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Health and Wellbeing Board

Wednesday 14 July 2021 at 6.00 pm

Conference Hall - Brent Civic Centre, Engineer's Way, Wembley, HA9 0FJ

This agenda was republished on 7 July 2021 to include item 5 and 13 July 2021 to include item 9

Please note that this meeting will be held as a socially distanced physical meeting with all members of the Board required to attend in person.

Guidance on the safe delivery of face-to-face meetings is included at the end of the agenda frontsheet.

Due to current restrictions and limits on the socially distanced venue capacity, any press and public wishing to attend this meeting are encouraged to do so via the live webcast. The link to view the meeting will be made available here.

Membership:

Councillor Farah (Chair)	Brent Council
Dr MC Patel (Vice-Chair)	Brent CCG
Councillor McLennan	Brent Council
Councillor Nerva	Brent Council
Councillor M Patel	Brent Council
Councillor Kansagra	Brent Council
Sheik Auladin	Brent CCG
Dr Ketana Halai	Brent CCG
Jonathan Turner	Brent CCG
Judith Davey	Healthwatch Brent
Carolyn Downs	Brent Council - Non Voting
Phil Porter	Brent Council - Non Voting
Gail Tolley	Brent Council - Non-Voting
Dr Melanie Smith	Brent Council - Non-Voting
Basu Lamichhane	Brent Nursing and Residential Care Sector - Non Voting
Simon Crawford	London North West Healthcare NHS Trust - Non Voting

Substitute Members (Brent Councillors)
Councillors:

Knight, Krupa Sheth, Southwood and Stephens

recycle for Brent

Councillors:

Colwill and Maurice

For further information contact: Hannah O'Brien, Governance Officer
Tel: 020 8937 1339; Email:hannah.o'brien@brent.gov.uk

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Notes for Members - Declarations of Interest:

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

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

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

***Disclosable Pecuniary Interests:**

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

****Personal Interests:**

The business relates to or affects:

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

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

or

A decision in relation to that business might reasonably be regarded as affecting the well-being or financial position of:
- You yourself;
- a member of your family or your friend or any person with whom you have a close association or any person or body who is the subject of a registrable personal interest.
-

Agenda

Introductions, if appropriate.

Item		Page
1	**Apologies for absence and clarification of alternate members** For Members of the Board to note any apologies for absence.	
2	**Declarations of Interest** 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	**Minutes of the previous meeting** To approve as a correct record, the attached minutes of the previous meeting held on 6 April 2021.	1 - 14
4	**Matters arising (if any)** To consider any matters arising from the minutes of the previous meeting.	
5	**Brent Health and Wellbeing Board Governance and the New Arrangements** This report presents to the Brent Health and Wellbeing Board the Brent Health and Wellbeing Board governance arrangements, the Health and Wellbeing Board work plan and the changed health and care landscape. N.B. This item was published to the agenda on 7 July 2021.	15 - 30
6	**COVID-19 Vaccination programme update** To update the Brent Health and Wellbeing Board on the COVID-19 vaccination programme.	31 - 44
7	**Brent Health Matters Update** This report presents the Brent Health and Wellbeing Board an update on the Brent Health Matters programme including additional areas of focus.	45 - 55

8 Joint Health and Wellbeing Strategy update 57 - 68

This report provides a progress update from the development group on activities so far and notes the emerging interim priorities.

9 Healthwatch Work Plan Approval 69 - 94

For the Brent Health and Wellbeing Board to note the work plan of the new commissioned service.

N.B. This item was published to the agenda on 13 July 2021.

10 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.

11 Date of next meeting

The next scheduled meeting of the Health and Wellbeing Board is on

Date of the next meeting: Tuesday 19 October 2021

Guidance on the delivery of safe meetings at The Drum, Brent Civic Centre

- We have revised the capacities and floor plans for event spaces to
- ensure they are Covid-19 compliant and meet the 2m social distancing guidelines.
- Attendees will need to keep a distance of 2m apart at all times.
- Signage and reminders, including floor markers for social distancing and one-way flow systems are present throughout The Drum and need to be followed.
- Please note the Civic Centre visitor lifts will have reduced capacity to help with social distancing.
- The use of face coverings is encouraged with hand sanitiser dispensers located at the main entrance to The Drum and within each meeting room.
- Those attending meetings are asked to scan the coronavirus NHS QR code for The Drum upon entry. Posters of the QR code are located in front of the main Drum entrance and outside each boardroom.
- Although not required, should anyone attending wish to do book a
- lateral flow test in advance these are also available at the Civic Centre and can be booked via the following link: https://www.brent.gov.uk/your-community/coronavirus/covid-19-testing/if-you-dont-have-symptoms/

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Brent

NHS
Brent Clinical Commissioning Group

MINUTES OF THE HEALTH AND WELLBEING BOARD
Held on Tuesday 6 April 2021 at 6.00 pm

PRESENT (all present in a remote capacity): Councillor Farah (Chair), Dr MC Patel (Vice-Chair, HWB and Chair, Brent CCG), Councillor McLennan (Brent Council), Councillor Kansagra (Brent Council), Councillor Nerva (Brent Council), Councillor M Patel (Brent Council), Sheik Auladin (Managing Director, Brent CCG), Jonathan Turner (Borough Lead Director – Brent, NWL CCG), Judith Davey (HealthWatch Brent), Basu Lamichhane (Brent Nursing and Residential Care Sector – non-voting), Simon Crawford (Director of Strategy, London North West Healthcare NHS Trust – non-voting), Carolyn Downs (Chief Executive, Brent Council, non-voting), Phil Porter (Strategic Director, Community Wellbeing, Brent Council, non-voting), Dr Melanie Smith (Director of Public Health, Brent Council, non-voting), Gail Tolley (Strategic Director, Children and Young People, Brent Council, non-voting).

Also Present (all present in a remote capacity): Robyn Doran (Chief Operating Officer, CNWL) Shazia Hussain (Assistant Chief Executive, Brent Council), Hannah O'Brien (Governance Officer, Brent Council), Fana Hussain (CCG), Isha Coombes (Programme Director, Brent Council), Gill Vickers (Interim Operational Director Adult Social Care, Brent Council), James Kinsella (Governance Officer, Brent Council), Councillor Butt (Leader, Brent Council), Angela D'Urso (Strategic Partnership Manager, Brent Council), Julia Mlambo (Partnership and Engagement Manager, Brent Council), Tom Shakespeare (Director of Health and Social Care Integration, Brent Council), Wendy Proctor (Strategic Partnerships Lead for Safeguarding Children, Brent Council), Dr John Licorish (Public Health Consultant, Brent Council).

The Chair led opening remarks and introduced Robyn Doran, Chief Operating Officer at Central North West London NHS Trust (CNWL), Janet Lewis, Central London Community Healthcare NHS Trust (CLCH), and Judith Davey, Chief Executive of Healthwatch Brent, to the Board.

1. Apologies for absence and clarification of alternate members

Apologies for absence were received from the following:

- Janet Lewis, Central London Community Healthcare NHS Trust
- Dr Ketana Halai, CCG
- Judith Davey, Healthwatch, apologies for lateness

2. Declarations of Interest

None declared.

3. Minutes of the previous meeting

RESOLVED: That the minutes of the meeting held on 20 October 2020 be approved as an accurate record, subject to an amendment in the attendees of the meeting to include Councillor McLennan.

4. Matters arising (if any)

None.

5. The single CCG and the Quartet

Phil Porter (Strategic Director Community Wellbeing, Brent Council) introduced the item on the single CCG and the quartet. The Health and Wellbeing Board had been receiving six-monthly update reports on the Health and Care Transformation Board, which had now formally came to an end and been subsumed within the "quartet" to take forward the agenda for adult care integration. The quartet would build on that work that had been done, for example the work done together to ensure hospitals were freed up as much as possible during the pandemic to support those who really needed them. Care homes were a key part of the work with a multi-agency approach led by care homes and Basu Lamichaane as the Chair. At the time of the meeting 87% of care home residents had been vaccinated in Brent and 75% of care home staff had been vaccinated. The care home support scheme had been introduced which provided a dedicated team working with care homes requiring improvement to improve their quality of care and CQC rating. Basu Lamichaane (Brent Nursing and Residential Care Sector) strongly agreed that vaccination uptake was going up, and there were lots of support initiatives from Brent including funding, webinars, leaflets and information cascading. In general care homes in Brent had managed the last wave well, he felt, and the weekly meetings had enabled care homes to share letters, policies, protocol, guidance and opportunities with each other. Care homes had resumed visiting with one designated visitor and the following Monday this would increase to 2 designated visitors.

In relation to rehabilitation and re-ablement, Phil Porter advised that an integrated approach was being taken and the rehabilitation beds in Birchwood Grove through wave 2 of the pandemic were very successful. This was tied together with a range of other projects as part of the Better Care Fund Bid (BCF), which was spoken about at the previous Board meeting and which the Board was asked to formally ratify at this meeting.

Robyn Doran (Chief Operating Officer, CNWL) introduced herself as the new health lead working in the quartet with other colleagues. In relation to the quartet, Robyn Doran advised that there were actually 5 members as part of the new structure and the idea behind it was to bring together all of the health and social care work and pull resources to have a very focused approach. It included herself and Phil Porter as co-Chairs, Dr MC Patel, Simon Crawford (LNWUHT) for acute services, Janet Lewis as the lead director from new community provider CLCH, and was well support by Jonathan Turner (Brent CCG) and Tom Shakespeare (Brent Council). The quartet would oversee and co-ordinate health care in particular and she felt the input from the Council had been incredible bringing services together. The quartet would build on the work around health inequalities, which was a number one priority alongside the vaccination programme. The second priority was Primary Care Network (PCN) development and reduction in practice variation. The third priority was to improve community and intermediary healthcare services and wrap services around individuals, and the final priority was mental health and wellbeing. The quartet met regularly with the "sectet", made up of 9 members, which in turn reported to the Integrated Care System (ICS).

The Chair thanked Phil Porter and Robyn Doran for introducing the item, and invited comments and questions from those present, with the following raised:

- In relation to 4.4.2 of the report in relation to levelling up the Board were pleased that resource was going towards diabetes in Brent and asked what specifically was being considered. Dr MC Patel (CCG) explained that there would be a large investment towards diabetes with clear priorities; the "rewind" project, which supported those on medication to work towards coming off medication; preventing people getting diabetes including picking up high risk patients early on and working with them; and working with

those who have had diabetes and high blood sugar for a long time alongside the health inequalities team. They would also target cohorts with HBO1 to encourage them to take more control and help those not already on the maximum therapies or who may not have access to all the interventions they could possibly have. There would also be management of cholesterol and blood pressure in diabetes. Sheik Auladin (CCG) added that as part of the merger into 1 CCG across 8 NWL Boroughs there was a promise made to Brent CCG around inequalities. An issue faced in Brent was the levelling up of investment in community and primary care, and as a result the ICS had looked at issues pertaining to diabetes in the community and Brent had received an investment of around £1.9m for diabetes. This would complement community services and primary care regarding diabetes management for the future. Jonathan Turner (CCG) added that there was a series of workshops in the design phase looking to increase the standards at primary care level through General Practice, tiers of care, and looking at investment in hubs to support General Practice and be a seamless interface between General Practice and Hospital, so that those with hyperglycaemic episodes would be able to seek the help of the hub. Other areas of focus for the CCG were obesity, cardiovascular issues and hypertension, and Long Term Conditions, and determining why there was low uptake in certain populations for bowel and cervical cancer screenings and childhood immunisations.

- The Board queried how the work of the quartet on priority one (reducing health inequalities and increasing vaccination uptake) would relate to that of the new vaccination hesitancy task force set up by North West London CCG. In relation to vaccination, Dr MC Patel advised that there had been a lot of effort from the Council, CCG, Health Inequalities Team and NWL trying to get those patients to come forward who had not yet had the vaccination within the relevant cohorts. A call centre was being set up to look at the top 10 practices with the highest decline rates and those listed as having contraindications to the vaccination, as a lot of practices had coded allergy as a contraindication to the vaccine and it was believed some practices may not have coded that correctly. The health inequalities team in the Council would provide additional resource to work with practices on reaching those patients who had not yet came forward. Pop up clinics were also proving successful at the Mosque so there was hope to continue with that, and a process had now been agreed with the Council was for those pop-ups to take place. In relation to queries on certain vaccination centres being closed for vaccination on certain days Dr MC Patel advised that all PCNs had a list of groups of people they could call upon to deceive the vaccine but were being mandated to work within the priority cohorts. He advised however that Brent had very minimal vaccination wastage. Jonathan Turner added that the Hive Centre was based in Harrow so something the quartet was not directly responsible for but that some clinics had never run every day in order to be as efficient as possible.
- The Board requested that an action plan for priority 2, PCN development, was brought back to the next Health and Wellbeing Board explaining exactly what was going to be done to reduce variation in practice across the Borough. Dr MC Patel advised that the quartet had set a goal for itself that in 3 years' time all practices would be functioning at the average of North West London practice. In Brent there was considerable variation in terms of outcomes and expected incidence of some chronic diseases, so the plan was to look at practices individually very carefully, with 10 identified to start with that had been particularly hard hit by COVID-19, looking at why the variance may be occurring and address it by offering support and assistance. This work would be underway once the second round of vaccinations had been done as that was the current priority.
- It was noted that an executive subgroup was proposed to be established for each priority and queried who decided who sat on those groups. Robyn Doran advised that there were 4 groups and subgroups within those and at the moment the proposal was that at least 2 of the quartet co-chaired the various subgroups. For example, Robyn

Doran and Dr MC Patel had just chaired the first meeting of the reducing health inequalities sub group, and they had brought in Shazia Hussain (Assistant Chief Executive, Brent Council) and other officers in the Council to ensure the work being done in the Council was not lost as part of the overall health inequalities work. Partner agencies had agreed to have senior representation from each of those agencies on the sub groups to ensure all agencies were well represented. Full membership of those subgroups was being worked on at the time of the meeting.

- Regarding the 4 care homes homes that were part of the care home peer support programme, the Board asked whether what had been put in place would be sustainable long term. Phil Porter advised that of the 4 homes that had been worked with 2 had gone from requires improvement to good. While he did not believe he could promise sustainability as it depended on the registered manager of the home, they were looking at how the team could be sustained as an ongoing project.
- A question was raised in relation to long covid and its impact on those with cardiovascular and respiratory diseases and whether there was any resources that would cover that. Robyn Doran advised that all health agencies had pulled together some long covid connects, but there was a piece of work across London looking at all the resources coming in.
- The Board asked how services for young people were being included in the work of the quartet. Robyn Doran explained that it would be part of the priority around community services and in discussion with Gail Tolley (Strategic Director Children and Young People, Brent Council). Young people and children would also be looked at by the quartet in relation to CAMHS, transition and mental health under the mental health priority. Gail Tolley confirmed that the sectet, which had 9 members, did include the Strategic Director for Children and Young People role as part of its structure.
- The Board queried what the relationship of the Brent locality to the wider NWL health system was regarding health investment and levelling up. Robyn Doran advised that the relationship between the quartet, the wider ICS and the health inequalities team was forming. There was a group which she sat on with Dr MC Patel looking at health inequalities at system level but there was yet to be a discussion on levelling up which was something she would be advocating. The metrics for the inequalities work were being formed. Phil Porter added that it was very new, and the quartet (made up of 5 members) and sectet (made up of 9 members) had a purpose of accountability.

RESOLVED:

i) To note progress against the plan agreed in 2020 / 21 and the transition to new governance arrangements.
ii) To provide a strategic steer and advice to support the delivery of the updated priorities and approach.

6. The COVID-19 Pandemic

COVID-19 Epidemiology

Dr John Licorish (Public Health Consultant, Brent Council) introduce the report outlining the epidemiology of the COVID-19 outbreak in detail. He highlighted that at the time of writing the report 835 people had passed away in Brent due to COVID-19 and that during the second wave of the pandemic there was a wider demographic across the Borough in terms of cases and deaths, including various ethnicities. The Board were advised that during the second wave the public health department were able to get better data with regard to ethnicity so had a better handle on the data of cases. In addition during the second wave

there was access to more testing. Subsequent to the timing of the report Dr John Licorish suggested that numbers were plateauing.

The Chair thanked Dr John Licorish for the introduction and invited comments and questions from those present, with the following issues raised:

- In relation to the ethnicity data in section 3.7, it was confirmed that this referred to mixed ethnic groups using the census summary.
- It was noted that statistically in the report Brent was at the bottom of NWL for vaccination figures, but was no longer the highest in terms of rate per 100k in comparison to Harrow, Hounslow and Hillingdon which all had higher vaccination rates. Dr John Licorish advised that the report looked at the entirety of the pandemic. There was significant disproportionality and Brent had initially been affected, but as the pandemic had gone on there was a broader set of people being affected and Brent was no longer the top for death rate. Dr Melanie Smith (Director of Public Health, Brent Council) added that currently the purpose of vaccination was to reduce hospital admission and death and vaccinations were not yet being given to cohorts that would have a big impact on transmission, therefore she would not expect the overall infection rate to be affected by vaccination levels at this stage, but would expect infection rate in older age groups to reflect vaccination rates which it did.
- The Board highlighted that the statistics within the report showed that the Caribbean community was lowest on vaccination uptake in the majority of data, despite various webinars being undertaken and community and faith leaders encouraging vaccination uptake, and queried what further work would be done to address the vaccination hesitancy within the Caribbean community. Dr Melanie Smith advised that there had been movement and while it was still differential that differential had reduced. The vaccination programme was being looked at through a more flexible and tailored approach now addressing not just beliefs but also practical barriers to people getting vaccinated. In addition, through library staff phone calls, something emerging as a finding for vaccination refusal was the influence of family and friends, so a lot of work had been done with trusted messengers and community leaders. Dr Melanie Smith suggested a focus could be on younger family members who may influence someone's decision to receive the vaccination. Dr John Licorish advised that the work done by enforcement and the community taking the vaccination to people had been admirable, as another issue was that the Borough was geographically challenged and getting around was difficult, meaning some residents were unable to travel to a vaccination hub.
- In relation to the geographical data of places which had been more affected by COVID-19 and the fact those locations were often highlighted for other indicators of health inequalities, the Board queried whether the Brent maps were comparable to other similar London Authorities. Dr John Licorish advised that there were similar maps in different places in London reflecting particular diversity and showed Brent had specific issues which brought into context the importance of the Brent Health Matters work addressing health inequalities.
- Members of the Board felt the difference between the Brent response of the two waves was noticeable and the work during the second wave had shown a positive improvement, particularly the work done on outreach and vaccination, street enforcement and communications with residents. Dr John Licorish agreed that he had seen an improvement in how the pandemic had been managed.

RESOLVED: to note the information provided in the paper.

COVID-19 Vaccination Programme

Dr Melanie Smith (Director for Public Health, Brent Council) introduced the report. The Board heard that the current priority was not just to get people vaccinated but also to improve vaccination equity across the Borough, and the vaccination programme aimed to do both by addressing the need to get large numbers vaccinated, twice, at speed, and also reflecting the need for a flexible and tailored approach, working with communities to understand barriers to vaccination. She told the Board that there were practical, geographical and digital barriers associated with vaccination and understandable concerns about the vaccinations given the disproportionate impact of COVID-19 and historic disproportion of inequalities in care. Brent was not doing as well as would be hoped and she advised that this was viewed as a system issue requiring the NHS, Council, third sector and communities to work together to address. Brent had set itself a high ambition, going higher than the NHS target of 92% uptake, and aiming for 92% uptake within each JCVI cohort by ethnicity and by deprivation. Dr MC Patel (CCG) endorsed the way forward in aiming for a 92% uptake within each JCVI cohort.

Simon Crawford (LNWUHT) advised that they were seeing low uptake amongst staff at Northwick Park Hospital, and had done a lot of work on the myths of the vaccine and used clinical staff as vaccination champions with had individuals who had already received the vaccination encouraging others, and whilst they had a captive audience with easy access to the vaccine and reliable information they were still not getting near 100% uptake with staff. He felt what was being done in the community was excellent and needed to continue, pushing messages, but wanted to recognise the difficulties and the fact some had very long held beliefs impacting their hesitancy.

The Chair thanked colleagues for the introduction and invited comments and questions from those present, with the following issues raised:

- The Board acknowledged the point made about locality of vaccination centres and difficulty travelling to them, and queried what more could be done to bring the vaccine to individuals. Dr Melanie Smith advised that they had experienced people being more willing to take up the vaccination if it was nearer to them, which was the reason behind the pop-up vaccination hubs, and work was being done for a vaccination bus which was hoped would make a difference. Dr MC Patel advised that many of the larger vaccination centres were open until 8pm and opened on weekends, and over Ramadan some clinics were starting late and running later into the night. There were also 2 satellite pop-up sites in the South of the Borough that could run every day and store the vaccinations, and the travelling pop-ups, but the limiting factor was resource and vaccination supply. There was also a need to factor in staffing, admin support, vaccinators, and IT. Dr John Licorish agreed that by bringing services and pop-ups into the community in a space communities were comfortable with this broke down some of the barriers such as the geographical barriers and gave an element of trust, and was a lesson not just for vaccinations but also how other services were delivered within the community.

RESOLVED: To note the vaccination programme.

Brent Health Matters Programme

Tom Shakespeare (Director of Health and Social Care Integration, Brent Council) introduced the work of the Brent Health Matters programme, which focused on health inequalities and was built on the pilot conducted in Alperton and Church End. The focus of the pilot was for community leaders and champions to lead on the development of hyperlocal action plans to address individual health inequalities in those 2 areas, and since

the pilot work was being done to expand that work. He highlighted the following key points in relation to the report:

- The establishment of a clinical service and team across mental health and wellbeing, which had been doing targeted work calling residents and had a dedicated phone line. That service was currently being reviewed and would focus on long term conditions, ensuring the service was having an impact Borough-wide as the programme expanded.
- The grants programme had begun, with 12 bids received from community organisations thus far. He felt that there were some really innovative and interesting ideas coming out of it.
- Organisations had been appointed to lead in the recruitment of health educators within the community and 20-30 of those would be community co-ordinators working to each of the 5 Brent Connects areas. A number of outreach days had taken place with community champions in Alperton and Church End and those outreach days would be taken forward as the programme went Borough wide. A large amount of communications material had been developed with the community champions including in different languages.
- The team had been purposeful in making clear the message that the work of the Brent Health Matters programme was not just about vaccination, which there would be a big focus on, but also about long term conditions and wider determinants of health with a long term approach.

The Chair thanked Tom Shakespeare for the introduction and invited comments and questions from those present, with the following issues raised:

- The Board queried whether it was possible to go door to door to encourage people to take up the vaccination and regular testing, similar to the work done during electoral registration and census drives. Dr MC Patel (CCG) advised that through regular meetings with PCN leads and GPs in practice forums he had been informed that many GPs and their practice staff had been to patients residences, knocking doors and asking if they would have the vaccination and their reasoning behind their decisions. The health inequalities team had also been phoning people. He agreed that it was something that should be done over and over again but the difficulty was visiting door to door unannounced from a health perspective could result in residents becoming resentful, and there had been some instances of GPs being threatened with being reported regarding the number of attempts made trying to get patients vaccinated. He advised that it was a difficult task and there were complexities with that approach. He assured the Board that a lot of practices, particularly in the South of the Borough where uptake was lower, had been calling on patients and even offering to vaccinate patients in their own homes.
- Going forward, CLCH would host the Brent Health Matters Clinical Team. Due to the vaccination figures in Brent, it had also been agreed that some of the health inequalities clinical team would devote time over the weeks following the meeting solely on covid vaccinations and those who had declined to try to help practices improve figures.

