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Community and Wellbeing Scrutiny Committee

Tuesday 15 September 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:

***Subject to confirmation at Annual Council; 14 September 2020**

Members	**Substitute Members**
Councillors:	Councillors:
Ketan Sheth (Chair) Colwill (Vice-Chair) Ethapemi Hector Shahzad Thakkar Aden Sangani Lloyd Daly	S Choudhary, Hassan, Johnson, Kabir, Long, Mahmood, Miller, Perrin and Shah 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, Brent Youth Parliament
Jenny Cooper, John Roche

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

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The press and public are welcome to attend this meeting. The Link to attend and view the meeting is available HERE.

Notes for Members - Declarations of Interest:

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

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

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

***Disclosable Pecuniary Interests:**

(a) **Employment, etc. -** Any employment, office, trade, profession or vocation carried on for profit gain.
(b) **Sponsorship -** Any payment or other financial benefit in respect of expenses in carrying out duties as a member, or of election; including from a trade union.
(c) **Contracts -** Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.
(d) **Land -** Any beneficial interest in land which is within the council's area.
(e) **Licences-** Any licence to occupy land in the council's area for a month or longer.
(f) **Corporate tenancies -** Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.
(g) **Securities -** Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:
- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party of trade union).

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

or

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

- You yourself;

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

Agenda

Introductions, if appropriate.

Item		Page
1	**Apologies for absence and clarification of alternate members**	
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 meeting as a correct record.	1 - 8
5	**Matters arising (if any)**	
6	**Brent NHS and Covid 19 Response and Recovery** This report provides an overview of the operational response by Brent's local NHS to the COVID-19 pandemic and the recovery plans and operational recovery, including planning for a possible second wave.	9 - 28
7	**BAME Communities and the Impact of Covid 19 in Brent** This report considers the impact of COVID-19 on BAME Communities in Brent.	29 - 40
8	**Single CCG for NW London and Development of the Integrated Care System** This report sets out the plan to form a single CCG and the vision for establishing an Integrated Care System (ICS).	41 - 52
9	**Any other urgent business** Notice of items to be raised under this heading must be given in writing to	

the Head of Executive and Member Services or his representative before the meeting in accordance with Standing Order 60.

Date of the next meeting: **Tuesday 24 November 2020**

MINUTES OF THE COMMUNITY AND WELLBEING SCRUTINY COMMITTEE
Tuesday 21 July 2020 at 6.00 pm

PRESENT: Councillor Ketan Sheth (Chair), Councillor Colwill (Vice-Chair) and Councillors Afzal, Ethapemi, Hector, Knight, Shahzad, Stephens and Thakkar, and co-opted members Mr Alloysius Frederick, Mr Simon Goulden and Rev. Helen Askwith. *All were present in a remote capacity.*

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

Apologies for absence were received as follows:

- Observer Jenny Cooper, National Teacher's Union

2. **Declarations of interests**

Interests were declared as follows:

- Councillor Sheth – Lead Governor for Central and North West London NHS Foundation Trust, Board member for Federation of St Joseph's Infant and Junior Schools, Board member of Harrow College an Uxbridge College and Board member for Daniel's Den Ltd
- Councillor Shahzad – spouse employed by the NHS
- Councillor Stephens – previously worked for Faculty of Sexual and Reproductive Health
- Councillor Colwill – Governor at St Gregory's School
- Alloysius Frederick – Chair of Governors at St Gregory's Catholic Science College, Chair of Governors at St Mary's Primary School, Governor at Newman College, Chair of All Saints Trust
- Rev. Helen Askwith – retired governor for Wembley Park Primary School

3. **Deputations (if any)**

There were no deputations received.

4. **Minutes of the previous meeting**

AGREED: That the minutes of the previous meetings held on 3 March 2020 and 16 March 2020 be approved as an accurate record of the meeting.

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

There were no matters arising.

6. **Brent Council and Covid 19 Service Response and Recovery**

Councillor Mohammed Butt (Leader, Brent Council) introduced the report providing 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. The Leader highlighted the impact the pandemic had on Brent residents and the number of people impacted by deaths in Brent. The Committee heard the Council had continued to provide almost all statutory services relied upon by residents throughout the pandemic, with the only exception being the library services due to Government guidance for them to close; however, outreach book deliveries were still done. A week prior to the Government's national lockdown on 23 March 2020 the Council's Gold Command was

formed enabling important emergency decisions to be made. The Council had received money from Central Government for costs incurred from COVID-19, which were approximately £46m, and an update on the financial impact of COVID-19 had been presented at the Cabinet meeting that month. The Council were making the case to Government that any costs associated with the lockdown should be refunded. The Leader added that the process of considering what services to restore, retain, reinvent or remove as part of the recovery process had begun.

The Chair invited Councillor Margaret McLennan (Deputy Leader and Lead Member for Resources, Brent Council) to speak to the Committee. Councillor McLennan informed the Committee she would be chairing a London Finance Forum that evening with the Chair of Resources, the GLA and other regional members to look at how Councils could take forward recouping finances spent as a result of COVID-19. To date £3.4m had been returned through campaigning efforts.

The Chair thanked Councillors for their introduction and invited members of the Committee to ask questions. The following issues were raised:

In response to what went well, the Leader noted collaborative working and the sharing of information to be able to communicate with residents, understand their needs and keep them informed. A weekly email had been sent to residents and leaflets had been delivered to all homes in Brent to ensure all residents could access information and have a way to communicate with the Council in some way. Carolyn Downs (Chief Executive, Brent Council) added that the rapid response in care homes had been done well. The Council had not waited for Central Government and had ordered PPE for care homes immediately, before shortages, meaning they had a constant supply they could give to care homes and then to schools and then front line staff. A local walk-in testing centre had also been established in Harlesden. Brent was doing more testing than anywhere in London, and the Borough had a low infection rate at the time of the meeting.

Regarding what did not go well, the Leader expressed that there were lessons to learn. He highlighted that messages from Central Government impacted how the Council had interacted and communicated with residents at the start of the pandemic. Carolyn Downs added that communication between local and regional London had worked less well as dissemination of information to the local level had not been quick enough and often the Council would find out information through the Government's daily briefing at the end of each day.

On the topic of care homes, the Committee heard that there had been a shortage of testing at the start of the pandemic which had been a challenge, with only sporadic testing being done with local health partners to help specific homes with outbreaks. Continuous lobbying to get tests for care home staff was done by West London directors and health colleagues and now everyone in care homes, including extra care schemes and supported living schemes, was able to be tested, with residents tested on a monthly basis and staff on a weekly basis. Elective services had been challenging as well as lab capacity and the practicalities of delivering tests. An outbreak had been identified within a care home 3 weeks prior to the meeting with 5 people testing positive. The case was identified nationally through test and trace and Melanie Smith (Director of Public Health, Brent Council) had been contacted. A meeting with Public Health England, Brent CCG and Brent Adult Social Care had took place and a plan put in place with no further deaths following that.

Continuing the discussion regarding care home response to the pandemic, the Committee queried evidence that some discharges from hospitals to care settings took place without knowing the patient's COVID-19 status. Phil Porter (Strategic Director Community Wellbeing, Brent Council) reflected that for the first 2-3 weeks of the pandemic the whole system was gearing up to support hospitals and get patients out of hospitals. He had a call

with G15, providers of housing and supported housing, very early on to look across London and identify all accommodation that was suitable to accommodate people discharged. He highlighted that Brent Council did not discharge anyone with an uncertain or positive COVID-19 status into care homes, but there were discharges made by health partners across the system as part of the change in discharge processes. Helen Woodland (Operational Director Adult Social Care, Brent Council) added that Adult Social Care had set up a step-down facility to support those who had a covid positive status and needed to be discharged, including a facility conversion that was being built for supported living with 11 flats, to take in people with COVID-19 who needed to be discharged but needed further support. Where a person was unable to be tested or there was a view they were covid positive steps were put in place to prevent them being discharged back into care settings.

In response to queries about PPE for other care settings and extra care settings not commissioned by the Council, the Committee heard that all providers in Brent, whether they were commissioned by Brent Adult Social Care or not, received PPE in order to prevent the spread of the virus. In the early stages of the pandemic care home staff were encouraged to self-isolate if they showed symptoms but asymptomatic staff may have provided care, therefore PPE was attributed as the key barrier to ensure that patients in care settings were protected from asymptomatic staff when testing was not possible. In response to whether the Council considered charging care homes for PPE, Phil Porter explained that with the level of PPE required in the early stages care homes would not have been able to source it so the Council used economies of scale to source and buy it for less. The purchase of PPE would have also placed an additional burden on care homes and he believed care homes would not have been able to fund it. It was expressed that when Central Government put additional burdens on the Council they would expect to be funded for those and that it was appropriate to have purchased PPE for care homes.

In considering the future response in care homes and the potential for a second wave, the Leader felt that the systems, processes and procurements were in place now to procure PPE immediately when required, and the collaboration with care homes was strong. Regular delivery of PPE to the civic centre was continuously taking place. Phil Porter added that the model for working with care homes agreed at the Health and Wellbeing Board in February 2020 had been fundamental in the ability to respond to the pandemic and care homes and the council had built a partnership that was ready for a second wave. It was noted that nothing would change in care homes until a vaccine or treatment was developed, with infection control, PPE and staffing to continue.

In relation to testing in Brent as a whole, directors expressed that in the early stages it was very difficult to put testing in place. The Wembley testing site that had been established was a drive through and only for those showing symptoms meaning those in high risk jobs without symptoms or those without access to a car were not able to get tested. This had led to the Council working with the Government to put the walk-in testing site in Harlesden which also tested those in high risk professions such as transport staff and shop workers. Directors felt the Government lacked appreciation of the reality of people's lives and some procedures suggested for the Harlesden site would not have worked such as using photo ID and booking in through a smartphone with internet. The Council lobbied and were able to agree with the government its own procedures for the Harlesden testing site which was now the most successful walk-in centre and results came through very quickly. It was noted that those accessing the test site were not necessarily representative of the people who lived in that local community, therefore going forward work would be done on that. It was felt by those present that there may be a disincentive in the demographic of Harlesden and other covid hit areas to getting tested as if a person tested positive it required them to not go to work for 14 days which had other implications such as sick pay. Phil Porter echoed those points and highlighted the care home infection control fund that was supporting carers to be paid if they were unable to go to work.

While testing in the Borough was going well directors were concerned about the national test and trace system. On average test and trace identified 2.2 contacts for every case in Brent which Dr Melanie Smith (Director of Public Health, Brent Council) believed to be an under-recognition of contacts. Test and trace was reaching 59% of people in Brent which was better than the national average however there was a need to get those figures higher to prevent a second wave. This had been reflected in messaging encouraging residents to co-operate with test and trace but it was believed there was a reluctance to do so. Dr Melanie Smith noted that the Council had limited influence over the national test and trace and did not have insight into its operating procedures. The Association of Directors of Public Health were lobbying to get access to scripts and standard operating procedures so that they could use local insights to suggest how the national model might improve its performance.

In concluding the discussion regarding the national test and trace system, Carolyn Downs noted that the mobile testing units would now be given to private sector organisations and directed by the Department of Health centrally. She expressed her personal view that testing units should be brought to a local or sub regional level for local areas to manage the resource themselves and direct it towards COVID-19 hotspots.

In relation to the impact of COVID-19 on BAME communities the Committee queried how quickly the Council realised this disproportionality and what specific solutions were put in place. The Leader expressed that COVID-19 had highlighted the inequalities in society and within the community and there was now a focus on inequality and the Black community, noting the Black Community Action Plan that had arisen as a result of Black Lives Matter. The action plan ensured that the next 2 years delivered for Black communities and included specific focus on COVID-19. The Leader added that there were underlying issues that would need a lot of effort to tackle. The Leader felt that there was focus needed on all marginalised communities and highlighted the importance of looking into the issues people face such as the type and quality of housing they live, and the front line occupations people work including carers, nurses, and transport workers. He added that when lockdown eased he did not want to slow down on this work. The conversation regarding disproportionality had also been started at a London Council's level.

In relation to specific COVID-19 hit areas in the Borough, such as Harlesden, Church End and Alperton, Carolyn Downs noted that the social distancing messaging became very targeted and hard hitting with specific messages in those areas to say more people had died in Harlesden than anywhere else in Britain. Moving forward the Council would have conversations with the CCG and at the Health and Wellbeing Board about what better support they could put in to those specific communities such as Alperton, Harlesden and Stonebridge. CNWL were putting in a very specific mental health support programme to help those communities deal with trauma and Carolyn Downs had been clear an area of focus going forward should be the quality of GP services in those areas.

