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Brent

Community and Wellbeing Scrutiny Committee

Tuesday 21 July 2020 at 6.00 pm

This will be held as an online virtual meeting.
The link to view this meeting online is available by clicking HERE.

Membership:

Members	Substitute Members
Councillors:	Councillors:
Ketan Sheth (Chair) Colwill (Vice-Chair) Afzal Ethapemi Hector Knight Shahzad Stephens Thakkar	Aden, S Butt, S Choudhary, Gbajumo, Gill, Johnson, Kabir, Kelcher, Mashari and Nerva Councillors: Kansagra and Maurice

Co-opted Members
Helen Askwith, Church of England Schools
Dinah Walker, Parent Governor Representative
Simon Goulden, Jewish Faith Schools
Sayed Jaffar Milani, Muslim Faith Schools
Alloysius Frederick, Roman Catholic Diocese Schools

Observers
Brent Youth Parliament
John Roche, Jenny Cooper and Azra Haque

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hannah.o'brien@brent.gov.uk

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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**	
2	**Declarations of interests** 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	**Deputations (if any)** To hear any deputations received from members of the public in accordance with Standing Order 67.	
4	**Minutes of the previous meeting** To approve the minutes of the previous meetings held on (i) 3 March 2020 and (ii) 16 March 2020 as a correct record.	1 - 12
5	**Matters arising (if any)**	
6	**Brent Council and Covid 19 Service Response and Recovery** To provide the Committee with an update of the public health response to the Covid-19 crisis, locally, regionally and nationally; and an overview of the impact of the emergency on a number of key services, including Adult Social Care, Children's Services, Housing and Cultural services.	13 - 32
7	**Scrutiny committee work plan update 2019/2020 report** The report updates Members on the Committee's Work Programme for 2019/20 and captures scrutiny activity which has taken place outside of its formal meetings.	33 - 44
8	**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.	

Date of the next meeting: **Tuesday 15 September 2020**

Brent

MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Tuesday 03 March 2020 at 6:00pm

PRESENT: Councillor Ketan Sheth (Chair), and Councillors Kansagra (Alternate member for Councillor Colwill), Kabir (Alternate member for Councillor Afzal), Ethapemi, Hector, Shahzad, Knight and Stephens, and co-opted members Rev. Helen Askwith and Mr Alloysius Frederick

Also Present: Councillors Long, Mitchell Murray and Lloyd.

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

Apologies for absence were received as follows:

- Councillor Thakkar
- Councillor Colwill, substituted by Councillor Kansagra
- Councillor Afzal, substituted by Councillor Kabir
- Co-opted member Mr Simon Goulden

2. **Declarations of interests**

Interests were declared as follows:

- Councillor Shahzad – spouse employed by NHS
- Councillor Ethapemi – spouse employed by NHS
- Councillor Sheth – lead governor of Central and North West London NHS Health Trust
- Rev. Helen Askwith – previously provided clinical governance information to Pembridge Palliative Care In-patient Service. Advice had not been provided since 2011.

3. **Deputations (if any)**

There were no deputations received.

4. **CCG Review and Proposals for Local Palliative Care Services**

Hugh Caslake (Head of QIPP and Performance, Brent Clinical Commissioning Group) introduced the report from Brent Clinical Commissioning Group (CCG), providing an update on the review and proposals for local palliative care services in Brent and three other North-West London boroughs. He explained that the Hansford review, an independent review into palliative care services by Penny Hansford, had been prompted by the suspension of the Pembridge Palliative Care In-patient unit, as a result of the resignation of the specialist consultant. The decision for the suspension was on the grounds of clinical safety. Since its suspension, the CCG had been unable

to recruit a suitably qualified consultant and the recruitment process was on hold while the full palliative care review was ongoing. The Committee heard that Brent CCG was not included in the commissioning of the independent Hansford review as Brent CCG had already completed an End of Life Care Review in March 2017 with a strategy developed from it. However, interviews had been conducted by Penny Hansford with Brent commissioners, providers, and wider groups and a workshop was held for Brent patients / stakeholders.

Regarding the current services for palliative care, the Committee were told that in-patient bed days for Brent patients in 2019/20 was a total of 2,410, and the percentage of Hospice at Home visits for Brent patients conducted by St John's Hospice in 2019/20 had increased by 214%, Day Care attendances in Brent had increased by 17%, and home visits by the Community Specialist Palliative Care Service for Brent patients had increased by 10%. The latest NHS England data did not include hospices as a reason for delayed transfers of care therefore data was not collected by any of the local hospices.

Hugh Caslake informed the Committee that of the four potential scenarios outlined in section 2.4 of the report, 3 were derived from the feedback of the workshops and specification from the clinical reference group, and 1 was derived from the Patient and Public Working Group feedback. He outlined each of the potential scenarios, acknowledging the nurse-led impatient unit scenario had came from engagement. The engagement work was intended to look at the entire pathway to palliative care including access and after care. Key points from the workshop findings included; care worked well once services had been accessed but information was inaccessible to navigate prior to that; care planning transparency needed improvement; further awareness of minority communities was needed; concerns around travel times were highlighted and; bereavement services needed to be planned earlier. The future of the Pembridge Palliative In-patient unit was a significant feature in resident concerns. A further series of engagement workshops would be held and finish 13 March 2020, with reports presented to CCG governing bodies and Overview and Scrutiny Committees. Should any substantial change to existing services arise from the engagement process a full public consultation would be conducted.

Regarding inequality of access with only 48% of people who had an expected death having contact with community palliative care services, Hugh Caslake expressed that he believed that figure would be reflected in Brent even though the calculations did not include Brent.

The Chair thanked Hugh Caslake (Head of QIPP and Performance, Brent CCG) for his introduction and invited the Committee to ask questions, with the following issues raised:

The Committee queried the relevance of the Hansford review to Brent considering the report was themed wholly on the Tri-Borough CCGs of Hammersmith and Fulham, Westminster, and Kensington and Chelsea. Sheik Auladin (Managing Director, Brent CCG) explained that discussions were held with Brent CCGs and Clinicians for the review, which gave an overview of the fabric of the local population in Brent, as well as the engagement workshop held in Wembley. It was highlighted that the Hansford review looked at the entire End of Life Care pathway not just the inpatient service.

Members queried the definition of ‘substantial’ in relation to the requirement that any substantial changes as a result of the engagement period would be subject to full public consultation. Hugh Caslake offered examples such as if any key components of a pathway were removed or added, or if a change impacted a specific cohort. The decision to change existing services would be the responsibility of CCG governing bodies and associated NHS bodies.

In response to how the services in Brent compared to other services across the country, Hugh Caslake explained that they had information across the four boroughs included in the review but there was no benchmarking he was aware of. He highlighted it depended on availability of other services and how they were commissioned in other areas. Benchmarking would take some time and had not been done as they were responding to a specific local issue.

The Committee felt that there was no financial information or costings other than a small amount of information in Appendix H, and that more modelling would have provided greater assurances. Hugh Caslake highlighted that the level of work on resources would be expected if a decision was made, but no options had been costed as the scenarios were not intended to be fully costed operational models. James Benson (Chief Operating Officer, Central London Community Healthcare NHS Trust) noted that it was particularly expensive to care for people in a hospice. Bed day was often between £400-700 a night. He highlighted that if they used money and resource in the community the care delivered from the back of that was significant, and he would be looking at asking those questions of what else could be bought with the resources. Sheik Auladin added that there was no plan to cut services and cutting services was not the purpose of the exercise.

The committee queried what factors had been considered to avoid the closure of the Pembridge Palliative In-patient Service. James Benson advised that the medical director and himself agreed that Pembridge needed to be temporarily closed due to the inability to find a lead consultant. He expressed that all providers within the NHS and charitable sector worked in fragile systems where workforce needed to be considered. The question they considered was whether the entire system was able to get enough clinical leadership to run 5 hospices. Subsequent to the agreement to close, all the CCGs and the provider agreed that the Trust would not recruit a lead consultant in the presence of a review as they would not know the outcome of the review. During discussion James Benson confirmed that Pembridge day care on call specialists provided clinical decision making between 5pm and 8am in the morning, and if concerns were raised there was a 2nd on call as part of the system response.

The Committee noted that, of the engagement so far, only 0.009% of Brent residents had participated and queried how the 4 scenarios were valid. Hugh Caslake highlighted that the 4 possible scenarios were not recommendations but engagement devices designed to elicit resident views around palliative care options, and that a further engagement was underway which invited any resident to submit ideas. Specific Brent resident engagement to date had included a focus group and workshop and patient events at Hospices in and around Brent.

Regarding how older residents in the South of the Borough found out about workshops, Jonathan McInerney (Senior Commissioning Manager, Brent CCG) informed the Committee that an advert had been published on the Brent CCG website and communications had gone through Healthwatch and membership lists to potential patients. The CCG also worked with hospices to encourage attendance at the workshops. The Head of Engagement (Brent CCG) had used a contact list through the voluntary sector to ensure protected characteristics were covered. Julie Pal (Chief Executive, Healthwatch) expressed that the numbers in the report showed concern about the level of engagement and as well as circulating information to people the best methods of engagement were to seek face-to-face conversations.

Committee members highlighted that availability of beds needed in future was not considered in the report. Hugh Caslake responded that data showed the expected number of deaths would increase 30% by 2030. He advised that if the case was made for a particular approach capacity would need to be addressed, and the options presented from the engagement would need to explain how the proposed model would address changes and developments in the need for service over the next 15 years. Committee members felt the review could have addressed this.

Regarding Continuing Healthcare (CHC) beds, Sheik Auladin explained that the CCG fast tracked patients as part of the CHC process. The investment was in the region of around £8.5m. Patients were managed at home and within nursing homes, and the CCG were aware nursing homes in Brent were very limited and it was difficult to access beds for patients. There had been no major issues around not having beds for patients to go into nursing homes until recently.

