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Health and Wellbeing Board

Thursday 24 July 2025 at 6.00 pm

Conference Hall - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Please note this will be held as an in person meeting which all Board members will be required to attend in person.

The meeting will be open for the press and public to attend. Alternatively, the meeting can be followed via the live webcast HERE.

Membership:

Councillor Nerva (Chair)	Brent Council
Rammya Mathew (Vice-Chair)	North West London Integrated Care Board
Councillor Donnelly-Jackson	Brent Council
Councillor Grahl	Brent Council
Councillor Knight	Brent Council
Councillor Kansagra	Brent Council
Robyn Doran	Brent Integrated Care Partnership Executive
Simon Crawford	Brent Integrated Care Partnership Executive
Jackie Allain	Brent Integrated Care Partnership Executive
Gina Aston	Healthwatch
Sarah Law	Residential and Nursing Care Sector
Rachel Crossley	Brent Council - Non-Voting
Kim Wright	Brent Council - Non-Voting
Nigel Chapman	Brent Council - Non-Voting
Dr Melanie Smith	Brent Council - Non-Voting
Claudia Brown	Brent Council - Non-Voting

Substitute Members (Brent Councillors)

Councillors:

M Butt, Farah, M Patel and Krupa Sheth

Councillors:

Hirani and Mistry

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

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit: **www.brent.gov.uk/democracy**

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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 1 - 10

To approve as a correct record, the attached minutes of the previous meeting held on 2 April 2025.

4 Matters arising (if any)

To consider any matters arising from the minutes of the previous meeting.

5 Update on the outcome of Brent's January 2025 Local Area SEND Inspection 11 - 22

To provide the Health and Wellbeing Board an update on the outcome of Brent's recent (January 2025) Local Area SEND Inspection, outlining the key findings, agreed action plan, and progress made against the actions to date.

6 Brent ICP Primary Care Transformation Executive Group Progress Update 23 - 44

This report provides the Health and Wellbeing Board with an update on the progress of the Brent Integrated Care Partnership (ICP) Transformation Executive Group.

7 Joint Health and Wellbeing Strategy Progress Update 45 - 154

This report provides a progress update following the approval of the refreshed Health and Wellbeing Strategy in July 2024.

8 Integrated Care Board (ICB) Reforms 155 - 162

This report provides the Health and Wellbeing Board with an update on the reconfiguration of the ICB and potential implications on services.

9 Better Care Fund Year-End 2024-25 and Plans for 2025-26 163 - 172

This report presents the Better Care Fund (BCF) 2024-25 which was submitted to the BCF Team and NHS England (NHSE) on 6 June 2025, and seeks formal ratification for the end of year report, and provides an update on the planning process for BCF 2025-26.

10 Health and Wellbeing Board Forward Look - Future Agenda Items

To discuss and agree any future agenda items for the Health and Wellbeing Board.

11 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Deputy Director – Democratic and Corporate Governance or their representative before the meeting in accordance with Standing Order 60.

Date of the next meeting: Thursday 13 November 2025

Please remember to switch your mobile phone to silent during the meeting.

- The meeting room is accessible by lift and seats are provided for members of the public on a first come first served basis.

MINUTES OF THE HEALTH AND WELLBEING BOARD
Held as a hybrid Meeting on Wednesday 2 April 2025 at 6.00 pm

Members in attendance: Councillor Nerva (Chair), Dr Rammya Mathew (Vice Chair), Councillor Mili Patel (Brent Council), Councillor Butt (Brent Council), Councillor Donnelly-Jackson (Brent Council), Jackie Allain (Director of Operations, CLCH), Patricia Zebiri (HealthWatch), Sarah Law (Residential and Nursing Sector), Dr Melanie Smith (Director of Public Health, Brent Council – non-voting), Nigel Chapman (Corporate Director Children and Young People, Brent Council – non-voting), Rachel Crossley (Corporate Director Community Health and Wellbeing, Brent Council – non-voting), Claudia Brown (Director of Adult Social Care, Brent Council – non-voting)

In attendance: Wendy Marchese (Strategic Partnerships Manager, Brent Council), Hannah O'Brien (Senior Governance Officer, Brent Council), Tom Shakespeare (Director of Brent Integrated Care Partnership), Steve Vo (Assistant Director of Place – Brent Borough, NWL ICS), Gina Aston (Healthwatch), Eleanor Maxwell (Senior Programme Officer – Better Care Fund Lead for Brent Borough), Sarah Nyandoro (SRO - Mental Health and Wellbeing Exec Group Brent Based Partnership (Brent ICP)), Matt Henshaw (Borough Director for Mental Health & Learning Disability Services - Brent & CNWL Lead for Neurodiversity), Will Holt (Change and Improvement Programme Lead, Brent Council), Josefa Baylon (Head of Integration, Integrated Neighbourhood Team Development)

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

Apologies for absence were received from the following:

- Kim Wright (Chief Executive, Brent Council)
- Councillor Grahl, substituted by Councillor Butt

2. **Declarations of Interest**

Personal interests were declared as follows:

- Councillor Nerva – Councillor Member of the North West London Integrated Care Board (NWL ICB)

3. **Minutes of the previous meeting (28 October 2024)**

RESOLVED: That the minutes of the previous meeting, held on 28 October 2024, be approved as an accurate record of the meeting.

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

The Chair advised the Board that a letter to the ICB had been sent, signed by himself as Chair and Dr Rammya Mathew as Vice Chair of the Health and Wellbeing Board, in relation to the NWL Forward Plan. They awaited feedback from that letter and looked forward to further engagement.

5. **Better Care Fund Planning Process 2025-26**

Steve Vo introduced the report, which provided an update regarding the Better Care Fund planning process for 2025-26. In providing an update, he highlighted the following key points:

- The national deadline for the plan to have been completed, agreed and submitted to NHSE was 31 March 2025, but, due to factors outside of the borough teams' control, including waiting for NWL ICB to review the finance and proposals, there was no agreement to submit.
- Brent had received an extension to submit their plan by 4 April 2025 which officers were aiming for.
- Members attention was drawn to the challenge of the ICB asking for a 50% reduction in additional ICB funding allocated to the Brent local authority, resulting in a decrease of £864k. The Board were advised that this would have an impact on winter planning and the Brent Borough Based Partnership were undertaking detailed analysis to assess the risk posed by the reduction and identify potential measures to achieve a balanced budget.
- As a result of the reduction in funding, decisions had been made to remove the Discharge to Assess physio service, which had been a pilot programme providing fast-tracked physio access to residents. This service was in addition to the existing Community Physio service and work was ongoing with CLCH to support those changes and reduce any risks as a result.
- Rachel Crossley added that she had delegated authority from the Board to sign the BCF off so that it was submitted on time. Unless there were major changes from the ICB then she would use that delegated power on 4 April 2025 to sign off and submit the plan.

The Chair thanked the presenters and invited contributions from those present. The following points were made:

- The Board acknowledged that the 50% reduction in additional funding would have an impact and asked how officers would make decisions about what schemes to take forward. Steve Vo advised there had been 3 additional schemes under review which all had a direct impact on hospital discharges, and one would impact step-down beds. The review had found that changes to the reablement service would have the least impact as it was a pilot scheme that had no established funds. Tom Shakespeare added that the Integrated Care Partnership (ICP) was looking to undertake a comprehensive review of the rehab and reablement service over the next few months to understand productivity and where the most impact could be made with the remaining resource regarding managing hospital flow and achieving good outcomes. He advised that, whilst the ICP were having to make rapid decisions driven by the ICB's financial position, there were plans to do an extensive piece of work to mitigate the impact of that reduction throughout the year.
- The Board asked how they could be assured that the planning process laid out met the needs of the community. Steve Vo advised that the majority of the plan was a rollover of activity of the previous year which was assessed and evaluated every year. Any new schemes that were put in place were monitored and had outcomes measured, and where they did not achieve what was expected they would be taken off the plan.
- The Board asked whether the reduction in funding affected existing contracts in place. Eleanor Maxwell explained that the majority of the funding was non-recurrent, so the ICP did not enter permanent contracts as it was unclear what the funding position would be in following years. However, the health system was very conscious about relationships with providers and patients, and so sensitive conversations had taken place between CLCH and the ICP about the impact of cutting the reablement service.
- The Board asked whether the impact of changes across NWL would help achieve waiting list targets and reduce numbers in A&E across all 8 NWL boroughs. Tom Shakespeare did not see that as the direction of travel, but saw it as an opportunity to review how the system looked at its collective resource to drive productivity. He felt that a direction of travel that took away resources from community settings and prevention would not help to achieve broader system goals, but recognised the financial challenges ICBs were under

and the need to play a part in supporting that. He emphasised that, locally and nationally, the system should be moving towards prevention and community services.

- Rachel Crossley echoed the importance of prevention and community services long term, and highlighted wider issues around NHS planning and local government planning not being aligned with long-term financial settlement. The ICP strongly advocated for the Better Care Fund and local government funding as a whole to be longer term to enable planning and recruitment of permanent staff, particularly as resource was being put into negotiations every year instead of being used to plan strategically in a preventative space. She thought there was merit in planning together at a national level and ICB level on the same timeline, early, and for a minimum 3-year period.
- In terms of mitigations and transitions as a result of the changes, Tom Shakespeare confirmed those conversations were happening and the ICP had been clear with partners about the need to mitigate risks and work together. He added that there would be opportunities to consider where to shift investment to have the biggest impact.

In concluding the discussion and noting the update, the Board thanked officers for the honest discussion and noted the events over the previous weeks leading to the 2025-26 Better Care Fund settlement for Brent. The Board advocated for and looked forward to a shared planning approach over a longer period of time in future years.

6. **Going Local – Integrated Neighbourhood Team and Radical Place Leadership**

Will Holt introduced the report, which provided an update on progress and next steps to develop Integrated Neighbourhood Teams (INTs) as well as ongoing work to develop a Radical Place Leadership (RPL) approach in Brent. He began his introduction by explaining that RPL focused on shifting power away from organisations towards communities and encouraged consideration of how services could be redesigned with residents as the clear focus so that services were being built around residents' multiple interconnected needs. The RPL approach aimed to empower partner organisations, neighbourhood groups and communities to take greater ownership of decision making and saw residents as collaborative partners in the process. To take the work forward, the Council had established an RPL Steering Group which brought together a range of colleagues across the local authority, health, education, police and VCS. The steering group had now agreed a model for RPL and agreed to initially start testing the approach in Harlesden, which was chosen due to the health outcomes, employment outcomes and deprivation levels there as well as the strong VCS presence in the area and willingness and energy of partner organisations. The steering group had identified 3 key pillars which were seen as fundamental to the vision which were; Health INTs; establishment of INT pilots in Harlesden on the wider determinants of health; and community power to empower communities to take ownership of local placemaking.

Josefa Baylon then provided information on the neighbourhood health aspect of INTs, reminding the Board of the extensive resident engagement that had been done with residents from 2022 and presented to the Board regularly. She emphasised that the priority areas identified had been done in collaboration with communities through face-to-face neighbourhood forums, online 'have your say' surveys and virtual forums. She added that, due to the nature of the localised approach, there would be differences in terms of specific neighbourhood hyperlocal priorities. Of the 5 neighbourhood areas, the programme was very active within Harlesden and Willesden, where Harlesden aligned closely with the RPL vision focusing on the wider determinants of health such as homelessness, financial hardship and housing. She explained that the aim was for all 3 elements to eventually come together as one, i.e. the health INT and wider determinants of health INT through an RPL approach.

In relation to the INT for the wider social determinants of health, some initial key priorities specific to Harlesden had been established around financial hardship, homelessness risk and

increasing school readiness. The INT would bring together colleagues from a range of Council services and partner organisations in a co-located collaborative space in Harlesden to work with residents in need and prevent escalations to crises. The team would operate on a case worker model with one member of an INT being the primary point of contact for a specific resident, and the INT may involve children's and adult's social workers, representatives from the VCS including Crisis and Sufra, debt advisors, employment support workers, colleagues from CNWL and social prescribers. The team should be strongly informed and supported by robust data and insight about the locality.

Will Holt added that community power would underpin the work being done, building on the co-ordinated work across the INTs to bring them closer together and develop a strong community power offer with ways to co-produce services. Officers were starting to look at how the approach would work in practice, offering the opportunity to devolve some decision-making powers to local communities and ensure ownership of what was happening in local areas. He added the importance of ensuring work was not being duplicated.

The Chair thanked presenters for the introduction and invited contributions from those present, with the following points raised:

- The Board welcomed what they saw as a compelling vision of the potential for INTs and RPL.
- The Board noted the information in the slide pack circulated with the agenda showing that Diabetes Virtual MDT had saved approximately £252,000 in potential hospital bed days and that personalised asthma action plans for children had increased from 23% to 100% resulting in reductions in A&E visits, and asked for an understanding of what the investment had been to achieve those outcomes. Josefa Baylon explained that there was no upfront investment for the diabetes workstream, so the INTs used investment already allocated through the specifications of NWL ICB. As such, MDT and diabetes services were compelled to work together to deliver what was best for diabetes patients with existing resources, and an impact analysis had shown that reduction in admissions. In relation to asthma, there had been an investment of £135k from the health inequalities fund for a period of 18-24 months to do that work. There was learning in relation to that workstream, for example the clinic had not started from day 1 of the pilot due to recruitment issues and information governance issues, meaning the pilot only ran for 6 months. The intention was to develop a toolkit of learning from that work. The Board recognised that the work had been done within existing contracts but highlighted that resource had needed to be moved around to deliver them, therefore having an evaluation of the impact on current services was crucial.
- Josefa Baylon advised members that a deep dive of the diabetes INT in Harlesden would be done in 6 months and the findings of that could be shared. That would include involvement from CLCH, primary care, ARRS staff and a diabetologist. One learning from early implementation was the importance of mental health on diabetes care as people may lose motivation to continue with their medication, and since that had been flagged there was now a dedicated IAPT Talking Therapy Lead for the neighbourhood who attended MDT to provide expert advice, and was a good case study demonstrating the importance of the non-medical model of intervention.
- The Board asked how officers undertaking this work had engaged housing colleagues within the Council and wider housing sector. Will Holt advised that since January 2025 a steering group had been established with membership across the whole council which included the Director of Housing Need and a Director from Crisis. Officers were conscious of ensuring there was strong housing representation within those decision making groups and had identified a gap in terms of how Housing Associations were represented so the team was exploring how to get them involved.

- Noting that Brent Council's Hubs were based around co-location, co-production and the wider determinants of health and tackled issues around housing advice, debt advice and immigration advice, the Board asked how this work would ensure it was not duplicating services already in place. Will Holt confirmed that the aim was to avoid duplication. Rachel Crossley added that the hub model and Family Wellbeing Centres (FWCs) were good examples of where support services were working, but often feedback received was that once service users reached a certain point there was a tendency to focus on eligibility criteria, so those working in hubs were still needing to navigate Adult Social Care or Children's Social Care. By bringing professionals closer to the community in one footprint, that took away some of the criteria so that professionals could genuinely work in the prevention space to help someone not end up in crisis, and the model being presented aimed to connect that all together as well as understand the assets already available in the community. Once that was understood there would be consideration of whether assets were being utilised to their full abilities, whether there were any that could be invested in, and how they might connect.
- In response to how ward members would be engaged on this work, Will Holt advised that there were plans to do some sessions over the next few weeks including a briefing seminar for all councillors to provide an overview of RPL. There was a need to work with ward councillors in Harlesden who would be good critical friends about how the model was being received on the ground.
- The Board asked about the scalability of the pilots being undertaken and how that might be done across all the Connect areas. Rachel Crossley responded that this depended on how successful the pilots in Harlesden were and whether the outcomes showed that it could be sustainable. If the pilot showed a model that worked then the team would look to scale that up. Officers were also working with the VCS for capacity building and trying to bring in funding through different routes.
- In terms of timescales, the Board heard that the steering group had agreed the model and the resource needed within that team, and officers were now reaching out to services in the Council to identify the individuals needed. It was hoped that some of the new approaches would be piloted from early May with an initial 1 day a week pilot, with a view to scaling that up over the next 2 years based on what worked well. The work being done in Harlesden was an initial 6 month piece of work that would feed into the budget conversations. If at that point it was not actively showing it would help with alleviating budget and demand pressures then a decision would need to be made on continuation of the scheme quickly.
- In relation to moving funding up the system, it was felt that by utilising the 3 key pillars identified this would help shift resource as less would be spent in that complex care area, so funding could come downstream to at-risk groups. As and when the INTs showed an impact, officers would build capacity within the local VCS so that they were better able to support themselves without intervention. Tom Shakespeare supported that shift from complex care to prevention from a health perspective and highlighted a national focus on this. He highlighted that as much as possible would be done within the existing resources available and where the approaches were most successful, they would be built into business as usual. He highlighted the need to await the NHSE and ICB reforms to see where the opportunities were for integration and alignment and joint incentives to drive sustained focus on this longer term.
- Given the significance of the approach for residents and wider public services, the Board asked how the programme would be evaluated. In terms of RPL, Rachel Crossley advised that there was consideration of appointing a learning partner to help. The steering group was considering the availability of data and insight resources and allocating resource there to do some modelling.
- The Board highlighted the risk of partners not buying into the programmes and asked whether the Board's commitment was shared by partners. Will Holt acknowledged the

challenge in getting partner buy-in but felt that the team was at a point now where there was clarity on what was meant by RPL and INTs which was helping to get partners on Board. Officers were being clear about the aims for Harlesden and buy-in had improved.

- The Board noted the report references to required culture changes and asked for further information. Rachel Crossley explained that, in the past, services had been trained in different ways to gatekeep, so there was a need to unlearn some of that behaviour. In terms of culture change for partners, the Council had been building trust with the VCS and spending time in each others' spaces and the next step would be to have clear conversations with VCS partners that whilst the Council may invest and help build capacity, not every project with Council involvement would be a funded opportunity. CNWL were also providing some capacity for this with some innovative leadership programmes, of which the VCS had strongly requested. Dr Melanie Smith added that there were 2 phases to the culture change, as it would be easier in Harlesden where there was a coalition of willing participants, and when the scheme moved to business as usual that may prove more difficult.
- The Board asked to what degree the cohort of people being supported through the model had a disability, and whether that was data that was being captured. They also asked whether other contextual data would be captured, such as housing need. Rachel Crossley advised that it was not yet clear whether the model would capture that information but it was something that would be considered as this would help inform patterns creating longer term conditions. The model should be capturing all protected characteristics in that space.
- The Board highlighted that there had always been barriers in terms of data sharing and collaboration with partners and asked how the scheme would capture the right data to ensure that work targeted the right support to the right people. They asked whether the new Social Progress Index (SPI) would help towards data monitoring. Rachel Crossley advised that the SPI would not achieve the particular aims of the model, but would help to track impact for longitudinal research. There had been a need to move the Council's mosaic systems so it would not be until the end of the year that the Council would be in a good position for data sharing, but in the meantime it could move fast on the sharing agreements.

As no further issues were raised the Board noted the report and approved the next steps. In drawing the discussion to a close, the Chair highlighted the importance of funding streams, timelines, partner buy-in, evaluation, culture change, information sharing and IT in order to ensure success for the model. It was agreed that a further update would be provided in 6 months.

7. **Adult Mental Health Workstream Update**

Sarah Nyandoro introduced the report, which provided an update on the data of mental health performance in Brent, the delivery of the mental health programme, plans for further work on cultural competence within the mental health and wellbeing priority programme, and a deep dive into data regarding mental health patients from the private rented sector. Matt Henshaw added that the NW2 and NW10 pilots linked with the Integrated Neighbourhood Team (INT) work discussed in the previous item and was a good example of collaboration with other services. The pilots had worked well, with an improved presence at Northwick Park Hospital and the project had enabled a focus on those communities and a place-based approach.

The Chair then invited questions and comments, with the following points raised:

- In relation to children and young people accessing specialist mental health support in the way they wanted to, the Board asked whether Kooth online was being used as one

of the options. Sarah Nyandoro confirmed that the Kooth online service was used across all 8 NWL boroughs, with the highest numbers accessing the service being children and young people from Brent. The highest outcomes in terms of children and young people's needs being met was also from Brent. The ICP was looking at a more preventative approach and one way of doing that was through increasing mental health support teams in schools and the number of schools being supported. The ICP Exec was also looking at the services they would like to develop as part of the transformation programme.

- The Board highlighted concerns that the data was lacking in relation to mental health and the Private Rented Sector, as a large proportion of Brent residents were private renters, and asked what would be done to obtain that data. Rachel Crossley advised that obtaining that data depended on what people recorded and what people disclosed, and with the private sector so broad and unregulated getting that data sharing in place was a challenge. There were other routes to that information, such as through GPs, but she was doubtful that person level data providing the full picture would ever be obtained. The ICP was working with services about what was collected and how to use that data to get a better understanding of residents.
- The Board asked whether there were any updates on whether funding for children and young people neurodiversity assessments would continue. Sarah Nyandoro advised that the funding had only been in place until September 2024 and current discussions were underway with NWL ICB regarding continued funding because demand continue to increase. There was no firm response on that, but the ICP had been told they were likely to receive the same non-recurrent funding. Nigel Chapman added that young people with acute mental health need continued to wait longer in Brent for services compared to other areas of NWL, and an area for priority and action arising from the recent local area SEND inspection was around reducing waiting times for specialist mental health services. As such, a commitment had been provided from the NWL ICB and CNWL to actively tackle that and have an action plan signed off in April 2025 which he hoped would give greater commitment and clarity of funding that was equitable across the NWL footprint.
- The Board commended the work the ICP Exec was doing around employment and highlighted the need to consider the impact of welfare benefit changes. They asked whether CNWL was in a position to know the number of people needing employment support. Matt Henshaw advised that CNWL was in a position to do that, and routinely captured people's employment status across all services. There was provision to provide specific support within community mental health teams around employment with employment specialists employed. Further information could be reported back to the Board.

As no further issues were raised, the Chair drew the discussion to a close and asked the Board to note the update. The Vice Chair requested that the mental health transformation plan for children and young people was presented to a future meeting.

8. Brent Children's Trust Progress Report

Nigel Chapman introduced the report, which detailed the activity of the Brent Children's Trust (BCT) over the reporting period. He highlighted that the areas of priority for BCT were listed, some of which clearly linked to existing subgroups in the ICP such as health inequalities, immunisations and mental health and wellbeing. Key Performance Indicator reporting went directly to the ICP Exec as referenced in the attached Governance Appendix. He highlighted that there was a need for BCT to obtain more holistic data across the whole partnership which had been asked for ahead of the next meeting. The local area SEND inspection outcome was published on Thursday 27 March 2025 which gave a good overview of the strengths of the local area partnership and showed there was good, effective, on the ground work and good

partnership activity with parents and carers, but still areas to improve, particularly related to waiting times. Overall, the outcomes showed that professionals were working hard to mitigate a system which was seen as not working particularly well for children with SEND nationally. Despite waiting times, inspectors found that children were not disadvantaged as mitigations were put in place whilst children were waiting.

The Chair thanked Nigel Chapman for his introduction and invited input from those present, with the following issues raised:

- The Board asked whether the new Autism Strategy and Autism Working Group would be co-produced with people with autism. Nigel Chapman confirmed that every strategy and piece of work implemented was co-produced alongside the Parent and Carer Forum.
- The Board asked how the development of the Welsh Harp Skills Resource Hub was going. Nigel Chapman replied that the Council was aiming to build the post-16 skills centre for young people with SEND there and were partnering with Woodhill School which was beside Welsh Harp. The capital required had been identified and the building was in its design stages. The intention was for that building to be operational by 2027 and progress on the hub would be presented to Cabinet.
- A new Travel Policy and Travel Training Policy had been agreed, co-produced with parents and carers, to enable those who were capable to undertake independent travel. It was highlighted that it would not be mandatory but offered to those able to travel independently to give them that opportunity. The policy was in its early stages, but the implementation was being monitored and going well.

As no further issues were raised, the Chair drew the discussion to a close and asked members to note the report.

9. **Healthwatch 2025-26 Work Programme**

Patricia Zebiri (Healthwatch Manager) introduced the report, which presented the draft plan of priorities for Healthwatch during 2025-26 and requested feedback and strategic input from the Health and Wellbeing Board to ensure alignment with health and care priorities. In introducing the report, she highlighted the following key points:

- Healthwatch Brent was delivered on 2.2 whole time equivalents, so the need to be careful and precise in where capacity and energy was spent was highlighted in order to demonstrate improvement and impact.
- One of Healthwatch's main objectives was to work with the community to drive the Healthwatch agenda with what mattered to residents, helping residents to have their voices heard so that changes and improvements could be made from a bottom up perspective.
- Healthwatch had an Advisory Board made up of local residents and people living, working or running businesses in Brent, where these priorities would be shared and monitored.
- Healthwatch continued to work with Adult Social Care and had looked at dementia care, autism and learning disabilities and carried out mystery shopping. Now Healthwatch were doing some independent customer service, ringing random customers who accessed Adult Social Care to understand their experience. Healthwatch had also gone back into the community to close the loop on their feedback, informing residents where their feedback had made a difference in order to encourage people to stay engaged.
- Healthwatch assisted with the engagement for Brent's Pharmaceutical Needs (PNA) assessment., helping to increase the level of engagement. Following that, work would

be done to raise awareness of pharmacy services in Brent to improve access to the right places.

- Healthwatch continued to look at GPs and GP access. It was recognised that services were stretched and finances were challenging, making it difficult to deliver services, but GP access continued to be the biggest issue raised to Healthwatch. Healthwatch continued to build on that work focusing on GP complaints and raising issues with GPs.
- Part of the Healthwatch service was signposting and supporting other community units, and currently the service was working with the Brent safeguarding team and the breast screening team to see how they could raise awareness of those particular issues from a health inequalities lens.

The Chair thanked Patricia Zebiri for the introduction and invited comments and questions from those present, with the following points raised:

- In terms of community engagement, the Board asked whether Healthwatch worked with Brent Health Matters (BHM) and whether there were any opportunities to collaborate to avoid duplication. Patricia Zebiri responded that Healthwatch worked closely with BHM and attended their events, but highlighted the importance of Healthwatch as an independent organisation that needed to remain impartial. She acknowledged that BHM was very good at sending information which Healthwatch ensured its grassroots partners were aware of so they could inform their residents.
- Dr Melanie Smith thanked Healthwatch on behalf of the Pharmaceutical Needs Assessment (PNA) Steering Group, as there had been a much improved response to the consultation as a result of their support.
- Noting the report stated that Adult Social Care had been responsive to the findings of Healthwatch, the Board asked if that was the case across the board. Patricia Zebiri acknowledged that when difficult information was brought to someone's attention it did take time to reflect and absorb, so Healthwatch might experience some push back initially, but she felt that generally the organisations they worked with understood the role of Healthwatch and the need to inform services what they were hearing.
- Noting that Healthwatch was looking to complete a piece of work on GP complaints and procedures, Board members asked whether they would be asking questions about protected characteristics within that. They heard that, once the workplan was signed off by the Advisory Board, project plans were developed with milestones, outcomes and expectations, which would all consider where the data was coming from. The aim was to use as much available data as possible.
- The Board asked whether there was anything Brent partners could do to help improve the capacity of Healthwatch. They heard that Healthwatch would benefit from some free or low-rent accommodation as they did not currently have an office base. If Healthwatch did not need to pay rent then it would be able to increase staff to full time capacity, which would make a difference in what it could deliver.

As no further issues were raised, the Board resolved to note the workplan.

10. **Health and Wellbeing Board Forward Look**

The Chair gave members the opportunity to highlight any items they would like to see the Health and Wellbeing Board consider in the future. Future items included the Children and Young People's Mental Health Transformation Programme, an update on Integrated Neighbourhood Teams, a review of the impacts of welfare benefits reforms and a care home sector update.

8. **Any other urgent business**

None.

The meeting was declared closed at 8:00 pm
COUNCILLOR NEIL NERVA, CHAIR

Brent NHS North West London	**Brent Health and Wellbeing Board** 24 July 2025
	Report from the Directorate of Children, Young People and Community Development

Update on the outcome of Brent's January 2025 Local Area SEND Inspection

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
List of Appendices:	Appendix 1 - Brent Local Area Partnership SEND Inspection Improvement Plan July 2025
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Nigel Chapman Corporate Director, Children, Young People and Community Development Nigel.chapman@brent.gov.uk Shirley Parks Director of Education, Partnerships and Strategy Shirley.parks@brent.gov.uk Dr Roxanna Glennon Head of Service, Inclusion Roxanna.glennon@brent.gov.uk

1.0 Executive Summary

1.1. The purpose of this report is to update Health and Wellbeing Board (HWB) members on the outcome of Brent's recent (January 2025) Local Area SEND Inspection. The report outlines the key findings, details the agreed action plan in response to these findings and updates members on progress made against these agreed actions to date.

2.0 Recommendation(s)

It is recommended that HWB:

2.1 Note the key findings of Brent's recent Local Area SEND Inspection.

2.2 Note the proposed action plan, and progress made against these actions to date.

3.0 Detail

3.1 Contribution to Borough Plan Priorities & Strategic Context

This report contributes to the furthering of Brent's Borough Plan 2023-2027. In particular, it contributes to the following Borough Plan priorities:

- Prosperity and stability in Brent,
- Thriving communities,
- The best start in life and,
- A healthier Brent.

This report also contributes to Brent's SEND Strategy 2021-2025. The priorities identified in the SEND Strategy 2021-2025 are as follows:

- Education, training and employment,
- Healthy lifestyles,
- Activities (community participation),
- Living independently and,
- My Brent.

3.2 Background

3.2.1 The Local Area (to include the Local Authority and North West London Integrated Care Board (ICB)) was inspected by Ofsted and Care Quality Commission (CQC) colleagues 27th - 31st January 2025. This was Brent's first Local Area SEND Inspection under the new SEND Inspection framework (further details of which can be found here). Of the three possible ratings, Brent achieved the highest – namely:

"The local area partnership's special educational needs and/or disability (SEND) arrangements typically lead to positive experiences and outcomes for children and young people with SEND. The local area partnership is taking action where improvements are needed."

The full report is available here.

3.2.2 To provide national context to Brent's performance in this Local Area SEND inspection, of the 54 area SEND inspections that have been graded so far on the new inspection framework:

- **14** local area partnerships have been graded as 'positive'
- **26** have been graded as 'inconsistent'
- **14** have been graded with 'significant concerns'.

3.2.3 The local area's trajectory over the last eight years has been one of continuous improvement in the area of SEND. Brent's previous Local Area SEND Inspection took place in May 2017 with a follow-up visit in May 2019. In May 2019, it was agreed that Brent as a local area had made sufficient progress against their 'written statement of action' which Brent was required to produce following its 2017 Local Area SEND Inspection in which Brent was found to have "significant areas of weakness".

3.2.4 The key findings of the 2025 Local Area SEND Inspection report can be summarised as follows:

- Children and young people with SEND typically receive the right help at the tight time, with some services such as the Children with Disabilities team described as providing a "highly effective offer",
- CYP's voices are central to decision-making about their needs
- CYP with SEND achieve well and gain positive outcomes, there is strong commitment to addressing health inequalities in the local area,
- In terms of leadership, leaders collaborative effectively, understand the needs of children and young people with SEND and their families well and commission effective and appropriate services.