RESOLVED: To note the refocus and the key work streams and endorse the whole system approach.

COVID-19 Outbreak Control Plan

Dr Melanie Smith (Director of Public Health, Brent Council) introduced the report, explaining that the initial covid outbreak control and management plan was agreed last June and as things had moved on considerably there was a requirement for all local authorities to revise and resubmit their plan which Brent had done. Presented to the Board

was the draft plan. Feedback on the plan had now been received from Public Health England, who found the plan to be generally sound. One area she was asked to strengthen in the plan was around support for self-isolation. The plan had gone through a peer assessment process with Public Health England, DHSC, JBC and other Boroughs in NWL., Following that, she was able to assure the Board that the need for strengthening support for self-isolation was about better articulation of what Brent was already doing rather than a need for additional action. Brent's offer to those self-isolating was equivalent to that which had been made to those shielding and included payments for those who met nationally determined eligibility criteria. Brent was due to offer increased support for self-isolation in the form of an offer of accommodation for those who would find it difficult to self-isolate within HMOs or multi-generational households and that offer would go live soon. The experience from other Boroughs was that there was not a lot of uptake on the offer of alternative accommodation but it was a useful addition to the response to Covid.

The Chair thanked Dr Melanie Smith for her introduction and invited comments and questions from those present, with the following issues raised:

- The Board queried whether there was any evidence that those who might have had or believed they had covid were declining the vaccination as they thought they had immunity already. Dr Melanie Smith agreed that this was something coming up in the calls the library staff were making. Those so reasoning were a small number and this was not the main reason for vaccination refusal, with pressure from family and friends being more significant, but she suspected that as the vaccination cohort age range reduced that this reason would become more prevalent and agreed to work on messaging around that. She advised that the library staff worked to a structured recording of a conversation and people were prompted if they did not address various reasons.
- The Board noted that the financial implications section of the report highlighted that Brent was underfunded, and queried whether that was impactful. Dr Melanie Smith advised that specifically with the outbreak control and management plan the basis of funding was initially quite arbitrary. However, she did not feel funding was inhibiting the response specifically within the outbreak control plan, but that was not to say that Brent should not have greater funding to address health inequalities.

RESOLVED: To note the plan.

The Chair thanked those who had contributed to the discussion and acknowledged the wealth of work ongoing across the whole system to tackle the pandemic and keep Brent residents safe, extending thanks to everyone.

7. Brent Children's Trust (BCT) Six Monthly Update

Gail Tolley (Strategic Director Children and Young People, Brent Council) presented the report which provided an update on the work of the Brent Children's Trust (BCT) over the past six months following the update provided to the Board in October 2020. The following key points were raised:

- There had been 3 meetings since October 2020 which focused on family wellbeing centres, which had begun a soft implementation process from September 2020 and was beginning to pick up speed and resource.
- The Trust had contributed to the Health and Wellbeing Board strategy update.
- A number of health colleagues including Dr Ketana Halai (CCG) had presented a paper from the CCG on a number of areas relating to children's mental health and wellbeing,

and the Trust was working to make some links in clinical areas and wellbeing areas for children and young people in terms of work in schools.

- Priorities for the coming year included children's health and wellbeing, working on parents' reluctance to take children to routine medical appointments during lockdown such as oral health appointments and immunisation, and childhood obesity. It was noted that reference would be made to healthy weight in childhood rather than obesity for the priority description. There would be a continued focus on special education needs and disability which was an area of joint accountability with Ofsted and CQC. Particularly the Trust were being alert to anything that may come out of any major national reviews as a result of the 2014 reforms that resulted in large increases in the number of Education Health and Care Plans (EHCPs). Children's mental health and wellbeing would also be a priority and there was a transformation plan for CAMHS being worked on. The Integrated Disabled Children And Young People's Service phase 2 would focus on integration with health colleagues but that had been paused from January 2021 due to the pandemic and would need revisiting. Transitions work, particularly around safeguarding, would be a priority, and young carers who it was expected would increase in population as a result of the pandemic. Gail Tolley advised that there was a large number of priorities, some of which built on work already being done, but there was also a need to be aware of any legislative changes that may come through in relation to children's health and additional needs, and the Trust wanted to retain the flexibility to bring those in if needed.

Members of the Board highlighted that in response to Covid-19 from an acute perspective colleagues had seen far more presentations of children in crisis through A & E at Northwick Park, and queried whether there was any plan for data collection on the acuity of presentation of children in crisis and analysis of what was leading to that. Many were new presentations and it was queried whether a broader piece of work was being considered to identify the increased prevalence of these presentations. Gail Tolley advised that the section in the report in relation to children's mental health and wellbeing was very much a summary, but some of the data in relation to the increase in presentations was included in the report and there had been discussions at the last meeting about how the Trust could get more upstream to support those children in communities through GPs and school settings. An invitation was extended to Simon Crawford (LNWUHT) to the next BCT meeting. Simon Crawford made an offer to pull together prevalence of data over the last 12 months. Sheik Auladin (CCG) added that there was a piece of work currently being undertaken at NWL ICS looking at a mental health task force. The work was time limited and looked at some of the issues raised regarding the number of young people and children presenting at A & E with complex needs. The task force was running on a weekly basis at the moment and Sheik Auladin was happy to share the outcome of the task force with Gail Tolley.

RESOLVED: To note the Brent Children's Trust key priority areas for 2021/22.

8. Joint Health and Wellbeing Strategy (JHWS) Update

Dr Melanie Smith (Director of Public Health, Brent Council) introduced the update, explaining that the Board was due to refresh the strategy the previous year but that following the pandemic the Board had agreed it needed to fundamentally rewrite and review the strategy to focus on health inequalities, which had not been caused by Covid but were exacerbated and highlighted by Covid. She advised that reworking the strategy during a pandemic had been challenging and she commended health colleagues for the time they had been able to devote to it. Progress was not as fast as they would like but she hoped the agenda of the evening's meeting demonstrated that colleagues were fundamentally reviewing the ways of working as a system and working with communities, being much clearer about the response to health inequalities and she felt they had set the groundwork

for a really good strategy. In relation to the report, Dr Melanie Smith highlighted the following:

- The Board heard that the team had reviewed what was known about need in Brent and done consultation through Healthwatch and Brent Health Matters. As a result of that engagement the strategy would have a much bigger focus on the greater determinates of health with an ambition to be broader than the previous strategy which focused on health and social care services. This had been echoed in the consultation findings where residents recognised the complex interplay of factors that determined their health and gave rise to health inequalities. The consultation also found that there was a desire from residents to focus on the needs of children and young people, particularly regarding mental health, wellbeing and mental illness.
- Emerging areas of focus for the strategy included ensuring everyone was able to make healthy choices, and making the healthy choice the easy choice for everyone. There would be a greater focus on healthy and sustainable communities and places and there would be a greater role for prevention of ill health, including prevention of mental illness and the promotion of mental wellbeing. This would be done in the context of recovery from Covid through the system and workforce.
- The strategy aimed to make much better use of data to ensure services were meeting the needs of all residents, with a need for a greater focus on consistent recording and use of ethnicity data, examining differences in access and outcomes by deprivation and an explicit focus on the needs of particular groups, including those with additional needs. There was a need to work with those who were using services and also reach out to those who were not using services, to allow them to influence how the services develop.
- The paper proposed the strategy was framed around a number of areas as outlined in the report, which the Board was asked to comment on and subsequent to those comments the work would be taken forward to the next phase.

The Chair thanked Dr Melanie Smith for the introduction and invited comments and questions from those present, with the following issues raised:

- The Board noted the synergies between the Climate Emergency Strategy, Black Community Action Plan, Poverty Commission findings and the Borough Plan with this work and wanted to see where this work fit in to the NHS planning process. The Board did not want to underestimate the impact of issues around housing, physical activity and active travel. Councillor McLennan (Deputy Leader, Brent Council) highlighted that all these strategies were framed by the Borough Plan and fit into each other, therefore cross-fertilisation across the strategies and embedding these right across the authority was important, as well as how it fed into the NHS. Councillor Neil Nerva (Lead Member for Public Health, Culture and Leisure) suggested health inequalities could be picked up as a long term objective for Cabinet, and felt there was a need to carry members on the journey through member development and engagement.
- The Board noted the importance of educators and parental guidance and support and the assets within the community.

RESOLVED:

i) To note the achievements so far in the development of the strategy.
ii) To agree the emerging areas of focus.
iii) To agree how the Board might interact with other key delivery programmes to assure itself of delivery in key areas, such as the Poverty Commission delivery plan.

iv) To agree the next phase of consultation.

9. Commissioned Community Services

Jonathan Turner (CCG) introduced the report, explaining that at the end of the previous year LNWUHT gave notice on some of the community services they had provided to Brent for a considerable amount of time. This had since been reviewed at ICS level and largely the vast majority of those services would now need to transfer to another organisation. The report explained how they had came to the conclusion of who would provide those services, and the following key points were highlighted in relation to the report:

- The aim was to stabilise services during a period of significant change of demand on health services and a changing NHS environment, with legislation anticipated to go through later in the year which would mean a move away from choice and competition commissioning to a more collaborative approach. Instead of running procurement processes the new model would look within the NWL health economy to determine who was best placed to provide those services. Given the timescale and the need to mobilise services they had ran a relatively short process to determine who to award to, and determined to award to Central London Community Healthcare NHS Trust (CLCH). There were also a limited number of services in Harrow but they were not relevant to this group. The award would include district nursing, nutrition and dietrics, respiratory, long term conditions in the community and children's services. There would only be a change in the provider of the services rather than the content of the services, with staff remaining the same. The contract award notice had been published which was a legal requirement and the period for challenging the award was about to expire. The expected transition date was 1 August 2021.
- The Board heard that the ICS would have hoped to do more community engagement prior to award but had not been able to due to the short timescales involved and the need to make a quick transition of services. They were going through a review process in terms of how they could continually improve the service specifications and that would involve members of the public and Healthwatch.
- There was a working group between CNWL, CLCH and LNWUHT to manage the transition and the quartet would be involved in the future, reporting into the ICS. Simon Crawford (LNWUHT) expanded, explaining that the weekly working group meeting focused on staffing issues, digital issues, estates issues, estates IT and workforce and there was a joint project plan in relation to that. He had been engaging staff on the change since December 2020 with major Teams meetings, and 2 weeks ago CLCH and CNWL joined the conversation with staff around the transfer process and were setting up their own engagement plan for staff transferring. It was expected that the effective working relationships already held with CLCH and CNWL would continue, and which had strengthened during the pandemic, and that partners would work together delivering effective services.

The Chair thanked the health colleagues for their introduction and invited comments and questions from those present, with the following issues raised:

- The Board noted that over the past ten years community services had been most impacted by commissioning, and this would be the 5th organisation they would work for in the past decade, and wanted to know whether staff would have the resilience to cope with another change. Simon Crawford advised that CLCH had a good reputation of providing community services to a number of Boroughs in NWL and across London and would have a Borough director lead managing those services. He added that CLCH were more robustly linked into the community framework across ICS around community

services and innovation and he felt they would have a stronger voice representing change and what should be different going forward. He highlighted that they also had a level of professional expertise in community services to draw upon. He felt the change would give a stronger voice and stronger cohesion through community services and better access to strong leadership, support and a sense of identity. In relation to supporting staff through the change he advised that he had continued to liaise major events since December 2020 to communicate to staff what was happening. He added that there was a relatively small amount of service transfer.

- A question was raised in relation to clinical governance, and Jonathan Turner advised there was an infrastructure at the moment of working groups, subgroups and various other groups looking at this aspect including practical issues such as transferring records from one system to another, and risks and issues would be logged. Simon Crawford added that they had experience of governance and transfer of clinical information through part of an Ealing transfer therefore colleagues were aware of what 'good' looked like, and had a robust process in place with CLCH and CNWL regarding logging all critical incident reports, complaints and there would be a process for handing those things over as well as the consideration of the safety and security of patient data.
- The Board highlighted that where there were lists of services a lot had broken links online and wanted to know where residents could access information about new changes, management, and whether there was an opportunity to have a single Brent services directory. Jonathan Turner advised that there was a communications workstream however until the notice period for the award had expired communications had been halted. All community leads across the different trusts involved and the CCG were working up a communications plan and there would be a series of announcements about the change, but he also acknowledged the need to ensure websites and information on how to access services was kept as up to date as possible. He was happy to link in with the Council's communications department for message streams.
- A query was raised about the STARRS service, and Sheik Auladin (CCG) confirmed that STARRS had always been a Brent service and was commissioned for community services for Brent residents and would continue delivering services in the same way, and the CCG had been trying to secure commitment from CLCH that it would remain where it was within Northwick Park so that it did not affect the flow into and out of the emergency department.

RESOLVED: To note the decision to transfer community services to CLCH and the transition process.

10. Healthwatch Commissioning

Julia Mlambo (Partnership and Engagement Manager, Brent Council) updated the Board on the Healthwatch recommissioning process. She advised that the Council had found a new provider who was present for the meeting. A lot of good practice had been learned from the procurement process. Brent's commissioning team had held a capacity building programme to support bidders, had service user involvement as part of the panel and had input from partners as part of the evaluation process as well as useful input from public health. The process of implementing the new service was now fully underway with most information handed over to the new provider. It was highlighted that the previous provider had been very co-operative and helpful with the handover project. The new provider was also a member of the health and wellbeing strategy development group so right from the start of their contract their work was being linked into policy.

Judith Davey, the new Chief Executive of Brent Healthwatch, introduced herself. She highlighted that the procurement process had been very good, particularly with the

involvement of service users and communities, and she looked forward to working with the Board moving forward. The key priority of quarter 1 was reaching out and ensuring they had the right links with the right people and relevant Boards. They would also be setting up a governance structure, so in addition to an advisory Board they would also have a grassroots steering group going out to where communities were and a network of independent experts.

RESOLVED: to note the outcome of the commissioning process and welcome the new Healthwatch provider and Board member.

11. **Better Care Fund 2021/22 Ratification**

The Board RESOLVED: to ratify the Better Care Fund for 2021/22.

12. **Any other urgent business**

None.

The meeting was declared closed at 20:09pm

COUNCILLOR HARBI FARAH
Chair

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Brent / NHS Brent Clinical Commissioning Group	**Brent Health and Wellbeing Board** 14 July 2021
	Report from the Strategic Director for Community and Wellbeing

Brent Health and Wellbeing Board Governance, ICP delivery vehicles and highlights update

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	Appendix 1– Governance structures 2021/22 Appendix 2 – BHWB work plan 2021/22 Appendix 3 – Health inequalities and diabetes
Background Papers	/
Contact Officer(s): (Name, Title, Contact Details)	Tom Shakespeare – Director of Integration tom.shakepeare@brent.gov.uk Angela d'Urso - Strategic Partnerships / Policy and Scrutiny Manager angela.d'urso@brent.gov.uk

1.0 Purpose of the Report

1.1 This report outlines the Brent Health and Wellbeing Board (BHWB) governance structures and the delivery vehicles of the Integrated Care Partnership (ICP) (see Appendix 1).

1.2 The report aims to bring into focus the changing landscape in health and seeks to engage Brent Health and Wellbeing Board input to future ways of working.

2.0 Recommendations

2.1 To note the delivery mechanisms of the Integrated Care Partnership Executive Committee (ICPEC), and the membership and priorities of the four executive groups.

2.2 To discuss the BHWB arrangements within this context and provide strategic direction to officers as required. Key considerations could include:

- Purpose and focus e.g. to allow for annual or bi-annual public engagement
- Membership e.g. to enable delivery of statutory responsibilities

2.3 To agree the draft work plan of the BHWB for 2021/22 (see Appendix 2).

3.0 Detail

The Brent Health and Wellbeing Board

3.1 Health and Wellbeing Boards (HWBs) are a statutory forum where political, clinical, professional and community leaders come together to improve the health and wellbeing of their local population. HWBs have a statutory duty to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

3.2 As well as its statutory role, the **Brent Health and Wellbeing Board** (BHWB) ensures system leadership across commissioners and providers working in Brent.

3.3 Current legislation states that health and wellbeing boards must include:

- At least one elected representative
- A representative from the Clinical Commissioning Group (CCG)
- The local authority directors of adult social services, children's services and public health
- A representative from the local Healthwatch

3.4 Beyond this minimum membership, other interested local stakeholders may also be invited to hold membership. These may include representatives of third-sector or voluntary organisations, other public services, or the NHS. The BHWB currently has a wider membership than statutorily defined, made up of voting and non-voting members.

3.5 Current BHWB membership is as follows:

Full members (voting):

- Cllr Farah (Chair), Brent Council
- Cllr McLennan, Brent Council
- Cllr Nerva, Brent Council
- Cllr M Patel, Brent Council
- Cllr Kansagra, Brent Council
- Sheik Auladin, Brent Clinical Commissioning Group (CCG)
- Dr M C Patel (Vice Chair), Brent CCG
- Dr Ketana Halai, Brent CCG
- Jonathan Turner, Brent Borough Director, CCG
- Healthwatch Brent

Full members (non-voting):

- Carolyn Downs, Brent Council
- Phil Porter, Brent Council
- Dr Melanie Smith, Brent Council
- Gail Tolley, Brent Council
- Mark Bird, Brent nursing and residential care sector
- Simon Crawford, London North West University Healthcare NHS Trust
- Robyn Doran, Central and North West London NHS Foundation Trust
- Janet Lewis, Central London Community Healthcare NHS Trust

3.6 There will be impacts on HWBs in the upcoming Health and Care Act, and officers will ensure we retain flexibility to respond to any new or changed statutory duties.

3.7 The draft work plan for the BHWB for 2021/22 has been compiled and is attached in Appendix 2. Consideration has been given to require standing items within the context of the new Integrated Care System (ICS) arrangements (detailed in subsequent

sections) and statutory focus relating to the emerging Joint Health and Wellbeing Strategy.

The Children's Trust

3.8 The **Brent Children's Trust** (BCT) is a statutory strategic partnership body made up of commissioners and key partners. The primary functions of the BCT include commissioning, joint planning and collaborative working to ensure that resources are allocated and utilised to deliver maximum benefits for children and young people in Brent

3.9 The BCT meets every two months to review progress against the priority areas of focus and address any emerging local and national issues. The BCT, through its Joint Commissioning Group (JCG), oversees five groups tasked with implementing specific priorities across the partnership.

3.10 The BCT, JCG and transformation groups have consistent attendance with representation from Brent Council and Brent Clinical Commissioning Group (CCG). Other key stakeholders also attend the JCG, which includes three school head teachers who have been active members since September 2017.

3.11 The BCT has identified a number of priority areas of focus for April 2021 to March 2022 as a result of emerging issues supported by local and national data:

a. Working with parents and carers to positively impact on children's health and wellbeing with specific focus on:
    1. Healthy weight in childhood
    2. Oral health
    3. Childhood immunisation
b. Special Educational Needs and Disabilities (SEND) – with a focus on early intervention and prevention in light of the major national review into support for children and young people with SEND to be launched in 2021.
c. Children and Young People's Mental Health and Wellbeing – with a continued focus on the delivery of the transformation plan.
d. Integrated Disabled Children and Young People Service 0-25 - with a focus on Stage 2, the integration of health and local authority provision, which was paused in 2020 due to Covid-19 Pandemic.
e. Transitional safeguarding between CYP and Adult Services - with a focus on adolescent safeguarding.
f. Young Carers - with a renewed focus on raising awareness of young carers across the partnership.

The Integrated Care System and local governance arrangements

3.12 On 11 February 2021, the Department of Health and Social Care published the White Paper 'Integration and innovation: working together to improve health and social care for all, which sets out legislative proposals for a Health and Care Bill. The White Paper groups proposals under the following themes:

- Working together to integrate care
- Reducing bureaucracy
- Improving accountability and enhancing public confidence
- Additional proposals to support public health, social care, and quality and safety

3.13 At the heart of the changes is the proposal to establish Integrated Care Systems (ICS) as statutory bodies in all parts of England. ICSs will be made up of two parts – an 'ICS NHS body' and an 'ICS health and care partnership'. The dual structure is a new development and recognises the two forms of integration that are needed to adopt a

population health approach aimed at improving the health and wellbeing of local populations: integration within the NHS (between different NHS organisations) and integration between the NHS and local government (and wider partners).

3.14 The ICS health and care partnership will be responsible for developing and performance managing a plan to address the system's health, public health and social care needs, which the ICS NHS body and local authorities will be required to 'have regard to' when making decisions. The membership of the partnership and its functions will not be set out in legislation – instead, local areas will be given the flexibility to appoint members.

3.15 The White Paper also recognises the importance of 'place', which is a smaller footprint than that of an ICS, often that of a local authority. This is the Integrated Care Partnership (ICP) level. The Department states that it has decided against giving place a statutory underpinning although it is explicit that there will be an expectation that ICS NHS bodies delegate 'significantly' to place level. The development of place-based partnerships will therefore be left to local determination, building on existing arrangements where these work well.

3.16 ICSs will be expected to work closely with Health and Wellbeing Boards (HWBs) and required to 'have regard to' Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. As stated, the future of HWBs in terms of any statutory changes introduced by the Health and Care Bill is currently unknown.

3.17 The new structures for collaboration and integration will be supported by a range of other measures, including:

- A duty to collaborate across the NHS and local government
- A shared duty on all NHS bodies to pursue the 'triple aims' of the NHS Long Term Plan (better health and wellbeing, better quality health care and ensuring the financial sustainability of the NHS)
- A duty on NHS trusts and foundation trusts to 'have regard to' the system's financial objectives
- The legislation will also be amended to assist organisations by enabling decisions to be taken by joint committees and to facilitate increased 'collaborative commissioning' across different footprints, for example, by enabling NHS England to share some of its direct commissioning functions with ICSs.

3.18 The Government has indicated that the Health and Care Bill would be prioritised, with a plan for changes to be implemented in 2022. This changing landscape provides the context for this paper and decision making within.

<u>The North West London Integrated Care System (NWL ICS)</u>

3.19 The **NWL ICS** is already functioning in shadow form and many of the structures that have been set up under the single CCG arrangements will prepare the system well for the anticipated legislative changes. The NWL ICS is led by an independent Chair and an interim Chief Executive has been appointed. The ICS is likely to be coterminous with the North West London borough boundaries currently in existence. The ICS is expected to come into force in a statutory sense by April 2022.

3.20 New operational guidance was issued in March 2021 and confirms the priorities of the ICS to be:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience and access
- Enhancing productivity and value for money
- Helping the NHS to support broader social and economic development.

