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Health and Wellbeing Board Supplementary Agenda

Monday 29 June 2020 at 6.00 pm
This will be held as an online virtual meeting.

Membership:

Councillor Farah (Chair)	Brent Council
Dr MC Patel (Vice-Chair)	Brent CCG
Councillor Hirani	Brent Council
Councillor McLennan	Brent Council
Councillor Kansagra	Brent Council
Councillor M Patel	Brent Council
Sheik Auladin	Brent CCG
Dr Ketana Halai	Brent CCG
Julie Pal	Healthwatch Brent
Carolyn Downs	Brent Council - Non Voting
Phil Porter	Brent Council - Non Voting
Dr Melanie Smith	Brent Council - Non-Voting
Gail Tolley	Brent Council - Non-Voting
Simon Crawford	London North West Healthcare NHS Trust - Non Voting
Mark Bird	Brent Nursing and Residential Care Sector - Non Voting
Jonathan Turner	Brent CCG

Substitute Members (Brent Councillors)
Councillors:

Agha, Miller, Krupa Sheth and Tatler

Councillors:

Colwill and Maurice

For further information contact: Hannah O'Brien, Governance Officer
hannah.o'brien@brent.gov.uk

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www.brent.gov.uk/committees

The press and public are welcome to attend this as an online virtual meeting. The link to view the meeting is available HERE.

Notes for Members - Declarations of Interest:

If a Member is aware they have a Disclosable Pecuniary Interest* in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent and must leave the room without participating in discussion of the item.

If a Member is aware they have a Personal Interest** in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent.

If the Personal Interest is also significant enough to affect your judgement of a public interest and either it affects a financial position or relates to a regulatory matter then after disclosing the interest to the meeting the Member must leave the room without participating in discussion of the item, except that they may first make representations, answer questions or give evidence relating to the matter, provided that the public are allowed to attend the meeting for those purposes.

***Disclosable Pecuniary Interests:**

(a) **Employment, etc. -** Any employment, office, trade, profession or vocation carried on for profit gain.

(b) **Sponsorship -** Any payment or other financial benefit in respect of expenses in carrying out duties as a member, or of election; including from a trade union.

(c) **Contracts -** Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.

(d) **Land -** Any beneficial interest in land which is within the council's area.

(e) **Licences-** Any licence to occupy land in the council's area for a month or longer.

(f) **Corporate tenancies -** Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.

(g) **Securities -** Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:

- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party of trade union).

(b) The interests a of a person from whom you have received gifts or hospitality of at least £50 as a member in the municipal year;

or

A decision in relation to that business might reasonably be regarded as affecting the well-being or financial position of:

- You yourself;
- a member of your family or your friend or any person with whom you have a close association or any person or body who is the subject of a registrable personal interest.
-

Supplementary Agenda

Introductions, if appropriate.

Item		Page
5	**The disproportionate impact of COVID-19 on BAME communities in Brent** To consider a report on the disproportionate impact of COVID-19 on BAME communities in Brent.	1 - 26
7	**Brent's Local Outbreak Plan** To consider Brent's Local Outbreak Plan.	27 - 58

Date of the next meeting: Tuesday 20 October 2020

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- The meeting room is accessible by lift and seats are provided for members of the public on a first come first served basis.

Brent / NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 29 June 2020
	Report of the Director of Public Health

Disproportional Impact of Covid-19 in Brent

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Dr John Licorish Consultant Public Health Community and Wellbeing Department

1.0 Purpose of the Report

1.1 The Chair of the Board requested a report specifically related to Covid-19 and the disproportionalities.

2.0 Introduction

2.1 Covid-19

Covid-19 is the disease caused by the novel coronavirus, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Coronaviruses are a set of viruses that are among the causes of common colds in Human Beings. They have also caused outbreaks of more serious illnesses Severe Acute Respiratory Syndrome (SARS) and Middle Eastern Respiratory Syndrome (MERS). The viruses are also found in other mammals.

The disease can present with no symptoms, mild symptoms or as a severe illness leading to hospitalisation and in some cases death. In England by the 17th of June 2020, the Department of Health and Social Care stated there were 157,797 laboratory confirmed cases of Covid-19. In England, the Office of National Statistics, up to 15th of June 2020, reported 45,432 deaths.

The burden of Covid-19 however is not shared equally in the society. Individuals within Black, Asian and Minority Ethnic (BAME) ethnicity, male Sex, older age, and already diagnosed with multiple underlying issues are all at increased risk of dying. Unsurprisingly those who lived in deprived areas also bear the brunt of the disease.

These inequalities are not new and there is evidence that Covid-19 has in some case increased them.

2.2 Data

The key to understanding the impact of Covid-19 and any infectious disease outbreak is data on the individuals who contract the disease and their health outcomes. This needs to be complete and timely. Unfortunately, Brent has been hampered by not having all the information that is required to mount an appropriate response from the time of the first Covid-19 cases until now. This is not a Brent specific issue and instead relates to how systems are organised and information parameters and flows which are largely centrally determined.

2.2.1 Brent Cases Information

Measure	Availability	Source	Limitation
Number of cases diagnosed with laboratory confirmed Covid-19 in Brent	Daily	Official Government Covid-19 website	Only covers those who have been tested mostly those who have been hospitalised
Breakdown of cases by Ethnicity	Not Available		
Breakdown of cases by Age	Not Available		
Breakdown of cases by Ethnicity	Not Available		
Breakdown of cases by address/electoral ward	Not Available		
Breakdown by socioeconomic status	Not Available		

2.2.2 Brent Covid-19 Hospitalisations Information

No hospitalisation data is currently available for Brent patients with Covid-19 with respect to number of cases, ethnicity address, age, sex or other parameters.

2.2.3 Brent Deaths Information

Unfortunately, some residents have succumbed to Covid-19. There are three potential sources of information for deaths:

- NHS Digital and Trust Data for those who die in hospital
- Office for National Statistics
- Brent Registrar's Office data

Measure	Availability	Source	Limitation
Number of deaths diagnosed with laboratory confirmed Covid-19	Daily	Official Government Covid-19 website	Until recently only covers those who have been tested mostly those who have been hospitalised
Number of deaths with Covid-19 mentioned on the death certificate	Weekly	Office for National Statistics Website	Guidance around death certification changed after the pandemic and deaths may not have had Covid-19 mentioned
Number of deaths in care homes, hospitals and other places	Weekly	Office for National Statistics Website	Guidance around death certification changed after the pandemic and deaths may not have had Covid-19 mentioned
Breakdown of deaths by Ethnicity in Brent	Not Available		
Breakdown of deaths by Age and sex in Brent	Available	Office for National Statistics Website	Not always up to date
Breakdown of deaths by Ethnicity	Not Available		
Breakdown of deaths by location in Brent	Published on two occasions since the pandemic started	Office for National Statistics website	Not always up to date

Measure	Availability	Source	Limitation
Breakdown by socioeconomic status in Brent	Not available but can be approximated using known health geography		
Rate per 100, 000 individuals accounting for age structure	Published on two occasions since the pandemic started	Office for National Statistics	Available

2.2.4 Brent resident deaths at Hospitals

Measure	Availability	Source	Limitation
Number of deaths at local hospital trusts	Weekly	NHS Digital	Includes all deaths of hospital patients, Brent's deaths are not separated out
Number of deaths at all hospitals	Weekly	Office for National Statistics	Delay in publication due to registration
Breakdown by ethnicity, age, sex, socioeconomic deprivation	Not available		

2.2.5 London Northwest University Healthcare NHS Trust data

London Northwest were asked to provide our data in relation to Brent residents. We have been analysing all our Covid-19 data in collaboration with Public Health England. The data for Brent alone is shown below. Of note, we do not have access to any data for Brent patients admitted directly to other hospitals. The data is also not yet complete in that we do not yet have all the outcomes for patients transferred to other hospitals following admission to London Northwest; outcomes are included where known.

The demographics of all the Covid-19 cases admitted to London University Healthcare NHS Trust in March and April 2020 is shown below.

		Brent	
		Cases	%
Sex	Female	204	35.7%
	Male	368	64.3%
Age	0-9	4	0.7%
	10-19	2	0.3%
	20-29	8	1.4%
	30-39	29	5.1%
	40-49	61	10.7%
	50-59	84	14.7%
	60-69	114	19.9%
	70-79	119	20.8%
	80+	152	26.6%
Ethnicity	White	121	21.1
	Mixed	3	0.5
	Asian	222	38.7
	Black	108	18.9
	Other	29	5.1
	Unknown	90	15.7
Deprivation quintile	1 (most deprived)	101	15.4
	2	186	28.3
	3	222	33.8
	4	104	15.8
	5 (least deprived)	44	6.7

The ‘unknown’ represent a significant proportion in which no ethnicity is recorded, usually because the respondent declined to state their ethnicity. The majority of patients were over 40 years old.

The outcome of these patients is shown below.

		Total cases	**No. ITU admissions**	**%**	**Ventilation**	**%**	**Number of deaths**	**%**
Sex	Female	199	20	10.0	6	2.9	63	30.6
	Male	334	67	20.0	34	9.2	86	24.6
Age	0-9	4	0	0	0	0	0	0
	10-19	2	1	50	1	50	0	0
	20-29	8	2	25	0	0	0	0
	30-39	29	5	17.2	3	10.3	1	3.5
	40-49	61	16	26.2	5	8.2	5	8.2
	50-59	84	23	27.4	14	16.7	12	14.3
	60-69	114	28	24.6	12	10.5	26	22.8
	70-79	119	10	8.4	4	3.4	46	38.7
	80+	152	2	0.1	1	0.7	74	48.7
Ethnicity	White	121	5	4.1	46	22.4	41	33.9
	Mixed	3	0	0	1	0.5	1	33.3
	Asian	222	31	14.0	73	35.6	59	26.6
	Black	108	20	18.5	50	24.4	32	29.6
	Other	29	9	31.0	8	3.9	8	27.6
	Unknown	90	22	24.4	27	13.2	23	25.6

Of note, the mortality in all ethnic groups is comparable and non-white ethnicities did not have a higher mortality, unlike the higher mortality shown in non-white ethnicities in national studies. PHE explain they group the ethnicities to provide larger numbers for analysis. However, we can also share the following more detailed breakdown of deaths;

Ethnicity	Grand Total	% Dead
Blamk	124	15%
African	66	18%
Any other Asian background	201	20%
Any other Black background	48	29%
Any other ethnic group	110	23%
Any other mixed background	5	20%
Any other White background	92	18%
Bangladeshi	4	25%
British	374	35%
Caribbean	123	28%
Chinese	8	50%
Indian	422	27%
Irish	48	35%
Not stated	218	28%
Pakistani	52	33%
White and Asian	1	0%
White and Black African	2	0%
White and Black Caribbean	3	33%
Total	1901	27%

The discharge destination is shown below. Note the data is incomplete as the outcome for some patients transferred from London Northwest to other hospitals for specialist care is not completely available.

		Total cases	**Discharge home**	**%**	**Discharge care home**	**%**	**Still inpatient as of April 30**	**%**
Sex	Female	199	104	52.3	8	4.0	1	0.5
	Male	334	199	59.6	9	2.7	5	1.5
Age	0-9	4	4	100	0	0	0	0
	10-19	2	1	50.0	0	0	0	0
	20-29	8	6	75.0	0	0	0	0
	30-39	29	24	82.8	1	3.4	1	3.4
	40-49	61	43	70.5	1	1.6	2	3.3
	50-59	84	52	61.9	0	0	2	2.4
	60-69	114	65	57.0	2	1.8	1	0.9
	70-79	119	61	51.3	3	2.5	0	0
	80+	152	50	32.9	10	6.6	0	0
Ethnicity	White	121	54	44.6	9	7.4	0	0
	Mixed	3	2	66.7	0	0	0	0
	Asian	222	126	56.8	1	0.5	2	0.9
	Black	108	55	50.9	2	1.9	0	0
	Other	29	7	24.1	1	3.4	0	0
	Unknown	90	12	13.3	2	2.2	4	4.4

We have looked at all deaths from Covid-19 in London Northwest by age and number of comorbidities. Note this is data from all Boroughs.

Age profile of deaths across London Northwest inpatient sites

Age	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100+
Percentage of deaths	0%	3%	5%	13%	27%	34%	13%	0%

The age profile of mortality is shown above. Most deaths occurred in those over 50 years old.

Number of pre-existing conditions

Pre-existing conditions	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8+**	**Total**
Percentage of deaths	2%	11%	19%	23%	22%	12%	7%	2%	2%	100%

The number of pre-existing comorbidities in those who died is shown above. Most deaths occurred in those with multiple comorbidities.

Research undertaken and planned
London Northwest University Healthcare NHS Trust is committed to providing the best possible care to our population. As part of this commitment pride ourselves on contributing to research, so our current and future patients can receive the most current treatment. We are proud of our contribution to the Recovery Covid-19 trial.

