	Community and Wellbeing Scrutiny Committee 5 July 2023
	Report from the Director of Public Health and the Managing Director, Brent ICP

Tackling Health Inequalities in Brent

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
No. of Appendices:	None
Background Papers:	None
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1.0 Purpose of the Report

This report sets out the national and local context to health inequalities; describes the extent of health inequalities in Brent, where data is available; and how Brent Council and health partners are tackling health inequalities, with a focus on how this work is delivered through the ICP (Brent Borough Based Partnership) and the work of the Public Health team and the Brent Health Matters (BHM) programme.

2.0 Recommendation(s)

Members of the Brent Community Wellbeing Scrutiny Committee are asked to note and comment upon the work that the ICP (Brent Borough Based Partnership) is undertaking in partnership with the voluntary sector, faith and community groups and local residents to identify and address health inequalities.

3.0 Detail

3.1 Background / Context (national)

Health Inequalities are unavoidable, unfair, systematic differences in health and health outcomes between different groups of people. These inequalities can involve different aspects of health and health care such as health status; access to, quality and experience of healthcare; behavioural risks to health, and the social determinants of health. As Professor Sir Michael Marmot stated,

"These serious health inequalities do not arise by chance, and they cannot be attributed simply to genetic makeup, 'bad' unhealthy behaviour, or difficulties in access to medical care, important as those factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society."[1]

Inequalities can be described between different population groups reflecting:

- socioeconomic factors such as income, education status or deprivation
- characteristics such as ethnicity, age, sex or disability
- social exclusion including homeless people, asylum seekers or refugees, those with substance misuse issues, those without recourse to public funds; and / or
- geography such as ward, local authority or region.

3.2 Within groups who are experiencing health inequalities, the experiences are not homogenous. How inequalities combine to affect specific groups and individuals is referred to as intersectionality. For example, the inequalities experienced by a female resident with substance misuse issues will differ from those of her male compatriots. The inequalities experienced by a homeless individual who has no recourse to public funds and is not proficient in English will differ from those who are proficient in English and have access to public funds.

3.3 Although, arguably, it is only since the Covid-19 pandemic struck that health inequalities have become part of the mainstream media discourse, the fact is inequalities have been known for some time. The World Health Organisation created the Commission on Social Determinants of Health Commission in 2005. The conclusion of the Committee, chaired by Professor Sir Michael Marmot, were that the inequalities in health were preventable by reasonable action and were not just avoidable but unfair.

[1] https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

The main recommendations of the Commission's report in 2008 "Closing the Gap in a Generation" were [2]

1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money, and resources
3. Measure and understand the problem and assess the impact of action

The then Director General of the World Health Organisation Dr Margaret Chan stated:

> "*This ends the debate decisively. Health care is an important determinant of health. Lifestyles are important determinants of health. But... it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place."*

3.4 The then Secretary of State for Health asked Professor Sir Michael Marmot to review evidence-based strategies for improving health inequalities. Importantly Marmot did not only rely on the academic literature but engaged widely with stakeholders to gain their insights and experiences. The Marmot Report, "Fair Society, Healthy Lives" (2010) outlined five key policy recommendations:

- Give every child the best start in life
- Enable all children, young people, and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health

Marmot was subsequently commissioned to examine progress in the following decade (to 2020). His key findings were that health inequalities had increased in England, while other countries were doing better at reducing health inequalities.

3.5 Following this, the pandemic years ensued and unsurprisingly COVID morbidity and mortality had its greatest impact on those already affected by health inequalities. The pandemic shone a light on existing health inequalities and amplified them.

3.6 The issue of health inequalities in the Black community was examined. The role of racism was acknowledged and is now classified as a public health problem. "Disparities in the Risk and Outcomes of Covid19" was published by Public Health England and highlighted the increased risks of dying of Black and South

[2] https://www.who.int/initiatives/action-on-the-social-determinants-of-health-for-advancing-equity/world-report-on-social-determinants-of-health-equity/commission-on-social-determinants-of-health

Asian minority ethnic groups which was confirmed by later analyses by The Office of National Statistics.

Background / Context (Brent)

3.7 The situation in Brent is a microcosm of the national picture. Long standing structural health inequalities exist both when compared to the national picture but also when examined within the borough.

3.8 Access to primary care, which residents have identified as a longstanding problem, was examined by a GP Access Scrutiny Task Group. Brent CCG as it was configured prior to merger was the 7th most under-doctored in London and had the most patients per nurse.