In relation to paragraph 2.1 of the covering report to the Hansford review which noted studies showing that 70% of people preferred wanted to die at home but died in an institution, the Committee discussed the costs of End of Life Care. Dr M C Patel (Chair, Brent CCG) explained that the figure was from national surveys, and that those people died in hospital as a result of other factors, not because it was less cost. He acknowledged that it was clear through national surveys and opinions that patients overwhelmingly preferred to die at home, and if they weren't delivering that then it was not satisfactory. Dr MC Patel addressed the need to hold early conversations with those who were dying and work with GPs to ensure patient wishes were recorded and carried out. Dr Lyndsey Williams (Clinical Director, Brent CCG) added that nationally the patients that were dying in hospital were those that wanted to die in hospital, and there was a patient review of where they would prefer to die. There was an opportunity to align local with national strategies to facilitate preferred patient care.Hugh Caslake confirmed that the percentage of patients who died in hospices was 6% in the most recent national quoted figures.

The Committee asked who would fund those who wished to die at home and what the impact to the Council would be. Sheik Auladin confirmed it would be the responsibility of CCG to support people to die at home, and that the CCG would work with the Local Authority's Adult Social Care Team for adaptations to the home for those who wished to die at home.

Contrary to the data that 70% of patients preferred to die at home, Committee members noted that 80% of those who had 1 admission to a hospice preferred to die

in a hospice, and felt that showed that there was a strong preference amongst those who navigated the hospice system to die there. Dr M C Patel highlighted that it was only a small proportion of the population, but took the point on board.

The Committee queried how much consideration had been given when appointing the independent reviewer to their previous links with hospices, to which Sheik Auladin highlighted that as Brent CCG did not commission the review they were not aware of the appraisal. Committee members felt that the review showed bias to a certain style of care and were unable to see other considerations within the review. They sought assurance that clinical practice was current. Dr M C Patel explained that the reviewer referred to the 2017 Best Practice report which looked at 68 care systems and determined what the best End of Life Care looked like.

Regarding option 4 and the establishment of a nurse-led service for patients who did not require specialist in-patient care, the Committee were informed that there had been an experiment in Leeds for those with complex conditions but did not need medical interventions, where a unit for those patients was ran by nurses. As a provider of hospices having a nursing lead specialist would mean the ability to provide a significant level of support and oversight of the in-patient service. The CCG would be asking questions over whether all hospices needed to be medically led or whether some could be run through nurses and therapists who would receive a significant level of training and support. It was highlighted that a number of hospices did not have a medic on site overnight.

The Committee queried what some of the findings were that had led to major challenge 2, inequality of access to services (paragraph 2.1) being identified. Dr Lyndsey Williams expressed that early identification was a national challenge, with the Hansford review supporting the national picture. The statistics were based on number of referrals made to specialist palliative care compared to the number of patients that died in hospitals.

Healthwatch's view on the review was sought by the Committee. Julie Pal (Chief Executive, Healthwatch) responded that the majority of engagement done on palliative care was undertaken by colleagues in Central London Healthwatch, and found there was a disconnect between what people expected from clinicians and its delivery, such as lack of consultant conversations, which residents did not appreciate. Healthwatch were conscious of the fact the CCG had done historical work on engagement with palliative care and welcomed the use of it. Healthwatch wanted to reach out to Brent residents to capture what they wanted from palliative service, and Julie Pal expressed that she did not recognise that the models offered in the review were something the residents would want. Many residents had a desire to die at home which meant understanding processes, legal requirements, how a death became reported and how the process of end of life care could impact religious rituals. She also highlighted that Brent residents did not recognise the level of investment the CCG were putting in to palliative care.

At this point in the meeting the Chair exercised his discretion to allow Council Members and members of the public to speak. Each speaker was allocated 3 minutes.

- Councillor Mitchell Murray (Wembley Central Ward) addressed the Committee. She was of the opinion that presenting officers were did not have all of the relevant information. She queried whether, during the review, those who had lost relatives had been spoken to. Councillor Mitchell Murray relayed her own family's experience of using Pembridge Palliative Care In-Patient Service, highlighting the excellent care she felt her brother had received, and her disappointment that others would not have the same opportunity. She urged the CCG to rethink the scenarios which she felt lacked understanding of the impact the Pembridge Service had.

- Tessa Van Geldron (Brent Labour Party) also relayed her personal experience of End of Life Care. She expressed that when her partner was End of Life he received no care, visits or pain relief. A complaint to the GP received no response. She expressed frustration with the at home care option as it was not there when it was needed, and meanwhile services were being shut down. She expressed concern that the formal consultation would not say it would involve the closure of a hospice.

- Councillor Long (Dudden Hill Ward) told the Committee that she had attended the public engagement events. Councillor Long asked the following questions:

    - Was there a plan to conduct engagement in the South of the Borough?
    - What steps had been taken to contact carers about the workshops?
    - What were Brent CCG doing about the expiration of the strategy that was developed as a result of the March 2017 review that was due to expire the current year?
    - What would the CCG do to relieve loneliness with the closure of Pembridge?
    - Why were fundraising attempts for Pembridge not taking place?

    She highlighted that housing in the South of Brent was not conducive to home care due to small terraced housing, and a hospital bed would not fit in many houses. She concluded that engagement needed improvement.

- Diana Collymore (Patient Representative, Brent CCG Integrated Governance Committee) felt there was a barrier between the Council and CCG and that councillors should be involved. She highlighted that those from the council and other members of the public had not been informed of the focus groups and some of the reports the Committee were working on weren't presented to the Community and Wellbeing Scrutiny Committee, such as the report on patient voice in Brent.

- Councillor Lloyd (Barnhill Ward) queried why the Hansford review did not refer to the March 2017 review of Brent services, and why it did not involve Harrow who were involved with St Luke's Hospice. She highlighted that while some of the report scenarios included the closure of 4-10 beds as a result of permanently closing the Pembridge, the Pembridge centre had more than 10 beds, and that missing from the report was the fast track CHC beds. She felt that residents were going to become reliant on charitable hospices.

The public and member contributions completed, the Chair asked for presenting officers to respond to any points raised.

Sheik Auladin acknowledged that South of the Borough needed to be engaged and would look for support from councillors to pull that together very quickly. He expressed that the place a resident received care would depend on the patient's circumstances, and for those who did want to die at home they were looking at doing assessments to take into account the patient's circumstances before the patient was cared for at home.

Dr Lyndsey Williams addressed the points around loneliness, highlighting that it was a very important consideration for End of Life Care as social isolation led to poorer health outcomes. Brent had recruited a Social Prescriber for every Primary Care Network (PCN) and was working on patient engagement with Local Authority and Voluntary Sector colleagues to support social isolation work. New posts had been approved to tackle social isolation and funding had allowed the CCG to follow through for those posts. She expressed that she appreciated councillors were dissatisfied with the level of tenant engagement but that the engagement work had been commended as an exemplar of what patient engagement should look like by the CEO of Healthwatch Central and West London.

James Benson apologised if communications had not gone to all historic users of the Pembridge service. He expressed that they had attempted to publicise the engagement process to all regular and historic users. Ongoing support was provided to families as well as patients in the last stage of their life. Regarding fundraising, the NHS constitution restricted him from raising money for the delivery of NHS care. He was able to raise funds for care not considered NHS care such as massages. He confirmed that the bed cost of Pembridge was no different than what a bed costed the charitable sector.

Further questions were raised regarding Social Prescribers. Dr Lyndsey Williams explained that they were band 4 employees, who were often of Social Worker background but that was not a requirement. It was a nationally open role for whatever the population needs were, for example in Kilburn the Social Prescribers supported patients with benefits, housing and the Department for Work and Pensions. The Social Prescribers saw patients in the reception area and GPs could refer a patient to them. The prescriber talked through their available paths, and Dr M C Patel expressed he could see a role for them in palliative care.

The Chair drew the discussion to a close and invited Committee members to make recommendations, with the following recommendations RESOLVED:

i) To conduct a full consultation before a final decision is made on the final proposals.

ii) That in the development of potential options which involve the closure of the Pembridge unit there should be detailed consideration of the future care needs and population of Brent.

iii) That development of potential options should consider Brent's most deprived communities. Benchmarking to be conducted with other London boroughs and best practice for palliative care as well as financial modelling for hospitals, hospices and home care.

iv) To demonstrate that a detailed and rigorous engagement had been carried out before developing the potential options for palliative care in Brent, and that no change is made until the results of the consultations are known.

v) That the whole system considers that appropriate specialist registrar leadership and training is provided in the development of a new model.

A number of action points arose throughout the meeting, with the Committee agreeing the following for Brent CCG:

i) To provide to the Committee the March 2017 End of Life Care review in Brent.

ii) To share with the Committee the demographic make-up of the Patient and Public Working Group.

iii) To provide to the Committee feedback about participants' satisfaction with the public engagement workshops.

iv) To provide to the Committee benchmarking information on need in comparison with other London boroughs.

12. **Any other urgent business**

None.

The meeting closed at 8:28pm

COUNCILLOR KETAN SHETH
Chair

Brent

MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Monday 16 March 2020 at 6.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillor Colwill (Vice-Chair) and Councillors Afzal, Stephens and Thakkar, and co-opted members Alloysius Frederick, Mr Simon Goulden and Rev. Helen Askwith (from 6:20pm).

Also Present: Councillor McLennan

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

Apologies for absence were received as follows:

- Councillor Ethapemi
- Councillor Hector
- Councillor Knight
- Co-opted member Dinah Walker
- Apologies for lateness from Co-opted member Rev. Helen Askwith

2. **Declarations of interests**

Personal Interests were declared as follows:

- Councillor Ketan Sheth – Lead Governor, Central and North West London NHS Foundation Trust

3. **Deputations (if any)**

There were no deputations received.

4. **Minutes of the previous meeting**

AGREED: That the minutes of the previous meeting held on 4 February 2020 be approved as an accurate record of the meeting.

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

There were no matters arising.

6. **Order of Business**

RESOLVED: that the Chair would take item 6, **To consider the local response to Coronavirus (COVID-19)**, and item 7, **Overview and Scrutiny Task Group Report: Childhood Obesity**, at the meeting, with the remaining items to be deferred until a future meeting, due to the very recent developments in Government advice in relation to the Coronavirus prior to the meeting. The Chair thanked all Officers for the detailed reports received.