Our Research and Development and Infectious Disease teams have worked really hard on this multi-arm trial and have recruited 100 patients. There have already been some important results, showing that dexamethasone (a steroid) reduced deaths by one third in ventilated patients and by one fifth in patients receiving oxygen. Overall, dexamethasone reduced the 28-day mortality rate by 17%. This research has given our patients access to cutting edge new treatments and both Remdesivir and Dexamethasone are now available for Covid-19 patients at the Trust.

We also recruited 200% of our recruitment target and 10% of all UK recruitment on the Gilead studies of Remdesivir, which is an extraordinary result. We have also recruited more than 700 people onto the ISARIC descriptive study.

We are particularly aware of the multi-ethnic and multicultural nature of the population we serve, which is reflected in our staff. As a Trust we have invested time and resource to support collection of a comprehensive dataset of clinical factors as well as outcomes in Covid and a number of research questions are being evaluated. This includes

- A descriptive analysis of patients admitted with Covid-19 across the Trust and their outcomes, in association with Public Health England
- An evaluation of predictive factors for severe disease in patients hospitalised with Covid-19 at Northwick Park Hospital
- A cohort study of Ethnicity, diabetes and risk of severe Covid-19 across the Trust

One of our infectious diseases doctors is developing a research collaborative with other hospitals that serve similarly diverse communities, to maximise the ability to detect influences on outcome of ethnicity and other factors.

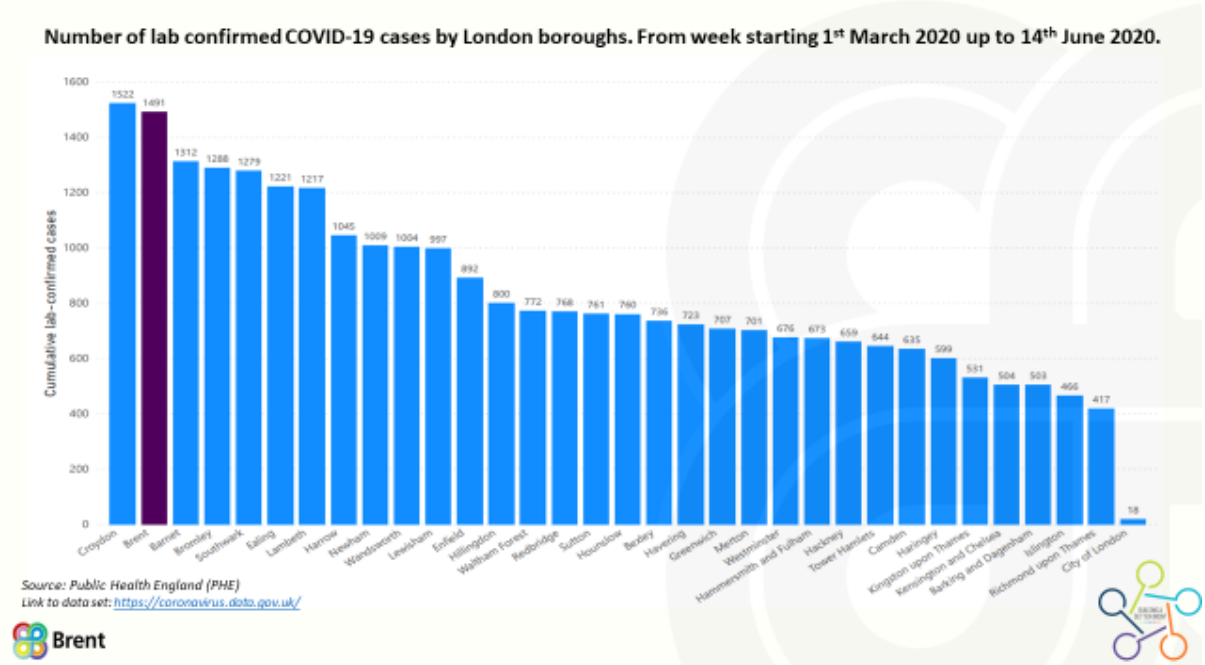
2.2.6 Brent resident deaths at Care Homes

Measure	Availability	Source	Limitation
Number of deaths at Care Homes	Weekly	NHS Digital	Delay in reporting due to death registration
Number of deaths reported to CQC	Weekly	NHS Digital	Delay in publication due to reporting system
Breakdown by ethnicity, age, sex, socioeconomic deprivation	Not available		

3. COVID-19 in Brent

3.1 Cases

Brent has the second highest number of confirmed cases in London 1491. It is to be noted that earlier in the outbreak and pandemic there were limitations in obtaining tests hence many cases would have been missed. There are also limits in asymptomatic individuals obtaining testing. The cases confirmed data is therefore, largely driven by hospitalised cases.



When we look at the rate per 100,000 individuals taking into account the different age profiles of the London Boroughs Brent has the second highest number of Covid-19 associated deaths for every 100, 000 individuals.

These deaths were originally only recorded in hospitals but later deaths in all settings were published by ONS. This data now includes deaths where Covid-19 is mentioned on the death certificate

Place of death

Provisional counts of the number of deaths registered in England and Wales, including deaths involving the coronavirus (COVID-19), by local authority, health board and place of death for which data are available.

COVID-19 Deaths (numbers) by local authority and cause of death, for deaths that occurred from 1st January, 2020 up to 5th June 2020 but were registered up to 13th June 2020, England and Wales.

	England	London	Brent	Ealing	Hammersmith and Fulham	Harrow	Hillingdon	Hounslow	Kensington and Chelsea	Westminster
Hospital	28,858	6,130	384	254	86	319	216	169	84	134
Care Homes	13,522	1,328	40	98	59	43	59	14	25	26
Hospice	631	99	4	16	4	3	7	8	2	2
Home	2,052	639	48	24	16	22	20	20	11	16
Other communal establishment	199	27	0	0	0	1	4	8	0	1
Elsewhere	170	48	2	4	1	2	2	2	0	3
Total	45,432	8,271	478	396	166	390	308	221	122	182

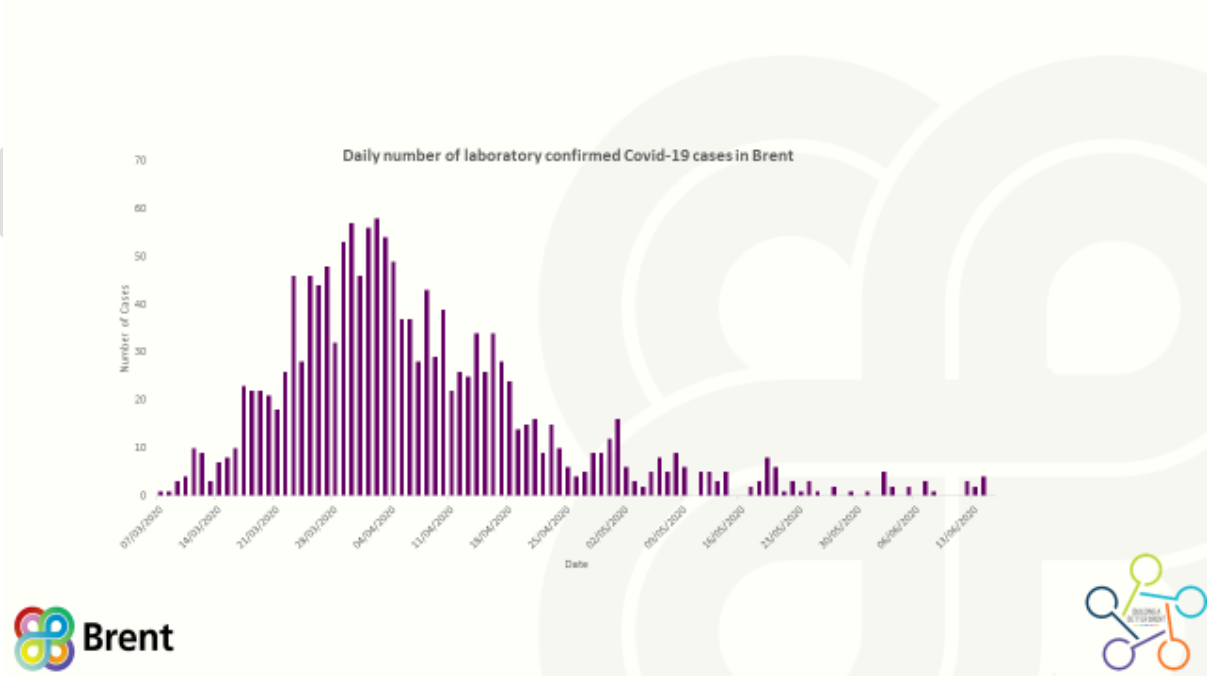
Notes:
- *Deaths (numbers) by local authority and cause of death, 2020 occurrences, by place of occurrence, England and Wales*
- *Deaths occurring in England and Wales registered on the General Register Office's Registration Online system (RON).*

Link to data set: www.ons.gov.uk

Brent

3.2 Progress of the Epidemic

When epidemiologist study infectious diseases, they look at the number of new cases per day and use a graph to show how this varies. This chart is called an Epi curve.

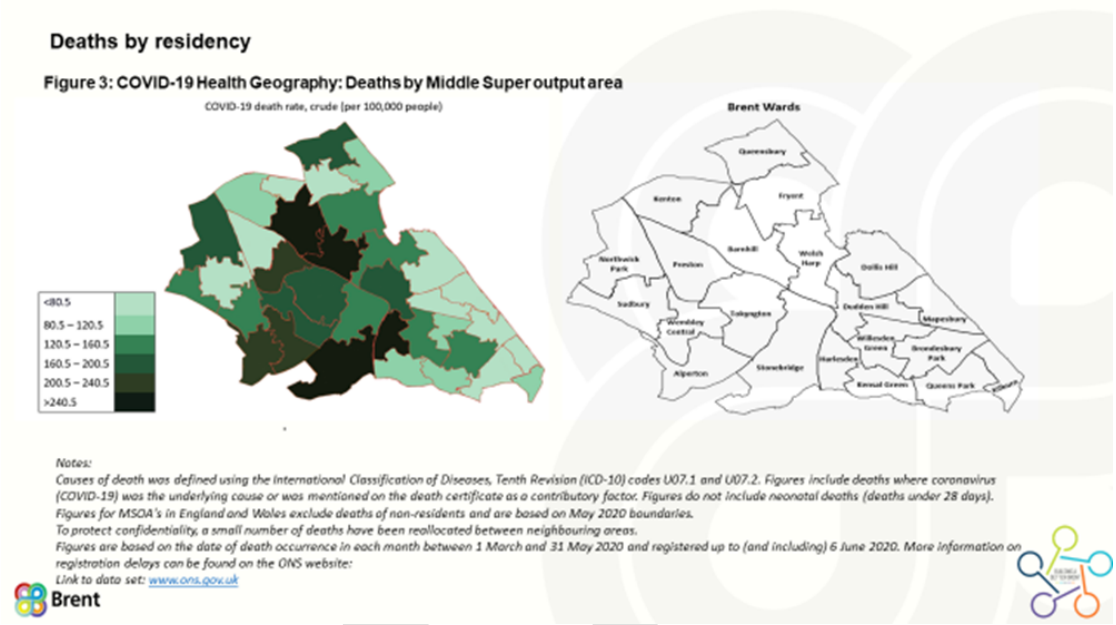


Brent

This Epi curve shows that the peak number of cases occurred in the beginning of April 2020.

3.3 Geographical Distribution of Deaths

As mentioned earlier the burden of disease and its worst outcome death is not distributed evenly and that is also the case in Brent.



The graph above shows the death rates using geographical units the ONS deaths occurring in each Middle Super Output areas and we compare them to electoral wards. The highest rates are in Harlesden and areas of Stonebridge and Barnhill.

4. Public Health England Report and its Conclusions

4.1 Ethnicity

ONS analysed 12,000 COVID deaths comparing death certificates to census data with the following findings:

When taking into account age in the analysis:

- Black males are 4.2 times more likely to die from a COVID-19-related death than White males;
- Black females are 4.3 times more likely to die from a COVID-19 related death than White females.

In the analysis, socioeconomic circumstances or deprivation was also analysed.

Deprivation includes looking at the income levels, housing, education and other similar factors of the area individuals live as this has an impact on health and disease and Covid-19. The more deprived the greater the risk from dying. As BAME populations tend to be more deprived, it is important to adjust for the influence of deprivation in looking at the impact of ethnicity. Doing so allows us to compare the risk of a deprived back male with a deprived white male and we find:

- Black males are 1.9 times more likely to die from a COVID-19-related death than White males;

The figure is the same if you compare a well-off black male with a well-off white male

The same scenario for black women:

- Black females are 1.9 times more likely to die from a COVID-19 related death than White females.