3.9 Inequalities in mental health and wellbeing were also being described. The Young Brent Foundation report covering the first three months of the Pandemic identified that depression in Black and Minority Ethnic young people increased by 9.2% whereas that in those in their white counterparts decreased by 16.2 %.

3.10 Also mirroring the national picture was the media attention which drew first to the health inequalities in Brent and subsequently to the action taken by communities to address these and the work done by Brent Health Matters and Brent Public Health.

Brent Health Inequalities Picture

3.11 The 2021 census[3] showed Brent has a young population (average age is 35 years of age). However, the number of people in the 50-64 age subgroup rose by 30.7% while the number of residents between 25-34 fell by 8.8%.

Brent is a truly diverse Borough: about 31% of the population identified with a non-UK national identity; less than half of the local population (43%) said they were born in England; 34.6% identified as White ethnic groups, 32.8% as Asian, 17.5% as Black, and 10% as Other ethnic groups.

Brent saw London's joint 3rd largest percentage point rise in the proportion of people who were economically inactive because they were looking after their family or home (from 4.9% to 6%), while 3.4% of Brent residents reported providing up to 19 hours of unpaid care each week.

Brent is ranked the 4th most deprived borough in London, with Stonebridge, Harlesden, Kilburn and Dollis Hill being amongst the most deprived in the borough[4].

[3] How life has changed in Brent: Census 2021 (ons.gov.uk)
[4] Microsoft Power BI Brent ward profiles

3.12 Given the above, ethnicity, potential language barriers for those who were not born in England, deprivation and age are likely to impact on Brent residents' health outcomes and access to services.

3.13 The COVID-19 pandemic starkly exposed how existing inequalities - and the interconnections between them such as race, gender or geography - are associated with increased morbidity and mortality risks[5]. Up until this point however the local health and care service was not systematically reviewing data through the wider determinants of health lenses, traditionally restricting analysis to age and sex only. Since the pandemic, with health inequalities becoming a major priority for the ICP, Brent is committed to a "no more averages" approach to data monitoring and reporting. Averages by their nature may hide where specific groups are underserved.

3.14 We are now committed to analysing data through age, gender, ethnicity, deprivation and disability and we aim to only use overall Brent and North West London averages for reference. This is work in progress. Where the way data is recorded does not support this approach, the ICP is committed to improving this. At the same time, we are designing and implementing tools that identify health inequalities in existing data. Some of the public tools, like the newly launched JSNA interactive toolkit and associated ward profiles continue to use averages to present data in a more accessible way and to provide an overview of the key health and wider determinants of health and well-being needs. Other tools like the Brent Health Matters Dashboard and the Hypertension Dashboard are bespoke tools which allow data analysis by demographic and socio-economic determinants thus providing a more accurate picture on the health inequalities in Brent. Those tools are aimed at service delivery and healthcare stakeholders and provide granular detail which informs targeted interventions.

3.15 Future plans include adding more bespoke dashboards for specific long-term conditions (i.e. cancer) as well as looking at health inequalities for each NHS Neighbourhood / Brent Connect area using the Core 20 Plus 5 framework (more detail in 3.21).

3.16 This approach has meant that, while our understanding of health inequalities can still improve, we have begun to expose major health inequalities in Brent. For example:

1. The proportion of children classified as overweight or very overweight is higher for Year 6 (39.6%) children than for Reception years (18.5%). Whilst these rates are decreasing and are overall lower than other boroughs in North West London, Stonebridge, Harlesden, and Willesden Green have higher prevalence compared to the overall borough. Those wards also have higher levels of income deprivation, income deprivation affecting children and higher levels of long-term unemployment. Furthermore, children of Black and Mixed heritage as well as those identifying as "any other" ethnicity have higher rates of overweight or very overweight compared to other ethnic groups.

[5] A perfect storm - health inequalities and the impact of COVID-19 | Local Government Association

2. Wider determinants of health have a strong impact on long term conditions, chronic diseases, and mental health. Evidence shows that in Stonebridge, the most deprived ward in Brent, 17% of the population is reported to have a long-term condition or disability compared to an overall 14% in Brent.

3. Hospital stays for self-harm, used as an indicator of mental health, show that although the overall Brent standardised admission ratio is 28, the ratio in Welsh Harp is 54, in Barnhill 41, in Harlesden, Kensal Green and Queensbury is 33.