7. **To consider the local response to Coronavirus (COVID-19)**

Dr Melanie Smith (Director of Public Health, Brent Council) introduced the update, explaining that the UK response to the novel Coronavirus which caused Covid-19 was based on an updated version of the established pandemic flu plan. There were 4 stages of the plan; contain, delay, research, mitigate, which the government moved from 'contain' to 'delay' on Friday 13 March 2020. This had meant a change to the case definition, and travel history was no longer relevant to diagnosis, which was now purely based on a high fever and a new continuous cough. The advice had changed an hour before the meeting to advise that anyone with symptoms should self-isolate at home for 7 days, and anyone in the same household as someone displaying symptoms should self-isolate for 14 days from the first day the person showed symptoms. It was important that containment measures remained based on respiratory and hand hygiene, which was effective, particularly before eating or drinking. The Committee were informed that the virus appeared to cause a mild self-limiting illness, and the expectation was for the majority of people to become ill. Most people would be able to manage with paracetamol but for those with underlying health conditions or those over 70 it could be more serious and more advice was expected in respect to those. Testing was no longer being done in the community, only to those admitted to hospital, and those admittances were for those who were very sick. Early admission for isolation purposes had now stopped, but Public Health England would manage any outbreaks such as in care homes.

Carolyn Downs (Chief Executive, Brent Council) explained the local response. The Council's Strategic Gold Group had been meeting regularly and were likely to meet more regularly in light of the new government advice. She explained that the situation was rapidly changing. An email to all staff would be sent stating that if they were able to work from home they should, but she was aware not every member of staff would be able to. All staff who were aware of any underlying chronic health conditions would be asked to work from home or come to arrangements with line managers if they could not, to avoid putting them at risk. The Gold Group would be considering issues around sick pay, annual leave and caring responsibilities at a meeting the following day. They would also consider their response for agency staff without access to sick pay. For the Council's general activities, all non-essential events organised by the council would be cancelled. They could not cancel the events of external stakeholders but assumed that those would be cancelled in light of the new advice. Statutory decision making for the council needed to continue, and Carolyn Downs suggested councillors with health conditions should think very carefully before coming to meetings. She would be writing to all councillors with this advice. Business continuity planning would need to be readdressed as a result of the new guidance to self-isolate for 14 days should any household members display symptoms. It was explained that this made the provision of services extremely challenging as the Council moved through the peak of the virus. Carolyn Downs advised that there were many voluntary community sector organisations providing services for the community that the Council would be signposting those who wished to help towards, and would consider using emergency powers to ensure funding to support those groups. She added that if schools closed an important issue they would need to consider was food hunger and children on free school meals, and she would meet with food banks that week to see how they could

support children. Gail Tolley (Strategic Director Children and Young People, Brent Council) added that this would also apply to Early Years settings.

Dr M C Patel (Chair, Brent Clinical Commissioning Group (CCG)) gave the Committee an update regarding the North West London picture. A flu plan centralised across North West London was being worked on to ensure the same approach was used across services. Over the following days, the CCG would be looking at plans for elective work and redeployment of staff where possible to assist local acute hospitals, who were trying to manage in very difficult circumstances. Three webinars would be hosted to work with local networks on how they would get themselves ready, and verbal consultations would be held where practices closed. He advised that a lot of single people would need to self-isolate who would need daily contact, which would be co-ordinated between the CCG, Local Authority and the Voluntary Sector together. GPs had been instructed to only make urgent referrals such as chest clinic, stroke clinic, and other referrals the GP deemed urgent. Two-week referrals and maternity referrals would continue in the same way until further advice was received. Only essential diagnostic testing would be carried out to avoid patients who may inadvertently take the virus to diagnostic services. Mental Health services were also being considered, with weekly meetings scheduled to discuss them. Practices had been asked to review all planned care work such as health checks, and make the appropriate judgements for their own practices. Advice was to triage all 111 bookings before they were brought into the surgery to protect patients and staff. Palliative care services would continue as usual, and care practices had been asked to undertake a clinical care assessment. Service closures included the Royal Brompton Hospital Echo Service until further notice. The CCG had been given 24 hours notice to set up and deliver a 24/7 primary care management service to those tested positive for the virus, for those well enough to be sent home but requiring ongoing care for the following 14 days. The service was undergoing increasing pressure and the guidance may change over the following 48 hours. A review was ongoing to look at supporting GPs with remote or home working. They were looking at where they could establish hubs where large numbers of practices went down to offer remote services to patients and some walk-in hubs. GPs had been asked to start coding those who had symptoms based on a clinical assessment to record the number of suspected cases of the virus. One primary care network had began making its own hygiene gel to supply to practices due to the shortage. A large issue was the shortage of protective equipment for GPs.

Councillor Hirani advised that Adult Social Care was where the Council's statutory duty lay for day-to-day services and also supported the most at risk group. He recognised that Covid-19 Brent Facebook and Whatsapp groups were in existence, but the immediate priority was those in the statutory service. They would be looking to speak with those groups.

In response to queries about providing hand gel throughout the building, Carolyn Downs advised that the Public Health England and NHS guidance was clear that hand washing with soap and water for 20 seconds was more effective than hand sanitiser, and the building offered many spaces for that. She advised that hospitals had removed their hand sanitisers as members of the public had been removing them, and most were out of stock. Hand sanitisers had been stocked and provided to front-line staff who had regular contact with the public such as those who went into people's homes.

It was agreed that the members' bulletin would be updated twice a week so that members were fully appraised and reassured that they could pass on messages within their own communities. A full briefing would be delivered to councillors with information on surgeries and other responsibilities.

8. **Overview and Scrutiny Task Group Report: Childhood Obesity**

Councillor Hirani (Lead Member for Public Health, Culture & Leisure) introduced the report presenting the final outcomes and recommendations from the Scrutiny Task Group set up to review childhood obesity. He felt that the recommendations of the report were very helpful, particularly its discussion of business rate discounts for companies who signed up to the Healthy Catering Commitment. The report would be taken to Cabinet and a report from Cabinet on each of the recommendations written.

Duncan Ambrose (Assistant Director, Brent Clinical Commissioning Group (CCG)) praised the process of the task group and felt the report was very comprehensive. The CCG were happy with the recommendations and felt they reflected the multiagency nature of the work that needed to be done.

Dr Melanie Smith (Director of Public Health, Brent Council) added that the approach the group took was very welcome. The framing of the issue within the context of the environment and circumstances parents and children lived in Brent was very helpful.

Gail Tolley (Strategic Director Children and Young People, Brent Council) echoed the praise, adding that the engagement was very helpful.

The Chair thanked all stakeholders who took part in the task group and contributed, expressing that the recommendations were powerful and went to the heart of the work the task group did.

As no questions were raised, the Chair invited the committee to make recommendations. The committee subsequently **RESOLVED**:

i) To agree they are satisfied to send the final report and recommendations to the Cabinet as well as the Governing Body of Brent Clinical Commissioning Group for a response.

8. **Any Other Urgent Business**

None.

The meeting closed at 18.39pm

Councillor Ketan Sheth, Chair

Brent	**Community and Wellbeing Scrutiny Committee** 21 July 2020
	Report from the Chief Executive

Brent Council and Covid-19: Service Response and Recovery

Wards Affected:	All
Key or Non-Key Decision:	Non-Key
Open or Part / Fully Exempt	Open
No. of Appendices:	Appendix 1 – Additional support provided to care homes in Brent
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Carolyn Downs Chief Executive, Brent Council Tel: 020 8937 1007 Email: chief.executive@brent.gov.uk

1.0 Purpose of the Report

1.1 To provide the Committee with an update of the public health response to the Covid-19 crisis, locally, regionally and nationally; and an overview of the impact of the emergency on a number of key services, including Adult Social Care, Children's Services, Housing and Cultural services.

2.0 Recommendations for the committee

2.1 For the Community and Wellbeing Scrutiny Committee to note the report and comment on its content.

3.0 Detail

3.1 Public health

Test and Trace

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

3.1.2 The contact tracing app, which is designed to support Test and Trace by identifying contacts in public spaces who may not be known to the case, is not available at the time of writing.

3.1.3 The more complex case management and contact tracing will be the responsibility of Public Health England (PHE). In London, this will be undertaken by the London Coronavirus Response Cell (LCRC). LCRC has been leading the London PHE response to Covid-19 since February and it also provides the link between local government and Test and Trace. Cases may be complex for a variety of reasons – they can relate to a particularly vulnerable individual, for example, a rough sleeper, or a setting, such as a school or care home, or reflect a number of cases with a possible link to a setting, for example, a workplace, or geography which need investigation to determine whether there is a local outbreak. PHE will work with the local authority's Covid-19 Health Protection Board to investigate and manage any incidents or outbreaks

Outbreak Control Plan

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

1. Care homes and schools

2. High risk places, locations and communities

3. Local testing capacity

4. Contact tracing in complex setting

5. Data integration

6. Vulnerable people

7. Local Boards

3.1.5 The Brent Covid-19 Management Plan was developed in line with London guidance from PHE, the Good Practice Networks and the SCG Subgroup on Test and Trace with oversight from the Health Protection Board which is chaired by the DPH and reports to Gold. The Plan was presented to the Health and Wellbeing Board on 29 June 2020.

Covid-19 Testing in Brent

3.1.6 There have been a number of different routes to testing in the borough. Throughout the pandemic, testing has been carried out on people admitted to hospital with Covid-19 type symptoms. In the early stage this was the only testing available and so it was likely that the number of infections was under-counted and the severity of the infection was over-estimated.

3.1.7 As cases began to be seen in care homes, testing for care home staff and residents was introduced. A national portal was opened through which care homes could request testing and / or the DPH could put forward homes for priority testing. In Brent, this was supplemented by testing provided by the NHS Care Home Support

Team, which carried out over 550 tests, and the Brent CCG Enhanced Care Home Support Team which tested almost 1000 people and is now retesting care home residents and staff.

3.1.8 Testing for members of the public with symptoms was introduced via regional, drive-through test centres, one of which opened in Ikea Wembley on 14 April. A second mobile test unit has been operating from Willesden Sports Centre car park two days a week from 5 May. This has now relocated to the car park at the Neasden Temple.