Further querying the Council's effectiveness of getting the message out to the community, noting street parties that occurred in Brent during the lockdown, the Committee asked what infrastructure was in place working with partners to widen the message. The Leader expressed that with 16 weeks of lockdown there came a period where people felt they needed space, with concerns around mental health and wellbeing. He felt those who engaged in street parties and other activities outside of the lockdown guidance were expressing their frustrations in a way that may have seemed alarmist and that it was essential to help and support people to come out of that enclosure, using knowledge and experience to build resilience within the community. The leader concluded by stating communications were improving all the time.

Committee members queried what mechanisms were in place during the lockdown to ensure that those who needed support with food received it. Carolyn Downs explained that

the Council had a triage system to ensure support was offered to everyone in Brent, with £100k spent per week to deliver food supplies to vulnerable people. Triage included a leaflet to all residents, the list of those identified as required to shield by the government, assessments through social workers of those who were vulnerable and might need food support, as well as a referral mechanism through mutual aid groups, voluntary groups or direct self-referral. In addition care agencies and GPs were sent messages asking for referrals if they were aware of someone in need of food support. There was no form filling to access food support and the process was very open. The Leader expressed that the community, mutual aid groups, voluntary groups and faith groups had come together to provide valuable support mechanisms and highlighted the importance of tapping into the resource of communities to deliver support. Eventually the Council had supplied food to an extraordinarily high proportion of people in the Borough. Committee members shared a story of a resident who had went without food for a number of weeks to which Carolyn Downs apologised for and to anyone who did slip through the net. She felt they had done everything within the Council's possibilities to reach all residents but asked for feedback from anyone who felt they could have done something better.

Regarding what the council did for those with disabilities, Carolyn Downs advised that in relation to food support the Council delivered incredibly well. Those who were homeless had been allocated accommodation, the wellbeing service had been available to those accessing support, and SEND schools had ensured a service was made available throughout the crisis for children. Phil Porter acknowledged that the risks of COVID-19 would remain for those shielding, which included people with disabilities, therefore going forward it was important to continue to monitor, manage and alleviate for those people and assist them to maintain a fulfilling quality of life while shielding. A member requested that the CCG provided data on the impact of COVID-19 to those with disabilities at the next scrutiny Committee meeting.

In relation to the delivery of housing and supporting homeless people during COVID-19, Phil Porter and Hakeem Osinaike (Operational Director for Housing, Brent Council) explained that they took in an unprecedented number of homeless people, with an increase in single homeless people presenting and a decrease in homeless families, accommodating over 250 people due to the reduced threshold for support. Work was now ongoing to support those people to move into more permanent accommodation, with the majority being placed into the private sector and HMOs. The Council were funding the accommodation people were placed in currently but were hoping to get those costs and ongoing costs back from the Government and were currently in the process of bidding for homelessness support grants from the charitable sector. During lockdown there had been a temporary increase in Local Housing Allowance and the Council had not received a response as to whether the increase would be retained, but would continue to ask the Government to permanently relax the rules regarding housing benefits for under 35 year olds to help them into single person's accommodation.

Regarding those being housed in HMOs and private rented sector accommodation, the Committee sought assurance that their accommodation was stable. Hakeem Osinaike explained that they were incentivising landlords to take individuals on for a 12 month social tenancy and once they had done that they would receive the incentive. All those receiving an assured short hold tenancy were getting an offer for 12 months. In response to requests for assurance that accommodation people were being placed in was suitable, it was explained that while inspections had initially paused in totality at the start of the lockdown statutory inspections had since resumed, meaning all HMO inspections and selective licensing agreements were being done for those being placed.

Continuing to discuss homelessness, the Committee heard there was a cohort with additional significant needs, sometimes including substance misuse and mental health issues, who were being placed with housing related support. A multi-disciplinary team led

by an experienced team manager and comprising housing staff, substance misuse staff, mental health staff and adult social care staff had been established to wrap services around that cohort. In addition, EEA nationals without recourse to public funds, which Brent had around 33 of, were being supported to find work and accommodation due to the Government extension of funding which had been extended until 31 December 2020. The group the Council struggled to support were those non-EEA nationals without recourse to public funds, which Brent had 12 of, due to limits in statutory duties. The Government had announced additional funding was available to bid for and the Council were preparing bids, which if granted would pay for legal assistance so that those people could normalise their stay through the Home Office. The Council were working hard to construct a service to support those people and ensure protections were in place to ensure those seeking immigration status did not become part of forcible deportation. It would seek assurance that there would be no need to co-operate with the Home Office before funding was received with the initial indication being that they would not have to and would not have to reveal the identities of those they assist.

The Committee moved on to query how the Council were putting infrastructure in place to support resident mental health and wellbeing, acknowledging that the pandemic could have exacerbated or triggered mental health issues. Phil Porter explained that the Council had a role for mental wellbeing and there was a cohort that bounced between the system which was where the multidisciplinary team would help. He added he was working with the CCG to look at the mental health practices they put in place as part of the work on disproportionality. Melanie Smith highlighted that the public health team had done a lot of work on 5+1 ways to wellbeing which was an evidence based self-help and mutual aid approach to mental wellbeing. She also highlighted the Good Thinking website which had adapted to COVID-19 and provided those digitally enabled with comprehensive, quality assured free resources suitable for a diverse London population. Officers and Committee members hoped it would be feasible to tap into the infrastructure of organisations that the Council already had relationships with to deal with mental wellbeing and loneliness. Conversations started with mutual aid groups had highlighted that they wanted a mechanism for referrals. Shazia Hussain (Assistant Chief Executive, Brent Council) expressed the reality that the Council did not have the resources to do that but did have a lot of third sector providers who already provided some of that support. Work was being done across partnerships to see if Brent could build on the voluntary work and infrastructure built to lead to better mental health outcomes, using voluntary organisations which had high engagement with the community to create links between services.

The Committee queried whether there was a telephone helpline service for those most vulnerable. Helen Woodland highlighted that through the wellbeing service there was a telephonic service contacting and checking on those known to Adult Social Care who may be struggling. Day centres had been closed but direct services staff had been running an outreach service for clients which included personalised activity packs, visiting them and calling them. Alongside this Adult Social Care in conjunction with Public Health had commissioned the social isolation in Brent project which was part of Gateway, offering outreach for loneliness. Helen Woodland expressed that there was a wider remit for voluntary, community and mutual aid groups to reach out to other parts of the community not eligible for Adult Social Care with regard to social isolation.

Regarding staff support during the pandemic, particularly in relation to paragraph 3.34 of the report noting staff volunteering to work weekends, evenings and overnight, directors acknowledged the willingness of Brent care staff to volunteer to do additional hours. Helen Woodland highlighted that the majority of care staff who did volunteer to work additional hours were not needed and in general staff worked their core hours, with any additional hours offset so that no one worked more than 5 days a week but were flexible with the days worked. The support offer for staff within Adult Social Care included a wellbeing resource package for all staff which all managers had been asked to discuss with staff members 1:1.

The offer included referral to Brent IAPT talking therapy service which was one of the only IAPT services in the country without a waiting list. This offer was open to all Brent staff as well as an Employee Assistance Programme and was already in place through COVID-19. Phil Porter listed the specific support that would be offered as a result of COVID-19 which was; a service for trauma commissioned by HR for those staff that had been redeployed to work in the mortuary and; covid specific risk assessments for all staff to undertake before returning to work, which assessed the individual's health history against their job role. The Public Health team had also been providing tailored infection training initially to care home staff and now to providers such as Network Homes. Public health were also providing tailored briefings for Council staff returning to the workplace. One final note regarding staff support was the regular communications from managers to Officers and from the Directors which had been mentioned positively in the staff wellbeing survey.

In relation to financial aid Brent Council had received from the Government to cover the costs incurred as a result of COVID-19, the Leader informed the Committee that they had received 3 lots of money totalling £22m from Government. The Committee heard that the costs, risks and pressures from COVID-19 amounted to over £46m, meaning the money received was just under half the amount needed, and the Leader foresaw extra risks and pressures as Brent moved forward that would push the impact closer to £50m. Separate money was received in relation to business rates grants as the Council needed to hand that out to businesses for dispensation. Regarding financial support for residents affected by COVID-19 going forward, the Council would look to provide that support through the Council Tax 13A policy passed at Cabinet which provided £150 contribution to Council Tax for the most vulnerable residents, and providing interest free loans to those struggling with finance and debt. As those who received money paid the loan back this could be used to support more people through hardship.

The Committee also queried what lessons had been learned regarding digital exclusion working through the coronavirus response stage. The leader informed the Committee that the Council were looking to provide laptops and broadband connections and a digital support package to Brent residents who were digitally excluded. Councillor McLennan (Deputy Leader and Lead Member for Resources, Brent Council) expressed that she had found it stark the level of digital poverty, which had made it difficult for clinicians to contact individuals during the pandemic as some families shared only one phone between them, for example.

In relation to schools, members asked what major risks had been identified going forward and how teachers and staff would feel about the full return in September. The Leader highlighted that they had spoken to schools and unions about ensuring the environment was safe for both children and staff, and the need to ensure parents were reassured to have the confidence to send their children to school. Work was being done with unions and schools to ensure risk assessments were robust and checked by Brent's Health and Safety Department. Gail Tolley (Strategic Director Children and Young People, Brent Council) explained that at the beginning of lockdown schools were asked to organise themselves into geographical clusters, and the clusters had been very supportive to each other. Weekly communications were done with schools and from 15 June 2020 she had begun school visits again, with 8 visited at the time of the meeting. Gail Tolley felt that schools were very ready and open to reopening to all children from September, and noted that during the lockdown all schools except one had remained open for key worker and vulnerable children. From 1 June 2020 schools had opened up to the specified year groups allocated by the Government and had managed well and supported each other. Two plans had been put in place for September which were; Plan A – the opening of all schools fully for September; and Plan B – blended learning including online learning, should there be a localised or broader lockdown. Regarding funding, Gail Tolley informed the Committee that money had been announced for support for disadvantaged pupils to ensure any educational gap was kept as narrow as possible with the distribution of that money having

just been announced. Overall additional funding for schools to cover covid-19 related costs had not yet been announced but the DfE had indicated it would happen. Gail Tolley highlighted that there was currently a lack of clarity regarding nursery schools and the Council may need to seek lobbying support for that.

Going forward, the Leader felt that they were ready for a second wave. Systems were in place for the procurement of PPE and collaboration was in place with care homes, boards and schools. Staff and councillors were now supported to work at home with equipment supplied for remote working and it had been made easier to make decisions without having to gather in one place through the use of virtual meetings. It was noted that communication techniques had significantly changed and the use of social media, emails and weekly bulletins had risen. There had been a rise in organisations and contacts wanting more collaboration with the Council, and the Leader felt the need to capitalise on the trust people now had for the council and build on the relationships gained. In addition more people were able to engage with the Council and participate through opportunities like Brent Connects Forums online, and the Council could gain insight and understanding to how Brent residents were feeling about the response through the COVID-19 resident survey. In response to whether there were any areas needing work in preparation for a second wave, the Leader felt that the Council would need to monitor what places in local lockdown, e.g. Leicester, were doing and take lessons from them in the case of a local lockdown.

Regarding the work on disproportionality going forward, Phil Porter informed the Committee that they were working hard with the CCG and CNWL to build resilience and support for people who might be at risk of a second wave through a local approach in areas such as Church End and Alperton, and through participatory research and experience of residents, as well as a broader top down approach, with the CCG conducting a care planning regime for those shielding. This care planning involved working with Public Health to ensure everyone would have their care plan and literacy built into it to ensure they understood their own personal risks. Going forward focus would be placed on outcomes and actions with a short term, medium term and long term approach. Short term actions would include communications and messaging, medium term outcomes would be gained through hyperlocal research and long term actions would be around housing.

Regarding food support in the event of a 2nd wave, Phil Porter explained that in stepping down the food support a plan was put in place to ensure that food support could be stepped back up very quickly if needed. Helen Woodland added that during the lockdown a choice made by the council was to relax the assessment regulations slightly for those who might have eligible care needs on a short term basis, and would be able to offer that again should there be another lockdown, but expressed the importance of not creating a dependency on that support.

The Committee agreed in conclusion that they were assured the Council had responded well during the response stage, and about the Council's response to the needs of the vulnerable, and were assured about the effectiveness of any future response to challenges.

7. **Scrutiny committee work plan update 2019/2020 report**
Noted.

