The Manchester Briefing on COVID-19

International lessons for local and national government recovery and renewal

Sixth briefing: Week beginning 11th May 2020

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What is 'The Manchester Briefing on COVID-19'?

The Manchester Briefing on COVID-19 is aimed at those who plan and implement recovery from COVID-19, including government emergency planners and resilience officers.

Each week we bring together international lessons and examples which may prompt your thinking on the recovery from COVID-19, as well as other information from a range of sources and a focus on one key topic. The lessons are taken from websites (e.g. UN, WHO), documents (e.g. from researchers and governments), webinars (e.g. those facilitated by WEF, GCRN), and other things we find.

We aim to report what others have done without making any judgement on the effectiveness of the approaches, or recommending any specific approach.

This week

We have provided four briefings:
Briefing A: Focus of the week - Health and Care: The challenges of system recovery
Briefing B. Lessons you may find helpful from across the world
Briefing C: Case Study - Opening social activities in Iceland
Briefing D: Useful webinars

Other information

Please register at ambs.ac.uk/covidrecovery if you would like to receive future briefings. If this is the first briefing you have received and would like to be sent the previous ones, please email events@manchester.ac.uk.

If you would be willing to contribute your knowledge to the briefing (via a 30-minute interview) please contact Duncan.Shaw@manchester.ac.uk

We also produce a blog series which you can access here along with other news about our team and our work.

Briefing A: Focus of the week - Health and Care: The challenges of system recovery

Introduction

COVID-19 has affected populations and individuals (people) – whether directly or indirectly. Compared to previous pandemics its effects are more far-reaching, and recovery will be not only focused on physical and mental health but also on the system; economic, infrastructure, the environment and wider humanitarian issues. We focus here on the challenges for the health and care system in the UK using the lenses of people, place and processes, which are underpinned by partnerships and power.[1] We show that recovery on health and care systems alone will not be sufficient to address the impact of this pandemic, and highlight the challenges for the health and care system.

People

Much of the focus within the English health and care system is now on 're-starting' services which were either paused or severely reduced during the peak of the pandemic. But 'service' provision may not be focused on the multiple and complex needs of *people* – particularly those with multiple conditions.

For example, emergency and urgent care services will continue to be delivered and restored to full function, for example for frail and elderly *people* who fall at home and require treatment. However, there may be issues with restoring linked services e.g. risk assessment and services to prevent future falls, or mental health assessments. In addition, services for the same group of *people* requiring additional (planned) services, such as hip replacements, cataract removal, may not be restored so quickly, partly due to the difficulty in ensuring ongoing operational social distancing in clinical settings, the redeployment of staff, as well as ensuring the ongoing supply of blood and medical stocks. These planned services not only are provided to help people return to health, but also improve quality of life and prevent further worsening of overall health and wellbeing. Long periods without such services may drive emergency and urgent care demand further, whilst the number of people on waiting lists grow.

Services may also not focus on *all* the needs of those who have been affected by COVID-19. For example, there is increasing evidence of the requirement for longer-term physical rehabilitation for those who have experienced COVID-19, as well as likely demand for mental health support. The mental health consequences for staff that have been involved in care provision are also likely to be significant. New support needs may also emerge during the recovery phase of the crisis such as economic strain leading to further unemployment, homelessness and mental health needs. In addition, health and care needs are already increasing e.g. from those subject to domestic violence or letting their health decline further during lockdown rather than seeking treatment.

> ***The challenge is*** ensuring that system recovery is focussed on the holistic needs of *people* requiring care, rather than a fragmented restoration of health services that prioritise clinical emergencies and may leave gaps in the support available for the total health and care needs of the population, not all of which can be addressed by the NHS.

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[1] De Savigny, D. & Taghreed, A. (eds.) (2009) Systems thinking for health systems strengthening. Geneva: World Health Organisation

Place

Within the English NHS a developing vocabulary of 'system', 'place' and 'neighbourhood is being promoted[2]: System (~1-3m people); Place (~250 - 500,000 people) – often a local authority area; Neighbourhood (~30-50,000 people) .

