	Health and Wellbeing Board 29 June 2020
	Report of the Director of Public Health
Disproportional Impact of Covid-19 in Brent	

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

1.0 Purpose of the Report

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

2.0 Introduction

2.1 Covid-19

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

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

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

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

2.2 Data

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

2.2.1 Brent Cases Information

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

2.2.2 Brent Covid-19 Hospitalisations Information

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

2.2.3 Brent Deaths Information

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

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

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

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

2.2.4 Brent resident deaths at Hospitals

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

2.2.5 London Northwest University Healthcare NHS Trust data

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

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

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

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

The outcome of these patients is shown below.

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

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

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

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

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

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

Age profile of deaths across London Northwest inpatient sites

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

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

Number of pre-existing conditions

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

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

Research undertaken and planned

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

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

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

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

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

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

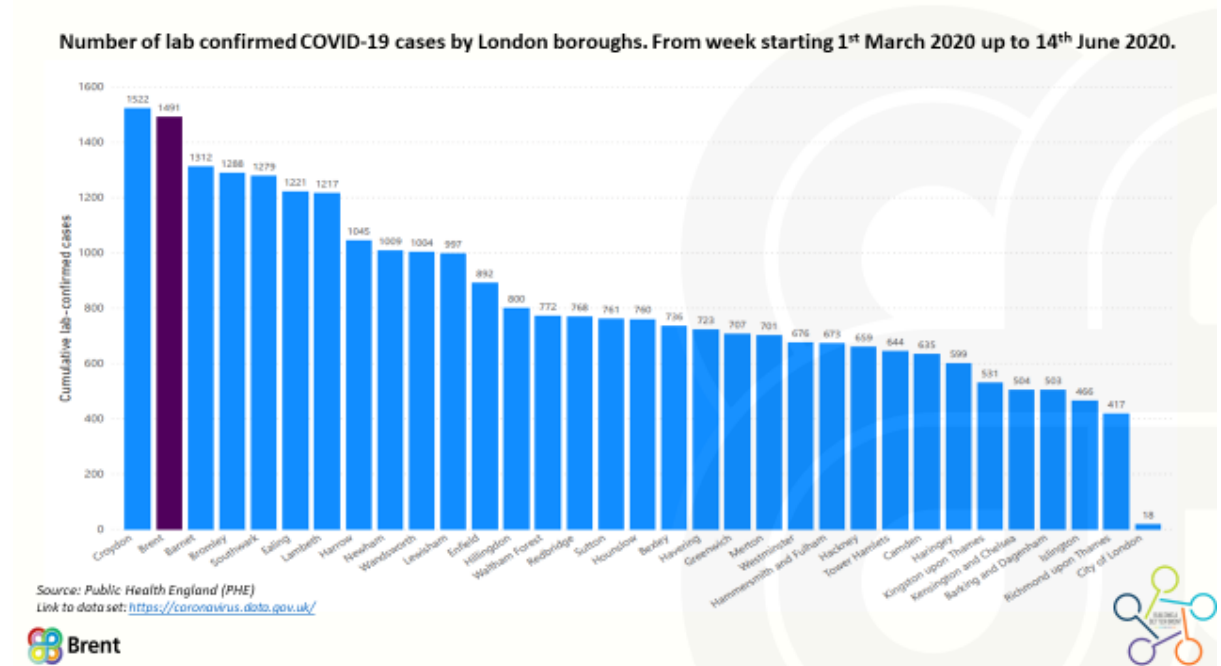
2.2.6 Brent resident deaths at Care Homes

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

3. COVID-19 in Brent

3.1 Cases

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



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

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

Place of death

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

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

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

Notes:

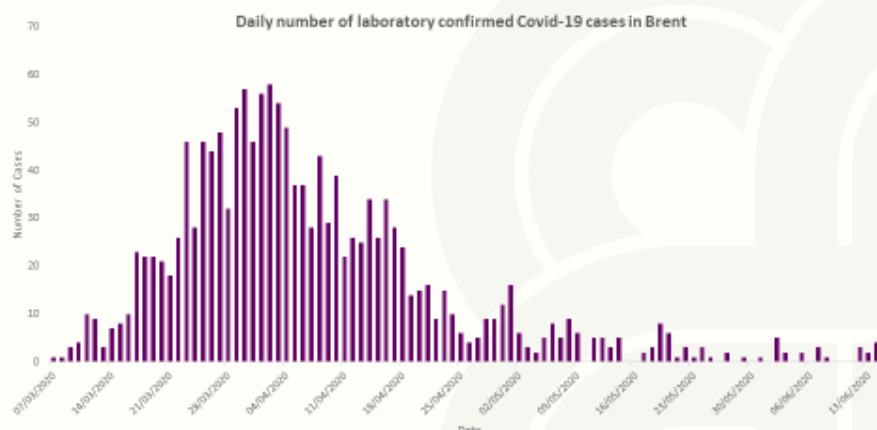
- Deaths (numbers) by local authority and cause of death, 2020 occurrences, by place of occurrence, England and Wales
- Deaths occurring in England and Wales registered on the General Register Office's Registration Online system (RON).

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



3.2 Progress of the Epidemic

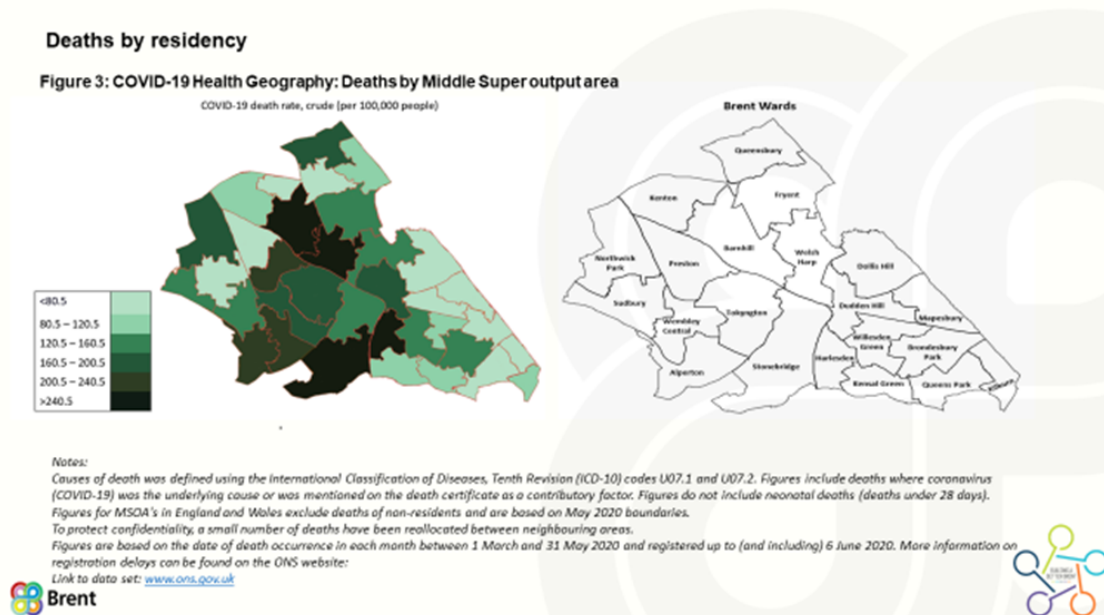
When epidemiologist study infectious diseases, they look at the number of new cases per day and use a graph to show how this varies. This chart is called an Epi curve.



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

3.3 Geographical Distribution of Deaths

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



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

4. Public Health England Report and its Conclusions

4.1 Ethnicity

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

When taking into account age in the analysis:

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

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

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

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

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

The same scenario for black women:

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

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

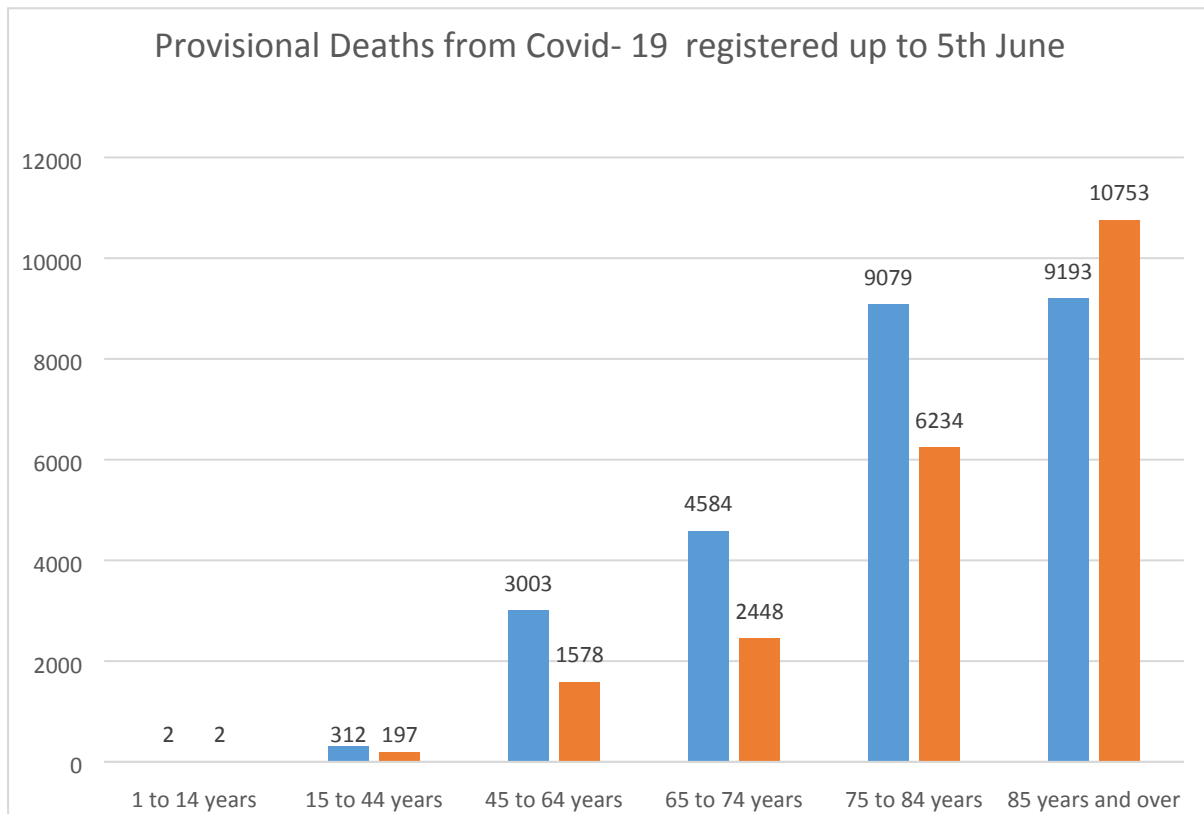
- Bangladeshi and Pakistani ethnic group males are 1.8 times more likely to die from a COVID-19-related death than White males;
- Bangladeshi and Pakistani ethnic group females are 1.6 times more likely to die from a COVID-19-related death than White females.

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

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

4.2 Age and Sex

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



4.3 Occupational Risk

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

4.4 Co-Morbid conditions

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

4.5 Socioeconomic Deprivation

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

5.0 Conclusions for Brent

5.1 Risk Factors – Vulnerability

5.1.1. Co-morbidity

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

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

5.2 Risk Factors – Exposure

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

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

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

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

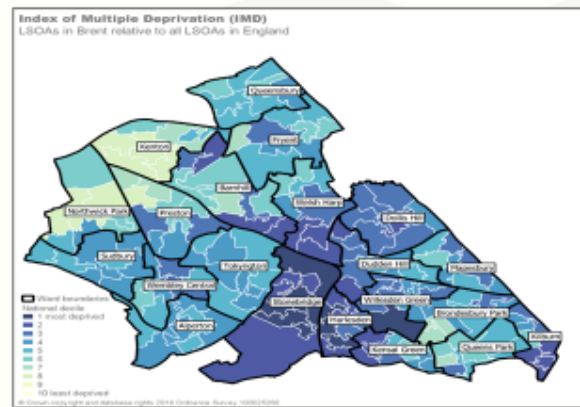
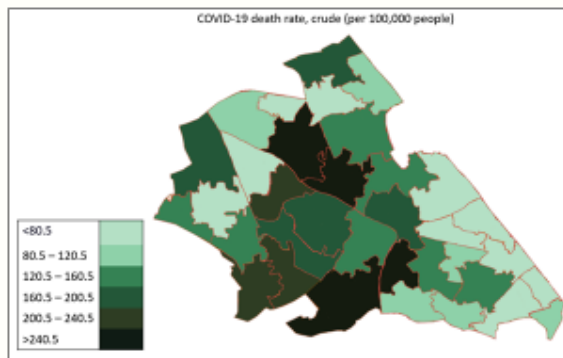
BAME community members are more likely to be frontline workers and less likely to be managers and able to influence their working conditions

