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Health and Wellbeing Board

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

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit:

www.brent.gov.uk/committees

The press and public are welcome to attend this as an online virtual meeting. The link to attend and 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.
-

Agenda

Introductions, if appropriate.

Item Page

1 Apologies for absence and clarification of alternate members

For Members of the Board to note any apologies for absence.

2 Declarations of Interest

Members are invited to declare at this stage of the meeting, the nature and existence of any relevant disclosable pecuniary or personal interests in the items on this agenda and to specify the item(s) to which they relate.

3 Minutes of the previous meeting 1 - 10

To approve as a correct record, the attached minutes of the previous meeting held on 10 February 2020.

4 Matters arising (if any)

To consider any matters arising from the minutes of the previous meeting.

5 The disproportionate impact of COVID-19 on BAME communities in Brent To follow

To consider a report on the disproportionate impact of COVID-19 on BAME communities in Brent.

6 Healthwatch work programme and engagement on COVID-19 11 - 50

To present a summary of the engagement work undertaken by Healthwatch Brent to understand the impact of the coronavirus on Black, Asian and Minority Ethnic residents.

7 Brent's Local Outbreak Plan To follow

To consider Brent's Local Outbreak Plan.

8 Pharmaceutical Needs Assessment update Verbal update

To receive an update on the Pharmaceutical Needs Assessment (PNA) process.

9 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Head of Executive and Member Services or his representative before the meeting in accordance with Standing Order 60.

10 Date of next meeting

The next scheduled meeting of the Health and Wellbeing Board is on

Date of the next meeting: Tuesday 20 October 2020

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.

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

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Brent

NHS
Brent Clinical Commissioning Group

MINUTES OF THE HEALTH AND WELLBEING BOARD
Held on Monday 10 February 2020at 6.00 pm

BOARD MEMBERS PRESENT:

Councillor Farah (Chair) and Sheik Auladin (Brent CCG), Councillor McLennan (Brent Council), Councillor M Patel (Brent Council), Councillor Tatler (Substituting for Councillor Hirani, Brent Council), Clair Thorstenston-Woll (substituting for Ian Niven, Healthwatch Brent), Carolyn Downs (Chief Executive, Brent Council, non-voting), Phil Porter (Strategic Director, Community Wellbeing, Brent Council, non-voting), Dr Melanie Smith (Director of Public Health, Brent Council, non-voting and Gail Tolley (Strategic Director, Children and Young People, Brent Council, non-voting).

ALSO PRESENT:

Tom Shakespeare (Director of Integrated Care, Brent CCG & Brent Council), Jonathan Turner (Deputy Managing Director, Brent CCG), Councillor Stephens, Piia Lavila (Healthwatch Brent, attending on behalf of Julie Pal), Hannah O'Brien (Governance Officer), Meenara Islam (Strategic Partnership Manager).

1. **Apologies for absence and clarification of alternate members**

Apologies for absence were received from:

- Dr M C Patel (Vice Chair)
- Councillor Hirani
- Julie Pal
- Mark Easton

2. **Declarations of Interest**

None declared.

3. **Minutes of the previous meeting**

RESOLVED: that the minutes of the previous meeting held on 7 October 2019 be agreed as a correct record.

4. **Matters arising (if any)**

There were no matters arising from the minutes of the previous meeting.

5. **Integration and the single CCG**

Sheik Auladin (Managing Director, Brent CCG) introduced the report, providing further background to the decision to move to a single CCG. Initially there were plans for

integration of the CCGs in 2020-21, but the model had reverted back to individual CCGs and would remain as one unit until April 2021 where there would be 1 CCG moving forward. From April 2020 onwards there would be a transition year, then a North West London wide approach from 2021-22. It was expressed that the reason for the push back was that there had not been full support from CCGs and local boroughs. They were currently looking at governance, and Mark Easton (Chief Accountable Officer, Brent CCG) had written to all Chief Executives of Councils and explained the need to begin moving ahead with local councils. Sheik Auladin highlighted the opportunity to pitch where the HWB wanted Brent CCG and the Council to work together more strongly.

As a result of the restructure there was a need to save money, so individual CCGs were undergoing a restructure process that would reduce operating costs. It was not known whether there would be further restructure once they had merged into a single CCG. As part of the merger there was a shift from eight Managing Directors to four Managing Directors. This would be revisited. The interim arrangements for Mark Easton's cover would act up for 3 months until recruited.

The Chair thanked Sheik Auladin for the update and invited the Board to ask questions. The following issues were raised:

- It was highlighted that there was uncertainty as to what an Integrated Care System was or how it would operate. Carolyn Downs (Chief Executive, Brent Council) expressed that it was hard to engage constructively without understanding the concept fully, and, with the threat of the same proposals that had been rejected, it was essential for the CCG and the Council to push integration as much as possible. Sheik Auladin agreed that it was jargonistic terminology, and highlighted that there were upcoming workshops about the Integrated Care System, which Chief Executives had been invited to.
- The CCG was not aware what apportionment of the £33.9b year on year NHS funding bill would be allocated locally, but advised that most investment would go to acute care and hospitals and revamping new sites. There was a push to have more hospitals and improve the set up at Hillingdon and Northwick Park but no other investment came to CCG other than year on year allocation. Sheik Auladin highlighted that there was a lot of investment into the Primary Care Network and GP contracts, which was promising but did not feel like enough. Councillor McLennan added that £4.5m was being allocated to community services.
- Regarding how the Health and Wellbeing Board could be confident that community services needed were delivered in areas of growth, Sheik Auladin highlighted that the GP registered population in Brent was a substantial 400,000 so they were trying to invest as much as possible into Primary Care Networks and Community Services. Jonathan Turner (Deputy Managing Director, Brent CCG) added that the planning assumptions for the following year showed a substantial gap needing to be covered through savings programmes, as demand would outstrip the investment going into services. It was believed that this would impact estates programmes in the Borough as revenue would not be covered for any potential new premises. Councillor Tatler (Lead Member for Regeneration and Environment) expressed that it was hard to see what the CCG were doing to secure more revenue to deliver the promise of medical

centres made 2 years ago to residents. Sheik Auladin advised that they lobbied NHS England on a regular basis and were looking at new premises. The only way they could manage the current system was to work closely with the Local Authority. The CCG were in discussions with the Council to resolve the need in South Kilburn.

As no further issues were raised, the Board **RESOLVED** to note the report.

7. **JSNA**

Dr Melanie Smith (Director for Public Health) introduced the JSNA refresh, explaining that the cover paper drew out key highlights from the more detailed "chapters" which followed. The Health and Wellbeing Board were asked to agree the publication of the JSNA. This would bepublished as separate chapters on the website to aid navigation through the large amount of information. The Health and Wellbeing Board were also asked to agree the Terms of Reference of the JSNA Steering Group. The new ToR would firm up its purpose and agree a core membership.

In the ensuing discussion the Board noted the following matters:

- The Council had set up a Poverty Commission Chaired by Lord Best, who the Board felt should look at the JSNA.
- The Board distinguished between two processes: agreeing the content of the JSNA refresh and subsequently revising the Health and Wellbeing Strategy (HWS) in response to issues described by the JSNA.
- The process for the refresh of the HWS was noted. This would commence with high-level early engagement workshops, discussing what the HWS priorities should be, and would involve partners in the Borough including Healthwatch. There would also be a workshop with services users. A draft HWS document would be brought to the April board for agreement and then go out to public consultation. A final document should be provided to the Board in the summer.
- The Board noted that there had been more recent studies into oral health in Harlesden and wondered whether that data could be added. Dr Melanie Smith advised that they were awaiting the completed survey data. The data in the JSNA for oral health came from externally validated surveys so while it was accurate it was not always timely. Dr Melanie Smith advised that once data was received it would be published, noting that the JSNA should be a dynamic document. She noted that the supervised teeth brushing initiative introduced in Brent had been associated with an improvement in oral health and increased update of dental care, which was hoped would have an impact on hospital admissions.
- Dr Melanie Smith advised that it was difficult to quantify the impact of estate regeneration on public health, and that the more focused the public health intervention the easier it was to attribute any change to the intervention.

The Board subsequently **RESOLVED**:

i) To agree to the publication of the JSNA refresh on Brent Council and CCG websites.
ii) To agree the refreshed Terms of Reference for the JSNA SteeringGroup which will undertake to keep the JSNA up to date.

6. **Resources and Public Realm Committee Task Group on Air Quality**

Councillor Stephens introduced the report, presenting the Air Quality Task Group Report for consideration and executive response. He highlighted that air pollution was the greatest environmental risk to ill health and fourth greatest risk to ill health generally but had been historically neglected by Local Authorities, the Government and Health Organisations. In July 2019 the Resources and Public Realm Scrutiny Committee commissioned an enquiry into air quality which Councillor Stephens chaired. The outcome was published in December 2019 and attached as an appendix to the report. Councillor Stephens pointed out recommendations 1 and 10. The first recommendation was for the Council and stakeholders to commit to meeting WHO guidelines on air pollution, which was in line with GLA and other London Council commitments. Recommendation 10 was for public health behaviour change campaign jointly led by the health sector and Council. The next steps were to ask if members would like to consider scope for better data sharing between health sector and council for the effects of air quality.

The Chair thanked Councillor Stephens for the introduction and invited comments from the Board with following issues raised:

- Dr Melanie Smith (Director for Public Health) welcomed the recommendations and agreed that there was a need for consistent public health messages on air quality. She suggested that there was a need to engage residents with what they could do to mitigate impact of poor air quality on health. Jonathon Turner (Deputy Managing Director, Brent CCG) added that the CCG were happy to correlate any data they had and that it could form part of the JSNA in future.

As no further issues were raised, the Board RESOLVED to note the Air Quality Scrutiny report and recommendations.

8. **Healthwatch Brent Annual Update and Social Isolation Report**

<u>Annual Report</u>

The Board received an update from Piia Lavila (Healthwatch Brent), explaining that the annual report highlighted how Healthwatch Brent met their statutory role as defined in the Health and Social Care Act 2012. Their core aim was to be an individual organisation that gathered and multiplied patient voices. She highlighted page 5 and page 15 for the Board to note, which showed how resident and patient voices were shared. One of the cases outlined in the report resulted in the voluntary team receiving an award and was now showcased in the Healthwatch England report that had went to Parliament in January.

The Board discussed the paper and noted:

- The Board supported the extension of Healthwatch Brent's contract for a further year.
- Disappointment was expressed that the experience of residents using Northwick Park had not been included in the annual report considering this had been identified as needing improvement in the CQC report. Patient and resident experience of palliative care was also noted by the Board as missing, and it was highlighted that South of the Borough did not seem to have a good experience of palliative care. Piia Lavila acknowledged the importance of palliative care and advised that Healthwatch Brent were in the process of planning 2021 and palliative care would be a priority. Regular visits to Northwick Park and other Hospitals across the London North West University Health Care Trust were conducted to gather patient feedback and was not in the annual report as it was ongoing data gathering. It was possible to share the data with the Board and noted that there was a brief summary on page 12 of the annual report.
- It was noted that in the previous year Healthwatch Brent had a smaller team, so did not reach all communities in Brent. In the current year, a specific engagement plan targeting hard to reach communities had been put together and those communities would be part of action plans going forward. 'Hard to Reach' had been defined as the communities they had yet to engage with.
- Councillor Farah added that himself and Phil Porter, Strategic Director Community Wellbeing, had regular quarterly meetings regarding Healthwatch Brent priorities.