Our interpretation of the term '*place*' is broader than this and relates to the local context where people live and work (neighbourhood) as well as within local authorities. Much of the activity during the response to COVID-19 has been at a 'place' level (as defined above) and then determined in detail, enacted locally and adapted to the local context. This 'bottom up' approach and local adaptation will be a challenge to maintain as response reduces. Within a place there appears to have been success in:

- Community connections, collaboration and support: there has been an immense contribution to date from "*general public and schools sewing scrubs and making visors, through business donating equipment, to community organisations offering extraordinary support*"[3]

- Working across organisations. There are numerous anecdotal reports, and evidence from interviews we have been conducting, of working together as never before in local networks and without organisational affiliations being a barrier to this. Our contacts suggest that this success has been at least in part due to less restriction from/impact of:
    - Information governance rules – information has been shared when deemed appropriate across organisations
    - Finance – less concern about limited financial resources or consideration of whose budget funding might come from
    - Central guidance – especially at the level of guidance on 'how' to do things
    - Regulation – reduced paperwork, inspections and assurance requirements

- Such inter-organisational working is also reported to have been established quickly in places where there was already a history of working across health and other organisations, in particular with local authorities. It is likely that the extent, scope and speed of partnership working has been heavily influenced by the place and by the history of such partnerships previously and it will be important to build on this during recovery.

Response to and recovery from COVID-19 has brought into focus the lack of alignment from the English government in terms of place (see Table), and this must be taken into account in recovery. There are other government departments (e.g. the Environment Agency[4]) who have other place definitions – these two are used here because of their crucial role in recovery.

[2] https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf
[3] https://beckymalby.wordpress.com/2020/05/05/what-do-you-want-to-keep-from-this-time-lessons-for-the-nhs-dont-let-the-old-world-bite-back/
[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/550194/Natural-England-offices.pdf

Local Resilience Forums (LRFs)	Sustainability and Transformation Partnerships (STPs) - NHS
"multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others … aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities"[5]	*"partnerships [NHS organisations and local councils] … to run services in a more coordinated way, to agree system-wide priorities, and to plan collectively how to improve residents' day-to-day health."* [6]
9 regions	7 regions (in England[7])
38 LRFs	49 STPs – of which 18 are now designated as Integrated Care Systems[8]

The challenge is that there is no single English government notion of place, since national structures are different depending on the lead department, and do not align. Effective partnerships for recovery need to develop at *place* level, despite this lack of alignment and may be best led by local authorities given their responsibilities for a range of vital services for people and businesses in defined places. . There is a clear link between place and working in partnership (see following section)

Partnerships

So far, much of the focus of the COVID-19 response has been in the health setting and within the hospital sector. However, the emphasis is rightly now shifting to other sectors, as recovery from COVID-19 will need to involve much more than just 'health' services. Local authorities from metropolitan districts and boroughs to county councils, as well as district councils[9] have been absolutely critical to tackling the spread of coronavirus. Every day they maintain crucial services. They have set up community hubs and have built on existing local teams. They provide food and shelter to people at risk, help local businesses stay afloat and have mobilised volunteers on a scale we have never seen before.

In particular, in the short and longer term, control of COVID-19 will depend on social care provision. In particular, the role of care homes, both residential and nursing, and the provision of care in the homes of those who are vulnerable, which has gained prominence during the pandemic. Prior to this there was already a documented "crisis" in social care[10] which has arguably been underfunded for many years. Whilst additional support for care homes to support the COVID-19 response has been provided[11], a more sustainable solution to

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[5] https://www.gov.uk/guidance/local-resilience-forums-contact-details#history
[6] https://www.england.nhs.uk/integratedcare/stps/view-stps/
[7] There are also 3 devolved administrations (Scotland, Wales and Northern Ireland) who are not part of this structure
[8] https://www.england.nhs.uk/integratedcare/integrated-care-systems/
[9] https://www.gov.uk/guidance/local-government-structure-and-elections
[10] https://www.health.org.uk/news-and-comment/blogs/what-should-be-done-to-fix-the-crisis-in-social-care
[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879639/covid-19-adult-social-care-action-plan.pdf

the sector will need to be found to ensure the sector can withstand both second and subsequent peaks of the virus and future novel pathogens, whilst ensuring the delivery of high quality, compassionate care to their residents and service-users.

A mechanism for recovery with this increased focus on the wider health and care system could be through STPs and Integrated Care Systems (ICS) across regional footprints. Whilst the government's ambition of all NHS areas being Integrated Care Systems by 2021[12] may have seem ambitious, COVID may have helped to support the development of these partnerships.

"In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve"[13]

There are calls for national guidance on "*when and how systems should make decisions on new ways of operating*"[14] and a recognition that there is a key role in this for local government: this is not only a 'health' issue. These non-statutory bodies (ICS) already contain leaders from different roles and organisations within geographical places, such as from the voluntary and emergency sector, councils and healthcare. They seem ideally positioned to help take up regional partnership delivery of the ongoing local recovery, provided the non-alignment at regional level with other civic emergency response partnerships can be addressed.

> ***The challenge is*** that effective recovery requires a systemic approach that is inclusive of the priorities and challenges for community-based and social services alongside those of hospitals. In a health system where there has been a huge emphasis on the acute hospital sector, it will require leaders from community health services, social care and general practice, as well as other parts of local government, and those that use their services, to be brought into the heart of design and prioritisation decisions about health and care provision, seeking and listening to the experience of staff and service users in partnership to ensure recovery.