5.3 Underlying Determinants

5.3.1 Socioeconomic Deprivation

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

Covid-19 and deprivation



Recently released national ONS data shows an increase rate of death for BAME individuals in particular these of black ethnicity.

Notes:

Causes of death was defined using the International Classification of Diseases, Tenth Revision (ICD-10) codes U07.1 and U07.2. Figures include deaths where coronavirus (COVID-19) was the underlying cause or was mentioned on the death certificate as a contributory factor. Figures do not include neonatal deaths (deaths under 28 days). Figures for MSOAs in England and Wales exclude deaths of non-residents and are based on May 2020 boundaries.

To protect confidentiality, a small number of deaths have been reallocated between neighbouring areas.

Figures are based on the date of death occurrence in each month between 1 March and 31 May 2020 and registered up to (and including) 6 June 2020. More information on registration delays can be found on the ONS website:

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



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

5.4 Care Homes

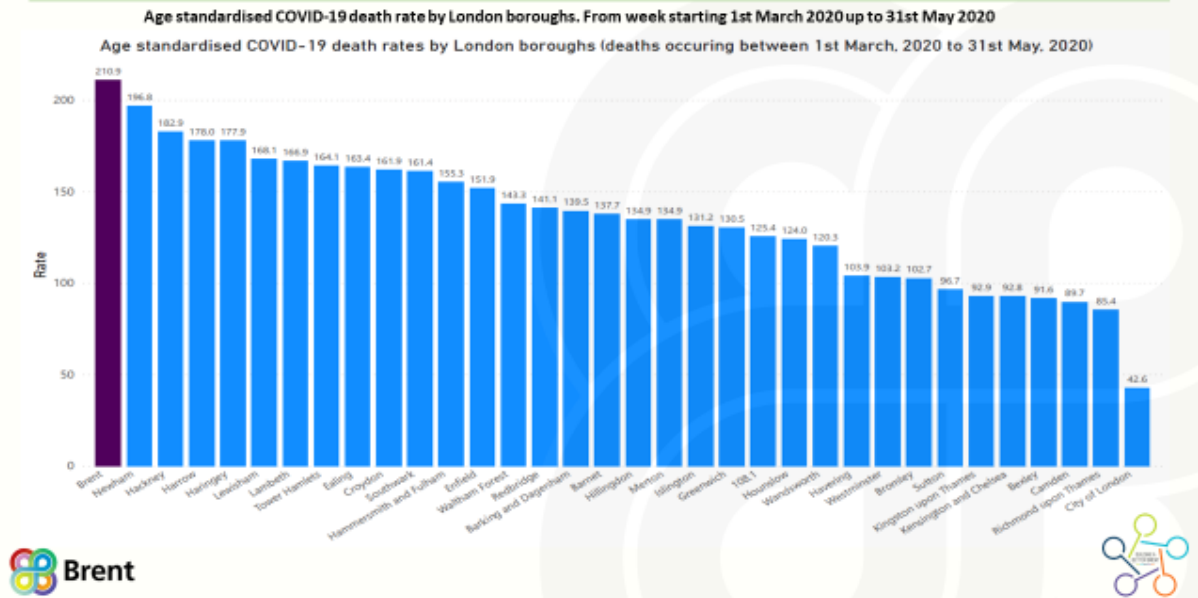
Covid-19 has the highest mortality rates in the older age group many of whom plus other individuals with vulnerabilities are found in Care Homes clients. In addition to the individual vulnerability of the clients. Managing Covid-19 outbreak in care homes is difficult for a number of reasons:

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

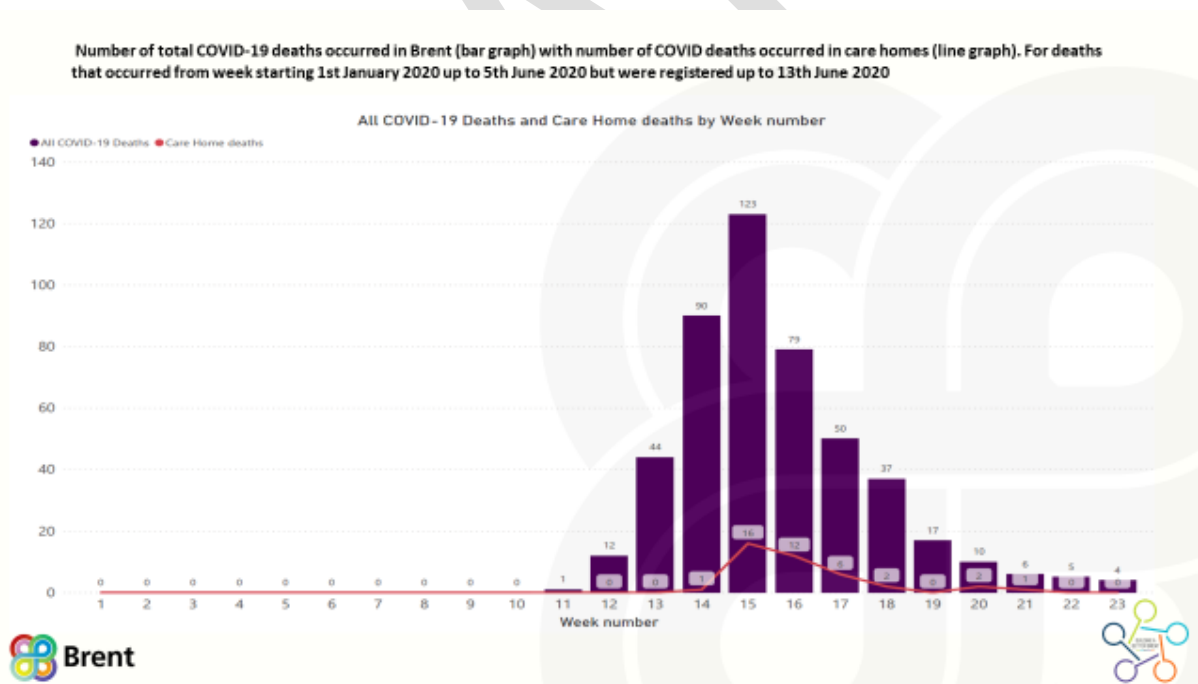
Brent through its Public Health and Adult Social Care Departments initiated a robust support mechanism to all aspects of operation including advice, training, staffing, infection control, testing, outbreak management as well as provision of PPE.