People of Bangladeshi and Pakistani, Indian, and Mixed ethnicities also had statistically significant raised risk of death involving COVID-19 compared with those of White ethnicity. After taking into account age and socioeconomic circumstances or deprivation:

- Bangladeshi and Pakistani ethnic group males are 1.8 times more likely to die from a COVID-19-related death than White males;

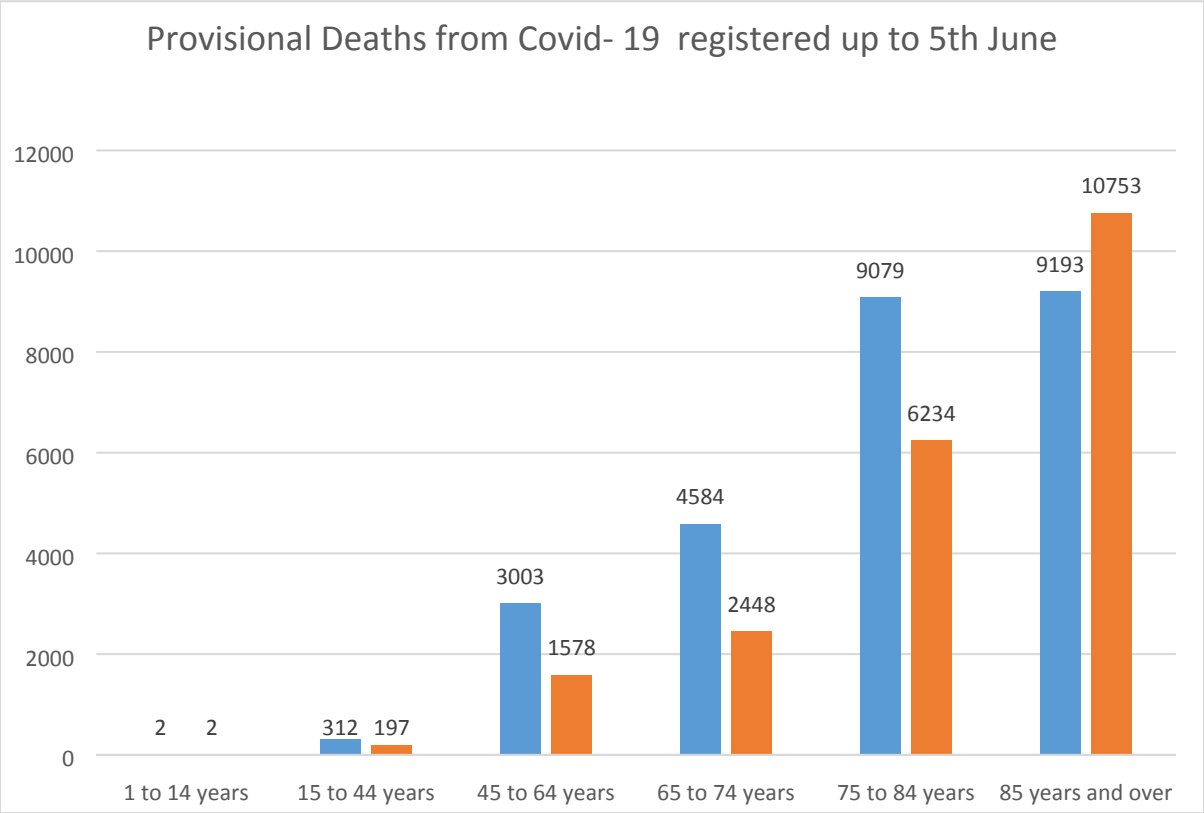
- Bangladeshi and Pakistani ethnic group females are 1.6 times more likely to die from a COVID-19-related death than White females.

Public Health England review also found increased risk of dying from those not born in the UK as opposed to those born in the UK. It is unclear whether this accounts for some of the ethnic differences.

Health inequalities between ethnic groups were entrenched before COVID 19 but it is possible that COVID is widening these.

4.2 Age and Sex

Covid-19 has caused increased risk of death in males and in the older population in England. In the graph of deaths registered up until 5th June 2020, males are indicated in blue and those in females in orange. The death rate taking into account the age distribution of the population is 109.6 deaths per 100, 000 for males whereas for females it is 62.5 deaths per 100,000 individuals based on ONS data for deaths occurring up until May 31st 2020.



4.3 Occupational Risk

The Public Health England notes that occupations with close contact to individuals such as health care workers have increased risk of dying from Covid-19. A review of 119 NHS deaths has shown disproportionately high numbers from BAME communities. Male workers in manual occupations also have higher risk of dying form Covid-19.

4.4 Co-Morbid conditions

Individuals with pre-existing conditions and particularly those with multiple conditions are at increased risk of dying from Covid-19. Diabetes plays a particular risk. NHS England funded study has shown that the increased risk of dying in hospitals with Covid-19 for an individual with Diabetes is 1.81 times more likely when compared to individuals without Diabetes. The Public Health England Review also found that Diabetes Mellitus was present on 21% of the death certificates with Covid-19. There is also some evidence that poor outcomes with Diabetes were noted with less well controlled disease

4.5 Socioeconomic Deprivation

The Public Health England found that deaths in the most deprived areas were double those in the least deprived areas. Survival in those from deprived areas was lower than those from most affluent areas even after adjusting for age, sex and ethnicity.

5.0 Conclusions for Brent

5.1 Risk Factors – Vulnerability

5.1.1. Co-morbidity

Brent has a BAME population with high levels of Diabetes Mellitus in particular and other long-term conditions leading to increased Covid-19 risk.

The cessation of face-to-face appointments has led many individuals either to believe primary care is closed or not to engage with the alternatives present. A&E and urgent care attendances are decreased and there is anecdotal evidence of distrust in the community of the safety of the hospital with regard to contracting Covid-19.

5.2 Risk Factors – Exposure

Brent BAME population are high users of public transport. Buses until recent measures by TFL were crowded as were bus stops in the Wembley and Harlesden area.

Brent BAME communities have high levels of inter-generational living with those at risk including the elderly and those with long-term conditions being exposed more than those in smaller households.

BAME communities have high attendance to temples, churches, mosques and other places of worship with large communal activities such as services, weddings and funerals. These were implicated in spread elsewhere and it is likely were these were factors in the early part of the epidemic

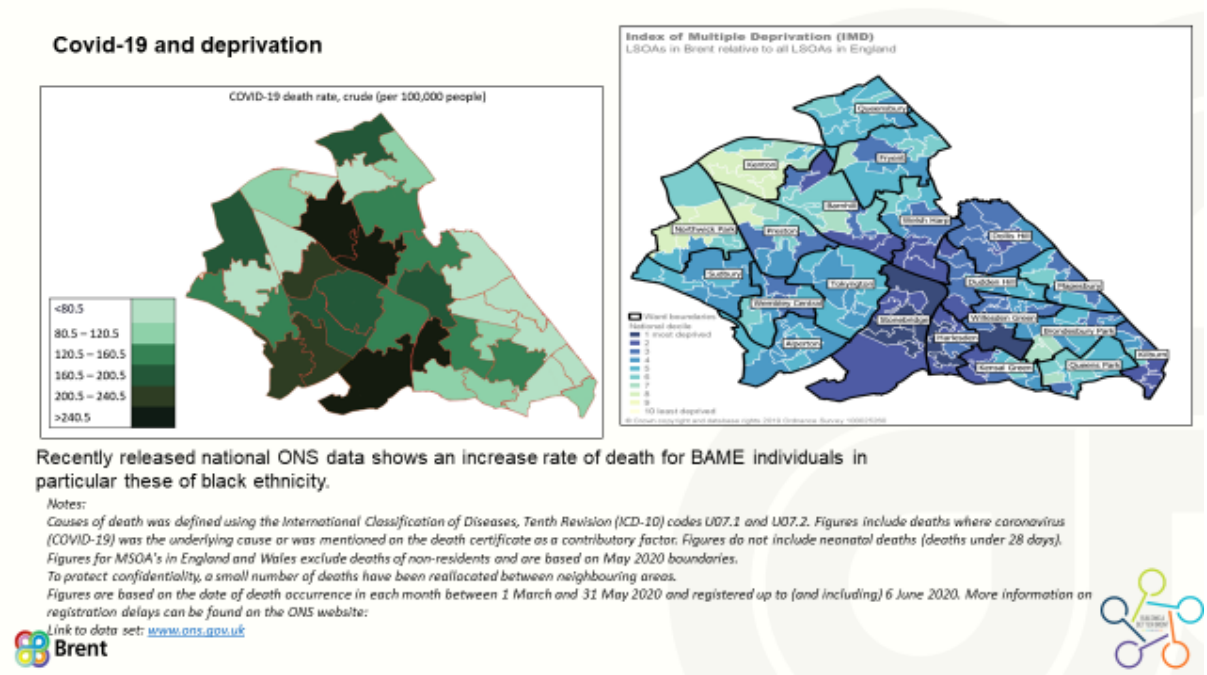
BAME community members are less likely to be working from home and often in zero hour contracts or cash in hand situations therefore less likely to be able to social distance or self- isolate.

BAME community members are more likely to be frontline workers and less likely to be managers and able to influence their working conditions

5.3 Underlying Determinants

5.3.1 Socioeconomic Deprivation

Brent has some areas of stark socioeconomic deprivation. As can be seen from the map below:



The areas of highest rates of Covid-19 mortality are within those most deprived

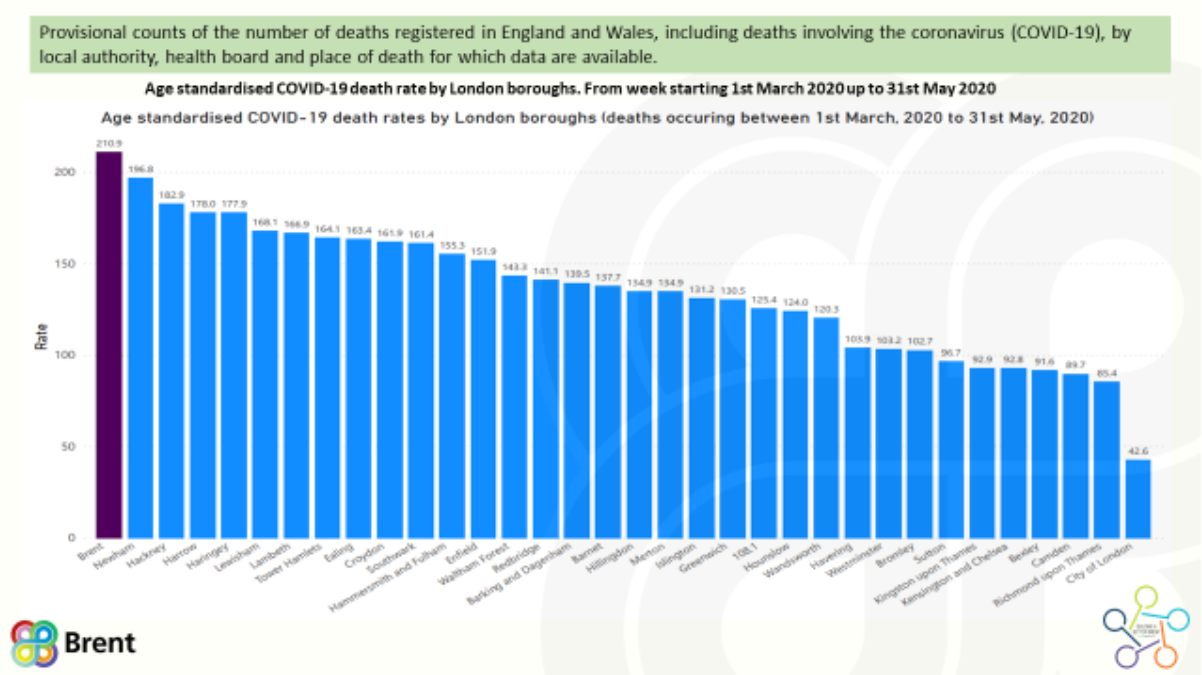
5.4 Care Homes

Covid-19 has the highest mortality rates in the older age group many of whom plus other individuals with vulnerabilities are found in Care Homes clients. In addition to the individual vulnerability of the clients. Managing Covid-19 outbreak in care homes is difficult for a number of reasons:

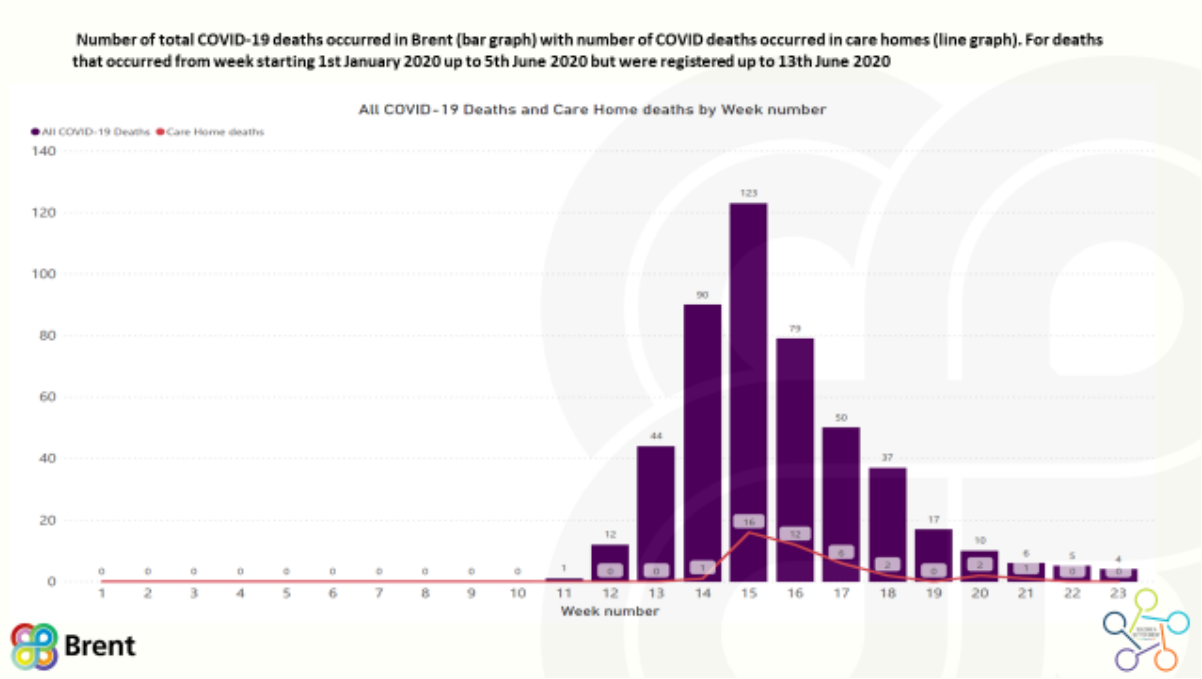
- Mobility of Staff
- Visitors in and out the home
- Entry of infectious patients from Acute Trust and elsewhere
- Managing isolation
- Training levels of staff

Brent through its Public Health and Adult Social Care Departments initiated a robust support mechanism to all aspects of operation including advice, training, staffing, infection control, testing, outbreak management as well as provision of PPE.

