MINUTES OF THE HEALTH AND WELLBEING BOARD
Held as a hybrid meeting on Thursday 17 September 2026 at 6.00 pm

Members in attendance: Councillor Grahl (Chair), Councillor Knight (Brent Council - alternate), Councillor Chadha (Brent Council), Councillor Rubin (Brent Council), Councillor Johnson (Brent Council - alternate), Dr Rammya Mathew (Vice Chair / Brent ICP), Dr Radhika Balu (GP & Clinical Director – Mental Health, WNL ICB), (Jackie Allain (Director of Operations, CLCH), Robyn Doran (Director of Transformation, CNWL, and Brent ICP Co-Chair), Katherine Shaw (CEO, HealthWatch Brent), Dr Ruth du Plessis (online) (Interim Director of Public Health and Leisure, Brent Council – non-voting), Claudia Brown (Director Adult Social Care, Brent Council – non-voting), Nigel Chapman (Corporate Director Children, Young People and Community Development, Brent Council – non-voting)

In attendance: Wendy Marchese (Strategic Partnerships Manager, Brent Council), Hannah O'Brien (Senior Governance Officer, Brent Council), Tom Shakespeare (Brent ICP Director), Shivani Dhrona (Neighbourhood Transformation Manager, Brent ICP), Mai Stafford (Head of Health Evidence and Insight, Brent Council), Nicola Brownjohn (Independent Chair, Brent Safeguarding Adults Board)

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

Apologies for absence were received from the following:

- Kim Wright (Chief Executive, Brent Council)
- Councillor Muhammed Butt (substituted by Councillor Knight)
- Councillor Dixon (substituted by Councillor Johnson)
- Patricia Zebiri (Healthwatch Brent)
- David Crawley (Healthwatch Brent)
- Daniel Shurlock (Head of Place Leadership, Brent Council)
- Simon Crawford (Deputy CEO, LNWHT)
- Rachel Crossley (Corporate Director Service Reform and Strategy, Brent Council)

2. **Declarations of Interest**

Dr Rammya Mathew declared a personal interest as GP at King's Edge Medical Centre, part of Kenton North Primary Care Network (PCN).

3. **Minutes of the previous meeting**

RESOLVED: That the minutes of the previous meeting, held on 16 April 2026, be approved as an accurate record of the meeting.

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

None.

5. **Safeguarding Adults Board 2025-26 Annual Report**

The Board received the Brent Safeguarding Adults Board Annual Report for 2025-26 from Nicola Brownjohn (Independent Chair of the Brent Safeguarding Adults Board), who highlighted the following key points from the report:

- She highlighted the importance of her independence in the role of Safeguarding Adults Board (SAB) Chair, bringing all key agencies and partners together to support safeguarding in the local area.
- The Board was required to work to a strategic plan, which for 2024 until the start of 2026 had focused on three main priorities; self-neglect; substance misuse and housing and; strengthening the learning from Safeguarding Adult Reviews (SARs).
- In relation to self-neglect, a toolkit had been developed for practitioners, and the SAB was now testing the impact of that and whether it was useful for staff. Whilst no longer a priority for the next year, self-neglect and the toolkit would be monitored over the next few years.
- The housing and substance misuse priority had been established following two SARs that had themes around housing and substance misuse and the complexities of that. Due to some of the needs of those who misused substances, the focus going forward for the next year would be around monitoring the learning from the deaths of those who misused substances.
- The final priority around implementing learning from SARs was now completed, with new governance arrangements for that.
- The annual report also presented the new strategic priorities identified at the SAB development day in January 2026; safeguarding those with complex care and support needs and; mental health and suicide prevention, particularly through a homelessness and substance misuse lens, working with the Public Health Team.
- In relation to the new priority around safeguarding those with complex care and support needs, Nicola Brownjohn explained that this included reviewing cases of those who did not meet the threshold for a Section 42 Safeguarding Enquiry, how partners worked together to understand what was going on for that person to prevent that case from becoming a Section 42 Enquiry in the long-term.
- Alongside the two priorities, the SAB would have ‘golden threads’ around community engagement, digital inclusion and monitoring the workforce.

The Chair thanked Nicola Brownjohn for her introduction and invited contributions from those present. The following points were made:

- The Board asked why the SAB had moved away from the priority around substance misuse and housing for the next year. Nicola Brownjohn advised that Public Health was already working with the Substance Misuse Team and the Housing Team within the Council to look at the housing needs of those who misused substances and it was felt that the SAB had gone as far as possible with that priority without duplicating existing workstreams. In addition, because a national requirement to review all deaths of those who misused substances had been established, it was felt that work was being captured through those different areas and if there was any learning to be had it would come through those workstreams.
- The Board asked whether the SAB was satisfied there was sufficient joined up working between the Homelessness Prevention Team, other housing services, Adult Social Care and safeguarding teams. Nicola Brownjohn advised that a Task and Finish Group, chaired by Crisis, was looking at how well those partnerships were working, particularly as housing was a consistent issue coming up in SARs. Peabody, a social housing

provider, was also taking part in SAB now and helping with issues around private housing. Claudia Brown added that there was a Housing and Mental Health Subgroup in Adult Social Care that had a very good relationship with housing, particularly for vulnerable residents. Adult Social Care also worked closely with housing through CMARAC, such as whether it was appropriate to move individuals involved in cuckooing which needed housing input.