The NWL ICS current priorities are:

- Recovering elective care and addressing the backlog of other unmet care needs
- Strengthening out of hospital care, with focus on prevention and management of long term conditions and improving outcomes for people with mental health needs, learning disabilities and autism
- Improving the workforce experience, best use of estate and driving innovation
- Ensuring fair allocations of resources

The Integrated Care Partnership Executive Committee

3.21 The **Integrated Care Partnership Executive Committee** (ICPEC) (formerly known as the Quartet) is the place-based partnership for Brent within the NWL Integrated Care System (ICS). The ICPEC meets fortnightly, and leads on the integration and systems working in order to improve delivery. Members are:

- A Strategic Director representing Brent Council
- A Director of mental health services (the Independent ICP Director)
- A Director representing community health services
- A Director representing local acute services
- Clinical Chair of Brent area CCG

3.22 The ICPEC has set its priorities and established four further executive groups as follows:

- Health inequalities and vaccination
- Primary Care Network (PCN) development
- Community and intermediate health and care services
- Mental health and wellbeing

3.23 The executive groups oversee the integration of the health and care systems their area of focus, with the following aims:

- System recovery post Covid19
- To provide senior operational oversight over key programmes relating to joint programmes of work between the council and NHS partners
- To monitor the progress of key milestones and actions across joint programmes
- To oversee the allocation of resources for joint programmes, and advise when reallocation is required.
- To provide a key point of escalation for joint programmes, and escalate risks and issues to the IPCEC if required
- To assimilate and appraise proposed interventions for joint programmes
- To manage the brokerage of dependencies for joint programmes when escalated

Executive groups

3.24 The **health inequalities and vaccination executive** (HI&VE) will initially focus on the following priorities:

- Increasing the take up of vaccination and testing amongst BAME and disadvantaged communities
- Increasing engagement, utilisation and awareness of services in communities
- Reducing variation of impact from long term conditions between communities

3.25 The membership of the HI&VE is as follows:

- MC Patel (Co-Chair), Borough Clinical Lead
- Robyn Doran (Co-Chair), Independent ICP Director, CNWL
- Shazia Hussain, ACE, Brent Council
- Martin Kuper, Medical Director, LNWH
- Ralph Elias, Head of Planning, LNWUHT

- Melanie Smith, Director of Public Health, Brent Council
- Tom Shakespeare, Director of Integration, Brent Council
- Isha Coombes, Programme Director, NWL CCG
- Philippa Galligan, Director, CNWL
- Subash Jayakumar, GP
- Janet Lewis, Director of Operations, CLCH
- Judith Davey, Healthwatch

3.26 HI&VE meets monthly. Terms of reference (ToR) have been drafted and agreed.

3.27 The **PCN development executive** (PCNDE) has as its priorities the following:

- Supporting development and maturity of PCNs and empowering them to innovate and be proactive in delivering services to meet population health needs
- Ensuring variations in care are highlighted and addressed at the earliest opportunity with relevant infrastructure to improve health outcomes
- Support PCN leadership development
- Ensure resilience and self-sustainability of PCNs and PCN practices in delivering primary care services in line with national and local directives

3.28 The membership of the PCNDE is as follows:

- MC Patel (Co-Chair), Borough Clinical Lead
- Janet Lewis (Co-Chair), Director of Operations, CLCH
- Jonathan Turner, Borough Director, NWL CCG
- Fana Hussain, Assistant Director of Primary Care, NWL CCG
- Dr John Licorish, Public Health Lead, Brent Council
- Dr Sadiq Merali, clinical representative
- Dr Dhanusha Dhamarajah, clinical representative
- PCN managerial leads

3.29 PCNDE meets monthly. Terms of reference (ToR) have been drafted and agreed.

3.30 The **community and intermediate health and care services executive** (CIHCSE) is focused on the following priorities:

- Improving the coordination and alignment of community and intermediate health and care services
- Establish clear interface between PCNs, community services and council services, including addressing the challenges of cross border service provision in North West London
- Evaluate impact of Covid19 on community health and intermediate care services, and establish joint programme of work to improve services and pathways in response
- Establish and embed a core minimum standard and offer to care homes, including sufficient care home capacity and infrastructure

3.31 The membership of the CIHCSE is as follows:

- Janet Lewis, Director of Operations, CLCH (Co-Chair)
- Simon Crawford, LNWHUT (Co-Chair)
- Isha Coombes, Programme Director, NWL CCG
- Jonathan Turner, Borough Director, NWL CCG
- Gill Vickers, Interim Director Adult Social Care, Brent Council
- Tom Shakespeare, Director of Integration, Brent Council
- Marie McLoughlin, Public Health Lead, Brent Council
- Basu Lamichhane, Chair of Care Homes Forum
- Dr Dhanusha Dharmarajah, PCN Director, Brent
- Jo Kay, Healthwatch

3.32 CIHCSE meets monthly. Terms of reference (ToR) have been drafted and agreed.

3.33 The **mental health and wellbeing executive** (MHWE) current priorities are:

- Increase engagement, utilisation and awareness of mental health support services in communities
- Reduce variation in mental health care and support for the local Brent communities
- Support people with mental illness to access employment opportunities
- Ensure housing and accommodation provision is accessible and reflects identified needs locally
- CYP/Transitions – ensure the additional needs and identified gaps as a direct result of the pandemic are addressed and aligned to the Children's Trust Board priorities
- Align identified areas of mental health inequalities from this work stream to HI&VE

3.34 The membership of the MHWE is as follows:

- Robyn Doran (Co-Chair), Independent ICP Director, CNWL
- Phil Porter (Co-Chair), Strategic Director Community and Wellbeing, Brent Council
- Sarah Nyandoro, NWL CCG
- Philippa Galligan, Director, CNWL
- Dr Nigel De Kare-Silver
- Dr Mohammad Haidar
- Danny Maher, VCS representative
- Marie McLoughlin, Public Health, Brent Council
- Brian Grady, Children and Young People, Brent Council
- Ala Uddin, Employment Lead, Brent Council

3.35 The MHWE meets monthly. Terms of reference (ToR) have been drafted and agreed.

3.36 The health and care transformation team are responsible for programme management support to the executives. All groups have agreed to review their ToRs at six monthly intervals to ensure they remain relevant and up to date.

3.37 The ICPEC executive groups have a clear focus on adults, with some focus on transitional arrangements. This recognises the successful Brent Children's Trust (BCT) in place, and links have been made across the work programmes of the ICPEC and the BCT (the Independent Director of the ICPEC attends the BCT to provide system accountability) and whole system oversight is considered by the ICP Board. The BCT may require change to ensure collaboration as may be prescribed in the emerging legislation. Details of the ICP Board are covered in a subsequent section.

3.38 Healthwatch provide key input at the executive group level as representatives of patient and community voices. Healthwatch is not involved in the ICPEC or ICP Board in order to preserve their independence and ability to provide challenge and scrutiny at the BHWB, of which they are a statutory member. Should statutory duties change in the new health and care legislation, the role of Healthwatch can be reviewed.

3.39 An example of successful systems working undertaken by the ICPEC executive groups is detailed in Appendix 3.

<u>The Integrated Care Partnership Board (ICPB)</u>

3.40 The **ICP Board** (formerly known as the Septet) meets to ensure progress of the ICPEC, and membership includes the ICPEC members plus the:

- Chair of the Brent Health and Wellbeing Board (BHWB) (voting member of BHWB)
- Lead Member for Public Health, Culture and Leisure (voting member of BHWB)

- Chief Executive of Brent Council (non-voting member of BHWB)
- Strategic Director for Children and Young People, Brent Council (non-voting member of BHWB)

Community and Wellbeing Scrutiny Committee

3.41 The BHWB ensures systems working, accountability and delivery. It does not diminish the role of the Community and Wellbeing Scrutiny Committee (C&WSC). Indeed the revisions should enable scrutiny increased system oversight as roles and responsibilities across the system will be clarified and coherent.

Strategic partnerships

3.42 The changes in health and care legislation will affect other strategic partnerships. The CCG is named explicitly in the Care Act 2014, the Children and Social Work Act 2017 and Working Together to Safeguard Children 2018 statutory guidance as a strategic partner for safeguarding children and adults (with equal responsibility to local authorities and the police). A letter sent from Ministers for child safeguarding in late June 2021 indicates that current CCG responsibilities will pass to the ICS Chief Executives.

3.43 Early conversations are happening and the ICPEC will consider responsibilities across the strategic partnerships – the Brent Safeguarding Adults Board (BSAB), the Brent Safeguarding Children Partnership (BSCP) and the Brent Community Safety Partnership (BCSP). This will then enable joint decisions with the strategic partnerships moving forward to ensure statutory duties are meaningfully discharged.

3.44 The ICP Independent Director and the ICPEC will ensure that there is appropriate representation from the ICP providers at the BSAB, and the ICP Independent Director has agreed to join the BSAB Executive. The NWL ICS is represented at the BSAB through the Safeguarding Adults leads. The BSAB has sought assurance that not only will ICS and ICP be represented at the BSAB, but also that adult safeguarding issues are on the agenda at the ICPEC, ICPB and the NWL ICS.

4.0 Financial Implications

4.1 There are no financial implications within this report.

5.0 Legal Implications

5.1 Health and Wellbeing Boards (HWBs) were formed under the Health and Social Care Act 2012. Their original purpose was to improve the health and wellbeing of the local population by providing a forum for health leaders (including those from NHS, local government and public health) to come together and agree health priorities and actions for the area. HWBs have a statutory duty to work alongside the Clinical Commissioning Group (CCG) to produce a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS) for the local population.

5.2 More recently there has been a growing movement towards more integrated care. The Department of Health and Social Care (DHSC) published the legislative proposals (White Paper) for a Health and Care Bill in February 2021. The proposals in the White Paper were a combination of: Proposals developed by NHS England (NHSE) to support the implementation of the NHS Long Term Plan. They form the main essence of the document as the NHS England/ Improvement engagement paper ‘Integrating Care’ proposes significant changes for both regional ‘Integrated Care Systems’ (ICS) and local place based partnerships for health and care ‘Integrated Care Partnerships’

(ICP). The central theme in the NHS's Long Term Plan is the importance of joint working with colleagues in local government and elsewhere, on the basis that neither the NHS nor local government can address all the challenges facing whole population health on their own. Additional proposals in the white paper relate to public health, social care, and quality and safety matters, which are dependent on legislative change.

5.3 A number of policy changes requiring action are set out with a timetable, which includes key milestones at April 2021 (shadow arrangements) and April 2022 (implementation).

5.4 As the proposals and governance structures develop and legislative changes are implemented, guidance from legal services will be sought.

6.0 Equality Implications

6.1 Health and Wellbeing Boards must also meet the Public Sector Equality Duty under the Equality Act 2010. S149 of the Equality Act 2019 provides that the Health and Wellbeing Board must, in the exercise of its functions, have due regard to the need to:

a) Eliminate discrimination, harassment and victimisation
b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

6.2 The Public Sector Equality Duty covers the following nine protected characteristics: age, disability, marriage and civil partnership, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

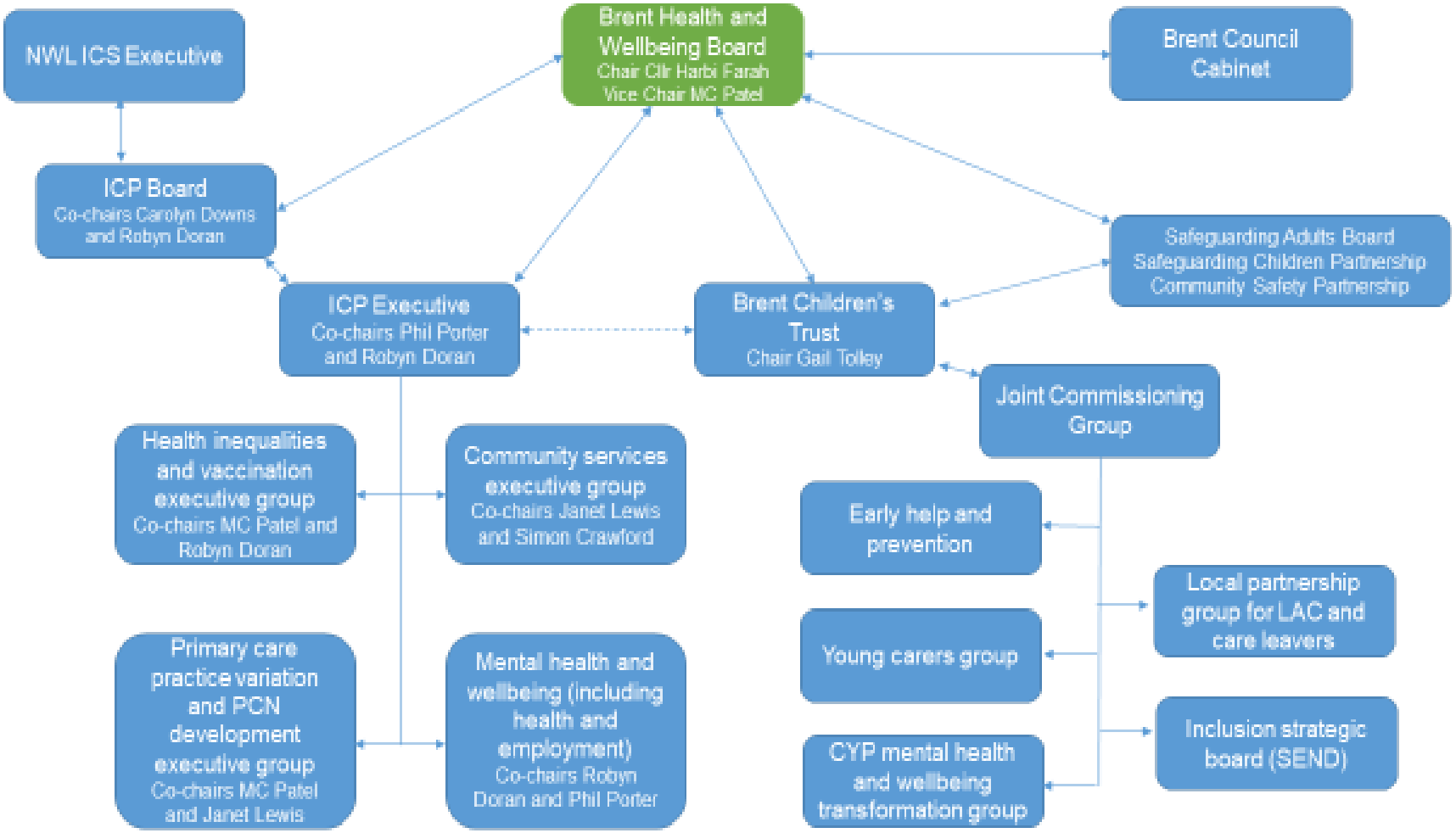
6.3 The Statutory Guidance states "*this is not just about how the community is involved but includes consideration of the experiences and the needs of people with relevant protected equality characteristics (as well as considering other groups identified as vulnerable in JSNAs) and the effects decisions have, or are likely to have on their health and wellbeing*".

Report sign off:

Phil Porter
Strategic Director, Community and Wellbeing

Appendix 1

Current governance structure 2021/22



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Appendix 2

Brent Health and Wellbeing Board - Draft Forward Plan 2021/22

Date of meeting	Item	Detail	Report author	Report sign off	Report requests made	Submission deadline	Governance deadline
14 July 2021	BHWB governance structure 2021/22	Governance refresh post 202/21 changes, ICPEC, ICPB update	Angela d'Urso / Tom Shakespeare	Phil Porter	04 June 2021	01 July 2021	02 July 2021
	Vaccination programme update	To note progress in the vaccination programme and any related surge planning activity	Jonathan Turner		04 June 2021	01 July 2021	02 July 2021
	BHM update	General update, with proposal to move six monthly BHWB updates	Tom Shakespeare	Phil Porter	04 June 2021	01 July 2021	02 July 2021
	Healthwatch work plan approval	To approve the new Healthwatch work plan for 2021/22	Julia Mlambo	Shazia Hussain	04 June 2021	01 July 2021	02 July 2021
	JHWS / JSNA update	To provide a progress update of activity to date	Angela d'Urso	Melanie Smith / Phil Porter	04 June 2021	01 July 2021	02 July 2021
19 October 2021	Joint Health and Wellbeing Strategy and JSNA	To approve draft strategy	Angela d'Urso	Melanie Smith / Phil Porter	06 September 2021	07 October 2021	08 October 2021
	ICP update (focus on mental health work stream)	Update, with focus on priority area identified	Tom Shakespeare	Phil Porter	06 September 2021	07 October 2021	08 October 2021
	BCT update	Six monthly update	Wendy Proctor	Gail Tolley	06 September 2021	07 October 2021	08 October 2021
	Safeguarding adults partnership update	Annual update, including priorities of safeguarding partnership	Daniel Morris	Phil Porter	06 September 2021	07 October 2021	08 October 2021
13 January 2022	Joint Health and Wellbeing Strategy delivery plan and PMF	To agree the delivery plan, PMF and any related amendments to governance structures	Angela d'Urso	Melanie Smith / Phil Porter	22 November 2021	23 December 2021	30 December 2021
	ICP update (focus on PCN improvement work stream)	Update, with focus on priority area identified	Tom Shakespeare	Phil Porter	22 November 2021	23 December 2021	30 December 2021
	Report from the C&W Scrutiny Committee task group on GP access	To note findings from the task group	James Diamond	Shazia Hussain	22 November 2021	23 December 2021	30 December 2021
	Health visitor commissioning - progress update	To note the outcomes of the recommissioning and new services and pathways	Gill Vickers	Phil Porter	22 November 2021	23 December 2021	30 December 2021
	BHM update	Six monthly update	Tom Shakespeare	Phil Porter	22 November 2021	23 December 2021	30 December 2021
	Healthwatch work plan progress update	Six monthly update	Julia Mlambo	Shazia Hussain	22 November 2021	23 December 2021	30 December 2021
16 March 2022	JHWS delivery plan progress update	Regular performance item to monitor delivery against JHWS	Angela d'Urso	Melanie Smith / Phil Porter	31 January 2022	03 March 2022	04 March 2022
	BCT update	Six monthly update and priorities 2022/23	Wendy Proctor	Gail Tolley	31 January 2022	03 March 2022	04 March 2022
	ICP update (focus on community and intermediate health and care services)	Update, with focus on priority area identified and priorities 2022/23	Tom Shakespeare	Phil Porter	31 January 2022	03 March 2022	04 March 2022

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Appendix 3

Health inequalities and diabetes

1.1 As referenced above, the CCG and the council are doing more joint work together, and one example of this is around health inequalities and diabetes. An Executive Group, sitting under the ICP Executive Committee has been set up specifically to address these health inequalities as part of a holistic approach, with a focus on the social determinants of health. Brent has a high prevalence of diabetes, which is due to a number of factors; including deprivation, obesity rates and a high number of people with south Asian heritage, (we know that people with this heritage are more susceptible to diabetes than other populations).

1.2 NWL CCG has developed dashboards with information about performance of different practices and Primary Care Networks across a range of metrics including the 3 treatment targets (optimal HbA1c, blood pressure and cholesterol) and the 9 care processes (which include carrying out regular checks on aspects such as BMI and retinal screening, amongst others).

1.3 The medical aspects of treating diabetes is only a small component affecting service user outcomes. Type 2 diabetes is largely a disease that can be prevented or controlled through lifestyle interventions, and so a diabetes check with a GP may involve titrating medications. This, however, will not on its own address the other lifestyle associated factors, which in turn are affected by the person's environment, such as housing, access to healthy foods, hours of work, opportunities for exercise etc.

1.4 It is therefore key that health and social care work together in partnership with our communities and the voluntary sector to help people to make the changes that they need, to either maintain a healthy outlook and prevent the disease entirely, or to prevent it from deteriorating further.

1.5 We have recently set up a work stream under the ICP Executive Group to look at health inequalities and diabetes, and we need to work with social prescribers and with our Health Champions to encourage people to make healthy choices, including diet, exercise, cooking and recreational opportunities.

1.6 As well as self-care and promotion of healthy lifestyles, it is important that we optimise the medical care that we can offer, and make it as accessible as possible.

1.7 North West London CCG has recently launched a standardised diabetes enhanced service, and has levelled up funding across the patch to ensure that those historically underfunded areas (including Brent) received additional investment to provide better care. This has meant that Brent has received an additional £1.9 million for investment into primary diabetes care.

1.8 The enhanced services is intended to enable improvements in diabetic care across the population of patients with diabetes by:

(a) Up-skilling and increasing the resource into the primary care workforce through supported diabetes education
(b) Reducing variations in diabetes care and outcomes across network populations
(c) Enabling better self-management of diabetes through care planning

1.9 As part of the service specification, GPs will need to:

- Deliver measurable improvements in clinical quality
- Enhance patient satisfaction with the care and support they receive

- Support the implementation of a clear clinical management pathway for diabetes
- Reduce the number of patients needing to have routine follow up appointments in secondary care
- Set up group consultations at Primary Care Network level

1.10 The CCG is setting up a dashboard to monitor diabetes outcomes and the primary care team will work closely with the PCNs to monitor the outcomes and to share best practice to enable more practices to reach the best standards. These standards are also being looked into at NWL level when the primary care System Oversight Meeting (SOM) is held. This means that Brent GPs need to attend an NWL level meeting and hold accountability for explaining what action is being taken to reduce any unwarranted variation in diabetes care.

1.11 In addition to the enhanced service, there are also new specifications for non-diabetic hyperglycaemia (which means that your blood sugar level is getting too high even though you do not (yet) have diabetes). It can be a sign of pre-diabetes, and indicates a stage at which lifestyle interventions should be undertaken to prevent the onset of diabetes.

1.12 For people already diagnosed with diabetes, some may be suitable for the REWIND programme. This stands for Reducing Weight with Intensive Dietary Support. As part of this programme all anti-hypertensive, diuretic and anti-diabetes drugs are stopped and Total Diet replacement is commenced. In basic terms, the programme consists of a low calorie, low carbohydrate diet that promotes weight loss and promotes natural control of blood sugar and reduces insulin resistance. The programme is not suitable and does not work for all patients, but is supported by trial evidence and can work for a number of patients. This programme has been launched in Brent and GP practices are identifying suitable patients to come forward for the programme.

1.13 In addition to general practice, there is also a community-based service called Brent Integrated Diabetes Service (BIDS). This provides an enhanced level of care, and allows general practice to access more specialised expertise in a community setting, such as diabetes specialist nurses, counselling psychologists and consultant diabetologist/ endocrinologist advice. The service aims to bridge the gap between primary and hospital care, and to upskill the level of knowledge on diabetes management within primary care.

1.14 The diabetes work stream will need to optimise the care pathways between primary care, the BIDS service and specialist hospital care, as well as pathways into preventative services or voluntary sector organisations that focus on prevention and lifestyle changes.

Brent vaccination performance

Health and Wellbeing Board

Contents

Introduction

- Health and social care partners have been working together now for some months on the Brent vaccination programme.
- The approach has now matured, and the partners have built up strong working relationships
- There is a programme meeting every Wednesday morning involving social care, public health, community services, the PCN Directors, and the ICP Director and ICP Co-Chairs to identify resourcing issues and further steps that we can take to enhance the programme
- The vaccination programme is now reaching the end of its cycle as we move to vaccinate the 18+ group, whilst continuing to improve performance against the higher risk cohorts 1-9.
- This week, a cycle of booster vaccinations was announced for the Autumn, which will be confirmed by NHSE at a later stage.