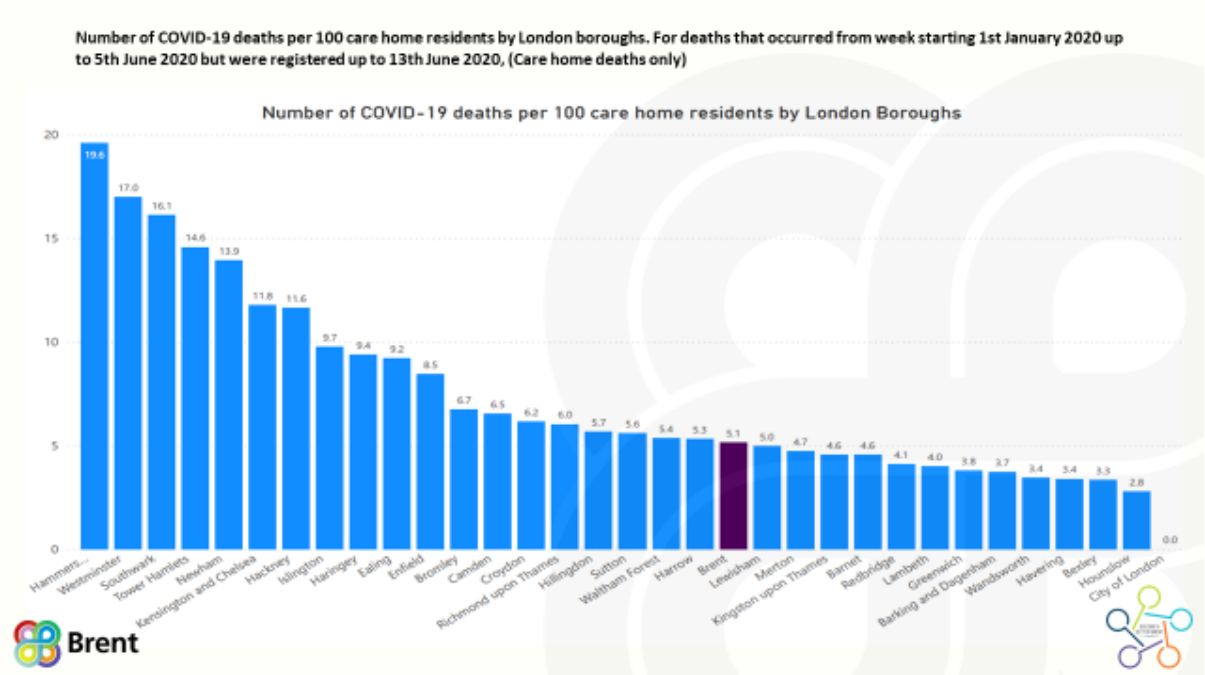
While any death is extremely unfortunate, this did mitigate some of the worst effects of Covid-19 despite the borough having the highest age standardised rate in London.



In addition, the outbreak in Brent in Care Homes happened at the same time as the outbreak in the wider community.



Despite this, the current number of deaths per care home bed contrasted with the overall death rate.



5.5 Current Situation

The lockdown in the UK commenced on the 23rd of March 2020. From the 10th of May 2020, there has been a gradual lifting of the lockdown. This has resulted in various parts of the economy returning to normal.

The government changed its Stay at Home slogan to “Stay Alert”

It is currently unknown how many individuals have been infected with Covid-19. As a result Public Health England’ and the Office for National Statistics are undertaking antibody tests, which show whether an individual has contracted the disease.

Latest results from Public Health England have indicated that between 12% and 18% of individuals in London have already been infected. Currently it is not known whether these antibodies protect against further illness.

As a result, there is large population at risk of contracting the disease. This suggests that there is a risk of a second wave occurring after lockdown measures are lifted.

In response, the Government has continued its Pillared testing strategy to ultimately allow anyone who needs a test to have it. In Brent, this has led to a local Covid-19 testing site in Harlesden in the area of greatest need.

The Government has also instituted a Contact Tracing system, NHS Test Track and Trace. This system aims to allow for all individuals who are positive to be contacted and advised to isolate for 2 weeks. There is also an App which has been trialled in the Isle of Wight but not yet in widespread use.

The public are still advised to follow national guidance, the current key messages are to social distance, maintain good hand hygiene, avoid public transport, work from home if you can and obtain a test if you have symptoms and self-isolate if you have been exposed to anyone with the virus.

In order to minimise the risk of a second wave of Covid-19 and to support the residents in Brent, who are some of the most at risk in the country, we continued to push out clear, consistent and hard-hitting messaging to remind people that Covid-19 is still a threat.

In addition to supporting the core government messages, the council has recognised that locally we needed to provide a more targeted approach to support our residents. This includes using stronger messaging on roadside banners in high-risk areas and working closely with trusted community groups to target specific communities.

Working with trusted local partners and community groups has meant that we can provide them with our key messages and they can repurpose and share them with their audiences in the most appropriate way.

We've used all our usual corporate communications channels such as e-newsletters and social media. We have also worked with local radio stations to hold phone-ins and have commissioned adverts to reach younger audiences.

5.6 Current Situation

5.6.1 Interventions to date: Brent Council

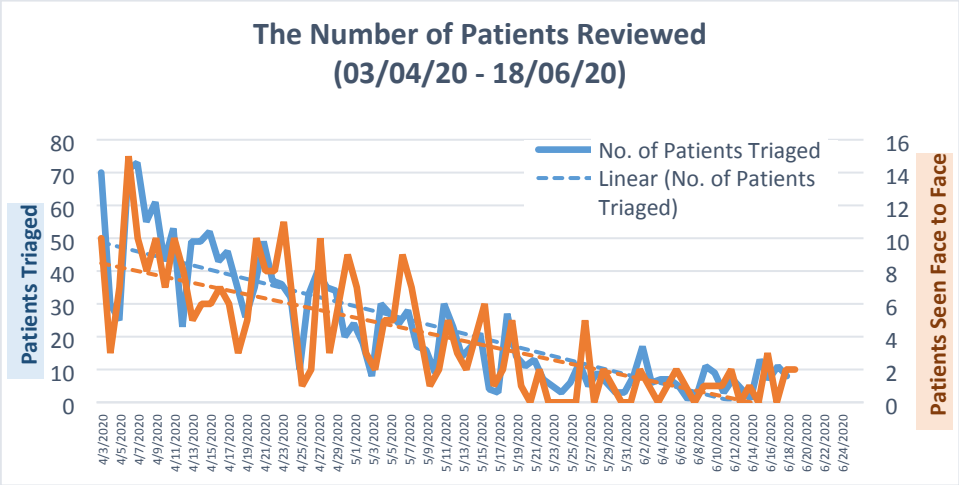
The Council has a comprehensive communications plan which aims to protect the community including its most vulnerable members including:

- People who are more at risk (see table below) including BAME residents
- Older people and people with underlying conditions
- People who are asked to self-isolate due to the new 'track and trace' system
- Younger people who may think the rules don't apply to them but could be spreaders in their homes or communities
- Council staff and Members (including staff who are working from home and others that need to come into the office)
- The CCG through North West London have commissioned a Community Voices piece which will provide useful insight into the impact of Covid-19 on the BAME community

5.6.2 Interventions to date: Brent NHS CCG

- In the first weeks of the pandemic during March 2020, the CCG rapidly set up a COVID "Hot Hub" at Willesden Centre for Health and Care. The "Hot Hub" was set up to see patients who were not so sick that they needed to go to hospital, but had suspected COVID that needed monitoring in the community.

Patients who had suspected COVID but were referred from 111 and from GP practices into the hub to be seen by a team of GPs and nurses and received an assessment. Pulse oximetry and oxygen was available on site and patient's breathing was assessed. Those who were well enough to stay at home were provided with pulse oximeters to take home and make daily checks and then alert the hub if their oxygen saturations deteriorated. In this way, the hub enabled patients to stay well at home and to take some of the pressure off the Emergency Department and local hospitals during the period of peak demand. The Hot Hub is still in operation and is seeing a number of patients face to face. Some patients are monitored remotely and given advice with virtual consultations. A few patients were seen at the hub and required conveyance to hospital in an ambulance. Figures to date are shown below and correspond with a rapid reduction in demand for services in line with the reducing number of cases. In the last week, it appears there has been a slight uptick in demand, which is possibly due to the relaxation of social distancing measures, but is too early to establish a trend.



- **Home visiting service for COVID patients:** The COVID Hub has also been providing in-hours COVID home visiting to those patients who have been clinically triaged and deemed as requiring a home visit.
- **COVID Testing** – in addition to facilities commissioned by central government, the CCG has commissioned its own COVID testing centre for key workers at the Hot Hub. This includes the antigen test (swabbing) and more recently rollout of the antibody test to establish if key workers in the health and care system have had COVID-19 in the past. This information is being fed upwards as part of a population study.
- **Care and nursing homes - t**he CCG has been working closely with the council and with the Enhanced Care Home Support team to provide an enhanced level of care to care homes during the pandemic. The Enhanced Care Home Team has been undertaking regular ward rounds, with daily calls to all care homes and fortnightly to all residential homes in Brent. This may take the form of a discussion (which may be by telephone or video call) with

the care home manager to discuss whether they have any concerns regarding clinical care and support for their residents. The service also offers general co-ordination support and liaison with the relevant GP practice or community service. The local authority has been offering close management support for care homes where staff members have become ill. The CCG has put in place a testing programme for care homes, with regular proactive COVID screening to ensure that asymptomatic carriers are identified and asked to self-isolate.

- **Weekly bulletins and twice weekly Silver Command meetings** - the CCG has established a weekly bulletin and twice weekly silver command meetings with Primary Care Network directors to understand the issues of general practice and to assist with matters such as ordering Personal Protective Equipment, and updates on availability of services in the acute sector.
- **Redeployment of Staff** - a number of CCG staff have been redeployed across the sector, mainly to acute providers. Several staff were redeployed into clinical roles in the Nightingale hospital at the Excel Centre and to rehabilitation units near Heathrow airport. Josefa Baylon (Head of Urgent Care) became the site manager for the Nightingale Hospital. Some staff were redeployed to the COVID incident centre at Marylebone Road.

6. Next Steps

6.1 Recommendations from the National Report: 'Beyond the Data'

Recommendations from the PHE report 'Beyond the Data: Understanding the Impact of COVID-19 on BAME communities':

6.1.1. Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.

6.1.2. Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.

6.1.3. Improve access, experiences and outcomes of NHS, local government and Integrated Care Systems commissioned services by BAME communities including: regular equity audits; use of Health Impact Assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.

6.1.4. Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of

COVID-19, especially for key workers working with a large cross section of the general public or in contact with those infected with COVID-19.

6.1.5. Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.

6.1.6. Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.