- The Board asked if the SAB did any work around cuckooing. Nicola Brownjohn advised that the second year of the current strategic plan had a golden thread focused on cuckooing and exploitation. The SAB had recently given endorsement to the Community Safety Protocol for Cuckooing and monitored cuckooing and other elements of exploitation through the multi-disciplinary CMARAC ensuring those individuals were seen as vulnerable and in need of safeguarding. A Task and Finish Group would be established in January 2027 around cuckooing and exploitation and the SAB podcast was due to publish a discussion around cuckooing, raising awareness of the new legislation and linking that with the children's partnership and its links with county lines. The Board welcomed the cuckooing safety protocol and that the SAB would be learning from data gathered around that.
- Robyn Doran confirmed that, whilst the restructure within the health system saw the ICB stepping back from the local position, it had been felt important that the SAB had a local ICP representative, particularly given the overlap on inequalities work, which had been agreed. She felt that having a local seat would ensure the ICB remained in touch with the trends and challenges within safeguarding.
- The Board asked whether the SAB had received reassurance that partners were working effectively with other local areas where there were individuals or cases involving more than one local authority, such as vulnerable adults who may move house or access services in more than one borough. Nicola Brownjohn advised that the SAB had identified a real strength in Brent in terms of taking individuals from other boroughs and sometimes continuing to work with individuals when they were no longer living in the borough. When people came through the Front Door and it was unclear who they were or where they were from, and she felt the investigation that took place was very good and the Front Door was very good at helping to connect individuals with services, including in other boroughs. Claudia Brown emphasised that Adult Social Care took a risk first approach, where individual cases were taken on without prejudice until that person was made safe, and once that had taken place, the local authority then worked to ensure the person was receiving services from the right place.
- In relation to self-neglect, the Board asked about wider communications or community engagement and how the community could play a role in identifying those who needed help. Nicola Brownjohn advised that the self-neglect toolkit had been launched a year ago, and the SAB was now reviewing how that was being implemented. The next step would be around community engagement work and developing easy read versions of the annual report for the lay person. She added that the self-neglect policy was published on the website, with clear descriptions around the stages in which to make a referral. Adult Social Care had recognised that this was not being utilised as much as it could so work was being done to promote that.
- As Cabinet Member for Housing, Homelessness and Renters, Councillor Johnson had recently met with Crisis, who had advised that they often dealt with individuals who did not want to access or receive help. He asked what support and guidance was provided in those circumstances to try to encourage individuals who were reluctant to engage to access services. Claudia Brown advised that Adult Social Care could still work with

those individuals as much as possible. She provided a recent example where a man had been living in his car and did not want to engage with services, but by building up a relationship the Council had now provided temporary accommodation for that person. Adult Social Care often worked with people when they were homeless or rough sleeping, visiting them on a regular basis, escorting them to appointments if needed and helping to move them off the street.

- In relation to domestic abuse and violence against women and girls, the Board asked whether the SAB had any focus on those issues. Nicola Brownjohn advised that this was overseen by the Community Safety Partnership and the Violence Against Women and Girls (VAWG) Panel, which did report to the SAB but the SAB did not oversee that work. Claudia Brown added that there was also a Vulnerable Adults Chairs Board where Chairs came together to discuss cases and referred cases to each other's Board's for advice where appropriate.
- Claudia Brown advised that all staff had now been trained on shared care planning and the service was building on the use of that.
- In relation to the timetable for a single patient record where all relevant services could access the same record, Dr Rammya Mathew advised that this was a national programme that was still a work in progress. Tom Shakespeare explained that this had been delayed because the national programme had subsumed the London Care Record implementation, and there was not yet a timetable for that. He agreed to provide an update on progress at a future meeting.

In concluding the discussion, the Chair thanked representatives for their responses and asked members to note the report.

6. West and North London 10-Year Strategy

The Board received a report and presentation from Radhika Balu introducing the emerging West and North London (WNL) 10-Year Strategy, developed following the creation of the new WNL Integrated Care Board (ICB) and aiming to improve population health outcomes, reduce inequalities, and make better use of the £12bn health and care budget. She sought the Health and Wellbeing Board's views on how the proposed strategic direction could be translated into local priorities, partnerships and delivery plans, which would ensure that the strategy reflected local priorities, supported delivery at borough level, and contributed to improving outcomes for residents across the system. Specific areas in the strategy focused on; population health and health inequalities, with emerging population priorities around early years and family support, children and young people, adults living with serious mental illness, people at risk of, or living with, long-term conditions, adults with complex health and social needs, healthy ageing and end-of-life care; prevention and early intervention; neighbourhood health and integration and; financial sustainability. The Health and Wellbeing Board's role within the strategy was around anchoring the strategy in borough priorities and JSNAs, aligning shared delivery across partners, defining local commitments, actions and ownership, and providing a clear route for feedback into the ICB. The presentation included as an Appendix in the agenda pack outlined some of the actions that would be undertaken and the expected outcome for residents and services.