Process

Process concerns all the activities that occur in response and recovery – and many of these cross organisational boundaries. Essentially this is about 'how' things are done.

It is clear that many processes during the response phase have not worked as well as many would have liked: For example:

- PPE/supply chain management and distribution. Military experts were brought in to support this process and criticised the efforts of the NHS[15]
- Testing for COVID-19, which has been a matter of contention since the start of the pandemic
- Tension between central control and locally-designed and led initiatives.

Another aspect of processes, which follows from the place and partnership issues already outlined, is the difference in the availability of measurement data for COVID-19. Reliable, trustworthy data on COVID-19 has

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[12] https://www.longtermplan.nhs.uk/
[13] https://www.england.nhs.uk/integratedcare/integrated-care-systems/
[14] https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/REPORT_STPs-one-year-to_go_FNL.pdf
[15] https://www.thetimes.co.uk/article/military-appalled-by-planning-fiasco-over-nhs-protective-kit-jdh369k6r

been sparse and difficult to collect frequently and in real-time outside of hospitals such as in community, social and primary care or home-based settings. Most national tracking data and regional dashboards for COVID is either available at a population level or only for hospital sites, meaning that the 'current state' is always biased towards acute provision, lagging and under-estimated – death reporting is a case in point.

Other data, for example, routine waiting lists for surgery have been less visible during this crisis although waiting lists were already over 4 million people with some waiting over 1 year prior to the pandemic, which will have exacerbated that further. Routine screening, dental checks and vaccination services have all but stopped but this data is currently under little scrutiny, not have the long-term implications of this for population health been highlighted.

Despite this many care processes have been newly established and seem to have worked well during this crisis. For example:

- Hospital discharge processes were able to enable the discharge of very long staying hospital patients quickly, having previously been unable to do so. There is learning from this for improved patient discharge, but also a requirement to consider the impact of e.g. insufficient support arrangements, should patients be discharged too quickly.
- New shift patterns and new ways of delivering clinical training have been established quickly
- Many clinical appointments in primary and secondary care have shifted on line or over the phone
- E-prescribing has increased in uptake rapidly despite being available to many for a number of years.

It could be that this sudden uptake of new ways of working and the establishment of new processes has worked well because of the clarity of purpose and shared aim of addressing COVID-19 – a political and moral imperative. This may have been supported by the limited dataset and performance criteria, focused only on COVID.

> ***The challenge*** is how to ensure that the new operational processes are retained when they have been found helpful, ensuring that these are evaluated well, and identifying where old processes need to be re-established, and when.

Power

In the first few weeks of the immediate response to COVID-19 we saw the NHS enact its pandemic plan, which incorporates a significant role for local and pseudo-regional (mega-) hospital providers under national direction. This makes a lot of sense; the need to step up hospital based critical care capacity was urgent and large-scale field hospitals needed to be established and staffed.

The need for a centrally (government) driven approach to response initially was at odds with the prevailing policy direction, although entirely appropriate at the time and supported by emergency legislation. The NHS Long Term Plan[16] was being implemented and was underpinned by a shift away from acute providers towards community resources and provision. In COVID-19 response however it seems that resources were needed to flow in precisely the opposite direction. Large acute NHS providers led the way, mobilising their networks and relationships for local delivery. Whilst this was arguably a pragmatic choice, other local organisations and their

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[16] https://www.longtermplan.nhs.uk/

relationships may have seen their power diminished. For example, clinical commissioning groups (CCGs[17]) whose role is "*deciding what services are needed for diverse local populations, and ensuring that they are provided*", had their power significantly reduced when emergency orders were imposed allowing NHS England to direct local commissioning powers[18], rather than reinforcing the role of CCGs in protecting the public and ensuring health of local populations. At present these powers are in force until the end of December 2020. It is as yet unclear whether the policy of increased focus on out of hospital services will continue, and whether CCGs will have their local powers reinstated in due course, although it remains the policy of the NHS in England as described in the NHS Long Term Plan.