The Board subsequently **RESOLVED** to note Healthwatch Brent Annual report.

Social Isolation Report

Piia Lavila (Healthwatch Brent) advised that there had been a great demand for information on services for social isolation and their goal was to put all that information into one document to work as a resource for the wider audience. She highlighted that there was a wide range of services available and the initiative came from local organisations highlighting that signposting and knowledge of these services could be improved. It was concluded that this could only be delivered when the Health, Social Care and Voluntary Sector came together and connected services. There was an opportunity to build a collaborative model between the health and voluntary sector, and some examples of existing models were showcased in the report. Particularly, Piia Lavila highlighted recommendations 2 and 5 of the Social Isolation Report, and asked for someone to take ownership and bring together those different organisations. An update could be presented to the Board in 3-6 months.

The Board discussed the paper and noted the following:

- Phil Porter (Strategic Director Community Wellbeing) agreed, and highlighted that community hubs had now come together with Social Prescribers to see how they could work better together. They were looking at identifying this as a priority for the health and care transformation board, and he advised that the Board may like to include it as a priority also.
- Tom Shakespeare (Director of Integrated Care, Brent CCG & Brent Council) advised that there was a social prescribing forum, and the CBS was an existing forum running sessions to bridge the divide between statutory and voluntary

organisations. He highlighted that this was an opportunity through link workers to be a catalyst for building that new model.

- Carolyn Downs (Chief Executive, Brent Council) advised that any new model should be put into the existing 5 hubs and not an additional one.
- Regarding what initially went wrong with the early co-ordination of services, Clair Thorstensen-Woll (Healthwatch Brent) concluded that they did not have a benchmark. They had looked at different services and noted that the blockage was that both the public and service providers did not know about them, so there had been no linkage or referral.
- It was highlighted that social prescribers would free up GP time as it was estimated that between 30-60% of GP appointments related to social issues. Sheik Auladin (Managing Director, Brent CCG) added that social prescribing in GPs was being invested in, with every GP required to have 1-2 depending on the size of the practice. Navigators and link workers had also been commissioned to link services.
- Jonathon Turner (Deputy Managing Director, Brent CCG)) advised that they were planning to monitor impact through the steering group, such as demand management for GPs.
- Sheik Auladin confirmed that the issue would be taken up as part of ongoing work

As no further queries were raised the Board RESOLVED to note the recommendations outlined in the 'Social Isolation in Brent – staying well in the community' report.

9. **Pharmaceutical Needs Assessment**

Dr Melanie Smith introduced the report, explaining that it proposed how the Board's responsibilities in relation to the Pharmaceutical Needs Assessment should be discharged. It was explained that the Pharmaceutical Needs Assessment (PNA) was governed by specific regulations and the Board was required to publish an update every 3 years. She suggested that the Board delegated the authority for conducting, consulting on and publishing the PNA to a Steering Group.

In response to the report, the Board raised the following:

- It was highlighted that the requirement to consult local pharmacists on potential new pharmacies could be a barrier to residents' access to services, as existing pharmacists could object to any recommendation for additional pharmacies.
- Membership of the Steering Group was discussed, with Dr Melanie Smith highlighting that the regulations governing the way the PNA was conducted limited the group. It was agreed that a representative from planning should attend the group and a nursing home representative.
- As part of the consultation it was suggested that a project ensuring residents were aware of all the various ways they could access prescribed medications was undertaken.
- Lobbying for updated regulations was discussed and actions resolved, below.

It was RESOLVED that

i) Councillor Farah (Lead Member for Adult Social Care), as Chair of the Health and Wellbeing Board, would take the issue of PNA regulations, including pharmacy regulations and membership of the steering group, to the London Health and Wellbeing Board and lobby to form a London-wide view

ii) A representative from the planning department and a nursing home representative would be added to the membership of the Steering Group.

10. **Enhanced Care**

Phil Porter (Strategic Director Community Wellbeing) introduced the report, which set out the shift in approach to working with care homes across health and social care. The report highlighted how commissioners and care homes worked in partnership to deliver improved outcomes for Brent residents, and set out frontline practice changes and progress to date. It was being positioned as part of delivering agreed priorities, and was a new way of working with care homes and managers as system leaders. Mark Bird (Birchwood Grange Care Home Manager) was the Chair of the Care Home Forum group. There had been a shift in the way the department worked and a move away from purchasing individual placements but supporting the whole of the home.

Mark Bird explained that, since Chairing the group, care home managers had their own vision, aims, objectives and regulations as well as contractual obligations with the Council and CCG, which had allowed them to become more integrated with other services, have a voice and commission new services with the CCG. Examples of closer working and bringing in other services to support care home residents include: There were now 500 trained care staff for supervised tooth brushing and administrating fluoride past. He noted the care home matters project and work done on oral care accessibility. NHS mail was now being rolled out across Brent to allow the communication of confidential data. There was an integrated pathway team that would need to be upskilled but was moving forward. There was a plan to look at how quality inspectors were engaging with providers.

Phil Porter also highlighted the measures in the paper, which focused on issues such as ambulance attendances and CQC ratings as a proxy for improving quality

The Chair thanked Phil Porter and Mark Bird for the update on enhanced care and invited comments from the Board with the following raised:

- Regarding advocacy for home care residents, Mark Bird confirmed that Healthwatch was looking at the acute sector and should be looking at the community sector as well. Previously residents were allocated a social worker for life but this was no longer available and often social workers were reallocated every ten weeks.
- Councillor Farah pointed out the success of the home care CQC rating that Mark Bird had achieved, highlighting that strong partnerships can achieve strong outcomes.
- The Board wanted to know how the forum could help care homes failing or needing improvement, to which Mark explained it was an area being looked at. In 2020-21 there was a plan to work with quality teams and inspectors and standardise audit procedures. It was highlighted that each home differed from

the next therefore this needed to be taken into account with inspections, and the value of trust was highlighted. Phil Porter added that the West London Alliance was looking to reduce bureaucratic burdens across care homes in all 8 Boroughs, and felt there was an opportunity to mechanise this for integrated commissioning across the CCG and Council.

- Mark Bird highlighted that he had been invited to work with NHS England as an adviser for care homes within their transformation team. He was the first manager to be invited to work with the chief nurse.
- It was highlighted that key stakeholders from local acute trusts were missing from the attendance of the meeting and an action resolved, below.

As no further questions were raised, the Board RESOLVED:

i) That Meenara Islam write to the new interim Chief Exec and Chair of LNWUHT advising that in future representation at the Board was expected.
ii) To note the improvement in joint working with care homes in Brent

11. **Any other urgent business**

Dr Melanie Smith provided an update on Coronavirus as the situation stood on the 10th February, explaining that it was a new virus and the UK response was determined by the fact it was new rather than that it was necessarily serious. The UK response, , was "contain", seeking to buy time to find out more about how the virus behaved before, or if, community transmission became an issue in the UK. The case definition had been expanded the previous week and the message from public health was that anyone who had returned within the previous 14 days from countries specified and had fever or cough or shortness of breath should not go to hospital but call NHS 111 for a risk assessment. The London North West Health Trust had put a well-defined pathway in place, and had conducted over 40 assessments in the community. At the time of the update there had been no confirmed cases in London, but 17 cases in Northwick Park being assessed on a precautionary case definition and patients were being isolated in Royal Free having been transferred in from outside London. The UK was fortunate in that PHE were able to test for the virus. At the time of the meeting, 1,114 individuals in the UK had been tested at the time of the meeting with 8 individuals testing positive for the virus. The burden of the response was falling on the NHS and PHE who were case finding, testing, isolating and contact tracing. Cases were being treated in hospital for purposes of infection control rather than in response to the severity of the illness. It appeared that serious illness was only being seen in the elderly or those with pre-existing conditions. The virus did not appear to cause severe illness in children. Dr Melanie Smith confirmed that at the time of the meeting the virus had not mutated, and that work was ongoing to produce a vaccine.

12. **Date of next meeting**

The next meeting of the Board was due to be rescheduled.

The meeting was declared closed at 19:44 pm

COUNCILLOR FARAH
Chair

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Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 29 June 2020
	Report from CEO Healthwatch Brent

Healthwatch work programme and engagement on COVID-19

Wards Affected:	All
Key or Non-Key Decision:	N/A
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:	2 Appendix 1 – COVID-19 – Focusing our Engagement Appendix 2 - Healthwatch Brent COVID-19 Community Engagement With Brent Residents and Care Schemes
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Julie Pal CEO Healthwatch Brent Julie.pal@communitybarnet.org.uk

1.0 Purpose of the Report

1.1 To present a summary of the engagement work undertaken by Healthwatch Brent to understand the impact of the coronavirus on Black. Asian and Minority Ethnic residents.

2.0 Recommendation(s)

2.1 To confirm the approach to engagement that Healthwatch Brent is proposing to take over the next six months to ensure the voices of Brent residents continue to be gathered and presented to the Health and Wellbeing Board for information and consideration.

3.0 Detail

3.1 CommUNITY Barnet has been commissioned to deliver the local Healthwatch contract in Brent from 1 April 2018.

3.2 Healthwatch Brent has established a network of charity, voluntary and community organisations committed to bringing the experiences of Brent residents of using health and social care services to the attention of the borough's key decision makers.

3.3 Healthwatch Brent is delivered by a Brent-based central core team, a partnership of Brent-based voluntary and community organisations and a team of volunteers.

3.4 The work programme of Healthwatch Brent will support the Borough's Plan for 'Building a Better Brent' by focussing on the strategic priorities: a borough where we can all feel safe, secure, happy and healthy.

3.5 Healthwatch Brent is delivered on a Hub and Spoke model. The Hub is the first point of public access and delivered by the core team located in Wembley. The Spokes consist of two groups – the Healthwatch Brent Advisory Board whose role it is to support the core team and shape the work programme around the needs of Brent residents. Membership of the Healthwatch Brent Advisory Board includes Brent User Group, Ashford Place, Brent CVS; Brent Carers' Centre; Brent Mencap, Brent Multifaith Forum; Young Brent Foundation, Elders Voice, Orchid Care, Jewish Care

3.6 Our strategic priorities for Healthwatch Brent are to:

- Encourage greater participation in health and social care
- Collecting evidence of increasing engagement with those residents from under-represented communities
- Demonstrate that Brent residents feel more able to express their views and to report they are listened to
- Demonstrate how Healthwatch Brent has been able to make a constructive contribution to support and enable informed decision making through the representation of the authentic voice
- Demonstrate Healthwatch Brent offers value for money, through our reach, production of reports, participation in strategic meetings and volunteer activity
- That Healthwatch Brent service offers added value by:
    - Establishing collaborative, open and cooperative partnership with existing providers;
    - Drawing upon the experience of partnership members by bringing together their combined expertise, knowledge and experience
    - Providing strong project management and coordination of a high quality service
    - Delivering cost-savings on engagement activities through using our existing channels;
    - Adding value of specialist knowledge provided by the Healthwatch Brent Network;
    - Adding value of local knowledge from trusted organisations who know Brent residents;

- Capability of reaching Brent households through newsletters, contacts and social media platforms delivered through HWB and the CVS Brent newsletter;

4.0 Financial Implications

4.1 There are no financial implications as all costs are within the agreed contract.

5.0 Legal Implications

5.1 Healthwatch Brent was established through the Health and Social Care Act 2012 to give users of health and social care a powerful voice both locally and nationally and formally launched in 2013 as an independent charity.