3.3.5 In addition to the above areas of strength, the following areas were identified as in need of improvement:

1. The local area partnership should update Education Health Care plans (EHCPs) in a timely manner after annual reviews and at significant points of transition to make sure that EHCPs reflect the current needs of children and young people with SEND accurately.
2. The local area partnership should improve the timeliness and uptake of the mandated antenatal check and six- to eight-week review.
3. NHS North West London ICB should reduce the lengthy wait times that children and young people with SEND experience for neurodevelopmental diagnostic assessments, specialist therapeutic interventions in CAMHS, and community paediatrician assessments.
4. The local area partnership should reduce the lengthy wait times that children and young people with SEND experience for assessments of their home equipment needs.

3.3.6 In response to the four identified areas for improvement (3.3.3, above), a Local Area SEND Inspection Improvement Plan has been created (Appendix 1). The Improvement Plan was created via the Inclusion Strategic Board on the 8th May 2025, which has representation from health, education, parents and carers and social care. The Improvement Plan was then shared with Brent Children's Trust (BCT) on the 22nd May for approval.

4.0 Stakeholder and ward member consultation and engagement

4.1 In forming their view of Brent's performance against the Local Area SEND Inspection framework, Ofsted and CQC colleagues undertook surveys of a full range of stakeholders, including parents of children and young people with SEND and professionals. During the inspection they spoke to children and young people with SEND, their parents/carers and professionals from health, social care and education.

4.2 As per 3.3.4, above, the Local Area SEND Inspection Improvement Plan was co-produced with a range of key stakeholders including parents/carers, health, social care and education.

4.3 Updates and changes to the agreed Improvement Plan will be co-produced with key stakeholders via the bi-monthly Inclusion Strategic Board. Amendments and updates to the Improvement plan will then be relayed to Brent Children's Trust for information and approval. Certain of the actions on the Improvement Plan are also captured as part of Brent's SEND Strategy 2021-2025 Action Plan. As evidence of progress made against Improvement Plan actions captured via the SEND Strategy 2021-2025 Action Plan.

5.0 Financial Considerations

5.1 Certain actions set out in the Local Area SEND Inspection Improvement Plan (see Appendix 1) are likely to carry significant financial implications for the local authority and the ICB. It is essential that these potential costs are carefully modelled and monitored, as achieving all of the agreed actions will be challenging within the constraints of existing budgets and limited resources.

5.2 For the 2025/26 financial year, it has been agreed to expand the SEND outreach team, funded through the High Needs Block of the Dedicated Schools Grant (DSG). While this funding arrangement supports the immediate implementation of the outreach expansion, there remains considerable uncertainty regarding future financial sustainability.

Key challenges include:

- **DSG Deficit Reduction:** The local authority faces ongoing pressure to reduce the existing DSG deficit of £13.6m, which may limit the availability of funds for new or expanded services in subsequent years.
- **Funding Uncertainty:** There is a risk that future government allocations for SEND may not keep pace with increasing demand or planned expenditure, creating potential funding shortfalls.
- **Cost Pressures:** Rising costs associated with delivering SEND services, including staffing, specialist provision, and placements, continue to place strain on available resources.

5.3 Given these challenges, it will be crucial to regularly review spending against the Improvement Plan and to explore opportunities for efficiencies, joint commissioning, and alternative funding streams wherever possible, without adversely impacting the quality of support provided to children and young people with SEND and their families.

6.0 Legal Considerations

6.1 Members are invited to note that a White Paper on SEND is expected to be revealed by the Department for Education this autumn. This paper may contain proposals for changes to the legislative and statutory framework that currently relate to SEND (most notably the Children and Families Act (2014) and the SEND Code of Practice (2015)). Were this to happen, the impact and timing of any proposed changes would have to be carefully considered by the Local Area Partnership.

7.0 Equity, Diversity & Inclusion (EDI) Considerations

7.1 The proposed actions contained in the Local Area SEND Inspection Improvement Plan are anticipated to improve equality of access to appropriate support services and may serve to reduce health inequalities in the local area.

8.0 Climate Change and Environmental Considerations

8.1 It is not felt that the proposals contained in the Local Area SEND Improvement Plan will impact upon the Council's climate and environmental commitments.

9.0 Human Resources/Property Considerations (if appropriate)

9.1 N/A

10.0 Communication Considerations

10.1 Brent's positive outcome in the Local Area SEND Inspection was communicated with external parties using Brent's social media channels. Internally, it was communicated to all staff by both the Chief Executive and the Corporate Director for CYP&CD.

Report sign off:

Corporate Director Nigel Chapman
Corporate Director of Children, Young People and Community Development

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Appendix 1: Brent Local Area Partnership SEND Inspection Improvement Plan July 2025

1. The local area partnership should update EHC plans in a timely manner after annual reviews and at significant points of transition to make sure that EHC plans reflect the current needs of the children and young people with SEND accurately.

Improvement Action	Impact Measures	Responsible Person	Date	RAG (action)	Progress Update
Update 50% of EHCPs where changes are requested following annual review (AR) within statutory timescales (Devon judgement – 4 weeks).	% of EHCPs where changes are requested following AR updated within 4 weeks.	Service Manager for SEND Statutory Services	March 2026		Brent is currently only updating EHCPs where changes are requested following AR for children in phase transfer year groups (11+ and 16+). From September 2025, the focus will extend to children in Year 9 to enhance preparation for adulthood (PfA) goal setting. It has been agreed to roll out a 'tracked changes' model following AR from Sept. 25 which will improve the administrative process and improve timeliness. This will be launched at SENCo forum 23/6/25.
Notify parents/carers of 'no change' to an EHCP following AR within statutory timescales (4 weeks) for 90% of plans where this is applicable.	% of parents/carers notified of 'no change' within statutory timescales.	Service Manager for SEND Statutory Services	March 2026		Brent is currently completing this task for all ARs, but not within statutory timescales. In the year to date, only 35% of ARs were processed of which 9% were processed on time. The annual review panel will be replaced by a weekly triage of annual reviews, to be held at Team Manager level and divided primary/secondary. The aim of this revised process is to improve timeliness and quality of decision making.
Work with all schools attended by Brent children with EHCPs to ensure that 90% of ARs are completed in a timely manner and paperwork supplied within	% of annual reviews completed within timescales.	Service Manager for SEND Statutory Services	March 2026		Most schools are completing ARs for children with EHCPs, but many are not completed to timescale. Currently only 64% of AR's are completed by schools and sent to the LA AND there are often delays in AR paperwork being sent to the LA.

two weeks of the AR taking place.					Through the SENCO Forum the importance of timely communication has been emphasised.
Update 95% of EHCPs where changes are requested following emergency annual review (AR) within statutory timescales (Devon judgement – 4 weeks) for children at risk of placement breakdown.	% of EHCPs where changes are requested following emergency AR updated within 4 weeks.	Service Manager for SEND Statutory Services	March 2026		Brent is currently completing this task for all emergency ARs, but not all are completed within statutory timescales. Key information about individual children is being shared, however, as appropriate.
Improve accuracy of changes made to EHCPs following AR.	Frequency of complaints relating to proposed changes to EHCPs.	Service Manager for SEND Statutory Services	March 2026		We have few complaints relating to the accuracy of changes made to EHCPs following AR. However, with a more demanding set of metrics relating to ARs in place, it will be important to also track the quality of work to ensure this does not dip following increased pressure on timeliness.

2. The local area partnership should improve the timeliness and uptake of the mandated antenatal check and six-to-eight week review.

Improvement Action	Impact Measures	Responsible Person	Date	RAG (action)	Progress Update
Improved CLCH booking process for Targeted Antenatal Checks	• Appointments booked 4-6 weeks in advance • DNAs rebooked prior to expected delivery date (EDD).	CLCH ONW Divisional Director / Dept Director of Ops Kim Lewis, Head of Clinical Services Brent Children	Q1	On track	In progress. Data now provided 8 weeks in advance to enable timely bookings. Team leads being monitored for application of new booking processes.
Staffing model review for completion of Universal Antenatal Checks	• Staffing group identified and signed off through CLCH governance process • SOP and training in place for staff • Increased appointment slots	CLCH ONW Divisional Director / Dept Director of Ops Kim Lewis, Head of Clinical Services Brent Children	Q3	On track	Internal review is underway ahead of taking to internal governance meeting.

	offered to pregnant women in Brent				
Identification of clinical space to undertake 6-8 week reviews Improved CLCH booking process for 6-8 week checks	• Increased appointment slots offered • Utilisation of SPA staff to book 6-8 week checks when new birth visits booked.	CLCH ONW Divisional Director / Dept Director of Ops Kim Lewis, Head of Clinical Services Brent Children	Q2	Needs attention	In progress. Identification of clinical space within the borough is an ongoing challenge.
0-19 service specification, KPIs and contract agreed and signed	• Staffing model contractually aligns with need to meet all mandated checks	CLCH and Public Health commissioners	Q1	Needs attention	In progress. Service specification agreed. Staffing model under joint CLCH / PH review to align with financial envelope.

3. NHS North West London ICB should reduce the lengthy wait times that children and young people with SEND experience for neurodevelopmental diagnostic assessments, specialist therapeutic interventions in CAMHS, and community paediatrician assessments.

CLCH Child Development Service/Community Paediatrics Collaborative

The Associate Medical Director for Children's Services within CLCH is undertaking a full service review of the child development service in Brent with a view to making recommendations that will seek to address the demand and capacity and financial shortfalls faced by the service. The final report and recommendations are due at the end of Q2 2025 for discussion at ELT.

Improvement Action	Impact Measures	Responsible Person	Date	RAG (action)	Progress Update
Undertake a Child Development Service (CDS) model review to quantify the demand/capacity gap and propose options to make best use of the available resource	1. Increased skill mix in recruitment. 2. Streamline internal assessment and diagnostic processes.	Dr Deborah Bird, Associate Medical Director CLCH With CLCH ONW Divisional Directors of Ops CLCH Head of Clinical Services CLCH Clinical Services Manager	Q3	On track	• Review of current demand and capacity and team skill mix options is underway. Work ongoing between CDS and Inclusion to refine the medical advice given during the EHCNAs process. Aim is to offer improved advice and free up clinician's time.

	3. Long-term waiting list/ RTT management				
Use of non-recurrent funding for outsourcing ASD assessments and CDC Initial Paediatrician assessments for wait list reduction	1. Waiting list management and reduction in RTT 2. Reduction in length of waiting time for an ASD diagnosis.	Christina Ioannou – Clinical Services Manager	Q2		• Contracts in place for both outsourced initiatives using CLCH and ICB underspend non-recurrently: 245 Initial CDC assessments to be completed by 31/5/25 and 130 ASD assessments to be completed by end of Q2. • Recovery trajectory for RTT reviewed on a weekly basis at Divisional RTT Meeting. • Weekly contract monitoring meetings held with external providers. • Despite the additional non recurrent funding, known demand exceeds known capacity and waiting lists will continue to grow once this ends.
Review of Brent ND pathway to align with NWL ICB ND core offer / specification work	1. Waiting list management and timely assessment 2. Equity of access with better signposting	Dr Deborah Bird, CLCH Associate Medical Director/ Dr Madhumita Mukherjee, Child Development Service Clinical Lead	Q2	.	• CLCH actively contributing to the NWL ND pathway project – Brent CDS data submitted • CDS clinical lead ND pathway review in final draft in anticipation of NWL wide core ND pathway roll out • Requires completion of NWL ICB core offer specification work to steer service development.
Reduce waiting times for Community paediatric assessments	18 week wait data for community paeds and size of backlog	Jackie Allain/ Kim Lewis (CLCH) / David Williams (tbc) plus Community Provider Collaborative	March 2026		No funding is currently available. Needs further internal discussion

CAMHS/CNWL

Improvement Action	Impact Measures	Responsible Person	Completion Date	RAG (action)	Progress Update
Reduce time for neurodevelopmental diagnostic assessments	18 week wait data and size of backlog	Andrea Shand (CAMHS) and Mark Walker (ICB) (tbc) plus Mental Health Provider Collaborative	March 2026		No funding is currently available. Needs further internal discussion
Reduce time for specialist therapeutic interventions in CAMHS	18 week wait data and size of backlog	Andrea Shand and Mark Walker (tbc) plus Mental Health Provider Collaborative	March 2026		No funding is currently available. Needs further internal discussion
Reduce time for specialist therapeutic interventions in CAMHS	18 week wait data for therapies and size of backlog	Andrea Shand and Mark Walker (tbc) plus Mental Health Provider Collaborative	March 2026		No funding is currently available. Needs further internal discussion
Improve CAMHS data quality available to the partnership	Establish regular data dashboard with clear data definitions	Andrea Shand (CAMHS)	March 2026		CLCH is developing new reporting dashboard for metrics which will include therapies and autism assessments for Under 5s. To be presented to ISB for comment Sept 25.

4. Local Area Partnership should reduce the lengthy wait times that children and young people with SEND experience for assessments of their home equipment needs.

Improvement Action	Impact Measures	Responsible Person	Completion Date	RAG (action)	Progress Update
Establish robust tracking system for tracking OT screening, assessment, approval, and delivery of equipment, including reporting to managers to provide oversight on the waiting list.	Timely assessment of home equipment needs – target 45 days	Head of Localities (Children with Disabilities)	June 2025		A waiting list is in place and is being monitored by a manager. To further support this process, a 'tracker' is being developed by Brent's CYP&CD data team.

Recruit to permanent OT team – Deputy OT manager post and OT posts.	Permanent resource in place	Head of Localities (Children with Disabilities)	June 2025		Job descriptions are now completed. Adverts for roles will be posted July 2025.
Consideration to be given to aligning the recruitment and retention package for OTs within CYP to that of OTs in ASC.	Retention of permanent staff	Director Early Help and Social Care	June 2025		A proposal will be developed for consideration.
Develop CPD programme for OTs comparable with ASC OTs	Retention of permanent staff	Head of Localities	September 2025		A CYP training plan is currently being developed

Brent NHS North West London	**Brent Health and Wellbeing Board** 24 July 2025
	Report from the ICP Managing Director
	Lead Cabinet Member for Adult Social Care, Public Health and Leisure - Councillor Nerva

Brent ICP Primary Care Transformation Executive Group Progress Report

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
List of Appendices:	Appendix 1 - Modern General Practice Infographic Appendix 2 - Enhanced Service Offer –Service Lines
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Zaid Dowlut Head of Place (Primary Care), NWL ICB az.dowlut@nhs.net

1.0 Executive Summary

1.1 This is a progress report giving an update on the projects being progressed within the primary care programme. It covers general practices only and summarises the proactive steps being taken to improve services and their uptake.

2.0 Recommendation(s)

2.1 To note the report, and to comment on the strategic direction of the Primary Care Transformation Executive.

3.0 Background

3.1 Brent's Primary Care Transformation Executive Group (PCTEG) is responsible for overseeing the delivery of primary care transformation and change priorities relevant to the local partnership and system.

3.2 The national General Practice Improvement Programme (GPIP), was introduced as part of the Delivery Plan for Recovering Access to Primary Care (2023) in light of growing challenges that threaten both patient care and the sustainability of services. These challenges include increasing demand, patients with complex, chronic conditions requiring more time and resources

and workforce shortages and burnout in general practice. These challenges are heightened in a place like Brent with significant socio economic issues, including a low employment rate of 64%, high levels of deprivation, a large proportion of children living in poverty and, a higher rate of morbidity e.g. 8% of adults have diabetes and 11% of adults have high blood pressure. The gap between patient demand and capacity available to meet it is widening. Additionally, there is greater emphasis on preventative care and mental health support. This broadens GPs' responsibilities, further straining resources. Current funding models for general practice do not fully address these significant pressures.

3.3. Modern general practice is the national response to these challenges, setting the NHS on a transformation journey to better align capacity with need, improve patient experience and improve the working environment for general practice staff. It aims to do so by

- Offering patient choice of access channel (telephone, online and in person) via highly usable and accessible practice websites, online consultation tools and improved cloud-based telephony systems.
- Gathering structured information at the point of patient contact (regardless of contact channel) to understand what is being asked of the service.
- Using one care navigation (and workflow) process across all access channels to assess and prioritise need safely and fairly, and to efficiently get patients to the right healthcare professional or service, in the appropriate time frame (including consideration of continuity of care) moving away from a 'first come first served approach'.
- Allocating existing capacity to need, making full use of a multi-professional primary care team, community services and 'self access' options where appropriate, and helping GPs and practice staff to optimise use of their time to where it's needed most.
- Building capability in general practice teams to work together and to access, understand and use data, digital tools and shared knowledge to lead, plan, implement, improve and sustain change.

3.4 The Brent Borough Plan 2023-27 priorities in terms of thriving communities and a healthier Brent including tackling inequalities and local services and those in the NWL ICB Joint Forward Plan 2024-29 align well with the principles outlined earlier about the Modern General Practice Model, namely,

- Establishing integrated neighbourhood teams with primary care at their heart
- Reducing inequalities and improve health outcomes through population health management
- Streamlining patient pathways, improving coordination between different care settings, and utilising technology to facilitate seamless transitions.

3.5 The NHS Ten-Year Health Plan published earlier this month reinforces the three shifts – "From hospital to community, treatment to prevention and analogue to digital"- and sets out the changes which will be required to deliver it. The Plan describes a neighbourhood health approach as an alternative to the hospital model of provision. This will involve primary care working in co-located multi-professional teams in neighbourhood health centres in local communities to deliver a preventative model of care, end the existing fragmentation and better

support those most in need, including those with long-term conditions. However, the funding to deliver these neighbourhood health centres (NHCs) is unclear at this stage.

3.6 The Plan states that there will be an expansion in the GP workforce and online advice into the NHS App which will improve GP access and ensure better patient experience. Additionally, neighbourhood health centres will be open for 12hrs/day, 6 days/week and be a 'one stop shop' for patient care, co-locating NHS, council and voluntary services Two new neighbourhood provider contracts will be available – single neighbourhood serving 50,000 population and multi-neighbourhood serving a 250,000+ population. The Plan sets out other proposals including e.g. digital transformation in out-patients' appointments and re-allocation of finances to out-of-hospital care over a 3 - 4-year timescale.

3.7 Our Integrated Neighbourhood Teams (INT) work being taken forward locally reflects the neighbourhood model described in the 10-year Plan. We aim to establish neighbourhood centres with dedicated leadership teams in the five neighbourhoods which will support multidisciplinary teams (MDTs), delivering co- located services and ensuring easy access to health and social care. The primary care priorities described in the next section of this report e.g. Child Health Hubs and the Local Enhanced Services are being delivered at PCN level and clearly, can be scaled up to a neighbourhood level as soon as feasible.

4.0 Priorities 2025-6

4.1 Improving Access to Primary Care

I. Objectives

NWL ICB launched its access improvement programme in 2023/4 in line with the Delivery Plan for Recovering Access to Primary Care (2023). Primary Care Networks were incentivised to put in place access and capacity improvement plans to:

- Empower patients: improve patient experience through consistent and high quality service, with access to a range of healthcare professionals, improve utilisation of NHS App, increase use of self-referral pathways and expand community pharmacy joint working.

- Implement modern general practice access: roll out of digital telephony and online consultations to manage 8am rush, care navigation and ensure continuity of care for those patients who require this, by enabling direct booking back into patients own GP practice, rapid assessment and response

- Build capacity: provide capacity and resilience in the system to manage the increase demand for appointments and manage complex and more vulnerable patients using multidisciplinary team (MDT) approach, with on the day demand being managed in at scale settings, more new doctors, retention and returner of experienced GPs and priority for primary care in new housing developments

- Cut bureaucracy: improve the primary care/ secondary care interface, and reduce the number of performance indicators in the Quality Outcomes Framework to free up resources for clinical practice

Building upon the progress made in 2023-24, the ICB required PCNs to undertake local patient and staff engagement through surveys and focus groups, in the autumn last year to inform its approach to the access programme 25-26. This was followed by PCNs submitting an expression of interest on their access improvement plans as a condition for securing funding in year to support continued progress on access. The outputs of the patient and staff engagement exercises enabled the ICB develop a new outcomes based access specification for implementation in 2025-6. This was launched as part of the 25-26 Enhanced Services Single Offer to support PCN implementation, aligning with the wider primary care strategy and neighbourhood development. The new specification reinforces the objectives of:

- Ensure timely, high-quality patient care at local general practice.
- Enable practices to manage demand and provide continuity of care to patients who most need it.
- Relieve system-wide pressures, i.e. urgent and emergency care

II. Service Overview

Primary care services provide the first point of contact in the healthcare system. They are the 'front door' of the NHS and include general practice, community pharmacy, dental, and optometry services. This report only covers general practice services.

51 GP practices operate in Brent, serving a total registered population of c 525, 582 patients, including non-borough residents. GP practices are grouped into 7 Primary Care Networks (PCNs), each led by a Clinical Director and staffed with a mix of clinical and non-clinical roles. Currently Brent primary care hosts nine 'Extended Access Hubs' (EHAs), as detailed in the following table; an increase of two since December last year in Harness PCNs.

Table 1- Extended Access Hubs

PCN	Extended Access Hub	Standard hub opening hours
Harness South PCN	Central Middlesex Hospital (Park Royal MC)	Mon to Fri – 6.30 pm to 8.00 pm Saturday 9.00am to 5.00pm
	Freuchen Medical Practice	
Harness North PCN	Wembley Centre for Health & Care	
	Wembley Park Medical Centre	
	Willow Tree Family Doctors	

Kilburn PCN	Staverton Surgery	Mon to Fri 6.30pm to 8.00pm Sat 9.00am to 5.00pm
K&W PCNs	Wembley Centre for Health & Care	Mon to Fri 6.30pm to 8.00pm Sat 9.00am to 5.00pm
	Lonsdale Surgery	
	Kingsbury Health and Wellbeing	
	Willesden Medical Practice	

The hubs provide access during the hours shown in table one above, offering both virtual and face to face appointments during core and extended service hours. The extended access policy aims to standardise service delivery, enhance patient awareness, and reduce healthcare disparities. It integrates the Additional Roles Reimbursement Scheme (ARRS) workforce more consistently and enables PCNs to utilise extended access capacity for routine care delivery. ARRS workforce is a variety of new healthcare roles within Primary Care Networks (PCNs) to enhance patient care and access to services. They include clinical pharmacists, health and well-being coaches, social prescribers and others.

PCNs have the option to deliver the service directly or subcontract it to an alternative provider. The extended access service complements existing practice operations, ensuring continuity of care through shared access to patient records by hub staff. PCNs are empowered to allocate extended access capacity based on local demand and service priorities. These changes provide PCNs with enhanced control and flexibility in utilising extended access capacity to optimise patient care. Patients may schedule hub appointments through their registered GP practice.

Each hub must deliver a minimum of 60 minutes per 1,000 adjusted patients per week. Appointments should be available for booking up to two weeks in advance. Same-day online booking should be available where triage is not required. Appointments should be accessible through both in-person and remote means. Some hubs deliver enhanced services at scale; i.e. providing some enhanced services as well as core services required under the national GMS contract, further supporting the needs of Brent's working population. Services such as childhood immunisations, flu vaccinations, and cervical screening are also provided for working families.

The workforce composition for extended access hubs is:

- Harness PCNs: GP, Nurse, Advance Nurse Practitioner and Health Support Worker
- K&W PCNs: GP, Nurse, Pharmacist and Health Support Worker,
- Kilburn PCN: GP and Nurses

III. Activity Overview

There has been consistent progress across primary care in improving access. GP appointment volumes across Brent show a consistent upward trend from

mid-2023 through early 2025, with notable increases during winter months, likely reflecting seasonal demand. There was a marked increase in digital appointment bookings, particularly through EMIS and NHS App platforms. This reflects the increased registrations of patients using the NHS App. At March 2025, a total of 288,295 patients (63.7% registered patients) had registered with the NHS App, underlining the upward trend observed during 2024-5.

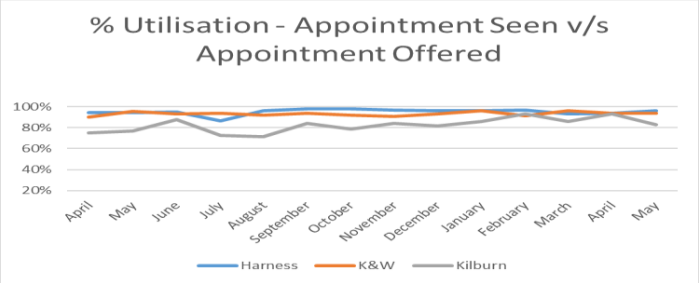
In 2023-24, a total of 172,819 appointments were provided by PCNs at the Enhanced Access Hubs with an overall utilisation of 98% Brent wide. An additional 5,974 appointments were provided within the core hours' same day access hubs with an overall utilisation of 90% Brent wide.

In 2024-25, a total of 178,097 appointment slots across 38,035 hours were offered outside of core practice hours and 165,970 were actually used, achieving an overall utilisation of 93% across Brent. The quarterly summary analysis of activity against plan is shown in table two below.

Table 2- Service activity 2024-25

2024-5	Indicative Activity Plan	Actual Slots Offered	Actual Slots Booked	Actual Slots Used	Utilisation based on Activity offered
Q1	51781	49,134	48,016	45,734	93%
Q2	41488	44,396	42,638	40,843	92%
Q3	39611	43,470	42,452	40,574	93%
Q4	38601	41,097	40,377	38,819	94%
Total	**171481**	**178,097**	**173,483**	**165,970**	**93%**

Service analysis 2024-25 in the line graph below shows the relative appointment utilisation rates across the PCNs. For example, Kilburn has a lower utilisation rate compared to the other PCNs.



In the current year to date, a total of 24,602 appointments across 5,540 hours were provided by PCNs in April and May, achieving an overall utilisation of 94% Brent wide. Individual PCNs utilisation is shown in table 3 below.

Table 3- Q1 2025-6 Activity by PCN

Month	Harness	K&W	Kilburn
Apr-25	94%	94%	93%
May-25	96%	94%	83%

IV. NWL Access Specification

The NWL ICB remains committed to enhancing access to primary care through a strategic blend of digital innovation, service redesign, and robust performance monitoring. This approach is fully aligned with the national Enhanced Access framework and underpins our broader ambition to deliver care that is equitable, timely, and centred around patients' needs.

The NWL ICB Access specification, introduced in April 2025, is designed to ensure that patients can access care promptly when required, while also enabling practices to maintain continuity of care where appropriate. The funding allocation is c£1.2m.

The specification supports general practice across North West London in developing resilient service models that make effective use of available resources. This is expected to result in improved access, more efficient use of clinical time, shorter waiting periods, and enhanced continuity and proactive care for patients with ongoing or complex needs.

All seven PCNs submitted their Access Improvement Plan by 30th June as required by NWL ICB. The respective plans describe the access model the PCN will implement to meet the specification's requirements. The following metrics will be used this year to measure PCNs' performance on access:

Type	Improvement Plan Requirements 2025-26
Plan	Improvement Plan (including Self-declaration)
Metric	90% of calls answered within 10 mins
Metric	90% of e-submissions are responded to by end next working day.
Metric	SNOMED coding to record direct clinical care that is **not in** the appointments ledger
Audit	Audit of use of clinical time
Metric	Continuity flag for at least 2% of the patient list is in place
Audit	Review of a 10% sample of the identified population
Metric	Increase registrations on the NHS App by 10%, or locally agreed measure ** Practices with ≥ 75% NHS App registration are required to demonstrate increased utilisation.*
Plan	Patient engagement via annual survey (>4% return) and engagement event

The recently published 2025 national GP Survey results show improvements in patients' experience of general practice, NHS dental and community pharmacy services when compared with 2024. 75.4% of patients had a good overall

experience of their GP practice, an increase of 1.5% from 2024. More patients reported they had tried contacting their general practice using their website or the NHS App compared to 2024. Across all three contact methods that patients were asked about (phone, practice website, and NHS App), around 50% of patients reported they generally found it 'easy' to contact their general practice. The results reflect the service improvements being made e.g. digital telephony and triage systems, training care navigators, Pharmacy First, are making it easier for patients to access primary care.

An analysis of these national results will be carried out to understand the extent of progress which has been made in Brent since 2024.

4.2 Enhanced Services Offer 25-26

The Enhanced Services Offer is a suite of 27 service lines (appendix two) delivered at practice/ PCN level. It promotes a consistent offer of services across the eight NWL boroughs to support improved population health outcomes. Service specifications are reviewed annually to ensure they continue to be fit for purpose and comply with national guidelines, e.g. NICE and best practice. An annual indicative activity plan is agreed with PCNs and their performance against the contract is monitored closely. Joint bi-monthly meetings are held with all PCNs, primary care Clinical Lead and the borough primary care team to review and discuss performance. The funding allocation 25-26 is c£8.2m.

In 2024-25, PCNs delivered higher activity volume against plan for the following services:

- Phlebotomy
- ECG and ABPM - strong delivery across 6 PCNs; 1 PCN under plan
- Spirometry- strong delivery in 4 PCNs. 3 other PCNs under plan
- Wound Care- strong delivery in Kilburn PCN but activity below plan for other PCNs

	Brent	Brent	Brent	Brent
Services	Plan	Activity	Payable	% Delivered
Spirometry	1,920	2,279	2,279	118.7%
Spirometry (Equipment)	1,920	2,279	2,279	118.7%
Phlebotomy	248,652	286,116	286,116	115.1%
Wound Care	21,828	17,747	17,747	81.3%
ABPM	4,980	8,159	8,159	163.8%
ABPM (Equipment)	5,952	8,159	8,159	137.1%
ECG	16,584	19,884	19,884	119.9%
ECG (Equipment)	18,036	19,884	19,884	110.2%
Diabetes Level 2 Insulin Initiation	480	533	397	82.7%
Diabetes Level 2 GLP-1 Initiation	612	717	621	101.5%
Diabetes Level 2 Insulin Optmisation or Intensification	696	1,584	818	117.5%
Early Onset Type 2 Diabetes Review	ly Onset Type 2 Di	775	563	
Latent TB Testing (Call & Recall)	780	2,785	2,785	357.1%
Initial Nurse Appointment	1,500	1,810	1,704	113.6%
Near Patient Testing	4,812	5,115	4,421	91.9%
Better than plan				
Worse than plan				
Early Onset Type 2 Diabetes Review				
Brent				

The following services underperformed against plan:

- Atrial fibrillation,
- Paediatric phlebotomy (5-13years),
- Warfarin monitoring,
- Diabetes level 2 MDT and
- Coil fitting for non-contraception (insertion or replacement)

Q1 performance 2025-6 is not yet available for reporting purposes.