The NHS needs to 'recover' some health services whilst still maintaining the ability to respond to cases of COVID-19. This highlights one of the key 'power' issues in the NHS - the NHS is not a single organisation, but a 'brand' used by a range of organisations - some wholly public sector, others hybrids, third sector or private independent operators - often collaborating together to support patients but sometimes competing for resources, reputation and using their financial or operational power in this. For example:

- One hot topic of discussion at present is the need to reconfigure hospital sites as COVID-19 positive ''hot' sites or COVID-19 negative 'cold' sites. Large acute providers and regional bodies may choose to reconfigure services in line with their longer-term strategic goals that may strengthen or re-establish as a priority specific care treatments and pathways for patients. However, these may not be aligned with local community wishes, and may not deliver optimum clinical outcomes for patients suffering with COVID-19 or other conditions due to existing care delivery inequalities[19]. The 'power' of size and influence of providers over the configuration of services across an area may be exerted here.
- The longer-term risk of reconfiguration options such as these is that whilst at present these seem sensible, pragmatic choices, how will such service reconfigurations be 'undone' later, if such reconfigurations do not serve wider population interests? They may increase inequity or drive poorer clinical outcomes.   The operational choices enacted now may have long term consequences, both positive and negative, for care delivery for populations. Little public consultation (if any) has been conducted, despite it being a legal requirement for significant reconfiguration of healthcare services[20].

It is also important to ensure that, as other health and care services resume, choices are made transparently and consistently about who is treated (and who isn't) given the limits of space, equipment, supplies and staffing. These choices are likely to be different for different populations and community partnerships may be significant in locally and regionally negotiating and agreeing these process priorities if they are permitted to exercise their power in this context.

The challenge is to ensure that the power of all parts of the health and care system, including the public, is recognised and can be exercised as recovery is planned. The longer-term consequences of decisions about service provision made as part of the COVID-19 response must be considered since some cannot be easily reversed.

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[17] https://www.england.nhs.uk/ccgs/
[18] https://www.hsj.co.uk/commissioners/nhs-england-takes-over-ccg-powers/7027203.article
[19] https://www.nuffieldtrust.org.uk/news-item/poorest-get-worse-quality-of-nhs-care-in-england-new-research-finds
[20] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

The challenges

The challenges of recovery are not only about health and care but about society as a whole.

- We need to focus on *people* and their holistic needs; this scope is broader than the provision of NHS services and involves local authorities, the third sector and others.
- We need to align recovery in a *place* that makes sense to the people and builds on how response to COVID has worked; rather than following administrative boundaries for the NHS or any other department.
- We need to consider recovery of the whole system and work in *partnership*; this must include the voices of people as part of a system-wide approach encompassing health, care and wider public sector organisations.
- We need to consider all *processes* within and across organisations; evaluating where they have worked and retaining them, and questioning the re-introduction of others.
- We need to ensure that the *power* of all parts of the health and care system is recognised and can be exercised; considering the longer-term consequences of decisions for society as a whole rather than only for the convenience of the NHS.

Recovery is not only an NHS, or a hospital, or a health issue, nor even a health and 'social care' issue. It is something for the whole system – which must include people who live and work in places and communities – and it is imperative that all parts of the system work in partnership, building on the way in which response to COVID-19 has broken down barriers and enabled new and improved processes.

Briefing B. Lessons you may find helpful from across the world

We provide the lessons under six categories, with sub-categories for ease of reference. We have selected lessons that are of specific interest to the recovery process although many also relate to the response phase, and the likely overlap between response and recovery.

This week our lessons on humanitarian assistance focus on mental health and vulnerable people in isolation. Economic lessons include equity, upskilling and reskilling in labour markets. Infrastructure lessons include those on waste management practices and re-opening infrastructure (linked to the 'ending lockdown' lessons in the 'governance and legislation' section). Environmental lessons address urban planning for renewal. Communications lessons focus on children and track and trace apps. The governance and legislation section includes lessons on exit strategies.

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Recovery: Categories of impact	Actions	Country/ Region	Source
Humanitarian Assistance			
Mental health	**Consider long and short term strategies for monitoring the populations' mental health, for example:** ▪ Collect data on the mental health effects of COVID-19 across the population and vulnerable groups ▪ Monitor and report the rates of anxiety, depression, self-harm, suicide, and other mental health issues ▪ Determine what psychological support is available to front-line medical/health-care staff and their families ▪ Determine the best ways to signpost and deliver mental health services for vulnerable groups, including online clinics and community support ▪ Use health messages to optimise behaviour change and reduce unintended mental health issues ▪ Design longer-term strategies to address an increased volume of mental health issues and their impacts on service demand ▪ Target population-level interventions to prevent and treat mental health symptoms (e.g. anxiety) and boost coping and resilience (e.g. exercise). ▪ Synthesise an evidence base of lessons learned for future pandemics, tailored to specific groups, to motivate and enable people to prepare psychologically and plan for future scenarios	UK	https://www.thelancet.com/pdfs/journals/lanpsy/PIIS2215-0366(20)30168-1.pdf
Volunteers	**Consider innovative ways to include volunteers and boost morale.** Micro-volunteering opportunities have been developed in Salford, UK. 'Heroes from Home' support the wider COVID-19 response by sharing important messages to help to keep communities safe during the pandemic. Volunteers are encouraged to use their own social media accounts to share or post information about Salford's response - helping to ensure it is highly visible and readily available to those who need it.	UK	https://www.salfordcvs.co.uk/home-heroes