Highlights – areas of focus

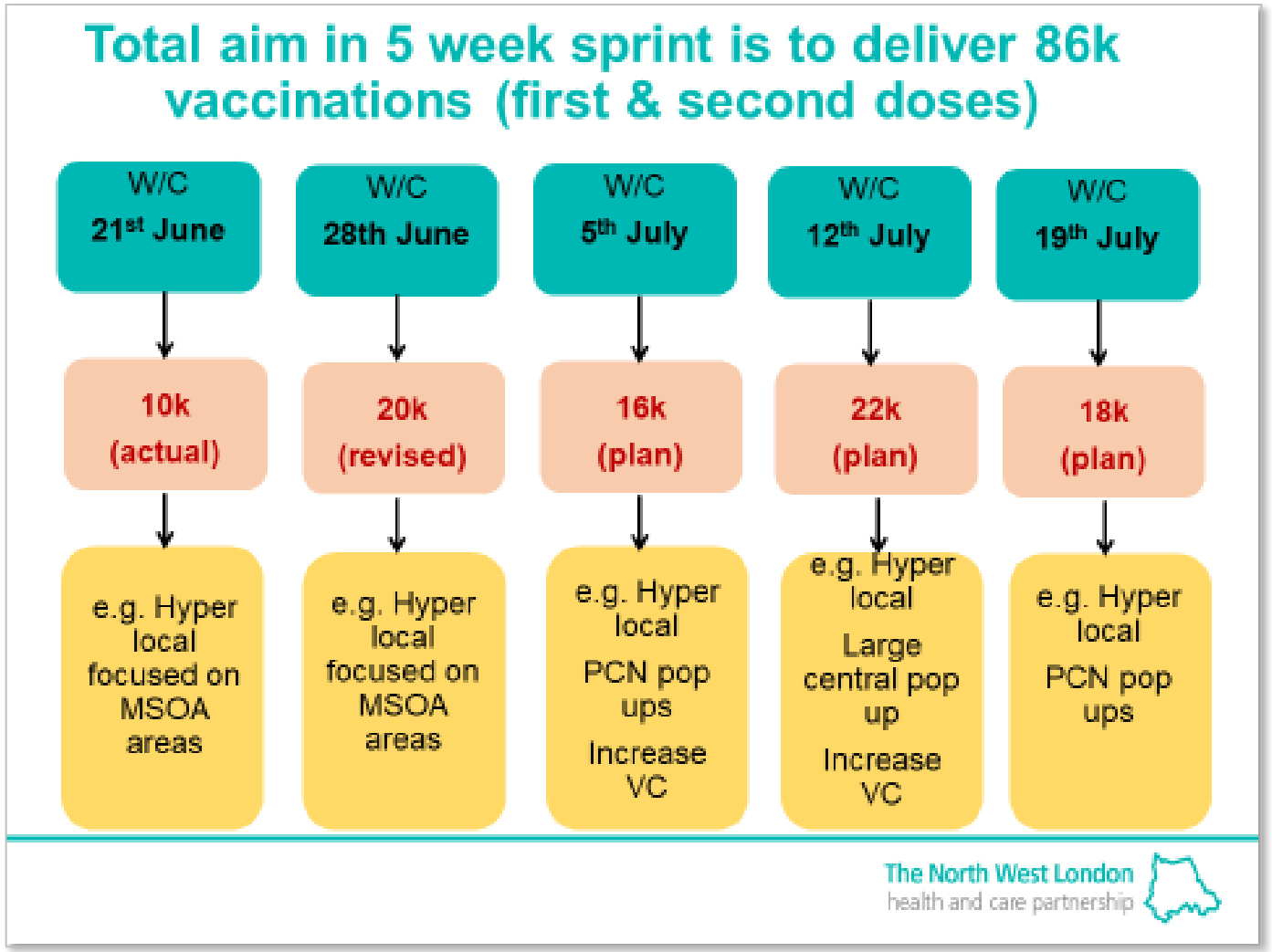
- Meeting with NWL team on 29/06/21 held re assurance of vaccine numbers. This week we need to deliver 2,430 first doses and 6,280 second doses to hit the targets. However from the w/c 5th July we need to deliver 6,570 first doses and it then stays at this level for the remaining 4 weeks
- From w/c 05/07/21 the targets for first vaccinations steps up significantly. We are mapping what workforce we need and where the gaps are to increase the flow.
- Communications and leaflet drops from council have increased, which are successfully driving up the number of walk-ins to Brent LVS clinics.
- We are likely to hit this week's plan but for next week securing enough vaccinators and administrators is challenging
- NWL team is doing a piece of work to reconcile the denominator issues –i.e. difference between ONS and registered list size etc. Estimate of how many people have left the borough yet remain registered.
- Community engagement meeting with Shazia Hussain was held 30/06/21 to focus on more proactive and better planned communication with communities
- Pop-ups continue in MSOA areas that are behind.
- We need to focus on securing additional vaccinators/ data entry people for future clinics, with an emphasis on the south of the borough. Potential future "Bridge Park" style events at weekends to increase the pace of vaccination and hit the challenging targets we have been set for the "re-opening" deadline.

Current performance

Cohort	24/04/21	13/05/21	23/05/21	15/06/21	24/06/21	Change 15/06/21-24/06/21
Care home resident	84.6%	85.6%	85.6%	86.7%	87.1%	+0.4pp
Age 80+yrs	83.6%	83.8%	84.1%	84.5%	84.6%	+0.1pp
Age 75-79yrs	82.5%	83.1%	83.5%	83.8%	84.0%	+0.2pp
Age 70-74yrs	81.4%	82.1%	82.5%	82.9%	83.2%	+0.3pp
CEV	75.0%	75.9%	76.4%	77.5%	78.0%	+0.5pp
SMI (age 16-64)	-	-	53.8%	60.3%	61.1%	+0.8pp
MH patients	-	-	-	64.3%	65.0%	+0.7pp
LD	-	-	-	72.5%	72.9%	+0.4pp

- The recent focus on second dose vaccinations, coupled with publicity around the AZ vaccine has slowed the pace of first dose vaccinations. Patients' requests for Pfizer vaccinations have increased since the publicity around AZ vaccines. NW London team were able to secure additional Pfizer vaccines in view of the surge in the Delta variant in five of the eight NW London Boroughs. The uptake in the table above reflects the recent increase in Pfizer vaccine availability.
- Outreach work through community-based vaccination clinics and the Covid bus have continued to increase uptake in the harder-to-reach communities and in 'at risk' populations, who are reluctant to attend large vaccine sites.
- Local Vaccination Sites (LVS) have stepped up clinic capacity and offer vaccinations on six days out of seven. Along with the mass vaccination sites the capacity in Brent has increased to over 20,000 appointments per week. The introduction of our first community pharmacy, Optipharm in Wembley from 11th June 2021 enables patients to access walk-in vaccine appointments on the high street.
- The Brent borough have been requested to deliver 86,000 doses in the period from 21st June to 25th July, the challenges for second dose AZ vaccinations remains a challenge. Plans are being stepped up to increase vaccination rates per week. The breakdown of vaccinations per week is set out overleaf. Any under-performance in a week will be rolled over into the next week.

Weekly vaccination sprint targets



Health inequalities – ethnicity

	Not Recorded	African	Any other Asian background	Any other Black background	Any other ethnic group	Any other mixed background	Any other White background	Bangladeshi	British	Caribbean	Chinese	Indian	Irish	Not stated	Pakistani	White and Asian	White and Black African	White and Black Caribbean	Grand Total
NHS BRENT CCG	55.7%	64.3%	84.1%	56.9%	69.8%	69.5%	64.8%	88.8%	84.9%	56.9%	76.1%	89.6%	84.2%	61.1%	79.7%	76.9%	64.3%	57.4%	74.3%
NHS CENTRAL LONDON (WESTMINSTER) CCG	55.3%	62.0%	72.3%	57.3%	66.3%	68.6%	67.3%	86.6%	84.4%	62.0%	62.7%	73.1%	78.8%	61.4%	61.3%	75.5%	64.8%	63.9%	70.5%
NHS EALING CCG	71.3%	65.1%	83.3%	62.0%	73.1%	72.4%	72.0%	87.6%	90.0%	61.8%	77.8%	87.0%	86.8%	63.2%	77.1%	83.7%	67.3%	65.3%	79.0%
NHS HAMMERSMITH AND FULHAM CCG	63.3%	61.7%	76.6%	54.7%	69.9%	63.1%	66.7%	77.8%	85.7%	54.1%	69.1%	82.5%	82.5%	70.5%	67.9%	75.5%	61.8%	54.4%	73.4%
NHS HARROW CCG	70.2%	67.4%	88.1%	64.2%	75.9%	77.3%	74.2%	87.4%	92.4%	65.0%	80.8%	91.8%	87.2%	73.4%	82.2%	82.3%	65.6%	67.0%	84.2%
NHS HILLINGDON CCG	67.7%	67.7%	86.3%	67.7%	77.2%	80.2%	78.2%	88.5%	93.1%	66.9%	77.8%	89.0%	89.1%	85.4%	80.3%	84.7%	62.5%	69.4%	85.5%
NHS HOUNSLOW CCG	78.0%	67.4%	84.1%	65.5%	75.1%	75.3%	73.7%	87.0%	91.0%	67.4%	79.2%	86.7%	86.4%	76.4%	81.6%	85.0%	74.6%	69.9%	82.4%
NHS WEST LONDON CCG	54.6%	65.2%	76.1%	57.5%	65.0%	68.9%	65.0%	82.8%	83.6%	58.6%	65.0%	76.6%	80.5%	61.1%	66.4%	72.9%	61.3%	60.1%	69.4%
NWL	**65.2%**	**64.9%**	**83.3%**	**60.0%**	**70.2%**	**71.4%**	**69.6%**	**86.1%**	**88.9%**	**59.6%**	**72.4%**	**88.3%**	**84.9%**	**68.8%**	**78.3%**	**79.5%**	**65.1%**	**62.0%**	**77.8%**

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Highest vaccine uptake across NW London is observed in the British (88.9%), Indian (88.3%), Bangladeshi (86.1%) and Irish (84.9%) populations.

Key (Relative RAG rate)

Lowest uptake rate within JCVI cohort

Highest uptake rate within JCVI cohort

Source WSIC Cumulative until 26th June 2021. The denominator is the total of JCVI Cohorts 1-9.

Brent health inequalities – ethnicity

JCVI/Ethnicity	Not Recorded	African	Any other Asian background	Any other Black background	Any other ethnic group	Any other mixed background	Any other White background	Bangladeshi	British	Caribbean	Chinese	Indian	Irish	Not stated	Pakistani	White and Asian	White and Black African	White and Black Caribbean	Grand Total
Care Home Resident	92.1%	81.7%	87.5%	70.8%	84.0%	61.5%	85.6%	100.0%	90.0%	76.4%	100.0%	94.5%	92.5%	100.0%	89.8%	100.0%	66.7%	84.2%	87.1%
Age 80+	73.0%	66.4%	84.8%	68.6%	75.8%	78.6%	88.3%	90.0%	94.1%	72.1%	81.4%	92.5%	91.9%	61.2%	87.1%	85.7%	73.2%	70.1%	84.6%
Age 75-79	69.8%	66.8%	86.3%	69.7%	74.3%	76.0%	81.5%	90.0%	91.2%	73.4%	83.7%	92.3%	89.5%	75.0%	87.3%	85.0%	71.4%	71.8%	84.0%
70-74 inc CEV	64.3%	70.2%	87.6%	60.5%	76.0%	79.2%	74.8%	95.8%	89.1%	59.5%	81.2%	93.8%	87.3%	70.6%	85.5%	83.8%	76.5%	59.3%	80.8%
Age 65-69	59.5%	69.1%	88.4%	63.8%	72.7%	81.1%	66.1%	87.8%	87.9%	61.8%	80.0%	92.0%	86.5%	76.4%	80.5%	75.5%	65.6%	64.0%	79.7%
16-64 inc Qcovid	53.9%	62.6%	84.8%	51.6%	69.0%	61.6%	62.0%	86.2%	76.2%	48.0%	71.8%	89.9%	78.3%	55.5%	75.5%	75.2%	60.3%	47.8%	70.8%
Age 60-64	52.7%	64.8%	82.6%	57.8%	69.2%	68.3%	61.9%	100.0%	85.8%	51.8%	73.7%	87.3%	81.7%	65.3%	80.1%	80.0%	63.5%	57.3%	72.8%
Age 55-59	47.6%	62.5%	81.5%	56.9%	67.6%	65.4%	60.9%	84.8%	83.7%	52.3%	71.8%	85.9%	78.5%	61.3%	79.4%	75.3%	60.0%	55.4%	69.7%
Age 50-54	46.7%	59.5%	79.0%	57.1%	65.7%	68.2%	55.3%	84.6%	79.1%	45.2%	70.9%	82.5%	70.5%	50.5%	76.0%	68.1%	61.6%	52.3%	65.5%
Grand Total	**55.7%**	**64.3%**	**84.1%**	**56.9%**	**69.8%**	**69.5%**	**64.8%**	**88.8%**	**84.9%**	**56.9%**	**76.1%**	**89.6%**	**84.2%**	**61.1%**	**79.7%**	**76.9%**	**64.3%**	**57.4%**	**74.3%**

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Highest vaccine uptake across Brent is observed in the Indian (89.6%), Bangladeshi (88.9%), British (84.9%) and Irish (84.2%) populations.

Key (Relative RAG rate)

Lowest uptake rate within JCVI cohort

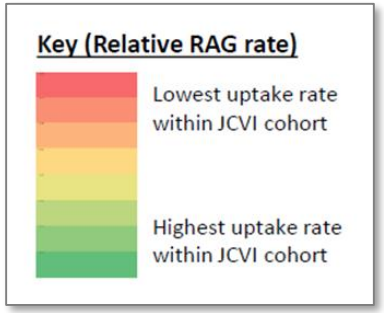
Highest uptake rate within JCVI cohort

Source WSIC Cumulative until 26th June 2021. The denominator is the total of JCVI Cohorts 1-9

Health inequalities – deprivation

	Most Deprived									Least Deprived		
	1	2	3	4	5	6	7	8	9	10	NULL	Grand Total
NHS BRENT CCG	65.0%	67.3%	70.7%	75.4%	77.6%	79.6%	79.3%	85.1%	75.6%	79.9%	60.7%	74.3%
NHS CENTRAL LONDON (WESTMINSTER) CCG	72.3%	72.1%	71.4%	70.7%	70.0%	69.1%	68.1%	70.0%	70.4%	74.7%	53.8%	70.5%
NHS EALING CCG	73.6%	75.8%	78.1%	77.8%	78.8%	80.5%	81.0%	83.1%	85.3%	82.0%	73.6%	79.0%
NHS HAMMERSMITH AND FULHAM CCG	69.1%	69.1%	71.5%	72.1%	73.3%	74.9%	76.4%	78.3%	81.0%	79.9%	54.1%	73.4%
NHS HARROW CCG	68.2%	80.7%	78.0%	78.9%	79.9%	83.2%	84.4%	86.8%	89.4%	92.5%	60.0%	84.2%
NHS HILLINGDON CCG	56.3%	81.2%	80.8%	82.5%	83.5%	86.3%	88.7%	85.9%	89.8%	90.8%	65.4%	85.5%
NHS HOUNSLOW CCG	75.9%	80.6%	80.2%	81.5%	81.9%	83.5%	84.0%	86.2%	85.3%	86.3%	78.1%	82.4%
NHS WEST LONDON CCG	71.4%	69.8%	70.0%	68.5%	68.9%	71.0%	68.3%	69.0%	68.8%	66.4%	61.7%	69.4%
NWL	**69.2%**	**72.4%**	**75.3%**	**76.9%**	**77.8%**	**79.6%**	**80.0%**	**79.5%**	**84.0%**	**88.4%**	**66.2%**	**77.8%**

- Vaccine uptake in the most deprived population groups in NW London (69.2%) is around 19% lower than the least deprived population groups (88.4%).
- This is consistent with the current position in Brent, albeit the gap is between deciles 1-8 (20% difference, 65.0% - 85.1%).



Source WSIC Cumulative until 26th June 2021. The denominator is the total of JCVI Cohorts 1-9

Brent health inequalities – deprivation

	Most Deprived								Least Deprived			
	1	2	3	4	5	6	7	8	9	10	NULL	Grand Total
Care Home Resident	75.4%	88.5%	88.1%	86.0%	85.7%	89.7%	90.0%	91.4%	100.0%	0.0%	100.0%	**87.1%**
Age 80+	72.7%	76.5%	81.6%	84.8%	87.9%	88.4%	90.6%	91.2%	86.7%	94.1%	100.0%	**84.6%**
Age 75-79	75.4%	77.2%	82.1%	84.3%	85.8%	87.5%	86.9%	92.7%	68.0%	100.0%	0.0%	**84.0%**
70-74 inc CEV	72.5%	74.6%	78.7%	81.3%	84.2%	85.3%	83.5%	86.9%	79.2%	88.9%	66.7%	**80.8%**
Age 65-69	69.2%	71.9%	75.2%	82.6%	82.7%	82.8%	82.5%	88.3%	79.5%	83.3%	85.7%	**79.7%**
16-64 inc Qcovid	61.0%	62.7%	67.4%	73.1%	75.2%	78.6%	77.3%	82.2%	77.4%	78.4%	58.8%	**70.8%**
Age 60-64	64.1%	63.9%	69.8%	73.5%	75.7%	77.5%	76.5%	85.7%	77.3%	90.0%	80.0%	**72.8%**
Age 55-59	61.5%	64.7%	65.7%	70.9%	72.6%	74.7%	73.2%	82.1%	64.2%	69.2%	40.0%	**69.7%**
Age 50-54	60.6%	61.3%	62.2%	66.0%	67.7%	69.4%	71.2%	75.2%	74.7%	69.2%	42.9%	**65.5%**
Total	**65.0%**	**67.3%**	**70.7%**	**75.4%**	**77.6%**	**79.6%**	**79.3%**	**85.1%**	**75.6%**	**79.9%**	**60.7%**	**74.3%**

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By JCVI Priority Cohort 1 to 9 and deprivation (measured at MSOA of residence and expressed as 10 deciles).

Key (Relative RAG rate)

Lowest uptake rate within JCVI cohort

Highest uptake rate within JCVI cohort

Source WSIC Cumulative until 26th June 2021. The denominator is the total of JCVI Cohorts 1-9

Brent health inequalities – PCN

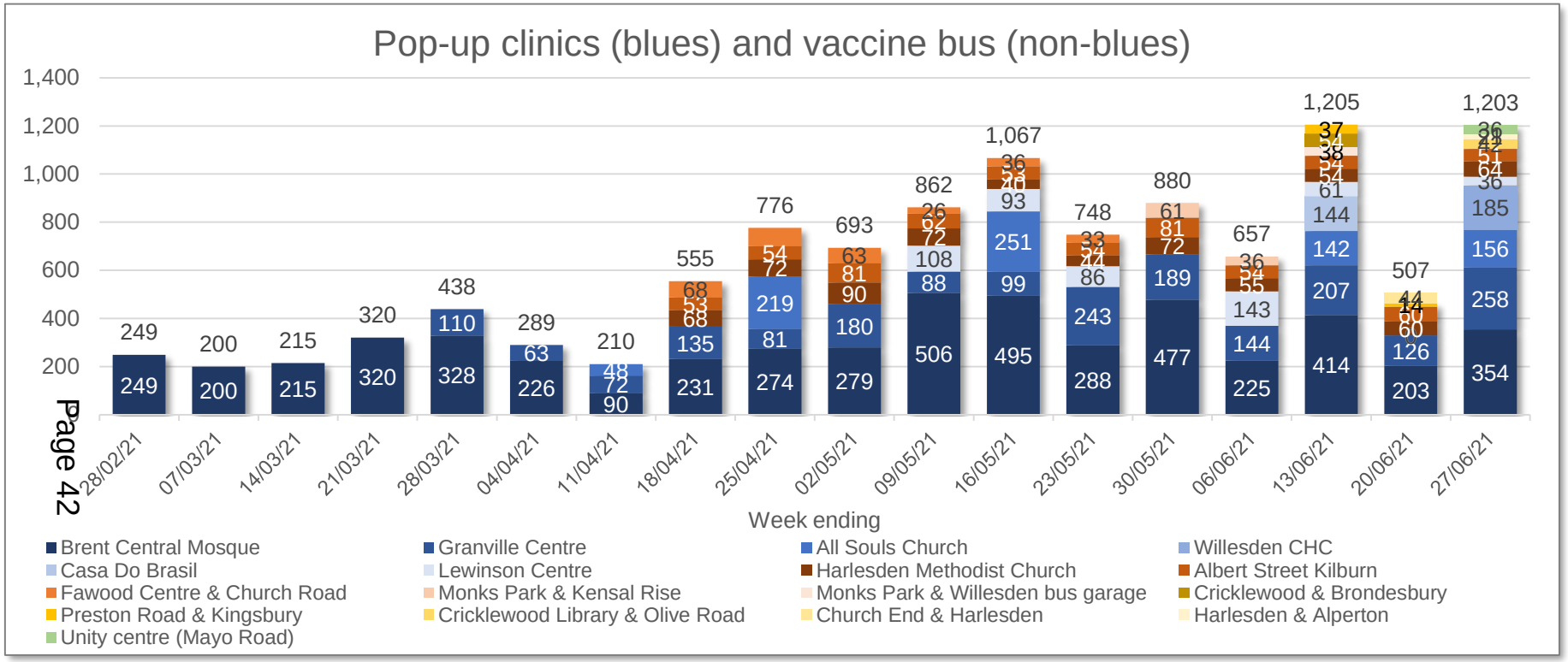
JCVI/PCN	Harness North	Harness South	K&W Central	K&W North	K&W South	K&W West	Kilburn Partnership
Care Home Resident	90.4%	82.4%	88.1%	90.7%	86.2%	78.8%	85.2%
Age 80+	88.5%	79.2%	87.6%	89.0%	80.7%	86.6%	81.3%
Age 75-79	89.5%	78.9%	86.6%	88.2%	78.4%	86.8%	80.2%
70-74 inc CEV	86.4%	77.1%	80.9%	85.5%	76.6%	83.7%	77.6%
Age 65-69	84.2%	75.2%	82.1%	82.9%	78.1%	81.4%	73.9%
16-64 at Risk inc Qcovid	78.5%	64.8%	70.0%	73.5%	65.8%	77.9%	66.4%
Age 60-64	77.8%	68.3%	73.2%	76.8%	73.2%	74.0%	67.0%
Age 55-59	75.8%	65.7%	72.9%	70.5%	69.7%	69.2%	65.7%
Age 50-54	69.9%	63.8%	65.5%	64.0%	68.1%	65.7%	61.0%
Grand Total	**80.0%**	69.6%	75.8%	77.8%	71.9%	75.9%	70.0%

Source WSIC Cumulative until 26th June 2021. The denominator is the total of JCVI Cohorts 1-9

RAG

- <75%
- Between 75% and 80%
- > 80%

Pop-up community clinics



Total vaccinations given:

11,074

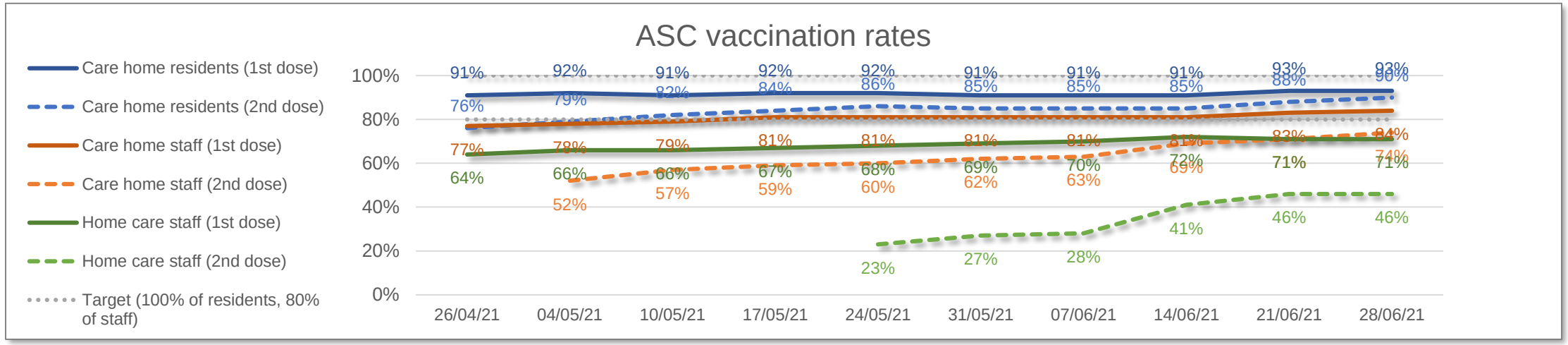
As at 27/06/21

Vaccine site	Site type	Doses
Brent Central Mosque	Pop-up	5,374
Granville Community Centre	Pop-up	1,995
All Souls Church	Pop-up	816
Willesden CHC	Pop-up	185
Casa Do Brasil	Pop-up	144
Lewinson Centre	Pop-up	527
Harlesden Methodist Church	Bus	691
Albert Street Kilburn	Bus	657
Fawood Centre & Church Road	Bus	302
Monks Park & Kensal Rise	Bus	97
Monks Park & Willesden bus garage	Bus	38
Cricklewood & Brondesbury	Bus	54
Preston Road & Kingsbury	Bus	51
Cricklewood Library & Olive Road	Bus	42
Church End & Harlesden	Bus	44
Harlesden & Alperton	Bus	21
Unity centre (Mayo Road)	Bus	36
Total		**11,074**

		Numbers on Foundry to 26/06/2021				Numbers on Foundry to 27/06/2021			
ICS	Site Name	Total cumulative Vaccinations 26/06/2021	Vaccinated 26/06/2021	Uploaded 26/06/2021	Backlog entered 26/06/2021	Total cumulative Vaccinations 27/06/2021	Vaccinated 27/06/2021	Uploaded 27/06/2021	Backlog entered 27/06/2021
NWL Brent	Park Royal Medical Practice	65,486	825	901	76	65,487	0	1	1
	Wembley Centre for Health and Care	33,928	110	112	2	33,928	0	0	0
	Willesden Centre for Health & Care	22,090	96	132	36	22,175	85	85	0
	Swaminarayan School - Neasden Temple	52,789	436	437	1	52,789	0	0	0
	Kingsbury Mandir	40,830	0	0	0	40,830	0	0	0

Adult social care

Cohort	Target	26/4/21	4/5/21	10/5/21	17/5/21	24/5/21	31/5/21	7/6/21	14/6/21	21/6/21	28/6/21	Change
Care home residents (1st dose)	100%	91%	92%	91%	92%	92%	91%	91%	91%	93%	93%	=
Care home residents (2nd dose)	100%	76%	79%	82%	84%	86%	85%	85%	85%	88%	90%	+2pp
Care home staff (1st dose)	80%	77%	78%	79%	81%	81%	81%	81%	81%	83%	84%	+1pp
Care home staff (2nd dose)	80%	-	52%	57%	59%	60%	62%	63%	69%	71%	74%	+3pp
Home care staff (1st dose)	80%	64%	66%	66%	67%	68%	69%	70%	72%	71%	71%	=
Home care staff (2nd dose)	80%	-	-	-	-	23%	27%	28%	41%	46%	46%	=



- Aligned to wider targets there are 4 specific targets that ASC are working to jointly with Health and social care providers through the local care provider forums (care homes, homecare, extra care and supported living).