4.3 Local Enhanced Services 25-26

Brent's Local Enhanced Service (LES) are designed to target key areas of population health need across the 5 neighbourhood geographies where enhanced care through general practice can significantly improve patient outcomes. Six schemes, co-designed with primary care networks were agreed with NWL ICB in May this year. They promote comprehensive, person-centred care that supports individuals at every stage of life — from early childhood through to older age and end-of-life care. The funding allocation for these schemes is c£2.48m. The schemes are:

1. Delivery of Healthy Child Clinics to identify and address obesity, unmet physical health and mental health needs in children, with a focus on targeting children from the most deprived postcodes in Brent. This LES aligns with NHS England's CORE20+5 framework and incorporates insights from the Marmot Review on reducing child health inequalities. Funding is based on need rather than activity, so proportionately more investment is targeted to populations with high deprivation.
2. Improved identification and management of children and young people with asthma
3. Proactive hypertension case finding to address undiagnosed high blood pressure and reduce cardiovascular mortality in Brent (which despite having a younger than average population has a significantly higher mortality rate from CVD compared to London and England).
4. Proactive care planning for high-intensity users (patients consulting > 20 times/ year with a general practitioner) and housebound patients, ensuring patients with complex needs are being identified and their care needs are proactively addressed.
5. Welfare checks for carers, including health and wellbeing assessments and signposting to relevant support services in the community.
6. Enhancing end-of-life care through early recognition, advance care planning, and coordinated multidisciplinary support, promoting the use of the universal care plan.

These services have been purposefully developed to align with the NHS's three strategic shifts: moving care closer to home, prioritising prevention, and

accelerating digital transformation. These schemes have been implemented since May this year across all PCNs and will be scaled up to neighbourhood delivery level as soon as feasible. Q1 performance data is being collated and will be reported to the Primary Care Transformation Executive Group next month. Tools to support operational delivery of these schemes have been developed. They include a key messages summary report and an indicative monitoring plan supporting phased delivery, targeting 100% achievement by end of Q4.

4.4 Cancer Screening and Early Detection

I. Cervical Screening 26-49 Cohort

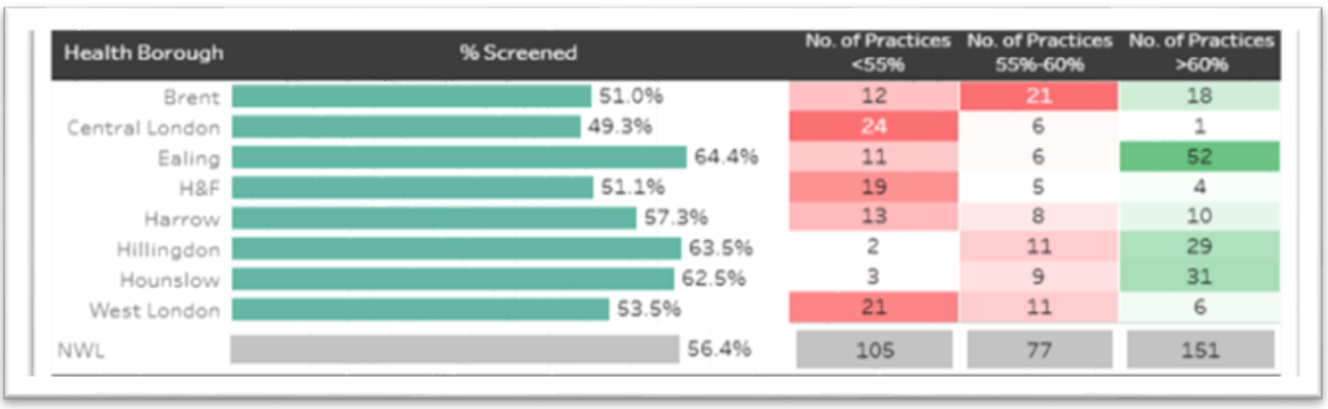
Since December 2024 cervical screening uptake in Brent has shown a steady upward trend, increasing from 49. 7 to 51.0 as of 4th July 2025. Our overall borough achievement is skewed by Pathfinders – with many of their patients being out of area, and their achievement only being at around 30%. While the progress made by the borough is encouraging, challenges remain:

- 18 GP practices have met or exceeded the 60% uptake target
- Currently, 33 practices across Brent remain below the 60% uptake threshold for cervical screening. This is well below the national efficiency standard of
- 75%, and the optimal target of 80%.

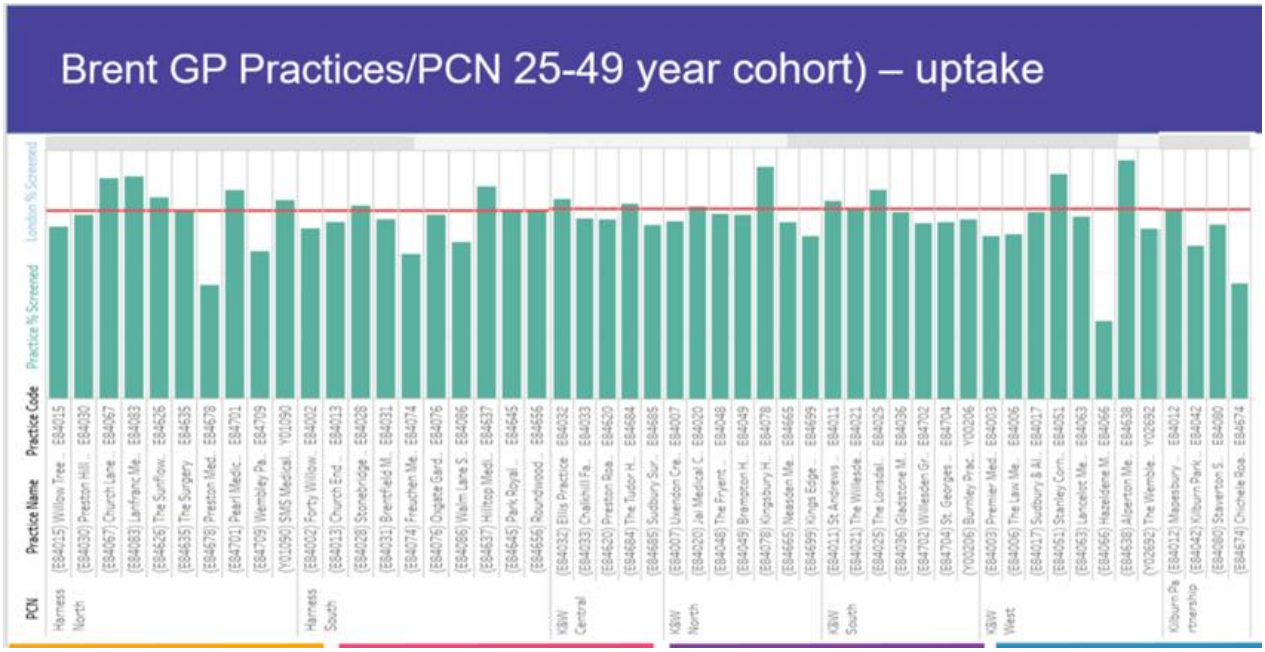
Local action to improve uptake is already being progressed. Primary Care teams are actively contacting these practices to offer targeted support from both the Borough and the NWL Screening Team. Practices with high uptake rates are also being engaged to share their strategies and identify opportunities to spread best practice.

Also call and recall systems are being strengthened. NWL is developing a Standard Operating Procedure (SOP) outlining high-impact call and recall procedures to help practices improve efficiency and outcomes. Cervical screening appointments are now being offered through Extended Access Hubs, including early mornings, evenings, and weekends, improving convenience for patients.

Brent remains the second lowest performing borough in North West London for cervical screening uptake, as shown in the diagram below.



Health Borough	% Screened	No. of Practices <55%	No. of Practices 55%-60%	No. of Practices >60%
Brent	51.0%	12	21	18
Central London	49.3%	24	6	1
Ealing	64.4%	11	6	52
H&F	51.1%	19	5	4
Harrow	57.3%	13	8	10
Hillingdon	63.5%	2	11	29
Hounslow	62.5%	3	9	31
West London	53.5%	21	11	6
NWL	56.4%	105	77	151



The ICP is committed to closing this gap through focused, community driven interventions that ensure equitable access and improved outcomes for all. For instance, NHS England (London region) are introducing a Human Papillomavirus (HPV) self-sampling pilot to women aged 25- 64, and being more than 6 months overdue for their next screening. The aims are to reduce inequalities and increase cervical screening coverage in London and to eliminate cancer in London by 2040 by achieving screening coverage rates of 70% and focusing on practices with coverage below 55%. Five Brent practices have been successful in their expression of interest for this programme. These have low screening uptakes currently. This initiative should contribute to increasing cervical screening rates in female population cohorts with deeply entrenched barriers that keep some women away from potentially life-saving screenings, including a fear of discomfort, embarrassment, cultural sensitivities and the struggle to find time for medical appointments.

A dedicated Brent Cervical Screening Working Group is being established in partnership with Public Health, Primary Care, and other key stakeholders. The group aims to:

- Strengthen integrated working across the system
- Identify barriers, risks, and population-specific challenges
- Develop a coordinated, data-informed action plan to improve cervical cancer screening uptake and early detection
- Community Engagement and Equity-Focused Outreach
- In collaboration with Brent Health Matters (BHM) and Public Health, Primary Care is proactively addressing cancer inequalities through targeted community events held in priority areas. These events will include:
- Participation from both the Clinical Cancer Lead and the Clinical Primary Care Lead
- Tailored messaging delivered in multiple languages to ensure inclusivity and cultural relevance

- Engagement with local residents to raise awareness and reduce stigma around cervical screening

Collaborative Working with NWL Cervical Screening Team - Brent is also working closely with the NWL Cervical Screening Team to ensure consistency with regional approaches and align efforts with best practice guidance. This includes joint planning, co-development of communications, and shared evaluation of pilot interventions.

II Other Cancers

Since January 2025 bowel cancer screening rates in Brent have remained steady at around 60% which puts us around average across NWL Brent. The inequality gap in bowel cancer screening uptake between declines 1 and 8 fell from 12.4% in 2023 to 9% in 2025. BHM are running a Bowel Cancer awareness campaign targeting individuals aged 50-74 years as part of its outreach work, and the clinical team also reaches out proactively to target groups of GP patients living in quintiles 1 and 2, where bowel cancer screening uptake is poor.

Brent is seeing a low uptake in Breast screening with rates being around 50%. National target is 70%.

A cancer programme plan has been developed to set clear priorities, to respond to local needs, to co-ordinate action and to reduce inequalities. The Cancer Programme Plan will articulate a clear vision, set strategic objectives, and define coordinated actions aimed at improving cancer outcomes across Brent. This plan serves as a strategic roadmap to drive measurable impact in the following key areas:

- Increasing uptake
- Cancer Prevention
- Early Detection and Diagnosis
- Treatment pathways

The plan reflects a commitment to collaborative working with Public Health, Primary Care Networks, the NWL Cancer Team, and community partners. It is designed to address inequalities, foster innovation, and ensure that every patient has access to high-quality, compassionate care at every stage of the cancer journey.

Improving screening coverage and early detection for cancers encouraging practices to adopt best practice to reduce variation and improve patient experience. Data shows that the lower uptake are around Harlesden, Stonebridge, Church End, Willesden Green, Neasden and some parts of Kilburn. This is due to higher deprivations scores, ethnic diversity and language barriers, lower health literacy and access issues.

4.5 Child Health Hubs

Five GP SPIN Fellows were recruited in May 2025. Child health hubs are being set up across the borough in six locations. Following an upskilling period, the

GP SPIN Fellows will run clinics initially at PCN level hubs from this month under supervision from consultant paediatricians from LNWH/Imperial Healthcare Trusts, thus enabling parents to access care quicker for children with complex medical needs and thereby stem referrals to acute hospital paediatric services. The intention is to scale up these hubs to a neighbourhood delivery model as soon as feasible in this year. The hubs' operational arrangements are being finalised including a single referral form and a standard operating procedure. GPs across the borough will be able to make referrals to the hubs' clinics from around 15 July. A guide to the child health hubs for Brent GPs is being produced as part of the launch and will be presented at a number of clinical meetings, including the GP Forum this month.

4.6 Primary Care Workforce Development, Education & Training

The NWL strategy on workforce development, education & training is predominately based on 5 delivery objectives:

- Developing the integrated neighbourhood teams outlined within the Fuller Stocktake
- Retention of the NWL workforce
- Workforce recruitment under the Additional Roles Reimbursement Scheme (ARRS)
- Transformation - Training Hubs supporting the primary care workforce in their development and upskilling needs
- Strategic workforce planning - identifying key metrics that can demonstrate the impact of new roles in primary care.

The local training hub's workforce priorities 2025-6 align well with these objectives. Hubs are also required to deliver against specific KPIs as listed below, to enable them meet their contractual requirements each year.

- Apprenticeships – offering both non clinical and clinical apprenticeships
- Continuing professional development (CPD) funding – offering CPD funds and utilising funds for each nurse employed within the borough, with c£333 allocated for each nurse for the year.
- Distribution of training delivered through various means such as websites, newsletters & emails
- EDI events organised and carried out within the borough
- Each PCN approved as a learning environment
- Placements organised for multi professionals within primary care with a key focus on allied health professionals (AHPs)
- Quality concerns logged and reported to NWL Training Hub
- Documenting number of GP Educators/Supervisors and supporting them to become GP Supervisors
- Local borough service delivery funds – utilised according to the local borough needs.

The local training hub is already carrying out a number of projects to meet these requirements. E.g.

- Recruitment and retention: – upskilling and creating new opportunities for our current workforce, increasing their skillset and knowledge and enabling better patient care.
  - ❖ 11 GP SPIN Fellows into post, with a mix of 3 pharmacists and 8 GPs thereby creating 5 diabetes hubs and 5 child health hubs across the borough
  - ❖ Nurse CPD funds have been allocated to enable nurses to train and upskill for their continuing professional development.
  - ❖ A Legacy Nurse is being recruited to mentor junior nurses within the borough.
  - ❖ NB Medical "Hot Topics GP Update" for GPs to provide GPs with the latest findings in medical research and guidelines.
  - ❖ Reception and admin training completed with a 70% attendance rate. E.g topics included dealing with difficult situations, telephone triage and customer care
  - ❖ Health Support Workers' course
  - ❖ Lunch and Learn sessions, based on training needs analysis, planned for the remainder of the year with the following sessions:
    - Asthma
    - Cancer
    - Documentation
    - Red Flags in primary care
    - Digital champions refresher
    - Diagnosing diabetes
    - Women's health

- Placements – increasing placements capacity for undergraduate pharmacy and nursing students with a pilot scheme organised with the training hub to host students for a set period of time.
- Learning environment approvals – We have 5 out of 7 PCNs approved as a learning environment with two remaining. By supporting the local PCN Educators, we aim to approve all 7 PCNs within this year.

4.7 Immunisations and Vaccinations

(i) COVID vaccinations: The COVID-19 Spring Campaign ended on the 17th June 2025. Brent has a total eligible population of 30,145 the uptake assumption is 17%. A total of 5,372 vaccinations were given by Community Pharmacies and 1,659 were given by PCNs. For the Spring campaign, the NWL Roving Team vaccinated 435 patients in care homes and 40 patients through the Making Every Contact Count (MECC) initiative.

Population Cohort	Brent	Uptake %
Care Home Residents	783	49.9
80+ yrs	11,475	26.2%
75-79 yrs	8,651	24.9%
Severely Immunosuppressed	5,074	10.9%
Immunosuppressed	2,862	8.7%

12-15 Severely Immunosuppressed	89	0.0%
12-15 Immunosuppressed	27	3.7%
05-11 Severely Immunosuppressed	133	0.0%
05-11 Immunosuppressed	31	3.2%
Total	29,125	21.8%

The COVID- 19 Autumn/Winter programme will run from 1 October 2025 to 31 Jan 2025. However, the majority of COVID-19 vaccinations should be completed by 19 December 2025. Eligibility will be as previous campaigns. In NWL, access for a COVID-19 Vaccination outside of the seasonal campaign will be available at Park Royal Medical Practice in Brent.

(ii) FLU

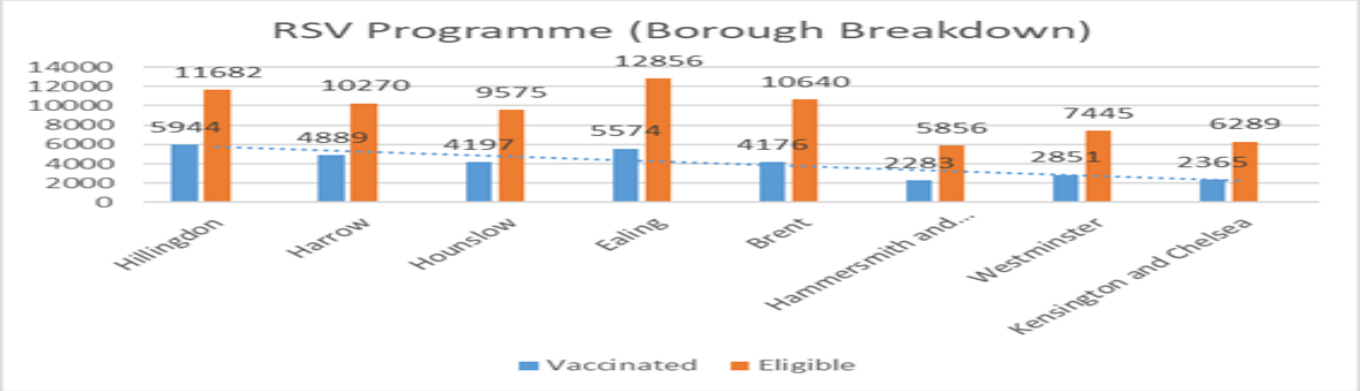
The flu campaign 2024 – 2025 ended on the 31st March 2025. Out of 191,080 eligible patients 59,871 (31.3%) were vaccinated. The table below shows the uptake for each cohort and whether it increased or decreased compared to 2023 -2024.

Organisation	Summary of Flu vaccine uptake % 2024 – 2025				
	65+	Under 65's (at risk only)	All Pregnant	All 2 year olds	All 3 year olds
NWL ICB	61.0	32.6	29.0	34.3	35.2
Brent	56.6 ↓	31.9 ↓	27.0 ↑	30.0 ↓	31.1 ↓

The flu campaign 2025/2026 will start in October for the majority of cohorts. There will be no changes to cohorts or timings. Pregnant women and all eligible children cohorts will start from 1st September 2025. All other adult flu cohorts will start from 1 October 2025 and will run until the 31 March 2026.It is anticipated that the majority of vaccinations will be completed by the end of November 2025, ensuring optimal protection ahead of the winter season.

(iii) RSV Vaccinations

To date, 86.3% (35,151) of the activity has been delivered through primary care with the maternal programme so far administering 9,119 RSV vaccinations to pregnant women across NWL. The table below shows the RSV activity by Borough (older adults); Brent achieving a 39.3% vaccination rate.



(iv) Childhood Immunisations - Measles update

Latest data available up to late June 2025 shows that Brent reported a notable increase in measles cases, though it is not among the top five boroughs in London for total case numbers. Brent has reported 9 confirmed measles cases so far in 2025. This represents an increase compared to 2024, when Brent had only 3 confirmed cases for the entire year. Improving the uptake of immunisations including MMR, with a focus on people from ethnic minority groups and living in deprived areas, is a priority for Brent Health Matters' CYP programme this year. Another factor which might affect uptake is that the timing of the two MMR vaccines is being compressed. We shall need to monitor if this affects uptake at all.

5.0 Stakeholder and ward member consultation and engagement

5.1 The primary care programme works closely with its key stakeholders including primary care networks, GP practices, their diverse workforce, NWL ICB teams and other teams in the ICP. Regular meetings are held in delivering the programme and supporting other programmes with their priorities.

6.0 Financial Considerations

6.1 There are no additional financial implications in this report. All projects are funded as part of the programme's allocations.

7.0 Legal Considerations

7.1 There are no legal implications at this time.

8.0 Equity, Diversity & Inclusion (EDI) Considerations

8.1 The projects outlined in this report are designed to address health inequalities across the borough. The overarching objectives of the primary care programme are to improve access for patients to the whole range of primary care services, to offer a consistently high quality, timely care at the patient's local GP Practice and that practices provide continuity of care where required. This report outlines in a number of instances the proactive steps being progressed already to improve services where gaps have been identified.

9.0 Climate Change and Environmental Considerations

9.1 There are no climate change and environmental considerations at this time.

10.0 Human Resources/Property Considerations (if appropriate)

10.1 There are ongoing estates challenges across GP practices in the borough. These are being addressed together with PCNs and NHS Estates Services as best as possible given the challenging financial environment.

11.0 Communication Considerations

11.1 There is ongoing engagement with key stakeholders across the programme including system partners, patients and carers.

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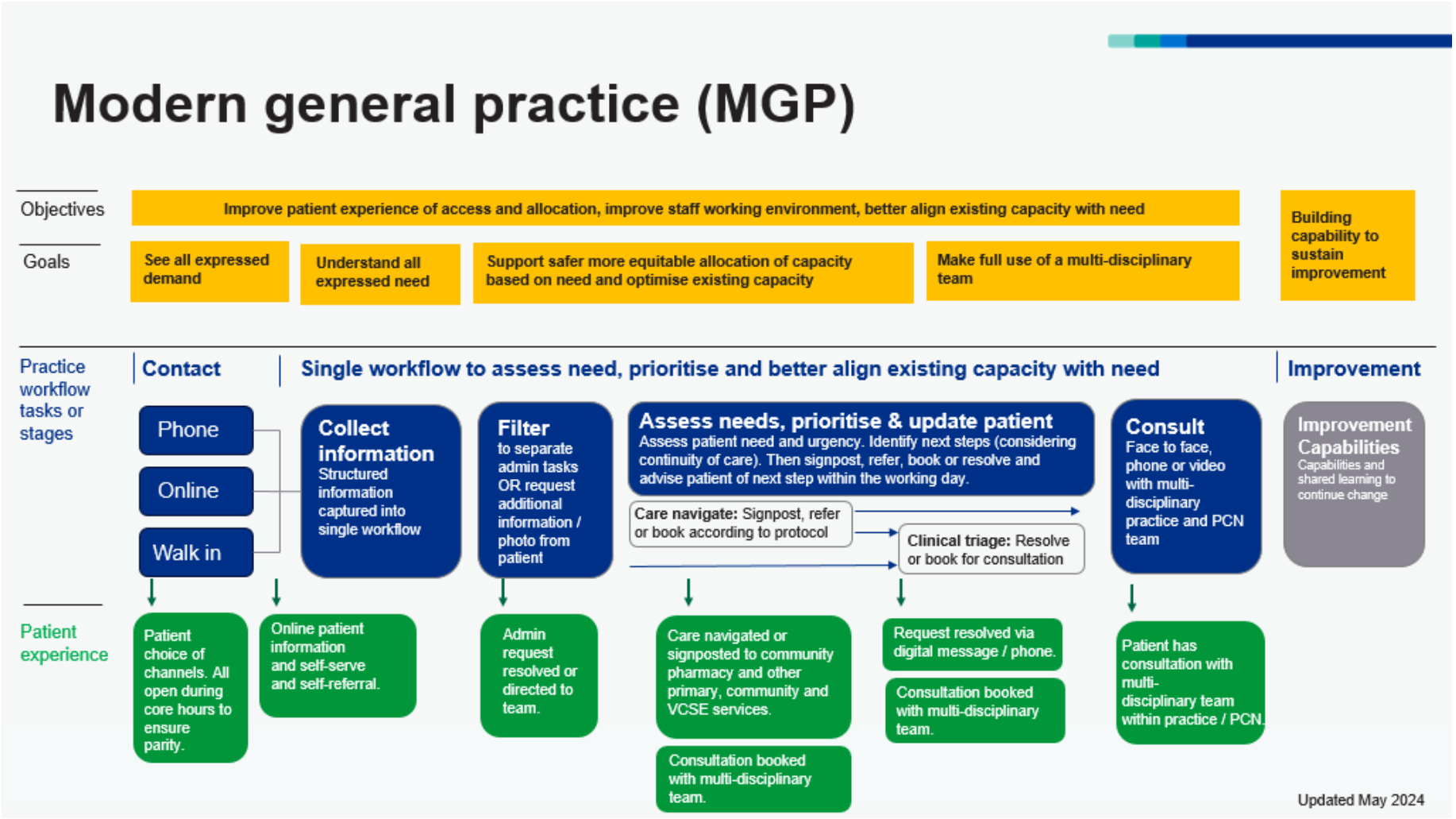
Appendix One

Figure 1: modern general practice model (updated May 2024)



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Appendix Two

Primary Care Enhanced Services Offer 25-26

1	Spirometry
2	Prescribing
3	Mental Health (SMI & CCMI)
4	Phlebotomy
5	Wound Care
6	ABPM
7	ECG
8	Diabetes (Level 1 & NDH)
9	Warfarin Initiation and Monitoring
10	Latent TB
11	Ring Pessary
12	Near Patient Testing
13	Paediatric Phlebotomy (2-4 Years)
14	Paediatric Phlebotomy (5-13 Years)
15	Paediatric Phlebotomy - Learning Disabilities
16	Diabetes Level 2 Insulin Initiation
17	Diabetes Level 2 GLP-1 Initiation
18	Diabetes Level 2 MDT
19	Diabetes Level 2 Insulin Optimisation or Intensification
20	Early Onset Type 2 Diabetes Review
21	Atrial Fibrillation
22	Respiratory
23	Hypertension
24	Safeguarding
25	Coil Fitting for Non-Contraception - Insertion and Removal
26	Asylum Seekers - Long Stay
27	Chronic Kidney Disease - Coding Review and Diagnosis and Enhanced Review

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Brent NHS North West London	**Brent Health and Wellbeing Board** 24 July 2025
	Report from the Director of Public Health, Leisure and Parks

Joint Health and Wellbeing Strategy: progress update

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
List of Appendices:	Appendix 1 – Joint Health and Wellbeing Strategy Refresh Appendix 2 - Progress tracker
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Dr Melanie Smith Director of Public Health Melanie.Smith@brent.gov.uk Agnieszka Spruds Strategy Lead – Policy Agnieszka.Spruds@brent.gov.uk Angelyn Francis Policy Support Officer Angelyn.Francis@brent.gov.uk

1.0 Executive Summary

1.1 In July 2024, the Health and Wellbeing Board endorsed a refreshed Health and Wellbeing Strategy, setting out a new set of commitments and priorities for the borough. The published strategy includes a commitment to provide annual progress updates. This is the first progress report since the refresh, offering an update on delivery against the new commitments. These are summarised in this report against each of the five themes with the full detail included in Appendix 2. The report also includes a couple of case studies to showcase innovative partnership work. Finally, the report draws the Board's attention to a future opportunity.

2.0 Recommendation(s)

2.1 To note the progress and challenges set out in this report, and to identify areas where additional support or collaboration could strengthen delivery and maximise impact.

2.2 To explore how the Social Progress Index (SPI) can be used to inform local service planning, resource allocation, and targeted intervention.

2.3 To review and respond to the opportunities outlined in section 6, particularly where cross-council or partner action could enhance impact.

2.4 To approve the proposed next steps outlined in section 7.

3.0 Background

3.1 Contribution to Borough Plan Priorities & Strategic Context

3.1.1 This report relates to Borough Plan Priority – A Healthier Brent.

3.1.2 Every Health and Wellbeing Board is required to produce a Joint Health and Wellbeing Strategy (HWS) which reflects local health needs and to which all partners should have regard.

3.1.3 The global pandemic exposed and highlighted health inequalities, prompting Brent to redefine its approach to developing a new Joint Health and Wellbeing Strategy. The current strategy represents a shift from previously health and care-focused objectives to a broader focus on the social determinants of health, adopting a more community-centred approach.

3.1.4 The original set of commitments in the strategy were largely narrative-based and appropriate at the time, and mostly achieved, but the BHWB requested that future commitments be more measurable. In response, the refreshed strategy included a new set of commitments with clear KPIs and baselines to better track progress and impact, though some narrative context remains important to fully understand their meaning and potential impact.

4.0 Progress Summary

<u>Overall progress</u>

4.1 Across the six themes of the Health and Wellbeing Strategy, a total of 49 commitments were tracked during this reporting period. As of the latest update:

- Achieved: 25
- Partially achieved: 6
- In progress/narrative: 18

4.2 Several initiatives have exceeded targets for example in diabetes support, housing adaptations, community mental health outreach, and the Urgent

Community Response (UCR) service. Brent's ability to scale and embed high-impact programmes such as School Streets, Family Wellbeing Centres, and the new Community Wellbeing Service highlights sustained progress in delivering accessible, resident-focused support.

4.3 Themes like Healthy Lives, Healthy Places, and Staying Healthy have made the most measurable gains, particularly where service infrastructure was already in place. In contrast, commitments linked to more structural or systemic change, such as inclusive research, demographic data improvements, and employment pathways from health settings remain in progress or under development.

4.4 The strategy's two underpinning themes: Healthy Ways of Working and Understanding, Listening and Improving have begun to establish foundations for more participatory, data-informed policy, including the launch of the Social Progress Index in June 2025. However, delivery here is at an earlier stage and will require sustained effort to realise the full intended impact.

4.5 In summary, Brent is delivering well against many of its core health and wellbeing priorities, with strong community reach and service delivery in place, while work continues to deepen impact in areas that require longer-term system and culture change.

4.6 Progress highlights by themes

4.7 This section provides key highlights and summary for the progress update. Each commitment is briefly outlined in the following format:

- Commitment number (as in Appendix 1)
- Status: Achieved/Partially Achieved/In progress/Narrative/Awaiting data
- Progress against KPIs

A more detailed breakdown is available in Appendix 2: Progress tracker.

4.8 <u>Healthy Lives</u>

"I am able to make the healthy choice and live in a healthy way, for myself and the people I care for"

4.8.1 There are 14 commitments under this theme. As of the current update:

- Achieved: 7
- Partially achieved: 2
- In progress/narrative: 5

4.8.2 Progress is strong overall, with several initiatives exceeding their original targets. Achievements include the expansion of the Diabetes Healthy Educators programme, the delivery of over 27,000 interventions through the UCR service (450% above target), an increase in reach through targeted communications, and the Period Dignity pilot.

4.8.3 Some areas remain in development or under review, including the Food Strategy (narrative), Healthy Start scheme uptake, and outreach work to improve childhood vaccination and asthma support, and the Admiral Nurses programme is delayed but expected to launch shortly.

4.8.4 Summary of progress by commitment:

- **1.1 Food Strategy development: narrative**
  Food Strategy project continues to be co-developed with communities and partners, so far the officers organised two workshops and engaged with 55 people from 37 local organisations in the first workshop and around 60 people from at least 28 organisations during the second one.

- **1.2 Public Health and Brent Health Matters events: partially achieved**
  Marked as partially achieved as the KPI was set at organising at least 40 events per month, but the received update suggests that teams continue to deliver 35 events on average.

- **1.3 BHM Grants: narrative**
  While no new grants were distributed in 2024/25, the focus was on supporting 2023/24 recipients and signposting them to additional funding opportunities.

- **1.4 Targeted communications: achieved**
  Approximately 42,000 people were reached out to through social media against 36,000 last year

- **1.5 Diabetes support: achieved**
  Target on track to be exceeded, with 9 Healthy Educators programmes delivered to date and 3 more scheduled by end of June.