Recovery: Categories of impact	Actions	Country/ Region	Source
Vulnerable people	**Consider the capacity of social work provision** and the need to identify a social work action plan to support families and vulnerable people as restricted movements are relaxed. This plan can identify: ▪ The social work skills needed to support families and vulnerable children ▪ The projected demand for such skills ▪ The capacity of the current social work system to deliver those skills ▪ Shortfalls in supply versus demand of skills ▪ Skills can be supported through non-social work providers such as volunteer organisations ▪ The training, supervision and resources are needed for volunteers to be safely involved ▪ What types of families and vulnerable children may be supported with those skills from non-social work providers ▪ The shortfall in families and vulnerable children who will need professionally-trained social workers ▪ How that shortfall can be addressed by professional social workers ▪ How many professional social workers can be trained, and when they will be available to work ▪ How to address any remaining shortfall in the short term	UK	Prof Lena Dominelli
Vulnerable people	**Consider the specific challenges faced by women, and women's services during COVID-19,** including: ▪ The pressure on vital sexual and reproductive health services (including for women subjected to violence) and how provisions can be maintained ▪ The provision of hotlines, crisis centres, shelters, legal aid, and protection services and impacts of scaling these back ▪ Identifying and evaluating outreach methods to support those at risk of abuse within their own home ▪ Plans for the safety of health workers (the majority of whom are women) who may be at risk of violence in their own home and at work ▪ How to include men in conversations about violence towards women	WHO-All	https://www.who.int/reproductivehealth/publications/vaw-covid-19/en/

Recovery: Categories of impact	Actions	Country/ Region	Source
Vulnerable people	**Consider social bridging to address loneliness and isolation for older people.** In California, the "Stay Home. Save Lives. Check In." initiative has been developed in partnership with the California Department of Aging, and three founding partners from the public, private and academic sectors. The project aims to counter strict social distancing with social bridging (one-on-one communication with older adults through check-in phone calls). The project will: ■ Train and mobilise >1000 people to telephone call older Californians to check on their well-being, direct them to resources, and connect them on a personal level ■ Prioritise reaching the most isolated older adults those living in pandemic hot spots, and those likely to be facing food insecurity via "Social Bridgers" ■ Train callers to assess basic needs and make referrals. Callers will use a tested call script to ensure consistency and reliability and will empathise with each individual's experience of this pandemic ■ Use Community Emergency Response Teams (CERT), trained volunteers affiliated with local public safety agencies ■ Utilise United Airlines employees in San Francisco, San Jose and Los Angeles as they have a robust employee donation and volunteer system for disasters ■ Use Sacramento State University gerontology students ■ Expand partnerships in the coming weeks. Members of the public are not being solicited as callers at this time	USA	Disaster Programme Specialist Listos California Social Bridging Project Fact Sheet https://www.gov.ca.gov/2020/04/24/governor-newsom-announces-initiatives-to-support-older-californians-during-covid-19-pandemic/
Economic			
Business regeneration	**Consider continuing the work of task forces focused on the building and development industry.** In Australia, the Victorian Government has set up a dedicated taskforce to energise the state's building and development industry as it continues running throughout the COVID-19 crisis. Government announced the approval of four new projects worth more than $1.5 billion dollars that will continue to function throughout pandemic shutdowns and economic recovery period.	Australia	CRO https://www.premier.vic.gov.au/new-taskforce-to-bolster-building-and-development-industry/

Recovery: Categories of impact	Actions	Country/ Region	Source
Business regeneration	**Consider expanding digital and e-commerce services especially in developing economies.** In Vietnam, the World Bank has stated that the economy has remained resilient. *Government measures to support economic recovery:* ■ A US$10.8 billion credit support package ■ Lowered interest rates ■ Delayed payment of taxes and land use fees for several business lines ■ Banks cut online transaction fees to encourage cashless payment *Industry measures to support economic recovery:* ■ Retailers encouraged orders by phone and apps which allowed retailers to hire more delivery personnel to meet demand ■ E-learning facilitated demand for hardware such as laptops and tablets and software services such as Zoom	Vietnam	https://www.vietnam-briefing.com/news/how-vietnam-sucessfully-contained-covid-19.html/
Equitable economic regeneration	**Consider how to support and enhance equitable economic regeneration.** In Hawai'i, plans to enhance and stimulate the economy in an equitable manner to: ■ Shift the reliance on a precarious tourist industry (which offers low wages to residents, especially women) and address the social and ecological costs of tourism ■ Establish an adjustment fund to support displaced workers though retraining, enabling professional mobility, and supporting social entrepreneurship ■ Establish gender and racial equity programs to enhance women's access to investment capital. This should extend beyond low-wage sectors, the commercial sex industry, and male dominated industries ■ Invest in subsistence living ■ Encourage traditional land- and sea-based practices to maximise the ecological and food system	Hawai'i'	https://humanservices.hawaii.gov/wp-content/uploads/2020/04/4.13.20-Final-Cover-D2-Feminist-Economic-Recovery-D1.pdf
Infrastructure			
Re-opening Social Activities	**Consider measures to ensure safe return to social activities.** See Case Study.	Iceland	http://umfi.is/verkfaerakista/vidbrogd-vid-covid-19/