3.1.9 Lastly, the CCG have been providing testing at the Covid-19 "Hot Hub" at Willesden Centre for Health and Care which has been providing care for patients who were not so sick that they needed to go to hospital, but had suspected Covid-19 that needed monitoring in the community.

3.1.10 All the above tests are antigen tests that detect whether someone is infected *at the time the test is taken*. PHE have also approved an antibody test which detects if someone has previously been infected. Unfortunately, this test requires a whole blood sample. At present we do not know whether, or for how long, the antibodies confer immunity. The antibody test is therefore of limited utility in making decisions on workforce deployment or for clinical management. Antibody tests for health and social care staff are available at the Hot Hub.

A Walk-Through Local Testing Site

3.1.11 The Council was approached by DHSC to pilot a local walk through Covid-19 testing site. The Council's aims in hosting a walk through testing site were:

- To provide a service to an area which had seen high numbers of Covid-19 deaths
- To provide a service for marginalised and excluded communities who would be less likely to access the mobile drive through testing
- To provide "wrap around" services through our existing community hubs and partnerships

3.1.12 The local testing site is located in Harlesden. It was built and is staffed through a DHSC contract. The Council's role has been community engagement, publicity and the provision of a dedicated booking line. Calls are handled by Customer Access staff who, as well as booking symptomatic residents a test the same or next day, use a triage script to explore whether residents need support with, for example, debt, housing, or accessing health services. If so, with residents' consent, their details are passed to Community Hubs staff who provide a call back service.

3.1.13 In the first two weeks of opening, 147 test had been carried out with 29 referrals to the Hubs, suggesting the offer was reaching those in need. In the week commencing 29/06/2020, a total of 541 tests were carried out with 54 referrals to the Hubs.

Infection prevention and control advice

3.1.14 The council's public health team have developed bespoke training and advice sessions on:

- Infection Control and Personal Care
- Infection Control and Personal Protective Equipment (PPE) in Early Years Settings
- Infection Control and PPE in School Settings
- Infection Control and PPE when returning to Face to Face work
- Infection Control for Community and Faith settings

3.1.15 Fifty briefings on Infection Control and PPE have been delivered with over 2000 participants from care homes, schools, early years, council staff and community organisations. These have proved very popular.

Health advice

3.1.16 During the pandemic, public health updated our advice on both physical and mental wellbeing to take into account Covid-19 and the lockdown, e.g. *staying happy and healthy at home*. Information has been made available by the website, by videos, by the Brent Magazine, by leaflets, including material provided to the mutual aid groups for their use and for inclusion in the food parcels delivered from Bridge Park.

3.1.17 The council's occupational health and public health teams have worked together to develop a risk assessment for staff to ensure they are safe in returning to the workplace. Public health has also provided advice to Facilities Management on safely reopening the Civic Centre.

Commissioned public health services

3.1.18 Sexual health, substance misuse and the 0-19 children's public health service commissioned by the local authority's public health team have had to adopt completely different service models during the pandemic.

3.1.19 In February and early March, the capacity of the online sexual health service was increased in order to reduce demand on clinics. The London Sexual Health Programme worked with the Faculty of Sexual and Reproductive Health and the British Association for Sexual Health and HIV to develop a consensus statement on which clinical conditions could be dealt with online or via telephone triage and the clinical algorithms in the e-service were adapted. This work meant that London was well placed to respond to the lockdown.

3.1.20 Initially in lockdown there was a marked downturn in demand for sexual health services. This reduction was temporary and demand is now rising. The DPH is working with the London Programme and the professional bodies to do a similar piece of work as undertaken prior to lockdown to agree priorities for a return to face to face service.

3.1.21 Substance misuse services also moved to online and to telephone interventions during lockdown. The Recovery Day Programme became virtual prior to lockdown in response to the clinical vulnerabilities of many of its clients. Service users were provided with prepaid mobile phones if needed to enable them to remain in contact with their key workers.

3.1.22 Referrals to substance misuse service have increased and have for several weeks been running at 3 – 4 times usual levels. There remains no waiting time to access services.

3.1.23 With the relaxation of lockdown, B3, the service user led organisation in Brent, has been able to introduce "park pods", and socially distanced small gatherings in parks which provide much needed structure and social contact for service users.

3.1.24 The 0-19 service was most restricted in its service offer. NHSE issued instructions to NHS services about which services should be paused in order to free up staff and facilities for redeployment. This included the public health commissioned 0-19 service. A positive development was the move to full seven day working with a phone and on line service. However most routine developmental checks were paused.

Health visitors continued new birth "visits" although lower risk visits were done by phone. Antenatal contact was restricted to high risk women. School nurses were redeployed, including to the Nightingale Hospital.

3.1.25 Negotiations are underway between DsPH and the NHS over the restarting of 0-19 services.

School aged immunisations

3.1.26 Children usually receive immunisation against human papilloma virus (HPV), meningitis ACWY and their teenage tetanus, diphtheria and polio in secondary schools. As a result of Covid-19 related school closures, many children have incomplete or missed immunisations.

3.1.27 Immunisations are commissioned by NHSE, not the local authority, and provided in Brent by Central and North West London NHS Trusts (CNWL). A catch up programme will be needed over the summer to ensure children are protected against vaccine-preventable diseases. Public health are working with CNWL to use Council premises including Bridge Park to deliver catch up clinics over July and August.

3.2 Housing

Homelessness

3.2.1 The Covid-19 pandemic and the consequent lockdown affected Housing in two major areas; homelessness and rent/service charge collections.

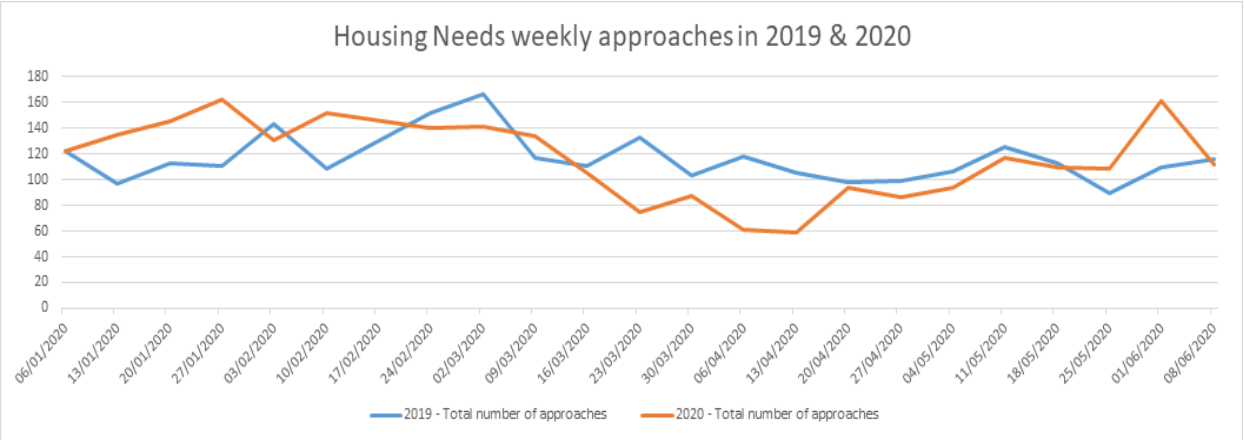
3.2.2 Following the lockdown announcement on 23 March, Luke Hall MP, Minister for Local Government and Homelessness, wrote to all Local Authorities on 26 March, asking local authorities to accommodate all rough sleepers, and people at risk of sleeping rough, including those people with No Recourse to Public Funds (NRPF).

3.2.3 The Council responded to this by providing emergency accommodation to verified rough sleepers, both directly from the streets and from emergency night shelters. This also referred to those who were at risk of rough sleeping, including those with NRPF and those with no or low vulnerabilities. This supported individuals to safely quarantine if required, as well as follow general social distancing guidelines. In addition, there has been a surge in homelessness demand from single people. These people were typically making temporary arrangements such as sofa surfing, adding to the new "flow" on the streets, or at risk of becoming rough sleepers.

3.2.4 This increase in demand, coupled with the effective lowering of thresholds related to providing emergency accommodation, has resulted in a large increase in the number of single homeless people who have been provided emergency accommodation by the council. As at 18 June, a total of 267 single homeless people have been accommodated.

3.2.5 In the initial weeks following the lockdown, there was a reduction of 54% of the normal weekly approaches from both families and single homeless people, compared to the same period last year. However, since mid-April, the number of approaches has been steadily rising, and are now on a par with the level of demand in 2019.

3.2.6 Fig 1 – **Weekly trends in the number of Housing Needs approaches in 2019 & 2020:** the number of approaches in the last week were similar to the same week in 2019.



Housing Management

3.2.7 The lockdown resulted in a number of people being furloughed or losing their jobs altogether. As a result, we have seen an increase in the level of rent and service charge arrears. Tenants who were owing rent to the Council prior to the lockdown have gone further into arrears and some tenants who were either previously in credit or were up to date with the rent and service charges, are also now in arrears. The latter make up 6% of tenants.

3.2.8 If the trend continues, we estimate that the HRA could potentially lose circa £2.7m worth of income and other tenures, such as temporary accommodation, i4B and First Wave Housing, may lose in the region of £3.3m.

3.2.9 The Council's position throughout the lockdown, has been to support tenants as much as possible through these difficult times. The Council enhanced its offer of financial support and advice in order to reduce the number of households falling into arrears. Any household affected has been encouraged to apply for Universal Credit or a Mortgage Holiday (leaseholder). Therefore, inability to pay should only be because of delays in payments. Households who are self-employed and unable to work are now being contacted, as they should have received their payment from Government.

3.2.10 During the lockdown, the Council has continued to deliver emergency and urgent repairs, which cover most of repair demand. In addition, we have continued to deliver essential planned maintenance, through which improvements are being made to internal and external areas of blocks. Health and safety checks, such as for gas and electrical installations, have continued where possible.