8. **Any other urgent business**
None.
The meeting closed at 09:00pm

COUNCILLOR KETAN SHETH
Chair

Brent	**Community and Wellbeing Scrutiny Committee** 15 September 2020
	Report from Brent Clinical Commissioning Group

Brent NHS and COVID 19: Response and Recovery

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	Appendix 1 – Phase 3 Letter – Summary of Priorities and Actions
Background Papers:	None
Contact Officer:	Mr Jonathan Turner, Deputy Managing Director, Brent CCG Jonathanturner2@nhs.net 0794 725 4871

1.0 Purpose of the Report

1.1 The purpose of this report is to provide an overview of the operational response by Brent's local NHS to the COVID-19 pandemic and the recovery plans and operational recovery, including planning for a possible second wave.

1.2 The report is structured into 3 main sections – the first reviews the COVID infection and mortality data and provides an analysis of the figures.

1.3 The second part looks at the immediate COVID response and what actions took place

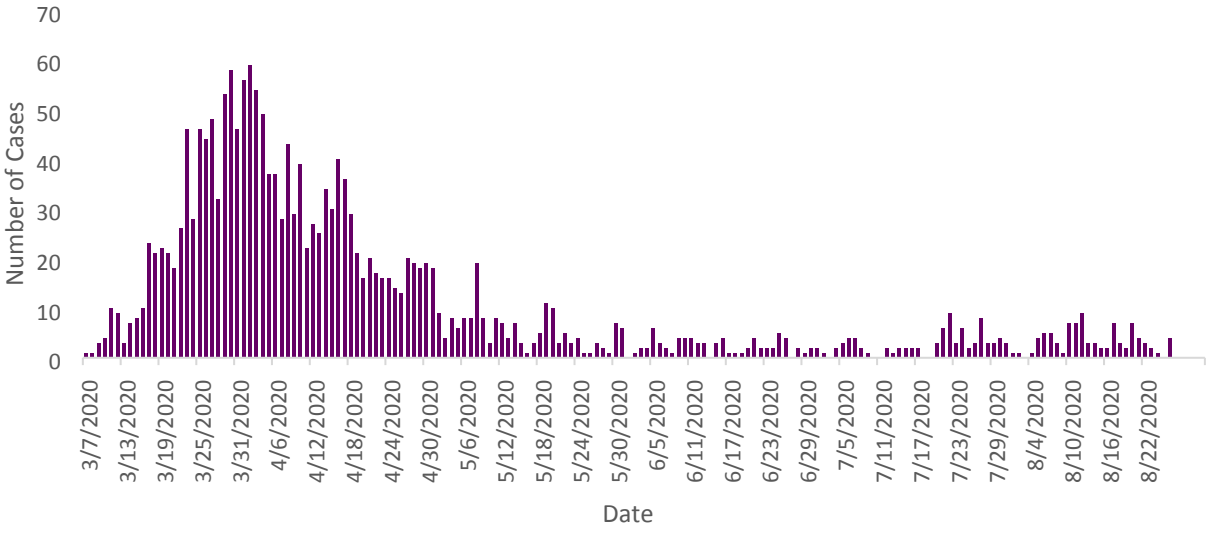
1.4 The third part looks at the COVID recovery phase and lessons learned from the pandemic.

1.5 There is also a finance section which covers the financial implications for the CCG as a result of the pandemic.

1.6 COVID-19 Infection Rates and Mortality in Brent

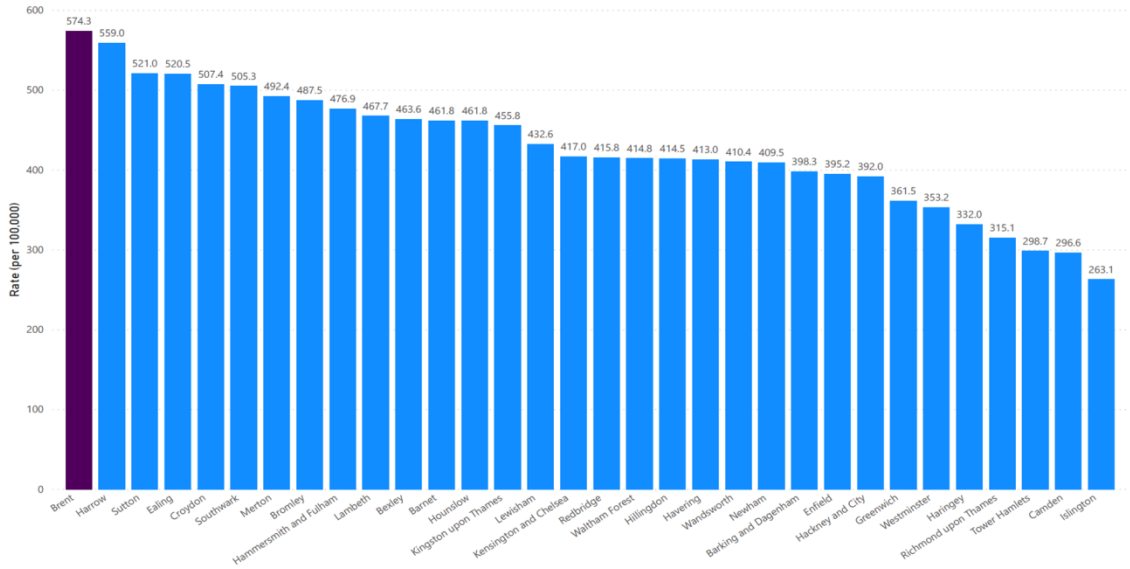
COVID-19 infections hit a peak in late March and early April of 2020, dropping significantly by May. Since then, we have had a low number of sporadic cases, but there has been a slight uptick in rates over recent weeks. The Council's Public Health Department and the CCG are monitoring this closely and the CCG has membership of the Health Protection Board, which monitors and updates issues relating to the control of COVID-19 infections.

Number of Daily Lab Confirmed Cases in Brent from 7th March 2020 up to 26th August 2020.



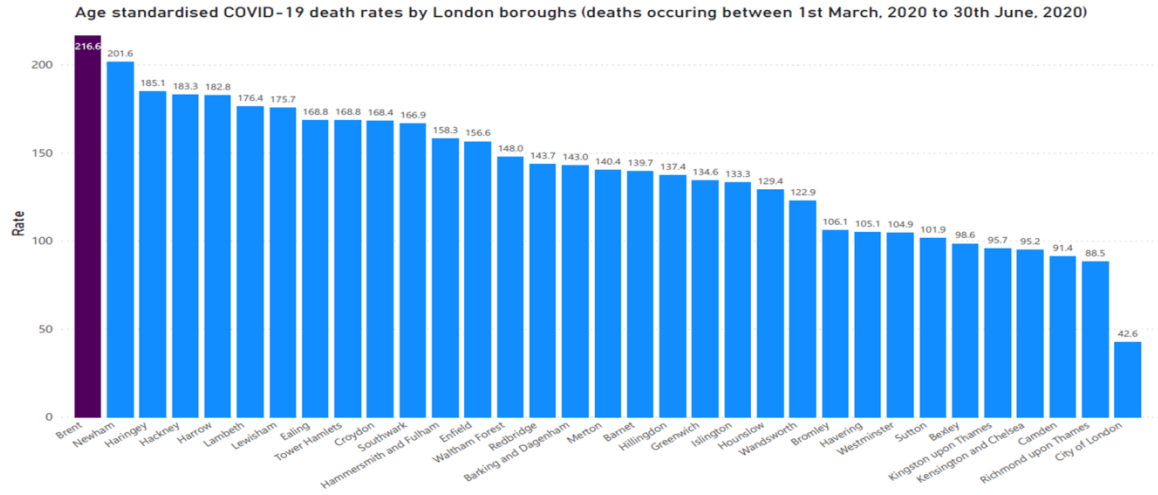
The cumulative rates of COVID-19 infections as detected by Pillar 1 and Pillar 2 testing is the highest in London, although it should be noted that this mainly reflects the very high rates of infections that the borough saw early in the pandemic, rather than the current state of affairs, which is that of a relatively low infection rate.

Lab confirmed COVID-19 cases rate (per 100,000 residents) by London Local Authorities. From week starting 1st March 2020 up to 26th August 2020.



1.7 COVID 19 Mortality

Overall mortality rates are not the highest in London, but when age is taken into account (Brent has a younger than average population), it has the highest age-standardised death rate in London. Some of this may be due to the early peak in COVID cases that was seen in Brent, and the 'compacted' nature of the infections, where large numbers of patients were arriving at A&E in ambulances with COVID symptoms during a short space of time. It is also likely to be attributable to a number of factors specific to Brent, including deprivation, the high BAME population and the high population density, with higher numbers of people living within close proximity and multi-generational households living together. Housing inequalities, air quality and density of transport usage are also likely to be factors.



1.8 COVID-Mortality Rates by Disability Status

The Scrutiny Committee has requested COVID infection data by disability status. Unfortunately, Brent-level data does not currently exist on this, so national data is all that we currently have. The national data is shown below. This appears to show a higher than average mortality rate for those whose status is "limited a lot" compared with the England average mortality rate. This is likely to be connected to the number of long-term

conditions and lower levels of activity that such people face.

Table 1: Rates of deaths involving COVID-19 and all deaths by disability status, 9 to 110 years of age, England and Wales: 2 March 2020 to 15 May 2020[1,2,3,4,5,6]

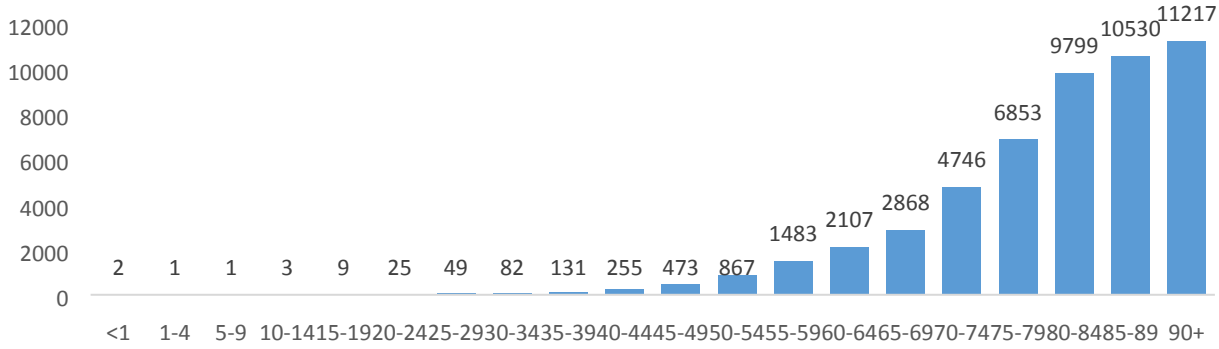
Disability Status	Sex	Covid-19 deaths	
		Rate per 100,000 population	Lower 95% confidence limit
Limited a lot	Male	199.7	193.65
Limited a lot	Female	141.11	135.95
Limited a little	Male	125.07	121.21
Limited a little	Female	68.95	66.51
Not Limited	Male	70.2	68.73
Not Limited	Female	35.64	34.7

Notes:
1 Causes of death was defined using the International Classification of Diseases, Tenth Revision (ICD-10) codes U07.1 and U07.2. Figures include deaths where coronavirus (COVID-19) was the underlying cause or was mentioned on the death certificate as a contributory factor. Figures do not include neonatal deaths (deaths under 28 days).
2 Figures are for persons usually resident in England and Wales, based on 2011 Census enumerations, and not known to have died before 2 March 2020.
3 Figures are for deaths occurring between 2 March 2020 and 15 May 2020. Figures only include deaths that were registered by 29 May 2020.
4 Age-standardised mortality rates are expressed per 100,000 population and standardised to the 2013 European Standard Population.
5 Age-standardised mortality rates based on fewer than 10 deaths are not presented due to low reliability and marked as ':'; figures based on 10 to 19 deaths are presented, but marked with 'u' to show low reliability.
6 The lower and upper 95% confidence limits form a confidence interval, which is a measure of the statistical precision of an estimate and shows the range of uncertainty around the figure. As a general rule, if the confidence interval around one figure overlaps with the interval around another, we cannot say with certainty that there is more than a chance difference between the two figures.

1.9 Age Related Mortality Data

Again, Brent-specific data relating to age is not yet available so we have shown England data. This shows that there is a strong correlation between increasing age and the number of COVID related deaths. People under 40 make up a very low number of the deaths and there is a jump in mortality at 70+.