Recovery: Categories of impact	Actions	Country/ Region	Source
Waste Management	**Consider waste management processes and priorities.** This should seek to maintain operations whilst minimising virus transmission. For example, operations in Paris: ▪ Wash and disinfect collection trucks every day ▪ Prioritise the collection of unauthorized garbage and street cleaning (using street washers and vacuum cleaners on pathways) ▪ Collect waste from streets e.g. each day ~1,000 municipal workers, ~250 garbage collection trucks, and ~100 road sweeping machines collect waste from the streets ▪ Clean ~140 public toilets in order to keep them open – thereby provide considerable health and dignity benefits to the most vulnerable. These facilities also have drinking water fountains ▪ Plan to manage the surge in the volume of waste when restaurants reopen (in Paris, the volume of daily waste has fallen by a third during closedown)	Paris	Paris. Délégation Générale aux Relations Internationale
Environmental			
Urban Planning	**Consider that strategic renewal should address different aspects of the environment**. This includes the built environment including buildings and roads and green spaces, like parks. Consider how future development of the environment can mitigate possible resurgence of COVID-19 infection by providing space to better facilitate social distancing. Consider: ▪ Incorporate into planning approval, criteria that new housing development proposals should include green space including 'green roofs' or communal gardens and squares ▪ Incorporate into planning approval, criteria that new building developments do not reduce public walkways – indeed, they should look to expand public walkways ▪ Use abandoned spaces as pocket parks (with limitations on the number of people allowed in together) ▪ Temporarily close roads to provide more walking space	Netherlands	CRO

Recovery: Categories of impact	Actions	Country/ Region	Source
Climate change	**Consider how COVID-19 may shape responses to climate change.** For example: ▪ Consider how trusted experts can support discussions about the climate change agenda and inform public policy ▪ Consider how new behaviours adopted through the pandemic can be encouraged to support the climate change agenda, and how people's adaptability can be harnessed ▪ Consider how short-term actions can be embedded in longer-term climate change actions e.g. the reduction of unnecessary air travel (e.g. for business meetings) and the encouragement of more home-working (e.g. using videoconferencing) ▪ Learn from 'known unknowns' – foreseen possibilities that are not obviously (such as pandemics and climate change) and therefore lacked effective emergency planning	UK	https://www.imperial.ac.uk/news/197473/how-will-coronavirus-shape-response-climate/
Communication			
Communication with children	**Consider sending personalised letters to children of keyworkers.** Children across Northampton, UK who had a parent that worked in the local police force, received a letter from the Chief Constable. The letter: ▪ Thanked children for 'sharing their parents' and for the child 'being part of the team' ▪ Thanked children for washing their hands properly, doing their school work and only going for one walk a day, making it possible for their parents to work	UK	https://www.northamptonchron.co.uk/lifestyle/family/northants-chief-constable-pens-letter-thank-colleagues-children-sharing-their-parents-2547276

The University of Manchester, Oxford Road, Manchester, M13 9PL, UK

Recovery: Categories of impact	Actions	Country/ Region	Source
Track and Trace	**Consider how to develop successful contact tracing and epidemiological investigations.** In Korea, the COVID-19 Data Platform is: ***Designed to:*** ▪ Support epidemiological analysts to quickly identify the transmission routes and places that an infected person has visited ▪ Use real-time analysis of data through location tracking, card transactions, and CCTV recordings for accurate tracing of routes and places ***The process of using the app is:*** ▪ Citizens voluntarily record their whereabouts on their smartphones using Google Timeline ▪ The 'My Timeline' function on the Google Maps automatically records the users location and routes ▪ Data on Google Timeline can be captured as screenshots and shared with epidemiological investigators, who will use the data to trace contacts ***The platform supports health officials to:*** ▪ Confirm the interview results of patient transmission routes with data on the system ▪ Allow big data analysis from real-time data feeds on COVID-19 patients, including their whereabouts and the time spent on each location ▪ Use these multiple data points to detect incidents of cluster infection and transmission sources for prompt ▪ Investigate	Korea	How Korea responded to a pandemic using ICT Flattening the curve on COVID-19
Governance and legislation			
Environmental policy	**Consider strategies to put the environment to the fore of policy-making.** For example, ▪ Consider sustainable recovery schemes that end fossil fuel subsidies in developed countries ▪ Consider whether specific growth targets which have been harmful to the environment are the most appropriate goal at this time ▪ Encourage a shift in hierarchy from GDP to the UN's 17 Sustainable Development Goals and the Paris Agreement, CITES or the Convention on Biodiversity	WEF- All	https://www.weforum.org/agenda/2020/04/covid19-coronavirus-climate-jennifer-morgan-greenpeace/