- **1.6 Brent Period Dignity Pilot: achieved**
  Target exceeded with 17 locations providing people with period products and menstrual health educational resources.

- **1.7 Tackling tooth decay in children: achieved**
  The oral health bus visited 23 schools so exceeded target of 20. 840 children were seen compared to 627 the previous year.

- **1.8 Healthy Start scheme: in progress**
  Uptake by Healthy Start card holders remains at 12% and impact is under evaluation.

- **1.9 Tackling health inequalities in children and young people: in progress**
  Outreach and groundwork underway to increase MMR uptake and support asthma management, with delivery expected to follow

- **1.10 Mental health practitioners: achieved**
  201 referrals received across 21 schools since Autumn 2023, with 81% progressing to intervention.

- **1.11 Brent Hubs: achieved**
  81.78% of enquiries resolved at first contact in May; 4,469 residents accessed Community Hubs so far this quarter, on track to match Q4 levels.

- **1.12 Stop Tobacco service: partially achieved**
  Referrals increased by 60%, but quit rate fell from 45% to 28%.

- **1.13 Rapid Response, now referred to as UCR: achieved**
  Annual activity exceeded by 450%, with over 27,000 interventions delivered and significant A&E attendances avoided.

- **1.14 Admiral nurses: in progress**
  Due to some governance-related delays, the Admiral Nurses have not yet been appointed. The scheme is now expected to launch in July.

4.9 Healthy Places

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

4.9.1 There are 15 commitments under this theme. As of the current update:

- Achieved: 8
- Partially achieved: 2
- In progress: 5

4.9.2 Delivery under this theme is progressing well, with successes in areas such as housing quality, school streets, accessible physical activity, and climate engagement. The School Streets programme has surpassed its annual target with 32 zones now in place, while over 21,000 private rental properties have been licensed and £7.7M invested in adaptations for disabled residents. Outdoor and accessible activities are reaching diverse communities and are now backed by stronger data collection systems.

4.9.3 Some areas remain in development or require further progress, such as the Healthier Catering Commitment and the Air Quality Champions initiative. Despite not meeting all KPIs, the Music Mile mental health project showed strong engagement and impact. Active travel outcomes were mixed, with traffic reduction targets achieved early but a decline in residents walking or cycling regularly.

4.9.4 Summary of progress by commitment:

- **2.1 Events for Ukrainian guests: partially achieved**
  Commitment partially achieved with 6 events delivered against a target of 12

- **2.2 Sport England Place Based Expansion Programme and Football Foundation Playzones: in progress**
  Steering group active and funding secured for early-stage work, but no delivery yet against physical activity KPIs.

  Challenges reported by services:

  Football Foundation Playzones progress seems to have stalled. Parks not able to commit to match funding for this. The lead officer will reopen the conversation to explore potential sources of funding.

- **2.3 Accessible physical activities programme: achieved**
  Programme of accessible activities is well-established and reaching diverse priority groups, with improved data systems now in place to strengthen impact tracking.

- **2.4 Private rental licensing and an adaptations programme: achieved**
  21,700 properties licensed (target: 12,000), with £7.7M invested in adaptations to support disabled residents.

- **2.5 Ealing Road Library Garden: achieved**
  12 outdoor events delivered with 122 adults and 164 children engaged, plus additional school participation and external funding secured.

- **2.6 "Together Towards Zero" grants: achieved**
  18 climate grants awarded in 2024/25 (target: 15), with Round 4 launched in May 2025.

- **2.7 Healthier Catering Commitment: in progress**
  6 new businesses signed up to date against a target of 20 for 2024, with further work and engagement underway.

- **2.8 The Music Mile – Mental Health Support programme: partially achieved**
  23 residents enrolled (target met), 14 performed at the festival, and 6 musicians delivered sessions against a target of 10. The project is spotlighted in section 5.1.

- **2.9 Air Quality champions: in progress**
  Initial recruitment delays, but two members of the Brent Health Matters team have now taken on the Air Quality Champion role and will support engagement at upcoming events.

- **2.10 Air Quality work in schools: in progress**
  Baseline travel data due July 2025, with outcomes to follow; educational

activity underway via Breathe Clean Brent project.

- **2.11 Active Travel: partially achieved**
  Traffic levels have met the 2027 target early, but active travel rates have declined to 29%; next data point due early 2026.

- **2.12 Supporting schools to lead local climate action and education: achieved**
  15 schools now use the Climate Action Guide, 20 leads trained, and 12 schools have created and started to implement action plans, with 10 more in progress.

- **2.13 SCIL Youth Provision Grant: in progress**
  19 EOIs received, 12 progressed to full applications, with 5 shortlisted for Cabinet approval to secure funding for delivery.

- **2.14 Family Wellbeing Centres: achieved**
  18,079 families accessed Family Wellbeing Centres in 2024/25, consistent with previous year's levels.

- **2.15 School Streets: achieved**
  School Streets expanded to 32 zones, meeting the annual implementation target and supported by ongoing evaluation and future trials.

4.10 Staying Healthy

"I, and the people I care for, understand how to keep ourselves physically and mentally healthy, managing our health conditions using self-care first. We have access to good medical care when we need it."

4.10.1 There are 13 commitments under this theme. As of the current update:

- Achieved: 7
- Partially achieved: 2
- In progress: 4

4.10.2 Delivery is progressing steadily across this theme, with strong outcomes in mental health access, preventative care, and support for carers. Notable successes include the 24/7 multilingual mental health support for Ukrainian guests and hosts, a significant reach through Community Connector outreach (over 1,100 residents), and reductions in unplanned hospital admissions for COPD, exceeding the target with a 5.32% drop. The Brent Carers Strategy continues to deliver well, and the Health Education contract outperformed its annual goal.

4.10.3 Some areas are still developing or require further scale-up. The Step-Up Pathway has seen limited uptake due to constrained delivery capacity, and the introduction of social prescribers in Adult Social Care is still in the pilot phase. Data is awaited on bowel cancer screening, and targeted hypertension work remains below target. While dementia-friendly library outreach has

expanded, full implementation and funding submission are pending. Overall, the theme demonstrates strong community engagement and early impact, but sustained effort will be needed to meet annual targets in several key areas.

4.10.4 Summary of progress by commitment:

- **3.1 Mental health services for Ukrainian guests and their hosts: achieved**
  24/7 mental health support now available for both guests and hosts, in Ukrainian, Russian, and English.

- **3.2 Bowel cancer screening services: achieved**
  19 events delivered in 2024/25.

- **3.3 Targeted hypertension work: partially achieved**
  56 patients supported between April 2024 and May 2025; activity continues but is currently below the annual target of 100.

- **3.4 Health Education contract: achieved**
  82 people were supported through health education and case management sessions, exceeding the annual target of 50.

- **3.5 Co-produced mental health events: in progress**
  20 workshops were delivered with 70% co-produced, demonstrating strong community engagement, but further sessions are required to meet the annual target of 50.

- **3.6 Supporting residents with GP registration: in progress**
  BHM and Public Health supported 123 people to register with a GP between April 2024 and April 2025 against the target of 150.

- **3.7 Mental health outreach and Community Connectors: achieved**
  Over 1,100 residents were engaged through 80 events led by Community Connectors, with targeted outreach and support for those most at risk of mental health crises.

- **3.8 Improving accessibility of libraries for residents living with dementia: partially achieved**
  Library service expanded to 12 dementia-friendly care homes and funding application work is progressing, but full delivery and ACE bid submission are still pending.

- **3.9 Introduction of social prescribers into ASC: in progress**
  Two social prescribers now embedded in Adult Social Care; pilot underway with evaluation focused on wellbeing, user experience, and demand reduction.

- **3.10 Brent Carers Strategy: achieved**
  Brent Carers Strategy delivery is on track, with over 1,000 carers supported,

including 35 new referrals, 71 assessments, and 64 young carers identified via the 2025 school census.

- **3.11 Prevention Strategy: achieved**
  Brent's Prevention Strategy has been finalised following extensive co-production and partner engagement, with delivery infrastructure now in place and KPI framework under development.

- **3.12 Tackling emergency hospital admissions for patients with COPD: achieved**
  Unplanned hospital admissions for COPD fell by 5.32% in 2024/25, exceeding the 5% target.

- **3.13 Step-Up Pathway: in progress**
  Scheme piloted and supported 3 residents in 2024/25; delivery capacity remains limited with only 1 dedicated bed in use.

4.11 Healthy ways of working

"The health, care and wellbeing workforce will be happy and strong; and the health and wellbeing system will recover quickly from the impacts of the pandemic."

4.11.1 There are 3 commitments under this underpinning theme. As of the current update:

- Achieved: 2
- In progress: 1

4.11.2 The Community Wellbeing Service has launched successfully, with 293 referrals in its first five months and a growing offer to support residents with complex needs. Recruitment through the Health Educators programme continues, with 46 Community Champions now active, employment pathways for residents referred via health and community routes exceeded its original target.

4.11.3 Summary of progress by commitment:

- **4.1 Healthy Educators programme for local communities: in progress**
  Community health recruitment has continued, BHM currently manages a total number of 46 Community Champions.

- **4.2 Community Wellbeing Service: achieved**
  The new Community Wellbeing Service has launched successfully, with 293 referrals received in its first five months and strong early progress in building accessible, partner-led support.

- **4.3 Pathways to employment for individuals referred by GPs, social prescribers, self-referrals, and local employment services: achieved**
  171 residents supported with employment opportunities.

4.12 Understanding, listening and improving

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

4.12.1 There are 4 commitments under this theme. As of the current update:

- Achieved: 1
- In progress/narrative: 3

4.12.2 This underpinning theme focuses on embedding lived experience and local insight into decision-making across adult social care, research, and service design. The evolution of ward-level insight sessions into the borough-wide Social Progress Index marks a major milestone, while co-production structures within Adult Social Care are now embedded and operating regularly. Inclusive health research is progressing, with foundations in place but delivery of participatory work still to begin.

4.12.3 Summary of progress by commitment:

- **5.1 Embedding co-production with residents in ASC: in progress**
  Co-production structures are now well-established and engaging residents on a regular basis, but further work is needed to deepen engagement with underrepresented communities and strengthen demographic recording practices.

  Request from services:

  In view of the low numbers of service users recorded from the Roma, Gypsy and LGBTQ+ communities, we would like to request support for the formation of a cross-organisational working group. This group would report to the existing Coproduction and Community Partnership Steering Group and look at how we can improve our engagement with the above groups, our understanding of their health and wellbeing needs and how we record this information. It would also explore and share examples of good practice when engaging with these communities.

- **5.2 Ward-data level sessions: achieved**
  The original ward-level insight sessions have now evolved into the development of Brent's Social Progress Index, launching in June 2025, to provide a more strategic and data-rich approach to understanding local needs.

- **5.3 Embedding the voices of service users in the design and delivery of treatment and recovery services: narrative**
  By the end of 2024/25, there were 35 Recovery Champions and 87 new attendees at BSAFE sessions, showing ongoing engagement with Brent's unique, resident-led weekend recovery service. Members are welcome to visit

the project or invite B3 to present at a future Board meeting as it's a strong example of local residents leading support in their own community.

- **5.4 Inclusive health research: in progress**
  Engagement with underrepresented groups is underway and several insight projects have been scoped, but participatory research has not yet started and key delivery milestones remain in progress.

5.0 Case studies

5.1 This section includes a number of projects that deserve a spotlight because of their innovation, partnership, response to community needs and positive impact on the health and wellbeing of Brent residents. These case studies are shared to help the Board identify opportunities for collaboration, scaling, or wider adoption, and to inform future priorities by highlighting what's working well on the ground. This is not an exhaustive list, and we recognise there are many other valuable initiatives underway across the borough.

5.2 Spotlight: The Music Mile Mental Health Support Programme

Context

5.2.1 In 2024, Kilburn-based charity Kilburn State of Mind launched the Music Mile Mental Health Support Programme, supported by the Public Health grant. Designed alongside a wider festival to celebrate Kilburn's rich musical heritage, the mental health support programme offered an innovative approach to supporting residents' wellbeing by offering locals music lessons and the chance to perform at the festival. By using music as a tool, the programme created a safe, inclusive space for residents to express themselves and build confidence.

Programme set-up:

- Professional music lessons in a one-to-one setting
- Opportunity to perform at the new Music Mile Festival in November 2024

Target group and participation

5.2.2 The initiative welcomed residents from all backgrounds, with a particular focus on reaching those less likely to access traditional mental health services. Notably, a significant number of participants were Black British men, a group identified as among the least likely to engage with conventional support. Their strong participation was a positive and encouraging outcome for a programme rooted in inclusion and accessibility. Of the 23 residents who joined the programme, 17 completed it and 14 performed live at the festival in front of friends, family, and the wider community.

Impact

5.2.3 Through one-to-one music lessons and the opportunity to perform at the Music Mile Festival, reported outcomes included increased confidence, reduced stress, and a renewed sense of purpose. These outcomes were based on participant feedback surveys, which highlighted the programme's positive impact on mental health and social connection.

"It definitely offered a certain structure to me that brought me out of, I would say, an unhealthy level of unhappiness."

Learning

5.2.4 The Music Mile Mental Health Support Programme demonstrates the power of creative, community-led approaches in promoting mental wellbeing.

Participant feedback and survey responses consistently highlighted the programme's positive impact, with many expressing a desire for it to continue and expand. Additionally, participants expressed a need for longer programme duration to allow for more meaningful engagement and sustained outcomes. Its success offers valuable insights for future initiatives, particularly in areas where similar needs and opportunities exist. This model could be adapted in other communities, helping to create more healthy places where people can connect, grow, and thrive.

5.3 Spotlight: Period Dignity Brent Pilot

Context

5.3.1 In 2024, Brent Council launched the Period Dignity Brent Pilot, a significant initiative aimed at tackling period poverty and stigma across the borough. The pilot, supported by a cross council team which brought together Public Health, Policy, Brent Hubs, Early Help and Libraries, focused on improving access to free period products and menstrual health education in community settings, including libraries, family wellbeing centres, and Brent hubs. The council partnered with Hey Girls to provide a universal offer developed to ensure all people who menstruate have access to free, eco-friendly period products and menstrual health education. 17 locations across the borough have been set up to distribute disposable and reusable period product options.

Impact

5.3.2 The initiative was co-designed with resident facing council services, to ensure it met the real needs of the community. It also included training for frontline staff to help them talk confidently and compassionately about menstruation, breaking down taboos and promoting dignity.

"It's not just about addressing a lack of access but about creating a culture where periods are normalised and no one feels shame or stigma"

5.3.3 During the trial approximately 17,000 products have been distributed to those in need. By embedding period dignity into everyday community spaces, the pilot not only met immediate needs but also laid the groundwork for long-term

change around menstrual health in Brent. The Period Dignity Brent Pilot stands as a transformative example of how local, place-based approaches can address health inequalities and promote wellbeing through dignity, inclusion, and community empowerment.

5.4 Spotlight: Community Wellbeing Service

Context

5.4.1 Launched in January 2025 at the New Horizons Centre in Harlesden, the Community Wellbeing Service builds on a successful pilot to deliver integrated, community-based support. Its aim is to enhance community resilience, address food insecurity, and provide holistic, preventative interventions that reduce the risk of crisis for vulnerable families in one community space.

5.4.2 Operating five days a week, the service offers a community shop, café, evening meal service, and wraparound support. An on-site Adult Social Care Day Service provides enriching activities such as arts and pottery, while also enabling carers and participants to access wider support. The Families Housing Needs service plays a critical role in addressing homelessness, working closely with co-located partners to deliver coordinated, person-centred support.

Impact

5.4.3 By bringing together services like Sufra, Brent Hubs, and Housing Options under one roof, the initiative has fostered a stronger local support network. This co-location model enhances collaboration, streamlines service delivery, and builds sustainable capacity across sectors. Residents benefit from more accessible, joined-up support that meets their diverse needs, and the service provides a supportive working environment, contributing to a more fulfilled and resilient health, care, and wellbeing workforce.

Learning and future plans

5.4.4 Looking ahead, the service aims to deepen integration with health services, including GPs, Social Prescribers, and Public Health officers. This will enable more seamless referrals and comprehensive wraparound care.

5.5 Spotlight: The Men United project

5.5.1 Launched in Spring 2023 as a 10-week pilot at The Unity Centre, the Men’s Health project began as a general health education programme. However, feedback from participants highlighted a greater need for emotional support and non-judgemental conversation. This led to the creation of Men United, a safe space focused on listening and connection.

5.5.2 Harlesden, an area facing significant deprivation and health inequalities, was chosen as the project's base. The Methodist Church, centrally located and close to services such as Crisis and Turning Point, provided an ideal setting.

5.5.3 The space offers a welcoming environment where men can experience a sense of belonging and access essentials such as food, warmth and toiletries, alongside social connection, activities and practical support. Partner organisations including Via, Brent Health Matters, CNWL and others attend regularly, providing pathways into advice, support and care for those facing challenges such as addiction, mental health difficulties, or insecure housing.

5.5.4 The project has since expanded, with organisations including GamCare, Brent Health Matters, The Cove, Via, and CNWL offering on-site support. Via's regular attendance marks a key development, particularly given the prevalence of addiction and gambling issues among attendees. Many participants face housing insecurity and lack family support. While direct housing assistance is not provided, the project signposts individuals to relevant services.

Impact

5.5.5 The Men United project has made a meaningful difference in the lives of its service users. It has supported men in making vital phone calls, accessing health services, and receiving referrals to organisations like Via and Adult Social Care. Several men have had eye tests and now wear prescription glasses for the first time.

5.5.6 In response to concerns around weight and wellbeing, physical activity sessions were introduced, including football, tennis, and outdoor gym use. One participant, previously morbidly obese and struggling with mental health, saw significant improvements, so much so that NHS staff reached out to commend the project's impact.

5.5.7 What began as a drop-in has grown into a space where friendships are formed, confidence is built, and men feel safe, valued, and connected.

"I come here because it's like a club and I've made friends(...) I've made at least half a dozen friends, and I get to see them regularly, every week(...) Before this I didn't have many friends and wouldn't see them for months on end(...) Having a chat and a haircut and speaking to others is just so relaxing(...) It sorts me out."

Learning and future plans

5.5.8 Men United has shown that consistent, trusted relationships are essential when working with vulnerable men. Many of the men involved face daily challenges such as addiction, homelessness, and social isolation. For some, this space is the only place they feel safe, welcomed, and heard.

5.5.9 The project offers more than basic support as it creates moments of joy, connection and purpose through activities like games, music, and conversation. These experiences have helped build confidence, reduce isolation and support mental wellbeing.

5.5.10 Next steps include growing the arts and creative offer to support self-expression and identity. A new strand of the project will focus on refugee and asylum-seeking men, helping them develop basic food safety skills to improve employability. Following positive feedback on recent health checks, more in-house health support is planned. Many participants remain disconnected from healthcare despite being registered with a GP. Inviting trusted clinicians into the space will help build trust and improve access over time.

6.0 Opportunities

Creative People and Places National Portfolio Programme 2026-29

6.1 Brent Libraries, Culture and Heritage Services and Brent Public Health have partnered with Fresh Arts, a Brent-based NPO[1] and key cultural partner, to develop a bid for a funding application for a programme which centres around social prescribing and creative responses to health needs. The bid was submitted in January 2025 to the Arts Council England (ACE) for the “Creative People and Places (CPP) National Portfolio Programme 2026-29”. The outcome of the bid is expected in October 2025. The CPP programme funds consortium partners in eligible local authority areas to empower local people to decide what kind of creativity and culture activity they want to experience in their place – the Arts Council England identified five London boroughs, Barking and Dagenham, Brent, Croydon, Enfield, and Newham as priority places for investment and engagement in creative and cultural activity.

6.2 This funding from ACE will allow the delivery of a programme rooted in Brent’s diverse community, choosing, creating and participating in excellent arts and culture experiences in the borough through community led, inclusive practice. At the heart of the programme are the Brent Creative Community Steering Group and The Young and Creative Panel these are representative networks of residents who will commission, co-create and support excellent arts and culture experiences and participatory opportunities. The programme will focus on the borough’s priorities, which are the health and wellbeing of the residents, arts engagement of diverse communities, young people and people with SEND boosting engagement in non-traditional spaces.

6.3 The bid by the Brent consortium is for £1M of ACE funding to be used over three years (beginning April 2026), with 15% of match-funding coming from the Brent partners. This funding will provide opportunities to focus on Brent community's priorities, which are the health and wellbeing of the residents, arts engagement of diverse communities, young people and people with

[1] NPO stands for "National Portfolio Organisation", which refers to cultural and arts organisations that receive multi-year regular investment from Arts Council England to deliver creative and cultural activities in line with its Let’s Create strategy.

SEND. The delivery of the programme will also be supported by partnership with University of Westminster, The Compass Learning Trust and The Young Brent Foundation.

6.4 The programme will aim to reach around 94,000 of Brent's residents through arts engagement at various places including schools, youth clubs, community centres and the borough's parks and green spaces. Through a range of exciting participation opportunities, the programme will target specific groups, centring and self-enabling residents unable to engage with art and cultural services in the usual way. The outcomes that this programme hopes to evidence are: increased engagement in the arts through community led practice, reduction of loneliness, improved sense of wellbeing, improved health outcomes, better use of community assets and improved wellbeing for Brent's residents including young people.

6.5 This programme will bring together significant local insights, relationships and expertise through the consortium (across local marketing knowledge, community engagement, heritage and cultural production and evaluation methodologies) which provides benefits for our local communities.

7.0 Proposed next steps

7.1 Continue to monitor progress against the current set of commitments, with a particular focus on those that are yet to be achieved.

7.2 Begin early planning for the next Joint Health and Wellbeing Strategy, which will replace the current one ending in 2027

7.3 Explore opportunities to align with the development of the new Borough Plan, also due in 2027, including collaboration with Brent's Corporate Policy Team on the 2026 Residents' Attitudes Survey to help inform shared priorities

8.0 Financial Considerations

8.1 None at this stage.

9.0 Legal Considerations

9.1 None at this stage.

10.0 Equity, Diversity & Inclusion (EDI) Considerations

10.1 In developing new 2024/25 commitments against the five themes, health inequalities are explicitly considered.

10.0 Climate Change and Environmental Considerations

10.1 In developing new 2024/25 commitments against the five themes, the potential to act to mitigate climate change has been explicitly considered,

particularly through commitments aimed at improving air quality or encouraging residents to engage in active travel.

11.0 Human Resources/Property Considerations (if appropriate)

11.1 None at this stage.

12.0 Communication Considerations

12.1 None at this stage.

Related documents available upon request:

- Outcomes of the Brent Food Strategy Workshop (Apr 2025)
- Physical activity timetable
- Social Prescribing within ASC
- Brent ASC Strategy

Report sign off:

Dr Melanie Smith

Director of Public Health, Leisure and Parks

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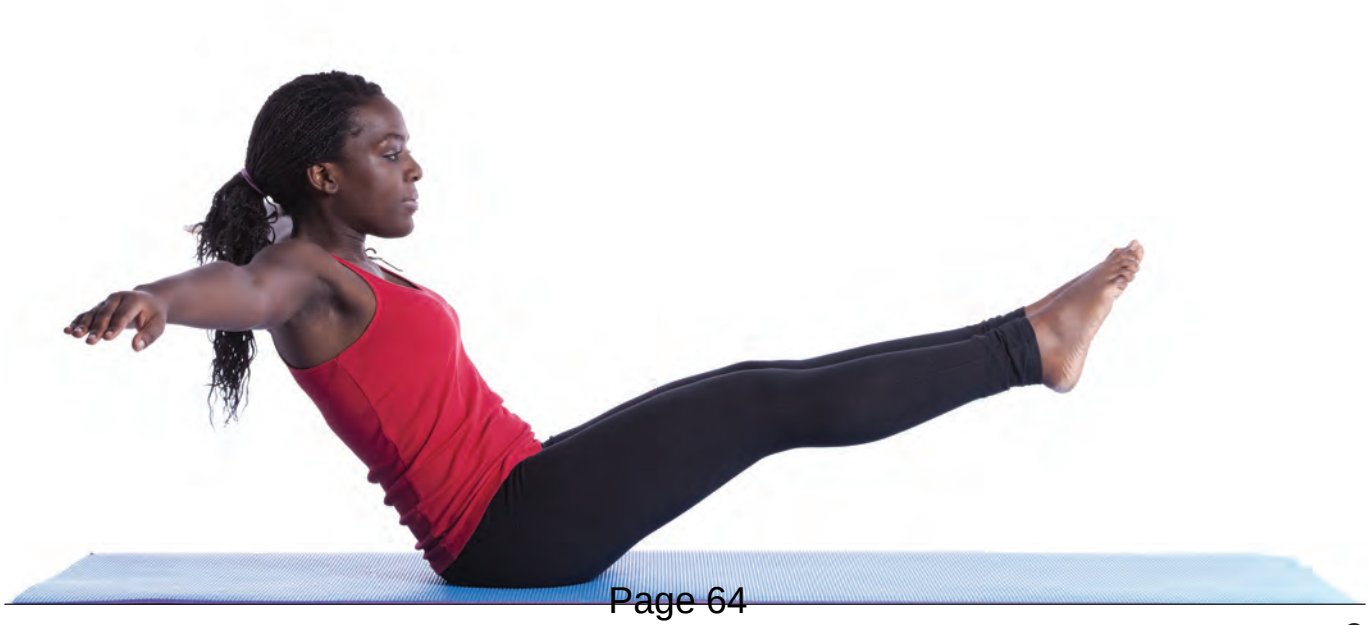
Brent Joint Health and Wellbeing Strategy Refresh

Tackling health inequalities

Contents



Brent Joint Health and Wellbeing Strategy

A Health and Wellbeing Strategy is a plan designed to improve the health and wellbeing of the local population. It identifies key health priorities and outlines the necessary actions to address them. This document is a refresh of Brent's original Health and Wellbeing Strategy, with a renewed focus on tackling health inequalities.

The global pandemic exposed and highlighted health inequalities, prompting Brent to redefine its approach in developing a new Joint Health and Wellbeing Strategy. The current strategy represents a shift from previous health and care-focused objectives to a broader focus on the social determinants of health while adopting a more community-centred approach.

Brent's Joint Health and Wellbeing Strategy was developed in partnership with residents, health organisations, and voluntary sector organisations.

This collaborative effort established five main themes within the strategy:

- **1. Healthy lives**
  I am able to make the healthy choice and live in a healthy way, for myself and the people I care for.

- **2. Healthy places**
  Near me there are safe, clean places where I, and people I care for, can go to relax, exercise for free, meet with like-minded people, and where we can grow our own food.

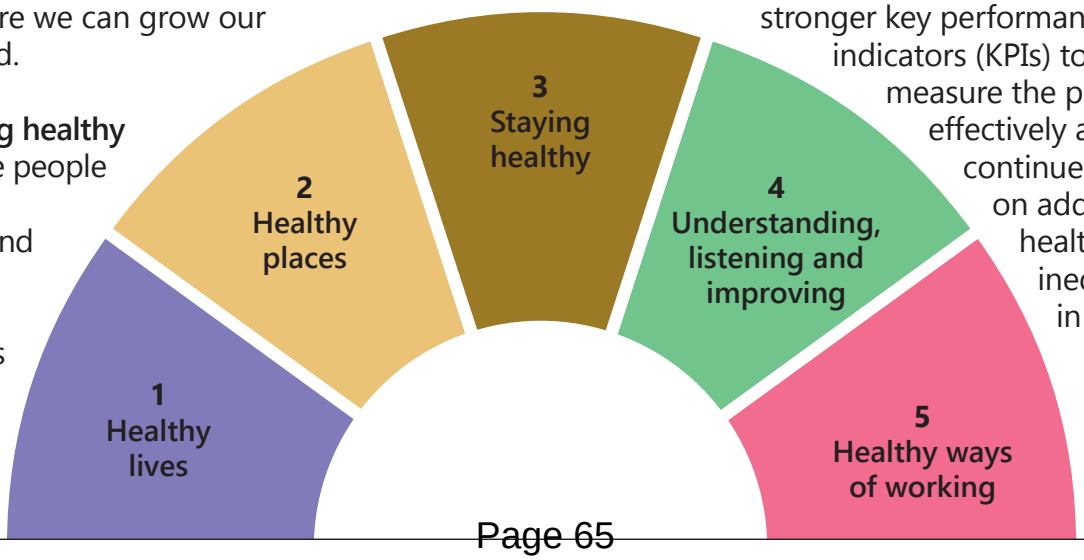
- **3. Staying healthy**
  I, and the people I care for, understand how to keep ourselves physically and mentally healthy, managing our health conditions using self-care first. We have access to good medical care when we need it.

- **4. Understanding, listening and improving**
  I, and those I care for, can have our say and contribute better to the way services are run; BHWB data are good quality and give a good picture of health inequalities.

- **5. Healthy ways of working**
  The health, care and wellbeing workforce will be happy and strong; and the health and wellbeing system will recover quickly from the impacts of the pandemic.

In January 2024, the Health and Wellbeing Board reaffirmed their commitment to these established priorities. Since most of the initial objectives have been achieved or become standard practice, all partners collaborated to propose the new commitments, which continue to be focused on addressing health inequalities.

The refreshed commitments feature stronger key performance indicators (KPIs) to measure the progress effectively and continue to focus on addressing health inequalities in Brent.