Deaths involving COVID-19 (numbers): by age, 2020 registrations, England and Wales: 3rd January 2020 to 14th August 2020[1,2,3,4,5,6]



Notes:
1 Coding of deaths by cause for the latest week is not yet complete.
2 For deaths registered from 1st January 2020, cause of death is coded to the ICD-10 classification using MUSE 5.5 software. Previous years were coded to IRIS 4.2.3, further information about the change in software is available.
3 Deaths involving COVID-19 have been included within weekly death registrations figures due to the pandemic.
4 Does not include deaths where age is either missing or not yet fully coded. For this reason counts may not sum to 'Total Deaths, all ages'
5 Does not include deaths of those resident outside England and Wales or those records where the place of residence is either missing or not yet fully coded. For this reason counts may not sum to "Total deaths, all ages".
6 These figures represent death registrations, there can be a delay between the date a death occurred and the date a death was registered. More information can be found in our impact of registration delays release.

1.10 Reasons for COVID Mortality Rates

There are many factors behind the death rates, many of them complex and intersecting. Work is underway at a national level as well as in NW London to understand the way health inequalities, particularly around race have impacted on Covid-19 outcomes. The CCG and the local authority are already doing a targeted piece of work around health inequalities that reports into the Strategic Delivery Board, including the following representatives:

- Chief Executive of Brent Council
- Strategic Director of Community Wellbeing (Brent council)
- Director of Public Health (Brent council)
- Chair of Brent CCG
- Lead Member for Adult Social Care

Short-term outcomes of this engagement exercise include:

- Change health behaviour to reduce risk of Covid-19
- Flu immunisations for individuals at risk of Covid-19
- Promote occupational health risk assessments across businesses

Medium-term outcomes include:

- Raise health literacy of long-term mental and physical health conditions including diabetes, hypertension, cardiovascular disease and mental health & wellbeing
- Increase cardiovascular disease, obesity and diabetes control, awareness, testing and self-testing with a particular focus on BAME communities
- Improve access to primary care

Longer-term outcomes include:

- Improve long-term health outcomes
- Increase in self-care and self-management
- Improve wider determinants of health
- Assess health impacts of Covid-19 on the community
- Monitoring and reporting staff ratios of BAME staff representation
- Scope interventions for an open access centre for diabetes and other long-term conditions

As a sub-stream of this work, the CCG is also working closely with Primary Care Networks in the most affected areas (such as Church End and Alperton) to address health inequalities specifically in relation to long-term conditions, such as diabetes, high blood pressure, asthma, COPD and obesity. The aim is to reach out to communities that are not always attending their GP practices and not engaged in health seeking behaviours to ensure a more proactive approach to managing their conditions.

North West London CCGs are running a major piece of work with a particular focus on BAME patients and staff, identifying meaningful, measurable ways that we can address the underlying health inequalities which have resulted in the widely-reported disproportionate impact on BAME people.

2 The Immediate COVID Response – March 2020

2.1 Acute Trust Response

As the scale of the pandemic became clear, NHS England began to issue guidance to NHS Trusts, STPs and CCGs regarding the response in a letter dated 17th March 2020 from Simon Stevens.

NHS acute trusts were asked to:

- Free up maximum possible inpatient and critical care capacity
- Prepare for, and respond to, the anticipated change in numbers of COVID-19 patients who will need respiratory support
- Support staff to maximise their availability
- Play their part in the wider population measures newly announced by the Government (i.e. the “lockdown”)
- Stress-test operational readiness
- Remove routine burdens, such as inspections etc, to facilitate the above

Part of this readiness included postponing all non-urgent elective operations and urgently discharging hospital inpatients who were fit to leave.

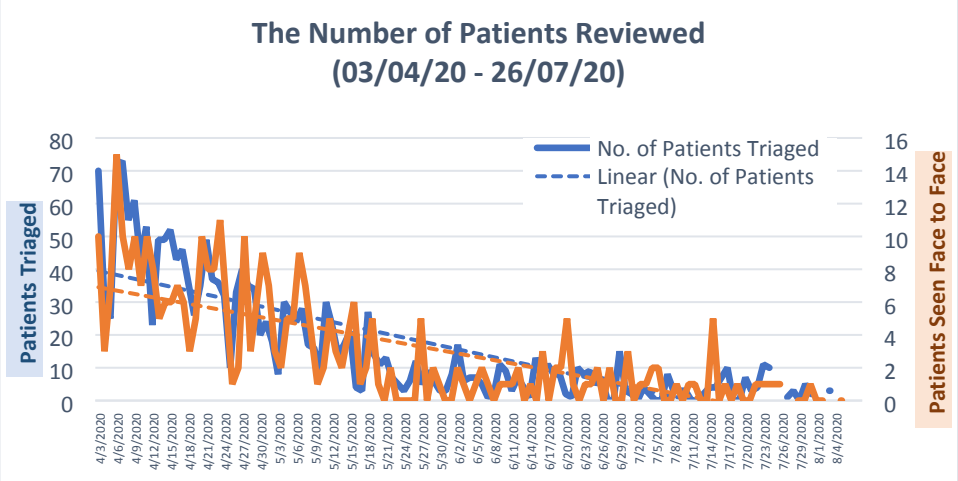
There was also a move to produce a step change in the quantities of oxygen supplies in hospitals to deal with the anticipated demand, and an increase in PPE ordering to protect staff and patients alike. This guidance was progressed and adhered to in all of our local hospitals serving Brent, including a more than doubling of ITU capacity at Northwick Park Hospital and St. Mary’s. At a London level, planning took place for the Nightingale Hospital at the Excel Centre in North East London, which opened on 3rd April 2020.

2.2 Primary and Community Care

- As part of the pandemic response, the CCG commissioned a COVID Escalated Care Clinic (known as the "Hot Hub"). Based at Willesden Centre for Health and Care, the Hub went live on 27th March 2020 and the CCG rapidly commissioned this model, with mobilisation taking place over the course of a weekend. The Hub was set up to see patients with intermediate level COVID-19 symptoms such as moderate breathlessness, so that these patients could be cared for and monitored in the community rather than putting further pressure upon the hospitals. The Hub proved to be invaluable during the peak of the pandemic and saw many sick patients. The majority were reviewed remotely by telephone or video-conferencing but the sicker patients were called in for review. A few patients needed to be admitted to hospital, but the majority were able to be monitored at home. The hub gave patients pulse oximeters and took regular readings from the patient by phone to check their oxygen saturations. In this way, a number of patients were monitored in the community and were able to recover at home without needing to be admitted to hospital.

  The CCG also set up a COVID PCR antigen testing centre for health and social care staff at Willesden, which allowed staff to be rapidly checked and to continue working if their test proved to be negative, freeing up staff from self-isolation at a time when they were critically required.

  The Hot Hub continues to operate at a low level and has been retained with reduced capacity in anticipation of a future surge, at which point it will be possible to step up capacity again to a higher level in line with demand.



Total Number of Patients Reviewed	3,737
No. of Patients Triaged	1899
% of Patients Triaged	51%
No. of Patients Reviewed Face to Face	341
% Reviewed Face to Face	9%
No. of Follow Up Telephone Consultations	1496
% of Follow Up Telephone Consultations	49%

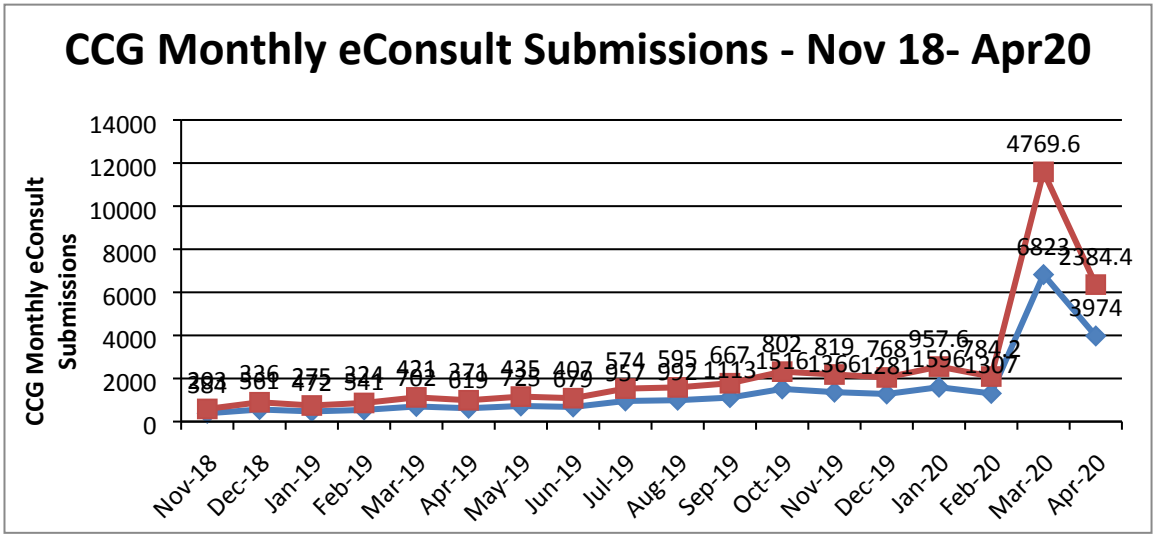
- Care Homes. Brent CCG worked closely with our Local Authority and ICP teams to support our GP practices in managing patients in our care homes during this difficult time. Practices who have patients registered in a Care Home confirmed that weekly virtual

ward rounds were being undertaken or there is a clear system in place for the Care Home to contact the GP practice. Named GPs have been put in place for each care home patient to ensure continuity and quality of care. The NWL CCGs Quality Team also supported testing in care homes, with nursing staff going out to swab patients and staff. Testing for care home staff was set up through the COVID Escalated Care Clinic.

- Advice & Guidance - practices have been referring patients through the Advice and Guidance system in the first instance so that they can receive advice from as much as possible rather than making referrals, unless they are 2 week waits or urgent. The Advice and Guidance function is now available using Vantage Rego at LNWHT and is available through the normal channels at Imperial.

- District Nursing- district nurses were invaluable during the pandemic and visited many housebound and "shielding" patients who needed assistance, such as getting INR tests done for patients who are taking anticoagulation therapy

- Use of E-Consultations in Primary Care – primary care rapidly increased its usage of e-consultations for patients who were able to use the technology. This became the default way of accessing general practice as it helped avoid unnecessary healthcare acquired infections of COVID in the population. However, face to face consultations were still available for those who needed them, or did not have the digital technology available. Weekend, bank holiday and evening appointments were also available at the GP Practice hub in Wembley Centre for Health and Care.



- Gold and Silver Commands – the CCG set up a Gold (CCG leadership team) and Silver (Primary Care Network Leads) Command structure during the pandemic to ensure that information was disseminated from the STP leadership to the front line and to ensure that feedback could be easily communicated up and down with free channels of communication. The CCG also set up a weekly COVID-19 bulletin to keep GP practices informed about the latest guidance and protocols involving COVID, and what other parts of the system were doing, including the Escalated Care Clinic, testing and hospitals.

3 The Recovery Phase

3.1 Acute Care

Hospitals have been working to establish COVID risk managed and COVID protected pathways. This means segregating parts of the hospital so that people receive a COVID test and then waiting for at least 7 days (to check for any symptoms) before visiting a hospital for a planned procedure. This is the “COVID protected” pathway.

However, for urgent care needs it is not possible to wait for a test before attending to people’s needs, so urgent care services like UTCs and ED Departments are screening patients at the door for COVID symptoms and then segregating them into parts of the waiting area that are designated for people with potentially COVID symptoms and those who do not have COVID-like symptoms. This is the “COVID risk managed” pathway. A common protocol for this has been developed across North West London in conjunction with NHSE & I and all acute trusts are following it.

Unless a face to face appointment is required for an examination, or is clinically urgent (e.g. 2 week wait cancer pathway), all outpatient appointments are now taking place on a “virtual by default” basis, meaning that virtual technology is used for these appointments. However, for those where a clinical examination is required, or who do not have access to technology an appointment on site can still be made so that people are not disadvantaged by digital exclusion.

Most outpatient appointments and elective procedures (unless urgently required) were disrupted or cancelled during the pandemic, as the bed space and personnel were required to help with the COVID effort and to make space for additional COVID wards. This was in accordance with the guidance letter received from NHS England. However, in the event that there are future surges or second waves in COVID activity, NHS England is clear that ceasing elective activity is no longer an option, and that the NHS is expected to continue seeing elective patients in a safe way, whilst also continuing to step up its COVID response for patients admitted non-electively. This will now be possible because of the ability to anticipate demand, the segregation of pathways and the planning that has taken place for a second COVID wave.

3.2 Primary and Community Care

Priorities for general practice in the recovery phase include:

- Making rapid progress in addressing the backlog of childhood immunisations and cervical screening through
- specific catch-up initiatives and additional capacity
- deliver through their Primary Care Network (PCN) the service requirements coming into effect on 1 October as part of the Network Contract DES

All GP practices must offer face to face appointments at their surgeries as well as continuing to use remote triage and video, online and telephone consultation wherever appropriate –whilst also considering those who are unable to access or engage with digital services.

