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
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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

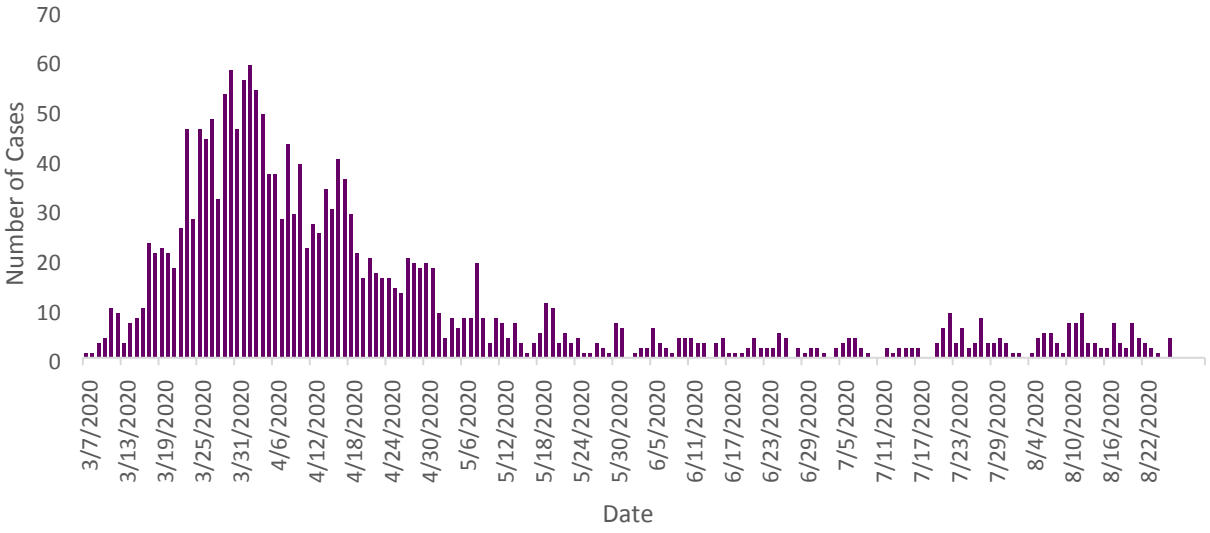
1.4 The third part looks at the COVID recovery phase and lessons learned from the pandemic.

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

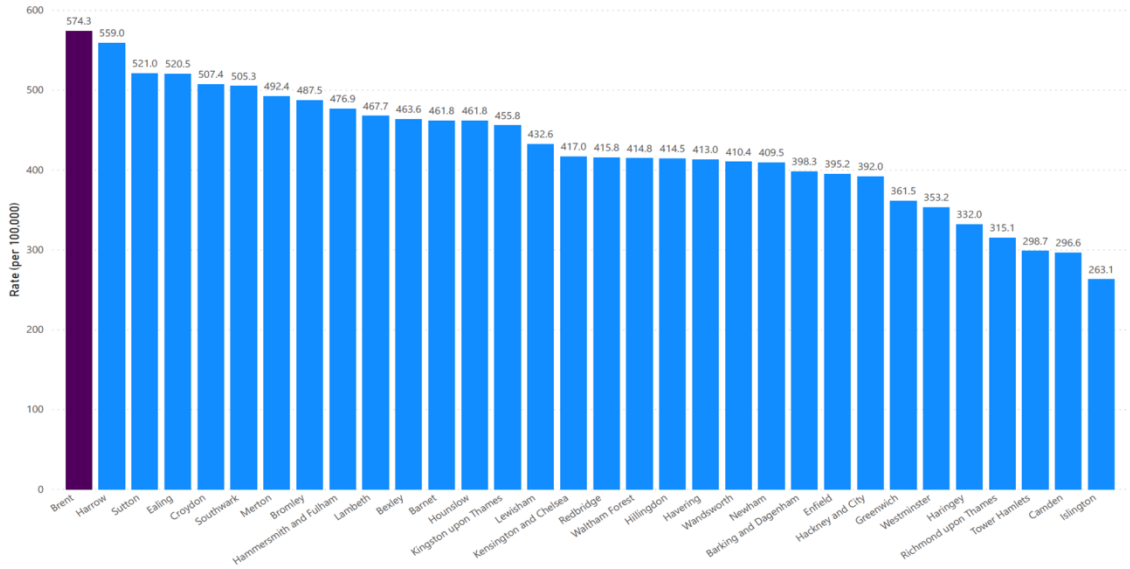
COVID-19 infections hit a peak in late March and early April of 2020, dropping significantly by May. Since then, we have had a low number of sporadic cases, but there has been a slight uptick in rates over recent weeks. The Council's Public Health Department and the CCG are monitoring this closely and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