About Brent

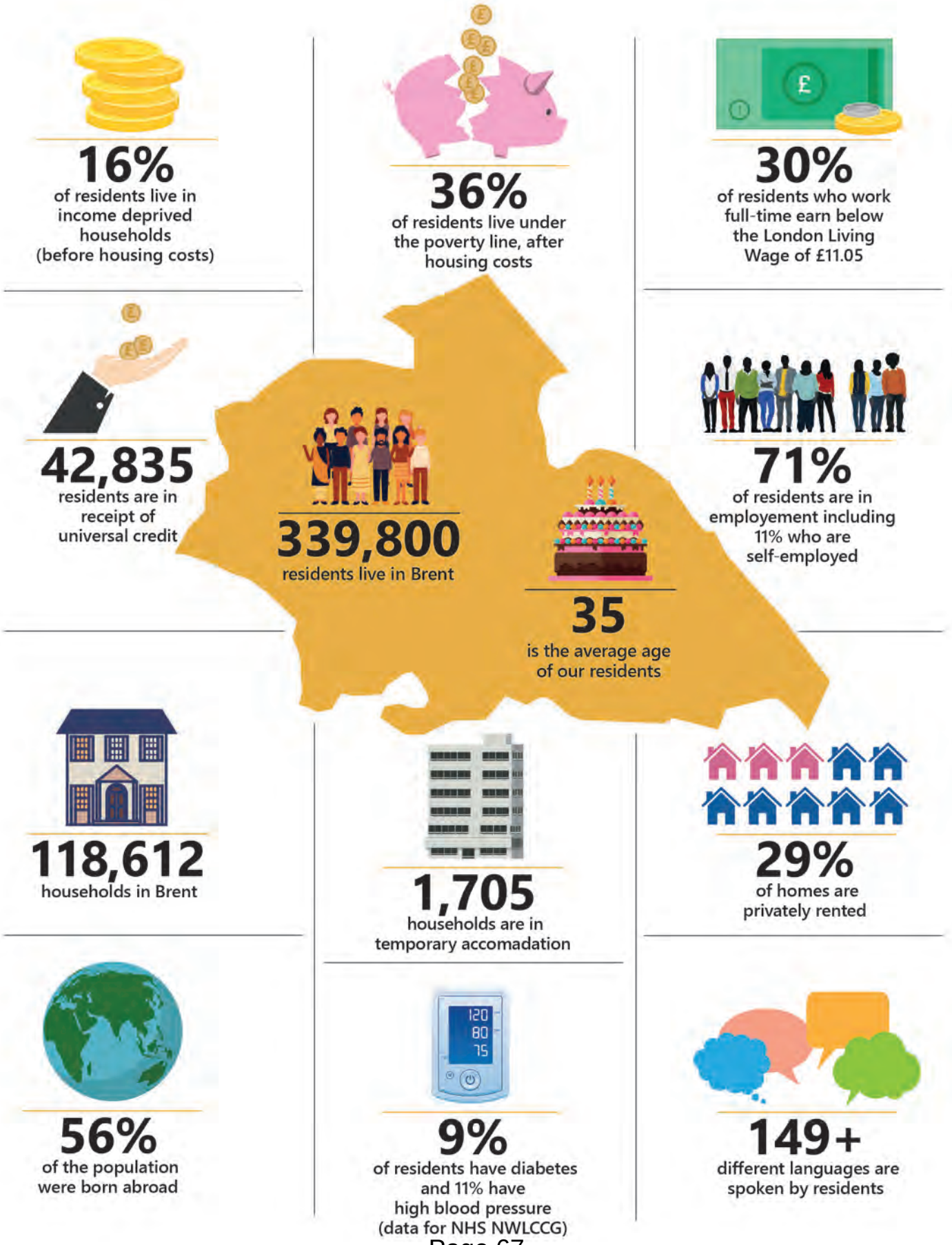
Brent is situated in North West London. It covers an area of 4,325 hectares, making it London's fifteenth largest borough; about 22% of this is green space. It is also the capital's seventh most populous borough, with a population of 339,800. Brent is also ethnically diverse with almost two thirds of the population (64%) from Black, Asian and minority ethnic groups, the third highest in London. A further 19% of residents are from White minority groups and the remaining 16% of residents are White British, the second lowest rate in London(1).

Brent has a young population; the median age is 35, five years below the average for England (40); 21% of local people are under the age of 18. It is one of the most diverse boroughs in London – 56% of the local population were born abroad, the largest proportion of any local authority area. We are also ethnically diverse, with 34% Asian, 35% White, 17% Black, and 13% Mixed and other ethnic groups.

The largest single group is the Indian population who comprise 17% of residents. The borough has the third largest Hindu population in England and Wales, and the tenth largest Muslim population (as a percentage of the population). Over 149 languages are spoken in the borough; 34% of residents do not have English as their main language – the second highest proportion in London.

(1) Source: Brent Open Data.

Key facts(2)



(2) Data source: trustforlondon.org.uk

Who is reponsible for delivering the Joint Health and Wellbeing Strategy?

The Health and Wellbeing Board is responsible for delivering the Joint Health and Wellbeing Strategy (JHWS).

Brent

healthwatch Brent

Brent ICP
Integrated Care Partnership

NHS
North West London

NHS
Central London Community Healthcare
NHS Trust

NHS
London North West University Healthcare
NHS Trust

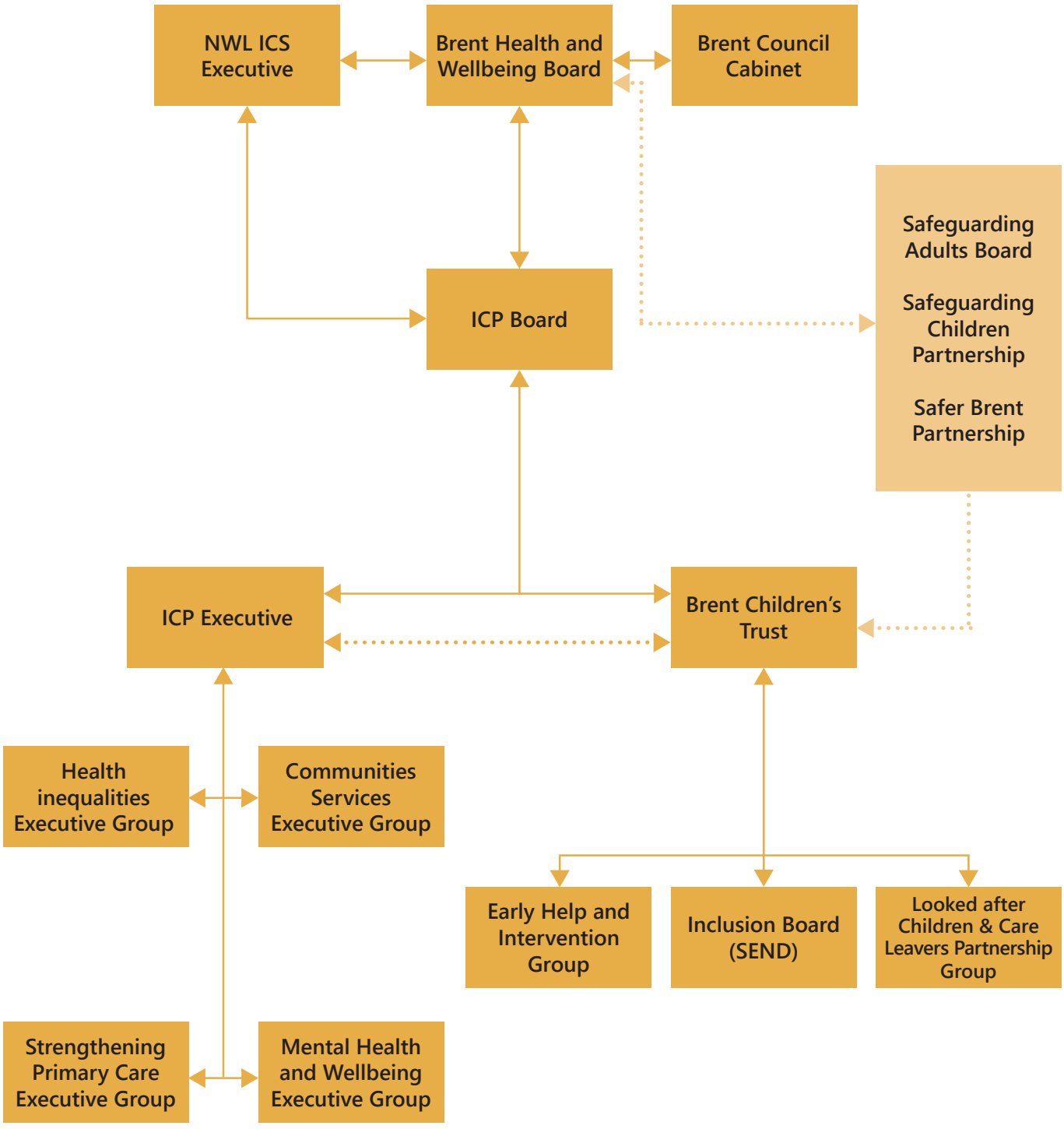
NHS
Central and North West London
NHS Foundation Trust

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. Health and Wellbeing Boards have a statutory duty to produce a Joint Health and Wellbeing Strategy (JHWS) for their local population, as set out in the Health and Social Care Act 2021. All Board members must have regard for the JHWS in the delivery of their health and wellbeing services and responsibilities.

The Brent Health and Wellbeing Board (BHWB) is made up of key partners, with representatives from:

- Brent Council (including Councillors, Public Health, Adult Social Care, and Children and Young People)
- NHS Brent Integrated Care Partnership Executive Committee
  - North West London Integrated Care Board (NWL ICB)
  - Central and North West London Mental Health Trust (CNWL)
  - Central London Community Health Care (CLCH)
  - London North West University Healthcare (LNWUH)
- Nursing and residential care
- Healthwatch Brent

As well as its statutory role, the BHWB ensures system leadership across commissioners and providers working in Brent. The Joint Health and Wellbeing Strategy (JHWS) outlines the key priorities for the BHWB. Much of the delivery of the strategy sits with the Integrated Care Partnership (ICP) and Brent Children's Trust (BCT).


NWL ICS Executive
Brent Health and Wellbeing Board
Brent Council Cabinet
Safeguarding Adults Board
Safeguarding Children Partnership
Safer Brent Partnership
ICP Board
ICP Executive
Brent Children's Trust
Health inequalities Executive Group
Communities Services Executive Group
Early Help and Intervention Group
Inclusion Board (SEND)
Looked after Children & Care Leavers Partnership Group
Strengthening Primary Care Executive Group
Mental Health and Wellbeing Executive Group

What are the health and wellbeing inequalities?

Health inequalities are ultimately differences in the status of people's health, that can be related to a range of different issues that impact on the opportunities they have to lead healthy, well lives.

These can include:

- If someone has any health conditions
- If people are able to access treatment when they need it
- The quality of the care and treatment when it is needed
- Behaviours including drinking alcohol and smoking
- Wider sociol and economic determinants of health, for example where someone lives, their housing situation, the nature of their job

Often these inequalities can be experienced by different groups of people for example:

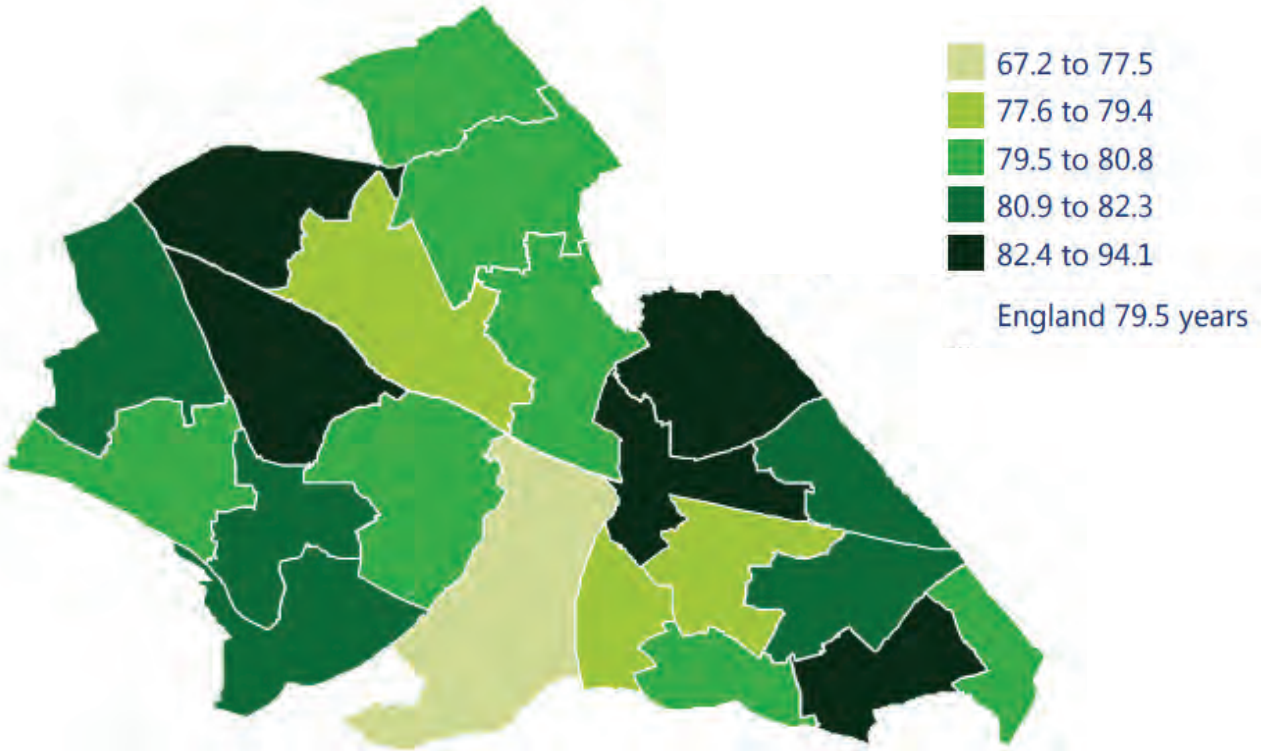
- Those living in more deprived areas and other socio-economic factors, for example those on lower incomes
- Younger and older people, those from black and minority ethnic communities and those living with a disability
- Socially excluded groups such as people experiencing homelessness

People will experience different and/or multiple combinations of these factors, and this will impact on the health inequalities they experience. A simple way of understanding the impacts of these factors is looking at the inequalities in life expectancy. Life expectancy for males at birth in Brent 2018-2020(3) is 80.4 years, female at birth is 85 years.

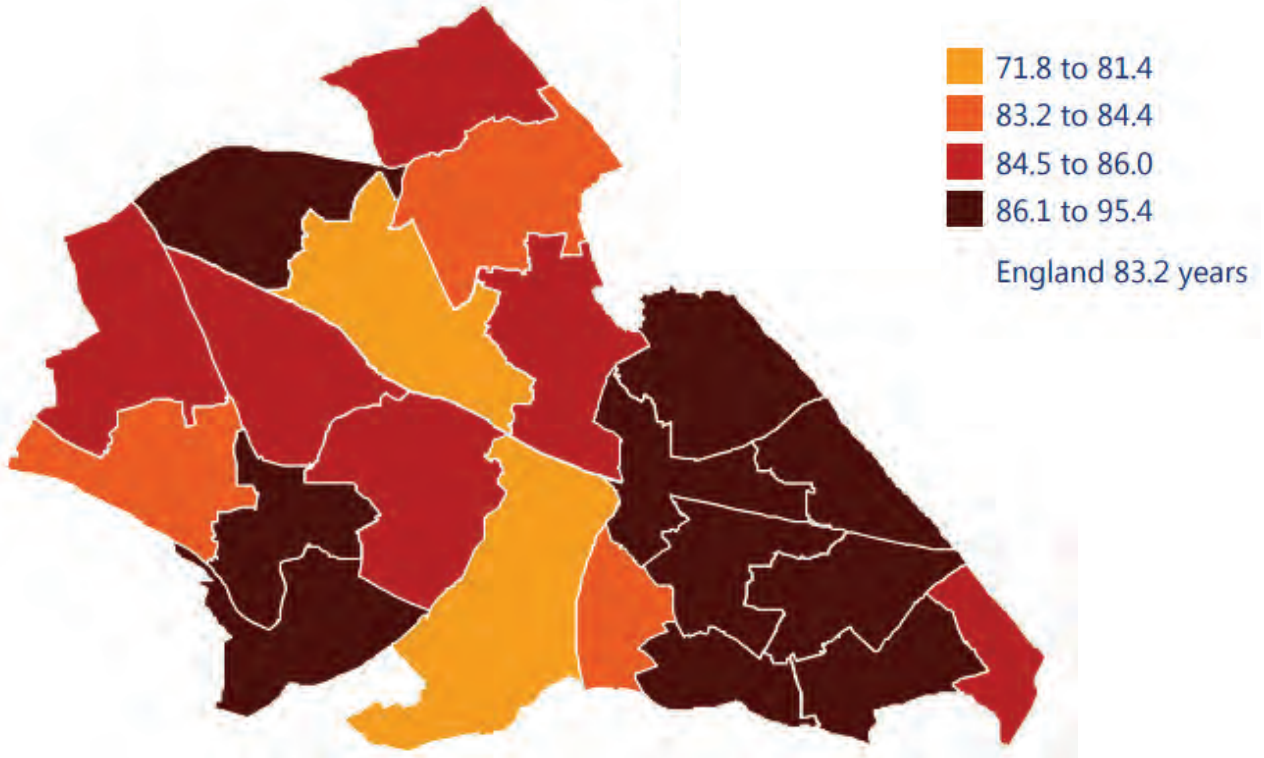
These are lower than most of our neighbouring boroughs. There are differences in life expectancy within Brent too, as shown in the following two maps.

(3) This is the latest available life expectancy data for Brent; no more recent data has been published as of July 2024.

Male life expectancy at birth (Brent 2016-2020)



Female life expectancy at birth (Brent 2016-2020)



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Brent will aim to give access to healthy, affordable food for all residents with a focus on food education and sustainability.

New and Refreshed Commitments

The table below illustrates the new commitments for the Health and Wellbeing Strategy. These commitments include brand new projects as well as ongoing activities that were not previously included in the main strategy. Capturing this work is essential not only for measuring its health impact but also for receiving the Health and Wellbeing Board's approval and spotlight. This visibility may allow some of these activities to be expanded and further benefit the community.

1 HEALTHY LIVES

I am able to make the healthy choice and live in a healthy way, for myself and the people I care for.

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.1	We will coproduce Brent's first food strategy in collaboration with community groups and other local organisations. This strategy will improve access to healthy, affordable food for all residents with a focus on food education and sustainability.	By improving access to nutritious food and improving understanding through education, we aim to bridge health gaps and foster equality in health and wellbeing across our communities.	The number of organisations involved in coproducing the strategy. Additional KPIs might be considered once the strategy is developed.	Currently, there is no formal food strategy in place for Brent. So far, we have engaged with 37 local organisations during the Visioning Workshop, who have contributed to developing the provisional scope of the strategy.	Public Health

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.2	We will deliver health and wellbeing community events throughout the Borough, including health checks and health promotion.	We monitor how we are reaching our more deprived communities and track the ethnicity of those taking up our offer. Some of our events will have a specific focus, such as those aimed at factory workers or particular faith settings. Additionally, we will coproduce community events to ensure they meet the needs of our diverse population. We will also provide targeted interventions at a community level, focusing on conditions such as CVD to Cardiovascular Disease (CVD), diabetes, and mental health.	Carry out at least 40 community events per month across five localities in Brent.	Public Health and Brent Health Matters currently organise and carry out health and wellbeing events throughout the borough. On average, they hold around 35 events per month, focusing on general health promotion, immunisation, and specific conditions like CVD, diabetes, cancer, and mental health issues.	Public Health

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.3	We will distribute a minimum of £250,000 in community grants to support projects aimed at improving the health, wellbeing, and development of children and young people.	All grant recipients will identify specific groups of children and young people who currently face health inequalities. By targeting these vulnerable populations, we aim to reduce health disparities and contribute to more equitable health outcomes within our community.	The number of community organisations supported.	The number of community organisations who were supported last year is: 46	Brent Health Matters
1.4	We will address inequities in access to NHS services through targeted communication activities.	By promoting access to NHS services through social media and flyers, we aim to reach people who currently do not access NHS services in a timely manner. This approach will help raise awareness and provide information to underserved populations, thereby reducing barriers to healthcare and addressing health inequalities.	Promote communications for at least three NHS services through social media and flyers, ensuring a reach of at least 6,000 people per month.	Work has started in collaboration with NHS colleagues. We have promoted the COVID spring booster campaign, the Pharmacy First campaign, and childhood immunisations (MMR), reaching approximately 36,000 people through social media and distributing 500 flyers.	Communication

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.5	We will provide Diabetes peer support and Digital inclusion programmes.	These initiatives aim to provide crucial support and resources to underserved populations, improving their health outcomes and access to digital health information.	Deliver at least six Healthy Educators programmes in the community, targeting Black, Asian, and Minority Ethnic (BAME), emerging communities and deprived neighbourhoods.	In 2023, we delivered five digital inclusion programmes, each consisting of six sessions, with 48 people graduating from the course. Additionally, we provided three diabetes peer support programmes, also with six sessions each, which 33 people completed.	Brent Health Matters
1.6	We will tackle period poverty through the rollout of Period Dignity Brent initiative, ensuring that residents have access to free, eco-friendly period products in publicly accessible council buildings across Brent and addressing stigmas and taboos that surrounds menstrual health.	Period Dignity Brent addresses health inequalities by ensuring accessible menstrual products for all, including disadvantaged groups such as asylum seekers, refugees, homeless people, or food bank users, by targeting distribution where we have identified the greatest need, in that way promoting period dignity and improving menstrual health outcomes.	This commitment will be measured by the number of sites providing the Period Dignity offer. We will track whether the offer is available at all the sites we initially targeted.	Currently there are six council buildings that can provide free period products. We have identified a further 10 locations to expand the offer.	Public Health Communications, Insight and Innovation

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.7	We will tackle tooth decay in children in Brent by delivering the mobile dental assessment and intervention programme (oral health bus) directly to primary schools with high rates of overweight and obesity.	We will target areas with high obesity rates, focusing on children living in the most deprived areas (deciles 1-3).	The number of oral health outreach events delivered at primary school: the target is 20. The number of children provided with dental assessments and interventions.	Last year the oral health bus visited 17 locations in close proximity to primary schools. 627 children from these locations were assessed last year.	Public Health
1.8	Further increase the uptake of Healthy Start Vouchers and vitamins	We will target all mothers, especially those from deprived areas, to ensure they have access to dental care and education. This focus will help reduce tooth decay in children by addressing the root causes and providing necessary resources and support to those most in need.	Increase the uptake of the Healthy Card Scheme among eligible Brent families by up to 5%. Up to 80% uptake of vitamin drops by residents from Family Wellbeing Centres and up to 30% uptake of pregnancy vitamins by residents in Family Wellbeing Centres.	Currently, the uptake of Healthy Start Card scheme among eligible families is 57% in Brent and the uptake of the healthy start vitamins among Brent families was not being reported.	Public Health

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.9	We will implement the BHM CYP team to tackle Health Inequalities in children and young people.	Our initial focus will be on increasing uptake of immunisation, improving asthma care and increasing awareness for mental health conditions. By targeting these areas, we aim to reduce health disparities among children and young people, particularly in underserved communities.	Total number of vaccinations given by the team. Number of children who received asthma reviews and management plans as a result of the team's outreach efforts.	This is a new initiative, so the baseline is 0.	Public Health Brent Health Matters
1.10	We will improve the mental health of school pupils through evidence-based interventions. Our skilled mental health practitioners liaise with teachers to identify children experiencing distress, increased absences, or social isolation.	By integrating mental health practitioners into schools and focusing on early, evidence-based interventions, we aim to provide equitable mental health support to all children, thereby reducing health disparities and promoting overall well-being.	The number of referrals. Percentage of referrals that progressed to interventions.	From September 2023 to March 2024, we received 98 referrals, of which 83 (approximately 85%) progressed to interventions.	Mental Health and Wellbeing Executive Group

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.11	We will continue providing tailored and accessible resources to most vulnerable residents through Community Hubs.	All Hub staff have received basic neurodiversity training, improving their flexible approach and enabling better support for residents with additional needs. This will improve residents' well-being and may reduce disparities between them and those without additional support needs.	The percentage of enquiries resolved at point of contact. The number of residents accessing Community Hubs.	The percentage of enquiries at the Community Hubs resolved at point of contact was 82% at the end of Q4 2023/24. The number of residents accessing Community Hubs was 5,510 in Q4.	Resident Services
1.12	We will address tobacco related inequalities in Brent via the government smokefree initiative. We will ensure our most vulnerable tobacco users such as pregnant smokers and smokers in drug & alcohol services are given the opportunity to quit.	By identifying areas of need, and engaging with underserved communities, such as the newly arrived communities and Paan consumers, to address barriers and co-produce a stop tobacco service that is accessible and culturally appropriate.	Number of organisations/ individuals (i.e. community champions) that engage with the initiative. Stop tobacco service activity as measured by number of referrals, those setting a Quit Date, or those that have Quit successfully using the programme.	We currently run a public health specialist stop tobacco service, with varying referral pathways into communities/ partner organisations. In 2022/23, 33 smokers joined the stop tobacco service, 45% of these managed to quit.	Public Health

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.13	In partnership with the London Ambulance Service, the Brent Rapid Response team will deploy clinicians alongside senior paramedics to provide urgent community care. This initiative aims to prevent avoidable hospital admissions and alleviate pressure on emergency services by managing Category 3, 4, and 5 patients directly in the community.	This service addresses health inequalities by providing quicker response times for Category 3, 4, and 5 patients, who typically wait longer for care. In Brent, where chronic conditions like diabetes and hypertension are common, timely and multidisciplinary care is crucial. The collaboration between BRR and LAS ensures these patients receive holistic and individualised treatment, improving health outcomes and reducing disparities.	The number of A&E attendances prevented by this pathway. The number of residents benefiting from this pathway.	This project is in the pilot phase. Currently, the pathway prevents approximately 30 A&E attendances every month. Data collected from the last six months suggests 5-6 patients a day benefit from this service.	Brent Integrated Care & Delivery Team, NWL ICB CLCH – Brent Rapid Response Team

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.14	We will appoint two Admiral Nurses to provide emotional care and support for families and patients at the pre-diagnosis stage or those already diagnosed with dementia. These nurses will offer skills and techniques to help families stay connected, manage fear and distress, advise on financial benefits and available support services, and ensure that both carers and patients receive the best possible additional care.	This commitment will tackle health inequalities by ensuring families and patients affected by dementia receive specialised, personalised support. Admiral Nurses will provide essential skills and techniques to manage emotional and practical challenges, reducing stress and improving quality of life. By advising on financial benefits and support services, they will help families access necessary resources, ensuring equitable care for all, regardless of socioeconomic status.	Each Admiral Nurse to have a minimum of 15 patients per case load of which at least 46% should have a BAME background. 75% of patients to remain at home rather than being admitted to a care home within a 12 month period. Reduction in GP visits commencing Admiral Nurse involvement. Reduction in Hospital admissions commencing Admiral Nurse involvement. 85% of patients/ carers/families to feel less isolated and feel that they can cope better following the support of the admiral nurse.	These are new posts, so no baseline yet.	Integrated Care & Delivery Team, NWL ICB

We will develop the programme of accessible activities in community spaces and parks, working with community organisations.

2 HEALTHY PLACES

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

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.1	We will organise regular social events for Ukrainian guests.	By improving access to nutritious food and improving understanding through education, we aim to bridge health gaps and foster equality in health and wellbeing across our communities.	This will be twofold; it will ensure Ukrainians will be able to meet other Ukrainians who are in the same situation as them, maintaining good mental health. The health inequality addressed is ensuring the Ukrainian community, which could otherwise be marginalised, remains included and supported.	At least one social event a month on average.	Communities and Partnerships

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.2	We will work with partners to create Sport England Place Based Expansion programme and Football Foundation Playzones initiative.	We will focus on residents in agreed locations (Stonebridge, Church End and Roundwood). By conducting consultations and data collection to identify community needs and gaps in provision, we aim to create inclusive spaces that promote physical activity and community engagement. This will address health inequalities by providing equitable access to sports and recreational facilities.	• Amount of funding secured from Sport England. • Number of community steering group established. • Numbers of people engaged in new activities. • Numbers of people new to Physical Activity.	Currently, there is no coordinated programme in the targeted locations (Stonebridge, Church End, and Roundwood). Initial consultations and community needs assessments are pending, and no funding has been secured yet.	Public Health London Sport Community Organisations

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.3	We will develop the programme of accessible activities in community spaces and parks, working with community organisations, for example walks programme, Our Parks, support to use outdoor gyms.	We will target residents, particularly those from priority groups such as children and young people, individuals with long-term health conditions, and inactive populations. By providing accessible activities, we aim to improve physical health, foster community engagement, and reduce health disparities among these groups.	• Number of programmes offered. • Number of participants. • Number of referrals made from health professionals.	Currently, there is no coordinated programme in the targeted locations (Stonebridge, Church End, and Roundwood). Initial consultations and community needs assessments are pending, and no funding has been secured yet.	Public Health London Sport Community Organisations
2.4	We will improve the quality of housing in Brent across the private sector though borough wide licensing of the private rental section and an adaptations programme that makes sure that disabled residents live in homes that meet their needs.	Poor quality PRS housing is a significant contributor to health inequalities as is housing which is unsuited to residents with disabilities.	Number of properties licensed; the target is 12,000. Amount spent on adaptations.	In 2023/24, 9,500 properties were licensed. In 2023/24, we have allocated £8.1m on adaptations.	Housing Services

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.5	We will develop Ealing Road library garden for community use and leisure, programming, plant growth, support health and wellbeing.	A lack of access to green space contributes to health inequalities.	Outdoor Programming: Number of Family Learning/Adult Events – 12	Current number of events from Spring 2024: 3 Family Learning/ Adult events, with 32 adults and 51 children participating.	Resident Services
2.6	We will review and refresh our approach to climate community engagement and encourage local green action through our Together Towards Zero grants.	Grants are allocated boroughwide to address all key themes in the climate strategy but applications from seldom heard groups and those particularly impacted by the adverse effects of climate change are particularly encouraged.	Number of community grants, target: minimum of 15.	In 2023/24 we allocated 23 grants.	Communities and Partnerships
2.7	We will further increase sign up to the Healthier Catering Commitment.	This initiative aims to promote healthier eating habits, particularly benefiting residents in deprived areas where access to healthy food options is limited.	• Number of businesses signed up to the Healthy Catering Commitment. • Aim for 20 new sign-ups in 2024. • Additional 10 new sign-ups each subsequent year.	Current number of businesses signed up: 0.	Public Health

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.8	We will work with partners from Kilburn State of Mind, Brent Council, networks, and volunteers to implement The Music Mile: Mental Health Support Programme, which aims to improve the mental health and wellbeing of residents from underserved groups and to revitalise Kilburn as a music destination.	This commitment will address health inequalities by focusing, but not limiting to, residents from Black, African, and Caribbean backgrounds. It will engage delivery partners who are musicians with prior experience in mental health support and will reach local residents attending the festival, thereby promoting mental health and wellbeing within underserved groups.	Number of individuals receiving music lessons and performance training: Target 20-30 participants. Number of semi-professional musicians who previously accessed mental health support delivering the lessons: Target 10 musicians. Number of local residents attending the festival, particularly those struggling with mental health issues and isolation: Audience target will be determined based on venue capacity.	This is a new project, so the baseline is 0.	Resident Services

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.9	We will tackle air pollution in Brent by recruiting Air Quality Champions to improve local understanding of air quality issues and provide practical advice on reducing exposure to air pollution.	Cleaner air benefits everyone, especially people living in areas with high pollution levels, which are often linked to lower income. This helps reduce health differences among different communities.	Number of Air Quality Champions recruited. Number of vulnerable or disadvantaged individuals reached and supported by the Air Quality Champions. The number of people involved in Air Quality projects that attend the associated workshops.	No Air Quality Champions have been recruited yet, so the baseline is 0.	Public Health
2.10	We will engage with school children to educate them and raise their awareness about air quality issues through interactive maps showing high and low pollution routes within a 5–10 minute walking radius of schools, and by organising educational air quality events.	By educating children about air quality and providing them with practical tools, we help protect their health, particularly those who are most vulnerable. This initiative promotes equal access to important health information, helping to reduce the disparity in health outcomes among different communities.	We will collect data through a survey to measure the number of children who have changed their travel habits to use lower pollution routes to school. The number of educational events organised related to air quality and pollution awareness.	We are currently supporting schools to submit their travel plan for this academic year and will use this years' data as the baseline. The data will be available by the end of July.	Public Realm

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.11	We will increase participation in active travel by creating safe environments where people can confidently walk, cycle, and use other forms of active transportation. Through the implementation of the Active Travel Implementation Plan, we aim to promote these activities to improve public health, reduce traffic congestion, and lower environmental impact.	Active travel, such as walking and cycling, boosts physical activity, which reduces the risk of chronic diseases. It also improves mental health by lowering stress and anxiety, particularly benefiting underserved communities with limited access to recreational facilities. Reducing car use cuts pollution and traffic, creating a healthier environment and lowering transportation costs for low-income families, allowing more resources for other needs.	We aim to reduce traffic levels to 994 million vehicle kilometres by 2027 by having fewer vehicles on Brent's roads or vehicles travelling shorter distances. We aim to increase the proportion of residents engaging in at least 20 minutes of active travel to 41% by 2026/27.	The targets were set pre-pandemic with Brent's baseline traffic at 1,098 million vehicle kilometres annually. The proportion of Brent residents doing at least 20 minutes of active travel a day is 31% as of 2022/23 data.	Inclusive Regeneration and Employment

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.12	We will equip Brent schools with the Climate Action Guide and Plan Template, support them through regular webinars and Climate Champions Network meetings, and provide Carbon Literacy Training. Additionally, we will participate in the "Our Schools Our World" programme to improve sustainability education and initiatives, ensuring every school has a trained sustainability lead to drive effective climate action.	By integrating sustainability into the curriculum and school activities, we foster a sense of environmental stewardship and provide equal opportunities for students to engage in green careers. Additionally, schools in disadvantaged areas will receive targeted support, helping to bridge the gap in environmental education and empowering all students to contribute to a sustainable future.	The number of schools actively using the Climate Action Guide and Plan Template. The attendance at the regular climate action webinars. The number of sustainability leads trained through the "Our Schools Our World" programme. The number of schools that have successfully created and implemented a climate action plan.	There are approximately 10 schools that use the guide. There were two webinars organised so far with the attendance of 13. This is a new programme, so the baseline is 0. This is a new project, so the baseline is 0.	Communities and Partnerships

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.13	We will distribute the SCIL Youth Provision Grant to fund structural changes and improvements to premises used by youth organisations, enabling better access and increasing facilities and activities for young people in the London Borough of Brent.	We are especially targeting highly deprived areas to tackle health inequalities and ensure that young people have access to a range of facilities and places where they feel safe and at ease.	The number of successful applications.	19 EOI's have been submitted out of which 12 have been progressed to application stage.	Early Help and Social Care

Funds from the SCIL Youth Provision Grant will help structural changes and improvements to premises used by youth organisations, enabling better access and increasing facilities and activities for young people in the London Borough of Brent.