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

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

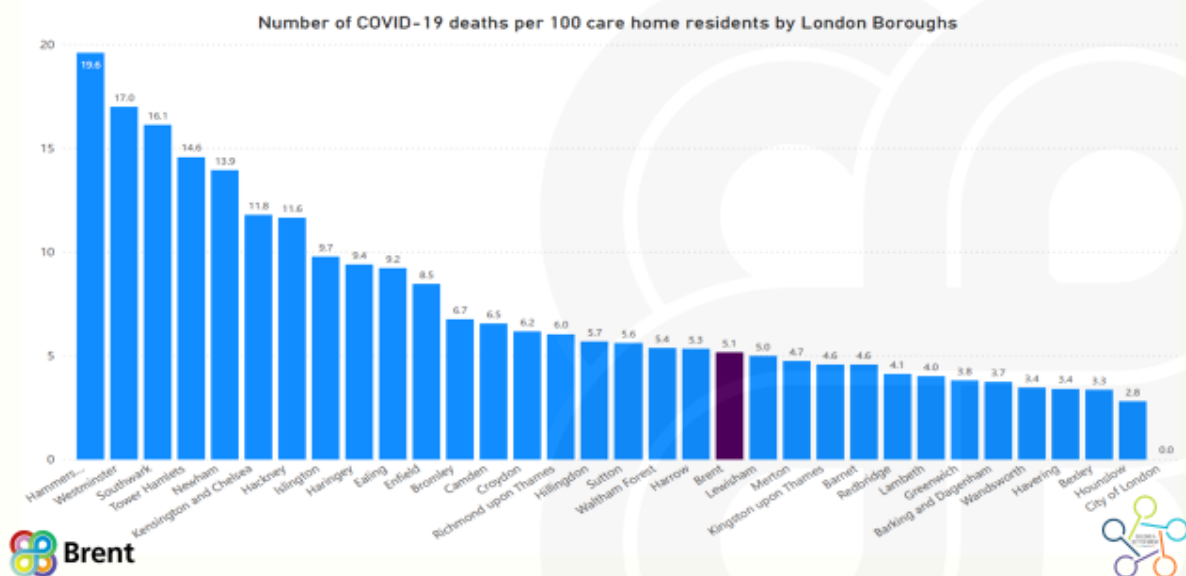


In addition, the outbreak in Brent in Care Homes happened at the same time as the outbreak in the wider community.



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

Number of COVID-19 deaths per 100 care home residents by London boroughs. For deaths that occurred from week starting 1st January 2020 up to 5th June 2020 but were registered up to 13th June 2020, (Care home deaths only)



5.5 Current Situation

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

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

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

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

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

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

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

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

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

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

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

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

5.6 Current Situation

5.6.1 Interventions to date: Brent Council

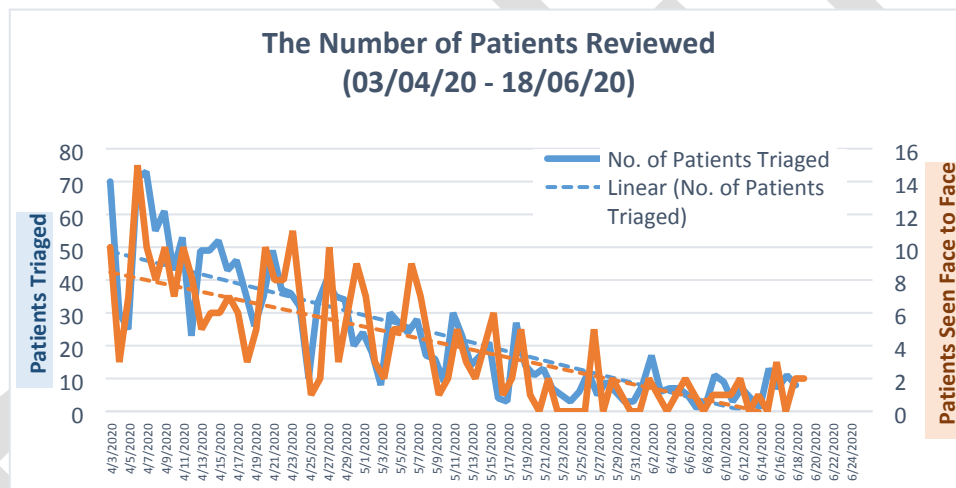
The Council has a comprehensive communications plan which aims to protect the community including its most vulnerable members including:

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

5.6.2 Interventions to date: Brent NHS CCG

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

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



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

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

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

6. Next Steps

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

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

- 6.1.1. Mandate comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems, including the mandatory collection of ethnicity data at death certification, and ensure that data are readily available to local health and care partners to inform actions to mitigate the impact of COVID-19 on BAME communities.
- 6.1.2. Support community participatory research, in which researchers and community stakeholders engage as equal partners in all steps of the research process, to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.
- 6.1.3. Improve access, experiences and outcomes of NHS, local government and Integrated Care Systems commissioned services by BAME communities including: regular equity audits; use of Health Impact Assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.
- 6.1.4. Accelerate the development of culturally competent occupational risk assessment tools that can be employed in a variety of occupational settings and used to reduce the risk of employee's exposure to and acquisition of

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

- 6.1.5. Fund, develop and implement culturally competent COVID-19 education and prevention campaigns, working in partnership with local BAME and faith communities to reinforce individual and household risk reduction strategies; rebuild trust with and uptake of routine clinical services; reinforce messages on early identification, testing and diagnosis; and prepare communities to take full advantage of interventions including contact tracing, antibody testing and ultimately vaccine availability.
- 6.1.6. Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions including diabetes, hypertension and asthma.
- 6.1.7. Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change. Fully funded, sustained and meaningful approaches to tackling ethnic inequalities must be prioritised.