The Chair thanked Radhika Balu for her presentation and invited comments and questions from Board members, with the following points raised:

- The Board echoed the aims and ambitions of the strategy, which councillors in particular highlighted was what the Council wanted to happen in the borough, with an area-based strategy. Dr Mathew agreed that the priority areas did chime with what partners were working towards in Brent, particularly around early years and

early intervention, and that approach had been adopted in Brent through family clinics and child friendly practices which had been shared as good practice with WNL ICB.

- The Board asked whether staff had been engaged on what they believed should change or be included in the strategy. Radhika Balu responded that the workforce felt that, whilst they did a lot for patients, many aspects of residents' lives impacting their health was outside of health staff's control such as housing and employment. From a management point of view, it had been recognised that there was a need to educate the workforce further about the wider determinants of health and to come together with other partners and services to find solutions for patients.
- The Board acknowledged that the figures on tooth decay for young people aged 1-3 years old were not where they hoped, and asked what the ICB wanted to see in the next ten years in terms of improving that figure. Radhika Balu advised that tooth decay was not solely a medical issue but also about how health services came together with public health, early years, and parents and carers to address the issue, such as through supervised tooth brushing or working in nurseries. Work in Harrow had shown that the number of hospital admissions relating to tooth decay could be reduced.
- In relation to the 1% left shift investment into neighbourhoods, the Board asked whether the need to reduce hospital admissions of adults with complexity living with multiple long-term conditions would deter partners from doing that prevention work. Radhika Balu responded that the 1% investment would most likely be allocated to early years and the core offer across the WNL area, including for CAMHS and the children and young people model. There was a lot of focus looking at how the ICB could deliver neighbourhoods well for children.
- Nigel Chapman advised that he and other Directors of Children's Services across the 13 boroughs were meeting regularly with the ICB around the children's workstream, with a priority focus on SEND. There was a full SEND reform programme being delivered which improved the way children's services worked with health and other partners around prevention and managing demand in early years. This connected to Best Start in Life which formed another priority, and there was also a mental health priority. He had recently met with the ICB and emphasised the need for equity in levelling up funding across the piece, and he felt there was a commitment from the new ICB to look at the data around that. The final area of priority for the children's workstream was around safeguarding the Family's First Partnership Programme which introduced a different approach to safeguarding and the role of health in multi-agency child protection teams.
- Ruth du Plessis welcomed the report and assured the Board that Public Health had been given the opportunity to contribute to the strategy. She welcomed the wider perspective on the social determinants of health which it was hoped would be backed with investment and funding. Public Health had also started work on Brent's Joint Health and Wellbeing Strategy and had been consulting with NHS colleagues to ensure there was alignment and joint learning.
- The Board asked whether the work would rely on AI and digital to succeed. Radhika Balu made the point that Imperial College Healthcare NHS Trust had recently ran a survey of 600 young people across North West London asking about AI and digital tools, and she had been surprised that the findings showed 75% of young people who responded did not prefer digital and AI tools and wanted more face-to-face interactions. However, digital tools were needed for primary care, secondary care

and community services in order to help healthcare services speed up and improve productivity and efficiency, so the ICB was planning to invest there, particularly with primary care where a Primary Care Digital Lead had been appointed.

- The Board was pleased to see a focus on inequalities in the Strategy but raised doubts over whether that priority would succeed. For example, they expressed that maternal healthcare had worsened, with the maternal mortality rate the highest it had been for over 20 years and disproportionately impacting Black and Asian communities. Despite this, the Royal Free Hospital Maternity Provision was being closed despite opposition from residents, the Council and local MPs. They also highlighted that healthy life expectancy had decreased by 3 years in the last decade, and therefore asked what this strategy would do differently to tackle inequalities and whether local areas should expect more frontline services to close. From a Strategy point of view, Radhika Balu advised that the strategy promised equity of care that was proportionate to the needs of the patient and the community which would support tackling inequalities in a hyper local way. Black and Asian populations were seeing worse health outcomes and therefore the strategy recognised the need to deliver services in a different way, asking residents how they needed their care delivered according to their needs. Access was also an important aspect of the work, ensuring the information was correct and easily available and that services were flexible and responsive to needs. As such, the strategy focused on equal outcomes across communities which may not necessarily mean each community received the same services.
- Having heard the response to how the strategy would look to tackle inequalities and reduce service closures, the Board highlighted that it would be useful to see a stronger commitment to maintaining some of the core services that residents already had access to embedded within the strategy, reporting that people were genuinely worried about their frontline services and hospitals closing. They called on the NHS to provide more assurance to residents. Radhika Balu acknowledged the points and confirmed that WNL ICB would listen to residents around what services, including core services, they wanted and base the offer around residents needs and wishes. Following a request from the Board, she confirmed that this could be made more explicit in the strategy.
- The Chair highlighted that privatisation was a concern for residents, which had accelerated in recent years, and more residents were identifying this as a cause of services becoming harder to reach, less accessible and less efficient due to the need to tell their stories to multiple different companies and input data into multiple websites. She asked whether there would be a focus on keeping services in house. Radhika Balu responded that the commitment was to keep NHS services within the NHS and she would ensure the feedback regarding privatisation was taken into account and fed back into the Strategy.
- Noting that the Strategy was being developed making use of particular datasets, the Board asked whether officers felt that they had the right data to build the strategy on. Radhika Balu responded that the data the WNL ICB received was very rich from multiple sources including primary care, secondary care and social care, which informed the ICB what was happening with residents, who was presenting often at hospitals and who had long-term conditions. Service user feedback had also been used to inform the strategy. Wider stakeholders, including Directors of Children's Services, had also been consulted in the creation of the strategy.