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.14	We will continue providing early multi-agency intervention and support through our Family Wellbeing Centres (FWC). By working with partners, we offer services including health, education, and wellbeing, taking a holistic approach to family needs. We will continuously analyse data from families to ensure our services meet their needs, preventing escalation to more specialist services.	By analysing data and collecting feedback from families, we ensure our FWCs offer services tailored to Brent's families' needs. This approach aims to equip FWCs with the ability to address issues before they become serious problems, which may prevent health disparities. Continuously analysing family data allows us to respond dynamically, ensuring services remain effective and relevant. Tailoring FWC offer based on family feedback reduces the risk of health inequalities.	The number of families supported by FWCs.	In 2023/24 a total of 18,113 families accessed FWCs.	Early Help and Social Care

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.15	We will support school with the introduction of a school street zone (Pedestrian and cycle zone) where feasible to restrict vehicle access and encourage active travel.	By introducing a school street zone, we can help improve air quality and road safety by reducing parking and congestion issues, and enhancing the environment around the school, which contributes towards a cleaner and greener Brent. School streets also support active travel within the school community, and children and parents will benefit from walking and cycling to and from school.	The number of schools with a school street zone, with a target of implementing three new zones per year, subject to consultation with stakeholders. In addition, we can measure the success of modal shift towards active travel by using the annual travel plan survey data for the individual schools.	The current number of school street zones is 31.	Public Realm

We will promote bowel cancer screening services in communities high at risk through awareness presentations and communications in different languages.

3 STAYING HEALTHY

I, and the people I care for, understand how to keep ourselves physically and mentally healthy, managing our health conditions using self-care first. We have access to good medical care when we need it.

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.1	We will provide mental health services in Ukrainian, Russian, and English for Ukrainian guests and all hosts.	This will ensure that residents who are affected by the war in Ukraine either as Ukrainians or hosts who are providing a home for Ukrainian guests have access to suitable mental health services in their own language (Ukrainians only).	Commission providers to provide: • face-to-face mental health support • 24/7 virtual mental health support	We have mental health provision for hosts, and face-to-face for guests. We are in the process of commissioning 24/7 virtual mental health support for guests.	Communities and Partnerships
3.2	We will promote bowel cancer screening services in communities high at risk through awareness presentations and communications in different languages.	This commitment will focus on communities with high risk of developing cancer such as people living in deprived areas, Pakistani, Black African, Black other ethnicities, and people with Severe Mental Illness (SMI).	Deliver 10 engagement events with target communities.	Delivered 9 bowel cancer screening awareness presentations to communities between December 2023 and April 2024. Working with the bowel cancer screening service at St Marks Hospital to arrange ordering of test kits for eligible people.	Bent Health Matters

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.3	We will deliver targeted work on hypertension in black communities.	We will focus on Black communities and individuals, aiming to reduce health disparities related to hypertension.	Support at least 100 patients with hypertension who haven't had a recorded blood pressure measurement in last 18 months.	Recorded blood pressure of 237 hypertensive patients and updated this on their GP records in 2023/24.	Brent Health Matters
3.4	We will deliver education and awareness sessions on healthy eating to local communities via our Health Educator contract.	People who don't normally access health care services such as those from BAME and emerging communities, as well as residents from deprived neighbourhoods. This initiative aims to reduce health disparities by providing essential health education and promoting healthy eating habits.	Deliver at least 50 health education and awareness sessions via our Health educator contract, targeting BAME communities. Successfully support at least 50 people with or at risk of developing Diabetes (or other conditions) to achieve their lifestyle/healthy eating goals.	Provided case management support to 66 people with or at risk of developing Diabetes in the last year (April 2023-2024).	Brent Health Matters
3.5	We will improve mental health awareness in Brent through coproduction of community engagement sessions.	We will target people with common mental health conditions, aiming to reduce disparities by providing essential mental health education and support.	Deliver at least 50 Mental Health awareness sessions. Co-produce at least 50% of sessions.	Mental Health team within Brent Health Matters delivered 20 workshops for communities in 2023/24.	Brent Health Matters

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.6	We will assist residents to register with a Brent GP.	This initiative aims to reduce health disparities by connecting residents with essential health and care services.	Aim to assist at least 150 residents in registering with a GP or accessing health services.	Public Health and Brent Health Matters supported 114 to register with GP last year.	Brent Health Matters
3.7	We will provide mental health outreach and raise awareness in our most impacted neighbourhoods through events and workshops. Additionally, we will recruit mental health Community Connectors to educate and empower these communities.	We have identified three areas in the borough with the highest number of A&E admissions due to mental health crises, with the vast majority of these admissions being from Black and Asian communities. This illustrates significant health inequalities in these areas, which we aim to address through targeted approach.	Reduced number of A&E admissions from people in mental health crisis and decreased percentage of approaches from Black and Asian communities. The number of mental health awareness events and workshops organised. Number of people engaged through awareness events and workshops and proportion of attendees from Black and Asian communities.	In 2023/24, 176 people presented to A&E with a mental health crisis, with 85% of these admissions being from Black and Asian communities. In 2023/24, we organised 129 events and 114 workshops and training sessions. In 2023/24, we engaged with 5,326 people.	Mental Health and Wellbeing Executive Group Brent Health Inequalities Team (CNWL) Brent Health Matters

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.8	We will improve the accessibility and appropriateness of the library service for Brent residents living with dementia.	This commitment addresses health inequalities by ensuring Brent residents with dementia have better access to tailored library services. Improved publicity, home delivery, dementia-friendly materials, and accessible cultural venues ensure these residents can engage with library resources. Additionally, seeking funding for specialised programmes supports their cognitive and social needs, promoting overall wellbeing and inclusion.	Increase the number of homes receiving deliveries to 15. Provide 6-8 boxes of dementia-friendly items, each containing 35 items, to homes. Successfully apply for and receive designation status for Brent Libraries under the Arts Council England Designation Scheme. Submit a successful Arts Council England (ACE) funding application by March 2025 (only one ACE application can be submitted at a time).	Current delivery: 10 Homes. Current stock: 15 items. This will be our first time applying for the ACE Designation Scheme and funding.	Resident Services

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.9	Pilot the introduction of social prescribing into ASC.	The pilot will help to support people who are on the cusp of adult social care and have been referred to Brent Customer Services. Referrals come from other services such as the social prescribers in the primary care networks and other such as self-referrals to adult social care. Referrals include groups from all communities many of whom will be experiencing health inequality.	Activity data and outcomes data: Number of referrals Types of referral/support requested Number of allocations to social prescriber coordinators Cases opened and cases closed Average length of intervention Outcomes Survey data –service user experience	No current baseline.	Adult Social Care

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.10	We will improve the information, advice, and guidance accessed by informal carers by implementing the Brent Carers' Strategy, which was co-produced with them.	Becoming a carer often has a negative impact, especially on young people. It affects their work, education, and mental health. Carers' wellbeing often deteriorates as soon as they take on caregiving responsibilities. Any additional support given to them could positively impact their wellbeing and reduce health inequalities between carers and those without such responsibilities.	The number of carers accessing services and resources. The number of young identified through the Early Help Assessment and Child and Family Assessment. The number of young carers being identified by their schools or health services.	Approximately 35 new young carers referrals to Brent Carers Centre. 924 adult carers accessed services and resources in the financial year 2023/24. Approximately 50 young carers identified through the combined Early Help Assessment and Child and Family Assessment. Approximately 60 young carers identified via schools.	Adult Social Care Early Help and Social Care

Improved information, advice, and guidance will be available for informal carers by implementing the Brent Carers' Strategy, which was co-produced with them.

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.11	Develop a Prevention strategy and implementation plan based on the Care Act principles of preventing, delaying and reducing the need for care.	The strategy and delivery plan is underpinned by the principle of reducing health inequalities. Part of the delivery plan will involve data analysis, scrutinising cohorts who we know to be at risk of developing or exacerbating health conditions and developing interventions which will reach them earlier.	As part of the plan a set of outcome measures will be developed. These are likely to include but not limited to; Increased uptake of support measures for carers Decreased number of people accessing social care services for the first time through a hospital admission Increasing number of people accessing Reablement services Increasing number of people accessing information and advice through the Brent website	Current there is no strategy or plan which brings together preventative interventions across health and social care.	Adult Social Care

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.12	We will reduce emergency hospital admissions for patients with Chronic Obstructive Pulmonary Disease (COPD) through delivering disease education, support self-management and techniques to manage their condition independently at home.	A disproportionate burden of COPD occurs in people of low socioeconomic status due to differences in health behaviour such as tobacco smoking, social and physical environment which play leading roles in lung disease development and is also associated with worse COPD outcomes. An effective intervention is to target and educate this cohort of patients.	5% reduction in unplanned admission from the previous year.	The number of NEL from Nov 2022 (M8) to October 2023: 347	Brent Integrated Care & Delivery Team, NWL ICB

We will deliver disease education, support self-management and techniques to help patients manage their condition independently at home.

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.13	We will reduce hospital admissions through the 'Step-Up Pathway', a service that utilises a dedicated bed to provide immediate care, accessible directly from community health services or via the A&E.	This approach reduces the need for hospital admissions. By optimising the use of hospital resources, the pathway improves access to healthcare for everyone, including the most at-risk populations, therefore reducing health disparities.	The number of residents receiving care within two hours	This is a new project, so the baseline is 0.	Brent Integrated Care & Delivery Team, NWL ICB

CLCH had introduced a 'step-up' pathway from rapid response into a community bedded unit, improving the utilisation of beds, reducing hospital admissions and freeing up hospital beds.

We will provide work opportunities via our community champions and Health educators programme for local communities.

4 HEALTHY WAYS OF WORKING

The health, care and wellbeing workforce will be happy and strong; and the health and wellbeing system will recover quickly from the impacts of the pandemic.

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
4.1	We will provide work opportunities via our community champions and Health educators programme for local communities.	We will target people who are unemployed from local communities, providing them with employment opportunities and training. This initiative aims to reduce economic disparities and improve health outcomes by engaging community members in meaningful work.	Number of new work opportunities provided to residents in Brent.	Local recruitment is prioritised within BHM with 14 Health Educators and 41 Community Champions recruited in 2023. This included two new Health Educators.	Brent Health Matters
4.2	We will improve partnership working through the new Community Wellbeing Service to enable those with health needs to access the holistic support offer addressing the cost of living.	The Community Wellbeing service will be accessible to residents with physical and mental health needs through referral routes with key partners.	Number of referrals from health and public health professionals to the new service.	This is a new service so no baseline.	Communications, Insight and Innovation

4 HEALTHY WAYS OF WORKING continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
4.3	We will improve partnership working through the new Community Wellbeing Service to enable those with health needs to access the holistic support offer addressing the cost of living.	The Community Wellbeing service will be accessible to residents with physical and mental health needs through referral routes with key partners.	Number of referrals from health and public health professionals to the new service.	This is a new service so no baseline.	Communications, Insight and Innovation

By improving the partnership working through the new Community Wellbeing Service it will enable those with health needs to access the holistic support offer addressing the cost of living.

4 HEALTHY WAYS OF WORKING continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
4.3	We aim to provide pathways to employment for individuals referred by GPs, social prescribers, self-referrals, and local employment services. By integrating these diverse referral pathways, we can ensure comprehensive support for those in need. Through this initiative, we aim to support individuals with mental health conditions in securing employment, with assistance from Twinings, Shaw Trust, the Department for Work and Pensions (DWP), and Brent Works	We aim to address health inequalities by providing employment opportunities to those with mental health challenges. Through this initiative, we can help reduce economic disparities, thereby improving overall health and well-being. Employment is a critical factor in improving mental health outcomes, and by supporting individuals in gaining employment, we help enhance their financial stability, social inclusion, and overall quality of life.	We aim to assist 160 people in gaining employment.	Our current baseline is 149 people with mental health supported into employment.	Inclusive Regeneration and Employment

We will develop and embed coproduction with residents in ASC and ensure services are accessible and culturally appropriate.

5 UNDERSTANDING, LISTENING AND IMPROVING

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

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
5.1	We will develop and embed coproduction with residents in Adult Social Care (ASC) and ensure services are accessible and culturally appropriate.	The Co-production Champions will work across a spectrum of services and community groups to engage individuals and partners in the coproduction and codesign of adult social care services. Working closely with Public Health colleagues we will identify groups who are less well served by Adult Social care e.g. Gypsy and Roma communities and develop engagement strategies and plans that are appropriate. We will review our system and practice around recording demographic groups to better reflect the communities in Brent (where we are able to make changes).	Activity data on engagements: Number of people engaged. Number of referrals to Brent Customer Services/Adult Social Care. Number of recorded service users from specific groups.	In Adult Social Care's recent self-assessment, we identified the following: 'We are also very aware that there may be groups we are under-serving. For example, over the past year, there were no service users who were identified as Roma, Gypsy and Traveller or with an LGBTQIA+ identity. This is not in line with what we know about the population composition within Brent and could reflect accessibility, disclosure and recording challenges. We recognise we have further work in this area to identify and engage with groups where there may be unmet need.	Adult Social Care

5 UNDERSTANDING, LISTENING AND IMPROVING continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
5.2	We will establish a programme of ward-level data insight sessions with elected members, including continued development of ward profiles to inform ongoing discussions between councillors and officers.(4)	Councillors will have a greater understanding around their residents, which will inform the strategic discussions and policy making process. This includes identifying trends across different wards, which often might be health or wellbeing related.	The number of sessions delivered	We have delivered four sessions in Spring 2024.	Communications, Insight and Innovation
5.3	We will continue working with service user groups, such as B3, to further embed the voices of service users in the design and delivery of treatment and recovery services.	This commitment directly addresses health inequalities by ensuring that the design and delivery of treatment and recovery services are informed by those who use them, particularly those from marginalised groups.	The number of individuals who have successfully completed the recovery champion course and are available to support and guide others through their recovery journey. The number of new attendees to BSAFE sessions.	By the end of the financial year 2023/24, there were 46 recovery champions who had successfully completed the course. In the financial year 2023/24, there were 99 new attendees at BSAFE sessions.	Public Health

(4) Pilot sessions and next steps are pending evaluation.

5 UNDERSTANDING, LISTENING AND IMPROVING continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
5.4	We will collect information with a range of groups and individuals in Brent and use this to understand and improve health.	This will include conversations with community groups and individuals who have everyday experience of health challenges. We will focus on topics that affect groups that currently have poorer health or are less well served by public health initiatives. We will take a community researcher approach where possible so that local people are involved in the planning, delivery and learning from the research.	Include people with lived experience in 100% bespoke health needs assessments over the next year. Take a participatory research approach in at least one evidence and insight project over the next year. Prioritise including representatives from at least two new community groups.	Where appropriate in terms of methodology, we have incorporated resident's view in 4 out of 6 (66%) bespoke needs assessments in the previous year. We currently engage with communities that have some established connect with public health. We aim to hear from more people in different communities within Brent.	Public Health

By improving access to nutritious food and improving understanding through education, we aim to bridge health gaps and foster equality in health and wellbeing across our communities.

Glossary

ASC
Adult Social Care

BAME
Black, Asian, and Minority Ethnic

B3
A Group in Brent which provides peer support and advocacy to drug and alcohol service users in Brent

BHM
Brent Health Matters is a borough-wide partnership programme that aims to engage with the community on a number of wide-ranging issues to reduce the health inequalities experienced in Brent.

Brent ICP
Brent Integrated Care Partnership brings together health and care organisations from across the borough to work collaboratively with all the health, care and wellbeing organisations that serve the community of Brent.

CYP
Children and Young People

CVD
Cardiovascular Disease

FWC
Brent Family Wellbeing Centres offer a wide range of free health, education and welfare services to families.

GP
General Practitioner

ICB
Integrated Care Boards are NHS organisations responsible for planning health services for their local population.

KPI
Key Performance Indicator

LGBTQIA+
Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and other identities

NHS
National Health Service

NWL
North West London

PRS
Private Rented Sector

Reablement
Reablement is a short term and intensive service designed to help people in their recovery after an illness or disability. It helps the patient to re-learn important skills needed for daily living whilst allowing maximum independence.

SEND
Special Educational Needs and Disabilities

Social prescribing
It is an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing.

VCS
Voluntary and Community Sector

Brent

healthwatch Brent

Brent ICP
Integrated Care Partnership

NHS
North West London

NHS
Central London
Community Healthcare
NHS Trust

NHS
London North West
University Healthcare
NHS Trust

NHS
Central and
North West London
NHS Foundation Trust

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Appendix 2: Progress tracker

1	**Healthy Lives** I am able to make the healthy choice and live in a healthy way, for myself and the people I care for					
	New commitment	**How will the new commitment address health inequalities?**	**KPI**	**Baseline**	**Update on KPIs**	**Lead**
1.1	We will coproduce Brent's first food strategy in collaboration with community groups and other local organisations. This strategy will improve access to healthy, affordable food for all residents with a focus on food education and sustainability.	By improving access to nutritious food and improving understanding through education, we aim to bridge health gaps and foster equality in health and wellbeing across our communities.	The number of organisations involved in coproducing the strategy. Additional KPIs might be considered once the strategy is developed.	Currently, there is no formal food strategy in place for Brent. So far, we have engaged with 37 local organisations during the Visioning Workshop, who have contributed to developing the provisional scope of the strategy.	**Narrative** So far, we have engaged with roughly 55 people from 37 local organisations during the Visioning Workshop, who contributed to developing the provisional scope of the strategy. In April 2025, a further 60 people from 28 organisations took part in the Food Strategy Workshop. A cross-sector Brent Food Partnership has now been convened, chaired by the Director of Sufra, and a dedicated Food Lead within Public Health was appointed in early 2025 to drive this work forward. Food Strategy Workshop Report (available upon request) includes detailed feedback on the current stage of strategy development.	Public Health
1.2	We will deliver health and wellbeing community events throughout the	We monitor how we are reaching our more deprived communities and track the ethnicity	Carry out at least 40 community events per month	Public Health and Brent Health Matters currently organise and carry	**Partially achieved** Public Health and Brent Health Matters currently organise and carry out health and	Public Health

	Borough, including health checks and health promotion.	of those taking up our offer. Some of our events will have a specific focus, such as those aimed at factory workers or particular faith settings. Additionally, we will coproduce community events to ensure they meet the needs of our diverse population. We will also provide targeted interventions at a community level, focusing on conditions such as CVD, diabetes, and mental health.	across five localities in Brent.	out health and wellbeing events throughout the borough. On average, they hold around 35 events per month, focusing on general health promotion, immunisation, and specific conditions like CVD, diabetes, cancer, and mental health issues.	wellbeing events for adults and children and young people throughout the borough. On average, they hold around 35 events per month, focusing on general health promotion, immunisation, and specific conditions like CVD, diabetes, cancer, asthma, men's health, women's health, and mental health issues.	
1.3	We will distribute a minimum of £250,000 in community grants to support projects aimed at improving the health, wellbeing, and development of children and young people.	All grant recipients will identify specific groups of children and young people who currently face health inequalities. By targeting these vulnerable populations, we aim to reduce health disparities and contribute to more	The number of community organisations supported.	The number of community organisations who were supported last year is: 46	**Narrative** Although no new grants have been distributed in the 2024/25 financial year, we have continued to support the organisations that received funding in 2023/24. The organisations were also signposted to additional funding opportunities, including other grants distributed by the Council and NHS, such as the Community Chest Fund.	Brent Health Matters

		equitable health outcomes within our community.				
1.4	We will address inequities in access to NHS services through targeted communication activities.	By promoting access to NHS services through social media and flyers, we aim to reach people who currently do not access NHS services in a timely manner. This approach will help raise awareness and provide information to underserved populations, thereby reducing barriers to healthcare and addressing health inequalities.	Promote communications for at least three NHS services through social media and flyers, ensuring a reach of at least 6,000 people per month.	Work has started in collaboration with NHS colleagues. We have promoted the COVID spring booster campaign, the Pharmacy First campaign, and childhood immunisations (MMR), reaching approximately 36,000 people through social media and distributing 500 flyers.	**Achieved** Working in collaboration with NHS colleagues, we have promoted the COVID spring booster campaign, the Winter Access to Services campaign, and changes to Maternity Services, reaching approximately 42,000 people through social media and distributing 500 flyers.	Communications
1.5	We will provide Diabetes peer support and Digital inclusion programmes	These initiatives aim to provide crucial support and resources to underserved populations, improving their health outcomes and access to digital health information.	Deliver at least six Healthy Educators programmes in the community, targeting BAME, emerging communities and deprived neighbourhoods.	In 2023, we delivered five digital inclusion programmes, each consisting of six sessions, with 48 people graduating from the course.	**Achieved** In 2024/25, we delivered 5 Diabetes peer support group programmes and 4 Diabetes digital inclusion programmes so far. 42 people completed the diabetes inclusion programmes and 65 people completed the diabetes digital inclusion programmes.	Brent Health Matters

				Additionally, we provided three diabetes peer support programmes, also with six sessions each, which 33 people completed.	2 more diabetes digital inclusion programmes and 1 more diabetes peer support group programme will be delivered by the end of June.	
1.6	We will tackle period poverty through the rollout of Period Dignity Brent initiative, ensuring that residents have access to free, eco-friendly period products in publicly accessible council buildings across Brent and addressing stigmas and taboos that surrounds menstrual health.	Period Dignity Brent addresses health inequalities by ensuring accessible menstrual products for all, including disadvantaged groups such as asylum seekers, refugees, homeless people, or food bank users, by targeting distribution where we have identified the greatest need, in that way promoting period dignity and improving menstrual health outcomes.	This commitment will be measured by the number of sites providing the Period Dignity offer. We will track whether the offer is available at all the sites we initially targeted.	Currently there are six council buildings that can provide free period products. We have identified a further 10 locations to expand the offer.	**Achieved** All 16 locations are providing period products in a range of disposable and reusable options across the Borough and providing people with access to menstrual health educational resources. In May the pilot was expanded to an additional location. 17 locations are proposed to continue to provide the offer.	Public Health Communications, Insight and Innovation

1.7	We will tackle tooth decay in children in Brent by delivering the mobile dental assessment and intervention programme (oral health bus) directly to primary schools with high rates of overweight and obesity.	We will target areas with high obesity rates, focusing on children living in the most deprived areas (deciles 1-3).	The number of oral health outreach events delivered at primary school: the target is 20. The number of children provided with dental assessments and interventions	Last year the oral health bus visited 17 locations in close proximity to primary schools. 627 children from these locations were assessed last year.	**Achieved** Last year the oral health bus visited 23 schools so achieved target of 20 840 children were seen last year compared to 627 children the previous year.	Public Health
1.8	Further increase the uptake of Healthy Start Vouchers and vitamins	We will target all mothers, especially those from deprived areas, to ensure they have access to dental care and education. This focus will help reduce tooth decay in children by addressing the root causes and providing necessary resources and support to those most in need.	Increase the uptake of the Healthy Card Scheme among eligible Brent families by up to 5% Up to 80% uptake of vitamin drops by residents from Family Wellbeing Centres and up to 30% uptake of	Currently, the uptake of Healthy Start Card scheme among eligible families is 57% in Brent and the uptake of the healthy start vitamins among Brent families was not being reported	**In progress** We are in the process of carrying out an evaluation to understand the full impact of the pilot. At 31/03/25 • 6875 vitamin drops have been given out • 2114 vitamin tablets have been given out • Majority of people who have been picking up the vitamins have been from the Kingsbury locality with Wembley close behind	Public Health

			pregnancy vitamins by residents in Family Wellbeing Centres		• 12% of people collecting the vitamin are healthy start card holders Going forward, health visitors will be carrying out the vitamin dissemination scheme in house	
1.9	We will implement the BHM CYP team to tackle Health Inequalities in children and young people	Our initial focus will be on increasing uptake of immunisation, improving asthma care and increasing awareness for mental health conditions. By targeting these areas, we aim to reduce health disparities among children and young people, particularly in underserved communities.	Total number of vaccinations given by the team. Number of children who received asthma reviews and management plans as a result of the team's outreach efforts.	This is a new initiative, so the baseline is 0.	**In progress** No vaccines given so far. Working with the Somali community in Harlesden to increase uptake of MMR. Approximately 250 children unvaccinated. So far group discussions with SEND parents, faith leaders, Somalian health professionals and with GP practices in Harlesden Identified PCN as Harness South based on inequalities starting with Brentfield GP practice. Identified paediatric lead for asthma. Conducted paediatric audit – developed an action plan Meeting with Asthma nurse to address the action plan	Public Health Brent Health Matters

					Asthma support day in Harlesden – saw approximately 50 children Mental health Community Connectors have engaged with various schools (primary and secondary) to raise awareness about mental health and the support that people can access. Targeted 5 schools for children's mental health awareness week in February. Started 'chat and chill' sessions at Family Wellbeing Centres. Developed mental health signposting database for parents and carers.	
1.10	We will improve the mental health of school pupils through evidence-based interventions. Our skilled mental health practitioners liaise with teachers to identify children experiencing distress, increased absences, or social isolation.	By integrating mental health practitioners into schools and focusing on early, evidence-based interventions, we aim to provide equitable mental health support to all children, thereby reducing health disparities and promoting overall well-being.	The number of referrals. Percentage of referrals that progressed to interventions.	From September 2023 to March 2024, we received 98 referrals, of which 83 (approximately 85%) progressed to interventions.	**Achieved** A total of 201 referrals were received across 21 schools from the start of the Autumn 2023 term. 162 referrals (81%) progressed to interventions, while 39 referrals (19%) did not proceed to any further intervention.	Mental Health and Wellbeing Executive Group
1.11	We will continue providing tailored and accessible resources	All Hub staff have received basic neurodiversity training,	The percentage of enquiries resolved	The percentage of enquiries at the Community Hubs	**Achieved**	Resident Services

	to most vulnerable residents through Community Hubs.	improving their flexible approach and enabling better support for residents with additional needs. This will improve residents' well-being and may reduce disparities between them and those without additional support needs.	at point of contact. The number of residents accessing Community Hubs	resolved at point of contact was 82% at the end of Q4 2023/24. The number of residents accessing Community Hubs was 5,510 in Q4.	In Q1 (to date), the resolution rate at Community Hubs remains at ~82%. 1,339 residents accessed Community Hubs in May 2025, bringing the Q1 total so far to 4,469. This is on track to match or exceed the Q4 baseline of 5,510, pending June data.	
1.12	We will address tobacco related inequalities in Brent via the government smokefree initiative. We will ensure our most vulnerable tobacco users such as pregnant smokers and smokers in drug & alcohol services and smokers receiving mental health support are given the opportunity to quit.	By identifying areas of need, and engaging with underserved communities, such as the newly arrived communities and Paan consumers, and regular shisha users, to address barriers and co-produce a stop tobacco service that is accessible and culturally appropriate.	Number of organisations/ individuals (i.e. community champions) that engage with the initiative. Stop tobacco service activity as measured by number of referrals, those setting a Quit Date, or those that have Quit	We currently run a public health specialist stop tobacco service, with varying referral pathways into communities/ partner organisations. In 2022/23, 33 smokers joined the stop tobacco service, 45% of these managed to quit.	**Partially achieved** In 2023/24, 53 smokers joined the stop tobacco service, 28% of these managed to quit.	Public Health

			successfully using the programme.			
1.13	In partnership with the London Ambulance Service, the Brent Rapid Response team will deploy clinicians alongside senior paramedics to provide urgent community care. This initiative aims to prevent avoidable hospital admissions and alleviate pressure on emergency services by managing Category 3, 4, and 5 patients directly in the community.	This service addresses health inequalities by providing quicker response times for Category 3, 4, and 5 patients, who typically wait longer for care. In Brent, where chronic conditions like diabetes and hypertension are common, timely and multidisciplinary care is crucial. The collaboration between BRR and LAS ensures these patients receive holistic and individualised treatment, improving health outcomes and reducing disparities.	The number of A&E attendances prevented by this pathway. The number of residents benefiting from this pathway.	This project is in the pilot phase. Currently, the pathway prevents approximately 30 A&E attendances every month. Data collected from the last six months suggests 5-6 patients a day benefit from this service.	**Achieved** • This service is now being referred to as **'UCR'.** • Monthly service updates are provided to ICB. On average, there are 350 – 400 referrals received in a month**.** The service has exceeded its annual activity plan by 449.6%, highlighting a significant increase in demand. Despite this surge, the team has scaled up effectively and managed the workload well. Activity figures are based on the total number of initial and follow-up contacts made by the Rapid Response Team with patients. The service receives approximately 375 referrals per month, equating to over 4,500 interventions in the 2024/25 financial year. These cases represent potential hospital admissions avoided, demonstrating the service's critical role in supporting urgent care needs. All patients referred have benefited from timely and responsive intervention by the team.	Brent Integrated Care & Delivery Team, NWL ICB CLCH – Brent Rapid Response Team
1.14	We will appoint two Admiral Nurses to provide emotional care and support for families	This commitment will tackle health inequalities by ensuring families and	Each admiral nurse to have a minimum of 15 patients per case	These are new posts, so no baseline yet.	**In progress** Due to some governance-related delays, the Admiral Nurses have not yet been appointed.	Mental Health and Wellbeing Executive Group

	and patients at the pre-diagnosis stage or those already diagnosed with dementia. These nurses will offer skills and techniques to help families stay connected, manage fear and distress, advise on financial benefits and available support services, and ensure that both carers and patients receive the best possible additional care.	patients affected by dementia receive specialised, personalised support. Admiral Nurses will provide essential skills and techniques to manage emotional and practical challenges, reducing stress and improving quality of life. By advising on financial benefits and support services, they will help families access necessary resources, ensuring equitable care for all, regardless of socioeconomic status.	load of which at least 46% should have a BAME background. 75% of patients to remain at home rather than being admitted to a care home within a 12 month period. Reduction in GP visits commencing Admiral Nurse involvement. Reduction in Hospital admissions commencing Admiral Nurse involvement. 85% of patients/carers/families to feel less isolated and feel that they can cope better following the support of the admiral nurse.		The scheme is now expected to launch in July. The updated KPIs will be: • Each Admiral Nurse maintained a caseload of XX patients, of which XX% were from a BAME background. • There was a XX% reduction in GP visits following the commencement of Admiral Nurse involvement. • XX% of carers reported feeling less isolated and more able to cope after receiving support from an Admiral Nurse.	