5.2 From 1 July 2015 its services have been delivered as an arms-length department of Community Barnet (CB) a charity and company limited by guarantee.

5.3 Financial and contract accountability remains with CommUNITY Barnet's Board of Trustees and delegated through the Chief Executive Officer to the Head of Healthwatch and the Healthwatch Brent Manager.

5.4 The current contract is a two-year contract issued to CommUNITY Barnet between 1 April 2018 – 31 March 2020 with an option to extend until 31 March 2021 is possible

6.0 Equality Implications

6.1 CommUNITY Barnet is committed to supporting Brent Council to meet its Public Sector Equality Duty as defined under the Equality Act 2010.

6.2 As part of the quarterly performance monitoring, data relating to reaching Brent's protected groups is captured.

6.3 Healthwatch Brent will continue to be committed to giving a voice to under-represented communities. The Healthwatch Brent Network has organisations which reflect Brent's diverse communities and we have used it to give a voice to these communities and support them to re-shape public services.
The table below summarises our network and the communities they reach and have engaged in health and social care:

6.4 All staff and volunteers receive equalities training. We are acutely aware of the role of local Healthwatch to amplify the voice of all local communities, with a special remit to hear from less often heard groups. We have been supplying equality monitoring data to Brent Council over the last 3 years, including that of our membership/friends.

6.5 We believe Brent's communities are represented within our reports as far as possible, but we constantly strive to reach more communities. Our staff team are committed to capturing the views of residents reflecting Brent's diverse and protected communities and sharing it with Brent Council.

7.0 Consultation with Ward Members and Stakeholders

7.1 Healthwatch Brent has set up an Advisory Board with membership drawn from Brent-based charities which supports the delivery of the contract.

7.2 This report has been drawn up in consultation with the Chair of the Health and Wellbeing Board and his officers.

8.0 Human Resources/Property Implications (if appropriate)

8.1 All human resources/property implications are considered within the parameters of the contract between London Borough of Brent and CommUNITY Barnet.

APPENDIX 1 - COVID-19 – FOCUSING OUR ENGAGEMENT

1. EXECUTIVE SUMMARY

Engagement

During April and May 2020 Healthwatch Brent staff carried out extensive community engagement, contacting, sourcing, listening and speaking to our residents about their experience of information, support and services for Covid-19. We significantly adapted our engagement methods and found new ways to listen to seldom-heard communities and those that are not connected online/digitally. We used online, telephone, surveys and conversations to gather feedback from 270 people (including some key workers), 7 care homes and 10 organisations.

We were keen to hear from residents but focused in particular on black and minority ethnic (BAME) people, which make up 14% of the UK population, but have accounted for over a third of intensive care patients in the coronavirus pandemic so far. One fifth of the NHS workforce are from ethnic minority backgrounds, but they make up more than two thirds of the frontline health workers who have died due to coronavirus in the UK so far[1]. This picture is evolving with new data constantly emerging so the report needs to be read within that context.

Findings

Some of the key themes to emerge from these engagements included:

- Requests that information was available in easy-read and community languages
- Residents struggled to understand the government's instructions and if or how they were relevant
- Many found the support from GPs unclear or unhelpful, and they struggled with the online consultations
- Some residents received food parcels, but didn't need them as they had other support
- Some residents are experiencing food poverty and economic poverty
- Many, including care homes, praised Brent Council for the way they had responded to the pandemic
- Families experiencing 'burnout' and anxiety due to the lack of respite, as family carers or home schoolers.
- Concern that mental health services may not meet the demand for services as the crisis continues
- Concern about the provision of appropriate counselling both for adults and young people
- Young people concerned both about their future but also in their role as potential 'super spreaders' and the public messages about young people not being seriously affected by the disease

Next Steps

The following key themes were identified and proposed next steps are detailed below. We are keen to work with the Health and Wellbeing Board and our statutory and charity partners to develop our proposals going forward.

Statutory and Community Partners Next Steps

1a. Mental Health and Wellbeing: Challenges related to stress, anxiety and isolation are overriding themes that cut across all the engagement, but particularly in relation to isolation in hospital; domestic abuse; single parents or families with young children (including in relation to poverty and over-crowding); health care for non-Covid conditions; ongoing risk of infection.

[1] https://themj.co.uk/Covid-19s-disproportionate-impact-must-prompt-action-on-inequalities/217733

Suggested next steps:

- Statutory and community partners plan appropriate messaging, guidance and signposting on mental health support for emerging and escalating mental health conditions
- Undertake a review of existing Brent based community mental health services and consideration of potential additional support, including social prescribing.

1b. Communication and Misinformation relating to lack of clarity or lack of awareness of where to access information on hospital services, burials and funerals; admission to and safety in hospital for non-Covid conditions and for ongoing information about the economic/employment situations, benefits and the continuation or not of current Covid food support schemes.

Suggested next steps:

- Statutory and community organisations provide, including in community languages, clarity, information, guidance and signposting to advice and advocacy organisations, on current and new food and economic support schemes and clarity on the safety and social distancing protocols for using health and social care.
- Further insight is gathered on Brent Council's, care homes' and other organisations' initiatives that have worked to help manage or reduce the potential mortality rate in care homes.

Healthwatch Brent Next Steps

1c. Experience of BAME frontline staff/key workers in health and social care

Given the challenges outlined above and recognising the urgency of the current situation, we propose to work with existing BAME Networks to learn from BAME frontline health and care staff and communities about:

- working collaboratively with our communities, frontline staff and across the system to highlight lessons learned both in the immediate period and longer term
- assessing how Covid-19 impacts on BAME staff particularly those working directly with patients and communities affected by COVID-19.
- identifying best practice and areas for improvement in connecting with communities and frontline staff to reduce inequalities and to make a difference both now and in the future.

1d. Healthwatch Brent Activity

Due to the impact of Covid-19 on different communities, we propose that with our charity partners and the Health and Wellbeing Board, we examine and focus activity more specifically to:

- assess how Covid-19 impacts BAME communities particularly in council wards and estates with a disproportionate number of residents affected by the pandemic. Given the disproportionate death rates as well as the numbers of those tested positive for COVID-19 in Brent, we aim to proactively work with communities and partners as a starting point.
- gather the experiences of affected communities in the context of their everyday lives
- determine what system and community responses need to be developed as a result. The resources produced can provide an evidence-base to hold 'listening' and 'change' conversations.
- consider whether there are lessons learned and new approaches that can be applied to other communities and the wider community going forward – particularly if another 'spike' in infections occurs in the autumn.

Secondary research into satisfaction, complaints and good practice could help identify key issues and further engagement could include: consideration of translation services in health and social care; advocacy services for in-patient and outpatient and social care; increase trust or understanding of services within different communities; identifying challenges and barriers that have become embedded through the pandemic; and the impact of public health factors on residents' health and wellbeing.

2. INTRODUCTION

This report has been prepared by Healthwatch Brent, based on the experiences and views of local residents as they live under the cloud of the pandemic whilst observing the government's instructions on saving lives, protecting the NHS and remaining alert. Healthwatch Brent engaged with Brent's diverse communities to gain better understanding of the disease's impact on these communities. We used different techniques and methods to gain access to hard to reach and seldom heard groups.

Black and minority ethnic (BAME) people make up 14% of the UK population, but have accounted for over a third of intensive care patients in the coronavirus pandemic so far. One fifth of the NHS workforce are from ethnic minority backgrounds, but they make up more than two thirds of the frontline health workers who have died due to coronavirus in the UK so far[2].

We have started to collate evidence which we believe can inform this work. Mindful of observing and maintaining social distance, these voices were captured using a range of online, virtual and digital techniques to engage with key worker, care homes and wider resident communities and gather their views of those accessing, using or delivering services. We relied on using digital media including WhatsApp, phone-calls, engaging with support groups and maintaining contact with prominent community members.

3. COVID-19 AND THE BAME COMMUNITY – RESEARCH AND EVIDENCE

There is increasing international evidence that Black, Asian and Minority Ethnic (BAME) people are at higher risk of death from COVID-19[3]. As of 12 June 2020, there were 150,000 confirmed cases COVID-19 England with almost 30,000 deaths in all settings[4]. Public Health England published their descriptive review of data on disparities in the risk and outcomes from COVID19 [5] in June 2020.

There is consistent emerging evidence confirming that that Black, Asian, Minority Ethnic communities including health and care staff are disproportionately affected by Covid-19[6]. Socio-economic factors and co-morbidities have been presented as possible explanations for the disproportionate number of BAME deaths and this has informed the scope and focus of national reviews.

Ethnicity data available in the intensive care national audit and research centre (ICNARC) reports on patients with confirmed COVID-19 that have been admitted to intensive care for at least 24 hours revealed (on 24th April 2020) that BAME people were at higher risk of developing severe COVID-19 disease[5]. A total of 5,993 patients with confirmed COVID-19 had reported data on ethnicity and 34.2% (2,055/5,993) of these patients were from BAME. This picture is evolving with new data constantly emerging.

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[2] https://themj.co.uk/Covid-19s-disproportionate-impact-must-prompt-action-on-inequalities/217733

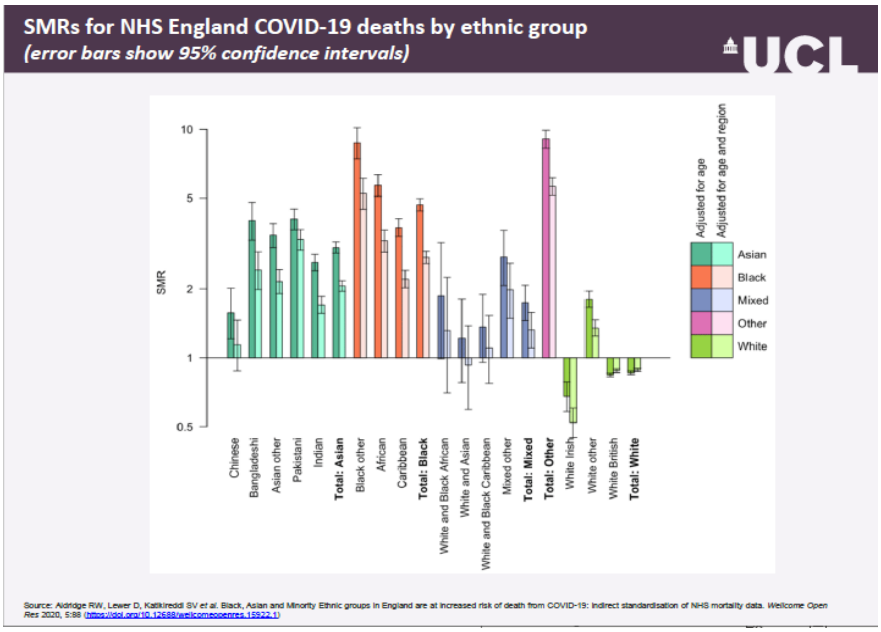
[3] CDC: Coronavirus Disease 2019 (COVID-19). Centres for Disease Control and Prevention. 2020; (accessed April 26, 2020). Reference Source