However, she highlighted that the same data platforms were not available across the whole footprint, and establishing that was a work in progress.

- The aim was for the strategy to be in mobilisation by November 2026.
- Tom Shakespeare echoed the previous comments, particularly around the 1% left shift of investment. He added that there was still work needed on the common core offer, particularly around mental health and CAMHS.
- The Board acknowledged the significant period of change the ICB had recently underwent and the hard work by colleagues.

As no further issues were raised, the Board resolved to note the emerging WNL ICB 10-year strategy and its proposed direction of travel.

7. NHS Neighbourhood Health Framework: Confirming Neighbourhood Geographies

The Board received a report from the Brent Integrated Care Partnership (ICP) providing an update on the review to determine the most appropriate geographical footprints for NHS neighbourhood health in Brent, summarising the evidence and stakeholder feedback, outlining the different geographical options considered and recommending that Brent adopted four NHS neighbourhood footprints covering Harlesden, Wembley, Kingsbury and Kenton, and Kilburn and Willesden. The report detailed the rationale for that recommendation to support sustainable integrated neighbourhood working.

Tom Shakespeare advised that the aim of bringing the report to the Health and Wellbeing Board was to agree a way forward regarding neighbourhood geographies in Brent, which Health and Wellbeing Boards were legally required to do. He reinforced the notion that neighbourhoods were a critical part of the future operating model, as outlined in the NHS 10-Year Plan, and therefore it was important a decision on a way forward was made as soon as possible to ensure the operation of healthcare services continued to be delivered smoothly. Brent currently operated a 5 neighbourhood model and there had been different views around the geography and alignment of those, particularly Cricklewood and Mapesbury ward and Willesden and Kilburn, with extensive work done to engage stakeholders and come to a resolution on those areas. A workshop a year ago had looked at the different options and there had been engagement through multiple primary care partnership forums. The ICP had also engaged LMC to support the reaching of a resolution. The detail of responses and proposals received during consultation was outlined in the report, which showed that there was no overall consensus on the way that neighbourhoods should be configured. The options put forward by different groups had been considered by the ICP's Neighbourhoods and Inequalities Exec Group who now recommended Option A within the report, which was a shift from five to four neighbourhoods, bringing Willesden and Kilburn together into one neighbourhood. He added that if the Board did not agree to that approach, the ICP recommended staying as is, with five neighbourhood areas.

Robyn Doran added that, from an operational point of view, the recommendation was focused how the ICP supported neighbourhoods, and it was felt that four neighbourhoods was operationally the most deliverable option without diluting the teams delivering care across neighbourhoods.

Jackie Allain commented from a CLCH perspective that CLCH had followed an internal governance process to review the options, with all clinical service managers proposing what they thought the best configuration of neighbourhoods was. All clinical leads had agreed that the four neighbourhood model would be the best way for them to provide focused delivery of care.

From an ICB perspective, Radhika Balu advised that it was important for the neighbourhood boundaries to be agreed as soon as possible so that they could be operationalised and the WNL strategy could be mobilised.

The Chair advised Board members that she had received several requests to make representations and she had agreed that they could have three minutes each to make their remarks, with the following representations made:

- Dr Mohammed Najim from Willesden Green Surgery spoke on behalf of the GP practices in Cricklewood and Mapesbury and Kilburn neighbourhoods in support of the ICP Exec's recommendation to bring Willesden and Kilburn neighbourhoods together. He highlighted that the local communities of Willesden and Kilburn were very similar, with the average Kilburn resident aged 37 and the average Willesden resident aged 36.5. Approximately 75% of both neighbourhoods were ethnic minorities, and both Willesden and South Kilburn had areas of both severe deprivation and relative affluence. As a lifelong resident in what he believed was Willesden, Dr Mohammed Najim was surprised to see his home placed in Kilburn neighbourhood on the neighbourhoods map. He advised that the line between Willesden and Kilburn ran through Gladstone Park, alongside Melrose Avenue and Lydford Road, with the North Circular dividing Willesden from Kingsbury communities and Willesden High Road separating Willesden from Church End communities. However, residents did not live by those boundaries. In addition, he highlighted that every GP practice across Cricklewood and Mapesbury Ward had formally written to the ICP asking to join the Kilburn neighbourhood, which the Board paper recognised and which reflected over 10 years of joint working, with both neighbourhoods built on the historic Council boundaries serving 85,000 patients and with shared workforce, leadership and services. Whilst that option had been discounted, he felt that this merger was a fair and practical compromise preventing the breakdown of staff and services and building on work done across the neighbourhoods including the coming together of practices to vaccinate thousands during the Covid-19 pandemic, having the borough's only breast cancer screening pilot for women in collaboration with Royal Free Hospital, and having the highest uptake of any neighbourhood for the new innovative cervical cancer cell swap pilot. He felt that without the merger of Willesden and Kilburn, Kilburn would be left below viable scale, and therefore its patients would be left behind, and the merger enabled an established workforce to be kept whole at a sustainable scale.
- Dr Amanda Craig, Kilburn PCN Clinical Director and Kilburn Integrated Neighbourhood Team Lead, then addressed the Board to outline her thoughts on the proposed neighbourhood model. In addressing the Board, she advised that she had been a clinical leader in Brent for many years and had established the first locality commissioning pilot over 30 years ago with what now formed Kilburn and Mapesbury and Cricklewood. She advised that those areas had worked together delivering and designing services and arranging the commissioning of services for over 30 years. She felt it would be a shame not to build on that historic relationship and split Mapesbury and Cricklewood from Kilburn. She highlighted that the two PCNs in Kilburn and Mapesbury and Cricklewood had very strong leadership which was clinically and managerially majority female and delivering well for children and women. Due to the strong joint working of the practices, which she advised formed the only group of practices based on localities, she felt it important that these areas were not split.

- Dr Azhar Hawa, Co-Clinical Director of Harness South PCN and Co-Leader of Willesden Integrated Neighbourhood Team spoke on behalf of the Harness South PCN. He advised that Harness South PCN had worked in partnership and collaborated with all organisations in the neighbourhoods programme and would continue to do so to ensure services for patients continued to get better. He advised the Board that, in July, the ICP Exec wrote to Harness South PCN with two questions – where Cricklewood and Mapesebury should sit and whether Wembley PCN should split into two. The response from Harness South PCN took no position on where the wards should sit, but made one ask that any boundary change was considered collectively across all neighbourhoods together and against the same criteria to ensure alignment. He advised that the merger of Willesden and Kilburn into one neighbourhood was never put to Harness South PCN and clinicians only heard of the proposals at a partnership forum in September where it appeared the decision had already been made. The assessment made by the ICP Exec in July showed that Kilburn and Willesden's population alignment were rated as strong and the neighbourhood needing further consideration was identified as Wembley, however several months later the recommendation now left Wembley unchanged and merged the neighbourhoods that the ICP had rated as strong. He urged the Board to review the evidence in Appendix B in terms of population needs, which identified the differences in the two populations in terms of deprivation, children's health, language and housing, which he felt did not support averaging them into one neighbourhood. In concluding his remarks, Dr Azhar Hawa added that the recommendation noted the need to agree a new leadership and representation arrangements for the merged neighbourhood, but cautioned that this would be a decision taken regarding primary care leadership with no primary care member involved in that discussion. As such, he urged the Board to decline recommendation one.
- The final representation was from Dr Nigel de Kare-Silver, Principal GP at Gladstone Medical Centre and Clinical Director for K&W (S) PCN / Co-Clinical Director for Willesden Integrated Neighbourhood Team. In opening his statement, Dr Nigel de Kare-Silver informed the Board that he had been a GP for over 30 years, serving the community against the backdrop of multiple NHS reforms, and he very much welcomed the neighbourhood approach that the country was moving towards, which he felt was based on localism and co-design instead of the traditional top-down directives from central offices. The neighbourhood approach offered health services and partners the chance to look at unique sub-populations and their distinct ethnicities, disease patterns and attitudes to health, and support people at a hyper local level. He highlighted that Willesden had been recognised as one of only two mature Brent neighbourhoods, where the team had been meeting fortnightly for 2-3 years, building strong professional and community relationships and developing a shared learning programme.
- Dr Nigel de Kare-Silver advised Board members that Willesden neighbourhood had been able to engage with parts of Brent with the highest deprivation, and he felt that going forward the Willesden neighbourhood needed to be ready to apply top-down directives from central government in the future. Currently, 90% of elite group membership had voted against changing the boundary. At the most recent K&W South PCN meeting there had been zero support expressed for the proposed merge between Willesden and Kilburn, and he called on the ICP Exec to invest in Willesden to maximise healthcare without further delay.