2	**Healthy Places** Near me there are safe, clean places where I, and people I care for, can go to relax, exercise for free, meet with like-minded people, and where we can grow our own food					
	New commitment	**How will the new commitment address health inequalities?**	**KPI**	**Baseline**	**Update on KPIs**	**Lead**
2.1	We will organise regular social events for Ukrainian guests	This will be twofold; it will ensure Ukrainians will be able to meet other Ukrainians who are in the same situation as them, maintaining good mental health. The health inequality addressed is that the Ukrainian community, which could potentially be marginalised, is not marginalised.	Number of social events available for Ukrainians (commissioned by the council)	At least one social event a month on average	**Partially achieved** The Romanian and Eastern European hub were commissioned to provide six events throughout the year in 2024/25. In 2025/26, fewer events will take place, and these will be through the new EDI community events funding.	Community Development
2.2	We will work with partners to create Sport England Place Based Expansion programme and	We will focus on residents in agreed locations (Stonebridge, Church End and Roundwood).	• Amount of funding secured from Sport England	Currently, there is no coordinated programme in the targeted locations (Stonebridge, Church End, and	**In progress** We worked with a number of community organistions and trusted partners to form a working group. Funding application made and Sport England have confirmed a commitment	Public Health London Sport Community Organisations

	Football Foundation Playzones initiative	By conducting consultations and data collection to identify community needs and gaps in provision, we aim to create inclusive spaces that promote physical activity and community engagement. This will address health inequalities by providing equitable access to sports and recreational facilities.	• Number of community steering group established. • Numbers of people engaged in new activities. • Numbers of people new to Physical Activity.	Roundwood). Initial consultations and community needs assessments are pending, and no funding has been secured yet.	of £289,560.00 throughout the development award. Community Steering group ToR established and group meets every 2 weeks. 3 trusted partners will be leading on the initial phase of research, mapping and consultation with residents to explore what the barriers are to being physically active. Neighbourhood approach. Links made to Brent Council Radical Place Leadership Programme which is being Piloted in Harlesden. Football Foundation Playzones – seems to have stalled. Parks not able to commit to match funding for this. Will reopen the conversation with potential external funding or Public Health grant funds	
2.3	We will develop the programme of accessible activities in community spaces and parks, working with community organisations, for example walks programme, Our Parks, support to use outdoor gyms	We will target residents, particularly those from priority groups such as children and young people, individuals with long-term health conditions, and inactive populations. By providing accessible activities,	• Number of programmes offered. • Number of participants. • Number of referrals made from health professionals.	Public Health currently operates an activity programme in parks. There is an ongoing need to increase participation and engagement, particularly among	**Achieved** See attached timetables Activities include: • Our Parks sessions in parks and community venues such as libraries and community halls • Sport in Mind – activities for people with mental health issues	Public Health London Sport Community Organisations

		we aim to improve physical health, foster community engagement, and reduce health disparities among these groups.		priority groups identified.	• Active Brent targeted activities for those new to exercise with an emphasis on social isolation and mental health • Disability Sports sessions at Willesden Sports centre – weekly club for young people • Running programmes (Couch to 5k) • Outdoor Gyms across 18 venues • Frailty classes for residents with strength issues • Padel Tennis for asylum seekers • Football sessions • Variety of fitness and movement classes Introducing a new data collection system to make collection of data from all activities easier to manage.	
2.4	We will improve the quality of housing in Brent across the private sector though borough wide licensing of the private rental section and an adaptations programme that makes sure that disabled	Poor quality PRS housing is a significant contributor to health inequalities as is housing which is unsuited to residents with disabilities	Number of properties licensed; the target is 12,000. Amount spent on adaptations.	In 2023/24, 9,500 properties were licensed. In 2023/24, we have allocated £8.1 on adaptations.	**Achieved** Number of properties that have been licensed in 2024/2024 is **21,700** Amont spent in Adaptations in 2024/2025 is **£7.7M**	Housing Services

	residents live in homes that meet their needs					
2.5	We will develop Ealing Road library garden for community use and leisure, programming, plant growth, support health and wellbeing	A lack of access to green space contributes to health inequalities	Outdoor Programming: Number of Family Learning/Adult Events – 12	Current number of events from Spring 2024: 3 Family Learning/Adult events, with 32 adults and 51 children participating.	**Achieved** Wrote a Successful funding application and received £6k from Culture Nature England / Libraries Connected Sept 2024. A grant for a 6 month project to develop Eal Rd lib's garden, and raise awareness of the importance and value of nature and wildlife to the local community Programme developed for children, adults and families to engage with the green outdoors and also gardening. Additionally to offer outdoor exercise formal and informally. This would address opportunities for improving physical activity for all ages. Also it would help with mental health wellbeing Achieved – see below stats. Includes one day of class visits x 4 classes Spring into the garden family gardening event 4 Apr 2024: 7A / 23C Coffee morning – Getting to know your garden 10 Oct 2024 – 8A Family gardening workshop 21 Oct 2024 – 6A / 23C RSPCA Bird Count: 25 Jan 2025: 10A / 12C	Resident Services

					Culture Nature Family gardening event 17 Jan 2025: 9A / 22C Poetry and nature – cl visits x 4 18 March 2025 – 120 C Bird nest box making family event 8 Apr 2025 – 8 families = 3A / 5C Beginners gardening in Spring family event 17 Apr 2025 19A / 29C Grand Union Canal walk family event 17 May 2025 – 17A / 15C Stretch exercise 31 May 2025 – 15A Culture Nature finale programming events x 2 in the gardening 31 May – 28A / 35C 12 events in total, see opposite column Total of 122A / 164C plus 120 school children for cl visit 18 Mar 2025	
2.6	We will review and refresh our approach to climate community engagement and encourage local green action through our Together Towards Zero grants	Grants are allocated boroughwide to address all key themes in the climate strategy but applications from seldom heard groups and those particularly impacted by the adverse effects of climate change are	Number of community grants, target: minimum of 15.	In 2023/24 we allocated 23 grants.	**Achieved** **In 2024/2025 (Round 3), a total of 18 grants were allocated.** The **fourth round of funding** was launched on **19 May 2025**, with applications open until **Spring 2026**.	Inclusive Regeneration and Climate Resilience

		particularly encouraged.				
2.7	We will further increase sign up to the Healthier Catering Commitment	This initiative aims to promote healthier eating habits, particularly benefiting residents in deprived areas where access to healthy food options is limited.	• Number of businesses signed up to the Healthy Catering Commitment • Aim for 20 new sign-ups in 2024 • Additional 10 new sign-ups each subsequent year	Current number of businesses signed up: 0	**Partially achieved** New officer in post working on this. Visiting businesses that have previously got HCC to review and renew New businesses on board – additional 6 Showcasing at London launch of HCC scheme in March 2026 Looking at getting a case study from Ace Café on the changes they have made to comply. Working with schools and planning to focus attention on businesses close to schools to reduce number of students using them at lunch times. Also working with these businesses to encourage healthier 'student' deals – smaller portions, grilled chicken wraps etc.	Public Health
2.8	We will work with partners from Kilburn State of Mind, Brent Council, networks, and volunteers to implement The Music Mile: Mental Health Support Programme, which aims to improve	This commitment will address health inequalities by focusing, but not limiting to, residents from Black, African, and Caribbean backgrounds. It will engage delivery	Number of individuals receiving music lessons and performance training: Target 20-30 participants.	This is a new project, so the baseline is 0.	**Partially achieved** Number of participants: 23 Music teachers with MH experience: 6 Community attendance: good turnout, 14 performers.	Resident Services

	the mental health and wellbeing of residents from underserved groups and to revitalise Kilburn as a music destination.	partners who are musicians with prior experience in mental health support and will reach local residents attending the festival, thereby promoting mental health and wellbeing within underserved groups.	Number of semi-professional musicians who previously accessed mental health support delivering the lessons: Target 10 musicians. Number of local residents attending the festival, particularly those struggling with mental health issues and isolation: Audience target will be determined based on venue capacity.			
2.9	We will tackle air pollution in Brent by recruiting Air Quality Champions to improve local understanding of air quality issues and provide practical advice on reducing	Cleaner air benefits everyone, especially people living in areas with high pollution levels, which are often linked to lower income. This helps reduce health differences	Number of Air Quality Champions recruited. Number of vulnerable or disadvantaged individuals	No Air Quality Champions have been recruited yet, so the baseline is 0.	**In progress** Initial recruitment delays, but two members of the Brent Health Matters team have now taken on the Air Quality Champion role and will support engagement at upcoming events.	Public Health

	exposure to air pollution.	among different communities.	reached and supported by the Air Quality Champions The number of people involved in Air Quality projects that attend the associated workshops.			
2.10	We will engage with school children to educate them and raise their awareness about air quality issues through interactive maps showing high and low pollution routes within a 5–10-minute walking radius of schools, and by organising educational air quality events.	By educating children about air quality and providing them with practical tools, we help protect their health, particularly those who are most vulnerable. This initiative promotes equal access to important health information, helping to reduce the disparity in health outcomes among different communities.	We will collect data through a survey to measure the number of children who have changed their travel habits to use lower pollution routes to school. The number of educational events organised related to air quality and pollution awareness.	We are currently supporting schools to submit their travel plan for this academic year and will use this years' data as the baseline. The data will be available by the end of July.	**In progress** Schools are currently working on their travel plans which includes a travel survey and these are to be submitted to TfL by 14/07/2025. Once approved by TfL we will be able to compare this years travel survey against last years one to identify changes in travel behaviour. This will also include details of schools that participated in the Breathe Clean Brent project to promote walking and cycling.	Public Realm

2.11	We will increase participation in active travel by creating safe environments where people can confidently walk, cycle, and use other forms of active transportation. Through the implementation of the Active Travel Implementation Plan, we aim to promote these activities to improve public health, reduce traffic congestion, and lower environmental impact.	Active travel, such as walking and cycling, boosts physical activity, which reduces the risk of chronic diseases. It also improves mental health by lowering stress and anxiety, particularly benefiting underserved communities with limited access to recreational facilities. Reducing car use cuts pollution and traffic, creating a healthier environment and lowering transportation costs for low-income families, allowing more resources for other needs.	We aim to reduce traffic levels to 994 million vehicle kilometres by 2027 by having fewer vehicles on Brent's roads or vehicles travelling shorter distances. We aim to increase the proportion of residents engaging in at least 20 minutes of active travel to 41% by 2026/27.	The targets were set pre-pandemic with Brent's baseline traffic at 1,098 million vehicle kilometres annually. The proportion of Brent residents doing at least 20 minutes of active travel a day is 31% as of 2022/23 data.	**Partially achieved** Latest TfL data shows annual vehicle kilometres have reduced to 970 million (2023), meeting the 2027 target early. However, active travel levels have declined slightly to 29% (from 31%). 2024/25 data is expected in early 2026.	Inclusive Regeneration and Climate Resilience
2.12	We will equip Brent schools with the Climate Action Guide and Plan Template, support them through regular webinars and Climate Champions Network meetings, and	By integrating sustainability into the curriculum and school activities, we foster a sense of environmental stewardship and provide equal	The number of schools actively using the Climate Action Guide and Plan Template.	There are approximately 10 schools that use the guide. There were two webinars	**Achieved** There are approximately 15 schools that use the guide. Webinars are being ran for the Our Schools Our World group. There have been two of these, with an attendance of 8 and 10. There has also been a climate action webinar on bid	Inclusive Regeneration and Climate Resilience

	provide Carbon Literacy Training. Additionally, we will participate in the "Our Schools Our World" programme to improve sustainability education and initiatives, ensuring every school has a trained sustainability lead to drive effective climate action.	opportunities for students to engage in green careers. Additionally, schools in disadvantaged areas will receive targeted support, helping to bridge the gap in environmental education and empowering all students to contribute to a sustainable future.	The attendance at the regular climate action webinars. The number of sustainability leads trained through the "Our Schools Our World" programme. The number of schools that have successfully created and implemented a climate action plan.	organised so far with the attendance of 13. This is a new programme, so the baseline is 0. This is a new project, so the baseline is 0.	writing for sustainability grants, with an attendance of 12. 20 Senior Programme Leads have been trained as part of the Our Schools Our World programme. There have been 12 schools that have successfully created and started to implement another plan. There are at least 10 more schools who are in drafting stages.	
2.13	We will distribute the SCIL Youth Provision Grant to fund structural changes and improvements to premises used by youth organisations, enabling better access and increasing facilities	We are especially targeting highly deprived areas to tackle health inequalities and ensure that young people have access to a range of facilities	The number of successful applications.	19 EOI's have been submitted out of which 12 have been progressed to application stage.	**In progress** 19 EOI's have been submitted out of which 12 have been progressed to application stage. Of the 12 projects, 5 were shortlisted and deemed suitable to progress towards Cabinet	Early Help

	and activities for young people in the London Borough of Brent.	and places where they feel safe and at ease.			to secure SCIL funding for works to be undertaken on the selected projects.	
2.14	We will continue providing early multi-agency intervention and support through our Family Wellbeing Centres (FWC). By working with partners, we offer services including health, education, and wellbeing, taking a holistic approach to family needs. We will continuously analyse data from families to ensure our services meet their needs, preventing escalation to more specialist services.	By analysing data and collecting feedback from families, we ensure our FWCs offer services tailored to Brent's families' needs. This approach aims to equip FWCs with the ability to address issues before they become serious problems, which may prevent health disparities. Continuously analysing family data allows us to respond dynamically, ensuring services remain effective and relevant. Tailoring FWC offer based on family feedback reduces the risk of health inequalities.	The number of families supported by FWCs	In 2023/24 a total of 18,113 families accessed FWCs	**Achieved** In 2024/25 a total of 18,079 families accessed FWCs.	Early Help

2.15	We will support school with the introduction of a school street zone (Pedestrian and cycle zone) where feasible to restrict vehicle access and encourage active travel.	By introducing a school street zone, we can help improve air quality and road safety by reducing parking and congestion issues, and enhancing the environment around the school, which contributes towards a cleaner and greener Brent. School streets also support active travel within the school community, and children and parents will benefit from walking and cycling to and from school.	The number of schools with a school street zone, with a target of implementing three new zones per year, subject to consultation with stakeholders. In addition, we can measure the success of modal shift towards active travel by using the annual travel plan survey data for the individual schools.	The current number of school street zones is 31.	**Achieved** We now have 32 school streets, 3 new ones were introduced as a trial in Nov 24 and 4 trial expansion zones 2 of which included the amalgamation of 2 zones into one larger zone hence the number being lower than expected. We have consulted on 3 more school street trials of which 2 will be progressed in the autumn 2025. One scheme is not to be progressed due to lack of support from residents. We have commissioned travel consultancy to conduct an independent annual report of the school streets programme for the next 3 years and the first report will be available in the autumn term.	Public Realm
3	**Staying Healthy** I, and the people I care for, understand how to keep ourselves physically and mentally healthy, managing our health conditions using self-care first. We have access to good medical care when we need it.					

	New commitment	How will the new commitment address health inequalities?	KPI	Baseline	Update	Lead
3.1	We will provide mental health services in Ukrainian, Russian, and English for Ukrainian guests and all hosts	This will ensure that residents who are affected by the war in Ukraine either as Ukrainians or hosts who are providing a home for Ukrainian guests have access to suitable mental health services in their own language (Ukrainians only)	Commission providers to provide: • face-to-face mental health support • 24/7 virtual mental health support	We have mental health provision for hosts, and face-to-face for guests. We are in the process of commissioning 24/7 virtual mental health support for guests.	**Achieved** We have virtual mental health provision for both hosts, and guests which can be accessed 24/7. Guest support is available in Ukrainian, Russian, and English.	Community Development
3.2	We will promote bowel cancer screening services in communities high at risk through awareness presentations and communications in different languages	This commitment will focus on communities with high risk of developing cancer such as people living in deprived areas, Pakistani, Black African, Black other ethnicities, and people with Severe Mental Illness (SMI).	Deliver 10 engagement events with target communities.	Delivered 9 bowel cancer screening awareness presentations to communities between December 2023 and April 2024. Working with the bowel cancer	In 2024/25 we delivered 19 events with target communities. We will continue to awareness about bowel cancer screening services in high-risk communities through awareness presentations and communications available in multiple languages.	Brent Health Matters

				screening service at St Marks Hospital to arrange ordering of test kits for eligible people.		
3.3	We will deliver targeted work on hypertension in black communities.	We will focus on Black communities and individuals, aiming to reduce health disparities related to hypertension.	Support at least 100 patients with hypertension who haven't had a recorded blood pressure measurement in last 18 months.	Recorded blood pressure of 237 hypertensive patients and updated this on their GP records in 2023/24	**Partially achieved** We supported 56 patients between April 2024 and May 2025.	Brent Health Matters
3.4	We will deliver education and awareness sessions on healthy eating to local communities via our Health Educator contract	People who don't normally access health care services such as those from BAME and emerging communities, as well as residents from deprived neighbourhoods. This initiative aims to reduce health disparities by providing	Deliver at least 50 health education and awareness sessions via our Health educator contract, targeting BAME communities. Successfully support at least 50	Provided case management support to 66 people with or at risk of developing Diabetes in the last year (April 2023-2024).	**Achieved** We case managed 82 people between April 2024 and March 2025.	Brent Health Matters

		essential health education and promoting healthy eating habits.	people with or at risk of developing Diabetes (or other conditions) to achieve their lifestyle/healthy eating goals.			
3.5	We will improve mental health awareness in Brent through coproduction of community engagement sessions	We will target people with common mental health conditions, aiming to reduce disparities by providing essential mental health education and support.	• Deliver at least 50 Mental Health awareness sessions. • Co-produce at least 50% of sessions.	Mental Health team within Brent Health Matters delivered 20 workshops for communities in 2023/24.	**In progress** The mental health team held 20 workshops for adults between April 2024 and April 2025. 70% of these workshops (14) were co-produced with communities. This is in addition to the outreach events done in the community.	Brent Health Matters
3.6	We will assist residents to register with a Brent GP	. This initiative aims to reduce health disparities by connecting residents with essential health and care services.	Aim to assist at least 150 residents in registering with a GP or accessing health services.	Public Health and Brent Health Matters supported 114 to register with GP last year	**In progress** BHM and Public Health supported 123 people to register with a GP between April 2024 and April 2025.	Brent Health Matters
3.7	We will provide mental health outreach and raise awareness in our most impacted	We have identified three areas in the borough with the highest number of A&E	Reduced number of A&E admissions from people in mental	In 2023/24, 176 people presented to A&E with a mental health	**Achieved** 585 people were supported by Psychology between November 2024 and March 2025.	Mental Health and Wellbeing

	neighbourhoods through events and workshops. Additionally, we will recruit mental health Community Connectors to educate and empower these communities.	admissions due to mental health crises, with the vast majority of these admissions being from Black and Asian communities. This illustrates significant health inequalities in these areas, which we aim to address through targeted approach.	health crisis and decreased percentage of approaches from Black and Asian communities. The number of mental health awareness events and workshops organised. Number of people engaged through awareness events and workshops and proportion of attendees from Black and Asian communities.	crisis, with 85% of these admissions being from Black and Asian communities. In 2023/24, we organised 129 events and 114 workshops and training sessions. In 2023/24, we engaged with 5,326 people.	Community Connectors engaged with 1139 people via 80 community events between December 2024 and May 2025. Held problem solving booths in various locations in the postcode areas to engage with residents and hear from them. Establishing drop-in sessions at various locations. Establishing regular presence with Brent Multi Faith Forum and delivering culturally sensitive and trauma informed training to partner organisations and in house colleagues.	Executive Group Brent Health Inequalities Team (CNWL) Brent Health Matters
3.8	We will improve the accessibility and appropriateness of the library service for Brent residents living with dementia	This commitment addresses health inequalities by ensuring Brent residents with dementia have better access to tailored	Increase the number of homes receiving deliveries to 15. Provide 6-8 boxes of dementia-friendly items,	Current delivery: 10 Homes.	**Partially achieved** All libraries now have Bronze status as dementia friendly venues • PEARL'S Dementia friendly café at Willesden Green Library, meeting weekly	Resident Services

		library services. Improved publicity, home delivery, dementia-friendly materials, and accessible cultural venues ensure these residents can engage with library resources. Additionally, seeking funding for specialised programmes supports their cognitive and social needs, promoting overall wellbeing and inclusion.	each containing 35 items, to homes. Successfully apply for and receive designation status for Brent Libraries under the Arts Council England Designation Scheme. Submit a successful Arts Council England (ACE) funding application by March 2025 (only one ACE application can be submitted at a time).	Current stock: 15 items. This will be our first time applying for the ACE Designation Scheme and funding.	• Dementia Friendly Venue Charter Case Studies also underway Joint funding application with PH/ Social Prescribing Manager to be submitted for PH Reserves. Draft completed and now meeting with targeted organisations to then be able to draft budget for all requirements. 4 organisations max for delivery – Elders Voice, Bhakti Dharma Residential Home, Pearls Dementia café, Ashford place – an identified café • Current delivery: 12 Care Homes. • Current stock: 30 items per box	
3.9	Pilot the introduction of social prescribing into ASC	The pilot will help to support people who are on the cusp of adult social care and have been referred to Brent Customer Services. Referrals	Activity data and outcomes data: Number of referrals	No current baseline.	**In progress** Two social prescribers have now been embedded into Adult Social Care as part of the pilot. Baseline data is being collected, and the evaluation will track wellbeing, user experience, and demand reduction using the	Adult Social Care

		come from other services such as the social prescribers in the primary care networks and other such as self-referrals to adult social care. Referrals include groups from all communities many of whom will be experiencing health inequality.	Types of referral/support requested Number of allocations to social prescriber coordinators Cases opened and cases closed Average length of intervention Outcomes Survey data – service user experience		agreed framework. See Appendix 5 with pilot overview for full evaluation criteria.	
3.10	We will improve the information, advice, and guidance accessed by informal	Becoming a carer often has a negative impact, especially on young people. It	The number of young carers accessing	Approx 35 new referrals to Brent Carers Centre.	**Achieved**	Adult Social Care

	carers by implementing the Brent Carers' Strategy, which was co-produced with them.	affects their work, education, and mental health. Young carers' wellbeing often deteriorates as soon as they take on caregiving responsibilities. Any additional support given to them could positively impact their wellbeing and reduce health inequalities between carers and those without such responsibilities.	services and resources. The number of carers registered on health and social care systems. The number of young carers being identified by their teachers or GPs.	Approximately 50 young carers identified through the combined Early Help Assessment and Common Formative Assessment Approximately 60 young carers identified via schools; we are exploring options to access GP data.	Approximately 35 new young carers referrals to Brent Carers Centre. - 71 assessments carried out in this period 924 adult carers accessed services and resources in the financial year 2023/24. Approximately 50 young carers identified through the combined Early Help Assessment and Child and Family Assessment -55 identified through CFA and 12 through EHA Approximately 60 young carers identified via schools - 64 YC identified in 2025 January schools census	Early Help
3.11	Develop a Prevention strategy and implementation plan based on the Care Act principles of preventing, delaying and reducing the need for care	The strategy and delivery plan is underpinned by the principle of reducing health inequalities. Part of the delivery plan will involve data analysis, scrutinising cohorts who we know to be at risk of developing or exacerbating health conditions and developing	As part of the plan a set of outcome measures will be developed. These are likely to include but not limited to; Increased uptake of support measures for carers Decreased number of people accessing social	Current there is no strategy or plan which brings together preventative interventions across health and social care.	**Achieved** The prevention strategy (available in Appendix 6) has been developed and shared widely with partners for feedback. This included forums such as the Carers Forum, Disability Forum, Provider Forum, Transformation Board, Ashford Place, and internal council teams. This feedback shaped the final version and formed the basis for the co-production element. Strategy has been published on the Brent website There are 5 core priorities that the strategy focuses on:	Adult Social Care

		interventions which will reach them earlier.	care services for the first time through a hospital admission Increasing number of people accessing Reablement services Increasing number of people accessing information and advice through the Brent website		• Improve quality of life of Adult Social Care customers in Brent focusing on social isolation and supporting people to live independently. • Improve Adult Social Care information, advice and guidance available so that people in Brent understand what is available and when to seek services. • Champion and lead the implementation of the six carer commitments for Brent. • Target preventative interventions for people with a mental health need to reduce deterioration of health and wellbeing. • Facilitating people to stay out of hospital through a comprehensive reablement service and a focus on the drivers for hospital admission in Brent. Some key deliverables emerging from the delivery plan are: • ASC JSNA • Developing an Outcomes Framework for Evaluating preventative intervention • Sustainable Mapping of Services across Brent borough for signposting customers • Development of Social Prescribing in ASC • Galvanising system on priorities as an outcome of engagement	

					• AskSARA and virtual equipment house for self assessment for minor aids and adaptations • Improving the supported employment offer for customers with mental health issues • A delivery plan was developed alongside the strategy following feedback from stakeholders • A draft set of KPIs has been created. Some are already measured, though progress will take time to show. • We are currently recruiting for a Prevention Lead, who will be responsible for taking the delivery plan forward and overseeing implementation whilst ensuring the progress is being maintained.	
312	We will reduce emergency hospital admissions for patients with Chronic Obstructive Pulmonary Disease (COPD) through delivering disease education, support self-management and techniques to manage their condition	A disproportionate burden of COPD occurs in people of low socioeconomic status due to differences in health behaviour such as tobacco smoking, social and physical environment which play leading roles in lung disease development and is also associated with	5% reduction in unplanned admission from the previous year.	The number of NEL from Nov 2022 (M8) to October 2023: 347	**Achieved** **There was a 5.32% reduction in 2024/25 in unplanned admissions compared to the previous year.** • 2023/24 COPD admissions = 357 • 2024/25 COPD admissions = 338 A reduction of 19 admissions	Brent Integrated Care & Delivery Team, NWL ICB

	independently at home.	worse COPD outcomes. An effective intervention is to target and educate this cohort of patients.				
3.13	We will reduce hospital admissions through the 'Step-Up Pathway', a service that utilises a dedicated bed to provide immediate care, accessible directly from community health services or via the A&E.	This approach reduces the need for hospital admissions. By optimising the use of hospital resources, the pathway improves access to healthcare for everyone, including the most at-risk populations, therefore reducing health disparities.	The number of residents receiving care within two hours.	This is a new project, so the baseline is 0.	**In progress** The Step-Up Pathway was piloted in 2024/25 with one dedicated bed available for community referrals. Three residents accessed the pathway following falls at home, receiving daily therapy for a period of between 1-4 weeks to support mobility and independence. All three were safely discharged with follow-on community care. While early outcomes have been positive, current delivery is constrained by limited bed availability.	Brent Integrated Care & Delivery Team, NWL ICB
4	**Healthy ways of working** The health, care and wellbeing workforce will be happy and strong; and the health and wellbeing system will recover quickly from the impacts of the pandemic.					
	New commitment	**How will the new commitment address health inequalities?**	**KPI**	**Baseline**	**Update on KPIs**	**Lead**

4.1	We will provide work opportunities via our community champions and Health educators programme for local communities	We will target people who are unemployed from local communities, providing them with employment opportunities and training. This initiative aims to reduce economic disparities and improve health outcomes by engaging community members in meaningful work.	Number of new work opportunities provided to residents in Brent.	Local recruitment is prioritised within BHM with 14 Health Educators and 41 Community Champions recruited in 2023. This included two new Health Educators.	**In progress** Local recruitment is prioritised within BHM with 14 Health Educators and 41 Community Champions recruited in 2023. This included two new Health Educators. 13 Health Educators remain employed by BHM. 3 Community Connectors were recruited for the BHM mental health team. 2 new Children and Families Link Workers are currently being recruited to. BHM currently manages 46 Community Champions.	Brent Health Matters
4.2	We will improve partnership working through the new Community Wellbeing Service to enable those with health needs to access the holistic support offer addressing the cost of living	The Community Wellbeing service will be accessible to residents with physical and mental health needs through referral routes with key partners	Number of referrals from health and public health professionals to the new service	This is a new service so no baseline	**Achieved** The Community Wellbeing Service officially launched from the New Horizons Centre in Roundwood in January 2025. The service commenced on a 2 day p/w basis, and has gradually upscaled to a 5 day p/w service in June. Whilst memberships are targeted at families, a pathway was established to allow single persons with health needs to access the holistic support offer. As of 1st June, 293 referrals have been received, 16 of which have been single persons referrals from health professionals. As the service embeds into the new location we will continue to strengthen the partnership	Communications, Insight and Innovation

					working and referral pathways with health professionals	
4.3	We aim to provide pathways to employment for individuals referred by GPs, social prescribers, self-referrals, and local employment services. By integrating these diverse referral pathways, we can ensure comprehensive support for those in need. Through this initiative, we aim to support individuals with mental health conditions in securing employment, with assistance from Twinings, Shaw Trust, the Department for Work and Pensions (DWP), and Brent Works	We aim to address health inequalities by providing employment opportunities to those with mental health challenges. Through this initiative, we can help reduce economic disparities, thereby improving overall health and well-being. Employment is a critical factor in improving mental health outcomes, and by supporting individuals in gaining employment, we help enhance their financial stability, social inclusion, and overall quality of life	We aim to assist 160 people in gaining employment	Our current baseline is 149 people with mental health supported into employment	For 2024/ 25 the MHE partners reported 171 jobs, including: • Full time 114 • Part time 56 • Apprenticeships 1	Community Development
5	**Understanding, listening and improving**					

	I, and those I care for, can have our say and contribute better to the way services are run; BHWB data are good quality and give a good picture of health inequalities					
	New commitment	**How will the new commitment address health inequalities?**	**KPI** s	**Baseline**	**Update on KPIs**	**Lead**
5.1	We will develop and embed coproduction with residents in ASC and ensure services are accessible and culturally appropriate.	The Co-production Champions will work across a spectrum of services and community groups to engage individuals and partners in the coproduction and codesign of adult social care services. Working closely with Public Health colleagues we will identify groups who are less well served by Adult Social care e.g. Gypsy and Roma communities and develop engagement strategies and plans that are appropriate.	Activity data on engagements: Number of people engaged. Number of referrals to Brent Customer Services/Adult Social Care Number of recorded service users on Mosaic from specific groups	In Adult Social Care's recent self-assessment, we identified the following: 'We are also very aware that there may be groups we are under-serving. For example, over the past year, there were no service users who were identified as Roma, Gypsy and Traveller or with an LGBTQIA+ identity. This is not in line with what we know about the population	**In progress** Carers on Carers Board that oversees the implementation of the Carers strategy Co-production steering group meets every three weeks attended by 2-3 people from community as well as representatives from ASC, Health and Community partners Co-production Advisory Board (meets quarterly- met July and September 2024, Jan and May 2025) attended by 14 residents and community group representatives Carers and service users attended Adult social care staff quarterly events in February and May 2025 and shared their feedback on Adult social care service delivery with ASC staff. **Number of Coproduction Residents Advisory and Inclusion Groups (CORAIG)**	Adult Social Care

		We will review our system and practice around recording demographic groups to better reflect the communities in Brent (where we are able to make changes)		composition within Brent and could reflect accessibility, disclosure and recording challenges. We recognise we have further work in this area to identify and engage with groups where there may be unmet need.	3 attended between 5 and 8 Customers and Carers, 3 Champions from the community and staff each. Held every month with themes. 1.Loneliness & Mental Health 2.Advice & Information 3.Self- Care Technology Testing of Better care and support assessment platform attended by 8 residents and 5 Community leaders Focus Groups for Tender Direct Payments and Brokerage Platform Easy Read + Forum: Attended weekly by 13 customers 1 Carer Forums attended-approximately 25 Carers attended the forum in March 2 Health and wellbeing days held for Carers in February and March 2025 approximately 50-100 Carers attended on each day **Number of referrals to Brent Customer Services/Adult Social Care –** • **2024:** 49,775 in coming pieces of work • 3,419 sent to Adult Social Care • **2025**: 189,10 incoming pieces of work.	