4. The prevalence of diagnosed diabetes in Brent remains higher (8.58%) than that for London (6.75%) and England (7.26%) and the trend is increasing. It is well known that rates of diabetes differ between different ethnic groups, but our local work is also now allowing us to focus on variations in health care received. For example, diabetes reviews for Asian or Asian British population are higher (75%) compared to the Brent average (73%). Conversely diabetes reviews for White and Other ethnic groups are lower (71% each). Certain areas in Alperton have rates of achievement for all 9 Key Care Processes (a marker of good quality care) which are higher than the Brent average while areas in Kilburn have lower rates.

5. Hypertension is known to disproportionately affect Black and Asian communities, but our more recent analysis allows for a more detailed understanding. For example, amongst people with hypertension whose condition is not controlled (and who are therefore at the highest risk of a stroke or heart attack) we see a disproportionate representation of Black Caribbeans. Black Caribbeans make up 15% of uncontrolled hypertensives, in comparison to 7% of the overall population. In addition, this high-risk group is skewed towards more deprived communities: 9% of the group is in the highest deprivation decile, in comparison to 6% of the population overall.

6. Overall, cancer screening remains low in Brent for all cancers. Within this are variations, for example in Asian or Asian British patients eligible for breast cancer screening the uptake is 47% (compared to 41% overall), whereas for the Other ethnic group uptake is 33%. Cervical cancer screening is decreasing in Brent for the whole population being now only 49%. In eligible Black or Black British patients, the rate is 54%, in the Mixed ethnicity group it is 52% whereas for Other ethnic groups it is 45%.

7. Social isolation, loneliness and higher levels of deprivation are all linked with pensioners who live alone. There is a clear link between loneliness and poor mental and physical health. The overall rate in Brent of people who live alone is at 27%. Outliers are Kilburn at 40%, Brondesbury Park and Willesden Green both at 38%, and Stonebridge at 35%.

Tackling Health Inequalities in Brent

3.17 The approach of the Brent Borough Based Partnership (the ICP) to health inequalities is rooted in proportionate universalism, a recognition of the wider determinants of health, co-production with our communities and a systematic approach to holding ourselves to account for examining and addressing inequalities in terms of ethnicity, deprivation, and disability (see the previous section).

3.18 Marmot recommends proportionate universalism, described as "the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need" as a core response to health inequalities. In practice, this means services which are both universal *and* targeted. This approach was exemplified by the local delivery of COVID vaccination. This combined mass vaccination centres, such as the one in Wembley, which operated at maximum efficiency, with more targeted offers, bespoke to local communities, such as the vaccine bus or delivery in faith settings. Appropriate targeting can only be developed and delivered in a dialogue with residents and through co-production.

3.19 Brent ICP's vision for residents is to deliver high quality and best value for all the core health and care services for the people of Brent by:

- Addressing health inequalities by delivering services in a way that responds directly to the needs of our communities
- Improving access to our services by increasing our workforce and appointments available at a time that suits people
- Personalising services by bringing a wide range of services together at neighbourhood level wrapped around the needs of residents
- Supporting people to maximise their independence, and caring for people closer to home

3.20 In order to achieve the above vision, Brent ICP's priority workstreams are:

- Tackling health inequalities
- Strengthening primary care
- Developing community care
- Mental health and wellbeing

3.21 In March 2022, national guidelines were released to focus the work on tackling Health Inequalities, called CORE20PLUS5. This describes the approach based on:

- Most deprived 20 % of the national and local population
- Plus population groups that can be identified at a local level who face Health Inequalities, including

- ethnic minority communities,
- people with learning difficulties, long term conditions
- other groups that share protected characteristics
- people experiencing homelessness, drug and alcohol dependence
- vulnerable migrants
- people in contact with the justice system

- Five clinical areas of focus which include:
  - Maternity
  - Severe mental illness
  - Respiratory diseases
  - Early cancer diagnosis
  - Hypertension

3.22 Within Brent, we had started work on tackling health inequalities with all our stakeholders including the voluntary sector prior to the national guidelines. The approach we have taken in Brent is to engage with our diverse communities to develop priorities and action plans to tackle the issues faced by people at a local level.

3.23 Brent Health Matters (BHM) was created in response to the inequalities highlighted by COVID. The initial focus of BHM was to inform and support communities with Covid restrictions and provide practical help on the ground based on individual community's needs. This progressed to supporting the communities with Covid vaccination, including busting some myths, providing education to ensure people were making informed decisions and, significantly, making vaccinations more accessible.