[4] https://www.google.com/search?q=covid+figures&rlz=1C1GCEB_enGB862GB862&oq=Covid+figures&aqs=chrome.0.0l8.3782j0j7&sourceid=chrome&ie=UTF-8

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf

[6] https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/BRIEFING_Impact-of-COVID-19-BME_communities-and-staff_FNL.pdf

At a presentation of Westminster City Council's BAME Network, University College London analysed NHS data from patients with a positive Covid-19 test who died in hospitals in England from March 1 to April 21. They accounted for differences in age and region and calculated the increased risk using the Standardised Mortality Ratio (SMR). Analyses matched by area (ward) of residence showed differences are significant for all BAME groups but there is substantial variation by minority ethnic groups. There were 1.63 times more Black patients in critical care than expected based on the matched population (10.6% vs 6.5%). For Asian patients the differential is reduced but still significant with 1.25 times more Asian patients than expected (15.3% vs 12.2%). This was done against the publication in the HSJ that 63% of BAME individuals accounted for deaths in hospital[7i]



In May 2020, the Guardian[8] carried an article of a study undertaken by Royal College of Midwives stating that 55% of pregnant women admitted to hospital with coronavirus in the UK were from BAME communities. The study suggested that for pregnant women from a BAME background is a strong predictor for the likelihood of being hospitalised rather than age and obesity.

In North West London, data[9] suggests that the themes emerging locally mirror those identified nationally. More specifically, in NWL the rate of COVID 19 Infections (as of 22nd April 2020) highlighted – consistently and since the beginning – that Brent had the highest level at 1252 people who tested positive for the virus compared to Kensington & Chelsea (K&C) at 416 people, more than 3 times as many. In terms of inequalities the data shows:

- Brent having over twice the population yet less than half of the greenspace compared to K&C
- Brent having over twice the level of overcrowding compared to K&C
- Brent having over twice the number of BAME communities compared to K&C

Feedback from community and voluntary sector organisations, residents, faith groups and the Healthwatch CWL report identified a range of themes relating to the impact of COVID 19 on the BAME and the wider community (see Appendix 1) which could be applied to Brent as a constituent part of NWL. Public Health England confirmed the risk of death from Covid-19 higher for ethnic minorities in **a recent review** PHE found that people of Bangladeshi heritage were dying at twice the rate of white Britons, while other black, Asian and minority ethnic groups had between 10% and 50% higher risk of death.

Impact of COVID-19 on mortality

Ethnicity has not been regularly recorded in death certificates in England which compromises the interrogation of the differential impact of COVID-19 on mortality amongst different BAME groups.

[7] Exclusive: deaths of NHS staff from covid-19 analysed – Cook et al HSJ (22 April 2020)
[8] https://www.theguardian.com/world/2020/may/16/bame-majority-pregnant-women-hospitalised-covid-19-troubling-midwives
[9] https://coronavirus.data.gov.uk/?_ga=2.223652696.270492364.1587650376-2057377103.1587650376#regions

However, daily NHS hospital death data are provided by geographical region, age and ethnicity. Adjusting for region is potentially important because in England COVID-19 has affected different parts of the country to a different extent. For example, London and the West Midlands, the two regions with the highest levels of BAME residents have had most COVID-19 cases. University College London used this data to examine the risk of death from COVID-19 by BAME group and through a sensitivity analysis test to see whether differences between BAME groups could be explained by regional differences in the ethnic make-up of the population[10].

4. HEALTHWATCH BRENT APPROACH AND ACTION

Engagement Methods

Given the emergent nature of the impact of COVID-19 on BAME communities including the workforce as well as the need for urgent action, North West London developed an approach to engagement working with patients, residents, communities and partners. These are set out below and have been utilised by the Healthwatch Brent team:

- Collaborative: Creating the space and facilitating conversations with and between individuals and organisations.
- Evidence-based & Person-centred: Ensuring a parity of esteem between the insight and experience of local stories and experiences and qualitative data / research evidence.
- Asset-based: Ensuring that the voices of communities and residents drive the work forward, ensuring that conversations are facilitated and reflect the wishes of those who participate in the work.
- Continuous and iterative: Constantly reviewing, evaluating and testing emerging themes so that they influence decisions in real-time.

Engagement Activity

Historically, Healthwatch has gathered the views of residents through surveys, face to face conversations, community stalls, briefing and e-communications. But, mindful of social distancing, we developed a safe programme which involved assessing, preventing and mitigating risks by implementing the government's instructions at the time to 'Stay, home; Protect the NHS and Save Lives'.

We were also mindful that there was a risk of COVID-19 widening inequalities caused by digital exclusion such as being residents being unable to purchase vital goods and services, look after their health and socially interact within the safety of their homes. We noted the positive endorsements of the Borough's community task force and response service. We are also mindful that digital exclusion is associated with social exclusion and poor health which if not tackled can result in a further increase in health inequalities.

Since the date of lockdown, 23 March 2020, we adapted our engagement methods to include:

- Joining and liaising with Mutual Aid groups being established across the borough
- Joining and liaising with ward and street-based WhatsApp groups
- Following elected members through their Twitter accounts
- Contacting care homes by telephone on how they are coping

[10] Aldridge R: Dataset: Black, Asian and Minority Ethnic groups in England are at increased risk of death from COVID-19. UCL Institute of Health Informatics: London, UK.
2020. http://www.doi.org/10.14324/000.ds.10096589

- Conducting telephone interviews with community organisations
- Promoting a survey Brent-wide asking for experience of accessing information about lockdown
- Collecting case studies from keyworkers – some of whom had been infected by COVID-19.

Appendix 2 summarises the engagement work Healthwatch Brent undertook between 23 March to 7 June 2020 with Brent residents and care homes to capture a snapshot of the BAME experience of the pandemic.

Care Home Interviews

We interviewed the care homes we had visited as part of our Enter and View Programme in 2018-19 and summarised their responses.

- Of the 7 care homes visited, 6 had not experienced any Covid-19 related deaths since the outbreak. Whilst it is not the role of Healthwatch to speculate on this information, the team noted that none of these care homes had raised concerns during our Enter and View visit.
- A case study from Carewatch Brent summarises their experience of continuing to deliver services to some of the borough's most vulnerable residents.
- We interviewed BAME keyworkers who had contracted the disease and summarised their reactions to receiving advice, information and support.
- We spoke with patients with underlying health conditions to listen to how they managed their fears and what they believed would help to minimise that.
- We spoke to different types of carers to better understand the dilemmas they have been facing during the current lockdown and how it has impacted on their mental health.

Community Engagement

The team also engaged with over a hundred different individuals reflecting many of Brent's diverse communities (summarised in the table below). We used a number of techniques including

- reviewing social media platforms including Face Book, Twitter, WhatsApp, and those for specific communities
- cold calling organisations, sending emails,
- using videoconference facilities
- attending online forums and
- sending out short surveys to community-based organisations.

Date 2020	Venue/ organisation	Age Profile	Gender	Ethnicity profile	Faith	Stakeholder description	# people
Apr	Brent Gateway		N/A	Brent residents	N/A	Carers	1
Apr	Brent Carers Centre		N/A	Brent residents	N/A	Carers	4
Apr	Elders Voice		N/A	Brent residents	N/A	Older people	1
May	Patidar House Satsang group	45-85 year	N/A	Indian	Hindu	BAME	1
Apr/ May	Asian women cancer support group	45yrs+	female	South Asian	Multi faith	Illness/BAME/Women	20
May	Pendrell Trust		N/A	Brent resident	N/A	Carer/social care	1

Apr/ May	BAME residents in supported living	18 +	90% female	BAME	N/A	Mental Health	25
May	Hibiscus Group	65+		Afro Caribbean	Christian	Older people	1
May	Elevated Exchange (local neighbours, Willesden)	18 +	50% female	Brent residents	Multifaith	Mental Health	11
	Apr/May	N/A	N/A	Brent residents	Multifaith	Food bank and wellbeing support recipients.	100 +

Some Brent residents mentioned using a WhatsApp Somali Coronavirus forum based outside of Brent and currently has 200 members. The coordinator was interviewed. He spoke of the needs of the Somali community in general, commenting on the lack of opportunities to work in partnership with other agencies to address gaps in needs and identifying some of the community assets they have. He commented that Brent Somali residents were active members of the forum and found it to be useful because many of the conversations were held in Somali.

The team were active participants in many Mutual Aid conversations taking place across the borough to listen to individuals and learn about their experiences.

In addition to contacting community organisations they followed many of the borough's elected members through their Twitter accounts so that we could ensure that the messages and information we shared with residents and community organisations was accurate.

Survey

Alongside the engagement work, the Healthwatch Team worked with NWL colleagues to ask Brent residents about their understanding on the guidance relating to social distancing and essential travel.

39 people completed the on-line survey, of which 46% had a pre-existing health condition or disability and 46% were from the BAME community. (Although less than the borough's profile, it revealed that people from BAME communities were participating in digital surveys.)

- Almost 60% stated that they were managing under the current situation though some made additional comments
- 1:4 said that they were beginning to be concerned about their mental health and wellbeing if the situation continued.
- 15% who needed help with food delivers were being helped by volunteers
- 10% expressed difficulty in booking online supermarket delivery slots.

The survey included a set of free text questions with responses which can be viewed in Appendix 3 and serve as a snapshot of the perceptions of Brent residents at a particular point in time.

It must be pointed at that reactions and responses to the pandemic are being developed through a continual learning process and that attitudes and perceptions may be variable going forward.

5.FINDINGS

Healthwatch Brent Engagement

Some of the key themes to emerge from these engagements included:

- Requests that information was available in easy-read and community languages
- Residents struggled to understand the government's instructions and if or how they were relevant
- Many found the support from GPs unclear or unhelpful, and they struggled with the online consultations
- Some residents received food parcels, but didn't need them as they had other support
- Some residents are experiencing food poverty and economic poverty
- Many, including care homes, praised Brent Council for the way they had responded to the pandemic
- Families experiencing 'burnout' and anxiety due to the lack of respite, as family carers or home schoolers.
- Concern that mental health services may not meet the demand for services as the crisis continues
- Concern about the provision of appropriate counselling both for adults and young people
- Young people concerned both about their future but also in their role as potential 'super spreaders' and the public messages about young people not being seriously affected by the disease

Public Health England Report

Public Health England is believed to be publishing a report acknowledging that factors such as racism and social inequality may have contributed to increased risks of black, Asian and minority communities catching and dying from Covid-19. The report due to be published in June 2020 is expected to acknowledge that historic racism may mean that people are less likely to seek care or to demand better personal protective equipment. The BBC stated that in the report stakeholders expressed "deep dismay, anger, loss and fear in their communities" as data emerged suggesting Covid-19 was "exacerbating existing inequalities".