					• 1585 sent to Adult Social Care **No. of Carers assessments completed**: 24/25: 259 25/26 so far: 46 **Number of recorded service users on Mosaic from specific groups** • 3 service users recorded as Roma • 5 as Gypsy/ Irish Traveller • 6 people recorded as “Intersex”	
5.2	We will establish a programme of ward-level data insight sessions with elected members, including continued development of ward profiles to inform ongoing discussions between councillors and officers.	Councillors will have a greater understanding around their residents, which will inform the strategic discussions and policy making process. This includes identifying trends across different wards, which often might be health or wellbeing related.	The number of sessions delivered	We have delivered four sessions in Spring 2024.	**Achieved** The original commitment to deliver ward-level data insight sessions with elected members has evolved into the development of Brent’s Social Progress Index (SPI) which is a public-facing, multi-layered data model designed to track and understand key quality of life indicators at ward level. Four ward-level insight sessions were delivered in spring 2024, and learning from those has informed the design of the SPI. The SPI has been launched on 25 June 2025 and will serve as a strategic tool to support	Communications, Insight and Innovation

					councillors, officers and partners in identifying trends, including health and wellbeing inequalities. This will underpin more informed policy decisions and engagement with local communities. Website analytics and SPI uptake in decision-making forums will be tracked to assess its reach and impact.	
5.3	We will continue working with service user groups, such as B3, to further embed the voices of service users in the design and delivery of treatment and recovery services.	This commitment directly addresses health inequalities by ensuring that the design and delivery of treatment and recovery services are informed by those who use them, particularly those from marginalised groups.	The number of individuals who have successfully completed the recovery champion course and are available to support and guide others through their recovery journey. The number of new attendees to BSAFE sessions.	By the end of the financial year 2023/24, there were 46 recovery champions who had successfully completed the course. In the financial year 2023/24, there were 99 new attendees at BSAFE sessions.	**Narrative** • By the end of the financial year 2024/25, there were **35** recovery champions. • In the financial year 2024/25, there were **87** *new* attendees at BSAFE sessions. Brent is one of the few boroughs in London that offers this kind of service. B3 is believed to be the only service in London that runs a recovery service on both Saturday and Sunday, entirely run by local residents in recovery from substance misuse. B3 run a wide range of activities to support people through their recovery. On average, nearly 70 local residents access the BSAFE Weekend Service each week.	Public Health
5.4	We will collect information with a range of groups and individuals in Brent and use this to understand and improve health.	This will include conversations with community groups and individuals who have everyday experience of health challenges.	Include people with lived experience in 100% bespoke health needs	Where appropriate in terms of methodology, we have incorporated resident's view in 4 out of 6 (66%)	**In progress** Through each new project research design (at scoping phase) as well as at the end of each project to establish learning from participant recruitment phase.	Public Health

		We will focus on topics that affect groups that currently have poorer health or are less well served by public health initiatives. We will take a community researcher approach where possible so that local people are involved in the planning, delivery and learning from the research.	assessments over the next year. Take a participatory research approach in at least one evidence and insight project over the next year. Prioritise including representatives from at least two new community groups.	bespoke needs assessments in the previous year We currently engage with communities that have some established connect with public health. We aim to hear from more people in different communities within Brent.	For 2024/25, we have conducted structured interviews and focus groups with: • People with lived experience of gambling • Professionals providing sexual health services • People at high-risk of sexually transmitted infections We have also been involved in setting up a research advisory panel that includes women with experience of perinatal depression We have not yet started a participatory research project but we have prepared a research council bid for resources to support this that will be considered in July and, if successful, start in September. In 2025/26, we are planning activities with other individuals/groups experiencing health challenges.	

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Brent NHS North West London	**Brent Health and Wellbeing Board** 24 July 2025
	Report from Brent ICP

Reconfiguration of the ICB and Impact on Services

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
List of Appendices:	None
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Jonathan Turner Borough Director, Brent ICP jonathanturner2@nhs.net Tom Shakespeare Director Integrated Care Partnership, Brent Council Tom.shakespeare@brent.gov.uk

1.0 Executive Summary

1.1. To provide committee members with an update on the reconfiguration of the ICB and potential implications on services.

Background/Context

1.2. In March 2025, NHS England announced that that ICBs would face approximately **50% in cost reductions** in the 2025/26 financial year in order to refocus resource on frontline care as part of the 10 Year Health Plan. This paper seeks to update the HWB on NHS North West London's work to respond to this, in line with NHS England's Model ICB blueprint and a strategic commissioning approach.

Overview

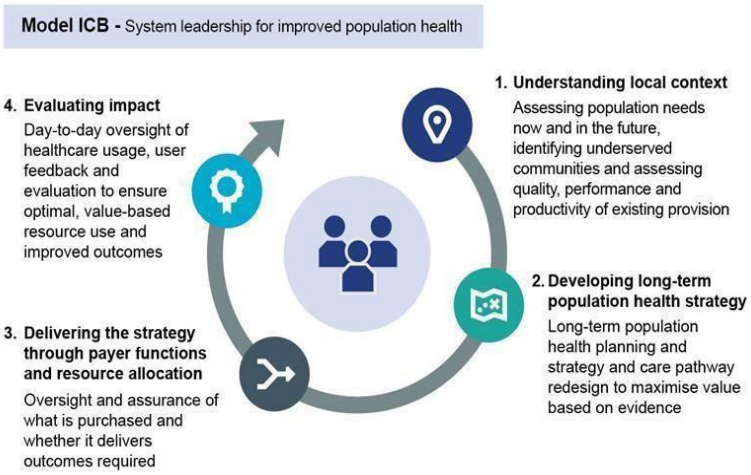
1.3. In March 2025, NHS England announced that that Integrated Care Boards (ICBs) would face approximately 50% in cost reductions in the 2025/26 financial year, in order to refocus resource on frontline care as part of the 10 Year Health

Plan. NHS Trusts were also directed to reduce spending on corporate functions to pre-pandemic levels.

1.4. The government also announced that it would be merging NHS England with the Department of Health Social Care, with similar cost reductions to the wider NHS.

1.5. This set of announcements was followed by NHS England's publication of a Model ICB Blueprint, setting out a new role for ICBs as a strategic commissioner – with the aim of assessing population needs and reducing inequalities, assessing the quality and performance of provision, developing a population health strategy, delivering the strategy, and evaluating impact.

Figure 1: A Model ICB



North West London Integrated Care System

NHS North West London

1.6. In May, the ICB submitted to NHS England a draft operating model for what the organisation might look like, working within the new strategic commissioner remit and the target funding envelope of £19 per head of population budgets for each ICB, (expected to be met within this financial year.

1.7. In June the ICB received NHS England's feedback on its Model ICB submission, which asked it to develop an options appraisal on future clustering with North West and North Central London ICBs, including the option of full merger.

1.8. The ICB's priority is to ensure that any decision is in the best interests of patients and residents in North West London, and that we become the most effective strategic commissioner that it can be.

1.9. In addition to developing as a strategic commissioner, there are many current functions undertaken by the ICB that will not be the ICB's responsibility in the future; ICBs are required to work partners to transfer responsibility for these safely over time.

1.10. To note:

- Further NHS England guidance on specific areas to build consistency and accelerate progress e.g. Safeguarding, SEND, CHC is expected by the end July.

- ICBs have been told they will continue to coordinate systems for this winter, therefore we will need to ensure that we have resilient processes in place for winter 25/26.

Drivers for change

1.11. When ICBs were established in 2022, they were given a wide range of both commissioning and provision responsibilities.

1.12. The national view is that this wide remit, along with the requirement on ICBs to ensure systems deliver financial balance, means that ICBs have struggled to use their powers to commission to the four ICS objectives:
- Improve outcomes in population health and healthcare.
- Tackle inequalities in outcomes, experience and access.
- Enhance productivity and value for money.
- Help the NHS support broader social and economic development

1.13. The NHS needs strong commissioners who can better understand the health and care needs of their local populations, who can work with users and wider communities to develop strategies to improve health and tackle inequalities and who can contract with providers to ensure consistently high- quality and efficient care, in line with best practice.

1.14. Improving strategic commissioning will support the realisation of the national ambition on the 'three shifts' outlined in the now-published 10 Year Health Plan:
- Shifting focus towards prevention
- Hospital care towards community/neighbourhood
- Analogue to digital technology.

1.15. The Model ICB Blueprint set out expectations for functions that new ICBs are expected to invest in over time:
- Population health management
- Expertise in health inequalities and inclusion
- Commissioning neighbourhood health
- Commissioning clinical risk management and intervention
- Core commissioning (e.g. contracting, purchasing, resource allocation, etc)
- Commissioning pathways (incl. specialised services and primary care)
- Evaluation methodologies using quantitative and qualitative data
- Understanding the causes, management and prevention of illness
- Strategy and strategic planning, including service redesign
- Strategic partnerships to improve population health
- User involvement, user-led design and deliberative dialogue

1.16. It also set out expectations relating to functions that are expected to transfer out of ICBs over time, along with an indication of the likely hosts:

Function	Transfer to
Oversight of provider performance	Regions
Strategic workforce planning	Regions/national

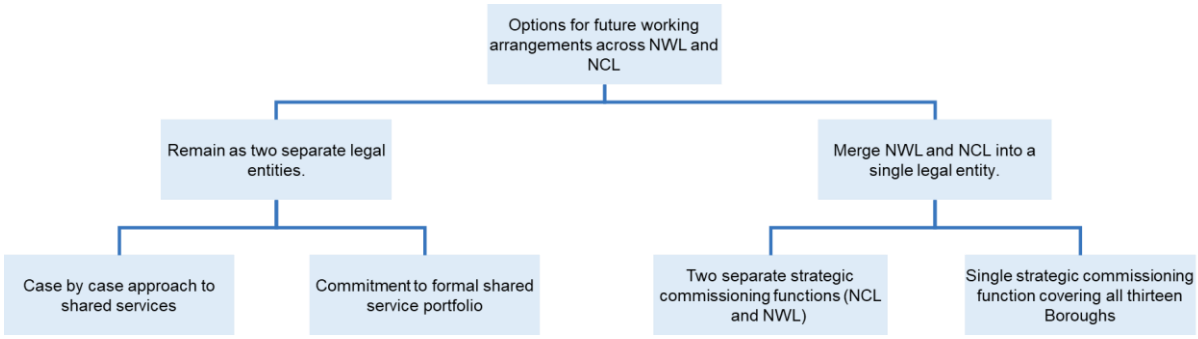
Infection prevention and control	Providers
Continuing Healthcare	Providers
Service development programmes	Providers
Development of Neighbourhood Health and place-based partnerships	Neighbourhood health providers
Safeguarding	Explore options to streamline and transfer some activities out of ICBs

2.0 Recommendation(s)

2.1. The options appraisal on future organisation form

2.2. Following the feedback from NHS England, which asked the ICB to develop an options appraisal for its future model, both NCL and NWL are working to develop these – considering the viability, benefits and risks of future design. The appraisal is being undertaken to support NHS North West London to become the best strategic commissioner for its population within the financial envelope it has available to it.

2.3. Draft options that are being assessed include:



2.4. The options developed will be evaluated to provide clear recommendation to the NWL Board. The initial proposed set of criteria are set out below, and are being reviewed by the NWL executive and senior leadership teams:

1. Improving patient outcomes through effective strategic commissioning
2. Strengthening Place and Neighbourhood arrangements to optimise outcomes
3. Retaining and attracting the best people
3. Protecting place neighbourhood, building neighbourhood health teams.
4. Resilient and cost-effective core functions
5. Time and cost of change.

2.5. The options appraisals is being discussed by the NCL and NWL Boards in public on 22 and 23 July respectively.

2.6. Indicative timeline and next steps

Now – Mid July: Work with leadership teams and relevant stakeholders to develop options appraisal.
Mid July – late July: Pre-ICB Board engagement
Late July: NCL ICB Board in public
Late July: NWL ICB Board in public

Beyond late July:

- Work with stakeholders and partners to develop the implementation plan
- Discussions with NHS England based on Board outcomes to define next steps
- Chair and CEO appointments process
- ICB Executive team consultation
- All staff consultation

2.7. The ICB continues to work towards 1 April 2026 as the start date for its new, reduced funding envelope.

Local Response

2.8. Whilst the ICB progresses with the merger decision and designing its new structure to meet the 50% reduction in resources, the leadership of the local ICP has taken discussions to our local ICP Executive Committee and we are in the process of completing a mapping exercise with a view towards integration across the partnership in the absence of an ICB staffing component within the borough-based partnership. The "integrator function" is expected to host any team members that support the development of Neighbourhood Teams and the progression of the ICP Partnership's priorities. We are also looking at whether partner organisations can take on more of the transformation functions that the ICB borough team are currently delivering, within their own transformation teams.

2.9. Bi-lateral meetings between each partner organisation and the ICP leadership team are happening during July and there will be discussions on an options paper at the next ICP Executive on 6th August 2025.

3.0 Contribution to Borough Plan Priorities & Strategic Context

3.1. Health and Wellbeing Strategy 2022-2027 – the national reforms are intended to have a more strategic focus on reducing health inequalities across all North West London boroughs, including Brent.

3.2. SEND Strategy 2021-25 – there is a national review of SEND legislation that the government is currently undertaking, and any structures will need to reflect these changes. Structures and posts within the ICB will need to reflect its changed statutory duties.

4.0 Stakeholder and ward member consultation and engagement

4.1. Working effectively with partners to take forward the Model ICB Blueprint

4.2. Whilst the decision following the board will be an important step forward for us, the model ICB development work continues in many areas, with a particular focus on those functions/ services which will no longer be delivered by the ICB.

4.3. This includes but is not limited to the neighbourhood integrator function, CHC, Complex care and some primary care functions.

4.4. Key points for partners at this time:

Co-design – the ICB is keen to continue to work most effectively with system partners to co-design the approach for services where responsibility for delivery is expected to transfer.
Staff - given all partners are having to restructure to some extent, we would like to work together to support staff and minimise the burden of redundancies.

4.5. To outline any consultation undertaken with stakeholders in developing the proposals and recommendations (both statutory and non-statutory) along with the engagement of ward members (where relevant).

4.6. Likewise, at a local level the Managing Director or the ICP will be engaging with all of the partner organisations about the best way to take the partnership forward in the absence of an ICB-hosted team, mapping current priorities and functions against future requirements and attempting to land a more provider-led transformation solution.

5.0 Financial Considerations

5.1. All ICBs in England are required to significantly reduce their operating costs by an average of 50% across England, and to hit an operating costs target of £19 per head of population.

6.0 Legal Considerations

6.1. Due regard will be given to legal human resources considerations e.g. where TUPE applies this will be honoured, and relevant contractual obligations to employees will be honoured such as contractual redundancy payments.

6.2. There are some legislative changes that the government is currently considering to frameworks such as the SEND framework, and both the council and the ICB in its future guise will need to adapt and comply with any changed legislative framework.

7.0 Equity, Diversity & Inclusion (EDI) Considerations

7.1. Equality and diversity will be monitored during the process and any ICB selection process to new posts within the structure will be designed to promote equality and diversity in selection.

8.0 Climate Change and Environmental Considerations

8.1. The ICB merger and reduction in headcount is likely to have a positive impact on climate change since it may allow for rationalisation of office space and the burning of fossil fuels to heat such offices.

9.0 Human Resources/Property Considerations

9.1. The changes will have an impact on ICB staff, with significant changes being made to the structures. Redundancies, whether through voluntary or compulsory means, will be required and the ICB will need to ensure that it meets best practice in change management processes to manage this change. If possible, staff will be redeployed within the NHS where they are displaced.

10.0 Communication Considerations

10.1. Decisions regarding the potential merger of the ICBs will be communicated via the ICB Communications Team following the decision with all key stakeholders, including the Council.

10.2. Ongoing communications regarding the restructuring and the 50% cost savings will take place via the Managing Director of the ICP into the Corporate Director of Service Reform and Strategy and the Chief Executive of the Council.

Report sign off:

Rachel Crossley
Corporate Director of Service Reform & Strategy

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Brent NHS North West London	**Brent Health and Wellbeing Board** 24 July 2025
	Report from Rachel Crossley Corporate Director of Service Reform and Strategy
	Lead Cabinet Member - Councillor Nerva, Adult Social Care, Public Health and Leisure

Better Care Fund - End of Year 2024-25 Reporting

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	N/A
List of Appendices:	N/A
Background Papers:	N/A
Contact Officer(s): (Name, Title, Contact Details)	Antoinette Jones Head of Place, Brent Borough Brent ICP Email: antoinettejones@nhs.net --- Eleanor Maxwell Senior Programme Officer Better Care Fund Lead for Brent Borough Email: eleanor.maxwell@brent.gov.uk Telephone: 020 8937 2195

1.0 Executive Summary

1.1 The purpose of this report is to present the End of Year (EoY) report for the Better Care Fund (BCF) 2024/25 which was submitted to the BCF team and NHS England (NHSE) on 6th June 2025.

1.2 This report seeks formal ratification from the Health and Wellbeing Board (HWBB) for the End of Year report, it should be noted that it has been signed off, pending formal HWBB approval, by Rachel Crossley, Corporate Director for Service Reform and Strategy under delegated authority, in order to meet the national submission deadlines.

1.3 It was also signed off by Northwest London Integrated Care Board (NWL ICB), Brent's Chief Finance Officer and reviewed by borough-based colleagues in Health, Adult Social Care and Finance.

2.0 Recommendation(s)

2.1 That the HWBB approve the 2024/25 Better Care Fund End of Year report.

3.0 Detail

3.1 The BCF Plan aligns with both Brent Council's Borough Plan 2023–2027 and the Health and Wellbeing Strategy 2022–2027, contributing particularly to Strategic Priority 5: *"A Healthier Brent."* The plan supports efforts to reduce health inequalities and deliver integrated, place-based health and care services tailored to the needs of Brents population. BCF schemes are structured to contribute directly to the outcomes outlined in both strategic documents.

3.2 Key points to note:

- 3.2.1 Brent Borough successfully met all National Conditions, including securing a signed Section 75 (S75) agreement.
- 3.2.2 A formal agreement was formally agreed by key partners in NWL ICB and Brent Council on 31st October 2024
- 3.2.3 Expenditure was reported in line with the agreed plan for 55 of 65 total schemes. The remaining schemes, which reported either underspends or overspends that balanced overall, reflect positively on the strengthened governance and financial monitoring processes. These variances demonstrate the system's responsiveness to local needs, a commitment to transparency with partners, and ongoing efforts to align spend with optimal outcomes for residents.
- 3.2.4 All spending, including variances, is tracked quarterly within the Council and subject to oversight and approval by the BCF Board.

4.0 Stakeholder and ward member consultation and engagement

4.1 All BCF End of Year reporting has been reviewed and agreed upon by relevant stakeholders.

4.2 There are no additional stakeholder and ward member consultation and engagement comments specific to this paper.

5.0 Financial Considerations

5.1 The table below summarises the financial values reported in the End of Year submission.

5.2 An overspend was reported under NHS Minimum Health contribution due to higher equipment costs in scheme 53. This was re-imbursed to the Council by NWL ICB.

5.3 An underspend was reported for the ICB Discharge due to lower staff costs within NWL ICB's Strategic Support Team, scheme 110.

Funding Source	Budget 24/25	EOY Actual	Difference
DFG	£5,799,407.00	£5,799,407.00	£0.00
IBCF	£13,344,692.00	£13,344,692.00	£0.00
NHS Minimum - LA	£10,114,127.00	£10,114,127.00	£0.00
NHS Minimum - Health	£18,729,888.00	£18,972,028.00	-£242,140.00
Additional NHS Contribution	£1,216,000.00	£1,216,000.00	£0.00
LA Discharge	£3,118,175.00	£3,118,175.00	£0.00
ICB Discharge	£3,124,905.00	£3,122,851.00	£2,054.00
Total	**£55,447,194.00**	**£55,687,280.00**	**-£240,086.00**
			Difference -ve = OVER BUDGET

6.0 Legal Considerations

6.1 None – S75 for 2024-25 remains in place to support the pooled funding arrangements.

7.0 Equity, Diversity & Inclusion (EDI) Considerations

7.1 None, as all the existing and new programmes will be delivered to all qualifying patients across Brent.

8.0 Climate Change and Environmental Considerations

8.1 There are no specific climate and environmental considerations relating to this paper.

9.0 Human Resources/Property Considerations (if appropriate)

9.1 There are no specific Human Resources / Property considerations relating to this paper.

10.0 Communication Considerations

10.1 There are no specific communication considerations relating to this paper.

Report sign off:

Rachel Crossley

Corporate Director of Service Reform and Strategy

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Brent NHS North West London	**Brent Health and Wellbeing Board** 24 July 2025
	Report from Rachel Crossley Corporate Director of Service Reform and Strategy
	Lead Cabinet Member - Councillor Nerva, Adult Social Care, Public Health and Leisure

Better Care Fund Plan Approval 2025/2026

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	N/A
List of Appendices:	None
Background Papers:	N/A
Contact Officer(s): (Name, Title, Contact Details)	Antoinette Jones Head of Place, Brent Brent Borough Brent ICP Email: antoinettejones@nhs.net --- Eleanor Maxwell Senior Programme Officer Better Care Fund Lead for Brent Borough Email: eleanor.maxwell@brent.gov.uk Telephone: 020 8937 2195

1.0 Executive Summary

1.1. The purpose of this report is to provide an update on the planning process regarding the Better Care Fund (BCF) planning process for the financial year 2025-26.

1.2. An interim update was presented to the Health and Wellbeing Board (HWBB) on 2nd April. At that time the final plan could not be shared as the HWBB submission date was in advance of approval process with all partners and the submission deadline.

1.3. The final BCF plan for Brent, developed in partnership including Northwest London Integrated Care Board (NWL ICB) was submitted on time to NHSE on Friday 31st March. It was approved in advance by NWL ICB, Rachel Crossley,

Corporate Director of Service reform and Strategy with delegated authority from the HWBB and overseen by Councillor Neil Nerva, Lead Cabinet Member Health. It was formally approved by NHS England on 30th May. Work is now underway to finalise the S75 contract between Brent Council and NWL ICB.

2.0 Recommendation(s)

2.1 HWBB members are asked to review and formally approve the BCF Plan for 2025/26.

3.0 Detail

Contribution to Borough Plan Priorities & Strategic Context

3.1. The BCF Plan aligns with Brent Council's Borough Plan 2023–2027 and the Health and Wellbeing Strategy 2022–2027, contributing particularly to Strategic Priority 5: *"A Healthier Brent."* The plan seeks to reduce health inequalities and deliver place-based health and care services tailored to local needs. It includes schemes designed to meet the outcomes of both the Borough Plan and the Health and Wellbeing Strategy.

Background

3.2. The previous BCF Plan (2023–25) covered two years with a minor update in year two. The 2025/26 plan represents a new plan covering a single financial year. A comprehensive review of all local authority-led schemes was conducted to ensure full compliance with BCF requirements, strategic alignment, value for money, and demonstrable impact.

3.3. Development of the plan required joint agreement and formal sign-off by Brent Council and NWL ICB to ensure compliance with national conditions and local priorities.

3.4. **Factors considered in the planning process**

- **NHS Minimum Contribution:**
  Increased by 3.9%, a more modest growth than the historical 5.66% uplift.

- **Overall Funding Status:**
  Most funding remains static

- **Additional ICB Funding**
  Funding was reduced by 50% to £621,072((from £1,216,000 in 2024/25). This was communicated on 20th March - just 10 days before the submission deadline – leaving extremely limited time to make informed and strategic adjustments.

- **Funding Pressures:**
  Rising operational costs have resulted in a real-terms reduction in available funding. As a result, efforts have primarily focused on

maintaining funding for existing schemes, leaving limited capacity to support new or transformational schemes.

- **Tighter Timescales:**
  The submission deadline of 31st March significantly shortened the planning period compared to previous years.

- **Strengthened Governance:**
  The Brent BCF Board has enhanced its governance framework, clarifying roles, strengthening accountability, and improving performance monitoring.

- **Improved Budget Management:**
  In 2024/25, Brent Council implemented improved processes for budget allocation and tracking, enhancing financial oversight and supporting planning confidence going in the new year.

Impact of Funding Reduction in Additional ICB Contribution

3.5. On 20th March 2025, NWL ICB confirmed a 50% reduction in Additional ICB Funding for Brent. This equates to a loss of £864,925 when comparing the total funding available under the 2024/25 plan (inclusive of Section 75 funding of £270,000).

3.6. The Borough-based team, in collaboration with the Director of Adult Social Care and the Integrated Care Partnership (ICP) Managing Director, have undertaken a detailed analysis to conduct a risk assessment to identify the implications and appropriate mitigation options. A review to understand options to mitigate the impact is ongoing and working with system partners.

3.7. In 2024/25, only 3 schemes were funded through the Additional Contribution, significantly limiting flexibility for cost reduction:

1. Step-down beds
2. LA staff in the reablement team
3. Physiotherapy team at CLCH delivering the rehabilitation function of integrated reablement service.

3.8. The majority of cost savings were realised by withdrawing funding from the third scheme—the physiotherapy function—on the basis that it had the least immediate impact on hospital discharge pathways. Additionally, one step-down bed was decommissioned for a nine-month period. A comprehensive risk assessment has been completed and shared with stakeholders. In response, a project has been initiated to review the current service model and pathways for Rehabilitation and Reablement. This includes:

1. Developing short-term options to ensure rapid access to therapy
2. Designing a long-term, sustainable service model that meets future demand

3.9. Despite mitigation efforts, the funding reduction will negatively impact Brent residents, leading to increased waiting times, missed opportunities for optimal intervention, and higher long-term care costs.

4.0 Stakeholder and Ward Member Consultation and Engagement

4.1 All BCF schemes commissioned by the local authority have been reviewed and agreed upon by the required stakeholders.

4.2 There are no further stakeholder and ward member consultation or engagement comments specific to this paper.

5.0 Financial Considerations

5.1 Funding

This table details the income within the BCF.

BCF Income - 2024/25 and 2025/26

Funding Source	Plan 24/25	Plan 25/26	Difference 25-26 to 24-25 (+ve = increase, -'ve = decrease)	Notes
DFG	£6,597,406	£6,597,406	£0.00	
Better Care Grant (new name for the IBCF and LA discharge funds combined)	N/A	£16,462,867	£0.00	Now all recurrent funding - very positive development supporting longer term planning.
LA Discharge Funding (now Better Care Grant)	£3,118,175	N/A		Now part of Better Care Grant, previously non recurrent.
iBCF Contribution (now Better Care Grant)	£13,344,692	N/A		Now part of Better Care Grant, previously recurrent funding.
NHS Minimum - Total (now also includes the ICB Discharge Funding)	£28,844,015	£32,418,883	£3,574,868.00	3.9% uplift v LY. Detailed breakdown in grey below.
NHS Minimum - LA	£10,114,127	£10,511,117	£396,990.00	This is the minimum figure set within the BCF by NHSE and part of the governance for the planning process. Uplift is not applied equally between NHS and LA portions.
NHS Minimum - Health	£18,729,888	£18,782,861	£52,973.00	
EX ICB Discharge - LA	N/A	£2,873,080	£0	Split to demonstrate the breakdown between LA and Health Commissioning
EX ICB Discharge - Health	N/A	£251,825		
NWL ICB Discharge Funding	£3,124,905	N/A		
Additional NHS Contribution	£1,216,000	£621,072	-£594,928.00	50% reduction, plus 2.6% uplift. This does not include the £270,000 removed from the BCF and transferred to LA via S75 in 24/25 and at risk for 25/26.
Total	**£56,245,193**	**£56,100,228**	**-£144,965.00**	
	Total Plan in 24/25	**Total Plan in 25/26**	**Total funding change between 24/25 and 25/26**	

Total LA Funding change between 24/25 and 25/26	**-£197,938.00**
Total Health Funding change between 24/25 and 25/26	**£52,973.00**

6.0 Legal Considerations

6.1 There are no legal implications at this time. A new Section 75 agreement will be required to cover the 2025/26 period and is in development currently.

7.0 Equity, Diversity & Inclusion (EDI) Considerations

7.1 There are no specific EDI considerations arising from this report. All services will continue to be delivered to eligible residents across Brent.

8.0 Climate Change and Environmental Considerations

8.1 There are no specific climate and environmental considerations relating to this paper.

9.0 Human Resources/Property Considerations (if appropriate)

9.1 There are no specific Human Resources / Property considerations relating to this paper.

10.0 Communication Considerations

10.1 There are no specific communication considerations relating to this paper.

Report sign off:

Rachel Crossley

Corporate Director of Service Reform and Strategy

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