27 June 2020

Dear Doctor Patel and Carolyn Downs,

Covid-19 Second Wave contingency/Recovery planning for Brent

Brent Patient Voice appreciates the response by the CCG Governing Body on 24 June to the questions we submitted to it. We note that some of the work being undertaken to plan ahead will be considered by the Brent Health & Wellbeing Board on 29 June. We strongly support the policy adopted by Brent CCG of contingency planning for a second wave of Covid-19 respiratory virus disease, and its policy of reducing health inequalities disproportionally affecting its Black, Asian and Minority Ethnic (BAME) population.

Accordingly we write urgently with what we believe are constructive suggestions for this planning for any second wave of Covid-19 in Brent. We see a real risk of a second wave in Brent especially from October 2020 in the winter season for increased risk of human respiratory virus diseases. There is a further risk that the easing of lockdown measures currently led by the Government may result in a rise in the current infection rate, which still remains the highest in Western Europe.

According to a number of measures it is now clear that, through no fault of the local NHS or the Council, Brent has so far had the worst outcomes of any area in the country from the pandemic. We attach an extract from the latest assessment by the Office of National Statistics which shows just how bad this was. We include these shocking numbers because we think they make a strong case for Brent to receive special help in resources, finance and the expertise of national epidemiologists and public health academics in preparing for a possible further outbreak or upsurge in cases.

We now know that Brent's high BAME population have a greatly increased mortality and morbidity risk from Covid-19 disease. We need to know how that was related to specific BAME groups by age, employment, area or underlying conditions, for example to especially our large number of South Asian ethnic male diabetics. There appears to be a strong case for revising the national "shielding" categories and replacing them with area specific categories.

What is needed ?

1 We suggest that the first need is a published full analysis by a medically qualified professional epidemiologist and public health academic of the first wave of Covid-19 to date in Brent and lessons learnt for any second wave. This could lead rapidly to contingency plan to include graded risks up to the equivalent of the second wave of the so-called Spanish flu of a century ago. We believe that the best protection so far against infection has all been self-help precautions: but the advice has changed as more has been learnt.

2 The second need is for a Public Relations campaign closely targeted at all Brent Covid-19 high risk groups especially the 'hard to reach'. We have encountered local people who have taken up the multiple false and misleading social media blogs minimising the Covid-19 risk and recommending dud treatments for Covid-19 e.g. drinking hot water, or inhaling steam. Particular focus is needed for those in our population for whom English is not a first language and who do not readily read complex letters such as those issued to “shielders” this time round, the homeless, illegal immigrant casual workers, and rough sleepers. South Asian high risk groups could be targeted through the Hindu temples and Islamic Mosques. Imaginative thinking is needed e.g there is an Ethiopian Christian Church in Cricklewood with a large congregation who could be targeted in Amharic. Serious public health activity is as much about communication as it is about medicine.

3 In practical matters an increased pro-active testing project for the asymptomatic population is needed for early warning of infection hotspots. Do the CCG and Brent have the powers to take all necessary action if required?

4 A joint project NHS/Brent Council is needed for increased testing, PPE stocks and quarantine isolation for all care and nursing homes in Brent.

5 A plan to allow exhausted staff to recover and to be cared for and remunerated in such a way as to assure them that they are truly valued – and will be supplemented by staff from elsewhere should a second outbreak hit Brent again.

Yours sincerely,

Peter Latham
Vice- Chair, Brent Patient Voice

cc Jo Ohlson, Accountable Officer, NW London Collaboration of CCGs

Extract from ONS assessment sourced 25.06.20:

“The area with the highest overall age-standardised mortality rate involving COVID-19 in England and Wales was Brent, with a rate of 210.9 deaths per 100,000 population, followed by Newham with a rate of 196.8 deaths per 100,000 population and Hackney with a rate of 182.9 deaths per 100,000 population.
The non-London local authorities with the highest age-standardised mortality rates included Middlesbrough with an age-standardised mortality rate of 169.2 deaths per 100,000 population, Hertsmere with a rate of 161.6 deaths per 100,000 population and Salford with a rate of 159.9 deaths per 1000,000 population. These mortality rates were also statistically significantly higher than the England and Wales average. and 13 of the 20 highest local authority mortality rates were in London Boroughs.”