It found that "historic racism and poorer experiences of healthcare or at work" meant individuals in BAME groups were less likely to seek care when needed or to speak up when they had concerns about personal protective equipment or risk.

Other possible factors include risks linked to occupation, co-morbidities such as diabetes and hypertension which may increase disease severity and are significantly higher amongst BAME communities points to racism and discrimination as a root cause affecting health and the risk of both exposure to the virus and becoming seriously ill which can increase the severity of Covid-19.

The report recommends:

- Better data collection about ethnicity and religion, including having this recorded on death certificates to accurately monitor the impact on these communities
- Supporting further research with the participation of BAME communities to understand the increased risk and develop programmes to reduce it
- Improving BAME groups' access to, experiences of and outcomes from NHS and other services - using audits, health impact assessments and better representation of black and minority ethnic communities among staff

- Developing risk assessments for BAME workers in roles where they are exposed to a large section of the general public or those infected with the virus
- Producing culturally sensitive education and prevention campaigns to rebuild trust and help communities access services such as contact tracing, antibody testing and a future vaccine
- Targeting BAME groups with culturally sensitive health messages to address conditions such as diabetes, high blood pressure and asthma
- Ensuring that Covid-19 recovery strategies actively address inequalities to create long-term change

6. NEXT STEPS

The following key themes were identified and proposed next steps are detailed below. We are keen to work with the Health and Wellbeing Board and our statutory and charity partners to develop our proposals going forward.

Statutory and Community Partners Next Steps

1a. Mental Health and Wellbeing: Challenges related to stress, anxiety and isolation are overriding themes that cut across all the engagement, but particularly in relation to isolation in hospital; domestic abuse; single parents or families with young children (including in relation to poverty and over-crowding); health care for non-Covid conditions; ongoing risk of infection.

Suggested next steps:

- Statutory and community partners plan appropriate messaging, guidance and signposting on mental health support for emerging and escalating mental health conditions
- Undertake a review of existing Brent based community mental health services and consideration of potential additional support, including social prescribing.

1b. Communication and Misinformation relating to lack of clarity or lack of awareness of where to access information on hospital services, burials and funerals; admission to and safety in hospital for non-Covid conditions and for ongoing information about the economic/employment situations, benefits and the continuation or not of current Covid food support schemes.

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- Further insight is gathered on Brent Council's, care homes' and other organisations' initiatives that have worked to help manage or reduce the potential mortality rate in care homes.

Healthwatch Brent Next Steps

1c. Experience of BAME frontline staff/key workers in health and social care

Given the challenges outlined above and recognising the urgency of the current situation, we propose to work with existing BAME Networks to learn from BAME frontline health and care staff and communities about:

- working collaboratively with our communities, frontline staff and across the system to highlight lessons learned both in the immediate period and longer term
- assessing how Covid-19 impacts on BAME staff particularly those working directly with patients and communities affected by COVID-19.

- identifying best practice and areas for improvement in connecting with communities and frontline staff to reduce inequalities and to make a difference both now and in the future.

1d. Healthwatch Brent Activity

Due to the impact of Covid-19 on different communities, we propose that with our charity partners and the Health and Wellbeing Board, we examine and focus activity more specifically to:

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- gather the experiences of affected communities in the context of their everyday lives
- determine what system and community responses need to be developed as a result. The resources produced can provide an evidence-base to hold 'listening' and 'change' conversations.
- consider whether there are lessons learned and new approaches that can be applied to other communities and the wider community going forward – particularly if another 'spike' in infections occurs in the autumn.

Secondary research into satisfaction, complaints and good practice could help identify key issues and further engagement could include: consideration of translation services in health and social care; advocacy services for in-patient and outpatient and social care; increase trust or understanding of services within different communities; identifying challenges and barriers that have become embedded through the pandemic; and the impact of public health factors on residents' health and wellbeing.

APPENDIX 1: DEDUCTIVE FRAMEWORK FOR CODING QUALITATIVE FEEDBACK

Code	Definition
1. Financial issues	**The impact of COVID and related measures on people's financial health**
Debt	Impact of COVID and related measures on people's debt
Rent/mortgage payments	Impact on rent/mortgage payments
Loss of wages	Impact on loss of wages
Impact on life/family/kids	Impact of financial issues on lifestyle, family and children
Ways of gaining/earning or increasing finances	Approaches that people submitting the data have taken to increase finances
Other	Other aspects not covered in the codes above
2. Employment	**The impact of COVID and related measures on employment**
Gain/loss of employment	Inc. redundancy
Experiences of furlough	Descriptions of people's experiences of being furloughed
Treatment by employers	Data describing how people have been treated by their employers
Impact of lockdown	Influence of lockdown measures on employment/going to work
Other	Other aspects not covered in the codes above
3. Relationships	**Anything to do with relationships with friends, family, partners who are cohabiting or not, including challenges but also ways to cope and new approaches to relationships**
Family	The impact of COVID and related measures on family relationships
Children	The impact of COVID and related measures on children & relationships with children (inc. visitations)
Extended family	The impact of COVID and related measures on relationships and life with the extended family (who live together or separate)
Partners	The impact of COVID and related measures on life with partners (cohabiting or non-cohabiting)
Parents & parenthood	The impact of COVID and related measures on parents and being a parent, including single parents, new parents or older parents who may also be self-isolating
Friends	The impact of COVID and related measures on friends and friendships
Other	Other aspects not covered in the codes above
4. Childcare	other aspects not covered in the codes above
Views and experiences of schooling	Inc. views on returning to school, and experiences of home schooling
Having children at home	Views about having children at home, inc. techniques to manage this, and impact on wider life of parents and children
Other	Other aspects not covered in the codes above

5. Housing	**Anything to do with housing, housing payments and conditions during the pandemic and related measures**
Overcrowding	Impact of overcrowding during the pandemic and lockdown (or vice versa)
Outdoor space	Descriptions and Impact of having/not having outdoor space
Multiple occupancy	Experiences of sharing with people who are not related, inc. use of communal spaces
Tenancy issues	Any positive or negative impacts on tenancy, or issues with landlords
Other	Other aspects not covered in the codes above
6. Mental Health	**The impact of COVID and the lockdown on people's mental health**
Finding and getting support	How, where are they getting support; the impact of COVID & related measures on finding and getting support
Managing existing mental health issues	How are people managing mental health conditions that existed before the pandemic, inc. continuing treatment
Coping strategies	How are people coping, what strategies are they implementing to look after their mental wellbeing
Other	Other aspects not covered in the codes above
7. Domestic Violence	**Anything related to the impact of COVID and related measures on domestic violence**
Impact of lockdown on DV	Influence of COVID and lockdown measures on DV
Support/help received	Impact of COVID and lockdown on support/help received by people experiencing DV
8. Sources of Information & understanding	**Where people finding information about COVID and related measures and what do they understand?**
People's understanding about COVID	What do people understand about COVID
People's understanding about lockdown and other COVID-related measures	What do people understand about lockdown and COVID-related measures
Sources of information	Where are people getting relevant information?
Understanding of the pandemic and related measures	What do people understand about the pandemic and related measures
10. Dealing with, and managing, death	**How are (non-frontline) people dealing with and managing death and the related processes during COVID**
Dealing with COVID related deaths	Emotional and practical factors related to dealing with deaths from COVID
Dealing with non-COVID related deaths	Emotional and practical factors related to dealing with other deaths during COVID

Experiences of and managing funerals	Emotional and practical factors of planning and attending funerals
11. Experience of (BAME) frontline staff	**Experiences people have shared of their frontline work during the pandemic**
Dealing with death	Views and experiences of death and dealing with death on their practice
PPE	Views and experiences of using PPE
Views of COVID & BAME	Views of the apparent inequalities related to COVID by BAME on frontline staff
COVID in their community	What are frontline staff saying about COVID in their communities; how they feel this is impacting their practice
Strategies for coping	What is said about how frontline staff are coping

Appendix 2:

Covid-19 Impact on Care Homes and Residents

Separate document

APPENDIX 3 – BRENT RESIDENTS' UNDERSTANDING OF GUIDANCE ON SOCIAL DISTANCING AND ESSENTIAL TRAVEL.

How has the outbreak affected you and your loved ones?	What has been working well for you and your family?	What additional support do you and your family need?
Yes We've been affected	Being at home	Information about services
My daughter was in her 1st year at Uni and was told to go home and her course was cancelled and she would get no online lectures. She has been completely dropped with no pastoral care and she still has to pay for her terms education with a student loan at 6% interest rate. This is no way to treat our young adults. She has been left with nothing. Bad university. At least she has a safe home to stay in while this is going on but not the case for many of her fellow student who did not live in the UK and got very little support getting themselves back to their countries or a safe place to stay in London if they were not able to get home. My young lodger who was staying with us while he prepped himself in a 'safe space' to take his A levels was very discombobulated at the beginning but the School Ark Academy has supported him very well. I am fine as I work from home anyway and I have continued to work and be paid. We are all very healthy with no underlying health issues.	The three of us are very gentle quiet people and have enjoyed each other's company. My daughter has caught up on her sleep after her very exciting time at Uni and no sleep and the young lodger has become secure and enjoyed a safe home and has started to blossom. I have given up smoking.	None.
Only relative is my mum I bring her food every second day. We social distance in her flat	I'm not working at the moment so visits out only for food	None
Not great	How am I meant to answer that !!!!!	More police presence on the street !!!
My elderly mother was unable to access regular healthcare and subsequently died at Northwick Park hospital of deteriorating conditions. Being in isolation elsewhere we were unable to help. We were also unable to be with her at the hospital.	Nothing concerning Northwick Park services.	Better communication and empathy at the hospital might have helped us to deal with everything remotely. But it seemed no extra effort being made by staff. When we asked for a priest to attend we were just told 'I don't think we're doing that at the moment'.
The social distancing and not being able to go out as much as you like or see friends and family. Plus not being to travel far.	Catching up with friends on the phone or social media. being able to catch up on things we hadn't go round to doing.	None

Restriction on activities for teenagers. Education on line facilities limited and apparently not directed towards encouraging reading as no Mainly teenager time, no advice on suitable books available on line might be accessed	Access to food supplies and deliveries of food.	We pay for help with purchase of extra food etc as needed.
The outbreak hasn't affected me and my family. It has affected our family friends/relatives because some of them have caught the disease as they have been going out to places quite often.	Me, my mum, my dad and my brother & sisters haven't been going out much apart from doing shopping and we all have been staying safe at home most of the time.	Me, my mum and dad live in England and the 3 of us are vulnerable so a volunteer is helping us to do the shopping every week/ every couple of weeks. My brother and my two sisters live in another country and they don't need no additional support. They all have been going out themselves to do their shopping once a week or every couple of weeks.
It is getting stupid. We cannot go outside because all the shops restaurants are closed. We cannot get a takeaway. I heard that some restaurant like McDonalds is open but not for customers I think it is bad. It should be open for customers.	I am doing exercise inside watching tv and doing yoga. Keep my garden clean put new compost on the ground.	I do not need additional support and my mum and dad look after me.
Cannot go out	The staying in	Nothing
Following guidelines regarding isolation and exercise. As usual activities put on hold have had to make a significant adjustment in daily life, routines and in the social sphere	Getting used to having to spend a lot of time indoors and not meeting people, difficult at times, Have made adjustments to getting supplies and exercise	No additional support currently
work has improved greatly as we now have online meetings. Before because I worked from home I was largely ignored which affected my mental wellbeing significantly.	video conferencing	none
We are all fine	Staying at home and staying safe	Nothing really
Have been ill, have a family member in ICU on ventilator	Resting, staying at home, hot fluids	have other family helping
I am "socially distancing", trying to stay 2 metres away from everyone whom I meet. When I have to go to the Post Office, to send money by MoneyGram to my foster-family in Kenya, I wear a disposable face-mask and a pair of disposable gloves. I do not own goggles but I do wear glasses. In my shopping-trolley, which I use as a disguised walking-aid, I carry a pack of disposable hand-sanitising-alcohol-wipes which I use to sanitise anything which anyone else has touched. I am very pleased that the Post	I have been sending and receiving more emails and phone-calls than I used to do before the lock-down. None of my family lives with me, but we keep in touch.	I do not need additional support, but thank you for offering it.