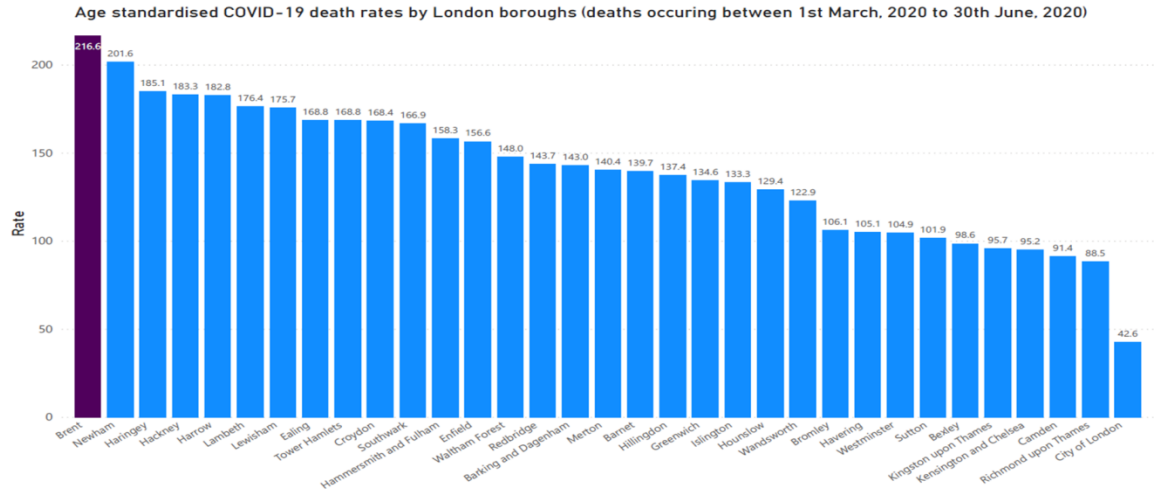
The cumulative rates of COVID-19 infections as detected by Pillar 1 and Pillar 2 testing is the highest in London, although it should be noted that this mainly reflects the very high rates of infections that the borough saw early in the pandemic, rather than the current state of affairs, which is that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

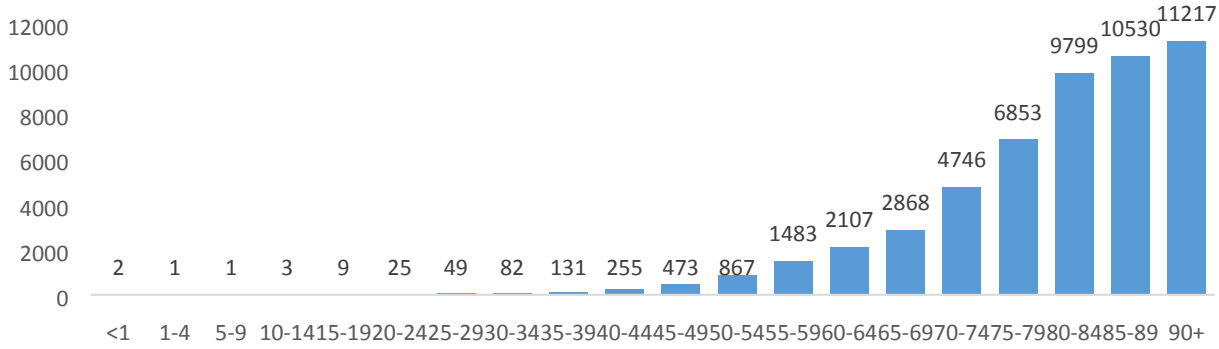
Disability Status	Sex	Covid-19 deaths	
		Rate per 100,000 population	Lower 95% confidence limit
Limited a lot	Male	199.7	193.65
Limited a lot	Female	141.11	135.95
Limited a little	Male	125.07	121.21
Limited a little	Female	68.95	66.51
Not Limited	Male	70.2	68.73
Not Limited	Female	35.64	34.7

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.