GP practices will be ensuring that everybody with a Learning Disability is identified on their register; that their annual health checks are completed; and access to screening

and flu vaccinations is proactively arranged.

3.3 Flu Vaccinations

In light of the risk of flu and COVID-19 co-circulating this winter, the national flu immunisation programme will be absolutely essential to protecting vulnerable people and supporting the resilience of the health and care system. This means delivering the flu immunisation programme will be more challenging in 2020/21 and an effective management and deployment of the programme will be more important than ever before.

Local factors and disease transmission at the time of immunisations are likely to influence the delivery, the approach and options available for practices. With these factors in mind, delivery of the programme will require a collaborative and flexible approach, while minimising the risk of transmission and ensuring we maximise flu vaccine uptake to protect the public from flu, especially the most vulnerable.

Primary care has remained robust and resilient over the COVID period. However, there is going to be an increased pressure on general practices, with COVID and flu co-circulating, especially in regards to potential additional patient cohorts for flu vaccines this winter.

The CCG is working closely with GP practices to significantly increase flu vaccination coverage this winter and to achieve a minimum 75% uptake across all eligible groups.

- In 2020/21 groups eligible for the NHS funded flu vaccination programme including additional groups:
    -
    - all children aged two to ten (but not eleven years or older) on 31 August 2020
    - those aged six months to under 65 years in clinical risk groups
    - pregnant women
    - those aged 65 years and over
    - those in long-stay residential care homes
    - carers
    - close contacts of immunocompromised individuals
    - health and social care staff employed by a registered residential
    - care/nursing home, registered domiciliary care provider, or a voluntary
    - managed hospice provider
    - New: Year 7 school age
    - New: 50-64 year old
    - New: household members of shielded patients

4 Restoration of Elective Surgery and Diagnostic Testing

The NHS continues to operate in a level 3 pandemic emergency, while planning our recovery, restoring services while safely managing Covid-19. Our priority is keeping patients and staff safe while delivering high quality, equitable services.

It is too early to set out a fixed timeline for full service restoration, or to say what the ‘new normal’ will look like in detail. Any changes to services will be locally led and driven by clinicians, on clinical need and safety grounds. Changes made in response to the pandemic are temporary.

It is expected that we will be further extending digital access to care, such as online GP appointments, as this is beneficial for patients (even when there is no pandemic). It is

also likely that we will continue to need a robust triaging model in place for the foreseeable future. This is to keep patients and staff safe.

NHS England issued a Phase 3 letter, setting out how the recovery phase should take shape from August 2020. This included:

- Accelerating return to near normal levels of non-COVID health services
- Preparing for winter demand, allowing vigilance for local COVID spikes
- Doing the above in a way that takes account of lessons learned during the first COVID peak

Specifically, the letter set out several targets, of which a fuller summary is set out in Appendix 1. The national targets include:

- Delivering 80% of last year's activity for overnight electives and for outpatient/ day case procedures rising to 90% in October
- 100% of last year's activity for outpatients and follow-ups from September through the balance of the year

The NWL system submitted a plan for these before the 1st September 2020 deadline.

4.1 Cancer Services

Cancer services across London are now being coordinated by a specialist 'Cancer Hub' led by The Royal Marsden and University College London Hospitals. The Hub makes sure that NHS hospitals continue to deliver as much cancer treatment as possible across the capital, with an initial focus on surgery, which requires critical care beds. It also supports hospitals across the NHS and independent sector to work together to maximise capacity and ensure that people receive the treatment that they need.

Patients remain under the care of their doctor or nurse specialist at the trust where they are currently being cared for - but they may move to another site for surgery. This is another example of how our response depends so much on us working together.

Decisions about the best approach to treatment will continue to be taken by specialist cancer doctors with their patients.

5 The Lessons Learned

5.1 Key Challenges and Pressures

The biggest pressure points in the system were all of those parts related to the urgent care response to COVID. This included UTCs, Emergency Departments, Intensive Care Units, COVID wards, the London Ambulance Service and 111. Because of the unplanned and rapid nature of the pandemic, these services were not always able to respond as rapidly as we would all have liked. The capacity for a future COVID surge has now been addressed as part of the winter planning, and additional capacity will be ready at hand in preparation for any anticipated surge response. Nevertheless, the local response was remarkable both in its pace and the degree to which all parties collaborated together to deliver the best care possible to patients in these testing circumstances.

Another key pressure has been the need to segregate non-Covid services from those with higher risks of infection.

The direction of travel has always been towards integrated system-wide working, so the groundwork for this was already in place.

We would not have been able to respond to Covid-19 as effectively has we been doing so in silos or with rigid organisational and geographical boundaries in place.

Our response to COVID-19 recovery could not have been delivered as effectively without working together. The pandemic has demonstrated that an integrated system approach is the safest model for patients, and is the most sustainable for the NHS.

A piece of work to gather lessons learned at North West London level is under review. We will share our findings.

In terms of working collaboratively across the system, we have learned that it is necessary to work together across geographical and organisational boundaries to defeat major challenges, like Covid-19.

We have learned that it is a more efficient use of NHS resources when we work together, allowing us to target our resources where they will do the most good for patients. We therefore expect to retain much of the system-wide approach as we return to normal.

6 Patient Engagement and Reassurance

The central priority of the NWL system is always to keep patients, citizens and staff all safe. We do not know when there will be full service restoration, but we do know that some aspects of the changes we have made in response to Covid-19 are things many patients want to keep, such as digital access to notes, and digital appointments.

There is an awareness within the North West London system that these digital tools don't work for everybody but this is supplementing our existing services or making them more flexible, not entirely replacing one model of care with another.

Brent CCG worked closely with stakeholders locally and at NWL level throughout the COVID lockdown period. Locally, we carried out weekly virtual meetings with patient representatives with a view to getting feedback on people's experiences, concerns and needs and respond to them. We partnered with the voluntary sector and local authority on a number of COVID response teams as well as our care navigators and social prescribing link workers, to address issues in the community, including mental health needs, mobilising volunteers and coordinating access to medicines and food. Through these channels we cascaded key national messages and raised awareness of COVID services and voluntary services that were still operational. With the NWL wide Community Voices project we facilitated interviews with Black, Asian and Minority Ethnic people in Brent to capture stories of their experiences. We are currently working with the local authority on the development of a project to address health inequalities in the areas within the borough that have been hardest hit by COVID. Included in those plans are a series of community virtual meetings with local lay leaders to develop an action plan, launch community champions and tailor communication messages more effectively throughout the recovery phase.

7 Second Wave Planning and Winter Pressures 2020/21

Winter planning is currently being co-ordinated across the North West London system and through local A&E Delivery Boards. Current planning assumptions are taking place on the most pessimistic assumptions:

- Levels of attendances and admissions are similar to winter 2019 (despite currently remaining lower following the pandemic);
- Another surge of COVID takes place equivalent to that experienced in the first wave of March/ April;
- Bed capacity is limited to 92% occupancy

The planned response is still in development and the first iteration is shortly due to be submitted to NHSE&I. The response includes the following measures (though there are more, these are some of them):

- Additional wards being opened by the acute trusts
- Expanded ITU spare capacity in readiness for increased COVID pressures
- National NHS Test and Trace testing centres in operation to ensure community isolation of cases.
- First response urgent care service providing community based crisis care functions of 24/7 assessment and home treatment as an alternatives to A&E or admission in place
- Increased number of Primary Care Mental Health practtioners. Improved discharge planning with robust 72hr follow-up, interfacing with primary care mental health practitioners
- Escalated Care Clinic - Digital and Video consultation Mon-Fri: 9.00am to 5.00pm (capacity can be increased). Face to face and home visiting provided.
- Re-direction pilot from UCC at Northwick Park Hospital to GP practices commences October 2020
- NHS 111 direct booking into GP surgeries/ Access Hubs
- Additional roles in primary care through the Additional Roles Reimbursement Scheme (ARRS) - for example additional physiotherapists
- Stepping up capacity in a number of services including Brent Community Rehab centre, Community Falls and Bone Health, and the new Community Cardio-Respiratory service.
- Discharge to Assess pathway in place including Home first. Opportunity to increase home first uptake of 20 per month.

8 Recommendation(s)

8.1 The COVID pandemic is still a live and evolving situation. We are planning for winter and a possible COVID second wave which may or may not materialise. Planning is taking place based on a relatively pessimistic scenario to ensure preparedness.

8.2 It is recommended that the CCG and the Council continue to take forward the joint work relating to inequalities highlighted by the COVID pandemic, ensuring that people get the best health and social care possible to decrease mortality from any second wave.

8.3 It is recommended that the CCG continues to be represented at the Health Protection meetings and to be involved in the council's Gold Command structure relating to any local outbreaks or enhanced levels of protection.

8.4 For the CCG to continue working as a system, in partnership with acute, community, mental health, primary care and social care to plan to reduce winter pressures and to ensure that there is sufficient and flexible capacity available to respond to a second COVID wave and/or increasing demand in ITU.

9 Financial Implications

9.1 As at M4 (July 2020), the CCG had incurred £6,863,890 in COVID expenditure, which is reimbursable from NHS England. This includes, amongst other items, the costs of additional PPE, the COVID Escalated Care Clinic (or "Hot hub"), the Hospital Discharge scheme, increased pathology costs for COVID testing and additional rota funding for 111.

The additional top-up funding from NHSE allows us to report a break-even position at M4.

Guidance has been issued signalling that a temporary financial management regime has been put in place to cover the period 1/4/20 to 31/7/20.

9.2 Summary of Guidance

- CCGs are expected to breakeven during this period, to achieve this allocations will be adjusted non-recurrently for M1-M4;
- CCG projected baseline expenditure has been calculated using a national model, based on M11 19/20 costs (uplifted for activity and price growth), 20/21 block NHS values and excluding the acute element of Independent Sector contracts commissioned by NHSE;
- Expectation is that allocations will be higher than spend nationally due to the block contract approach with NHS providers, however, the difference between projected monthly net expenditure and the 2020/21 monthly allocation will be prospectively adjusted prior to month 2 reporting;
- CCGs will be monitored against adjusted allocation position, 'reasonable' adjustments will be made on working day 10 to the allocation to bring CCGs to balance. The guidance states that 'Projected allocations can both increase and decrease a CCG's overall allocation'. The expectation is that CCGs will report a break even position months 1-4;

- Guidance on Mental Health Investment Standard to be published at a later date.

9.3 Local Authority Contributions to the Hospital Discharge Scheme

Different arrangements were put in place during the COVID period for patients discharged from hospital, and the normal panel process to assess eligibility for social care funding was temporarily ceased. Instead, the NHS became responsible for funding placements through that period, with a process for the CCG to apply for NHS England for funding those placements.

There is on-going work to agree the LA financial contributions to the Hospital Discharge pooled budget, with some outstanding issues pertaining to the ongoing costs of patients placed during the COVID period and any legal challenges that may be made by service users. Once resolved, the final agreement will be included in the extension to the BCF s75 agreement.

10 Legal Implications

10.1 There are no legal implications arising from this report.

11 Equality Implications

11.1 Equality implications are noted relating to BAME and health inequalities that have been highlighted as a result of the COVID pandemic. The report notes joint work taking place between the council and CCG to improve the situation and to reduce health inequalities, redirecting resources into those areas most at need.

12 Consultation with Ward Members and Stakeholders

12.1 Due to the emergency nature of the pandemic the capacity to engage with ward members and stakeholders was limited and the local NHS followed centrally controlled guidance from NHSE and implemented it as part of an emergency response.

REPORT SIGN-OFF

Sheik Auladin
Managing Director Brent CCG

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APPENDIX 1

Phase 3 Letter – Summary of Priorities and Actions
A: Accelerating the return of non-Covid health services
A1 - Restoring full operation of cancer services
- Ensuring sufficient diagnostic capacity
- Increasing endoscopy capacity to normal levels
- Expanding the capacity of surgical hubs to meet demand
- Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment
- Fully restarting all cancer screening programmes
A2 - Recover the maximum elective activity possible between now and winter
- In September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October (while aiming for 70% in August)
- Systems need to very swiftly return to at least 90% of their last year's levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October
- 100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).
- Elective waiting lists and performance should be managed at system as well as trust level
A3 - Restore service delivery in primary care and community services
- GPs, primary care networks and community health services should build on the enhanced support they are providing to care homes
- CCGs should work with GP practices to expand the range of services to which patients can self-refer, freeing-up clinical time
- From 1 September 2020, hospitals and community health and social care partners should fully embed the discharge to assess processes
- The Government has further decided that CCGs must resume NHS Continuing Healthcare assessments from 1 September 2020 and work with local authorities using the trusted assessor model
A4 - Expand and improve mental health services and services for people with learning disability and/or autism
- Every CCG must continue to increase investment in mental health services in line with the Mental Health Investment Standard
- Systems to validate their existing LTP mental health service expansion trajectories for 2020/21
- Actions in respect of support for people with a learning disability, autism or both
B: Preparation for winter alongside possible Covid resurgence.