Healthcare staff

Cohort	Target	10/5/21	24/5/21	7/6/21	14/6/21	28/6/21	Change 14/6/21-28/6/21
LNWUHT	100%	78%	81%	83%	83.6%	83.3%	-0.3pp
CNWL	80%	94%	-	96%	98%	98%	=
Primary Care	80%	85%*	86%**	85% (two doses)***	86% (two doses)***	86% (two doses)****	=
CLCH	80%	81%	87%	90%	90%	92%	+2pp

* Based on staff directly employed by the practice, including GP partners but not including PCN staff, in 41 practices. Awaiting responses from 10 practices.

** Based on staff directly employed by the practice, including GP partners but not including PCN staff, in 48 practices. Awaiting responses from 3 practices.

*** Based on staff directly employed by the practice, including GP partners but not including PCN staff, in 41 practices. Awaiting responses from 10 practices.

**** Based on staff directly employed by the practice, including GP partners but not including PCN staff, in 46 practices. Awaiting responses from 5 practices.

Brent / NHS Brent Clinical Commissioning Group	**Health & Wellbeing Board** 14 July 2021
	Report of the Community Wellbeing Strategic Director

Health Inequalities/BHM Programme - update

Wards Affected:	All
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	0
Background Papers:	0
Contact Officer(s): (Name, Title, Contact Details)	Tom Shakespeare Director of Integrated Care, Brent Council Tom.shakespeare@brent.gov.uk

1.0 Purpose of the Report

1.1 To update the Board on the progress being made by the Brent Health Matters Programme related to tackling Health Inequalities and to describe the approach being taken and impact being achieved.

2.0 Recommendations

2.1 Note and provide comment upon the progress of the programme and delivery to date and the approach being adopted to the programmes alignment with the Brent wide strategy to tackle Diabetes.

2.2 Note and provide comment upon the key actions being implemented by the five individual BHM programme work streams and the resulting impact they are having in terms of activities contributing to our strategy to tackle Health Inequalities.

2.3 Provide comment and endorse the ‘whole system’ approach of NHS and council partners under a single programme of work, with consideration to the alignment of Health Inequality strategies.

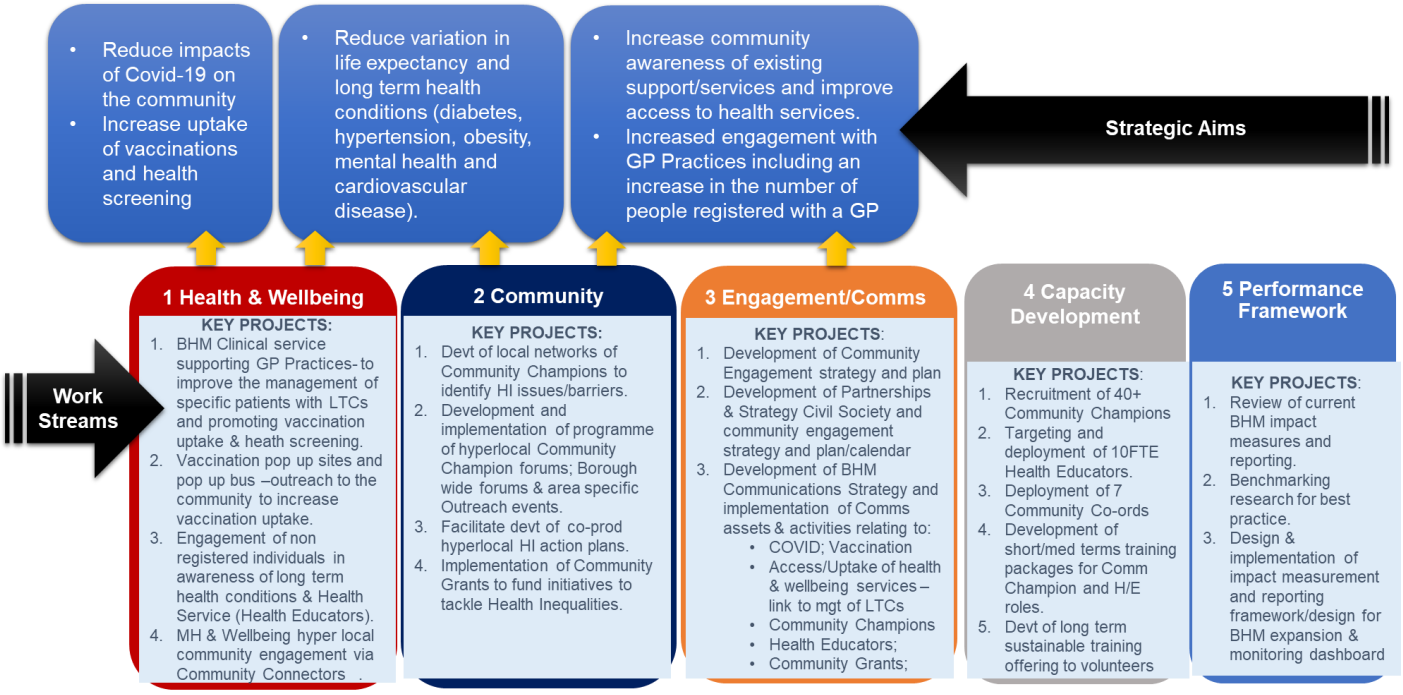
3.0 Brent Health Matters programme-approach to tackling Heath Inequalities

3.1 The Brent Health Matters Programme approach is designed to adopt the principles of 'proportionate universalism' across three phases of activity:

1. Build capacity to engage with the community.
2. Use that capacity in a uniform way to tackle Health Inequality issues that affect most of the community.
3. Target that capacity to engage a significant minority of the population with an approach that is tailored to their specific needs.

- We have therefore structured the programme design to deliver an approach that tackles universal needs (represented by aims such as those related to Covid-19 vaccination and borough wide health issues such as diabetes) and then interacts with specific minority communities with targeted and thematic community engagement and integrated clinical support.

- The Brent Health Matters programme structure includes 5 key work streams represented in the diagram below - the work streams are specifically aligned with the delivery of the programme's Health Inequalities strategic aims:



- Current programme impact is measured in 3 ways: COVID infection and vaccination rate PIs; specific health PIs that measure the improvement in long term health condition performance for individual cases referred to the BHM Clinical Service and activity impact measures – that evaluate the capacity building; community engagement; and communication activity levels.
- A new BHM Programme Impact Evaluation matrix and Dashboard will be rolled out at the start of July that will assimilate these measures.

3.2 *Health and Wellbeing Work Stream: progress*

Brent Health Matters Clinical Service (BHMCS)

- The Brent Health Matters Clinical Service (BHMCS) is currently provided by London Northwest University Healthcare NHS Trust however, provision will shortly be transitioning to Central London Community Healthcare NHS Trust. The service provides a multi-disciplinary team of health professionals, focusing on reducing inequalities through targeting the hard-to-reach and less engaged population groups, and supports them to better manage their health specific health conditions.
- The current structure of the BHMCS consists of a Team Lead (Physiotherapist), Clinicians (3WTE), Healthcare Coordinators (2.6WTE), admin staff (2WTE), Mental Health Practitioner (1WTE) and a Mental Health Coordinator (1WTE). Some vacancy factor exists within the team. The BHMCS is also working closely with the ICP team, GPs and other health and social care services to improve the care of patients on their caseload.
- The initial focus of this team has been on improving the uptake of preventative services, particularly flu vaccinations and improving health outcomes for a range of long-term conditions.
- There is substantial variation between different GP practices in Brent in relation to how well long-term conditions(including Diabetes) are managed, as evidenced by multiple indicators such as those related to: diabetic control; cardiovascular conditions; and the prevalence of specific forms of cancer.
- A key strategic universal aim for the BHM Programme Clinical Director is to have all GP practices in the borough functioning at least at the average performance level of the NWL sector, for key performance indicators related to their management of patients with long-term health conditions.
- The intension is therefore a data driven strategy, assessing relative GP practice performance, but additionally considering local intelligence about community driven health priorities and then targeting BHM Clinical support accordingly. The service is therefore helping practices to improve their performance and the level and quality of support to their patients.
- The future BHM Clinical Service (with guidance form the BHM Clinical Director) will therefore identify the lowest performing practices for prioritised support, along with specific patients from across the borough referred separately, due to their emerging health condition status.
- The BHMCS are currently working with 10 GP practices located in Church End and Alperton and have contacted 2,300 patients referred to them, where an initial Health and Wellbeing assessment has been undertaken.
- Following initial assessment, the team have provided a number of interventions for these patients including blood tests, flu vaccinations, asthma control tests as well as providing bespoke health promotion and education on key messages tailored for patient needs. In addition to this, many patients have been signposted or referred to other health and social care services where relevant.

Activity Impact Measures:

- 323 patients have been given flu vaccination
- 865 comprehensive health assessments completed
- 187 patients had blood, BP checked for LTC management
- 685 patient care plans updated
- 560 patients have received bespoke health education

- The team have also supported the Covid vaccination programme, in terms of myth busting and working towards improving uptake of the Covid vaccinations through telephone discussions with reluctant patients.

Activity Impact Measure:

- 1,965 patients called
- 153 vaccinations booked

- The team provide the Patient Advice Line where patients can ring regarding any non-clinical queries related to their health or social care. This service was initially provided to only Church End and Alperton residents, but has now been extended to all Brent residents and though initial uptake was poor, call volumes have risen, with a refocus on providing COVID vaccination information and booking vaccination appointments.

Activity Impact Measure:

- 545 calls received
- 194 vaccinations booked
- 351 individuals supported with general health and Covid queries

- Recently the service began providing the clinical team to support vaccination activities via the vaccination bus.

Mental Health and Wellbeing- CNWL involvement in the BHM Programme:

- CNWL have a Mental Health Practitioner and a Mental Health Coordinator who work to support the holistic assessment of patients who are referred to the BHM Clinical Service as part of the multi-disciplinary team.
- They also have a very effective community engagement strategy delivered through their Community Connector role. Community Connectors work as positive role models raising awareness and sharing key information that will enable the community to make positive choices about their health and wellbeing. Roles recruited from the local community, with emphasis on strong community connections and local languages. The piloting of the role has been viewed as successful and there are now 5 FTE Community Connectors deployed.

Activity Impact Measure:

The Community Connectors have delivered a number of collaborative initiatives including the following examples:

- The team are holding consultations with the community to raise awareness of mental health service and increase uptake. They are using data from the recent mapping to engage with various organisations and groups to hear from them and amplify their voice through the community connectors. They are using the learning from these consultations to develop and deliver workshops guided by local communities. For example: An emotional health and wellbeing session was delivered to the Jason Roberts Foundation with Councillor Ketan Sheth on 25th May. Another session is planned for September. Work with Faith Leads is moving to the next phase. An evaluation of the project was drafted.
- The team are building stronger relationships and working in collaboration to create a toolkit that will support faith leads with knowledge and skills to support their congregants who present with mental health and wellbeing needs more effectively in the future. The project also aims to create a partnership between the MF Forum and MH Provider to learn from each other, and the development of MH friendly places of worship.
- Young people's leads are collaborating with Brent Young Foundation to support young people's mental health.
- Currently the team are focusing on delivering a diabetes workshop in Gurjarati to 20,000 devotees at the Willesden Temple. This is developed in collaboration with people from the temple who want a culturally appropriate diabetes prevention workshop. This will be delivered in July to coincide with an annual festival held by the temple and will feed into the wider BHM diabetes strategy.
- The team are also supporting the induction of health educators and continue to support at vaccine bus sites.
- In the news: The Team Manager was nominated and went to 10 Downing Street to tell the Prime Minister about the work of Brent health Matters. Team have been approached by the Evening Standard who are doing an article on how community centres are working really hard to increase vaccine confidence in African Communities.

3.3 *Community Work Stream: Update*

Health Inequalities Community Engagement Capacity Building

- 5 additional Community Co-ordinators have been recruited and are now in post. Each Co-ordinator has both a role in building local community capacity and networks in the 5 Brent Connects areas to identify key local Health Inequalities priorities and develop local HI action plans; and a thematic role to support key population groups across Brent e.g. younger people; the Somali community; those with common mental health issues etc. (see table below)

Coordinator	Area	Specific roles and themes
Arushka Theagarajah	Harlesden	• Borough wide event planning and coordination • Homelessness • Brent Health Clinical teams
Lee Pittock	Wembley and Kilburn	• Younger people • Family Wellbeing Centres • Health Educators
Nabina Ibrahim	Kilburn	• Training • Champion Recruitment
Najla Ahmed	Harlesden (Church End focus)	• Somali Communities • Training/Mental Health
Shanti Chingen	Willesden	• Domestic Violence • Champion recruitment • Brent CVS lead
Umit Jani	Wembley	• Mental Health • CRM • CNWL Team Contact
Yoel Berhane	'Kingsbury and Kenton'	• Elderly groups • Carers • Disabled groups

Activity Impact Measures:

- There are now 27 active Community Champion volunteers across the 5 Brent Connects areas.
- Over 80 different VCS organisations and specific communities/population groups have been directly engaged by the Community Co-ordinators

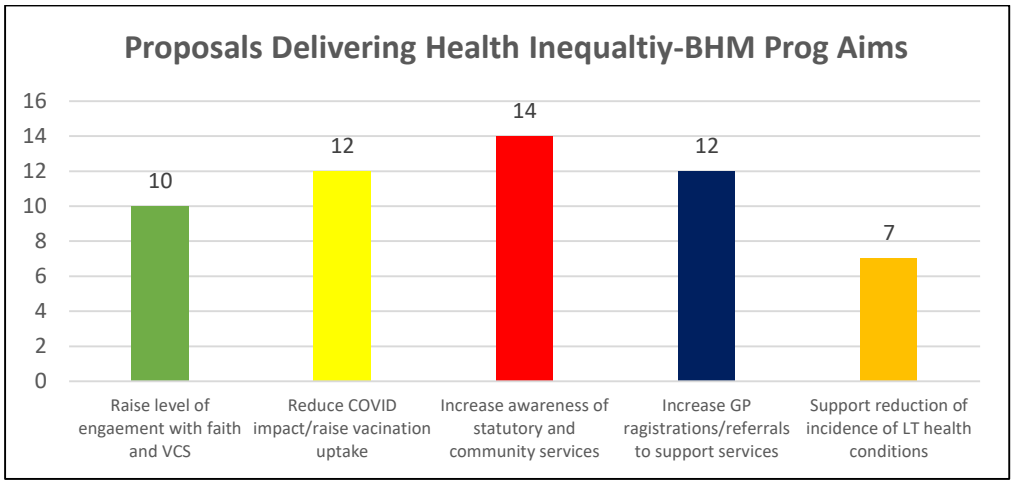
- Our Health Educators Partner, Brent Carers Centre are co-ordinating a delivery partnership that includes: SAAFI; PLIAS; Kilburn PCN; Brent Mencap; and Brent Community and have recruited 12 Health Educators to date (with 8 more in the pipeline) and are ensuring they have access to an extended range of hyperlocal community organisations; faith groups; business; schools etc. The recruited Health Educator team includes an individual with an MSC in Public Health, a previous diabetes champion, and an ex nurse/nurse lecturer who established a diabetes clinic in Trinidad.

- The £250,000 BHM Community Grants scheme has been delivered targeting capacity building funding at organisations that can credibly engage on both universal health inequality issues and with specific minority groups.

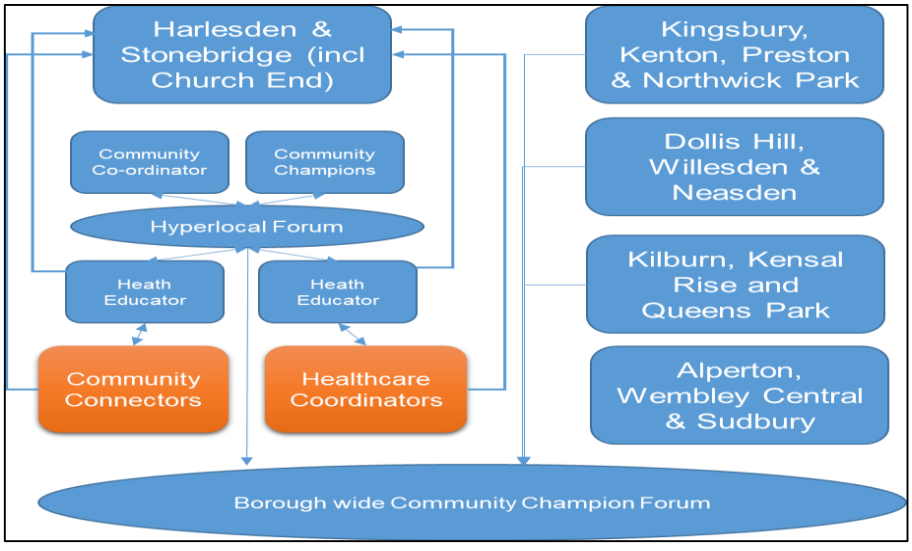
Activity Impact Measure:

- The funding programme was open from mid-February to the end of April with the 4th and final evaluation round held on May 5th.
- Over the 4 rounds of evaluation 26 applications from both individuals (4) and organisations (22) were received (one was declined prior to evaluation as it was a second application from a previously successful organisation) and of the 25 evaluated -18 were approved (62%) and 7 were rejected (28%).

- The applications ranged from £1k to the £25 max per organisation, with the average funding request being £13,940 and the average award being £9,241.
- The remaining funding (£18,984) was allocated to a grass roots proposal developed with a small organisation working with the Somali community who requested capacity building assistance to develop a mental health crisis prevention initiative.
- The initiatives include those proposing health education and mental health and wellbeing community interventions (3 specific to Diabetes) and a number delivering support for residents to undertake activities to improve their physical condition.
- Proposals were from individuals, VCS and faith organisations-the table below shows the relationship between the proposals and Health Inequality Strategic Aims



- The programme has now built the capacity to deliver a pan-borough focus, engaging additional localities, each with dedicated Community Co-ordinator and Health Educator resource interacting with area specific Brent Connect local forums. The model will also facilitate collaboration and alignment with the other roles engaging the community such as the MH and Wellbeing Community Connectors (CNWL) and the BHM Clinical Service Healthcare Co-ordinators (BHMCS) as shown in the diagram below:



- Borough-wide Community Champions Forums will be used to share thinking on co-produced initiatives across the borough and to develop a borough wide approach to key themes. For example, the Community Forum on 29th June focussed on community engagement related to **Diabetes.** The event highlighted the work being done in Brent by VCS groups such as the Oshwal Association in relation to their health webinars on long term health conditions; Pathway to Wellness with their promotion of Healthier Lifestyles; alongside the view of a local GP, Dr Intkhab Raja on Diabetes prevalence in Brent. There was also a presentation from the National Diabetes Prevention Programme. The session held local forum breakout sessions to understand from the community how the BHM programme can engage effectively on the topic of Diabetes and work in partnership with community organisations and stakeholders.

3.4 *Communications Work Stream Update:*

This work stream has delivered a multi-channel COVID/Vaccination campaign:

Activity Impact Measure:

Younger People and Targeted Groups

- As younger cohorts come online to receive their vaccine we are adapting our approach, including: comms specific to issues relating to this age group - fertility, pregnancy, breastfeeding, etc. positive messages about 'getting your life back' by getting the vaccine – research showing that younger people want to socialise, go on holiday, go to festivals, etc. messages around the impact on family and friends – keeping them safe and bringing them along if they haven't already got the jab
- We have already produced a film with a Kilburn GP about fertility, pregnancy, breastfeeding issues and have translated and Easy Read versions of assets scheduled for our social media feeds. We are also looking at ways to plug into mum's groups and parents via schools.
- We have approached organisations such as the Jason Roberts Foundation and Young Brent Foundation with the idea of creating podcasts involving and aimed at young people. These will be very much along the lines of 'Get the facts' and will have a good representative panel of young people from the borough.
- We have produced a video that accentuates the positives of getting the vaccine and everything young people will have missed. We also have an asset that encourages younger people to bring their older relatives with them when they get their vaccine.
- We have also spoken to local radio stations about both placing adverts and arranging interviews with Cllr Mclennan. Both The Beat and Roots FM have offered interview opportunities alongside an advert campaign and we have ongoing discussions with Global FM to produce an advert to run over a number of stations.
- For the first time we have also scoped out the potential to use Spotify to advertise and are progressing well with that option too.