6.1.7. Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

6.2 Brent Specific Suggestions

6.2.1 Short Term Brent Specific Actions based on our findings:

Actions	By Who	By When
Data: • Mandate ethnicity data collection in all aspects of NHS and Social Care interaction both Covid-19 related and otherwise including testing and contact tracing interventions • Regular reporting to all partners in the health care system	London North West Acute Trust Council Performance Team	1 month End of data collection
Co-Morbid Conditions and Diabetes • Improve Diabetes Control in all patients with particular reference to BAME. This could be effected by monitoring HBA1C of all patients not measured recently or with poor control using disease registers and a digital recall system • Diabetes awareness in BAME communities in Brent via outreach • Diabetes testing in BAME communities in Brent via outreach or self-testing	Brent CCG Brent Public Health Brent CCG	3 weeks 4 weeks 4 weeks

Actions	By Who	By When
Co-Morbid Conditions • We will need to accelerate the work that we have started regarding long-term conditions as we know that these increase the risk factors for a poor outcome following COVID-19 infections – for example diabetes, hypertension, high cholesterol, heart conditions and asthma are all co-morbidities that affect COVID-related outcomes. We will need to put a greater emphasis on prevention and lifestyle, working hand in hand with the Public Health Department	Brent CCG	
Covid Testing • For the time being, the Hot Hub will remain in place, albeit at reduced capacity, so that it is ready for any second wave or resurgence in cases • Services are being reconfigured across the STP area to ensure that testing takes place in healthcare facilities prior to elective surgery and that people are encouraged to "talk before you walk", in order to screen out any potential COVID symptoms before people pitch up at a healthcare facility. High risk, potentially COVID patients are being segregated from lower risk non-COVID pathways.	Brent CCG Brent CCG	
BAME Engagement • Improve access of BAME communities to primary care including registration campaign to improve awareness of non-face to face options for service • Improve access of registering of all homeless improve awareness of non-face to face options for service in BAME communities to primary care including • CCG communications team will work closely with the local authority communications team to emphasise the importance of accessing services *early* if Brent residents or workers have symptoms. We will need to promote the availability of testing and the fact that hospitals do have enough capacity to see patients. The communications teams also need to promote messages on social distancing and reducing risks.	Brent CCG Brent CCG Brent CCG Brent Council	3 weeks 3 weeks

Actions	By Who	By When
Health Literacy • Targeted Health literacy campaign in BAME communities in culturally appropriate forms considering the underlying health belief models and behaviours across faith and ethnic groups • Covid-19 communications media campaign with NHS and Council communications working together including GP communications • LNWT Campaign with BAME communities to let communities know the Trust is open and safe to attend • Use current and recently generated insights by community groups and the system to tailor further responses	Brent Council Brent Council CCG LNWT Brent Public Health	4 weeks 4 weeks 4 weeks 4 weeks
Occupational Health • Support other organisations in the borough with frontline workers in ensuring risk assessments for BAME and all other workers with regard to managing the risk of Covid-19 • We have been putting in place risk assessments for all of our healthcare staff across the NWL STP area, which includes BAME risk factors, age and co-morbidities and ensures that the highest risk staff are kept away from the high risk environments	Brent Public Health Brent CCG	4 weeks

6.3 Mitigation Measures

The evidence suggests COVID-19 is largely a manifestation of underlying health inequalities and socioeconomic deprivation. As a result, the solutions to it lie with addressing these two issues. There are also some issues related to the system response such as ethnicity monitoring, increasing health literacy and long-term condition management, which are again not Covid-19 specific issues but reflect underlying inequalities.

7. Process for developing the medium and long-term actions

1. Bring Health and Social Care closer together to address health inequalities:
    - Health in All Policies programme including health impact assessment for Council programmes and projects
    - Jointly funded and commissioned projects and work streams
2. Long- term conditions community health promotion programmes to be commissioned to
    - Promote self-care
    - Develop Stonebridge/Harlesden Intervention:

Bridge Park Health Living Centre

The Healthy Living Centre aims to address underlying social determinants which are contributing to poor health such as social isolation, exercise and community cohesion. The key to Healthy Living Centres are working with the community and using established services the council and other providers have to target the neediest communities.

PH Led Recovery College

The aim of the PH Led Recovery College is to help build support systems, provide confidence with integrating back into the community and strive to remove the stigma associated with mental and physical health.

The offer of courses/training programmes that will encourage residents to be active in their own self-care and wellbeing, learn how to counteract and manage their conditions, and, equip themselves with the tools to live a happy and fulfilling life. The college will follow an educational model that seeks to give people the tools and skills to become architects of their own recovery or to support someone else with their journey.

3. Monitoring and reporting of ratios of BAME staff representation at all levels of Council and Trust as large BME employers in the borough at all levels including senior management. Include plans to address the disparity such as targeted fast track programmes
4. Health Equity Audits, including BAME and deprivation measures, to be mainstreamed throughout the health and social care system.
5. Assess the health impacts of Covid-19 on the community
6. The conversion of the Central Middlesex Hospital site into Diabetes and Long Term Conditions open access centre for Harlesden, Stonebridge and the surrounding area

    The NHS and the council will commission a piece of work around health inequalities manifested by Covid-19 and the underlying structural determinants.

    This will be will be reported back to the Health and Wellbeing Board with an Action Plan.

Report sign off:

Phil Porter

Strategic Director Community Wellbeing

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Brent / NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 29 June 2020
	Report of the Director of Public Health

Brent COVID 19 Management Plan

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	12 – A. PHE London Coronavirus Response Centre and London Local Authorities for supporting the management of COVID-19 incidents and outbreaks, including those in complex settings B. Resident journey through Test and Trace C. Brent outbreak plan for care homes D. Brent outbreak plan for schools E. Brent outbreak plan for early years settings F. Brent outbreak plan for rough sleepers and hostels: under development, to be agreed with PHE: **to follow** G. Brent outbreak plan for transport hubs: under development, to be agreed with PHE: **to follow** H. Brent outbreak plan for places of worship: under development, to be agreed with PHE: **to follow** I. Brent outbreak plan for workplaces J. Brent COVID 19 communications strategy
Background Papers:	Nil
Contact Officer(s):	Melanie Smith Director for Public Health, Brent Council melanie.smith@brent.gov.uk 020 8937 6227

1.0 Purpose of the Report

1.1 This paper with the accompanying appendices forms the Brent COVID 19 Outbreak Control Plan. The paper is structured according to the seven themes specified in national guidance.

2.0 Recommendation(s)

2.1 The Health and Wellbeing Board is asked to review and note the Brent COVID 19 Outbreak Control Plan. As the Plan covers prevention as well as control measures, it will be termed the Brent COVID 19 Management Plan.

3.0 Detail

3.1 Following the initial wave of COVID 19 in England and the easing of the national lockdown, Test and Trace is central to the government's COVID 19 recovery strategy. This strategy requires local government to develop local outbreak control plans, centring on seven themes:

1. Care homes and schools

2. High risk places, locations and communities

3. Local testing capacity

4. Contact tracing in complex setting

5. Data integration

6. Vulnerable people

7. Local Boards

3.2 Contact tracing is a well-established means of controlling the spread of infectious diseases. In response to COVID 19, contact tracing is required at a new scale. The effectiveness of test and trace as a control measure depends on easily accessible testing at scale with results available rapidly. It also critically relies on people's ability and willingness to self-isolate for 7 days, if they have symptoms, and for 14 days, if they have been in contact with a case of COVID 19. As we will not know who is or is not immune, there is a real possibility that people will be asked to quarantine more than once.

3.3 On Thursday 28th May the UK government launched NHS Test and Trace. This relies upon an online web-based tool (Contact Tracing Advisory Service, CTAS) which is used by both contact tracing professionals and members of the public to input information about cases and contacts, plus a workforce of call handlers and health professionals who will carry out phone-based contact tracing for individuals who are unable or do not want to access digital technologies. Approximately 25,000 individuals have been recruited to the national programme.

3.4 The contact tracing app, which is designed to support Test and Trace by identifying contacts in public spaces who may not be known to the case, is not yet available

3.5 The more complex case management and contact tracing will be the responsibility of Public Health England (PHE). In London this will be undertaken by the London Coronavirus Response Cell (LCRC). LCRC has been leading

the London PHE response to COVID 19 since February. The interface between local government and Test and Trace will be through LCRC.

3.6 "Complexity" may result from a particularly vulnerable individual, for example, a rough sleeper, or a setting, such a school or care home, or reflect a number of cases with a possible link to a setting, for example, a workplace, or geography which need investigation by PHE to determine whether there is a local outbreak.

3.7 In London, PHE and APDH London have worked to define and agree the respective roles of LCRC and local government. These are described in section 7 and in Appendix A.

3.8 Appendix B shows how people move through the NHS Test and Trace service.

4.0 Care homes and schools

4.1 Within their Outbreak Control Plans, Councils are required to plan for outbreaks in care homes and in schools. As Brent has, unfortunately, seen a number of outbreaks in care homes, the local arrangements for responding to these and supporting homes have been in place since the beginning of April with joint working between ASC, public health and the CCG. The prevention of care home outbreaks was identified as a priority early in the pandemic. ASC working with public health proactively supported care homes with the provision of PPE and infection prevention training. The CCG mobilised clinical support to homes. Daily calls continue to be made to all care homes to monitor the situation.

4.2 Since the launch of Test and Trace, one care home incident in Brent has been detected, indicating that the system is able to detect care homes outbreaks (although this incident was in fact a continuation of an earlier incident, which was known to the Council). An Incident Management Meeting was convened by PHE with ASC, public health, primary care, infection control colleagues as well as the home. The agreed action plan has been completed and ongoing monitoring is in place. The Brent Care Home Outbreak Plan forms Appendix C.

4.3 The vast majority of schools and a number of early years settings have remained open for the children of key workers and vulnerable children throughout the duration of the pandemic. Further to the government announcement on 28 May that all of the government's five tests for the wider opening of schools have been met, Brent schools have been able to open more widely with small numbers of pupils in specified year groups. The Strategic Director Children and Young People advised and supported schools to form geographic clusters from the start of the pandemic, an arrangement which has supported resilience in the sector and facilitated the sharing of good practice. Regular webinars for early years providers, headteachers and Chairs of Governors with the Strategic Director have allowed timely, two way communication and the provision of tailored advice. The Director of Public Health (DPH) has joined these webinars as necessary to provide public health advice. Regular meetings have taken place between the teaching unions and senior officers.

4.4 In preparation for the government's requested wider opening from 1st June, schools have updated their arrangements and plans. Public health and CYP have supported both early years settings and schools with infection prevention training which has been accessed by over 870 members of staff. Supplementary PPE has also been provided to early years settings and schools in line with government guidelines. CYP have also coordinated the procurement of signage on behalf of schools in preparation for wider opening. The Operational Director, Safeguarding, Partnerships and Strategy, with Brent health and safety advisors, has also reviewed risk assessments from community schools.

4.5 The Brent Schools Outbreak Plan forms Appendix D, the Early Years settings plan is Appendix E.

5.0 High risk places, locations and communities

5.1 In addition to care homes, settings and schools, other locations or communities may be particularly vulnerable to an outbreak of COVID 19. For example, a neighbouring borough has had a case of COVID 19 in a hostel for homeless people with problematic substance use. Contact tracing in this instance was particularly challenging as a number of residents had left the hostel and dispersed across London. An Incident Management Meeting was convened by PHE involving public health teams from 5 Boroughs. The Find and Treat Service visited the hostel to test staff and residents and with PHE provided advice on infection prevention and cohorting (keeping groups with similar exposures, in this case use of a shared kitchen and bathroom, together and separate from other groups). Find and Treat also provided outreach to street drinking contacts. As a result of learning from this incident, the Outbreak Plan for Hostels and Rough Sleepers is being revised with PHE and Find and Treat.

5.2 A number of London Boroughs (Camden, Barnet, Newham and Hackney) are part of a national Good Practice Network designed to disseminate learning. Each borough has a lead area(s). Camden have convened thinking on outbreaks associated with Transport Hubs and Barnet are leading on outbreaks associated with Places of Worship. Standard Operating Plans for these settings are under development with PHE.

5.3 Outside London a number of outbreaks have occurred associated with food preparation plants. In Brent Regulatory Services have already contacted all the food manufacturers and large warehouse and distribution centres to confirm COVID 19 safe working practices and social distancing amongst employees are in place. However, investigation of thee outbreaks suggests that employees sharing HMO accommodation and traveling to and from work together may have allowed transmission. Accordingly, Regulatory Services will work with Private Housing Services to ensure appropriate advice is provided to employees and employers on transmission outside the workplace. The Brent Workplace Outbreak Plan is being reviewed to take account of learning from these outbreaks in food processing plants.

6.0 Local testing capacity

6.1 Easy access to testing with rapid notification of results is essential for contract tracing to be effective as a control measures. There are a number of routes to testing locally.

6.2 Residents with symptoms suggestive of COVID 19 can ask for a test at www.nhs.uk/coronavirus or by calling 119. Testing should be done within 5 days of the onset of symptoms. There are options for home or drive through testing. Home testing has the advantage of not requiring symptomatic residents to leave their home. However, capacity is limited and tests do "sell out" each day. Drive through testing is available at fixed regional or mobile sites. The "local" regional testing site is now at Heathrow. A mobile unit has been visiting the care park at Willesden Sports Centre on Tuesdays and Wednesdays. This unit has proved one of the busiest in London. In preparation for the Sports Centre re-opening in July a new site is being secured.