6.2 Brent Specific Suggestions

6.2.1 Short Term Brent Specific Actions based on our findings:

Actions	By Who	By When
Data: <ul style="list-style-type: none"> Mandate ethnicity data collection in all aspects of NHS and Social Care interaction both Covid-19 related and otherwise including testing and contact tracing interventions Regular reporting to all partners in the health care system 	London North West Acute Trust Council Performance Team	1 month End of data collection
Co-Morbid Conditions and Diabetes <ul style="list-style-type: none"> Improve Diabetes Control in all patients with particular reference to BAME. This could be effected by monitoring HBA1C of all patients not measured recently or with poor control using disease registers and a digital recall system Diabetes awareness in BAME communities in Brent via outreach Diabetes testing in BAME communities in Brent via outreach or self-testing 	Brent CCG Brent Public Health Brent CCG	3 weeks 4 weeks 4 weeks

Actions	By Who	By When
<p>Co-Morbid Conditions</p> <ul style="list-style-type: none"> We will need to accelerate the work that we have started regarding long-term conditions as we know that these increase the risk factors for a poor outcome following COVID-19 infections – for example diabetes, hypertension, high cholesterol, heart conditions and asthma are all co-morbidities that affect COVID-related outcomes. We will need to put a greater emphasis on prevention and lifestyle, working hand in hand with the Public Health Department 	Brent CCG	
<p>Covid Testing</p> <ul style="list-style-type: none"> For the time being, the Hot Hub will remain in place, albeit at reduced capacity, so that it is ready for any second wave or resurgence in cases Services are being reconfigured across the STP area to ensure that testing takes place in healthcare facilities prior to elective surgery and that people are encouraged to “talk before you walk”, in order to screen out any potential COVID symptoms before people pitch up at a healthcare facility. High risk, potentially COVID patients are being segregated from lower risk non-COVID pathways. 	<p>Brent CCG</p> <p>Brent CCG</p>	
<p>BAME Engagement</p> <ul style="list-style-type: none"> Improve access of BAME communities to primary care including registration campaign to improve awareness of non-face to face options for service Improve access of registering of all homeless improve awareness of non-face to face options for service in BAME communities to primary care including CCG communications team will work closely with the local authority communications team to emphasise the importance of accessing services <i>early</i> if Brent residents or workers have symptoms. We will need to promote the availability of testing and the fact that hospitals do have enough capacity to see patients. The communications teams also need to promote messages on social distancing and reducing risks. 	<p>Brent CCG</p> <p>Brent CCG</p> <p>Brent CCG Brent Council</p>	<p>3 weeks</p> <p>3 weeks</p>

Actions	By Who	By When
Health Literacy <ul style="list-style-type: none"> Targeted Health literacy campaign in BAME communities in culturally appropriate forms considering the underlying health belief models and behaviours across faith and ethnic groups Covid-19 communications media campaign with NHS and Council communications working together including GP communications LNWT Campaign with BAME communities to let communities know the Trust is open and safe to attend Use current and recently generated insights by community groups and the system to tailor further responses 	Brent Council Brent Council CCG LNWT Brent Public Health	4 weeks 4 weeks 4 weeks 4 weeks
Occupational Health <ul style="list-style-type: none"> Support other organisations in the borough with frontline workers in ensuring risk assessments for BAME and all other workers with regard to managing the risk of Covid-19 We have been putting in place risk assessments for all of our healthcare staff across the NWL STP area, which includes BAME risk factors, age and co-morbidities and ensures that the highest risk staff are kept away from the high risk environments 	Brent Public Health Brent CCG	4 weeks

6.3 Mitigation Measures

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

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

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

Bridge Park Health Living Centre

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

PH Led Recovery College

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

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

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

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

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

Report sign off:

Phil Porter

Strategic Director Community Wellbeing

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