Supply of Affordable Housing

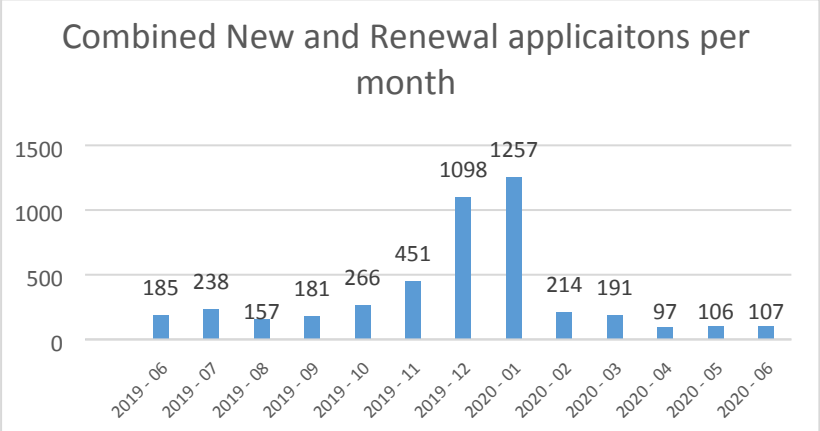
3.2.11 In addition to homelessness and income collection, the lockdown and social distancing in particular, has affected the development of new homes. When the lockdown first commenced, most development sites across London ceased. In Brent, only two of our sites initially stopped but they too were able to get back on site within three weeks. This meant that by the end of April, all of our building sites were in operation.

3.2.12 All sites remain fully operational and are working under government guidelines. This means that social distancing has to be observed on site. With social distancing, contractors are unable to have as many operatives on site as they would have liked, and so completions dates are being pushed back. Although the Council is contractually

protected from financial claims from contractors, under standard Force Majeure clauses, they will be entitled to claim for Time Extensions based upon these circumstances.

Landlord Licensing

3.2.13 There are two main functions associated with the licensing of Private Rented Sector (PRS) properties, the processing of licence applications which allows for the specifying of conditions that need to be adhered to by the licence holder and the compliance inspection of Houses in Multiple Occupation (HMOs) in order to make sure that those conditions are being met. The renewal of Borough wide HMO licensing came into effect on 1 February 2020 and that contributed to a spike in applications for both renewals and new applications. The following graph shows the combined numbers of all licence applications received since June 2019.



3.2.14 Although the graph shows a reduction in applications received since lockdown, the numbers are not much lower than forecast. As such, Covid-19 and the lockdown has had a limited impact on license applications so far and we believe that the overall levels of applications/properties licensed over the five year period of the scheme will not be affected as a consequence.

3.2.15 With regards to compliance inspections, this function was halted as a consequence of Covid-19 as it was assessed to be too risky to have officers entering and inspecting HMOs. With the relaxing of social distancing, Public Health guidelines and PPE these inspections have resumed, on what is assessed to be lower risk HMOs (those with fewer occupants), from 1 July 2020.

3.2.16 Nevertheless, during the time where officers were not able to carry out inspections, they have been reviewing and following up on open cases with landlords. Since 1st March 2020, we have been able to close 526 of such cases.

3.3 Adult Social Care

3.3.1 Throughout the period when the pandemic was at its peak and through lockdown, Adult Social Care (ASC) have adjusted the services delivered by teams to continue to offer as much business as usual activity as possible and to support an increased number of clients with Covid-19 specific needs. The option to make easements to the Care Act 2014 was put in place by the government but this option was not exercised by Brent. The service continued to deliver all adult social care related statutory functions in addition to providing a wider range of support.

3.3.2 Core changes to services were as follows:

- The Duty Team mobilised quickly to transform the service into a Wellbeing Team (the normal duty team continued to operate alongside this service, so people could either be supported through the wellbeing pathway if their need for support was as a result of Covid-19 or, through duty if it WAs a regular need for a care assessment and ongoing package of care). This team operated seven days a week and from 8am–8pm for five weeks. It continues to operate now but has reverted to core operating hours. The team was supported by having a new mosaic episode in place and dedicated phone lines for both the public and medical professionals. The mosaic episode allowed us to record and track individuals, outcomes and spend, but also provided a more proportionate assessment. This phone line operated as an emergency response, widening support available to people who had short term care needs as a result of self-isolation or those included in the shielding group. People were directed to Brent CVS (which had been funded to provide wider community support) if they could be supported in this way. The Wellbeing service therefore supported those people who were the most vulnerable and in the most need of support, or those who we believed were more vulnerable to exploitation or abuse through community support routes. Initially, the single biggest request for help was with the delivery of food parcels, and an automatic referral was set up to the Brent Council food delivery hub, that allowed delivery of ongoing food supplies on a weekly basis. All individuals in receipt of food deliveries through this route have since been reassessed, and where necessary, alternative ways of accessing food have been put in place for them. The Team completed over 900 care assessments and contact assessments between the end of March and end of May.

- The Community Review Team transformed how they worked, and completing phone based risk assessments for clients who cancelled or suspended their care, as well as those individuals who usually attended a day centre but would not be able to for the foreseeable future. They also followed up with some of our high risk and very vulnerable clients and families, and provided a regular check in service for people who need to be checked on and completed on-going reviews for people who have been provided with care through the wellbeing service. This team additionally made calls to clients on the NHS shielding list to ascertain whether they needed any further support through this period.

- The Complex Care Teams are continuing to work extremely hard to complete assessments and manage care for those people who really require it. Many of our complex care social workers continued to complete visits if they were required, with many of our really challenging clients requiring quite a bit more support. Our most anxious clients were allocated a nominated point of contact in the Complex Team to manage the additional complaints and contact received as a result of increased anxieties.

- The Urgent Care and Hospital Teams were at the very front line of our response. Integrated Rehab and Reablement continued to support people both in the community and those coming out of hospital. They continued to complete visits as necessary. Our Hospital Discharge and Home First teams worked in and with the hospitals daily, including forming a joint discharge team with our CHC colleagues. Our Urgent Care services also geared themselves up to work seven days to support the increased need to discharge.

- The Community Learning Disability Team has been working hard to support individuals and families who may not be able to access the normal respite and day services. They have been checking the most high risk individuals are managing and

producing risk assessments and risk management plans for some of our LD clients who struggle to adjust to changes in their routine.

- Direct Services were also at the front line of care provision, and managed to keep the John Billam day centre open longer than any other day centre in Brent to support those people with the most complex needs, including severe autism. They are still working hard to support residents at Tudor Gardens and to do outreach to day centre clients who cannot go out at the moment. Direct Service staff were organised into teams to support the wider care home sector where we faced staff shortages in care homes. With support from PII and public health colleagues, all Direct Services staff (137) were given training and guidance on delivering personal care safely in the current climate.

- Transformation, PII and BCF teams have been invaluable in helping us to respond quickly and flexibly to all the changes to systems, processes and legislation we have needed to manage. They have also supported the creation of rotas, liaison with other departments and partners and managed communication flows so everyone stayed in contact and informed. Our performance team has produced a daily dashboard allowing senior managers to see volumes of activity and adjust staffing accordingly.

- Commissioning have been completely vital in managing our care providers. Placement Review Officers (PROs) have been checking in daily with their nominated providers, picking up issues from staffing to infection control. Every Care home and Home Care agency had a nominated PRO who was in daily contact with them throughout this period. Our commissioning service have also been working tirelessly to source PPE for our staff and providers, as well as setting up additional step down capacity for patients who need to be discharged quickly. Additionally, they have been working really hard to support our home care providers to manage people in the community, including managing those who have tested positive for Covid-19. They have been running weekly webinars for providers, supported by public health colleagues and health partners, to support them in delivering care and answering their questions, ensuring they all understood infection control measures, resolving issues for them.

- We have been able to reallocate home care workers into care homes who have staff shortages, and we have been able to reallocate care packages to other home care providers as necessary. PROs also supported care providers to complete a daily data return so we are able to see capacity across the whole of London.

- The Safeguarding team ran a duty service, as well as volunteering staff for other areas of the business. They worked with the Domestic Violence Abuse services (DVA) to provide a specific source of support for people at risk of or experiencing Domestic Abuse. This was an area we have seen a spike in since more people were asked to stay at home. Depravation of Liberty work is continuing, and they continued doing visits as necessary. Safeguarding activity remained steady, and the safeguarding team are still undertaking urgent visits and pro-active work.

- Our Occupational Therapists have offered their support to a range of teams, from providing advice over the phone to staffing an out of hours rota to support wider volunteers across the council who are calling people on the shielding list.

- The Emergency Duty Team have continued dealing with out of hours crises as normal.

3.3.3 Similarly, our care providers have responded amazingly. Working in really difficult circumstances, they supported people who tested positive for the virus without complaint, and found additional capacity when asked to.

3.3.4 A couple of other extraordinary achievements to note:

- A survey was sent out to all ASC staff requesting people to volunteer to support extended hours of the wellbeing team, EDT and asking whether staff would be prepared to provide personal care if necessary. We have had over 100 staff volunteer to work evening, weekends, overnight, and to deliver personal care.
- As well as working with our direct services staff to be able to support staffing in care homes, we also worked with a few of our Homecare providers to setup and run a carers recruitment drive for them. A process was set up whereby the council recruits, DBS checks and allocates staff who may have lost their jobs through this crisis and may consider working in care, into different care agencies.
- A contract with our Gateway provider was set up to provide support around social isolation, food and medication delivery to those people in the shielding group or anyone self-isolating and in need of more support.
- Legal advice was sought on the changes to the Care Act as a result of Covid-19 legislation and the implications for practice. Weekly newsletter are being drafted for staff and practice implications are covered via this newsletter, with guidance.
- The Principal Social Worker (PSW) has produced a power point/narrated training package for wider council staff on supporting vulnerable clients and how to identify and refer them. This has been given to 200+ volunteers and contact centre workers, and a video was adapted on safeguarding for adults and children for volunteers which was sent out to our wider VCS and volunteer/mutual aid groups.
- The PSW also runs a weekly web based practice forum for staff, to support them to resolve practice issues and have a space to discuss the challenges of working in different ways to support vulnerable people.
- Despite the pandemic, the only Adult Social Care Skills Academy in London was launched during April, offering six defined training and development pathways for social care staff and ensuring all staff are registered and participating in at least the core training pathway.