Recovery: Categories of impact	Actions	Country/ Region	Source
Exit strategy	**Consider a 'traffic light' approach to communicate the exit plan to the public.** This is a plan that will explain what is permitted and prohibited at each phase of easing the lockdown. The first phase would deliberately be called red, to ensure people stopped to think before they did things: *The red phase* ■ Some shops could re-open with strict social distancing, as most supermarkets do now ■ Many shops might choose not to re-open for commercial reasons e.g. as demand would be low ■ Travel should be discouraged and many international flights banned *The amber phase* ■ Over-65s should live as if under a hard lockdown ■ Daily new cases <500 persons, Testing capacity >100k, Tracing capacity >50%, Shielding ■ Work if your workplace is open and if you have a 'clear' reading on your contact tracing app. Use masks where possible. Otherwise only leave home as for Hard Lockdown ■ Unlimited private car journeys allowed, although people are discouraged from crowded destinations ■ Vary the rush hour with different opening and closing times to minimise pressure on public transport and reduce crowds ■ Patrons encouraged to show a 'clear' reading on your contact tracing app. Must follow social distancing ■ Wear masks and gloves when using public transport ■ Restaurants could reopen but with strict seating demarcations to uphold social distancing ■ Smaller shops could reopen **The green phase** ■ Daily new cases <100. Testing + tracing in place. Public gatherings <100 allowed ■ Sporting events or mass gatherings could take place, and places of worship can reopen ■ Mass transit could return to normal ■ The return of international flights should be based on the risks of flying to other countries ■ Macro-economic policies such as cutting VAT rates might be employed to boost spending	UK	http://www.algorithmiceconomics.com/wp-content/uploads/2020/04/ending_lockdown.pdf Tony Blair Institute of Global Change: A sustainable exit strategy: Managing uncertainty, minimising harm

Briefing C: Case Study - Opening social activities in Iceland

The Icelandic's Directorate for Health has issued guidelines for how organisers should run a range of social activities as the lockdown measures are relaxed. This case study outlines those guidelines but you should refer to the original advice provided by the Icelandic authorities (websites referenced in text):

Opening campsites, caravan parks, small guest-houses[1]

When opening these establishments as well as running organised tours and outdoor recreation activities, organisers should:

- Prevent guests from entering/participating if they are: under quarantine; in isolation or awaiting test results; isolating due to a COVID-19 infection within the last 14 days; displaying symptoms
- Clean and disinfect all common areas and contact surfaces at least twice per day
- Limit to 50 people the number of people allowed in each disease control space (where a disease control space is an indoors or outdoors division of an area)
- Ensure the social distancing 2-metre rule is respected
- Provide easy access to hand-washing facilities and hand sanitiser
- Limit interactions between different travelling groups

Opening activities for 16 year olds and younger[2]

When operating activities for this age group, all restrictions are lifted for children and teens, 16 years and younger, in preschools and primary and lower secondary schools, and in sports and youth activities. Organisers are permitted to return to pre-COVID operating procedures and:

- Note that the 2-metre social distancing rule does **not** apply to this age group
- Not restrict the number of participants
- Permit all indoor and outdoor sports and youth activities
- Open all ski areas to children and teens for training
- Open swimming pools, dressing and swimming areas for training
- Permit all sports competitions between children at the preschool and primary and lower secondary school age - no spectators allowed
- Encourage special hand-washing and hygiene measures

Opening sports activities for individuals aged 17 and over[3]

When operating activities for this age group, organisers must adhere to the following restrictions:

- In outdoors areas, at most 7 people (including coaches) are allowed in the size of a half football field (2,000 m2)
- In indoors areas, at most 4 people (including coaches) are allowed in the size of one handball court (800 m2)
- Indoor dressing facilities are not used
- Adult swimming is allowed, at most 7 people – using dressing/shower facilities is permitted.
- Emphasise respect for the 2-metre social distancing rule

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[1] https://www.landlaeknir.is/utgefid-efni/skjal/item41443/

[2] http://umfi.is/verkfaerakista/vidbrogd-vid-covid-19/

[3] http://umfi.is/verkfaerakista/vidbrogd-vid-covid-19/

- Competitions for adults are prohibited unless the 2-metre rule is applied – no spectators allowed
- Encourage special hand-washing and hygiene measures
- Swimming pools are closed to the public

Instructions for travellers

Travellers and travel operators must adhere to the following restrictions:

- Carriers transporting international passengers into Iceland are required to complete a Public Health Passenger Locator (PHPL) form, or similar.
- All passengers will be required to present such a form during border checks.
- According to IATA, a PHPL form is completed by passengers to whenever public health officers suspect a communicable disease is on-board a flight and the information will help public health officers to contact passengers if exposed to a communicable disease.