3.24 Diabetes and Mental Health were identified as priorities by communities in all localities following the pandemic. BHM worked with the communities and GP practices to provide diabetes risk assessments, diabetes reviews, supporting with education and promotion of healthy lifestyles. Mental Health support for communities included increasing awareness of mental health issues, providing bite-size mental health first aid training and bespoke support for some communities e.g. bereavement support for Somali women.

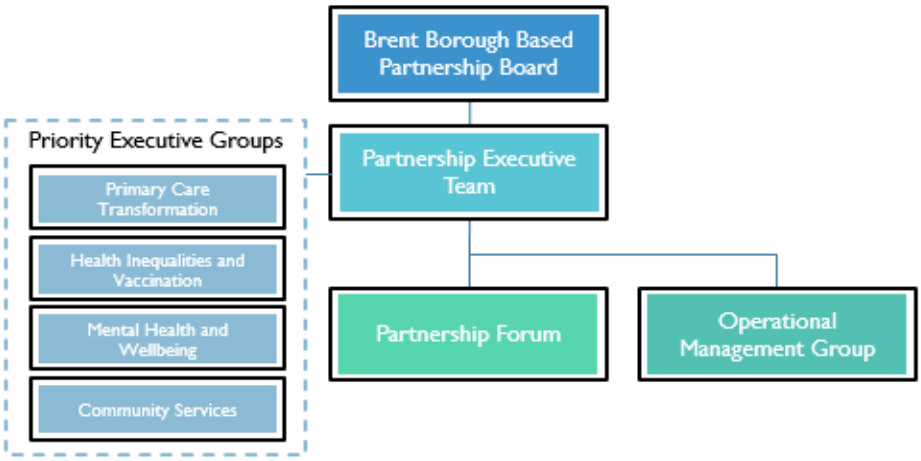
3.25 Recently, BHM has included hypertension as a focus area and are supporting communities with case finding and management of hypertension working closely with the Primary Care Networks (PCNs).

Governance

3.26 The Brent Borough Based Partnership (the ICP) was established in 2022, with an Executive Group for each of the transformation priorities. These Groups meet each month and report to the ICP Executive Group, also meeting monthly.

The ICP Executive reports to the Brent Borough Based Partnership Board (the ICP Board).

3.27 The Executive Groups are co-chaired by senior members from across all partners within the ICP. The co-chairs of the Health Inequalities and Vaccination Executive are Robyn Doran (Brent ICP Director) and Dr Haidar Mohammad (ICP Clinical Lead). The Group includes senior representatives from key partner organisations within the Council, NHS and the voluntary sector. There is also representation from a Community Champion to ensure all stakeholder groups are represented in the decision-making and scrutinising process.



Role and Responsibilities of Brent ICP and Public Health in Tackling Health Inequalities

3.28 Brent Public Health's work on health inequalities, using a social capital approach, predates the new integrated health and care systems. However, the Borough Based Partnership (the ICP) has enabled a step change in the reach and breadth of the work and provided a significant increase in capacity.

3.29 The close working together of the Public Health team and Brent Health Matters is such that partners and the community often do not recognise them as two separate teams. However, the two teams have complementary skills and specialisms.

3.30 The Public Health team provides intelligence products around health inequalities, including qualitative and quantitative understanding of inequalities. The team also provide evidence through the use of surveys, focus groups and the development of evaluation tools to ensure the robustness of the work being undertaken

3.31 Public health leadership, in particular the Public Health Consultant and the Public Health Strategist Health Inequalities, work directly, and through Brent CVS, with large charities, small charities, faith groups, community groups and informal community activists and leaders to build trust with communities and to understand their identification of need.

3.32 The Brent Public Health Inequalities team consists of an agile team that works alongside the BHM team delivering specialist public health intervention such as vaccination or screening. The Public Heath team also have specialised work streams focusing on children, refugees and asylum seekers and emerging communities.

3.33 The BHM Team in collaboration with the Brent Public Health Inequalities Team acts as the delivery arm through which objectives are delivered on the ground.

3.34 BHM and the Public Health team organise themselves around both geographic areas of focus (the Brent Connects areas) and thematic or subject matter lead areas.

The role of Brent Health Matters in Tackling Health Inequalities

Why the programme was set up

3.35 Between March and June 2020, Brent had the highest age-standardised mortality rate for deaths involving COVID-19. During this first wave of the pandemic, Brent experienced a death rate of 216.6 deaths per 100,000 people. This was significantly higher than the London average of 141.8 deaths per 100,000, and the England average of 88.7 deaths per 100,000.