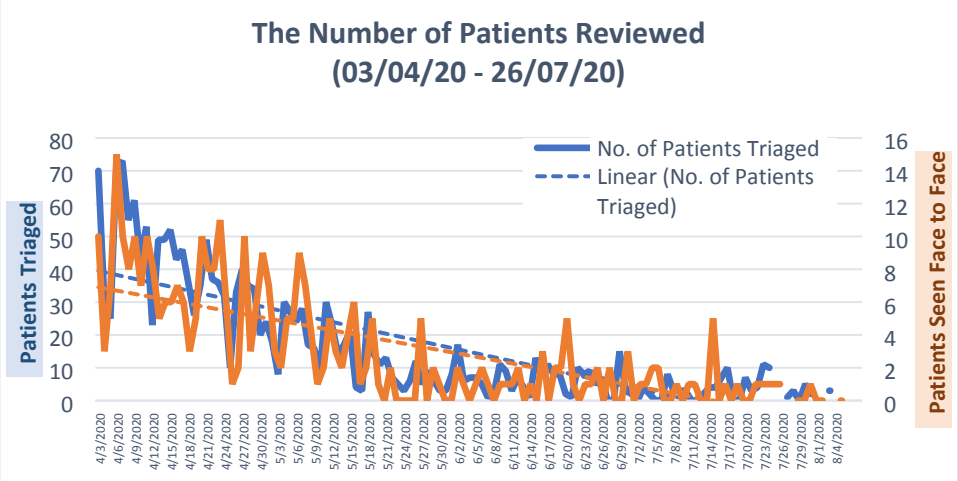
There was also a move to produce a step change in the quantities of oxygen supplies in hospitals to deal with the anticipated demand, and an increase in PPE ordering to protect staff and patients alike. This guidance was progressed and adhered to in all of our local hospitals serving Brent, including 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%

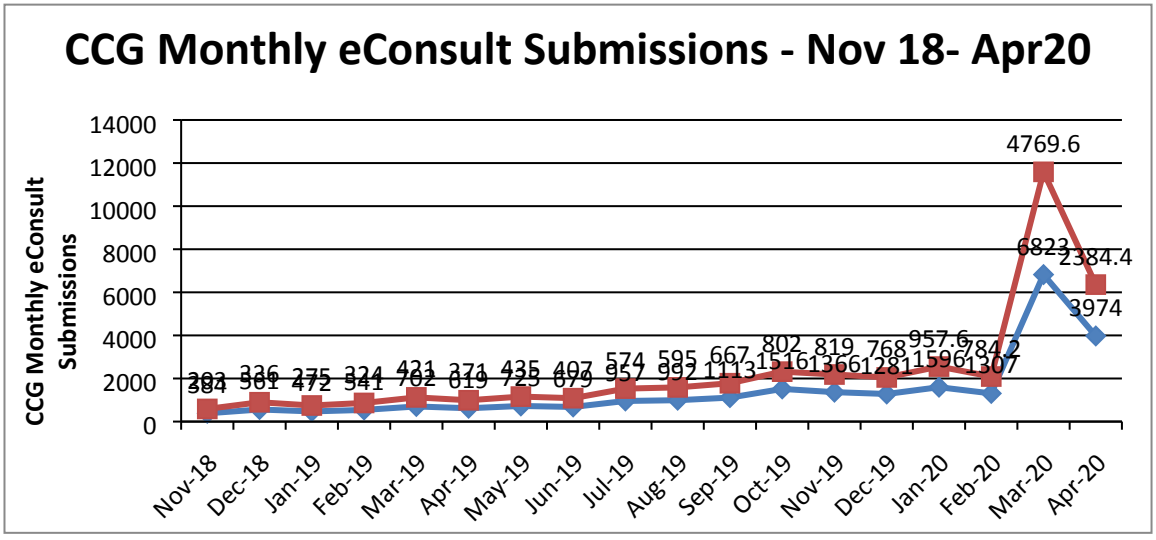
- Care Homes. Brent CCG worked closely with our Local Authority and ICP teams to support our GP practices in managing patients in our care homes during this difficult time. Practices who have patients registered in a Care Home confirmed that weekly virtual

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