6.3 Testing is available for children and adults. Children aged 11 and under need to have their swabs taken by their parent or guardian.

6.4 Care home residents and staff can access testing via the national portal, homes can request this themselves or the council can put forward homes for prioritisation.

6.5 The CCG provide a walk in testing centre at Willesden Centre for Health and Care. Initially for key workers, this now provides testing for those who are unable to take their own swabs.

6.6 Brent has seen higher death rates in areas of increased deprivation, overcrowding and with larger BAME communities, reflecting both increased exposures and increased susceptibilities. A pilot community testing site has therefore been located in Harlesden.

6.7 The above tests are all for antigen testing i.e. they test whether someone has the virus *at the time of the test*. Test and trace relies upon this to determine whether an individual or their contacts need to self-isolate and for how long.

6.8 A PHE approved antibody test exists. However, at present antibody testing is not helpful as a population control measure (although there may be a considerable demand for antibody testing should it become more widely available). The presence of antibodies simply shows that an individual has had the virus. It does not indicate immunity (the antibodies may not "neutralise" the virus and antibody levels may decline over time, so re-infection and infectivity may occur even in someone with a positive antibody test). Furthermore, at this time the antibody test requires a whole blood sample and the availability of phlebotomy is a limiting factor.

6.9 In the event of an outbreak centred on a local area, a workplace, a place of worship or similar, mobile "pop up" testing could be helpful in targeting testing. Work is underway between APDH and LCRC to agree a prioritisation framework for mobilising "pop up" testing and with DHSC on operationalising the arrangements for this.

7.0 Contact tracing in complex settings

7.1 The Director of Public Health, Consultants in Public Health and the council EHOs routinely cooperate with PHE on the investigation and management of local outbreaks. These arrangements and relationships will form the basis for contact tracing in complex situations for COVID 19.

7.2 During COVID 19, PHE in London has established the LCRC which has brought together the three sub regional Health Protection teams. Capacity in the health protection function in PHE London has been more than doubled by redeployment of staff within PHE London and recruitment of an additional cohort of public health and EHOs returning to practice.

7.3 The respective responsibilities of LCRC and local authorities have been agreed between PHE and ADPH London. The overarching approach to managing **complex settings and outbreaks** is as follows:

- LCRC will receive notification from NHS Test and Trace, undertake a risk assessment and give advice and provide information to the setting on management of the outbreak;
- LCRC will manage cases and contacts, and provide advice on testing and infection control;
- LCRC will convene an Incident Management Team (IMT) if required;
- LCRC will inform the relevant local authority SPoC;
- The local authority will follow-up and support the setting to continue to operate whilst managing the outbreak, including, if required, support with infection prevention and control measures and PPE access;
- The local authority will support wider aspects of the response, such as support for any vulnerable contacts who are required to self-isolate

The overarching joint approach to managing **community clusters** will be as follows:

- The local authority or LCRC will receive notification from Tier 2
- The local authority will inform the LCRC SPoC/LCRC will inform the local authority SPoC
- The local authority will convene an IMT
- The local authority will provide support to the community
- LCRC will support the local authority in their risk assessment of and response to an identified community cluster

These arrangements are described in more detail in Appendix A of this paper - PHE London Coronavirus Response Centre and London Local Authorities for supporting the management of COVID-19 incidents and outbreaks, including those in complex settings.

7.4 The COVID Health Protection Board (see 11.1) has identified in Brent those setting and scenarios which require more detailed descriptions of roles and

responsibilities and the development of setting specific Standard Operating Procedures (SOPs). To each of these settings, a Consultant in Public Health (CPH) has been allocated along with a service lead to work together to localise the London SOPs:

- Care Homes: Marie McLoughlin (CPH, CWB) and Andrew Davies (Head of Commissioning, Contracting and Market Management ASC). SOP - Appendix C
- Schools: Marie McLoughlin and Jen Haskew (School Effectiveness Lead Professional, CYP) SOP - Appendix D
- Early years: Marie McLoughlin and Sasi Srinivasan (Early Years Manager) SOP - Appendix E
- Rough sleepers and hostels: John Licorish (CPH, CWB) and Coco Khan (Single Homelessness Service Manager, CWB) SOP - Appendix F
- Transport Hubs: John Licorish and Tim Martin (Transportation Planning Manager, R&E) SOP - Appendix G
- Places of Worship: John Licorish and Anne Kittappa (Senior Policy Officer) SOP - Appendix H
- Workplaces: John Licorish and Shamsul Islam (Senior Regulatory Service Manager, R&E) SOP - Appendix I

7.5 While PHE has increased its capacity by redeployment of staff within PHE and a national recruitment campaign, the demands upon individual London authorities are likely to be less predictable. The established mutual aid arrangements for public health may need to be invoked. In the first instance, this will operate across NWL.

7.6 “Local lockdowns” have been suggested as a possible control measure in the local authority response to COVID 19. However, to date no new powers have been conferred upon Councils to order local lockdowns though central Government could introduce legislation on a temporary basis regulations which could introduce local lockdowns for limited areas. This is not necessarily a problem as control measures based on transparency, communication and consensus are much to be preferred being proportionate and likely to be more effective than attempts to enforce behaviour change.

7.7 The council’s local and targeted communication form an important part of our COVID 19 management plan. As the Covid 19 lockdown continues to loosen across the UK, Brent specific messages – which are clearer and harder hitting than the national messages – are needed to help local communities fully understand the continued health risks and protect themselves and others against the virus. The council is focusing on messages such as:

- Brent has one of the highest Covid death tolls: Stay 2 metres apart
- Don’t bring the virus home to a loved one: limit contact with others
- Protect yourself and others: Get tested today if you have symptoms

The corporate comms team is continuing to share these kind of messages through various print, digital and broadcast channels and are also working closely with community, faith and mutual aid groups, to target harder to reach audiences. The comms team is also working closely with London Councils to

help develop the pan-London approach to Test and Trace comms. A core script for Test and Trace, written in simple language, is being developed as part of a communications toolkit which all London boroughs can use and adapt for local circumstances. The comms materials are being tested with audiences and will reflect London's diversity. The core aim of the pan-London Test and Trace comms is to supplement the national campaign and raise awareness of NHS Test & Trace and build trust and engagement with contact the tracing system.

8.0 Data integration

8.1 At the time of writing, the Council is receiving data daily on individual cases' age and postcode of residence. These are being mapped to look for patterns. However, this data is insufficient to allow detection of outbreaks which are not associated with place of residence for example workplaces. We are therefore reliant on NHS Test and Trace and PHE to detect potential linked cases. Representation has been made to PHE on the data fields we would wish to receive in order to allow us to use local knowledge to detect potential outbreaks.

9.0 Vulnerable people

9.1 When NHS Test and Trace advises cases and their contacts to self-isolate, the scripts also ask if people will require assistance to do so and, if so, whether their personal details may be passed to the local authority. To date no Brent cases or contacts have been passed to the Council for assistance. The response will be based upon the systems that the Council has put in place to respond to the shielded, using the same data flows, staff, scripts and signposting to mutual aid groups or the community hubs.

9.2 While the council's systems to respond to vulnerable or isolated residents who are asked to shield are well established, there are likely to be other groups of residents who will find it difficult to self-isolate, for example, due to insecure housing or employment. It is unclear what the expectations of the council may be in these situations in the absence of new duties.

9.3 To book a test with NHS Test and Trace requires an email address or phone number since the system uses text messages, email or phone to instruct cases how to share details of contacts and places visited. Recognising that this would exclude some residents, the council has worked with DHSC to pilot the first community testing site in London. Situated in Harlesden, booking is currently via a dedicated phone line (020 8937 4440). This is staffed by council Customer Access staff who have been making calls to the shielded. As well as booking residents a test (currently either the same or following day), staff follow an established triage script to explore whether residents need support with for example debt, housing, or accessing health services. If residents identify support needs and consent their details are passed to Council staff who usually work in our Community Hubs. The Hubs team call the resident back and offer their usual tailored support and onward referral, albeit remotely. Primary care, sexual health and substance misuse services have all been "stood up" ready to take referrals via the Hubs team.

10.0 Local Boards

10.1 The existing council contact tracing working group has widened its membership to include the CCG and PHE and as the COVID 19 Health Protection Board has overseen the development of the Outbreak Control Plan. The Board reports into Gold. The Health and Wellbeing Board will act as the local member-led Outbreak Engagement Board which will provide public facing engagement and communication

11.0 Performance of Test and Trace

11.1 Data has been published on the numbers and percentages of cases who were reached by Test and Trace and asked to provide details of their contacts. From 28th May to 10th June, 10,192 cases were reached and asked to provide details of their close contacts. This represented 72.6% of positive cases: 24.5 % of cases were not reached (3,435 people with a positive test) and 3% cases did not provide contact details (418 people).

11.2 These 10,192 cases provided details of 96,746 contacts of whom 90.6% were reached.

12.0 Financial Implications

12.1 The Government has identified £300m to support local authorities in England develop and implement their plans to control COVID 19. Allocations of this funding were made on the basis of the public health grant. Brent will receive £1,993,129 or £5.92 per capita.

12.2 It is disappointing that with robust and current measures of the differential impact of COVID 19 on communities, particularly older and more deprived and more diverse communities, national government used the historical identification of public health spending by Primary Care Trusts to distribute funding for outbreak control. This has resulted in Brent, which has the highest death rate in the England and Wales and the second highest number of cases in London, receiving significantly less funding than some neighbouring boroughs, which have been far less impacted by COVID19.

13.0 Legal Implications

13.1 PHE has responsibility for protecting the health of the population and providing an integrated approach to protecting public health through close working with the NHS, Local Authorities, emergency services and government agencies. This includes specialist advice and support related to management of outbreaks and incidents of infectious diseases.

13.2 Under the Care Act 2014, Local Authorities have responsibilities to safeguard adults in their areas. These responsibilities for adult social care include the provision of support and personal care (as opposed to treatment) to meet needs arising from illness, disability or old age.

13.3 Under the Health and Social Care Act 2012, Directors of Public Health in upper tier and unitary local authorities (which include Brent Council) have a duty to

prepare for and lead the local authority public health response to incidents that present a threat to the public's health.

13.4 Over and above their existing responsibilities as Category 1 responders under the Civil Contingencies Act 2004, pursuant to the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, upper tier and unitary local authorities are required to take certain steps to protect the health of their local population and in particular, they are required to provide information and advice with a view to promote the preparation of health protection arrangements by key health and care partners within the local area.

13.5 Medical practitioners have a statutory duty to notify suspected and confirmed cases of notifiable diseases to PHE under the Health Protection (Notification) Regulations 2010 and the Health Protection (Notification) Regulations 2020

14.0 Equality Implications

14.1 Current data provided to the Council from Test and Trace cases only includes age and residence. Given the disproportionate impact on people of black and Asian heritage there is an overwhelming argument for the introduction of ethnicity monitoring into CTAS.

15.0 Consultation with Ward Members and Stakeholders

15.1 The prevention of and response to outbreaks has been discussed with:

- Brent Multi-faith Forum
- VCS Theme Leads
- Head Teachers
- Care Homes Provider Network

Report sign off:

Phil Porter

Strategic Director Community Wellbeing

Appendix A

Joint Agreement between the PHE London Coronavirus Response Centre and London Local Authorities for supporting the management of COVID-19 incidents and outbreaks, including those in complex settings

Version: 5
Date: 27 May 2020
Review date: 30th June 2020

Overview

This joint agreement provides a framework for joint working between the PHE London Coronavirus Response Centre (LCRC) and the public health structures in London Local Authorities (LAs) for managing COVID-19 outbreaks, complex settings and community clusters.

This agreement will be kept under monthly review initially due to the rapidly changing regional situation and guidance, and fluctuating capacity across the system. This document is therefore intended to be flexible and adaptable for local operation due to the different support and capacity arrangements available in local systems in London.

Rationale for the joint agreement

- To have a joint collaborative and co-ordinated approach to supporting London settings including care homes, extra care housing and supported housing, local hospitals, workplaces, prisons, primary care settings, schools, nurseries and homeless hostels in managing COVID-19 outbreaks
- To improve understanding and access to services, reduce transmission, protect the vulnerable and prevent increased demand on healthcare services
- To share outbreak information to facilitate appropriate measures
- To have a Single Point of Contact (SPoC) in LCRC and in each local authority to facilitate data flow, communication and follow up
- To provide consistent advice to settings and local public health teams

Joint approach

The overarching joint approach to managing **complex settings and outbreaks** will be as follows:

- LCRC will receive notification from Tier 2, undertake a risk assessment and give advice and provide information to the setting on management of the outbreak;
- LCRC will manage cases and contacts, and provide advice on testing and infection control;

- LCRC will convene an Incident Management Team (IMT) if required;
- LCRC will inform the relevant local authority SPoC;
- The local authority will follow-up and support the setting to continue to operate whilst managing the outbreak, including, if required, support with infection prevention and control measures and PPE access;
- The local authority will support wider aspects of the response, such as support for any vulnerable contacts who are required to self-isolate, as per London's 6 Point Plan (Appendix 1) and national 7 themes of outbreak management plans (Appendix 2).