- In addition to the focus on young people, we are also mindful of the communities where uptake of the vaccine is still below where we would want it. Namely the Black Caribbean and deprived communities in the south of the borough. One of the ways we are looking to address this is by increasing our communications in particular areas that have been targeted by the Vaccine Bus. An example has been sending a leaflet to every household in Kilburn to advise them of the multiple opportunities to get vaccinated as the bus stops in that part of the borough repeatedly over the next two weeks.
- We are also getting different language versions of the Vaccine Bus asset, including in Romanian and Portuguese. Both relating to particular communities in Harlesden and Willesden respectively. We are working with Cllr Sangani to arrange two short videos from a number of community representatives in different community languages promoting the bus specifically coming to Alperton for the first time and generally around the borough.
- Finally multi-channel communication support was used to promote a successful mass vaccination event (well over 2000 vaccinated) at Bridge Park Leisure Centre delivering circa 65,000 A5 leaflets to every home and business in the eight wards around Bridge Park: Alperton, Stonebridge, Kensal Green, Wembley Central, Tokynton, Harlesden, Dudden Hill & Willesden Green and parallel promotion through social media platforms such as the Community Champions WhatsApp Group.

4.0 Brent Health Matters Programme support to the Brent Integrated Model of Care for Diabetes

4.1 Brent Borough in collaboration with stakeholders intends to build on the NWL Diabetes Model of Care and aims to integrate care pathways spanning a continuum of public health, primary care, community services and acute service provision. In order to achieve this, work will be undertaken with PCN Clinical Directors and wider stakeholders to deliver the following:

- Type 2 Diabetes Prevention (Non-Diabetic Hyperglycaemia)
- Type 2 Diabetes diagnosis & Management
- Medicines Optimisation
- Achievement of 3 treatment targets
- Review within 3 months if off target

To date there have been a number of engagement events to agree how the following will be achieved:

- Improve uptake of structured education for patients with Diabetes
- Improve the 3 treatment targets and 9 care processes for patients with diabetes focusing beyond targeting just sugar levels and through joint and agreed goal setting and management plans with patients
- Proactive management of high risk patients who do not have the 3 treatment targets under normal range (hba1c/BP and Cholesterol) and support remission where appropriate.
- Encourage self- care and healthy behaviours as part of diabetes treatment, especially physical activity, reduced intake of simple carbohydrates, weight loss, adequate sleep and no exposure to cigarettes

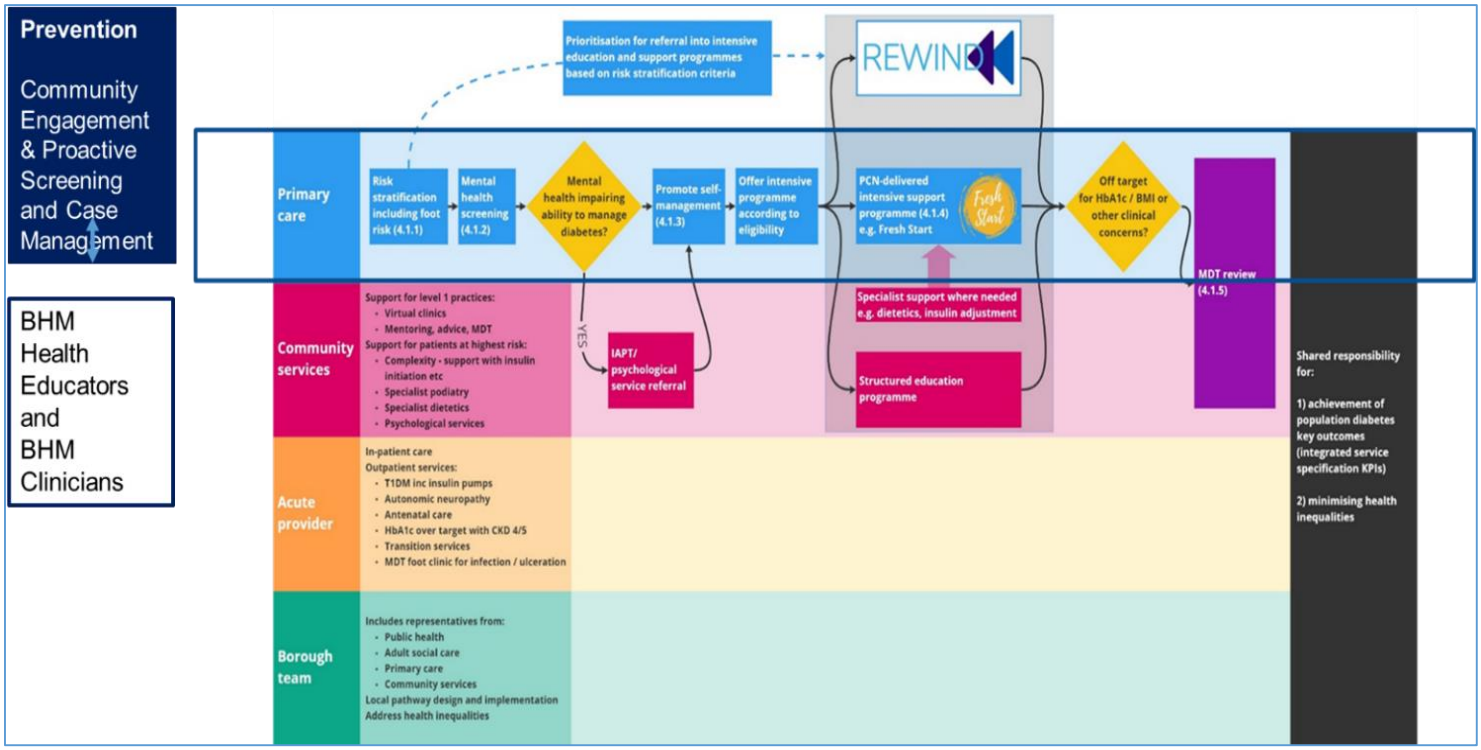
- Ensure early identification and management of foot risks
- Integrate Mental Health provision into the care pathways for patients
- Digitally enabled care for patients where appropriate e.g. Virtual consultations
- Reduce health inequalities and unwarranted variation in care of patients using PMH approach

Proposed next steps:

- Establish a multi-agency Diabetes Steering Group to oversee the development and delivery of diabetes services in Brent, ensuring a seamless interface across settings of care, with reduced bureaucracy and hand offs with the following immediate priorities:
    - Provide a strategic overview of service transformation including the development and delivery of services.
    - Develop opportunities to work at 'scale' including integration of pathways and joint commissioning opportunities
    - Improve engagement and communication with residents of Brent across the sectors and use feedback from residents to help shape diabetes services to meet the needs of residents in Brent
    - Support providers to increase diabetes performance including achievement of treatment targets and attendance to structured education

4.2 Brent Health Matters Programme can support the prevention element of the Integrated Model of Care for Diabetes continuum in a number of potential ways subject to confirmation by the Diabetes Steering Group:

- The Communications work stream can undertake a campaign of universal messaging on Diabetes prevention and messaging tailored to Brent populations know to have higher prevalence of Type 2 Diabetes.
- The Community work stream can use its Community Coordination; Community Champion; and specifically its Health Educator capacity to improve engagement with the community with a universal campaign of messaging and engagement events (encourage healthy behaviours) and undertake targeted support to connect harder to reach minority communities promoting better self-care and connecting them to community services and to NHS services appropriately including the BHM Clinical Service.
- The BHM Clinical Service can undertake proactive screening and case management of patients (referred from Brent GP practices and the BHM community engagement teams) who are at risk, or currently managing Type 2 Diabetes.



5.0 Brent Health Matters Programme- planning the next Phase

5.1 The BHM prog has gone through a phase of capacity building:

- Recruiting: Community Co-ordinators; Community Champions; Community Connectors.
- Establishing a Health Educators Partnership and recruiting 12 Health Educators.
- BHM Clinical Service expanding it level of support to GP practices.
- Delivering a BHM Community Grants programme to invest in community capacity building.

5.2 We now need to make choices about how the additional capacity we have built is invested to achieve a sustainable legacy for the Programme.

The next phase of the BHM Programme will involve engaging with key stakeholders with the aim of developing an outline plan to underpin the next 6-9 month of programme delivery.

Report sign off:
Phil Porter
Strategic Director Community Wellbeing

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Brent NHS Brent Clinical Commissioning Group	**Brent Health and Wellbeing Board** 14 July 2021
	Report from the Strategic Director for Community and Wellbeing

The emerging Joint Health and Wellbeing Strategy (JHWS)

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt:	Open
No. of Appendices:	1 Appendix 1 – Health and Wellbeing Strategy Infographics
Background Papers	None
Contact Officer(s): (Name, Title, Contact Details)	Melanie Smith - Director of Public Health melanie.smith@brent.gov.uk Angela d'Urso - Strategic Partnerships / Policy and Scrutiny Manager angela.d'urso@brent.gov.uk

1.0 Purpose of the Report

1.1 This report outlines the emerging interim priorities of the Joint Health and Wellbeing Strategy (JHWS).

1.2 The report seeks to engage Brent Health and Wellbeing Board (BHWB) input into the ongoing development of the JHWS, with a focus on the interim emerging priorities.

2.0 Recommendations

2.1 To note the work so far to develop the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS) and to note the emerging interim priorities currently in stage two consultation.

2.2 To provide any strategic input to the JHWS development process and the emerging interim priorities.

3.0 Detail

Background

3.1 Health and Wellbeing Boards (HWBs) are a statutory forum where political, clinical, professional and community leaders come together to improve the health and wellbeing of their local population. HWBs have a statutory duty to produce a joint

strategic needs assessment and a joint health and wellbeing strategy for their local population. The **Brent Health and Wellbeing Board** (BHWB) has responsibility for this duty.

3.2 The Brent Health and Care Plan 2017-21 was agreed by the BHWB in 2017. It has nine priorities:

- Helping people stay well, in mind and body
- Helping those disproportionately affected by cancer, heart disease and respiratory illness
- Making the management of long term conditions more consistent
- Making sure residents can access the services they need at a place and time that best suits them
- Helping those in the latter stages of their lives live with dignity
- Improve life expectancy for those with serious and long term mental health needs
- Protect the mental and physical health and wellbeing of children and young people across the borough
- Universal access to consistently high standard of care
- Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed

3.3 The Plan also had six 'big ticket items', as follows:

- Joined up services helping residents get well and stay well
- New models of care – greater access to more effective services
- Joining up older people's services
- Improving outcomes for people with mental health illness
- Transforming care – supporting people with a learning disability
- Make Central Middlesex Hospital a centre of excellence

3.4 In July 2019, work began to refresh the plan, along with the JSNA. Work was paused when the Covid19 pandemic hit.

<u>The Emerging JHWS</u>

3.5 At the October 2020 BHWB meeting, the BHWB agreed that in the context of the seismic changes and fundamental issues exposed by the pandemic, a fundamental rewrite of the **Joint Health and Wellbeing Strategy** (JHWS) was required. The BHWB also agreed the focus of the JHWS should be a whole systems approach to tackling health inequalities and wider determinants of health inequalities, as exposed and exacerbated by Covid19. The BHWB also gave clear instruction that the JHWS must be developed with communities, and that consultation throughout the development process was critical.

3.6 Officers developed the detailed project plan based on the discussion and agreement at the BHWB 20 October 2020 meeting.

3.7 A strategy development working group was established. Nominated officers from across the BHWB partners attend. The group meets monthly and is responsible for the delivery of the project plan. Activity has included:

- Developing a project plan and securing sign off from the BHWB
- Reviewing the JSNA, creating a Covid19 chapter and commencing a fundamental refresh of the JSNA, with a new methodology and approach, in line with the scheduled publication dates of the JHWS. Our new approach will have an explicit focus on ethnicity, deprivation and disability and on the wider determinants of health and the outcomes achieved by commissioned and provided partner services.

- Reviewing key relevant national publications e.g. The King's Fund 'The Health of People from Ethnic Minority Groups in England' and 'Build Back Fairer: The Covid19 Marmot Review' produced by the University College London Institute of Health Equity and commissioned by the Health Foundation
- Designing the first and second phase of consultation and engagement, and analysis of emerging findings
- Identifying other relevant consultation and engagement that can add value to the prioritisation and strategy development process, for example the lived experiences gathered as part of the Poverty Commission and community voice as part of the Brent Health Matters programme.

Stage one consultation

3.8 For the first stage of consultation, Healthwatch was commissioned to consult with our most vulnerable, seldom heard communities and those most impacted by health inequalities. Essentially communities were asked three key questions:

- What were the inequalities they experienced that impacted on their health and wellbeing
- What they thought were the drivers of those inequalities
- What they thought could be done about it – across communities and services

As part of the first phase of consultation, officers worked with Healthwatch to develop a survey and virtual roadshow approach, as well as data analysis mechanisms.

3.9 The Healthwatch consultation took place during February 2021, with an online and physical survey distributed to target audiences and six virtual community roadshows held. Healthwatch targeted the consultation through their networks – the aim was to speak to those who were most affected by health inequalities, the most vulnerable and those who were seldom heard.

3.10 Key findings from the roadshows were:

- There is a strong focus on wellbeing, with consultees considering the role of strategic partners to be one of supporting people by making self-care easy. There were a number of ideas around how this could happen, but the most frequently heard priorities were:
  - Improving access to reasonably priced fresh fruit and vegetables (not from a supermarket)
  - Decreasing unhealthy food availability e.g. fast food outlets on High Streets
  - Improving access to high quality green space, with desires for community gardens, more allotments and improving accessibility to green spaces
- Young people and the impacts of the pandemic upon them is a clear priority for many, with concerns about their mental health needs, now and into the future
- Active volunteers and community groups are well connected in their areas, but there is a job to do in how we engage to connect to those who need information, advice and guidance the most

3.11 There was a differential between how people describe their priorities for health and wellbeing and the language used in the health and wellbeing sector. For example, people did not describe tackling obesity as a priority, but they did describe wanting access to healthier foods, improved community facilities and green spaces to exercise in. This will be reflected in the development of the JHWS and our activity.

3.12 Responses identified barriers that people feel prevent them from effectivity accessing services and opportunities. These included time, financial resources, other responsibilities e.g. as a primary carer, digital exclusion and language (including technical language).

3.13 The Brent Health Matters Time to Talk event also provided a number of key insights:

- We need to rethink how we are seeking to connect with the community (particularly in relation to young people and older, frail people), and we need to allow the time and space for genuine co-production.
- There is clear feeling that people with disabilities have been profoundly impacted by the Covid-19 pandemic and this is a key group affected by health inequalities.

3.14 There has also been input from key steering groups that is relevant in the development of the emerging priority areas, for example the need to ensure an effective focus on children, young people and families weaved throughout the whole strategy.

3.15 In April 2021, the BHWB agreed the following interim emerging priority areas to take forward to the next phase of consultation:

- Ensuring a healthy standard of living for all, and making the healthy choice the easy choice
- Create and develop healthy and sustainable communities and places
- Strengthen the role and impact of ill health prevention, including mental health
- Working to ensure a rapid recovery of the system and its workforces, including a better, more consistent use of data to ensure we meet the needs of all service users
- Ensuring those who need services are able to influence how they work, and that they are able to access them when they need them

The BHWB agreed that children, young people and families are embedded within these priorities, rather than considered as a separate priority.

3.16 The BHWB also noted that wider determinants such as creating fair employment and improving access to high quality housing emerged as inequalities that people state impact upon their health and wellbeing. The BHWB agreed this insight is shared into the relevant key council strategies e.g. the Poverty Commission delivery plans, and the BHWB would take steps to ensure these plans address the needs identified.

<u>Stage two consultation</u>

3.17 Given the insight around shared language uncovered in the stage one consultation, the emerging interim priorities were reworked by the strategy development working group to take forward to Stage 2 of the consultation as follows:

- Healthy lives (ensuring the healthy choice is the easy choice)
- Healthy places (creating and developing sustainable communities and places)
- Staying healthy (ensuring people can practise self-care, and know where and how to get the help they need when they need it)
- Healthy workforces (ensuring our workforces and systems recover rapidly post pandemic)
- Healthy ways of working (ensuring people can influence the design of the services they need or access, and ensuring our data is fit for purpose)

Further detail on the emerging interim priorities is contained in Appendix 2. These infographics (and an easy read version) have been produced to support the stage two consultation.

3.18 Stage two of the consultation is essentially seeking to understand stakeholder and key community group opinion of the interim emerging priorities, focused on the following questions:

- Have we interpreted what people told us in stage 1 correctly? Have we missed anything?
- Do the priorities make sense for you/those you care for/your client groups?
- If they are correct, what can we – services and communities – contribute to these priorities?

3.19 Healthwatch and officers will be consulting throughout June and into July. Stage two consultees include partners, key external and internal forums, and key community and voluntary sector groups, for example:

- Safeguarding partners
- Voluntary and community sector partners, e.g. Thematic Leads Group
- Forums including the Disability Forum, Care Leavers' In Action and Brent Health Matters Community Champions network

We are working closely with BHWB members to ensure effective engagement across the system.

3.20 Consultation is through a variety of mechanisms, including specific workshops and sessions e.g. at the Youth Summit. An all members session is being organised and the Community and Wellbeing Scrutiny Committee is providing pre-policy input at this meeting. A digital survey was launched in June. Emerging findings will be presented to the BHWB in July.

3.21 As part of stage two, a Brent Council Senior Management Group (SMG) session was held in June to discuss health inequalities and how the council can work to maximise impact in this area. Officers have followed up the session with offers to attend team meetings. Given the nature of the emerging priority areas, the membership of the strategy development working group was expanded, and there is now representation from all council departments.

<u>The JSNA and other data</u>

3.22 A partnership workshop has also taken place on our approach to developing a JSNA to be published alongside the new JHWS, which is scheduled to be published by the end of 2021. The JSNA will identify the key inequalities affecting in key thematic areas in line with the emerging priorities, specifically through the lenses of ethnicity, disability and deprivation. Working groups for each thematic area are being established, and there is representation from all council departments and BHWB partners. Highlights from the emerging JSNA are show in the infographics attached in Appendix 2.

3.23 As part of the JHWS development process, officers have also reviewed national literature and evidence. A key report has been the Health Foundation commissioned report by UCL Institute of Health Equity to investigate how the Covid19 pandemic has affected health inequalities in England. The 'Build Back Fairer: The Covid19 Marmot Review' highlights the inequalities in social and economic conditions before the pandemic that contributed to the high and unequal death toll. Priorities in the Marmot review include:

- Give every child the best start in life
- Create fair employment and good work for all
- Ensure a healthy of standard of living
- Healthy and sustainable places and communities
- Strengthen role and impact of ill health prevention

The Marmot review findings reflect the findings of our local consultation.

<u>Next steps</u>

3.24 Following on from stage two consultation, a draft strategy will be produced. This will then go forward to stage three universal consultation, which is scheduled to commence in the autumn. A final strategy and delivery plan will then be developed for agreement by the Cabinet and the BHWB.

3.25 The JSNA and JHWS will be published together. Officers are working towards a publication date at the end of 2021.

4.0 Financial Implications

4.1 In terms of the JHWS development, there are resource implications for both Brent Council and Brent NHS CCG in terms of officer time and engagement work with the public. The latter is unlikely to be significant and can depend on getting support from partners in kind. It is anticipated that any associated costs will be funded from the existing budgets.

5.0 Legal Implications

5.1 The duty in respect of Joint Health and Wellbeing Strategies (JHWSs) is set out in s116A of the Local Government and Public Involvement in Health Act 2007, as amended. In addition, the Health and Social Care Act 2012 places a duty on local authorities and Clinical Commissioning Groups (CCGs) to develop a Health and Wellbeing Strategy to take account of, and address the, challenges identified in the Joint Strategic Needs Assessment (JSNA). Pursuant to the Care Act 2014, the Council has a duty to ensure a clear framework is developed to meet its wellbeing and prevention obligations under the Care Act.

5.2 The Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (Statutory Guidance) 2013 states "*Health and Wellbeing boards will need to decide for themselves when to update or refresh JSNA's and JHWS's or undertake a fresh process to ensure that they are able to inform local commissioning plans over time. They do not need to be undertaken from scratch every year; however, boards will need to assure themselves that their evidence-based priorities are up to date to inform the local commissioning plans*".

5.3 In preparing JHWSs and JSNAs, Health and Wellbeing Boards must have regard to the guidance issued by the Secretary of State, and as such, boards have to be able to justify departing from it.

6.0 Equality Implications

6.1 Health and Wellbeing Boards must also meet the Public Sector Equality Duty under the Equality Act 2010. S149 of the Equality Act 2019 provides that the Health and Wellbeing Board must, in the exercise of its functions, have due regard to the need to:

a) Eliminate discrimination, harassment and victimisation
b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

6.2 The Public Sector Equality Duty covers the following nine protected characteristics: age, disability, marriage and civil partnership, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

6.3 The Statutory Guidance states "*this is not just about how the community is involved but includes consideration of the experiences and the needs of people with relevant protected equality characteristics (as well as considering other groups identified as vulnerable in JSNAs) and the effects decisions have, or are likely to have on their health and wellbeing*".

Related documents:

Item 8: Brent's Joint Health and Wellbeing Strategy - progress update
Brent Health and Wellbeing Board, 6 April 2021

Report sign off:

Phil Porter
Strategic Director, Community and Wellbeing

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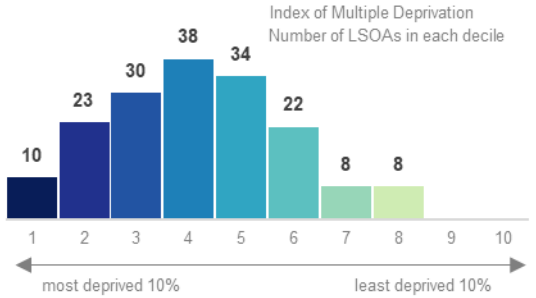
Deprivation

The pandemic has highlighted that health inequalities are exacerbated by the levels of deprivation people live in



Deprivation is a key factor in people being able to make healthy choices. Deprivation varies across the borough. The Indices of Multiple Deprivation 2019 show that Stonebridge is the most deprived ward in the borough

Alcohol

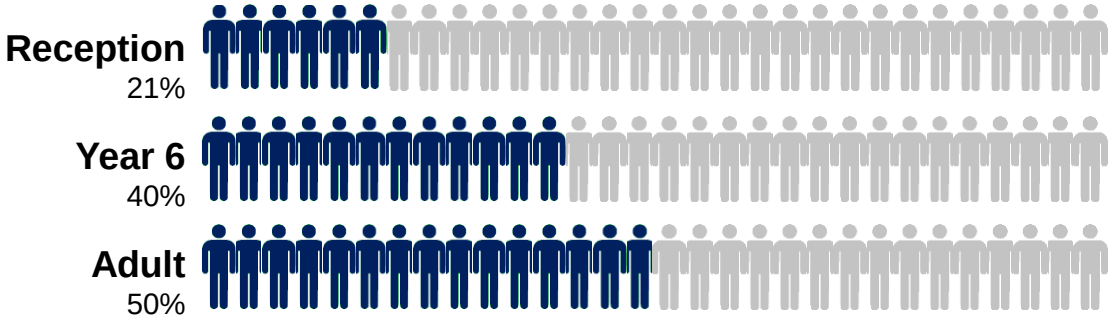
16%

Admissions to hospital for conditions which are attributed to alcohol increased in 2018/19 to 646 per 100,000

Currently, deaths for conditions attributed to alcohol are lower than the London average, but these are likely to lag behind the admission so will increase if we do not turn the tide on the admissions

Healthy weight

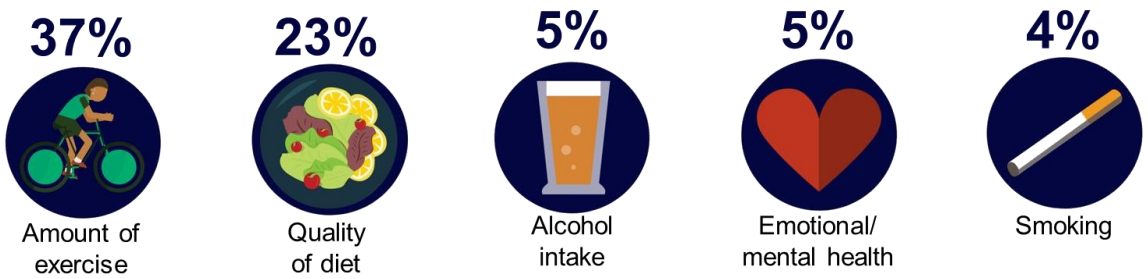
In the consultation, no-one mentioned obesity, but being able to have a healthy diet and lifestyle was important. Data show that in Brent the proportion of people who are overweight increases by age group.