IATA give example forms at https://www.iata.org/en/programs/safety/health/locator-form/Iceland National Commission pf the Icelandic Police, Department of Civil Protection and Emergency Management 22.04.2020

Instructions for beauty salons, hairdressers, opticians and similar activities with proximity to customers[4]

When providing personal care every facility/employee is responsible to maintain emergency levels of civil protection. Staff and customers must adhere to the restrictions that:
- Prevent staff and customers from entering/participating if they: are under quarantine or have been abroad in the last 14 days; are in isolation or awaiting test results; are isolating due to a COVID-19 infection within the last 14 days; displaying symptoms
- Respect the 2 metre rule
- Keep good ventilation, open window
- Remove any distance signs where possible and appropriate
- Set up facilities to disinfect contact surfaces as often as possible, at least between customers
- Staff wash hands between each customer
- Ensure staff wear personal protective equipment (PPE) in case of suspected infection, otherwise, no PPE is needed. If both the staff and the customer are asymptomatic (or improved), and other conditions are met, it is possible to not wear masks and gloves, but put a strong emphasis on hand washing.
- Remove ancillary items for customers to use (e.g. magazines, coffee pots)
- Dispose of rubbish in sealed bags and place in bins
- Sprinkle all equipment (tables, chairs, tools) between guests with appropriate disinfectant as often as possible, at least between customers.

The government also provides advice for the opening of *physiotherapy services* (https://www.landlaeknir.is/servlet/file/store93/item41436/sj%C3%BAkra%C3%BEj%C3%A1lfun%20og%20samb%C3%A6rilegt02.05.2020.pdf).

This case study should be ready alongside the official instructions from the government of Iceland – available from the URLs provided in the footnotes.

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[4] https://www.landlaeknir.is/servlet/file/store93/item41435/Pers%C3%B3nuleg%20%C3%BEj%C3%B3nusta-snyrting-h%C3%A1rgrei%C3%B0sla01.05.2020.pdf

Briefing D: Useful webinars

Taken place in the past week	Webinar Title	Link to presentation
7.5.2020	Socio-economic Implications of the COVID-19 Pandemic on Developing Countries and the Role of South-South and Triangular Cooperation	https://zoom.us/rec/play/uJJ_IeGgqDo3Sdz BswSDAPIvW429fPisg3cc-6EJmkvjVHMBYVDzNLAbYrFbpgBO0mSfusFf nItfGvLJ?startTime=1588854714000
7.5.2020	Delivery Drones & COVID19	https://www.youtube.com/watch?v=tG13X MS1xQc
7.5.2020	Communicating Risk: How people respond to risk and what that means for communication	https://www.youtube.com/watch?v=taoX7I 9UBNQ&feature=youtu.be
7.5.2020	COVID-19: Opportunities for Resilient Recovery	https://www.undrr.org/event/webinar-covid-19-opportunities-resilient-recovery
7.5.2020	Business Resilience in the Face of (COVID-19)	https://undrr.zoom.us/rec/play/65UtIuGgr2 43S4DBsQSDBKMtW43vK6ms1idMqFbnU_g ACYGOlGjY7ATYrNgxqQLQURLH0uKdXG9R8 Z?startTime=1587625089000
Coming up		
Date	Webinar Title	Link to registration
18.5.2020	The economic implications of COVID-19: A webinar series from the Princeton Bendheim Center for Finance	https://bcf.princeton.edu/event-directory/covid19/
19.5.2020	Disaster by Choice: Why Disasters Are Not Natural.	https://zoom.us/meeting/register/tJAlf-CgqTMjGtdrBaMrJDoaqGpjzSCMCFVN
19.5.2020	The Big Rethink: 'Decarbonizing the Hard Way'	https://us02web.zoom.us/webinar/register /3515886042156/WN_FPI4SLxAQWG9lIRUK 7CCzw
26.5.2020	The Big Rethink: 'Lessons For Greenfield Megaprojects'	https://us02web.zoom.us/webinar/register /6015886049337/WN_ffwIX4EMQwKV1FaS bTtaEg