B1 - The Chief Medical Officer and DHSC may decide in September or October to implement a policy of regular routine Covid testing of all asymptomatic staff across the NHS
B2 - Prepare for winter by sustaining current NHS staffing, beds and capacity, while taking advantage of the additional £3 billion NHS revenue funding for ongoing independent sector capacity, Nightingale hospitals, and support to quickly and safely discharge patients from NHS hospitals through to March 2021
B2 - Prepare for winter by expanding the 111 First offer to provide low complexity urgent care without the need for an A&E attendance, ensuring those who need care can receive it in the right setting more quickly
B2 - Prepare for winter by system maximisation of use of 'Hear and Treat' and 'See and Treat' pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 emergency departments
C: Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for our staff, action on inequalities and prevention.
C1 - Workforce planning and transformation that needs to be undertaken by systems to enable people to be recruited and deployed across organisations, sectors and geographies locally
C1 - All systems should develop a local People Plan in response to these actions [set out in the Phase 3 letter]
C2 - Work collaboratively with your local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities, and regularly assess this progress
C2 - Restore NHS services inclusively, so that they are used by those in greatest need. This will be guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian communities, by 31 October
C2 - Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes
C2 - Strengthen leadership and accountability, with a named executive Board member responsible for tackling inequalities in place in September in every NHS organisation
C2 - Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities.
Financial arrangements and system working
Move towards a revised financial framework for the latter part of 2020/21 *(in which there will be no retrospective payment mechanism)*
Organisations within the system are required to come together to serve communities through a Partnership Board
Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system.
Plan for developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health
Summary plans by 1 September / final plans by 21 September

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Brent	**Community and Wellbeing Scrutiny Committee** 15 September 2020
	Report from the Director of Public Health

Covid-19 and Brent's Black and Minority Ethnic (BAME) Communities

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer:	Dr Melanie Smith Director of Public Health Melanie.smith@brent.gov.uk Tel: 020 8937 6227

1.0 Purpose of the Report

1.1 To provide an overview of the underlying causes of the patterns of infection and mortality from Covid-19 among Brent's Black and Minority Ethnic (BAME) communities, and set out the actions by the NHS and Public Health to identify and address the disproportionate effects of Covid-19.

2.0 Introduction

2.1 Covid-19 is the disease caused by the novel coronavirus severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Coronaviruses are a set of viruses that are among the causes of common colds. They have also caused outbreaks of more serious illnesses including Severe Acute Respiratory Syndrome (SARS) and Middle Eastern Respiratory Syndrome (MERS). COVID 19 can present with no symptoms, mild symptoms or as a severe illness leading to hospitalisation and in some cases death.

2.2 The burden of Covid-19 has not been shared equally in the society. Older people, men, those living in deprived areas, of BAME heritage, who are obese

or who are living with underlying health conditions have all been at increased risk of dying with COVID 19.

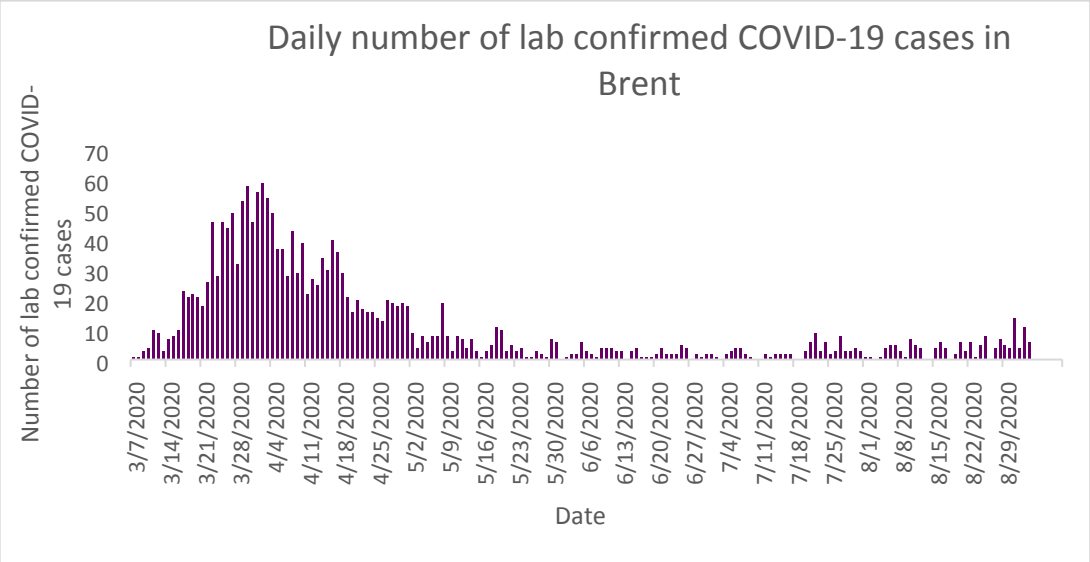
2.3 Health inequalities are not new but in many cases COVID-19 has increased these.

3.0 COVID 19 in Brent

3.1 Morbidity

3.1.1 During the pandemic (up to the beginning of September), almost 300,000 laboratory confirmed cases of Covid-19 had been diagnosed in England with 40,849 cases in London and 1,949 in Brent. Brent has had the second highest number of positive cases amongst London Boroughs. The true number of infections will be higher than this due to asymptomatic infection and limited testing particularly in the early stages of the pandemic when London and Brent were particularly affected.

3.1.2 Cases in Brent peaked the first week in April then declined to a low the week commencing 11th June. Following the announcement of the impending lifting of lockdown the week of the 18th June and the actual lifting on the 23rd of June cases have been on a gradual trajectory upwards with fluctuations.



3.2 Mortality

3.2.1 According to the most recent publication by the Office for National Statistics (ONS) between 1st March 2020 and 31st July 2020, there were 51,831 deaths involving COVID 19 in England and Wales[1]. Taking account of the age structure of the population, this equates 90.2 deaths per 100,000 population (the age standardised mortality rate). Over this period there were 491 deaths

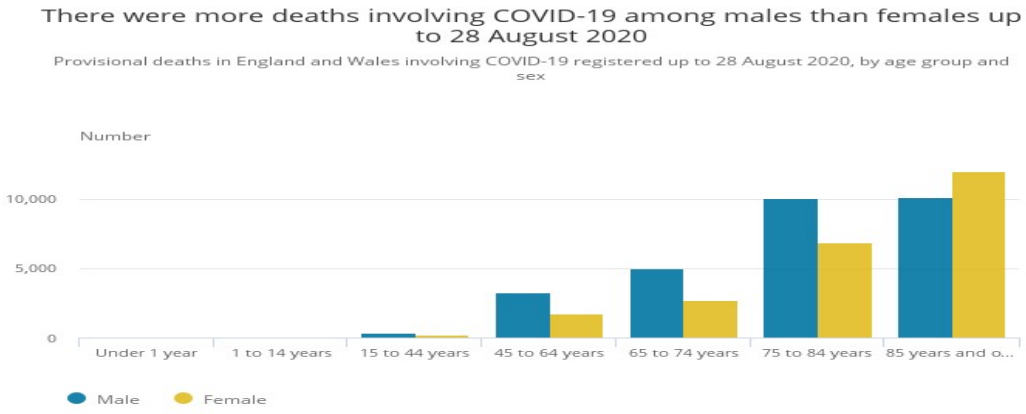
[1] "involving COVID-19" refers to deaths that had COVID-19 mentioned anywhere on the death certificate, whether it was the underlying cause of death or not

involving COVID 19 in Brent, an age standardised mortality rate of 218 per 100,000.

4.0 Disproportionality

4.1 ONS and Public Health England have analysed COVID deaths and have shown a disproportionate impact by age, gender, ethnicity, deprivation of area of residence, occupation and underlying health conditions.

4.2 Nationally and in Brent, higher death rates have been seen in men than in women.



Source: Office for National Statistics – Deaths registered weekly in England and Wales

4.3 As the female population is older than the male it is important to adjust for age when comparing rates in men and women

4.4 Table 1: Numbers and age adjusted rates for deaths involving COVID 19 1st March 2020 to 31st July 2020

	Persons		Men		Women	
	Deaths	Rates	Deaths	Rates	Deaths	Rates
England	49,232	91	27,130	119	22,102	70
London	8,536	143	5,042	195	3,494	103
Brent	491	218	300	299	191	156

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

4.5.1 BAME populations in England and Wales are younger than white populations and as age is a strong influence on death rates, it is important to take account of age. When this is done:

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

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

4.5.2 In the analysis, socioeconomic circumstances or deprivation was also analysed. Deprivation measures consider income levels, housing, education and other features of the area where individuals live. These measures are known to have a significant impact on health and disease. The more deprived areas had mortality rates twice that of less deprived areas. This analysis was undertaken at a national level. Locally there was an observed correlation between deprivation and numbers of deaths. However the smaller numbers and the location of care homes mean statistical correlations cannot be demonstrated.

4.5.3 As BAME populations tend to be more deprived, it is important to adjust for the influence of deprivation in looking at the impact of ethnicity. Doing so allows us to compare the risk for a black male living in an area of deprivation compared to one living in an affluent area:

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

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

4.5.4 Some, but by no means all, of the disproportionate impact of COVID on Black communities can be attributed to deprivation.

4.5.5 People of Bangladeshi and Pakistani, Indian and Mixed ethnicities also had statistically significant raised risk of death involving COVID-19 compared with those of White ethnicity.

4.5.6 After taking into account age and socioeconomic circumstances or deprivation:

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

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

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

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

4.5.9 Occupations which have close contact with large numbers of other people, for example health and social care staff, have an increased risk of dying from Covid-19.

4.5.10 Individuals with pre-existing conditions and particularly those with multiple conditions are at increased risk of dying from Covid-19. Of particular importance appear to be obesity, diabetes and hypertension. One study showed the risk of dying in hospital in England with Covid-19 for an individual with diabetes is 1.81 times time more than that of an individual without diabetes. Public Health England found that diabetes mellitus was present on 21% of the death certificates with Covid-19. There is also some evidence that poor outcomes with diabetes were noted with less well controlled disease

5.0 Possible reasons for the disproportionate impact

5.1 There are three possible reasons for the disproportionate impact of COVID on BAME communities:

1. Increased exposure to the virus
2. Increased susceptibility to severe disease
3. Access to and use of health care

5.2 Exposure to the virus

5.2.1 Brent BAME population are high users of public transport. Buses in particular remained crowded during the pandemic as did bus stops in the Wembley and Harlesden area.

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

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

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

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

5.3 Susceptibility to severe infection

5.3.1 While levels of adult obesity are relatively low in Brent (compared to England), 50% of residents are overweight or obese. It is estimated that over 11% of the adult population has diabetes, compared to an England rate of 8.5%. Diabetes is more prevalent in Black and South Asian patients, and our high levels of diabetes may be one reason for the higher death rate seen locally.

5.3.2 Fewer patients are recorded on their GP records as having high blood pressure than is the case for England (12.4% compared to 14%). While this may indicate a lower prevalence, the size of our Black and South Asian communities who would be expected to have higher rates of hypertension might suggest under diagnosis. Of those who are diagnosed, significantly fewer patients have their blood pressure controlled in Brent than nationally.

5.4 Access to and use of health services

5.4.1 It has been hypothesised that more deprived communities may have poorer access to health care and that this could have played a part in the pattern of mortality (the inverse care law). Early in the pandemic, NHS England instructed primary care to move away from face to face appointments in favour of telephone and on line access. There was a concern that this model of care may have disadvantaged the digitally excluded.

5.4.2 There is some evidence from elsewhere that Black men were particularly unwell on presentation to hospital and more likely to be admitted direct to ITU. This could indicate a reluctance to seek help earlier or a more rapid progression of disease in this group of patients. There is no evidence of poorer outcomes for BAME patients admitted to secondary care locally. However the completeness of recording ethnicity limits our ability to analyse this.

6.0 Action taken to date to address health inequalities

6.1 The disproportionate impact of COVID reflects entrenched structural inequalities within society which will not be remedied in the short term and over which the council and the NHS have limited influence. However there are actions which the council and the NHS can and should take, both in the immediate and longer term and for the borough as a whole and targeted on particularly affected areas or communities.