3.3.5 A huge amount of work was undertaken in relation to our care providers, particularly our care homes. Brent has a diverse population, with 61 care homes covering residential, nursing, learning disabilities and mental health and with a total capacity of 1,189 beds. Of the people placed in care homes in Brent, only c. 30% are funded by Brent Local Authority, with the remainder being a combination of self-funders and individuals placed by other local authorities or health partners. We also have seven extra care schemes. Brent has a relatively high proportion of care facilities compared to other boroughs, and is a net ‘importer’ of care residents from central London Boroughs. Brent therefore has had a significant safeguarding responsibility in supporting residents funded through other boroughs.

3.3.6 Brent has been one of the hardest hit areas nationally in terms of Covid-19 incidences and deaths. Despite the high level of early incidences, we have responded quickly and comprehensively from the initial outbreak, working with care homes and extra care schemes to protect our vulnerable residents. As a result, we have been able to minimise the uncontrolled expansion of infections through our homes. Recent data suggests that despite Brent having the second largest number of deaths in London, and also having seen the impact of Covid-19 earlier on in the pandemic than the rest of London, our care homes have fared proportionately far better than many other London boroughs with a lower number of Covid-19 related deaths. Tragically, a total of 195 deaths in care homes have been recorded in Brent

since the beginning of March 2020 to June 2020. However, it is not possible to identify how many of these deaths are directly attributable to Covid-19 as regular community testing and testing in care homes was not achieved until the end of April 2020. Public Health Analysis suggests that deaths in care homes is at the lower end of the scale across London during this period. There should nonetheless be some caution in relation to the data, as it has been drawn from multiple data sources. Further analysis will be done in future to review the position once there is more confidence in the source data. Overall, all evidence suggests that proportionate to the proliferation of the infection in the community, the performance in care homes was very good.

3.3.7 The key elements of the additional support provided to care homes in Brent is summarised as follows (full details are included in Appendix A):

- **Personal Protective Equipment (PPE)** - Local and sub-regional procurement and distribution of PPE, funded through the funding provided to councils, distributed to homes on an equitable basis to ensure that no care home was short of essential personal protective equipment.
- **New accommodation** - Establishment of a new council commissioned 11 bedded extra care facility to support people being discharged from hospital who are Covid-19+ or are needing to self-isolate due to vulnerable individuals at their usual place of residence for up to 14 days, and to minimise additional outbreaks in homes.
- **Staffing** - Support in providing and co-ordinating agency staff to care homes where there are staff self-isolating or shielding, including management capacity, to ensure that care provided remained high quality and safe throughout the pandemic.
- **Daily monitoring of pressures or support needs** - Daily calls through Provider Relationship Officers to all care home provider Registered Managers directly to monitor Covid-19 incidences, infection control procedures, staffing levels, testing utilisation, access to GP or NHS support.
- **Support and guidance** - Weekly care home forums (hosted virtually) for all providers to ensure all providers are sighted on the latest guidance, support and best practice from national and local partners.
- **Infection control and training** - Additional training has been provided for infection control, swabbing and other support through local public health and through a NW London NHS team.
- **Clinical support** – Expansion of existing Enhanced GP care home support to cover all care homes.
- **Testing** - Local co-ordination of testing through the Provider Relationship Officers, to try and ensure that testing provided through the myriad of routes (local, sub regional and national) is targeted at care homes with the highest risk or with Covid-19 incidences.
- **Cost pressures** - Inflationary uplifts in both the council and Funded nursing care (FNC) rates went live from 1 April, in line with modelled underlying cost bases in care homes. Additional pressures around staffing and PPE have been supported directly through the council.
- **Infection Control Grant** – Distribution of the central government grant for infection control has been achieved in Brent.

3.3.8 Using a combination of local agreements and partnership with health and the Government self-registration scheme, all Brent care homes have now been tested, including MH and LD homes. Very few positive infections have been found and the testing is working well. Testing is also now being completed in other care settings, including Extra Care and Supported Living. Work is being undertaken to agree the

regularity of this on an ongoing basis across the system. Where necessary and if there is ongoing concern, homes to be tested are prioritised by the Brent Commissioning Team and testing visits are arranged and coordinated by them, with tests being carried out by NWL CCG staff. The majority of homes are arranging their own testing and re-testing via the online government portal.

3.3.9 In a more general sense, commissioners continue to provide support where they can, providing staff and PPE, and co-ordinating additional support where necessary. Local authority public health colleagues are providing on going daily online training sessions as well as telephone support on PPE guidance, infection control and other issues. Where more support is needed, the NWL Care Homes Team or the Enhanced Care in Care homes Team will undertake support visits to homes. The rate of people passing away in care homes is currently back to the levels that we would expect to see pre-Covid-19, and all care homes in Brent are currently infection free.

3.4 Children's Services

3.4.1 Brent Children's and Young People (CYP) took swift and targeted action to support children and families from the beginning of the pandemic and throughout the lockdown period, ensuring that children's safeguarding needs continued to be met. Revised practice guidance was issued 16 March to support practitioners in risk assessment, prioritisation of contact with children and families and to support home visits where appropriate. This guidance has been kept regularly updated.

3.4.2 Every child known to CYP (including Children in Need, Children subject to a Child Protection Plan, children with an Education, Health and Care Plan, young people known to the Youth Offending Service and Looked After Children and care leavers) has been risk assessed, with contact arrangements by telephone or home visits in place based on identified levels of risk.

3.4.3 The level of contacts through the Brent Family Front Door declined significantly through April and May, with contacts at approximately 50% of the rate at the same time last year. Contact rates have now increased, returning to comparatively similar levels for this time of year seen in previous years. Additional risks have been identified for children and families, including a rise in child poverty as well as domestic abuse, which will need to be addressed in the recovery period.

3.4.4 During the lockdown period, there have been indications of the increased challenges in keeping vulnerable adolescents at home and safe during the lockdown. The Vulnerable Adolescents Panel is reviewing the impact of the lockdown on adolescents to ensure that Council wide and partnership actions address identified risks for young people.

3.4.5 Educational Health Care Plan (EHCP) assessments have continued to be reviewed at weekly virtual panels, incorporating multi-agency professionals throughout the pandemic period, with numbers consistent with the previous year, or slightly higher. In line with the amendment to provision, within the Coronavirus Act, professionals are using "reasonable endeavours" to provide reports on the children/young people, when for instance face to face contact has not been possible.

3.4.6 All pupils with EHCPs have been risk assessed by their school or setting and these risk assessments are quality assured and discussed with schools if further detail is required. They are RAG rated to ensure timely review. Weekly meetings have taken place with the headteachers of Brent special schools, to ensure adequate safe-

guarding arrangements are in place for children who remain out of school, and respite/playground offers have been made to priority families.

3.4.7 Brent Council's responsibilities and duties as a Corporate Parent have been prioritised and maintained. Social workers and Personal Advisers to Looked After Children and care leavers have been maintaining contact with children and young people, undertaking welfare checks and providing reassurance and support. Foster carers were contacted and were provided with a child-friendly information leaflet to help explain the Covid- 19 situation to children. The LAC Health Team with CNWL NHS Trust identified LAC with underlying health conditions, who were contacted by their social workers for a specific welfare check. Practice guidance was put in place to support delivery of statutory services including information on remote working, visits to LAC and care leavers and work undertaken by contact, fostering and kinship teams.

3.4.8 The vast majority of schools and a number of early years settings have remained open for the children of key workers and vulnerable children throughout the duration of the pandemic. The Strategic Director Children and Young People advised and supported schools to form geographic clusters from the start of the pandemic, an arrangement which has supported resilience in the sector and facilitated the sharing of good practice. The Strategic Director has convened weekly meetings with headteachers and regular webinars for early years providers and Chairs of Governors with the Strategic Director have allowed timely, two way communication and the provision of tailored advice. The Director of Public Health (DPH) has joined these webinars as necessary to provide public health advice.

3.4.9 Brent CYP has also been actively promoting the attendance of vulnerable pupils. A task group chaired by the Head of Inclusion, with representation from Brent school clusters and reporting to Children's Services Leadership Team is coordinating work to support vulnerable pupils during the lockdown period.

3.4.10 Laptops are being allocated to support vulnerable children access education. Brent has ordered the full allocation provided by Government of 729 laptops for vulnerable children and care leavers (711 for vulnerable children in Brent schools and care leavers in education, 18 laptops for disadvantaged children in year 10 in community maintained schools).

3.4.11 Further to the government announcement on 28 May that all of the government's five tests for the wider opening of schools were met, Brent schools were able to open more widely with small numbers of pupils in specified year groups: Reception, Year 1 and Year 6 in Primary, and up to 25% of pupils in Years 10 and 12 for some face to face support from teaching staff in Secondary. Special schools have been able to welcome more children back in these specified year groups in accordance with a child's individual risk assessment.

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

3.4.13 The Covid-19 CYP Department recovery plan focuses on key actions to continue to develop the response to the needs of vulnerable children and families. Priorities include:

- Restoring increased face to face work with children subject to Child Protection plans, LAC and Care Leavers, with particular attention to post trauma and bereavement
- Reviewing and expanding, in collaboration with health, post trauma and emotional wellbeing support e.g. for looked after children and young people after a significant period of isolation, including bereavement support where LAC have experienced loss of family members
- Retaining some of the additional scheduled phone contact for more vulnerable young people in the early evening and at weekends
- Retaining online support services and tools being provided by for example YOS workers and keyworkers and Family Support Workers in Family Solutions and Accelerated Support Team
- Working within the Children's Trust with health partners on aligning recovery plans for services for children
- Planning for the expected increase in referrals when early years settings, schools and colleges are fully returned in September
- Developing resilience of children's services for the autumn when significant pressures are expected
- Reviewing the current arrangements with Barnardo's in preparation for the opening of family wellbeing centres later in the autumn.
- Roundwood Youth Centre activities ceased on 20/03/20. Plans for a phased opening are now being considered. Roundwood Alternative Provision School is being progressed for opening in January 2021.

4.0 Alternative Options Considered

4.1 None to be considered

5.0 Financial Implications

General Fund

5.1 Excluding Covid-19 related pressures, CWB was forecast to break even. The impact of the pandemic on this department is currently estimated to be £12.5m.