Healthy Living

I am able to make the healthy choice for myself and those that I care for and we can live in a healthy way

The 2018 Resident Attitudes Survey (RAS) asked what behaviours people wanted to change to improve their health



Barriers

Barriers to residents keeping healthy:

- Financial constraints
- Work/Caring constraints
- Lack of motivation
- Language
- Digital exclusion

Food

Food insecurity and access to fresh fruits and vegetables was understood to be a driver and source of health inequality.

Residents commented on the choice of fresh fruits and vegetables in their local areas, especially as many high streets had several fast-food shops that discourage healthy behaviour in residents

59% of adults regularly eat **five-a-day**

Sources: Brent RAS 2018; PHE fingertips Obesity profile; wider impacts of Covid 19 on health; Local Alcohol Profiles for England; IMD 2019; Healthwatch survey

This is us.
This is Brent.
We are English and Irish, Indian and Windrush,
We are Somali, Italian, Romanian, Chinese.
We sing in temples, in pubs and in stadiums.
We speak on the high-roads, in the libraries (shush),
and on the Bakerloo line.
From Stonebridge to Cricklewood
From Queensbury to Queens Park
From Kilburn to Kensal Green,
We are mixing, melding, sharing, cooking,
dancing, praising, raising, playing.
We are unplanned and unfiltered,
We are the first place people come to
and the place people stay.
We are the past, the present and the future.
This is us.
This is Brent.

We are not just a borough of culture,
We are the Borough of Cultures.

London Borough of Culture legacy

In 2020 Brent was the London Borough of Cultures. The work will continue in the borough, celebrating its diverse people and culture. As part of the legacy they developed Spacebook. Spacebook gives local people a way to see useful information on spaces for hire in the borough all in one place, from function rooms and dance spaces, to community halls and music venues. We need to build on the legacy of the London Borough of Culture 2020.

Parks

Parks are a priority for residents, and they would like them improved so they can be used more. Parks needed:

- Better lighting for use after dark
- Public toilets to be available
- To feel safer

Healthy places

Near me there are safe, clean places I and people I care for can go to exercise for free, meet with like-minded people, and we have the opportunity to grow our own food

Youth voice

The Youth Survey asked "How do you think we can make Brent a better place for young people?"
The second most commented theme was to have more activities. Many young people mentioned safety, access to, and facilities in parks.

To have more public activities take place, to be social

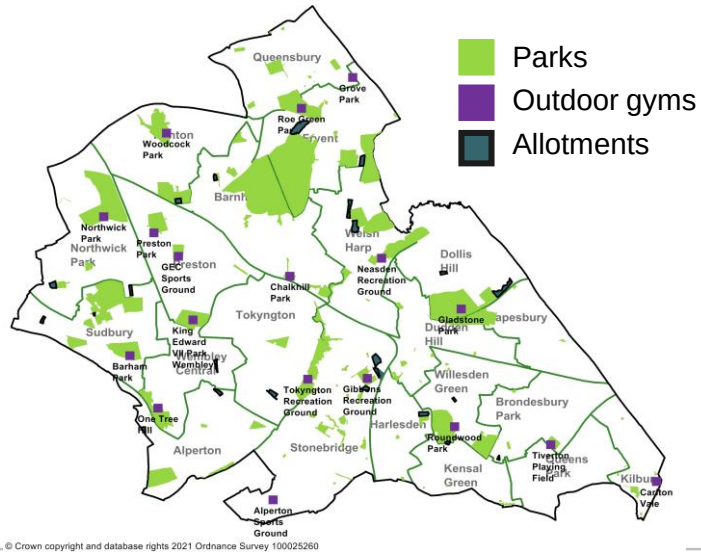
Add more libraries, green space and pick up litter more constantly

Outdoor spaces

Food growing has come to the fore as a result of Covid – access to community gardens or spaces to grow your own food for those who want to was highlighted in the previous engagement by Healthwatch

Access to green space is important for both physical and mental wellbeing. However, not everyone has equal access to the green space they need to improve their personal wellbeing, or the space they have access to is not suitable.

Parks, outdoor gyms, and allotments



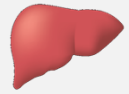
Source: https://www.ons.gov.uk/economy/environmentalaccounts/articles/howhaslockdownchangedourrelationshipwithnature/2021-04-26; https://neweconomics.org/2021/01/escaping-green-deprivation

Cancer screening

In 2020, cancer screening in Brent was worse than the national average for all indicators (breast; cervical; and bowel). If caught early, there is a higher chance that cancer can be successfully treated

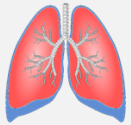
Risk factors for Long Term Conditions

This Risk factors for heart disease, stroke, cancer and diabetes are being overweight and inactive. Healthy eating and physical activity can mitigate these risk factors. There are discrepancies among ethnic groups both in prevalence and mortality rates from different diseases, including heart disease and stroke; liver disease; cancer; respiratory disease; and diabetes. Enabling self-care for people who have these diseases is important to allow them to manage their condition.



Liver disease

12.9



Respiratory disease

11.5

Cancer

44.4

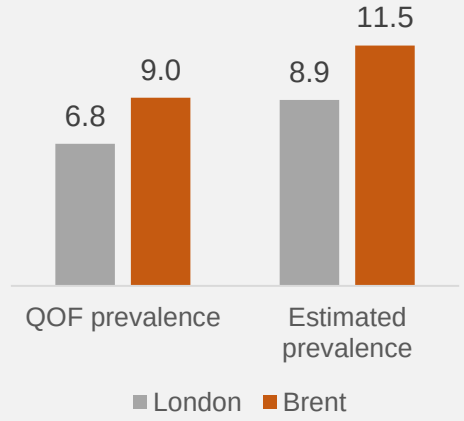
Heart disease and stroke

30.6

Diabetes

Under 75 preventable mortality rate (per 100,000 population)

Diabetes prevalence



1 in **5** adults have a common mental disorder

Staying healthy

I know what keeps me and those I care for healthy, both physically and mentally, and am able to stay healthy; we are able to manage health conditions we have using self-care first and also have access to good medical care as needed

The Policy Institute at King's College London found

43%

expected their mental health to be worse due to Covid

Five +1 ways to wellbeing

Evidence suggests building these actions into your daily life can help to improve your mental health and wellbeing. A combination of all of these behaviours will help to enhance individual wellbeing and may have the potential to reduce the total number of people who develop mental health disorders in the longer term

Young people

The youth strategy conducted a survey of 613 young people; one of the overarching topics of concern highlighted by the young people was the impact Covid and lockdown had on their mental health.

Risk factors for young people's mental health were Brent is worse off than the national average:

- Low-income families
- Family homelessness

Risk factors

Socio-economic factors impact mental health such as housing, employment, and deprivation. Mental health affects different ethnic groups differently. Overall, Asian people have better mental health, conversely, black and Irish groups have more mental health hospital admissions.

Source: PHE profiles: children's mental health and wellbeing; public health profiles; mental health and wellbeing; JSNA; https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england#Overall

The workforce

The pandemic has put a great strain on our health and council workers. The continued stress they have been under is taking its toll. The Guardian reported that "*A quarter of NHS workers are more likely to quit their job than a year ago because they are unhappy about their pay, frustrated by understaffing and exhausted by Covid-19, a survey suggests."* The challenge in front of us now is how to recover – how to catch up on the work which has been deferred and provide the care needed.

1 in 4

NHS workers are more likely to quit their job than a year ago

New way of working

In February 2021, the Department for Health and Social Care published the white paper: Integration and Innovation working together to improve health and social care for all. This paper proposes new ways of working for a health and care Bill. It introduces Integrated Care Systems (ICS); these will comprise of two parts, the ICS NHS body (responsible for NHS strategic planning and allocation decisions) and ICS health and care partnerships which will develop a local plan to address the system's health, public health and social care needs. This is a new more collaborative way of working.

Healthy workforce

The workforce will be healthy and happy; and the health and wellbeing system will recover quickly

Mutual aids and volunteering

The long term effects of Covid is an unknown quantity; the impact of Covid on individuals will affect our healthcare's recovery and resilience. Although much of the pandemic was terrible, the way the communities came together to support each other was a true joy. People united against inequality and disease. Ideally we would foster and enable this true community spirit to keep growing and connecting.

Source: https://www.theguardian.com/society/2021/mar/30/one-in-four-nhs-workers-more-likely-to-quit-than-a-year-ago-survey-finds

Collaborative ways of working

Brent Health Matters is a programme set up by the Health and Wellbeing Board to tackle health inequalities, the avoidable, unfair and systematic differences in health between different groups of people. This is a combined piece of work between Brent Council, Brent CCG, CNWL (mental health service providers), Northwick Park Hospital and local GPs. Community engagement and understanding the local community is key to this work. This programme will build up a better picture of our population's health and a greater understanding of the barriers different populations face to accessing healthcare and health messages, enabling these barriers to be overcome.

Healthy ways of working:

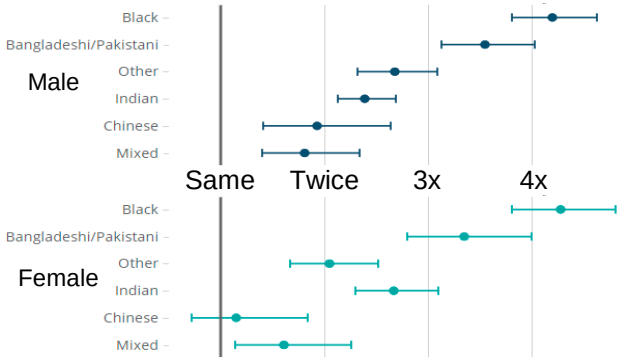
Hearing, understanding, and working with the public

I, and those I care for, can have our say and contribute to the way services are run; Data are good quality and give a good picture of health inequalities

Data quality

The pandemic has also highlighted health inequalities, specifically inequalities due to disability, ethnicity, and deprivation. We need to understand our population better, we need to understand who is affected by what better. To do this, we need to improve the quality of our data.

Likelihood of dying from Covid compared to white ethnic group



Source: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020

Brent / NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 14 July 2021
	Report from Judith Davey, Healthwatch Brent

Healthwatch Brent work plan 2021-22

Wards Affected:	All
Key or Non-Key Decision:	Non-Key Decision
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	4: Appendix 1 – Healthwatch work plan overview Appendix 2 – Healthwatch engagement strategy Appendix 3 – Healthwatch governance and prioritisation process Appendix 4 – Healthwatch role in new structures
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Jo Kay, Healthwatch Brent Manager jo.kay@healthwatchbrent.co.uk Julia Mlambo, Community and Voluntary Sector Partnerships Manager julia.mlambo@brent.gov.uk

1.0 Purpose of the Report

1.1 To provide the Health and Wellbeing Board with an update on progress in development of the Healthwatch draft work plan for 2021/22, following the completion of a competitive tender process that resulted in the contract being awarded to The Advocacy Project.

1.2 The proposed work plan outlines how the new Healthwatch Service, provided by The Advocacy Project intends to deliver the Health and Wellbeing Board's aims of ensuring that all residents in the borough, particularly the most vulnerable, are able to influence the commissioning and delivery of the health and social care services in Brent.

1.3 The work plan also outlines how the Healthwatch service will be able to support the development of the Health and Wellbeing Strategy, ensuring that communities are at the heart of the process.

2.0 Recommendation(s)

2.1 The BHWB note progress in implementing the new Healthwatch Service, and the development of the draft work plan 2021/22.

2.2 That the BHWB requests a six monthly update on the delivery of the work plan.

3.0 Detail

Activity April – June 2021

3.1 The new Healthwatch Service was commissioned in January 2021, and the contract was signed during February 2021. During the first quarter of 2021/22, officers have been to mobilise the service in line with the plans set out in during the commissioning process.

3.2 During the first quarter of the year much of the activity has focused on set up of a new service including:

- Transition from former service provider and hand over of critical work packages
- TUPE and recruitment to vacancies
- Developing an internal governance structure
- Ensuring Healthwatch representation on key working groups and committees

3.3 Healthwatch has supported BHWB partners in engaging with excluded communities to increase vaccination take up, alongside other Voluntary and Community Sector (VCS) partners. Healthwatch has also attended a number of events in support of the Health and Wellbeing Strategy consultation process.

3.4 This provided the opportunity for Healthwatch to further improve its understanding of local communities, build relationships with key stakeholders and develop links to relevant health and social care services. A particular focus of the first three months has been developing robust links to the Brent Health Matters programme given the similar focus on engagement with communities to address health inequalities.

Governance

3.5 Healthwatch has developed a governance process that ensures it is independent, transparent, open and robust. The attached Prioritisation Process demonstrates how the Healthwatch Service will work with an Advisory Group to agree what issues the Healthwatch Service will see as a priority for investigation (please see Appendix 3).

3.6 Healthwatch will work constructively with the Health and Wellbeing Board and other statutory partners and will work in a spirit of partnership, sharing information, informing stakeholders about work we are undertaking and supporting work that improves patient/service user experiences. It will retain its independence, but where possible be flexible and align with and support

strategic priorities. Collectively by gathering intelligence from different partners and patient voice will inform and influence next year's priorities for 2022/23 as well as BHWB key strategies.

Draft work plan 2021/22

3.7 The attached draft work plan (please see Appendix 1) and engagement strategy (please see Appendix 2) details activity Healthwatch will undertake in 2021/22. The Healthwatch service will:

- Develop a community engagement approach based on a sequential model, which prioritises where health and care partners have identified key communities and groups. The sequential approach will enable Healthwatch to develop an in depth understanding of communities, their needs and how statutory services can best meet them. The emphasis on engagement with BAME groups, particularly black communities, links to BHWB areas of focus.

- Undertaking Enter and View actions in line with the Healthwatch statutory function across all services to ensure user voice, service users, families, carers and staff are heard. Ensuring that issues are identified, recommendations are robust and appropriately fed back to decision makers.

- Reviewing its delivery in the context of the changes to the Health and Social Care Act. The service will need to ensure that its functions are aligned to the new governance structures of the Integrated Care System (ICS) and Integrated Care Partnerships (ICP) (please see Appendix 4).

- Supporting the development of the Joint Health and Wellbeing Strategy, to ensure that the priorities contained in the strategy reflect the real needs of Brent communities that will be evidenced by the work and reports Healthwatch produce.

- Contributing the COVID recovery actions, for example supporting vaccine take up and test and trace activities.

- Maintain its core function to capture patient voice across the full spectrum of health and social care

4.0 Equality Implications

4.1 The Healthwatch Service has been assessed against the Equality and Diversity Policy so that it ensures we are fully committed to and undertaking action under the Equality Act 2010 and other forms of legislation that combat discrimination and promotes equality and diversity.

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Appendix 1. Healthwatch Brent Workplan Overview

Introduction

The Healthwatch Brent (HWB) Workplan of priorities is set by the HWB Advisory Group, made up of:

- 1 trustee from The Advocacy Project Board (Chair of the Advisory Group)
- 2 representatives of the Brent Grassroots Steering Group
- 2 representatives from the Independent Experts Network (different people will be invited to attend as representatives of the network as required by the agenda).
- 4 members of the public
- 2 Healthwatch Brent volunteers
- Healthwatch Manager

The Advisory Group determines which aspects of health and social care will be looked at as a priority each year as set out in our Prioritisation Process; Appendix 3. This group is currently recruiting members of the public through an interview process and electing voluntary and community sector partners who represent a wide variety of community partners. Once the full Group is in place by the end of July, it will then be able to start setting priorities and will have its first full public meeting in September 2021.

In the meantime we have created an draft Workplan 2021/22 to ensure we are responsive to current circumstances. This workplan includes:

Engagement Plan

An ambitious engagement plan has been devised in Quarter 1 to understand the experiences of diverse communities in Brent. Figure 1. sets out the timeframe in which we will be engaging communities to ensure patient and public voice is heard.

Figure 1

Workplan Timeline

Project	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Engagement Programme: Stonebridge communities			■	■	■	■	■					
Engagement Programme: Harlesden, Willesden Green communities				■	■	■	■	■				
Engagement Programme: Wembley Central, Kenton, Queensbury communities						■	■	■	■	■		
Engagement Programme: Dollis Hill communities							■	■	■	■	■	
Engagement Programme: Barnhill, Fryent communities								■	■	■	■	■
Enter & View Report: Minimal impact from Covid-19			■									
Enter & View Report: High impact from Covid-19			■	■								
Follow up on 2019-20 recommendations			■	■	■	■						
Follow up on recommendations ongoing						■			■			■
Health & Wellbeing Board	■			■			■			■		
Community and Wellbeing Scrutiny Committee	■			■		■		■		■		■
CCG/ICS Governing Body	■		■		■		■		■		■	
Health & Wellbeing Strategy engagement				■	■							

The Healthwatch Service will work with HWB volunteers, Community leaders, Community forums, Service Users and Patient Participation Groups to capture the views of Brent residents. The attached Engagement Strategy will enable us to embed User Engagement and Community Development at the heart of the Healthwatch Service, ensuring Healthwatch is empowering user voices and Patient Voices are heard across the Integrated Care Partnerships structure by improving access to health services, with a particular focus on the poorer and most diverse groups.

The Engagement Strategy; Appendix 2 also utilises council demographic data to identify ethnicities, areas of deprivation and health inequalities so we can target wards and communities for engagement. We are also working with the Voluntary and Community Sector to utilise their knowledge and experience and ensure we are not duplicating. This means we better understand the languages we need to use for materials and the community assets and leaders we need to work with. We are already working on stage 1 see Figure 1.To effectively address multiple barriers, that diverse community groups face we need to understand what those barriers are and co-produce sustainable solutions with affected communities. We will engage with community groups in settings and ways that are convenient to them, rather than inaccessible structures and data collection methods that exclude people.

We want people to be able to tell us what issues are important to them, so we have set up a simple online survey Tell us your views :: Healthwatch Brent where people can tell us about any experience with any service.

To ensure we are reaching a wide representation across diverse community groups in Brent and the Healthwatch Service is not digitally excluding residents, we will:

- Utilise a range of communication channels like online surveys, digital sessions, social media, video, infographics, phone, drop in or focus groups.
- Develop a community database with tailored information about how each community group wishes to engage with the Healthwatch Service, detailing preferred communication channels to enable them to effectively influence and inform Healthwatch priorities.
- Create Task and Finish groups that target identified groups to ensure the right voices can influence service design and delivery and reduce the barriers in accessing local assets.
- Ensure we have a visible presence within the community – through attendance at meetings, local forums, decision making boards, partnership projects etc.
- Evaluate demographic data to evidence reach, address gaps and ensure diverse representation.

The Healthwatch Service will also use a range of prompts when engaging with people to encourage them to give feedback on relevant issues:

- Impact of Covid-19 and access to vaccinations
- Experiences of delays and backlogs in health and social care
- Mental health services for adults and children

This feedback will build our understanding of the issues faced by the community and help inform future priorities for Healthwatch Brent.

Engagement on the Health and Wellbeing Strategy

We are working with colleagues to deliver focus groups to gather views on the draft health and wellbeing strategy through the next few weeks. This will ensure public participation in defining the aims of the strategy.

Working in partnership with stakeholders

We are actively engaging with existing networks and meetings to ensure we understand upcoming health and social care priorities, represent the wider public, and ensure effective engagement of the public in planning and commissioning. For example:

- Being an active member of the Health and Wellbeing Board, using upcoming meetings to present our Annual Report, project reports and supporting the development of the Health and Wellbeing Strategy
- Working with the Adult Safeguarding Board to investigate concerns about the low rate of safeguarding alerts recorded from diverse communities.
- Working with the Community and Wellbeing Scrutiny Committee looking at GP access and following up on previous Healthwatch Brent recommendations for GP services.
- Working with neighbouring Healthwatch to coordinate input at the North West London CCG Governing Body and Primary Care Co-commissioning meetings to ensure there is effective public engagement in decision making.

Enter & View

We have published two reports following up on Enter & View visits undertaken by the previous HWB provider to understand what has changed during the pandemic.

We have raised the issues arising from the reports with Adult Social Care and the Adult Safeguarding Board.

Previous Recommendations

We want to ensure there is continuity of using intelligence to improve services, previous provider recommendations have been reviewed and the Healthwatch Service is following up on how they have been acted upon.

Some of these are quick wins, for example 'Identifying Young Carers in Substance Misuse Households in Brent' made recommendations that we can check through conversations with the substance misuse providers and carer organisations.

Similarly, The Advocacy Project can give feedback on the recommendations made in 'Cancer Screening for People with Learning Disabilities in Brent' through our user involvement project, My Health, My Choice.

Other recommendations will require undertaking further Enter & Views and will need to be considered by the HWB Advisory Group alongside the other potential priorities.