6.2 In the short term, action has focused on mitigating the impact of COVID and preparing for a possible second wave.

6.3 Testing

6.3.1 Early identification and self-isolation of cases of COVID is an important tool in reducing community transmission. The initial model of community testing was for regional testing centres (originally located at Ikea Wembley, then moved to

Heathrow) with mobile testing units (originally located in the car park at Willesden Sports Centre two days a week, now at Neasden Temple car park). Tests were booked through the internet or by phone and residents were asked to drive to the test centre. Recognising that this model risked excluding residents without easy access to the internet or a car, the Council negotiated with DHSC and Deloittes to site a hyperlocal walk through test centre in Harlesden – one of the areas of Brent which had been particularly badly hit.

6.3.2 The Harlesden test site can be booked through the Council (as well as through the national portal). This arrangement allows us to offer wrap around support from the Community Hubs team where needed and to provide work arounds for residents without email, phones or ID.

6.3.3 Between 10th June and 6th September 2020, 8826 tests have been completed at the Harlesden site, of which 3492 were booked through the Council. The ethnicity of those booking through the council was:

6.3.4 Table 2: Ethnicity of those booking a COVID test through the Council

Ethnicity	
White	1048
Black African, Black British, Black Caribbean	794
Prefer not to say	701
Asian, Asian British	446
Other	274
Mixed, multiple ethnic groups	145

6.4 **Communications**

6.4.1 One of the recommendations from the PHE report 'Beyond the Data: Understanding the Impact of COVID-19 on BAME communities' was for the development and implementation of culturally competent COVID 19 education and prevention campaigns. In response to the disproportionate impact of the pandemic, the council has developed targeted communications including working with local community leaders to reinforce individual and household risk reduction strategies and to reinforce messages on early identification, testing and diagnosis.

6.4.2 Working collaboratively, London boroughs and the GLA have developed culturally competent communications tools which resonate with Londoners, including information in community languages. The tool kit has been shared with local community and mutual aid groups who have been encourage to make use of its material freely.

6.4.3 Nonetheless, community engagement continues to show that local people feel a need for more consistent and repeated messaging. We will continue a proactive campaign including writing to every household in the Borough.

6.5 **Occupational risk**

6.5.1 In response to the recognition both of the clinical risk factors for severe COVID and the increased risk for BAME, older and male staff the Council's Occupational Health and Public Health teams devised a bespoke risk assessment. This is being completed by all staff before their return to the workplace.

6.6 **Health and Wellbeing Board Consideration and Response to Disproportionality**

6.6.1 In May 2020, a report detailing the disproportional impact of Covid-19 on certain communities was presented to the Health and Wellbeing board. Following this, an Inequalities Working Subgroup of the Board and a Strategic Oversight Group has been formed to drive work to reduce health inequalities in the short, medium and long-term.

6.6.2 The work will involve both a borough wide and hyperlocal approach. The borough wide approach will entail core interventions identified by the Subgroup. The 'hyperlocal' approach will target areas disproportionately affected by Covid-19. A fluid approach will be taken to identify and target specific areas and communities requiring a hyperlocal intervention with the Alperton and Church End localities being focused on in the first instance.

6.6.3 The Working Subgroup is currently meeting on a weekly basis with representation from Brent Council, Brent CCG, LNWLHT and CNWL to ensure Brent takes a joint approach to tackle health inequalities. *The core purposes of the subgroup is to:*

- *Oversee and drive the operational delivery of the borough wide and hyperlocal action plans.*
- *Identify any blockages to individual organisations or to Strategic Oversight Group as appropriate.*
- *Ensure there are strong links with the core work of representative organisations and the local community.*

6.6.4 The Strategic Oversight Group is meeting on a monthly basis with strategic and executive input from Brent Council, Brent CCG, LNWHT and CNWL. *The core purposes of the Strategic Oversight Group is to:*

- *Provide direction in light of the decisions of the Health and Wellbeing Board.*
- *Unblock any issues that the subgroup are unable to tackle.*
- *Provide oversight and challenge to ensure progress.*

6.6.5 In line with the recommendations of the PHE report 'Beyond the Data: Understanding the Impact of COVID-19 on BAME communities', the Working Group have agreed that the voice of the communities most affected must inform action to improve outcomes in target areas. For this reason, community engagement will form the basis of the hyperlocal approach with two Community

Co-ordinators will be recruited in early October to act as a focal point across partners and communities in Church End and Alperton.

6.6.6 Initial meetings with both communities took place on Tuesday 8 September and Wednesday 9 September 2020. Local community leaders from a range of faith, community and voluntary organisations were invited to speak about:

- How Covid-19 has affected local residents
- What has been done well to protect people from Covid-19
- What could have been improved to better protect people from Covid-19
- What can be done differently to protect people from a potential second wave
- What can be done to reduce health inequalities in the long-term

6.6.7 Representatives from Brent Council, Brent CCG, CNWL and LNW University Healthcare NHS Trust were there to briefly set the context and listen to the views and thoughts of the community.

6.6.8 The communities' views supported a need for Community Champions to:

- help shape health and wellbeing messages around Covid-19
- distribute messages to the community through various channels
- empower people to be active and promote healthy living
- actively engage with the community on health issues

6.6.9 The Community Champion opportunity was well received by the community; several attendees have already volunteered to become a volunteer. In addition paid Community Health Educator roles have been proposed which would be remunerated positions open to community members who are able to contribute more time to this work.

6.6.10 A programme of follow-up community meetings will be developed to take this work forward.

6.6.11 In response to recommendations from the PHE report 'Beyond the Data: Understanding the Impact of COVID-19 on BAME communities', Public Health and the CCG are developing a proposal to engage a community research partner to support community participatory research. Researchers will engage with community stakeholders engage as equal partners to understand the social, cultural, structural, economic, religious, and commercial determinants of COVID-19 in BAME communities, and to develop readily implementable and scalable programmes to reduce risk and improve health outcomes.

6.7 **New model of primary care**

6.7.1 Brent CCG is developing a new multidisciplinary health team to 'take primary care to the people'. Initially this will operate with 10 GP practices in Church End and Alperton. A dedicated team of health professionals will be recruited

with condition specific expertise to provide capacity, case management and to link residents with existing health services.

6.8 Themes from the Church End and Alperton community engagement events

6.8.1 **Church End**

- Participants praised Northwick Park Hospital's response to the pandemic.
- People are still afraid to visit public buildings.
- Some of are not fully informed of information/advice therefore educating residents is crucial.
- Many people are not wearing masks, particularly on Church Road. Messages around facemasks need to be clear without offending people.
- Question of whether health services play a key role for self-care and those with long-term conditions (such as diabetes and hypertension)
- Need to invest in Church Road and the local community, as the area is unappealing. This is reflected by local drug dealing, crime, poor employment opportunities and run down businesses.
- Many people face multiple issues even before the pandemic including stress and financial issues.
- New people are approaching foodbanks.
- People tested for Covid-19 are not reflective of the local community – question of what we are doing to encourage people to take tests.
- Young people face mental health issues, which is a primary reason for large gatherings and house parties in the area. Young people are aware of the risks but they are battling with their mental health. Need role models/influential people from area through to communicate through songs and messages. Need to think about education, prospects and access to networks.
- Access to GPs online has been difficult, especially for those whose first language is not English. Confidence in services is low.
- Older people are more isolated now.
- Worry that people are being forgotten about if they need medical help but don't engage with health services or local support. A helpline was

suggested so people's needs can be explored to signpost them to support and services. Need to build local people's knowledge.

- Concern over people who are not eligible for support services but housed in HMOs.

- Educating and raising knowledge of landlords will help maintain hygiene standards.

- Need to hear from those who have lost people.

- Attendees are happy to be a part of the solution by working with us as community champions.

6.8.2 **Alperton**

- Messaging needs to be reinforced and shaped for people who do not speak English as their first language.

- Channelling tailored messages through places of worship and Asian radios would be effective. Could work with the Multi-faith forum.

- Measures are not being followed on high road - displays and signboards are insufficient. Signs on shops are usually handwritten. Some shops are doing well which could be replicated by other shops.

- Need to work with community leaders to identify vulnerable people eg create register of HMOs.

- Strategy needs to focus on prevention and long-term outcomes.

- Community is pessimistic as opposed to central government, which changes guidelines frequently.

- Many organic community groups exist which need to be engaged with.

- More enforcement needed where people aren't following measures.

- Easy to get GP appointments, however many people are nervous. They need health services but uptake is low. Lack of internet and no phone line is another issue.

- National Covid-19 test system was down and busy highlighting the barriers to securing a test. Testing may not be reflective of local communities – may need to encourage people to take tests and raise

awareness of sites.

- Issue of people having symptoms but not getting tested due to risk of losing job or income.

- There are opportunities despite the negatives – people are walking and being active whilst maintaining social distancing measures.

- Attendees look forward to working with us to find solution

REPORT SIGN-OFF

Dr Melanie Smith

Director of Public Health

Brent	**Community and Wellbeing Scrutiny Committee** 15 September 2020
	Report from the North West London Collaboration of Clinical Commissioning Groups

North West London Clinical Commissioning Group, and Integrated Care System for North West London

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	3 Appendix 1 – Timeline for establishment of the single CCG Appendix 2 – Proposed Governance Structure for single CCG Governing Body Appendix 3 - Transition Governance Structure during Covid-19
Background Papers:	0
Contact Officer:	Jo Ohlson, Accountable Officer, North West London Collaboration of Clinical Commissioning Groups

1.0 Purpose of the Report

1.1 To set out our vision for North West London: Start well, live well, age well. This includes the plan for form a single CCG and the vision for establishing an Integrated Care System (ICS). During Covid-19, we have moved faster towards working together as a system, as it has been a necessary part of the response to the pandemic. We could not have responded as effectively as we did to Covid-19 by working in isolation, or with providers prioritising competition over collaboration.

1.1.1 Our vision for a North West London ICS is to reduce inequalities and achieve health outcomes on a par with the best global cities. Care will be integrated within a single system, focused on the needs of the individual and unhindered by organisational boundaries. We will combine our collective resources, clinical

expertise and local knowledge to build a fair, effective and accessible health service for all.

1.1.2 The main focus of the report will be the Single CCG case for change, as that is the proposal we are currently consulting with local authorities and GP member practices on.

1.1.3 We will be glad to provide further updates on the development of the North West London ICS during this process.

2.0 Recommendation(s)

2.1 We invite the Committee to acknowledge that in order to achieve our vision we need to have one organisation buying and commissioning services for all in North West London. This means moving to a single CCG. A single CCG will allow us to:

- Reduce duplication in ways of working, allowing more time and money to be put into patient services.
- Work more effectively with both NHS and local authority service providers to improve patient wellbeing and care, with improved quality and consistency of local health and care services
- React quickly and consistently to the continuing pandemic and recovery.
- Support delivery of the ICS vision.

2.2 We invite the Committee to note that we have engaged with stakeholders as a system on the first case for change, and we are now engaging for a second time due to the change in timeline.

2.3 We invite the committee to recognise that the case for change is not significantly changed since our initial period of engagement, and that this is an administrative change, with no changes to services or patient behaviours.

3.0 Detail

3.1 As set out in our Long-Term Plan, we are working in a national context where areas will work as a single ICS setting the strategy for health and wellbeing and agreeing consistent health outcomes on behalf of our residents. Each ICS is expected to have a single CCG.

3.2 The NHS is moving away from a commissioning-provider split. ICSs will be partnerships between the NHS and local authorities. An ICS is not a legal entity, but a voluntary partnership.

3.3 The eight CCGs in NW London agreed in September 2019, that a single CCG was the right direction of travel. It was also agreed that 2020/21 would be a

transitional year focused on financial recovery, developing a single CCG operating model and working through financial implications.

3.4 Circumstances have meant that the NHS has changed rapidly since September 2019. North West London has been one of the hardest hit parts of the country in the Covid-19 pandemic and through the crisis our system and constituent boroughs have clearly demonstrated the benefits of strong borough based partnerships delivering care to their local populations and working as a system to a common framework and set of standards. For example, it was essential during the pandemic that we were able to move patients from one hospital to another, and that providers were able to share information regularly about where the highest and lowest Covid-19 pressures points were in the system at any given time.

3.5 As we continue to work towards becoming a single CCG we want to build on previous experience and conversations, taking our learning and experience of working across health and local government in recent months to deliver services for our residents.