Office only allows 4 customers at a time inside. After I have finished in the Post Office, I walk from there to Sainsbury's Supermarket to buy fresh food and household items. The staff there control the number of customers entering the store, so there is always a long queue outside. Inside the store it is impossible to avoid coming face-to-face with other customers, some of whom are not wearing masks, which I think is stupid of them. Many of the staff, but not all, wear masks. There are well-disciplined queues for the checkouts, with coloured tape on the floor marking the 2-metre intervals. There are transparent screens between the checkout operators and the paying customers.		
Nervous about situation Angry at government's delay and lack of testing Financial loss	Getting on well Enjoying time together	Truthful factual news reporting
It's terrible	Nothing	I am looking after my both elderly parents with dementia and other high risk health issues
It has changed the way we behave	Sanitizer and hand washing	None
Yes	No going outside	None
We have moderated our way of life to be fully compliant with COVID-19 protocols.	All of the changes; we have adjusted well.	We are fine at the moment.
We are having to find creative ways to manage our emotions and energy levels. As a family 1 parent is working from home and home schooling the children whilst the other parent is a keyworker and is still working.	having family time	none
We are Lockdown in the house for the last four weeks.	We are getting ready-made food from Swaminarayan Temple, Neasden.	N/A
Physical distancing has meant that we have changed the way we interact - now only by telephone and email rather than face to face. I also miss getting out and about, having had to cancel several planned days out / away.	More time to work through my ever growing list of things to do, e.g. garden tasks.	None, although I'd like to cut down on the number of times per week I need to go shopping for food. It has been impossible to get a home delivery slot from any of the supermarkets, which means I have to risk coming into contact with others every two or three days or so.
Not very much	We have been minimising direct contact more so because my sister is in the a high risk category	None really

It's been a shock. I've received a letter from the NHS telling me to shield and self-isolate as they have identified me as someone at risk of severe illness if I catch Coronavirus (also known as COVID-19). This is because I have an underlying disease or health condition that means if I catch the virus, I am more likely to be admitted to hospital than others.	With God's grace none of my family are infected yet.	To be identified by Supermarkets to be in the extremely vulnerable and at risk category. Despite registering in the Government website, no one has contacted me at all. Consequently, I've been unable to get priority access to shopping delivery slots.
unable to visit families, theatres etc, going shopping, unable to buy plants, meetings have been cancelled, variety of life	just doing things about the house and garden	would be helpful to have help with food shopping
We've been staying in other than for food shopping.	Everything has been fine.	None.
I've been working from home for several weeks now. Anxious tray govt is incompetent to increase testing in community setting with no clear plan other than social distancing! We need clarity how they going to increase community mass testing to trace and isolate cases. It's just anxiety!	I've been having friends who help with shopping. Very lucky and thankful	My family has been asking me to come home but unsure how to manage travelling without exposure! Occasionally friends unable to help with shopping so not sure sometimes whom to ask. I don't want to be a burden
My levels of anxiety, already diagnosed as clinically high, have been heightened	nothing frankly	On Monday I emailed CNWL Single Point of Access CNWL NHS Foundation Trust. Today (Thursday) they emailed to ask how I was and tell me they were over-worked. Mental health support is so poor that I suspect there will be deaths due to it
I am furloughed from work, and staying indoors systematically, except to go food shopping or exercise.	Daily physical exercise, mostly indoors	So far, no additional support needed, thank you
Some work colleagues have died and my parents neighbours both died of COVID	Working from home has been effective as we have the technology at work to allow this	My parents are over 70 and have still not been able to get support to get their shopping. They do not have LTCs but are still in a higher risk group but not high risk enough to get help
We have been staying in much more. Family meals and walks.	Shared meals - sometimes arguments! Doing more things together	None
I am in self-isolation as I am a fulltime carer for my 93 year-old dad who has some serious health issues. Very limiting.	Thanks to a volunteer, we get some food shopping. I also like the quiet sometimes	Online shopping has NO DELIVERY SLOTS!!That should be opened for us vulnerable people. Thanks for volunteers bringing basics. I would like more food support.
Dramatically	Facetime, WhatsApp phone calls	I think we are OK we are coping best we can
well I trying cope I am support worker but I was of work couple weeks Ii have underline	communication in England abroad. I	all year wrong MP want votes there in same things as us to but should an office

health issues reading seeing news each time became so worried nobody telling u proper truth I had go back work keep me busy .just trying take care myself stay on top of things ..but scary for me I live alone .I speak my parents daily not same seeing them .I fear worry if something happen me who will know .I pray father God to keep me safe as I see too many people die. I don't understand everyone get flu get treated can't find nothing help cure people. Just leave them to die without dignity. Lots nurse doctor die there are who to care for us .some days I cry .if family from abroad call see how I am it is scary haven't to speak about i.e. normally clean my house I become more obsessive in cleaning ..	hate breaking alone here day how people dying	set up at their home if want connect ask question just hear someone voice.as loneliness is my biggest situation as a carer it hard dealing patients dying you got come home to deal with the mental side of things.
Me and my partner work from home and exercise in the park every day. We miss being having our daughter to visit but she works (emergency services) in an office and doesn't want to infect us.	Once set up, working from home has been efficient - but obviously limited. I usually engage with communities and businesses and it is not appropriate to do that now.	We are fine
Restrictions in social interactions, shopping and going to work.	Social distancing. Online food shopping has got easier.	None
I and my husband were both symptomatic.	I am working from home but my husband is not allowed to work from home since he works for NHS Administration team.	I have a small baby and hence need some priority over supermarket shopping/delivery

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Appendix 2:

Healthwatch Brent COVID-19 Community Engagement With Brent Residents and Care Schemes

EXECUTIVE SUMMARY

This report summarises the engagement work Healthwatch Brent undertook between 23 March to 7 June 2020 with Brent residents and care homes to capture a snapshot of the BAME experience of the pandemic.

We interviewed the care homes we had visited as part of our Enter and View Programme and summarised their responses.

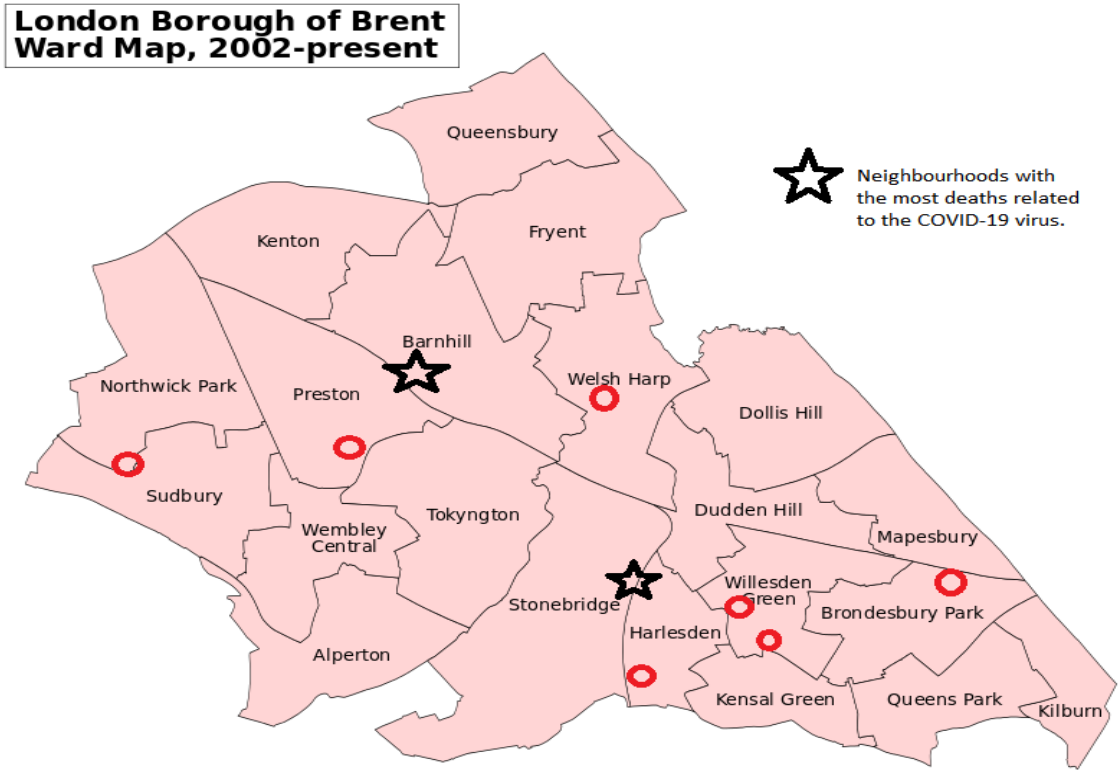
- Of the 7 care homes visited, 6 had not experienced any Covid-19 related deaths since the outbreak. Whilst it is not the role of Healthwatch to speculate on this information, the team noted that none of these care homes had raised concerns during the Enter and View visit.
- A case study from Carewatch Brent summarises their experience of continuing to deliver services to some of the borough's most vulnerable residents.
- We interviewed BAME keyworkers who had contracted the disease and summarised their reactions to receiving advice, information and support.
- We spoke with patients with underlying health conditions to listen to how they managed their fears and what they believed would help to minimise that.
- We spoke to different types of carers to better understand the dilemmas they have been facing during the current lockdown and how it has impacted on their mental health.

Introduction

Healthwatch Brent has engaged with Brent's diverse communities, with the specific aim of gaining a better understanding of the impact of the coronavirus on these communities. We have used different techniques and methods to gain access to hard to reach and seldom heard groups. With the implementation of social distancing, we changed our approach by using digital media such as WhatsApp, phone-calls, support groups, and contact with prominent community members.

The aim of the engagement was to capture a snapshot of the BAME experience of the Covid-19 pandemic. We were particularly interested in reaching communities that are seldom heard, such as the Somali Community. We contacted Residential Care Homes, Sheltered and Supported Housing Schemes whom we had visited as part of our Enter and View programme in 2018-19 to find out about how they had been coping with the pandemic. We spoke with keyworkers in the BAME community who had contracted Covid-19, carers balancing their responsibilities and ordinary residents to gather information about their experiences between Mach – June 2020.