- Further detailing the work happening in Willesden, Dr Nigel de Kare-Silver advised that he worked closely with Dr Azhar Hawa as co-Chairs of Willesden INT as well as public health analysts to map out priorities, with data showing Willesden had a high number of people with serious mental illness, the largest number of children aged 0-5 years old as well as older adults, and pollution caused by the North Circular Road identified as a cause of illness amongst the most deprived groups in the area. Willesden had also pioneered the new health hub paediatric model that was now being adopted across NWL and had delivered targeted children's services where most needed. He highlighted that, in his view, Kilburn and Willesden were distinct neighbourhoods with different geographies, population needs and disease profiles and he felt that each area needed localism. He stated that creating a large, merged neighbourhood between Willesden and Kilburn risked diluting that localism and would result in conflicting priorities on a limited budget.
- In concluding his remarks, Dr Nigel de Kare-Silver advised that Willesden was operationally ready to deliver, and asked the Health and Wellbeing Board to vote against a merge between Kilburn and Willesden to allow for a hyper-local approach reflecting the distinct needs of each of the populations, instead of further administrative delays to implement what he described as unnecessary and unwanted organisational change.

The Chair thanked those who had attended the meeting to represent their views and the views of their patients and organisations, and invited comments and questions from the Board. The following points were raised:

- In noting the proposal to move to a four neighbourhood model by merging Kilburn and Willesden neighbourhoods, and in hearing the representations made during the meeting and the written submissions received, the Board asked how two merged neighbourhoods with potentially different health needs would account for health disparities. Tom Shakespeare acknowledged that there were differences between each neighbourhood as well as differences in need within neighbourhoods. The suggested model put forward had been a weighing up of many different factors that the ICP Exec had made a judgement on, but he acknowledged that there was no perfect solution. Dr Rammya Mathew further explained that there was a balance to be had in relation to neighbourhood populations, where the aim was for the model to feel very local but there was also a need for neighbourhoods to be operational and able to deliver for residents. This required a certain amount of capacity from a primary care perspective as well as provider organisations who delivered care to communities. She explained that with the 5 neighbourhood model, Kilburn had the smallest population of around 34k registered patients, and Wembley had the highest number of registered patients at around 250k, which she expressed was a significant variance. The proposal to merge Kilburn and Willesden reduced that variance to some extent.
- The Board asked whether there were any reputational or financial risks if Brent Health and Wellbeing Board was unable to reach an agreement. Tom Shakespeare reminded the Board of the proposed 1% left shift in funding which would go to each WNL borough, which he anticipated would increase over the years, which was reliant on mobilising the agreed neighbourhood model. As such, he advised it was essential to have a settled position on the neighbourhood geographies. If the Health and Wellbeing Board was unable to reach a decision, the recommendation was that the default current neighbourhood position would remain.

- The Board asked what the staffing implications were with the proposed change. Jackie Allain advised that CLCH, as a provider of community services, had a variety of different teams with different numbers of staff, where some teams were much larger such as the community nursing teams who were able to manage the 5 neighbourhoods and some teams were much smaller such as the respiratory teams, heart failure teams and some children's teams where they struggled to cover the neighbourhoods because they consisted of only 5-6 people. As such, working within the 4 neighbourhoods gave those staff the ability to focus on a smaller number of neighbourhoods. Further explaining, she advised that the more neighbourhoods that were established, the more multi-disciplinary meetings clinicians were required to attend, which reduced the time clinicians had available to provide care. A reduction in neighbourhoods reduced the number of meetings clinicians were required to attend, meaning more time would be available to care for patients. Robyn Doran added that, operationally, the merging of the two neighbourhoods would make it easier for CNWL to align staff with patients.
- In terms of what patients wanted for their neighbourhoods, Tom Shakespeare advised that direct patient engagement had not taken place for these proposals because they were operational in nature and based on how health services organised around patients. Whilst direct engagement exercises with patients had not been undertaken, he understood that patients felt smaller areas were better to enable more direct engagement, accessibility and visibility, which was counter to what providers had fed back around how staff were arranged. As such, there was a need for a balanced position.
- Further discussing the impact of the changes on patients, the Board asked whether patients would see any difference in the service they received. Tom Shakespeare advised that in many ways the proposals were around how services were organised operationally and therefore the impact on patients should be relatively minimal. As an example, a patient attending a GP practice in Cricklewood and Mapesbury would remain with the same GP practice and would likely have very little awareness of how services and staff were commissioned and organised.
- Whilst it was recognised that the decision was operational, the Board asked what structures would be in place going forward so that local residents could have a say in the delivery of neighbourhood healthcare services. Tom Shakespeare responded that a lot of infrastructure for feedback had already been built, such as through community forums. A number of neighbourhoods already had established leadership teams with routes to ensure patient voices were heard, and those existing mechanisms would continue to be utilised. There were well established and deep connections with hard-to-reach communities and faith groups through the work of Brent Health Matters that could also be harnessed. The ICP Exec also wanted to ensure all partners were represented as part of the governance arrangements, including primary care, providers, voluntary and community sector organisations and others to ensure they were being heard across all parts of the system.
- Board members agreed with the sentiment that Cricklewood and Mapesbury did not easily fit into one neighbourhood or another, and understood the rationale for merging the two neighbourhoods together to enable Cricklewood and Mapesbury residents to benefit from the innovative work of both neighbourhoods, particularly Willesden's work around child health and Kilburn's work on frailty. Dr Rammya Mathew added that it was recognised that the merge was contentious, with a

strength of feeling from both those who supported the merger and those who opposed the merger, but from a primary care perspective it was important for all parties to see the opportunities in the decision made and not see the decision as a barrier for what primary care could do for residents.