3.6 Borough-based partnerships for the provision of care are a key building block for the ICS. This requires a strong partnership of providers at borough level for implementation and delivery. It is agreed that this needs to be co-designed by local authorities and NHS bodies together. We have collectively agreed across health and local authorities that in the interim for each borough, we will have three NHS leads covering primary care, community care and mental health respectively. They will work jointly with the Local Authority lead to develop integrated care provision for local residents. A lead for acute services will also link in with the borough team.

3.7 Local CCG borough teams led by dedicated Associate Director, will work with practices and local partners to deliver local responsibilities. There will a shared CCG COO working across two or three boroughs.

3.8 30th September is still the current timeline for our single CCG submission.

3.9 The North West London Single CCG Governing Body Proposed Membership is:

- The Chair
- Eight Primary Care Clinicians (one from each borough)
- One independent clinical chair (from the above group of clinicians, with that borough nominating an additional member to ensure borough representation)
- One Sessional GP
- The Accountable Officer
- The Chief Finance Officer
- Secondary Care Specialist
- A registered nurse (chief nurse)
- Five Lay Members

- Director of Public Health representative for the eight local authorities (non-voting)
- A Practice Nurse and Practice Manager from North West London (non-voting).

3.10 The ICS governance has developed including the following:

- A joint local authorities leaders and CEO and NHS CEOs group.
- A joint partnership board including local authority representation
- A Clinical and quality group.

4.0 Financial Implications

4.1 The operating plan we put forward for 20/21 (i.e. before Covid-19) was a commissioning budget for the 8 North West London of just under £3.5billion.

4.2 The single CCG is expected to facilitate financial sustainability, as duplication ties up resources. We have made some savings by implementing joint arrangements across our CCGs. NHS organisations will work together to ensure that the NW London health system breaks even overall.

4.3 The savings target from the creation of a single CCG is £17m.

4.4 North West London commits to increasing the proportion of CCG allocation in Out of Hospital Care, while recognising that we have a CCG deficit of £100m and system deficit of £230m.

4.5 North West London will level up additional primary care services across North West London over the next four years, so consistent services are offered to patients. An additional £18m will be invested in primary care across North West London. Brent will be the biggest beneficiary of this investment with an additional £8m at the end of four years.

4.6 In recognition of health inequalities across North West London London, we will make substantial progress towards fair share allocations based on population need in the next 5 years, faster than national timetable. We will also consider how best to address inequalities in boroughs within the borough allocation. (See also Section 6.0: Equalities Implication.) Brent will be the biggest beneficiary of the faster move to fair shares funding with an additional £16m at the end of five years.

5.0 Legal Implications

5.1 The eight CCGs would cease to be separate legal entities and the single CCG would be the successor legal entity.

5.2 The single CCG will be held accountable through the existing statutory processes, such as local government scrutiny committee, and Healthwatch groups and work with local borough Health and Wellbeing Bords.

5.3 Each local area will maintain a CCG borough committee, taking into account the needs and demographics of residents. This relation can be represented as follows:

5.4 We ask the Committee to note that the Single CCG Case for Change does not involve any service changes or changes in patient behaviour, and that it is an administrative reform, not a reform to patient care.

6.0 Equality Implications

6.1 There are two aspects to the equalities considerations regarding the single CCG case for change. The first is the impact on patients, and the second is the impact on staff.

6.2 It is our expectation that the single CCG would be beneficial for patient and resident health inequalities. Our vision is to reduce inequalities and achieve health outcomes on a par with the best of global cities. The single CCG as part of the ICS will focus on improving population health locally and at the level of the ICS. This will require strengthened and integrated borough-based provision.

6.3 By joining up our resources, we can address imbalances between the boroughs in terms of population affluence and CCG and/or Trust finances. In recognition of health inequalities across North West London, we will make substantial progress towards fair share allocations based on population need in the next five years, which is faster than national timetable.

6.4 Reducing inequalities is particularly important for Brent and we have committed to level up primary care services, increase the investment in community services achieving equity in access and outcomes for Brent residents.

6.5 Our shared clinical strategy places health inequalities at its heart – and this can only be achieved by working together as a system. For example, it would not be possible to adequately address long-term conditions such as asthma without considering air quality and housing quality.

6.6 Workforce equality implications are under careful consideration as part of the staff consultation, which includes an Equalities and Health Inequality Impact Assessment (EHIA. This EHIA is a review of the possible impacts that the reorganisation into a single CCG could have on staff. The key aims of the EHIA are to:

- Gather evidence on the breakdown of North West London staff through available data from the North West London Staff Survey and WRES (Workforce Race Equality Standard) data.

- Identify potential risks where certain staff groups may be disproportionately affected by the change.

- Implement mitigations, which will reduce any negative disproportionate impact on staff groups, and enhance any positive impacts that may arise from the move to a Single Operating Model.

6.7 NHS North West London is currently in the first stage of the EHIA process to identify possible staff concerns, risks, and mitigations.

7.0 Consultation with Ward Members and Stakeholders

7.1 We will be attending the Joint Health Overview and Scrutiny Committee (JHOSC) on 7 September 2020, as well as Brent Community and Well Being Scrutiny on 15th September.

7.2 A best practice approach to patient and public involvement is central to our approach. We are already working with Healthwatch, patient groups and local people to develop proposals for how this will work in practice.

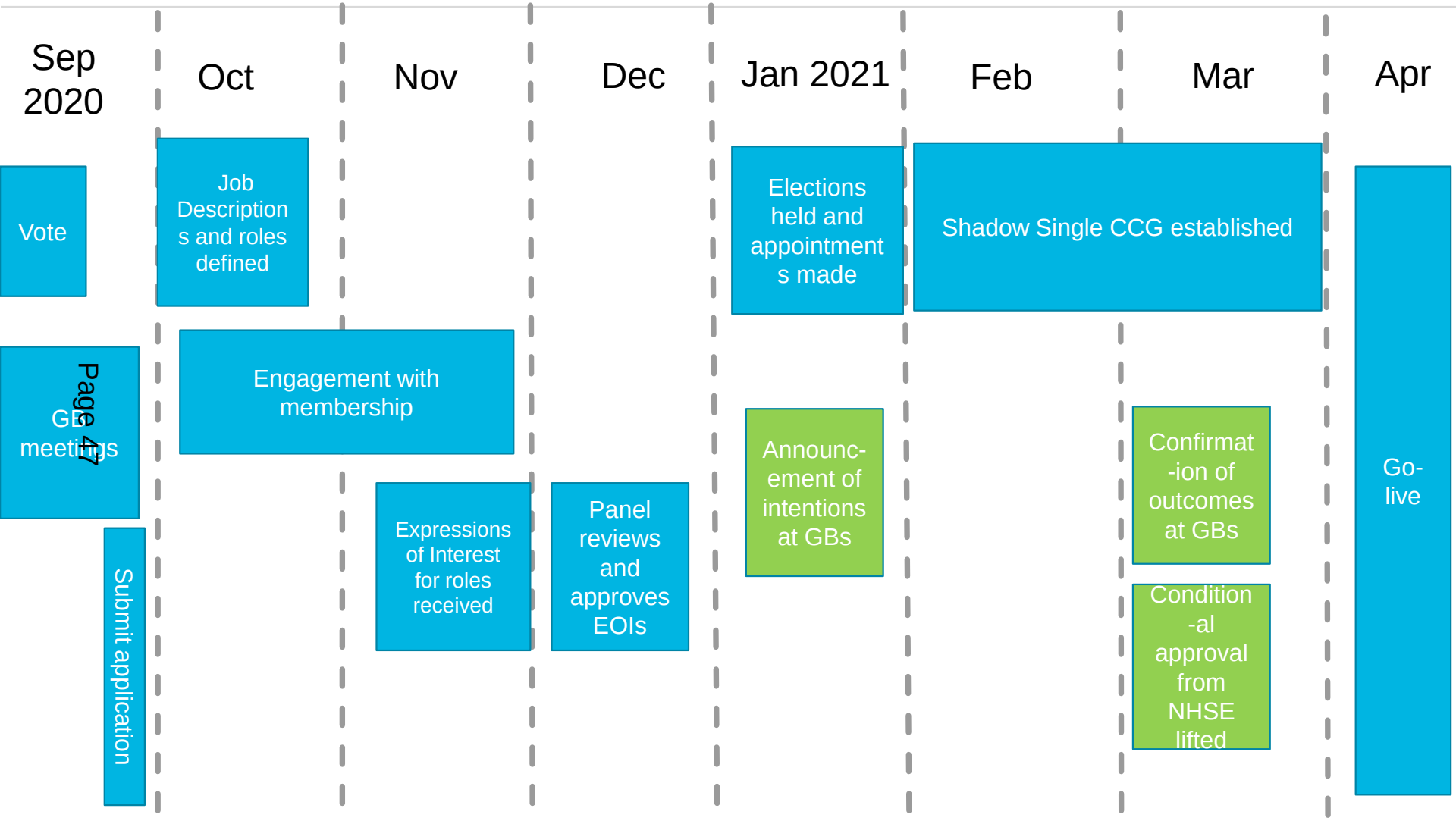
7.3 The single CCG will retain a strong local presence, including responsibility to work with local people and stakeholders, to listen to their feedback and to involve them in shaping services. The borough committee will include patient representation.

7.4 Our aim is to enhance patient and public involvement and engagement in the new system, ensuring that we consistently listen to patient and resident voices. This is being taken forward through our EPIC (Engage-Participate Involve-Collaborate) programme in partnership with Healthwatch.

REPORT SIGN-OFF

Jo Ohlson: Accountable Officer, NW London Collaboration of CCGs

Timeline: establishment of the single CCG



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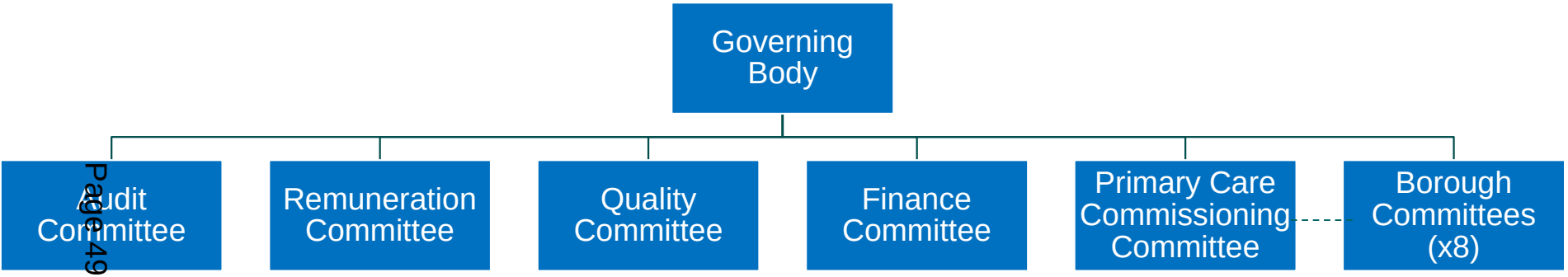
NW London CCG: Proposed Governance Structure

Proposed governance structure



Borough Committees to discuss and make recommendations to the PCCC on Primary Care related issues.

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Transitional ICS Structure 2020/21, during Pandemic

ICS Chairs Board
Chair: ICS Chair Dr Penny Dash (from September 2020)
Assurance of ICS decisions
NHS Trust Chairs, 2 x CCG Chairs, up to 2 LA Leaders
1xmonth

Partnership Board
Chair: Dr Penny Dash (from September 2020)
Major strategic decisions
ICS CEO, All CEOs, 2x GPs, 1 LA CEO, 1 LA DASS, 1 DPH, AHSC, ICHP, ICS Exec Team
1xmonth

LA Leaders & NHS Group
Chair: tbc
Collaborative working to shape strategy, policy, and significant service developments
8 LA Leaders, 8 LA CEOs, ICS CEO, CCG AO, MH & Community NHS CEO
Timing tbc

Gold
Joint Medical, Nursing & Ops Group (triumvirate)
Chair: Prof Julian Redhead
Medical Directors, Nurse Directors, CCG Clinical Leads, COOs, ICS PDs, DPHG
2x week

NHS CEOs Group
Chair: Lesley Watts
Operational decisions relating to NHS response
CEOs, CCG AO, 2 GP Chairs
2x week

Clinical & Quality Group
Medical Directors, Nursing Directors, GP leads, Directors of Public Health

CCG Chairs' Group
Alignment of NWL CCGs executive decisions
CCG Chairs, CCG AO

NHS Functional Groups e.g. COOs/HRDs/CFOs

NWL Local Authorities CEO Strategic Resilience Board
2x week

NWL Local Authorities DASS Group

NWL ICS NHS Programmes

12 August 2020
* To be reviewed

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