Speaking to care homes



The care homes consulted were evenly distributed across the borough. Brent has recorded the second highest COVID-19 deaths in London after Newham. The Church End area, has been reported as the neighbourhood with the most COVID-19 deaths - 28 deaths reported between 1 March and 17 April, more than anywhere else in the England.[1] The Avenue area of Barnhill was listed as the fifth in the list of neighbourhoods with the most COVID-19 deaths.

All the care homes were contacted by telephone and explained that Healthwatch Brent was following up after the Enter and View visits previously to find out how they were managing during the lockdown. When we spoke with them in early April, all of them confirmed that they had felt supported by Brent Council and had received regular supplies of personal protective equipment and support from council officers. As figures started to emerge about Brent's high Covid-19 related deaths we decided to re-contact these care homes and spoke with the scheme managers – all of whom were from BAME backgrounds and invited them to share their experiences of delivering residential care during the pandemic.

Outcome of Feedback from Care Homes

Seven care schemes were interviewed. Table 1 provides a brief description of the experiences shared by staff, family and relatives. Six of the care schemes did not have to hospitalise any of the residents of staff due to COVID-19; unfortunately, one scheme [Tulsi House] suffered several Covid-19 related deaths including that of a staff member. All the care schemes interviewed were

[1] The New Statements, 1 May 2020 'These are the neighbourhoods hit hardest by Covid-19' (based on figures published by the Office for National Statistics)

subject to Enter and View visits during 2018-19. No concerns had been raised about six schemes who were also able to confirm that no Covid-19 related incidents had taken place up until the time the Healthwatch Team contacted them. Tulsi House which is managed by Westminster Home Care Ltd had received complaints about their care practices and also had lost one member of staff and several residents to Covid-19. Concerns about Tulsi House had already been raised to Brent Council's Adult Safeguarding Team.

The team also spoke with Carewatch Brent who wrote a report about their experiences of working with Brent Council. The report is attached in the annexe and paints a positive picture of their experience of receiving support and PPE from Brent Council.

Speaking to Covid-19 patients and their families

We wanted to speak to BAME residents who had contracted Covid-19 about their experience of having the disease and whether they felt they could access enough information about services and support.

Individual members of the community were approached by telephone and asked to share either their experiences, or that of a close relative, during the pandemic. We were particularly interested in hearing from seldom heard groups including members of the Somali community.

The majority of people we spoke with included key workers, carers and vulnerable residents.

The questions posed were:

- How have you been affected by the pandemic?
- Have the found it easy to find clear and understandable information about keeping safe during the Covid-19 pandemic?
- Are you or your relative in the at-risk category?
- Were you or a close relative hospitalised?
- Were you or your relative satisfied with the services you received?
- Since the pandemic, have you or your relative received help from; a Covid-19 support group, a family/relative, a neighbour, a paid carer, or other?
- What other information would you like to share with us?

Case studies:

Patients who had experienced Covid-19 symptoms or confirmed diagnosis

Case Study 1 [Somali Male 45-55 yrs]

Occupation: Bus Driver

Tested positive for COVID-19. Was ill for 2 months. He decided that he would not be hospitalised, because he did feel safe in hospital. His elderly mother was hospitalised and was on a ventilator. He complained that the hospital did not feed his mother properly. He said, "They leave the food next to the patient, and it's up to them if they eat." He also complained about the lack of information and support for relatives. His mother made a full recover, even though the hospital did not expect her to recover. He has relied on close relatives for support when he was ill. He has

returned to his job as a bus driver, and he continued to assist his mother with shopping and other tasks.

Case Study 2 [Somali Male 60 yrs]

Occupation: Teacher

A close friend of Case Study 2 was interviewed. The teacher was hospitalised and tested positive for the virus. The wife did not understand what was happening to her husband, and she felt that staff did not try and explain any of the procedures. The husband was placed on a ventilator. He was able to stop using the ventilator at one point. The wife was confused when the nurses then said they did not expect him to survive, and that she should come to look at him through the glass partition. The wife thought her husband was getting better. After two days, the teacher passed away. The wife felt strongly that there was lack of clear explanations; no translator was provided. According to the account received, the staff were cold and distant in their communications. The wife of the deceased relied on close family for support and was not aware of any other support available.

Case Study 3 [Somali Male 30 yrs]

Occupation: Care Worker

This young care worker contracted the virus and became unwell for a short period. His sister also contracted the virus at the same time. Both recovered quickly and were not hospitalised. They have both since returned to their jobs. The virus appeared to have made very little impact on this young care worker and he did not shown any anxiety about being exposed to the virus due to his job.

People living with underlying conditions:

Case Study 4 [Somali Female 50-55 yrs]

Occupation: Domestic cleaner

Case Study 4 was diagnosed with cancer at Northwich Park Hospital at the beginning of the year. She was told that the cancer had spread and was untreatable. The resident decided to travel to a German hospital to seek a second opinion as many members of the Somali community are more confident about receiving clinical advice from non-UK healthcare professionals. She was informed by the German doctors that the cancer was localised, had not spread, and that she needed an immediate hysterectomy. She returned to London to make arrangements. Unfortunately, the closure of international borders as a result of the pandemic prevented her from returning to Germany. This experience reinforced this person's view that the UK health system could not be relied upon. However, many members of the Somali community are unlikely to use the statutory complaints procedures which raises the question on how services can improve without a trusted feedback process.

Case Study 5 [Indian Female 50-55 yrs]

Occupation: Receptionist/Organiser

Case Study 5 suffers from some underlying health conditions but has managed to stay healthy during the pandemic. She mentioned how she has followed a clear routine and has invested in masks, sanitisers, and cleaning products. She has relied on close family and did not feel the need to use any outside organisations. She said, “Indian people rely on themselves and close family members. We don’t have any central meeting places or activities which bring us together.” The husband was the member of the family who did all the shopping, while the rest of the family remained indoors and isolated. The daughter was attending university and is now being taught through online classes. The residents complained about the lack of information in community languages, and she stated that she was not happy with how the news media had covered the pandemic. She has participated in The CovidLife research project survey but felt puzzled about what to do apart from following the government’s mantra.

Case Study 6 Asian Female 69 years

Occupation: Semi-Retired NHS worker

Mrs H had been given the ‘all clear’ from her GP earlier in the year after receiving treatment for Breast Cancer. However, Mrs H had not received a letter from the NHS to confirm that she was a clinically venerable person who should be shielded. She is a member of an Asian Women’s Cancer Support Group and it was through them that she found out about her status and needed to maintain strict social distancing due to her illness. Mrs H contacted her GP who confirmed her status and contacted the NHS who then sent her the letter of notification which unlocked a menu of support services. Despite also having other underlining health conditions, Mrs H was reluctant to maintain her outpatient treatment as was fearful of contracting Covid-19. However, she now fears that she will be penalised for missing out on her ongoing treatment and is becoming increasingly anxious.

Despite everything, Mrs H has considered herself lucky because despite being a total IT novice, she had her husband to show her how to access services and be socially connected. Mrs H in turn supported her peer group who faced language barriers and gave out information in Gujarati relating to Covid and also helped her peer group to learn some of the IT skills in order to socialise with friends and family. Mrs H mentioned that having support of her own community communication help her reassure about the authenticity of information relating to Covid 19.

Listening to carers

Case study 7 [56 years] White Female.

Occupation: Full time unpaid Carer of 29 year old son with learning difficulties.

Ms A is a single mother who has been looking after her only son who has a learning disability. She has been reliant on state benefits for over 25 years and been a Brent resident all her life. Ms A, lives in a council-owned 2 bedroom lower ground floor flat with access to a small communal garden which she has been using during the lockdown for keeping fit. However, the continued lockdown has taken a toll on Ms A’s mental and physical health as she has had no respite for the past 12 weeks.

Prior to the lockdown, her son attended a day centre 3 times a week and supported by a paid carer who would take her son out on for regular outings. All of this support ended with the

lockdown. The son didn't understand why his liberties had been taken away and his behaviour became progressively disruptive and unruly. His enforced isolation also meant that he began to emotionally eat to off-set his boredom. This created an additional strain on Ms A as she could not afford the extra food her son was demanding which caused her additional distress.

To further complicate Ms A's situation, she now has to invest in PPE equipment and is worried that her Direct Payment will not cover her costs.

Case Study 8 Male (Asian 45-60 years)

Occupation: Pharmacist

Mr A is a Brent pharmacist who lives in a multigenerational household with his wife and elderly parents. Following the announcement of lockdown and Brent GPs moving to online consultations – the responsibility for medicine provision and consultations has fallen on community pharmacists. His pharmacy was initially not prepared for the change in service provision and staff did not have adequate supplies of PPE. However, this was soon rectified and Mr A was provided a face mask which he wore throughout his duty rota responding to the stream of patients and residents collecting medication and wanting advice. Mr A was working six days per week to meet demand. Over the period of lockdown he has become increasing physically and mentally exhausted. He was terrified that he would become a carrier of the coronavirus and inadvertently pass the infection onto his elderly parents in spite of all the precautions he took in accordance with both government and professional advice. Mr A has had minimal contact with his parents since lockdown and this has caused much distress for all the family. Mr A feels the government has not taken into account the risks faced by key workers who are not part of NHS and that all the support is being given to hospital-based NHS workers. There is also no additional support for key workers living in joint households. If Mr A is worried that if has has to continue providing the same level service for few more weeks, he would suffer from exhaustion and would not be able to carry on working as a pharmacist.

Case Study 9 Female 75 years plus [Afro Caribbean]

Occupation: Volunteer Community Worker

Mrs W is an active member of an Afro-Caribbean luncheon club for the elderly based in Willesden. The weekly social club has had to stop operating since the Covid-19 lockdown. This has resulted in suspension of the luncheon club resulting in the attendees feeling socially isolated. Mrs W as an elder had found solace by volunteering at the club and had formed positive relationships with the attendees and enjoyed caring for them. She now feels anxious that there is no one available to check up on these individuals – many of whom have no wider support networks so felt that she needed to look out for them.

Mrs W provided a telephone befriending service to many of the attendees who were not digitally literate and had no social media accounts. Mrs W mentioned that these attendees were terrified by the media coverage of the pandemic, the focus on deaths and not recovery and the pervasive nature of the virus and refused to leave the house even to pick up essentials. Some of the club members were living in poor housing conditions and she was concerned about their welfare but didn't know where to go for assistance. However, Mrs W with her daughter's support prepared meals for some of the members who were particularly frail and unable to prepare any meals for

themselves or to purchase ingredients. Unfortunately, after few weeks of voluntarily cooking food at home for some of the elderly members, she had to stop as she could no longer afford to give away free food. Mrs W, asked if there were any organisations that would help with a small grant for her continue providing food to the venerable of the Afro Caribbean elderly community? Mrs W experienced a great deal of guilt because she was unable to help the attendees and many of them kept calling her hoping that she could help them.