Gathering intelligence for next set of priorities

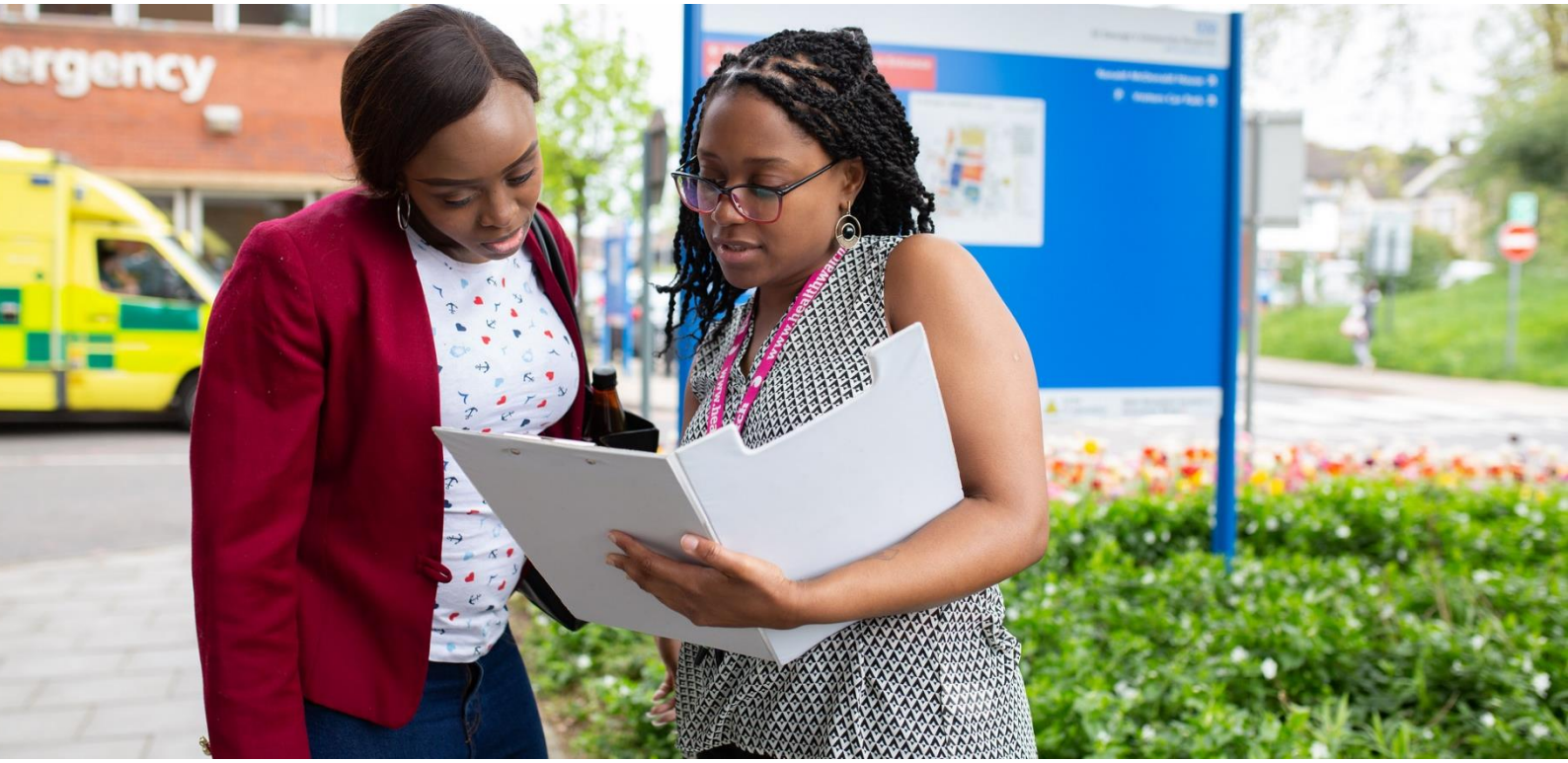
We are already working with the community and stakeholders to ensure the most vulnerable and diverse groups, including learning disabilities, mental health, older people and dementia, dual diagnosis, Black, Asian and Minority Ethnic groups and LGBTQ groups are heard. The Healthwatch Service will support diverse communities to speak up, enabling Healthwatch to gather insight and intelligence on people's experiences to tackle inequalities and improve the design and delivery of local health and care services.

In the first Quarter Healthwatch has identify potential new priorities by engaging with Service Users, Patient Voices, HWB Volunteers and Councillors, potential priorities are:

- Safeguarding reporting – helping the Adult Safeguarding Board understand why the vast majority of safeguarding reports are for people that are white British, and so few are from other ethnic backgrounds.
- GP access – understand the positive and negative experiences of people in Brent getting a GP appointment and the type of service they receive.
- Mental Health services – working with existing voluntary sector networks to gather intelligence on good and poor practice in accessing services. This may be GP or community mental health services.
- Access to dentistry – local and national feedback indicates many challenges in getting NHS dentistry treatment.

We are gathering local intelligence to take to the HWB Advisory Group to agree which issues will be confirmed as priorities for this years workplan.
The workplan is a live document that is regularly updated and will be published on the Healthwatch Brent website.

Healthwatch Brent:
Engagement Strategy 2021-22



Introduction

Healthwatch Brent is committed to engaging with the diverse population of Brent to hear their experiences. Our organisational strategy sets out how we collate and theme those experiences, raise them with providers and commissioners, and bring about improvements.

The engagement undertaken by Healthwatch Brent is approached in three ways

- Continuous Engagement
- Focussed Engagement
- Projects

These are detailed below.

Continuous Engagement

Anyone can contact Healthwatch Brent with the experiences of health and social care services, at a time and in a way that works best for them:

- Via an online form on the website
- Via email
- Via our freephone number
- Face to face to staff and volunteers at events and engagement on the high street when safe to do so.

We use a continuous engagement approach; capturing permissions to add people to our engagement database so we can contact them again about their experiences of other services. By doing this we develop a bank of patients and public we can contact during other projects and surveys.

This engagement is open to everyone and we work in partnership with local organisations and events. Recently this has been by attending the Vaccination Bus and other stakeholder events that are being planned as lockdown eases.

Focussed Engagement

We have used Brent Council's detailed data on the make up of each ward to understand the communities in the borough. We have produced a plan which focusses on each of these communities in turn, to ensure we plan our approach and use the right languages and community assets to reach people in those communities. The order is decided by approaching the largest communities and/or highest health inequalities first in certain wards.

Plan order	Ward	Target Audience
1	StoneBridge, Harlesden	Black African and Caribbean
2	Stonebridge, Willesden Green	Those experiencing health inequalities and/or disability
4	Wembley Central, Kenton, Queensbury	Indian
5	Dollis Hill	Pakistani

Plan order	Ward	Target Audience
6	Barnhill, Fryent	Arab
7	Queensbury, Preston	Romanian
8	Wembley Central, Alperton	Portuguese
9	Alperton	Polish
10	Willesden Green	Italian

As each group is a broad category, we will break down each category so we ensure we are using the appropriate languages and methods of contact.

We ensure we work with local community and voluntary sector partners, to maximise existing connections and knowledge. We will make online and printed materials available in a sufficient range of languages to reach the majority of people in those communities.

We ask for more detailed equalities monitoring information, encouraging people to self identify their culture and preferred language. As mentioned previously, we ask for permission to retain peoples details and contact them again in the future about relevant issues, thus developing a continuous engagement approach.

We use a project management approach to engagement planning with a template set of activities we use to ensure a systematic approach:

Stage	Action
Research communities and groups to contact	List known groups Research other databases for further groups Make contact with key stakeholders about best way to approach groups
Confirm message and presentation	Agree wording of question to be asked or information to be shared Arrange design, alternative languages and formats, online and hardcopy
Identify team involved and how they will do the work	Confirm staff and volunteers undertaking the project, brief them and give them the questions and information
Make contact with groups and community champions	Contact people and groups who will provide a way into the wider community. Agree opportunities to meet people and gather their views
Engagement	Engage with the communities and groups
Collate feedback	Input hardcopy forms into online survey or database
Analyse feedback	Pull out key stats and themes

Produce report on themes	Short report on process and themes
Publish report and share with stakeholders	Publish on website. Ensure key stakeholders from comms plan receive a copy
Update everyone who contributed	Emails to everyone with a copy of the report and where else it has been shared.
Diarise follow up on any recommendations	

Projects

Projects are larger pieces of work, identified by the Healthwatch Brent Advisory Group as set out in our Prioritisation Process. They are about specific services for example A&E or care homes, or specific conditions such as mental wellbeing or diabetes.

Priorities are selected from what we hear from the public, voluntary and community sector and health and social care providers and commissioners. We work with the services involved and commissioners to understand the issues and challenges, and then use surveys, face to face engagement and our statutory power to enter and view services to hear people's experiences, along with their carers, families and the staff involved in the service. We target project engagement at people who use the service or may have the condition.

We then publish a report on our findings along with any recommendations, and work with the provider and commissioner to monitor how the recommendations are actioned. We regularly publish the impacts and outcomes on services that come about because of our work.

Healthwatch Brent

Governance and Prioritisation Process

May 2021

Document control

Version	1.0
Author	Steve Inett
Approved by	The Advocacy Project Board of Trustees
Date approved	20 May 2021
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Review date	20 May 2022

Policy statement

Healthwatch Brent makes its decisions in an open and transparent way and ensures the interests of the people of Brent are always put first. This process outlines the steps taken to ensure priorities are evidence based and lead to substantive impact in the community. The governing regulations and standards are:

- The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 – referred to as Regulation 40 throughout this document.
- Freedom of Information Act 2000.
- Seven Principles of Public Life (Nolan Principles).

This policy applies to all relevant decisions made by Healthwatch Brent.

Relevant decisions

Regulation 40 requires Healthwatch Brent to have in place and publish procedures for making relevant decisions. Relevant decisions include:

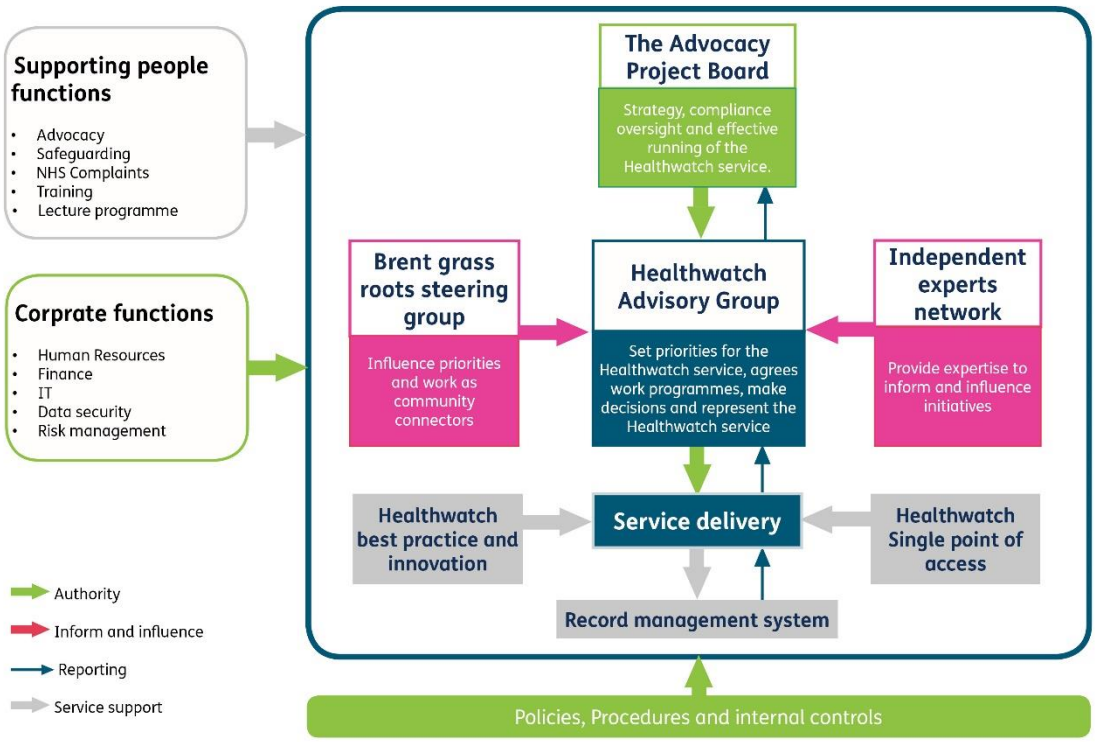
- How to undertake our activities.
- Which health and care services we are looking at covering with our activities.
- The resources we will use on our activities.
- Whether to request information.
- Whether to make a report or a recommendation.
- Which premises to Enter and View and when those premises are to be visited.
- Whether to refer a matter to Overview and Scrutiny Committee.
- Whether to report a matter concerning our activities to another person.

- Any decisions about sub-contracting.

Relevant decisions do not include day-to-day activity that may be required to carry out exploratory work prior to making a relevant decision.

1 Responsibility for priority setting

Healthwatch Brent Governance model



The Advocacy Project Board of Trustees

The Advocacy Project is the organisation that holds the contract for Healthwatch Brent. It is the employer of staff working within Healthwatch Brent. It delegates the line management of the Healthwatch Manager to the CEO (who is also a trustee as this is a unitary board) and delegates priority setting to the Healthwatch Brent Advisory Group.

The Advocacy Project Board of Trustees must be assured that the governance structure and processes in place to deliver Healthwatch Brent are robust and that the service meets its contractual and statutory obligations. It should also ensure the highest standards of quality and adherence to best practice, in particular the Healthwatch Quality Framework.

The Advocacy Project Board will periodically review the decisions, initiatives and activity taken by Healthwatch Brent to continue to assure itself that the governance structures

and bodies are fit for purpose. It will do this through reporting from the Manager via the CEO, as well as having a representative on the Advisory Group.

Healthwatch Brent Advisory Group

Aims of the group:

- To ensure there is collective responsibility in setting the priorities and strategic direction of the organisation as set out in the Healthwatch Brent Workplan and Strategy.
- To ensure the views of the Brent Grassroots Steering Group are heard in the prioritisation process.
- To ensure the views of the Independent Experts Network are heard in the prioritisation process.

Objectives:

- Work in constructive partnership with the members of The Advocacy Project Board, Brent Grassroots Steering Group, Independent Experts Network, staff and volunteers
- To have active oversight of the process for setting annual priorities for the organisation
- Regularly review the list of priorities, receive updates on potential new more urgent priorities and advise how the list of priorities should be adjusted.
- Monitor the progress of project work and other activity on priorities, hold staff and volunteers to account if they are not progressing things effectively and that stakeholders are aware of any significant delays in project timeframes.
- Identify what difference a Healthwatch intervention has made and take a view on whether it is enough.
- Advise on utilising Enter & View effectively
- Evaluate whether we are effectively balancing how we raise the voices of the public and challenge services to improve, with ensuring we work in a professional, collegiate, constructive manner with stakeholders.
- Consider whether Healthwatch Brent is suitably visible to public and stakeholders.

Membership:

- 1 trustee from The Advocacy Project Board (Chair of the Advisory Group)
- 2 representatives of the Brent Grassroots Steering Group
- 2 representatives from the Independent Experts Network (different people will be invited to attend as representatives of the network as required by the agenda).
- 4 members of the public
- 2 Healthwatch Brent volunteers
- Healthwatch Manager

The Advisory Group determines which aspects of health and social care will be looked at as a priority each year. It must remain independent of any undue influence and be free to select the priorities it feels represent the best for the residents of Brent. Transparency, rigour, and objectivity are the basis for the Advisory Group's effective and successful working.

There are two mechanisms for them to set the priorities of Healthwatch Brent:

- Annual priority setting
- Regular review of the workplan and recommendations of new priorities throughout the year

Annual Priority Setting emerging

The Healthwatch Brent Workplan of priorities is set by April each year. Potential priorities can come from a number of sources:

1. What Healthwatch Brent has heard from the public

Healthwatch Brent records issues throughout the year that could be potential priorities (see the section on Regular Review).

2. Health commissioning plans

Integrated Care Systems and Partnerships are required to produce an annual plan. Strategic meeting such as governing body meetings, Health and Wellbeing Board and strategy, Health Overview and Scrutiny Committee give further intelligence on strategic issues.

3. Social care commissioning plans

Social care commissioners plan forward decisions that impact on commissioning. Meetings of the council cabinet and social care committee provide further intelligence.

4. Intelligence from the Brent Grassroots Steering Group and other community and voluntary stakeholders

The Grassroots Steering Group shares local experiences and issues of concern and provides links with local voluntary sector infrastructure and charities delivering health and social care services.

5. Intelligence from other projects delivered by The Advocacy Project

The experiences of people gathered via the advocacy, personal health budget and user involvement work that The Advocacy Project also deliver are a rich source of issues for Healthwatch Brent to investigate further.

6. Joint working proposals from neighbouring Healthwatch and Healthwatch England

Neighbouring boroughs will be undertaking work that either impacts on Brent residents or residents can contribute to. Healthwatch Brent works closely with its neighbours but needs

to ensure it has capacity before it commits to any joint working. This also applies to Healthwatch England campaigns.

Some of these priorities involve ongoing involvement in meetings and monitoring the progress of agreed areas, some will mean doing additional work to understand the service and the experiences of the public. Healthwatch Brent gathers as much information as possible on the aims of each potential priority, any known timescales and an understanding of what form the work might take.

The paid team compiles the information on any potential priority which it shares with the Advisory Group to ensure they have all available information to make a decision.

The Advisory Group receives the information and agrees which ongoing and monitoring priorities will be included in the workplan.

The Group will have the power to delegate some of the relevant decision making to the Lead Officer of Healthwatch Brent, for example, small pieces of work which do not have a substantive impact on staff or financial resources.

For priorities requiring additional work which requires a project approach, the Advisory Group ensures Healthwatch Brent only agrees to projects they have the capacity to deliver. They select based on:

- potential for most impact and change
- what can be realistically resourced?
- ensuring seldom heard groups are represented.

This process uses the Healthwatch England Research project Planner Questions to interrogate each proposal fully:

Project objectives - What the is project seeking to achieve

Criteria	Action	Date
Does this fit with our strategic objectives and statutory remit?		
What is the evidence base for this work?		
What is the proposed impact on individuals and the community?		
Can we influence change, or is there an organisation better placed to do so who we can work with or approach?		

How will we undertake our activities?		
Which services will we cover?		
What additional information will we need to request and who from?		
Is an Enter and View required? What premises will be included? What is the timescale?		

Resource requirements (people and financial)

Does this fit with our overall work plan? Do we have the staff and volunteers to deliver?		
How much will we spend? Are there additional funding requirements to		

Project deliverables - What difference or impact will the project have?

What will be the outcome of our work? How will we demonstrate impact? A report? Recommendations?		

Communication - Who will be interested in our outcomes and impact?

Does this need to be referred to the local Overview and Scrutiny		
Who will we share our planned work and our findings with?		
Do we need to subcontract?		

This list becomes the workplan and is then shared with the public and stakeholders. These decisions and any others, including those delegated to the Manager, are recorded in the minutes. Once a decision has been made, the staff team is responsible for implementation and delivery, with an agreed reporting process to Group.

The dates and details of how the public can observe each Advisory Group meeting and the minutes of each meeting are published on the Healthwatch Brent website.

2 Regular Review

Healthwatch Brent is continuously 'horizon scanning' for issues that were unforeseen and may become urgent. The Advisory Group meets bimonthly and reviews new information and intelligence. It then reviews the Healthwatch Brent Workplan and determines whether new work should be added to the workplan, replace an existing workplan priority, or be rejected as a priority due to insufficient resource.

The Advisory Group also receives updates on the progress of projects and activities and information about levels of resources so that they can weigh the capacity of the organisation.

The group operates by discussion and consensus and is attended by the trustee representative from The Advocacy Project Board, who has the authority to escalate to the Board any activities that they consider to be contrary to the contract performance framework, the statutory duties or best practice.

The Advisory Group is empowered to take agreed actions forward within the allocated budget and available resources and determine delivery timeframes.

3 Outcomes

Healthwatch Brent follow up all recommendations they make through projects with the relevant organisations. For larger projects there is an outcome review at six and/or twelve months after the project report is published. These outcomes are monitored in the Impact Tracker recommended by Healthwatch England and published in a regular impact report. Where there is resultant service change this is recorded in You Said We Did and published.

The Advisory Group receives these documents, so they can review the effectiveness of Healthwatch Brent in carrying out its aims and having sufficient impact.

4 Dealing with Breaches of this Process

If a decision is taken in the name of Healthwatch Brent without authorisation in the manner set out in this process document, The Advocacy Project Board will determine what action is needed. This may be to either approve the decision retrospectively, or to reverse the decision.

If the breach of the agreed procedure is considered to have also breached the contract between Healthwatch Brent and Brent Local Authority, it will be reported to the Local Authority and further action agreed between the Local Authority and Healthwatch Brent.

In each eventuality, actions will be minuted and published on Healthwatch Brent's website.

5 Review of This Process

This process will be reviewed annually by The Advocacy Project Board. Additionally, it will be reviewed in response to a breach or any feedback that indicates a more urgent need for review. Any amendments to this policy and the procedures governing the making of relevant decisions will require a simple majority of board members voting in favour.

The amended policy document will be published on the website of Healthwatch Brent as soon as is practicable.

6 Equality, Diversity, and Inclusion statement

Healthwatch Brent is committed to ensuring all decisions made are free from any form of discrimination on the grounds of age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, in accordance with the Equality Act 2010.

Healthwatch Brent will monitor this policy to identify whether it is having an adverse impact on any group of individuals and act accordingly.

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Healthwatch Brent: Our role in the new integrated health and care system of Brent and North West London

June 2021

Introduction

The Advocacy Project took over the contract for Healthwatch Brent on 1st April 2021. This comes at a time of significant change in the NHS, namely the development of the North West London CCG and Integrated Care System, into which Brent CCG has been merged. It also comes at a time of impending statutory change with the White Paper 'Integration and innovation: working together to improve health and social care for all', which sets out legislative proposals for a health and care Bill. Although this predominantly aligns the law with the NHS England direction of travel for the last few years, it may mean further change for North West London and Brent Council once the bill has been debated and passed.

As described in the Healthwatch Brent Strategy and Independence Policy, we know we cannot work in isolation from the rest of the system and are committed to:

- Work in a spirit of partnership, sharing information, informing commissioning and provider organisations about work we are undertaking and supporting their work that improves patient/service user experiences.
- Share intelligence that we have received from the public.
- Ensure our activities align with organisations' timescales.
- Meet with system partners regularly to discuss shared areas of concern and monitor an action plan made up of agreed issues, Healthwatch Brent report recommendations and CQC findings.
- Act as a critical friend for consultations commissioners undertake.
- Provide input in high level strategic issues where there is a need to look at how to work with the public or give a high level view.

Healthwatch Brent will use it's close links with the system to keep pace with the changes and adapt to fit with new structures and ways of working.

Healthwatch Brent involvement in the development of the Integrated Care System (ICS)

System Level

We will ensure we are involved in the development of the wider system, working with the governing body of the North West London CCG and in the future the ICS.

Using our published Prioritisation Process the Healthwatch Brent Advisory Group will take into account the priorities of the ICS and Brent Council when setting the priorities for Healthwatch Brent.

Place Level

Healthwatch Brent will continue to support the Covid-19 vaccination programme as we have recently with the Vaccination Bus and speak to communities about vaccine uptake and vaccine access issues.

We will work with the Integrated Care Partnership and Brent Primary Care Networks and hospital and community trusts to improve community and intermediate health and care services for adults, children and young people.

We will also work closely with the Brent Council Community and Wellbeing Scrutiny Committee and the Brent Health and Wellbeing Board. We will also work closely with Brent Social Care Commissioning and the Brent Public Health team. We will work with services for adults, children and young people.

We will work in partnership with neighbouring Healthwatch to gather intelligence on hospital services that we confirm through our prioritisation process. This might include looking at discharge, planned procedures or rehabilitation services.

We will work with the Care Home Forum to share our enter and view visit reports and feedback on progress against our recommendations.

We will work with mental health services for adults and young people to ensure equity of access and quality across the borough.

Neighbourhood Level

Healthwatch Brent is committed to hearing all voices but particularly those of our diverse and seldom heard communities. We will do this via our Brent Grassroots Steering Group which is a network of individuals, groups and organisations from those communities who will support our intelligence gathering and priority setting. We will also proactively make contact with those communities to gather their views. This will support programmes such as Brent Health Matters to reduce health inequalities and gather feedback from seldom heard communities to inform the work of the programme.

We will work in partnership with GP practices and Patient Participation Groups to understand the experiences of the public when using primary care services in Brent.

We will work within ongoing Covid restrictions to contact people via a range of methods, including face to face where possible, to ensure everyone has access to Healthwatch Brent.

Social Care

We will link the range of consultative forums and the Youth Parliament in Brent Council with our Grassroots Steering Group to ensure a joined up approach to engagement and avoid ‘consultation fatigue’ in the members of those groups.

We aim to be pro-active partners to the Community and Wellbeing Scrutiny Committee and provide intelligence on services it scrutinises. We will also work with them on joint projects, for example, we might agree to jointly review the new Home Care commissioning arrangements once they have been able to bed-in.

Conclusion

Healthwatch Brent will be a key partner and source of intelligence to support the continuing transformation and integration in health and social care