- In terms of the wider benefits of neighbourhood working, Tom Shakespeare advised that the vision behind neighbourhood working was to wrap care around the patient by providing more integrated services closer to home to deliver better outcomes. Having a settled decision on neighbourhood geographies was an essential building block to enable that to happen.

As no further issues were raised, the Chair thanked officers for their responses and those who had attended to make representations regarding the proposals, as well as those who had provided written submissions during the process, and led a vote on the proposal to adopt four NHS neighbourhood health footprints for Brent. By a simple majority, the Board **RESOLVED:**

i) To agree the adoption of four NHS neighbourhood health footprints for Brent, comprised of the following wards:
   a. *Harlesden:* Harlesden and Kensal Green, Roundwood, Stonebridge
   b. *Wembley:* Northwick Park, Sudbury, Wembley Central, Alperton, Preston, Wembley Hill, Wembley Park, Tokyngton
   c. *Kingsbury and Kenton:* Kenton, Queensbury, Kingsbury, Barnhill, Welsh Harp
   d. *Kilburn and Willesden Green:* Kilburn, Queens Park, Brondesbury, Willesden Green, Dollis Hill, Cricklewood and Mapesbury.

ii) To confirm that support be provided by the ICP to the merged Kilburn and Willesden area to establish effective collaborative leadership and representation arrangements.

iii) To request a further update on neighbourhood health implementation is presented to the Health and Wellbeing Board.

8. Cancer Health Needs Assessment

The Board received a report from Mai Stafford presenting the Cancer Health Needs Assessment, outlining the statistics on cancer in Brent and the work being done to reduce cancer and its impact on Brent residents. In introducing the needs assessment, she advised that the report had been prepared in collaboration with public health, NHS services and insight from residents. The focus of the assessment was on the four most common cancers in the UK; breast, prostate, lung, and bowel, as well as the national screening programme for cervical cancer, and head and neck cancer where Brent's population had a high level of risk factors. She then highlighted some of the key statistics regarding cancer screening in the borough:

- Brent was underperforming on screening across the board, tracking below the NWL average for all three national cancer screening programmes (cervical, breast and bowel). HPV vaccinations were in decline and substantially lower than London and national averages. A substantial age gap in screenings was present with younger eligible cohorts having a lower screening uptake than older age groups. A low screening take up rate correlated with higher deprivation, and there were varying take up rates of screenings by ethnic groups.
- There was rising incidence in total cancer cases in Brent, with overall prevalence highest among white ethnic groups and individuals living in more deprived areas.

Those highest at risk of prostate cancer were Black ethnic groups which mirrored national trends, but she highlighted local qualitative research revealed a critical lack of awareness regarding prostate cancer symptoms and when/how to seek medical support among Black African and Black Caribbean residents. Head and neck cancer was a specific local concern due to higher than average rates, disproportionately affecting men and individuals form South Asian ethnic groups. Tobacco use, and specifically smokeless tobacco, was highly prevalent among men and South Asian communities and was identified as a major contributing factor to Brent's elevated rate of head and neck cancer.

- Diagnosis via national screening programmes or GP referrals led to significantly more timely diagnosis and better treatment outcomes compared to emergency routes. Brent was successfully moving away from emergency diagnoses, with the proportion of total cancers diagnosed via non-optimal pathways dropping by 11% between 2017 and 2024. Despite this, some cancers were more likely to show delayed diagnoses, and lung, bowel and cervical cancers were less commonly diagnosed through screening or GP referrals compared to total cancers.
- Both 3-year and 5-year survival rates were statistically significantly lower in Brent compared to NWL averages for cancers overall, specifically lung cancer, and survival rates were notably lower for head and neck cancer.
- Some of the cancer initiatives being provided in Brent focused on leveraging community assets through working with community champions to improve the reach and trust of cancer prevention services, and successful localised outreach models included the 'man van', providing prostate cancer screening for Black men, and Brent Health Matters outreach work and cancer screening awareness events. Public health and the ICP also delivered cancer programmes including Brent Stop Tobacco which provided digital support for the Smoke Free App, a culturally appropriate chewing tobacco cessation initiative, and proactive targeting of registered smokers by primary care with current tobacco users invited for lung cancer screenings, a non-responder bowel cancer screening call project, rollout of HPV self-sampling through primary care, and bespoke support for those in CORE20 most deprived communities to access cancer prevention and early diagnosis through Brent Health Matters.
- Brent and WNL ICB had detailed data for bowel, breast and cervical cancer screening that supported inequalities monitoring and improvement.
- Public Health aimed to integrate cancer prevention into other strategies, including a Men's health strategy and Food strategy.
- The Board was asked to acknowledge the findings of the needs assessment and advocate wherever possible for cancer services to keep services focused on cancer prevention and ensure cancer featured prominently in the new Joint Health and Wellbeing Strategy being drafted.