CWB Department	Additional costs due to Covid-19 £m	Loss of income due to Covid-19 £m	Total impact due to Covid-19 £m
Housing	2.8	2.5	**5.3**
Culture	0.3	0.4	**0.7**
Public Health	0.0	0.0	**0.0**
Adult Social Care	6.5	0.0	**6.5**
Total	**9.6**	**2.9**	**12.5**

5.2 Within the Housing Needs service, an additional £2.5m is forecast to be spent on accommodating the increased demand and providing temporary accommodation to homeless people through the outbreak. Most of these clients are considered to be formerly hidden homeless and have been accommodated by the Council as part of the emergency response. The £2.5m includes the cost of accommodation, food provision and security in hotels, as well as one-off costs for making permanent placements into the Private Rented Sector. It is expected that families will be relocated from hotels into Private Rented Sector accommodation. However, whilst a significant proportion of clients will have their rents covered by Housing Benefit or EEA nationals grant, a

residual ineligible group will result in ongoing housing costs to the Council. Of the £2.5m forecast, £1.2m can be attributed to the cost of continuing to support the cohort with no recourse to public funds throughout Q3 and Q4. This forecast is net of specific government grants and assumed Housing Benefit income.

5.3 There are also potential costs of £0.3m forecast to be incurred on commissioning a homelessness support contract from the charitable sector and additional temporary staffing resource, both of which are necessary to cope with the increased demand.

5.4 In addition, the loss of rental income from Housing Needs tenants in General Fund properties is forecast to be £2.5m. The rent collection rates across broader Temporary Accommodation have dropped from circa 95% prior to the Covid-19 outbreak down to 75%. This can be partially attributed to delays in newly homeless people registering and receiving Housing Benefit towards their accommodation costs. However, another factor in the decline in rent collection is that tenants ineligible for Housing Benefit may be less able to pay rent due to the wider economic impact of Covid-19. The loss of rental income from i4B and First Wave Housing is forecast to be £0.8m for the full financial year based on the year to date collection rates.

5.5 The Culture service, which encompasses Libraries and Leisure Centres, is also expected to be impacted by Covid-19. Sports centres have forgone their expected income during the lockdown and support has been provided for operational and mothballing costs for the leisure centres. The loss of income from leisure services at Bridge Park and Vale Farm is estimated to be £0.3m, and the cost of mothballing Vale Farm and Willesden Sports Centre is forecast to be £0.3m. In addition, £0.1m of income generated by libraries is expected to be lost across the full financial year.

5.6 The Covid-19 outbreak has not resulted in significant extra costs for Public Health. The total grant for 2020-21 is £21.8m and reserves stand at £3m.

5.7 In Adult Social Care, the major financial impact of the Covid-19 pandemic is the cost of procuring PPE and distributing it free of charge to care providers. The Council is better able to source and buy this equipment than many care providers who would struggle given the competitive market. Allocating it out to providers is part of the emergency response, but also prevents further pressure on the cost of care as if this was left to providers themselves, they may not achieve value for money and would pass on increased costs to the Council. As of the end of June, £2m worth of PPE had been purchased and the estimated usage rate is £114k per week, which results in the forecast of £5.9m. At this stage it is anticipated that the procurement of PPE on behalf of care providers will continue until at least the end of the financial year.

5.8 For the duration of the emergency, care packages made by the CCG for clients discharged from hospital will be covered by the NHS. However once the emergency is declared over it is likely that the Council will need to cover these costs. The CCG packages agreed during the emergency are typically 20% more expensive than the usual cost to the council, and there have been approximately three times as many clients placed as would typically be made during this period. From Q2 to Q3, £0.4m is forecast for these excess costs as placements are continued until they can be renegotiated. There is also a forecast cost for additional staffing to provide the necessary care assessments which have not yet taken place for this cohort.

5.9 There are some additional direct minor costs as a result of COVID-19 such as paying directly for care home agency staff, and for kitting out the Peel road discharge facility. These costs total £0.1m.

HRA

5.10 The budgets for the Housing Management function are contained within the ring-fenced Housing Revenue Account (HRA), which has a balanced budget set for 2020-21. The total potential budgetary pressure as a result of the ongoing pandemic is currently estimated to be £2.9m.

HRA	Additional costs due to Covid-19 £m	Loss of income due to Covid-19 £m	Total impact due to Covid-19 £m
HRA	0.2	2.7	**2.9**

5.11 Rent is a primary source of income and £2m of the total pressure is attributed to the increase in rent arrears. This is based on the decline in rent collection rates experienced to date, extrapolated to forecast a full year impact of £2m.

5.12 Setbacks to new build developments are expected to result in a delay in letting new properties out to tenants, therefore increasing the loss of rental income further by £0.3m. However, it is not anticipated that the expenditure on new builds will be significantly lower than the annual capital budgets.

5.13 In addition, it is forecast that 10% of service charges income will be under-recovered, which is estimated to be £0.4m. This is in line with Bank of England forecasts on consumer credit and debt recovery.

5.14 Additional costs of £0.2m are forecast to be incurred on providing estate caretaking services through the pandemic without compromising on the standards of service. This includes sourcing additional PPE and employing additional temporary staffing resource to provide cover for colleagues staying in isolation.

5.15 The HRA operating reserve currently stands at £1.4m and the identified pressures will continue to be closely monitored through the changing environment. Mitigating action, such as re-scheduling major works and new build capital investments, will be considered if required, to avoid the HRA going into deficit.

6.0 Legal Implications

6.1 The Government brought into law the Coronavirus Act 2020 to make a number of changes in order to deal with the effects of the pandemic and to bring into legal effect a number of measures relating to the lockdown and give the Government powers to make additional regulations in this regard.

6.2 No legislative changes have been made to the areas of landlord licensing and homelessness. The Ministry of Housing and Local Government have issued to local authorities guidance letters and provided funding regarding the housing of rough sleepers during the period of lockdown arising from the pandemic.

6.3 In relation to adult social care, the Coronavirus Act 2020 enabled local authorities to make a number of easements in respect of their statutory duties under the Care Act 2014, with local authorities being able to decide to reduce a number of statutory duties under the Care Act 2014 to discretionary powers. Brent Council has not carried out any such easements and many other local authorities have also not chosen to do so. No changes have been made to the law on mental capacity and deprivation of liberty safeguards though the Government has provided guidance during the lockdown period on these issues.

6.4 In relation to housing management, the Government has ordered a stay on the eviction of tenants from residential properties and a stay on possession court hearings until 23 August 2020.

6.5 Although no changes to primary legislation have been made relating to the areas of education, schools and children social services, the Department for Education has issued guidance to schools and local authorities regarding attending schools and children's social care services. Regulations have been introduced to make temporary changes regarding private fostering, fostering and adoption, care planning and residential care.

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

6.7 A report was submitted to Cabinet on 20 April 2020 and to the Audit and Advisory Committee on 5 May 2020 setting out details regarding the Council's emergency planning and GOLD arrangements that were enacted as a result of the pandemic and lockdown.

7.0 Equality Implications

7.1 The council, as a public authority exercising public functions, is subject to a general public sector equality duty (PSED) under section 149 Equality Act 2010 (EqA). The PSED requires public authorities to have "due regard" to:

- The need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the EqA.
- The need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it. This involves having due regard to the need to:
    - remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
    - take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it; and
    - encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.
- The need to foster good relations between persons who share a relevant protected characteristic and those who do not share it. This includes having due regard to the need to tackle prejudice and to promote understanding.

7.2 The Covid-19 pandemic has affected us all, changing the way we live in the short to medium-term – and we do not yet know what the long-term holds. Looking deeper, it

has become clear that the pandemic and resulting lockdown have disproportionately affected people with certain protected characteristics. Those who are vulnerable have needed help more than ever.

7.3 This report demonstrates that Brent Council, guided by the Public Sector Equality Duty (PSED), has taken account of this disproportionality, worked hard to assist and protect our residents throughout this time, and will continue to do so.

8.0 Consultation with Ward Members and Stakeholders

8.1 The Council continues to make reasonable efforts to communicate with and take on board the views of service users affected by decisions and inform residents and stakeholders as quickly as possible about any changes to service provision. Where appropriate and reasonably practicable, changes to the Council's decisions are made following responses from service users and others.

8.2 During lockdown we have sought to provide at least fortnightly Member web cast briefings with questions and answers. Many Councillors have kept in touch through email and phone in addition to the webcast briefings and the very regular Member email briefings. Since the government changed legislation to enable virtual council meetings, we restored essential political decision making in this way with the Cabinet meeting on 20 April being the first such meeting, followed by the Planning Committee and Audit Committees both in April and Full Council on 13 July. Effectively, Member led decision making is now back in place for all decisions other than those specifically related to the pandemic.

Report sign off:

Carolyn Downs
Chief Executive

Appendix A

Additional Support provided to care homes in Brent:

- **PPE:** Purchase and distribution of PPE by Brent Council started on 27 March, with Brent being the first borough to distribute PPE directly to all providers. To date, £1.6m of PPE has been purchased by Brent local authority and distributed to care providers on a weekly basis. 100% of respondents to the care home survey reported that they felt they had sufficient PPE as a consequence. We are forecasting that we will be spending £6m per year on PPE going forward. None of these costs have been passed onto any care providers in Brent. However, clarity of funding for PPE is required given that we anticipate that all care providers will require an ongoing supply until an effective vaccine has been developed and deployed.
- **New Accommodation:** The facility at Peel Road was set up within a week and was open to accept patients from 9 April. This included fitting the building with hospital beds and other required equipment, as well as sourcing, training and commissioning a care provider to provide care over a 24/7 contract. The cost to the council to set up and furnish the facility as well as ongoing care costs was £86K.
- **Staffing:** A dedicated team within the local authority was established that operated seven days a week, and out of hours, coordinating agency staffing and deployment of council employed carers. This ensured that wherever possible, staff were allocated consistently to a single place of care, minimising the risk of cross infection and improving the consistency of care. The team began working with providers on 4 April and have placed 41 staff in 8 homes covering 1476 hours of care as to date in June.
- **Daily monitoring of pressures or support needs** - Daily calls through Provider Relationship Officers are recorded on a daily record and escalated to senior leaders within both the council and Clinical Commissioning Group (CCG), with appropriate actions put in place as required. Each care home has also been given a dedicated officer to be their single point of contact allowing for the building of a two way relationship and communication, not limited to data and information reporting requirements for homes. A consistent and named officer to support all homes was already established in Brent, allowing us to move immediately to a system of daily contact and communication. This therefore has been in place since 16 March. Support provided has ranged from advice and guidance, to resolving very practical issues at the beginning of the crisis with officers going out to purchase groceries and personal hygiene supplies for homes and residents, and sourcing hard to get items such as thermometers so that homes had sufficient basic equipment to manage infection.
- **Support and guidance** - Weekly care home forums have had regular attendance of approximately 40 people each week. Additional training and support includes bereavement and mental health support, infection control, medications management and a range of other national offers. Further, the local authority has funded, commissioned and is managing a Positive Behaviour Support worker to support providers to manage individuals with mental health issues, dementia or other conditions that mean that they are struggling to comply with social distancing requirements or infection control measures in both care homes and in Extra Care and psychologists from CNWL are providing bereavement and loss support to care home staff and residents.
- **Infection control and training** - This has included daily virtual training, access to public health advice on weekly calls and visits to homes from a clinical NW London support team. Public Health colleagues in Brent have developed and are delivering weekly web based training in infection control and have undertaken visits to specific homes where there are concerns, to train staff in person. 95% of care homes report

through the care home survey that they have accessed training delivered by Brent in infection control and proper use of PPE. They have also provided risk assessments for care home staff to support and encourage staff to return to work where they have been concerned about the risk of infection, and they have provided on going advice to care homes around infection control.

- **Clinical support** –Further support was also provided through a NW London clinical nursing support team to advise on infection control, shielding residents and good practice and nursing requirements. This is in addition to the existing support provided by GPs and the NHS 111*6 services. Coverage of the NHS 111*6 service and nominated clinical leads have also been extended to Extra Care providers.
- **Testing** - The ambition is to move towards regular testing to ensure more effective prevention of further outbreaks. Many homes in Brent have been supported by the NWL Care Home Support Team, working with the local authority PROs, to co-ordinate and undertake testing and at the same time train and support care home staff to be able to administer the tests themselves in the future accurately. Survey responses show this has been both effective and valued. The ability for local commissioners to share local knowledge, prioritise homes to test and to work with local health partners to deliver a responsive service has worked well. In contrast, survey responses highlight ongoing issues accessing testing kits via the portal or other centralised routes.
- **Cost pressures** – To support these pressures, all providers have been paid in advance up to June 2020 and the offer has been made to providers for the council to fund loans to support cash flow if required.
- **Infection Control Grant** –Care homes received payments per bed to support infection control. Just under £1.2m has been distributed to care homes since Mid-May.

Brent	**Community and Wellbeing Scrutiny Committee** 21 July 2020
	Report from the Assistant Chief Executive

Community and Wellbeing Scrutiny Committee Work Plan 2019/2020

Wards Affected:	All
Key or Non-Key Decision:	Non-Key Decision
Open or Part/Fully Exempt:	Open
No. of Appendices:	Appendix 1 - Community and Wellbeing Scrutiny Committee Work Programme 2019-2020
Background Papers:	None
Contact Officers:	Pascoe Sawyers Head of Strategy and Partnerships, Brent Council pascoe.sawyers@brent.gov.uk 020 8937 1045; James Diamond Scrutiny Officer, Strategy and Partnerships, Brent Council james.diamond@brent.gov.uk 020 8937 1068

1.0 Purpose of the Report

1.1 To update members of the scrutiny committee about the work plan for 2019/2020 and highlight activities outside the cycle of committee meetings.

2.0 Recommendation

2.1 To review the report, including the work plan as set out in appendix 1.

3.0 Detail

3.1 The Community and Wellbeing Scrutiny Committee provides oversight of adult social care, children's services, education, housing, Public Health, wellbeing and culture by holding Cabinet to account for decision-making and delivery of improved outcomes and strategic priorities across services and departments. In addition, Council has delegated to the scrutiny committee the responsibility for scrutinising and holding to account NHS providers and commissioners. [1]

3.2 The committee meeting in March 2020 agreed the report of the members' scrutiny task group on childhood obesity, which will be submitted to the Cabinet for their consideration and to respond to the report recommendations. However, the reports on Her Majesty's Inspectorate of Probation (HMIP) on Brent Youth Offending Service, and Contextual Safeguarding were deferred. The cancellation of the 22 April 2020 meeting also meant a report on School Standards and Achievement Report 2018-19, including Action Plan for Raising Achievement of Boys of Black Caribbean Heritage, could not be discussed. However, the chair has proposed to reschedule it along with the deferred items in the 2020/2021 work plan, which is still draft and will be submitted to Council in September.

3.3 Scrutiny of the NHS and local NHS healthcare services has continued. The committee formally responded to the 2019/2020 Quality Accounts of Imperial College Healthcare NHS Trust and will respond to other Accounts when they are sent to the committee. However, members should note that changes to regulations in response to Covid 19 mean that NHS Trusts have now been given longer to complete their Quality Accounts for 2019/2020 and documents from other Trusts may not be sent until later in the year. Publication schedules are being checked with the provider Trusts in the north-west London area.

3.4 The scrutiny committee monitors reports from the Care Quality Commission (CQC) as they have implications for quality standards at the main provider Trusts as well as primary care practices. In the past, scrutiny committee meetings have focused on CQC reports, for example, in December 2018 following the CQC report on London North West Healthcare NHS Trust. Members should note that the CQC published an inspection on 15 June 2020 with a rating of Good for Central London Community Healthcare NHS Trust. However, the chair on behalf of the committee is proposing to write to the Chief Executive of the Trust to request further information because the report had implications for community healthcare services delivered in the London Borough of Brent.

4.0 Financial Implications

4.1 There are no financial implications arising from this report.

5.0 Legal Implications

5.1 There are no legal implications arising from this report.

6.0 Equality Implications

[1] Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

6.1 There are no equality implications.

7.0 Consultation with Ward Members and Stakeholders

7.1 Non-executive members who are members of the committee will discuss this report.

Report sign off:

SHAZIA HUSSAIN
Assistant Chief Executive

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Appendix 1: Community and Wellbeing Scrutiny Committee Work Programme 2019-2020

Tuesday 9 July 2019

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1. Substance Misuse: Treatment, Recovery and Wellbeing Service	Cllr Krupesh Hirani, Lead Member for Public Health, Culture and Leisure	Dr Melanie Smith, Director of Public Health		No	No	No
2. Palliative and End of Life Care	Cllr Harbi Farah, Lead Member for Adult Social Care		Brent Clinical Commissioning Group	No	No	Yes
3. Urgent Care Centre, Central Middlesex Hospital	Cllr Harbi Farah, Lead Member for Adult Social Care		Brent Clinical Commissioning Group	No	No	Yes
4. Childhood Obesity: Members' Task Group Scoping Paper	Cllr Krupesh Hirani, Lead Member for Public Health, Culture and Leisure	Dr Melanie Smith, Director of Public Health		No	No	Yes

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

Wednesday 4 September 2019

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1.Home Care Recommissioning	Cllr Harbi Farah, Lead Member for Adult Social Care	Phil Porter, Strategic Director Community Wellbeing		Yes	No	No
2. Proposals for Cricklewood Health Centre	Cllr Harbi Farah, Lead Member for Adult Social Care		Brent Clinical Commissioning Group/Barnet Clinical Commissioning Group	No	No	Yes

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

Wednesday 27 November 2019

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1.Brent Safeguarding Adults' Board Annual Report	Cllr Harbi Farah, Lead Member for Adult Social Care	Phil Porter, Strategic Director Community Wellbeing	Independent Chair, Brent Safeguarding Adults' Board	No	No	No
2.Peer Review: Adult Safeguarding	Cllr Harbi Farah, Lead Member for Adult Social Care	Phil Porter, Strategic Director Community Wellbeing	Independent Chair, Brent Safeguarding Adults' Board	No	No	No
3. Brent Local Safeguarding Children Board Final Report	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director Children and Young People	Independent Chair, Brent Local Safeguarding Children Board	No	No	No
4. New Multi-Agency Safeguarding Children Arrangements in Brent	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director Children and Young People	CCG representative Police representative	No	No	No

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

Tuesday 4 February 2020

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1.Single Homeless Prevention Service	Cllr Eleanor Southwood, Lead Member for Housing and Welfare Reform	Phil Porter, Strategic Director Community Wellbeing		No	No	No
2. Brent Council Housing Management Services	Cllr Eleanor Southwood, Lead Member for Housing and Welfare Reform	Phil Porter, Strategic Director Community Wellbeing		No	No	No
3. Brent Council Housing Repairs	Cllr Eleanor Southwood, Lead Member for Housing and Welfare Reform	Phil Porter, Strategic Director Community Wellbeing		No	No	No

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

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Monday 16 March 2020

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1. Brent Youth Offending Service HM Inspectorate of Probation (HMIP) Report	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director Children and Young People		No	No	No
2. Contextual Safeguarding Task Group: One-Year Update	Cllr Mili Patel, Children's Safeguarding, Early Help and Social Care	Gail Tolley, Strategic Director Children and Young People		No	No	No
3. Overview and Scrutiny Task Group Report: Childhood Obesity	Cllr Krupesh Hirani, Public Health, Culture and Leisure	Dr Melanie Smith, Director of Public Health		No	No	Yes

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

Wednesday 22 April 2020

Report	Cabinet Member/s	Strategic Director/s	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1. School Standards and Achievement Report 2018-19, including Action Plan for Raising Achievement of Boys of Black Caribbean Heritage	Cllr Amer Agha, Lead Member for Schools, Employment and Skills	Gail Tolley, Strategic Director Children and Young People		No	Yes	No

** Delegated health scrutiny under part 4 of the Local Authority Regulations 2013

21 July 2020

Report	Cabinet Member/s Leader	Strategic Director/s Chief Executive	External	Cabinet Forward Plan Item	School Education Item	Health/NHS Item **
1. Brent Council and Covid 19: Service Response and Recovery	Council Leader Cllr Muhammed Butt	Carolyn Downs, Chief Executive		No	No	No

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