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

Health Inequalities/BHM Programme - update

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

1.0 Purpose of the Report

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

2.0 Recommendations

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

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

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

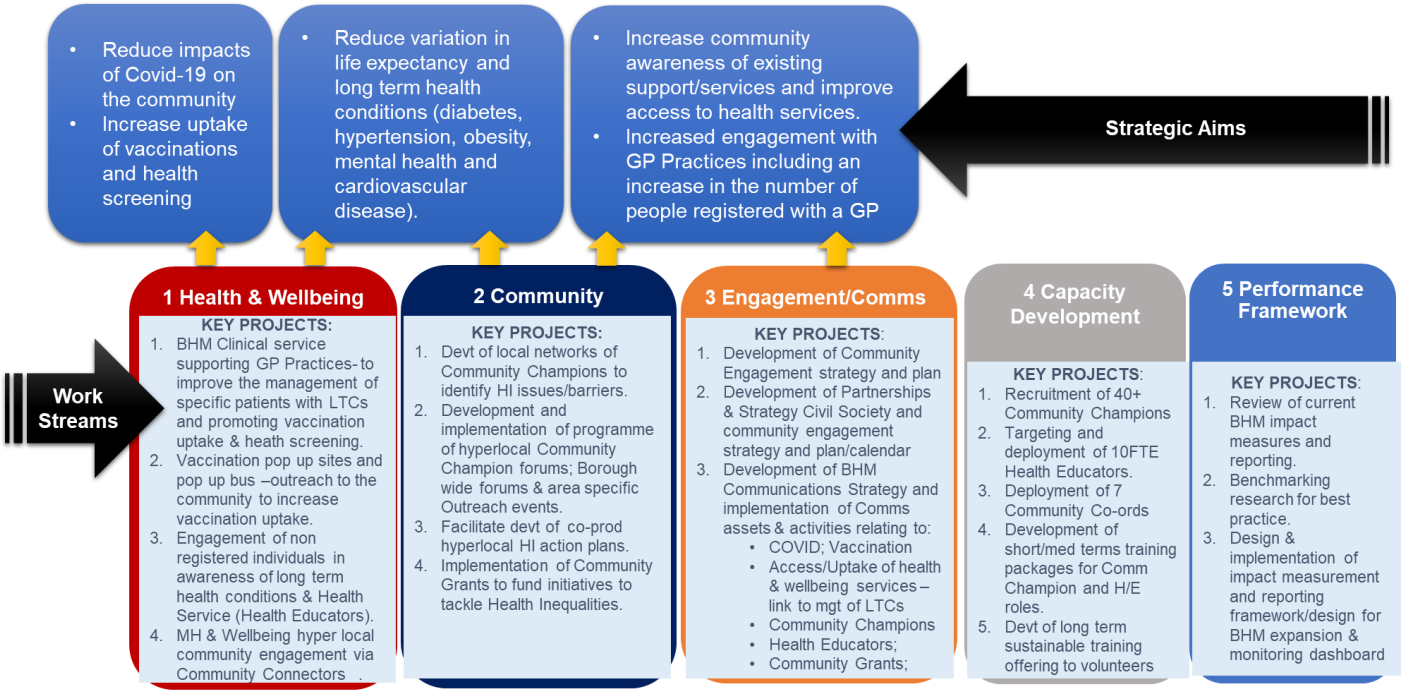
3.0 Brent Health Matters programme-approach to tackling Heath Inequalities

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

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

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

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



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

3.2 *Health and Wellbeing Work Stream: progress*

Brent Health Matters Clinical Service (BHMCS)

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

Activity Impact Measures:

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

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

Activity Impact Measure:

- 1,965 patients called
- 153 vaccinations booked

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

Activity Impact Measure:

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

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

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

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

Activity Impact Measure:

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

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

3.3 *Community Work Stream: Update*

Health Inequalities Community Engagement Capacity Building

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

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

Activity Impact Measures:

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

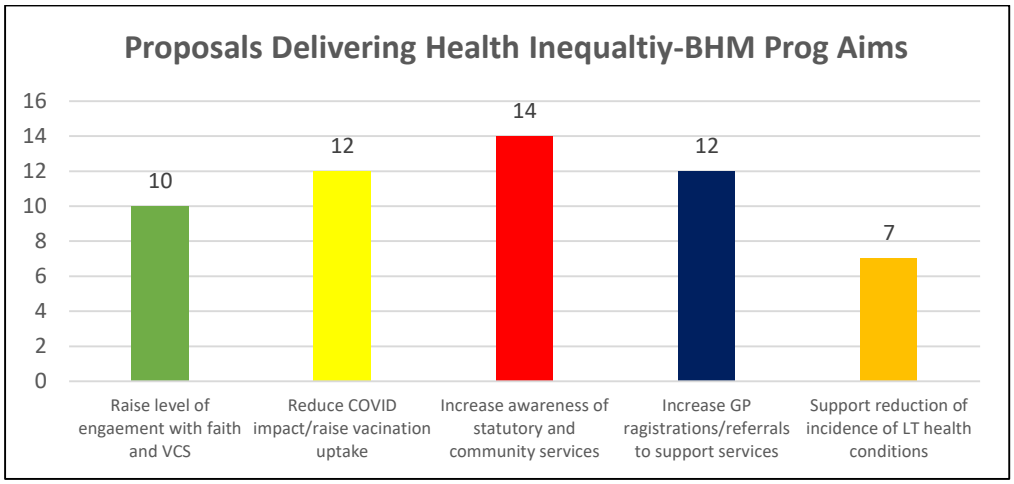
- Our Health Educators Partner, Brent Carers Centre are co-ordinating a delivery partnership that includes: SAAFI; PLIAS; Kilburn PCN; Brent Mencap; and Brent Community and have recruited 12 Health Educators to date (with 8 more in the pipeline) and are ensuring they have access to an extended range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

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

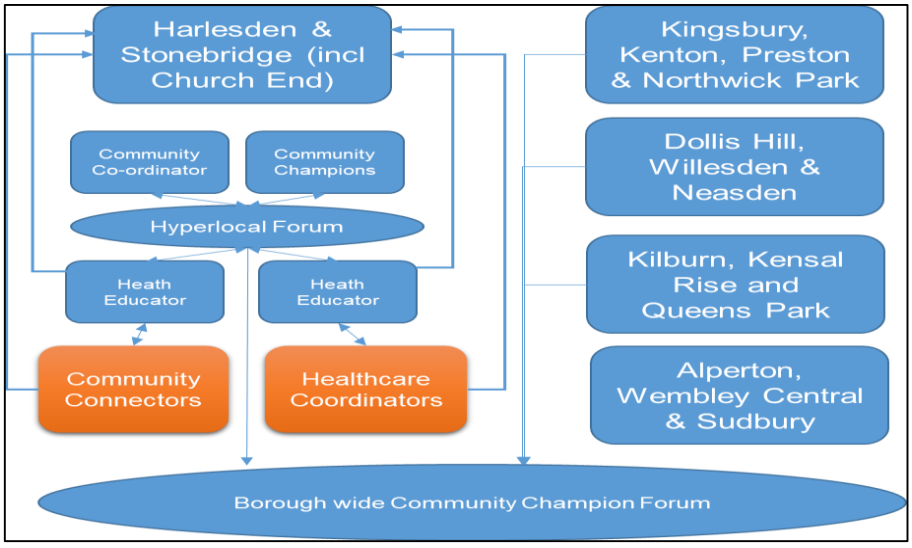
Activity Impact Measure:

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

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



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



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

3.4 *Communications Work Stream Update:*

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

Activity Impact Measure:

Younger People and Targeted Groups

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

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

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

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

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

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

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

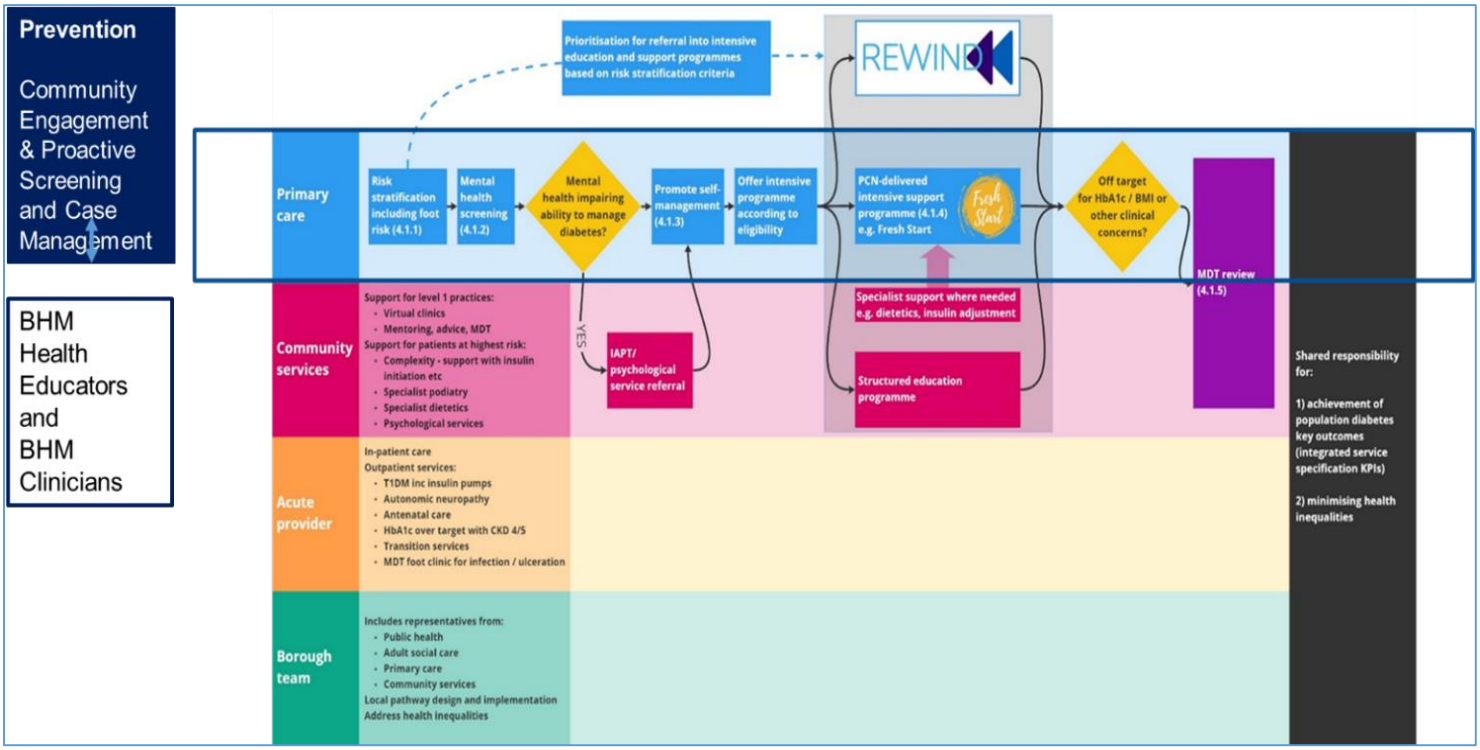
- Ensure early identification and management of foot risks
- Integrate Mental Health provision into the care pathways for patients
- Digitally enabled care for patients where appropriate e.g. Virtual consultations
- Reduce health inequalities and unwarranted variation in care of patients using PMH approach

Proposed next steps:

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

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

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



5.0 Brent Health Matters Programme- planning the next Phase

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

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

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

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

Report sign off:
Phil Porter
Strategic Director Community Wellbeing