The overarching joint approach to managing **community clusters** will be as follows:

- The local authority or LCRC will receive notification from Tier 2
- The local authority will inform the LCRC SPoC/LCRC will inform the local authority SPoC
- The local authority will convene an IMT
- The local authority will provide support to the community
- LCRC will support the local authority in their risk assessment of and response to an identified community cluster

Appendix 3 provides further information on the joint approach by setting type.

Contact details for Single Point of Contact (SPoC)

SPoC for PHE LCRC is LCRC@phe.gov.uk

SPoC for Brent is TrackandTrace@brent,gov.uk

Appendix 1 – 6 Point Plan for Local Authority wider response (London CEO Task and Finish Group))

GO LIVE **Point 1: Core requirements**	**Point 2: Vulnerable groups**	**Point 3: Community and economic impact**	**Point 4: Local partnership response**	**Point 5: Connecting and engaging communities**	**Point 6: London regional resilience**
Establish a LA Contact Tracing Lead and WG	Identifying potentially vulnerable groups	Understanding local community and economic impact	Partnership engagement	Mitigating low take-up of the national model	Local and regional resilience
Focus on Outbreak Management	Understanding vulnerability	Community Impact Checklist	Joining-up local intelligence with partners	Understanding barriers to engagement	Potential voluntary secondment to LCRC
Establish a local Data Hub	Role of shielding and 'shielding plus' services	Workforce Impact Checklist	Developing joint-action plans with partners	Focus on vulnerable groups and personas	Mutual-aid arrangements
Workplaces and buildings				Baseline and enhanced communications	
Developing a toolkit: In addition to the six-point plan set out above a toolkit of practical guides, structures, role profiles, scripts, and best-practice examples is being developed for LA's to access, co-design and develop,					

Appendix 2 – Local Outbreak Control Plans themes (DHSC)

Local Outbreak Control Plans will centre on 7 themes

1. **Care homes and schools**
   Planning for local outbreaks in care homes and schools (e.g. defining monitoring arrangements, potential scenarios and planning the required response)

2. **High risk places, locations and communities**
   Identifying and planning how to manage high risk places, locations and communities of interest (e.g. defining preventative measures and outbreak management strategies)

3. **Local testing capacity**
   Identifying methods for local testing to ensure a swift response that is accessible to the entire population (e.g. defining how to prioritise and manage deployment, examples may include NHS, pop-up etc).

4. **Contact tracing in complex settings**
   Assessing local and regional contact tracing capability in complex settings (e.g. identifying specific local complex communities, developing assumptions to estimate demand and options to scale capacity)

5. **Data integration**
   Integrating national and local data and scenario planning through the Joint Biosecurity Centre Playbook (e.g., data management planning, including data security, NHS data linkages)

6. **Vulnerable people**
   Supporting vulnerable local people to get help to self-isolate (e.g. facilitating NHS and local support, identifying relevant community groups etc) and ensuring services meet the needs of diverse communities

7. **Local Boards**
   Establishing governance structures led by existing Covid-19 Health Protection Boards in conjunction with local NHS and supported by existing Gold command forums and a new member-led Board to communicate with the general public

Appendix 3 – Summarised roles by setting (LAs and LCRC)

	Setting						
	Care settings	**School and Early Years**	**Workplace**	**Primary care**	**Prison/custodial institutions**	**Homeless and/or hostel**	**Community cluster**
London Coronavirus Response Centre response	- Receive notification from Tier 2 - Gather information and undertake a risk assessment with the setting - Provide advice and manage cases and contacts, testing and infection control - Provide information materials to the setting - Recommend ongoing control measures - Convene IMT if required - Provide information to DsPH and advice/recommendations for ongoing support						- Receive notification from Tier 2 - Support Local Authority in their risk assessment of and response to an identified community cluster
Local authority response	- Prevention work and respond to enquiries (As per Appendix 1 and 2) - Support vulnerable contacts who are required to self isolate - Liaise with setting to provide ongoing advice and support for testing, communications, infection control and PPE - Participate in IMT if convened by LCRC - Local communications e.g. briefings for Cllrs, local press inquiries, comms with the public - Liaise with CCG, GPs and other healthcare providers to provide ongoing healthcare support to setting						- Receive notification from Tier 2 - Convene IMT - Provide support to community which may include translated materials, support to self-isolate, advice and enforcement - Liaise with the local CCG, GPs and other healthcare providers - Local communications (e.g. Cllr briefing, local press inquiries, comms with public)

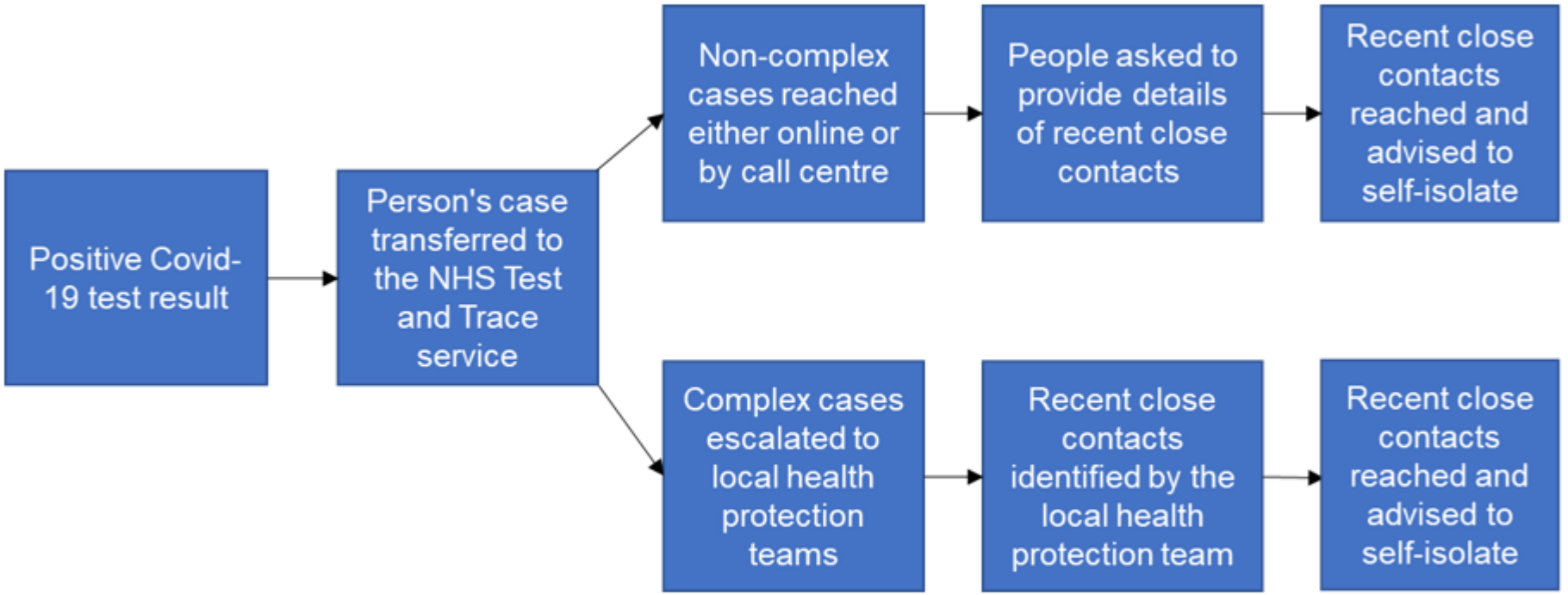
Appendix 4 – Governance and Key Guiding Principles

PHE will fulfil its statutory duty as outlined below by receiving the notification of outbreaks, undertaking the risk assessment and providing public health advice in accordance with national guidance or local SOPs.

As per this joint agreement and in line with the statutory roles outlined below, local authorities and PHE will conduct follow up of these settings and fulfil their statutory duty for safeguarding and protecting the health of their population.

- PHE has responsibility for protecting the health of the population and providing an integrated approach to protecting public health through close working with the NHS, Local Authorities, emergency services and government agencies. This includes specialist advice and support related to management of outbreaks and incidents of infectious diseases
- The health system has a shared responsibility for the management of outbreaks of COVID-19 in London
- Infection control support for each setting will be provided in line with local arrangements
- Under the Care Act 2014, Local Authorities have responsibilities to safeguard adults in their areas. These responsibilities for adult social care include the provision of support and personal care (as opposed to treatment) to meet needs arising from illness, disability or old age
- Under the Health and Social Care Act 2012, Directors of Public Health in upper tier and unitary local authorities have a duty to prepare for and lead the local authority public health response to incidents that present a threat to the public's health
- Medical practitioners have a statutory duty to notify suspected and confirmed cases of notifiable diseases to PHE under the Health Protection (Notification) Regulations 2010 and the Health Protection (Notification) Regulations 2020

Appendix B – Resident journey through Test and Trace



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Appendix C - Brent Outbreak Plan for Care Homes

15/06/20

	Summary actions
The Local Authority model: core requirements and structures	**Core requirements for engaging/co-ordinating with Care Homes:** • A complete list of Care Homes with contact details to be available. • ASC to develop a Single Point of Contact (SPoC) for each care homes – this should be through the PRO who is attached to each home
Symptoms of Covid-19 in a staff member	• Manager on a daily basis to inform the PRO of any changes that are occurring in the home • If a staff member is showing symptoms of Covid 19 they must be sent home immediately to self-isolate for 7 days. • Staff member to organise a test • If test is negative staff member to return to work when feeling better • If test is positive, staff colleagues should not need to self-isolate as social distancing should have been adhered to and PPE worn by the staff members if 2 metres cannot be followed. • If social distancing hasn't been observed, or PPE not worn appropriately, all members of staff that have come into contact with positive staff member need to self-isolate for 14 days and not come into work.
Symptoms of Covid-19 in a resident	• Manager of the home to email LCRC if a resident has symptoms of Covid 19. • Test kits to be sent to the home for the resident to be tested • Resident to be isolated. • If test is positive, LCRC (Level 2) will contact the home with advice initially.
Households of symptomatic staff	• Household of staff with symptoms should stay at home and self-isolate for 14 days • If the staff member test is negative, the household members can end their self-isolation • If household members develop symptoms they must arrange a test for themselves
Supporting and protecting	• Consider specific residents who may need additional support as a result of being asked to self-isolate.

vulnerable groups	• Ensure staff are wearing the appropriate PPE equipment
Prevention work and respond to enquiries	• Public health team to support care homes with preventive work • SPoC to respond to any queries from Care Homes • Ensure risk assessments are reviewed where relevant
Access to PPE	• Council to supply PPE to care homes (this is under review and may not continue indefinitely) • Care homes to continue to order their open supply of PPE. • If Care home has a shortage of PPE contact the National supply line • If Care home is unable to obtain PPE – contact the LA who will speak with the NWL Alliance group
Leading the local partnership response	• LCRC will convene Local IMT if required with support from Public Health • Public Health to liaise with the local CCG/ GP and other health providers
Infection control follow up together with CCG named person	• Public Health to provide further infection control training if required • Public health to liaise with LCRC if the outbreak becomes complex. • Consider mitigating the risk of individuals refusing to be tested • CCG to identify a named
Governance	
Local communications e.g. briefings for Cllrs, local press	• Agreement for press release and briefings to be decided at IMT meeting

Appendix D - Brent Outbreak Plan for School setting

	Summary actions
The Local Authority model: core requirements and structures	**Core requirements for engaging/co-ordinating with School settings:** • A complete list of schools in Brent with contact details to be available. • CYP department to provide a Single Point of Contact (SPoC) for schools
Symptoms of Covid-19 in a staff member of pupil	• If a child/staff member is showing symptoms of Covid 19 they must be sent home immediately. • The child should be isolated from the rest of the bubble where possible • PPE must be worn by any staff member supporting a child waiting to go home, if 2 metres cannot be adhered too, prior to the parent collecting the child. • The school should inform the parent to have the child tested via the portal or by calling 111 if they don't have access to the internet. • The remaining pupils and staff members in the bubble don't need to self-isolate, they can stay in school • LCRC (Level 2) will contact the school with advice initially and will carry out a risk assessment.
Positive test in staff or pupil	• If a child/staff member is tested *positive,* schools need to notify LCRC and the SPoC • All pupils and staff in that bubble need to be sent home immediately. • LCRC (Level 2) will contact the setting with advice initially, but eventually this will only be when there is 2 or more positive cases. • Swabs to be sent to pupils and staff members at home. • LCRC will contact the school with the results
Household contacts of staff or pupils test positive	• Household members to stay at home and self-isolate for 14 days • If symptoms develop to contact the portal or 111 for a test.
Supporting and protecting vulnerable groups	• Consider specific residents who may need additional support as a result of being asked to self-isolate. • Shielding team from LA to contact those who are self-isolating to establish if they need any assistance
Prevention work and	• Public health team to support schools with preventive work • SPoC to respond to any queries from schools • Ensure risk assessments are reviewed where relevant

response to enquiries	
Liaison with schools and support with communication to parents	• CYP department to liaise with specific schools as appropriate • CYP department to notify schools more widely through the headteachers bulletin. • CYP department to support communication with parents which will be in the first instance through their child's school
Leading the local partnership response	• LCRC to Convene Local IMT if required with support from Public Health • Public Health to liaise with the local CCG/ GP and other health providers
Infection control follow up	• Public Health to provide further infection control training if required • Public health to liaise with LCRC if the outbreak becomes complex. • Consider mitigating the risk of individuals refusing to be tested