The Chair thanked Mai Stafford for her report and invited comments and questions from those present, with the following points raised:

- Ruth du Plessis made the point that almost half of the population would be affected by cancer in their lifetime, and so there was a need to ensure a focus on cancer and cancer prevention and garner as much support as possible to promote screenings and encourage people to come forward earlier for diagnosis and treatment. She

confirmed that cancer prevention would feature as one of the priorities of the new Health and Wellbeing Strategy.

- Board members advocated for the 'man van' and asked whether there would be a national screening programme for prostate cancer. Dr Rammya Mathew explained that there had been a significant national review conducted where the UK National Screening Committee decided against recommending a national screening programme for prostate cancer. During that review, a separate question asked whether a screening programme should be offered for particular communities, such as Black men in particular, and again the Committee stated that the evidence did not support recommending that. She confirmed that this had been a controversial decision amongst campaign groups who felt very differently and it was still a live topic of discussion. The message she and other primary care providers were giving in practice was that if someone felt they had risk factors, a family history of prostate cancer or felt concerned about their prostate cancer risk then they should come forward, and she reassured the Board that primary care was a lot more open to offering prostate cancer screening than it had been several years ago.
- Noting the national decision taken on prostate cancer screening, the Board asked whether there was any mechanism to undertake a local initiative on prostate screenings or whether Brent was bound by that decision. Radhika Balu advised that if a particular community was disproportionately affected by prostate cancer she would suggest the local partnership considered the option to undertake a pilot programme for specific communities, and that there was nothing preventing primary care going into the community to talk about screenings. Ruth du Plessis confirmed that a pilot to promote prostate cancer screening in particular areas would be possible, and she was pleased to hear the passion of the Board on this topic.
- Radhika Balu cautioned that vaccination rates were reducing. She reminded Board members that there was now significant evidence that the HPV vaccination prevented cancer, and therefore if the HPV vaccine uptake reduced in Brent then this would result in more cervical cancer rates in Brent in the future compared to other areas. As such, she emphasised the need to engage residents about vaccination and asked the Board to consider other options to prevent an increase in cervical cancer rates in the future. Dr Rammya Mathew advised that the HPV vaccination was delivered through schools rather than primary care through a commissioned service which was currently being reviewed by Public Health as it was felt that the delivery of the programme could be improved. She confirmed that there was a national target to eliminate cervical cancer by 2040 through screening and vaccination and therefore it was important to target those who were not taking up the screening and vaccination offer. Ruth du Plessis advised that there were early signs that uptake was increasing from the work Public Health was doing in schools to improve uptake, but highlighted the challenges in terms of the negativity and hesitancy towards vaccination from the Brent population. There was often misinformation around vaccinations and therefore deep engagement work was needed with communities in innovative ways to talk about the importance of vaccination in order to improve uptake.
- In relation to the statistic that the 3 and 5-year cancer survival rates in Brent were lower than the NWL average, the Board asked if there was any clear reason that might be. Ruth du Plessis advised that the national data showed people were not getting screened or coming forward for support when they got symptoms. Public Health and primary care encouraged anyone with a cough lasting longer than 3

weeks to see their GP and to see their GP if they discovered a lump in their breast. The preference amongst health professionals and Public Health was for people to come forward for a check and get a negative diagnosis rather than miss getting checked, particularly as the evidence suggested that the sooner someone came forward then the more effective their treatment and outcomes. She suggested the survival rates may also be affected by poor underlying health, smoking, pollution and lifestyle factors. Public Health continued to encourage people to live healthy lives as much as possible.

- The Board commended the bowel cancer self-screening test that had been sent to people over 60 and asked for an update on the outcome of that programme at a future meeting.

The Chair thanked officers and members for their input on this report and asked for a report back to the Board in the future outlining the different preventative health initiatives being undertaken in local communities to help prevent cancer, including the outcome of the bowel cancer screening programme and a proposal on taking forward a pilot on prostate cancer screening for specific communities. She asked Board members to continue to advocate for cancer prevention and early detection services and affirm that cancer prevention and care should be included in the new Health and Wellbeing Strategy in development.

9. **Forward Planning**

The Chair gave members the opportunity to highlight any items they would like to see the Health and Wellbeing Board consider in the future.

10. **Any other urgent business**

None.

The meeting was declared closed at 8:00pm

COUNCILLOR GWEN GRAHL, CHAIR