, production and deployment of vaccines is the most important way to be prepared for a pandemic
- We should actively plan for the worst case scenario. We should plan for possible restrictions on social contact – such as lockdowns – and seek to understand the policies that could describe these measures that offer the greatest benefit for the least harm. Delays in introducing policies like lockdowns are costly – each day of delay in introducing lockdown in March 2020 may have led to an extra week before lockdown could be lifted.
- We should be extremely wary of measures such as school closures or broad-brush contact tracing in schools, which cause harm to children in order to protect older generations. These measures, while well intended, may do more harm than good. The youngest children are likely to suffer more than older children if measures are introduced, and so should be protected from these measures wherever possible.
- Systems for testing and contact tracing, which may (for some viruses) reduce the need for lockdowns, should be maintained in a state of readiness for future pandemics. For a respiratory virus that is easily spread, these approaches need to be implemented in a granular and proportionate manner, and avoid asking people to isolate unless the chance of them being exposed to the virus is significantly higher than that in the wider population
- In many industries, a shift to remote working – at least for a time – can reduce human to human contact without affecting long term productivity. Society should retain this option, and be unafraid to use it in future.
- The design of care homes needs to respond to the needs discovered during the pandemic. Care homes should feature en-suite rooms that provide enough space for residents to eat, live and relax in. Larger homes should be divisible into smaller units for infection control purposes during an outbreak, and consideration must be given to the safe movement of food, linen and medicines around the home
- There is no substitute for stockpiling of PPE, or developing the ability to mass produce it within the UK. A good contingency plan, backed up by the investment needed to prepare for its implementation, is crucial.
- Human contact defines our society, and most of us would struggle enormously if forced to socialise solely in cyberspace. We need to continue to find ways to get the social contact humans need – particularly for care home residents – while minimising the opportunity for

virus transmission. If the evidence suggests that some interactions- such as outdoor, socially distanced gatherings – are dramatically safer – we should follow this evidence to its logical conclusion

Wider recommendations

While the main purpose of this report has to be to inform the response to a future pandemic, we have learned so much through our shared experience from 2019-2022 that is more broadly applicable. The recommendations below are applicable to our normal lives, and normal work in 'interpandemic' periods, and I would ask the Health and Wellbeing Board to seek assurance on them:

- Inequality was present in Stockport before the pandemic, but has now widened. We need to take consistent action to both reduce socio-economic inequality, and reduce the health consequences that flow from the inequality. This means addressing the causes and consequences of poverty, that have been exposed so clearly by the current cost of living crisis. It means focusing on the causes of differential attainment in schools, and not resting until the most disadvantaged children achieve similar outcomes to the rest of our children. These issues should be a key focus for the council, the NHS and our wider partnerships.
- While we can never be complacent, the spontaneous formation of mutual aid groups and the impact that voluntary action had during the pandemic was truly phenomenal. Public Sector organisations should work – by default – with community groups, rather than in isolation from these groups – and should seek to provide points of connection to community groups through both normal and pandemic work. The work of these groups – and the day in, day out work that the voluntary sector delivers is genuinely worth celebrating.
- Our relationships and our unity of purpose in responding to the pandemic – were crucial enablers of an effective response. We learned about how to respond to the pandemic together, developed a new, shared vocabulary together, and found out what worked and what didn't work at pace. Our values-based approach to how we work, which overcame our reliance on hierarchy, policy and detailed rules was a big part of this, and should continue to shape our approach in the future.
- The pandemic highlighted roles of social care workers, unpaid carers and volunteers working in our communities, and emphasised the differences in the esteem in which these essential care givers are held, compared to NHS staff such as nurses. It is crucial that we remember this brief period of time when these roles became visible, and continue to recognise and appreciate the selfless contribution that these workers, volunteers and carers provide, as well as redoubling our efforts to ensure that people in these key roles have a meaningful voice in local and national decision making that affects them and those they care for.

Thanks

I would like to thank everyone who contributed – in whatever capacity – to the efforts to protect people in Stockport from the risk presented by COVID-19, and to limit the harm caused by restrictions on normal activities. A list of such people would be likely to include practically the entire staff of the council, local NHS organisations, community groups and many of our close partners, but also many residents who took individual actions – whether linked to mutual aid groups or acting

alone. Since I can't thank these tens or hundreds of thousands of people by name, I would at least like to name and thank the following people who have contributed to this report:

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- Simon Armour
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Closing words

I took on the role of Director of Public Health for Stockport in June 2023, some time after the restrictions had been lifted and at a point when, for most of us, life had thankfully returned to something much closer to normal. It feels to me as though some things have gone back to how they were before, some will never be the same again, a tremendous amount has been learnt, and we have emerged from a mass collective experience unlike any most of us had previously gone through or even anticipated.

To everyone on the front line in Stockport, managing and preventing outbreaks, delivering the vaccination programme, providing care and treatment to those who needed it, providing essential practical and emotional support to our most vulnerable residents I am deeply humbled and grateful. This Report tells Stockport's Pandemic Story, or at least one detailed and thoughtful version of it, but every resident of Stockport and everyone who worked to keep people safe and well has their own pandemic story.

It can be all too easy to put the whole pandemic behind us but it is important we all hold on to those stories, remember the resilience, creativity and adaptability we showed in the face of incredible uncertainty, fear, loss and isolation. Our people, and our services are still recovering. And it is essential we learn the lessons so that we are better prepared for the next pandemic, and so that our population is healthier, more equitable and has the strength to weather future storms, whatever form they may take.

Jilla Burgess-Allen

Director of Public Health, 2023 -