Appendix E - Brent Outbreak Plan for Early Years settings

	Summary actions
The Local Authority model: core requirements and structures	**Core requirements for engaging/co-ordinating with the early years settings:** • A complete list of early years settings with names and contact details to be available. • CYP department to provide a Single Point of Contact (SPoC) for settings
Symptoms of Covid-19 in a staff member or child	• If a child/staff member is showing symptoms of Covid 19 they must be sent home immediately. • The child should be separated from the rest of the bubble • PPE must be worn by any staff member supporting a child waiting to go home, if 2 metres cannot be adhered too, prior to the parent collecting the child. • The setting should inform the parent to have the child tested via the portal or by calling 111 if they don't have access to the internet. • The remaining children and staff in the bubble don't need to self-isolate, they can stay in the setting. • LCRC (Level 2) will contact the setting with advice initially and will carry out a risk assessment.
Positive test in staff or child	• If a child/staff member is tested *positive,* settings need to notify LCRC and the SPoC • All children and staff in that bubble need to be sent home immediately. • LCRC (Level 2) will contact the setting with advice initially, but eventually this will only be when there is 2 or more positive cases. • Swabs to be sent to children and staff members at home. • LCRC will contact the early years setting with the results
Household contacts of staff or child test positive	• Household members to stay at home and self-isolate for 14 days • If symptoms develop to contact the portal or 111 for a test.
Supporting and protecting vulnerable groups	• Consider specific residents who may need additional support as a result of being asked to self-isolate. • Shielding team from LA to contact those who are self-isolating to establish if they need any assistance
Prevention work and	• Public health team to support settings with preventive work • SPoC to respond to any queries from settings • Ensure risk assessments are reviewed where relevant

respond to enquiries	
Liaison with settings and support with communication to parents	• CYP department to liaise with specific settings as appropriate • CYP department to notify settings more widely through electronic updates • CYP department to support communication with parents which will be in the first instance through their child's setting
Leading the local partnership response	• LCRC to Convene Local IMT if required with support from Public Health • Public Health to liaise with the local CCG/ GP and other health providers
Infection control follow up	• Public Health to provide further infection control training if required • Public health to liaise with LCRC if the outbreak becomes complex. • Consider mitigating the risk of individuals refusing to be tested
Governance	

Brent Outbreak Plan for Workplaces

24/06/20

	Summary actions

Prevention	• LA communication
	  ○ of government regulations and advice to Food businesses, Licensed premises, Businesses, High Streets: Regeneration and Environment
	  ○ of public health advice (social distancing, testing, self isolation) to employees: Communications
	• LA inspection of food premises, enforcement if needed
	• Workplaces: adopt COVID secure working practices

Core requirements and structures	**Core requirements for responding to a COVID 19 incident associated with a workplace:** • Currently, the local authority is dependent on PHE or a workplace notifying it of a possible outbreak

Two or more positive cases in a workplace within 2 weeks of each other	• Risk assess workplace LCRC / LA:
	  ○ Contacts of positive cases self isolating?
	  ○ Other symptomatic employees?
	  ○ COVID 19 secure workpractices?
	  ○ Contact with the public?
	  ○ Staff contact outside the workplace (travel / accommodation)
	• Public facing workplace / additional cases: convene Incident Management Team

IMT	**Membership:** • PHE (convene and chair) • LA public health • Regulatory services • Business support / town centre manager if appropriate • CCG / Acute Trust if admissions associated with the workplace • LA Communications • Representative of the workplace with decision making authority **To consider:** • Changes to working practices needed? • Indications for closure of the workplace?

	• Further testing? How – home tests / tests kits sent to workplace / staff booked by employer into existing test site / mobile unit? • Communication to workforce • Communication to customers, if appropriate? • Communication to the public? • Monitoring mechanisms
Post incident	IMT to consider lessons learnt and adapt outbreak plan for workplaces as necessary

Appendix L - Brent COVID 19 communications strategy

Brent Council

Coronavirus (COVID-19) Recovery Communications Plan

For internal use only

Lead Officer	Carolyn Downs	Communications Leads	Rob Mansfield/Shazia Hussain
Lead Member	Cllr Muhammed Butt	Version Number	V1
Status	Draft	Last updated	01/06/2020

Contents

1. Introduction:

The World Health Organisation confirmed that COVID-19 was a global pandemic on January 13, 2020. By March 26, the UK was officially locked down and life changed dramatically overnight. Brent Council's strategic response to ensure local residents and businesses were protected was supported by a detailed communications plan to inform our communities. This communications plan worked well, during the initial response period, but now needs to be evolved as the situation moves from response to recovery.

The Government strategy has now moved from a total countrywide lockdown to a looser, more targeted version of lockdown – which is based around a Track and Trace system to lock down individuals or groups of individuals when required rather than locking down all of society. This is a more complicated phase from a communications perspective as simple messaging such as 'stay at home' is not now appropriate.

It is also cannot be known how the "R" rate may change following the Government's loosening of the lockdown. Brent is one of the hardest hit places in the UK – currently 2nd only to Newham as the most affected borough in London. Now that more is known about the virus, it is believed that there is a link between higher death rates and a number of factors. These include: the diverse population of Brent (with evidence now showing some BAME people are 4 times more likely to die from Covid than other sections of the population); poverty and inequality (e.g. multi-generational households, HMOs, jobs where you need to be physically present and a greater reliance on public transport).

As the lockdown is loosened, Brent Council will need to ensure that local communities fully understand the health risks and how they can continue to protect themselves and others against the virus.

2. Objectives

Given that Brent is the most diverse borough in Europe and one of the poorest areas in London, our main communications objective is to inform people in Brent, who are some of the most at risk in the country, about the actions they can take to protect themselves and others and in doing so minimise the spread of Covid 19 as lockdown restrictions are loosened.

A secondary objective will be to support the relevant objectives of the broader London-wide and nation-wide communication strategies by sharing relevant information through our channels.

3. Audiences

The next phase of communication is relevant to everyone who lives or works in Brent but there are also some specific audiences who are more at risk for which the next phase of communications is particularly relevant. Therefore the key audiences we will try to reach in this phase are:

- People who are more at risk (see table below) including BAME residents
- Older people and people with underlying conditions
- People who are asked to self-isolate due to the new 'track and trace' system
- Younger people who may think the rules don't apply to them but could be spreaders in their homes or communities
- Council staff and Members (including staff who are working from home and others that need to come into the office)

The table below sets out a list of suggested audiences to target during this campaign to ensure messaging is clearly understood by all sectors of the community:

Audience	Ways to target	Responsibility
Somali	Engagement with Brent Somali Community Centre: • Initial letter/meeting of introduction Targeted communications in own language	Sarah Whyte + Duval Akonor
Urdu	Engagement with Pakistan Community Centre (Pakistan Welfare Association): • Initial letter/meeting of introduction • Targeted communications in English & Urdu	Sarah Whyte + Duval Akonor
Hindi	Engagement with Brent Indian Association – The Brent Carers Centre:	Sarah Whyte + Duval Akonor

	• Initial letter/meeting of introduction • Targeted communications in English & Hindi	
Afro-Caribbean	ACPO, Brent: • Initial letter/meeting of introduction • Targeted communications	Sarah Whyte + Duval Akonor
Older people in general (particularly those on the Gov's shielded lists which we now have the data for)	General messaging about social distancing and health: • Your Brent • Radio, Print, TV • On-line • Work with Age UK to target messaging	Sarah Whyte + Duval Akonor
Young (16 – 35) & (35 plus)	General messaging about social distancing and spreading the virus: • Social Media (Facebook, Twitter, Instagram, Tik Tok) • Podcasts • Young Brent Foundation	Chris Murray

4. Strategy

It is a fast-changing landscape and after several months of lockdown our messaging needs to be both impactful and tailored to our audiences in Brent if it is to be noticed and acted upon.

This communications plan is part of a three-pronged communications approach.

1 – National Government communications is mainly focused on promoting the Track and Trace initiative. We will compliment and support this messaging only where appropriate. We are not using 'stay alert' messaging.

2 – We will use harder hitting, clearer, action led language, statistics and information that is more carefully tailored to our diverse audiences in our borough wide communications.

3 – We will make use of community, faith and mutual aid groups to help spread more specific information to our various harder to reach and more at risk audiences including BAME residents.

The reason we are taking this three-pronged approach is that many of our audiences do not trust the government or official sources of information as much as they trust 'people like me'. There is a lot of evidence-based research, including from the annual Edelman Trust Survey and various MORI polls, that suggest that audiences have more trust in communications and messaging when it comes from people in their own community so utilising these secondary voices will be vital if we are to influence hard to reach groups.

5. Key messages:

- People are still dying, covid-19 hasn't gone away

- Keep your distance to protect yourself and others
- Self-isolate and book a test if you get any of the symptoms

In addition to the three main messages above, there may also be some more detailed messages around track and trace, including the hyper-local trial site in Harlesden, and also linked to Covid and warmer weather.

6. Tactics:

Corporate Communications

Channels	How we can use them
Traditional – digital boards, posters, signage	Increased use of social distancing signs in hotspots areas. Now that more people are out and about, we will target areas that are either known hotspots (e.g. Harlesden, Ealing Road or Kingsbury High Road) or which have specific 'pinch points' and are likely to have high footfall.
Social Media, including paid for promotion on: Facebook Tick Tok Instagram YouTube Twitter	For hard-to-reach consider paid-for campaigns Post in specific social media groups Use different languages and build a suite of social media assets
E-news	For all regulatory advice & guidance
Media	Press and Radio easy to target and could be used as a partner to create content for us. Also packaging up content for journalists (e.g. BBC London) Ask them if we can use their content for our campaigns such as the BBC Asian network piece

Community Engagement

Community Groups	Provide target audience with a suite of messaging they can then be shared within the community by trusted leaders. Find out what they need from us to deliver the message well and support them.
Multi-faith forum	Good for delivering messaging before important events, prayers etc. Embed the messages with community leaders. Understand through engagement how they influence their communities.
Celebrity & influencers – George the Poet for example/leader of the Council	

7. Lead spokespeople

- Cllr Muhammed Butt, Leader
- Carolyn Downs, Chief Executive
- Melanie Smith, Director of Public Health

8. Risks

- Working with community groups and using secondary voices can take time to set up
- Despite all our best efforts to work with secondary voices, people may still ignore our messages and do what they want
- Brent could experience a second wave of the virus and even a possible local lockdown.

9. Scoring / Evaluation

- Feedback from community groups
- Feedback on social media to our messaging both on and offline
- Understanding how the messages are landing
- Campaign engagement/take-up
- Social Media
- Web traffic
- On-street signage including highways
- Media engagement (stories, content, wraps)

10. Appendices

1 – Time To Talk, Talk Show on The Beat FM

Time To Talk is a long standing, monthly phone-in programme hosted on The Beat 103.6 FM. Brent Council have worked closely with The Beat 103.6 FM in the past to raise awareness of issues such as Youth Employment, Drugs and Male Mental Health.

The Beat 103.6 is a local radio station whose main target audience is African-Caribbean people aged 16-24.

A live two hour radio phone-in on Monday 15 June between 7-9pm will focus on the impact of Covid-19 on the Black (and minority ethnic community) in Brent and look at what actions need to be taken to reduce the impact of Covid-19 on communities going forward.

Clare Clottey will host the show. Suggested guest panellists could include Councillor McLennan, Deputy Leader of Brent Council, Tebussum (Tebs) Rashid from Step Up Hub, John Licorish from the council's public health team, and at least one local young person nominated by the Young Brent Foundation.

The aim of the programme would be to encourage the local community to engage in a conversation about Covid-19 and to use that opportunity to get across key public health messages (re. social distancing, the risk of a second spike etc.) primarily to The Beat's main target audience, which is African-Caribbean people aged 16-24.

2 – Young Brent Foundation, 'The Listening Podcast'

Concept:

The Young Brent Foundation (YBF) is seeking to develop a bespoke 'conversation' with young people via a podcast to discuss COVID-19 and the impacts on communities, families and friendship groups.

They aim to develop a range of extensive podcasts to reach out to the BAME and hard to reach young communities in and across Brent.

YBF will work with Your Only Young Once (YOYO) who are experienced in audio documentary/ podcast making with a strong technical, facilitator and research skills. They have a track record of working with young people and session planning.