Table 1 Name of Care Scheme	Description of Scheme	Impact on Staff	Impact on Families & Relatives	Hospitalisations due to COVID-19	Other Feedback
Arran Court, Sheltered Housing **Wembley HA9 ONU**	Arran Court is a sheltered housing scheme with 31 flats – there are 1 bedroom and 2 bedroom flats. The facilities at Arran Court include lift, lounge, guest facilities and garden. New Residents are accepted from 55 years of age. Currently Arran Court has 31 tenants.	Impact has been minimal. Manager keeps in touch with residents while social distancing.	Families bring shopping and leave it outside their relatives door or downstairs. Some residents decided to stay with their family at the beginning of the pandemic	No hospitalisations due to virus.	They were happy with Brent Council supply of PPE.
Avonhurst Sheltered Housing Scheme **Willesden** **NW2 4DF**	Avonhurst is a general sheltered housing scheme with 40 residents.	Manager keeps in touch with residents and visits weekly to carry out fire alarm test and other duties. Manager continues to arranges GP appointments, food deliveries, checks residents needs and arranges cleaning for them and any repairs.	Social distancing, no visits unless a health professional.	No hospitalisation due to virus. One person is shielding.	When we go back to normal we will create a 'hub' and arrange art lessons and cake decorating activities. Network Homes has arranged external cleaners to come in 7

					days a week. They are wiping handles, doors, etc., and have put up a notice saying “No visits unless from a health professional”.” “We are very well taken care of.”
Tower House **Tower Road** **NW10 2HP**	Tower House Residential Home registered for a maximum of 8 service users. The majority of people at the home were living with dementia	All staff and residents tested negative. Staff constantly test the temperature of residents, and they keep monitoring them closely.	Families have given feedback to Manager. They were happy with all residents testing negative for the virus.	No hospitalisation due to the virus. All residents tested negative. Two residents went into hospital for other issues - they both tested negative before going to hospital and were still negative on returning to the care home.	Very happy with Brent Councils supply of PPE
Tulsi House	Tulsi House is an extra Care scheme with 24	The Manager (Network Homes) works remotely, and speaks to the tenants	Some residents are shielding. Relatives in contact through	The care services are provided by Westminster Home	It took a while for get adequate supplies of PPE.

Wembley **HAO 2RA**	hours / 7 days care; it has 36 flats.	and carers every day. Westminster Home Care is responsible for the care services. Some staff are currently unwell and have tested positive for the virus.	phone. Several residents tested positive for virus.	Care Ltd. Several residents have tested positive for the virus. A number of deaths due to the virus including the loss of a care worker. 1 or 2 residents are currently in hospital. "Sometimes we complain to the hospital if we believe a resident has been released too early. If we feel they are still poorly, we inform the hospital on behalf of the resident."	
Visram House **Acton Lane**	Extra Care Scheme with 84 one bedroom and 15 two bedroom purpose built, self contained flats. Day time staffing to deliver ongoing care and assistance. Night time staffing to help with evening routines, assistance in bed,	Staff have remained free of the virus. Staff all OK.	Social distancing in place - with no visitors allowed. A risk assessment is currently being carried out, so as to assess the possibility of using the communal area for	No hospitalisation due to the virus. No one has tested positive for the virus.	Excellent supply of PPE.

	toileting and monitoring for wandering.		one to one visits from relatives/family members.		
Lee Valley Care Home **Wembley** **HA9 7QU**	A Residential Care Home for those with enduring mental health problems and Dementia. Currently there are 7 users. They have expanded into the neighbouring property, with 3 residents.	A risk assessment was carried out for staff who do not have safe access to transport. No staff sickness.	Most residents do not have close relatives. One resident has a sister in Ireland, and face-time calls are used.	No hospitalisations. No one has tested positive for the virus.	"Brent Council has been wonderful with the supply of PPE and with support in general. Only one resident has the capacity to go out to the shops unaccompanied.
167 Willesden Lane [CMG]	A supported living service providing personal care support for people with profound and multiple learning disabilities.	One member of staff was afraid to come to work because of the risk of travelling on public transport. The staff member decided to resign due to her anxiety.	The service was closed to all visitors. Manager has arranged video calls to relatives frequently. One relative looks through the glass doors, while keeping a safe distance, so as to see her son.	No hospitalisations. One staff member had a cough and temperature; but tested negative for the virus. All resident test negative for virus.	Abundant supply of PPE

CAREWATCH BRENT – COVID-19

1. WHAT CONTIUES TO WORK

- Devoted Workers – both office and field-based have shown a 'business as usual' attitude to work despite the challenges with COVID-19 and continue to support clients as though nothing changed
- Implementation of our contingency (Business Continuity) plan - Following the Government announcement of a pandemic, we prioritized services to our most vulnerable clients. Some family members who live with our not-so-vulnerable clients agreed to help due to a high initial staff absence.
- Receiving referrals both from the local authority, the CCG and the private sector and have been able to provide support to some clients depending on need
- Supporting 2 of our clients in the community having recovered from COVID-19 (and confirmed no longer contagious). We have achieved this as we have enough Personal Protective Equipment (PPE) and are following the Public Health England (PHE) Guidance.
- PPE we have, include goggles, gloves and aprons, hand sanitizers, face masks and face shields. We have enough to last us more than a week
- Continue to maintain contact with clients, suppliers, commissioners and the public through the diversion of our main line to mobile phones to promote remote working from home for some office staff
- Retained 80% (20% are off due to sickness, lack of child-care, shielding, self-isolating or because they are scared to be on the frontline) of our workforce still providing a service on the field. This is just enough to support 80% (20% are either self-Isolating, shielding, cancelled visits or have family members supporting them) of our clients who are still requesting daily visits.

2. THE CHALLENGES

- During the first few weeks of the pandemic many staff were absent for various reasons and excuses; but things are settling down now, with a small number of staff shielding and/or isolating and others returning to work. Majority are key workers whose regular clients are refusing care from cover staff.
- One member of staff is off sick with COVID - 19 (test confirmed positive) also a key worker with numerous calls on his rota. We have no idea when he is coming back to work
- Some staff are on sick leave due to stress and this is in part because they are working their normal shifts on top of covering for absent staff
- There is a lot of scare mongering and negative press about the virus. Staff are not convinced it is safe to work even with the correct PPE and guidance from PHE. E.g staff travelling by public transport believe that they can catch the virus on the bus because a lot of bus drivers have lost their lives to COVID-19, or because other people travelling on the bus are already infected by the virus and may pass it on to them. Majority of the staff travel by public transport to visits.
- Office Staff are enabled to work from home to minimise any need for travel and being exposed unnecessarily to any risk of catching the virus. However, there is a need to maintain some presence in the office to provide field staff with PPE and other supplies, deal with the posts and any emergencies, and to receive items from suppliers.
- Only 2 out of 100 staff took the COVID-19 test despite everyone being offered the opportunity to be tested. The few that agreed to be tested did not have access to a car to drive to the test centers. Home testing kits would have been helpful in these situations.
- Some staff did not take the test for fear that they would test positive. A few felt they would be exposed to the virus if they visited the test centre
- We are unable to force staff who are 'isolating' to take the test as there is currently no guidance on this; and we have no means of proving whether they genuinely need to be off 'sick' or for other reasons

- Sourcing of PPE was difficult immediately post-lockdown; largely driven by a scramble from many sectors looking to secure PPE. It was evident that suppliers were benefitting from the situation, which ultimately led to increase in costs and in delays in delivery. We initially spent a lot of money to buy more than our usual supplies. As demand exceeded supply, suppliers asked for payment in advance of delivery which took away the privilege of a 30-day interest free paying facility
- PPE suppliers are currently not living up to their promises over what they can deliver and when. Hand sanitizers we ordered left the warehouse but were never received. It took a while for us to be able to provide staff with hand sanitizers
- Concerns around recruitment - While Carewatch Brent is paying a better wage since 1st April 2020, provides good terms and conditions of employment, the sector as a whole is hard to recruit to and we consistently have vacancies meaning even a small number of staff absence has a large impact on the services we provide. We are monitoring rotas and moving staff around where need be; and have planned contingencies but we still have anxieties about the number of people we can recruit.
- Where we have managed to get new recruits through a free DBS (COVID first request), we face other challenges around providing relevant training as we no longer provide classroom -based training. Some recruits are unable to access training on-line (which we have sourced external training providers to assist us with). Workbooks and training resources provided are not returned for assessment and therefore, the recruitment process can often not be progressed.
- Some prospective workers send applications for the sake of it and will not respond to text messages, emails or telephone calls once CVs are received and shortlisted.
- Growing issue around childcare - School provision for frontline staff is not consistent and what is available does not necessarily support our workers, especially in the evening and night. A lot of the parents also simply refuse to send the children to school for fear they may catch COVID-19. Affordability to pay privately for child-care is an issue for many of our staff especially those who would normally rely on family members for childcare and are not able to do so at present due to social distancing rules.
- Assessment of client needs - In some cases, we have moved reviewing of care plans to a phone-based system. This does lose some of the human contact but is working for now especially where family members are off work and free to contribute to the assessment process when they would otherwise not be available or be able to afford the time.
- There is currently a lot of tracking and reporting of staff and client absence and COVID-19 issues; creating extra work for staff and it would be good for some co-ordination of these requests are quite repetitive. We currently have no idea whether this data will be shared, in what format, and whether this will be helpful information for us

3. THE SUPPORT WE GET AND STILL NEED

- Brent Council has kindly given providers an uplift in fee rate of 0.40p (2.56%) per hour from 1st April 2020. We have increased our pay rates by 0.50p per hour in line with National Minimum Wage requirements and to make us a more attractive employer. We would benefit from a review of the fee rates especially due to the significant loss of business and the extra costs incurred from changing the way we normally work, paying extra overhead costs etc. We are keen to negotiate with the local authority should they give us the opportunity
- Even though Brent is kindly helping us to recruit new staff, and is certainly helping us to access valuable training, it will be helpful if we could access some simple and easy to follow care certificate training for new staff. Carewatch has provided some external training resources but these are currently very stretched as most providers in the network have a great demand for it.
- We have weekly Urgent Home Care Forum meetings via Microsoft Team meetings where the Local Authority staff talks through updates. These meetings are very helpful.

- Brent Council also organized a Public Health infection control training session (emphasis on COVID-19) for providers (also held through Microsoft Teams) which was very valuable. We are planning to have another session for our field staff.
- We have weekly Microsoft Team meetings with Head Office and other franchisees in the Carewatch Network where we share ideas/ experiences and practices. Different offices appear to be dealing with different challenges across England and Scotland; Shortage of PPE being the greatest challenge it appears.

4. PPE – BRENT COUNCIL SUPPORT ETC.

- Brent Council has exceeded our expectation in terms of support over these difficult times.
- In terms of PPE Supply, we have been given enough gloves, aprons, hand sanitizers, goggles and face masks. We are usually invited on a weekly basis on a Friday to pick up supplies from the Civic Center. This is very well organized with planned time slots for providers so the waiting time is minimal. We could not ask for more and are very grateful.
- Brent Local Authority deserves a round of applause for supplying enough PPE and for many more things; and we should be remembering them at 8.00pm on Thursday evenings when we clap for our health care heroes.
- We hope to resume to better 'normality' after lockdown with a focus on being a better digitally connected business; implementing lessons learned and embracing efficient processes.

Jane Mensah

Registered Manager

Carewatch Brent

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