3.36 COVID-19 had a disproportionate impact on Black and Asian ethnic groups and those living in more deprived areas. This reality highlighted the entrenched structural inequalities that exist in Brent, putting some groups at higher risk of poor health than others. The pandemic also shone a light on the low level of trust and confidence communities had in health and social care services.

3.37 The Council, NHS and VCS (voluntary and community sector) recognised that dedicated staff and resources was required to be able to truly tackle health inequality issues in Brent.

3.38 As a result of this, the Brent Health Matters programme was established in September 2020, to take a whole system partnership approach towards a shared vision of tackling health inequalities in Brent. Importantly, partners agreed that listening to and working with local people, groups and organisations is key to ensuring that the programme addresses the health inequality issues faced by diverse communities.

Who the programme reports into

3.39 The Brent Health Matters programme reports into the Health Inequalities and Vaccination Executive Group, which reports into the Brent ICP executive group.

The key health challenges it seeks to address with Brent's communities

3.40 The Brent Health Matters programme initially focussed on protecting people from Covid-19 and supporting Covid vaccination. Currently, diabetes and mental health are the key challenges being addressed through the programme, as communities voiced their concerns about the high prevalence of both health conditions. The programme is now working on including cardiovascular disease (CVD), including hypertension case finding, into its priorities.

Stakeholders the programme works with

3.41 The core programme team consists of staff from the Council, Central London Community Healthcare NHS Trust (CLCH), Central and Northwest London NHS Foundation Trust (CNWL), Public Health and Brent Carers Centre. CLCH and CNWL are the employers of the clinical team and the Community Connectors. Brent Carers Centre are commissioned to provide the Health Educators service

3.42 The stakeholders include all the above organisations, primary care, the voluntary sector and faith organisations. The programme works in partnership with a wide range of community organisations, including over 400 VCS organisations and community leaders.

How the BHM team works with communities differently

3.43 The Brent Health Matters programme has established five 'locality teams' to work in each of the 5 Brent Connects areas. Each team includes:

- Community Coordinator (Council)
- Public Health Officer (Council)
- Community Connector (CNWL)
- Clinical team (CLCH)
- Health Educator (Brent Carers Centre)
- Strategy and Partnerships Officer (Council).

3.44 Community Coordinators with the locality team focus on community engagement activities in each locality area. This is done by proactive engagement with communities, reaching out to them by face-to-face interactions, virtual meetings, attending their regular events and phone calls.

Through this approach, they have been able to establish and maintain a network of community contacts and Community Champions, to be the voice of the diverse communities in Brent. This enables each locality team to co-produce and co-deliver local action plans in each of the five areas.

3.45 Through this approach, the programme is able to maintain a feedback loop between communities, the council and NHS to ensure that resources address the key challenges that pose a barrier to health equity.

3.46 A number of other boroughs have Community Champions and outreach programmes. A particular feature of the local programme is the combination of roles in the locality teams bringing together in virtual teams a range of staff from the Council, the voluntary sector and (uniquely) clinicians.

3.47 The inclusion of clinicians in the teams enables in reach into communities to include a health intervention, such as health check, and for liaison with other health services including onward referral. It is important that BHM does not only offer advice and information. It takes health services to communities, as described below.

Examples of events held

3.48 One of the priorities of the Brent Borough Based Partnership (the ICP) is to improve access to local services. The programme works towards this priority by taking health and social care services out into the community through community events, which are co-developed and co-delivered with VCS organisations and community leaders.

So far, the programme has held **112** health and wellbeing events in a range of community spaces including community centres, shops, libraries, factories and places of worship.

6,206 people have attended these events and **5,203** people have had health checks.

We have collected structured feedback from 512 attendees since February 2023 which is summarised below:

- 96.1% agreed or completely agreed that staff treated them with respect and dignity
- 95.7% agreed or completely agreed that staff explained everything in a way they could understand
- 96.1% agreed or completely agreed that staff listened to what they had to say

- 95.5% answered or very likely when asked if they would recommend the event they attended to a friend or family member

Factory Work

3.49 A particular example of work by Public Health and BHM is the outreach to a local factory. Five events have been held, including two with night shift workers.

Qualitative learning is that many of these workers have multiple jobs leaving them little time to access health services, let alone attend to their physical and mental wellbeing.

Six hundred and eighteen workers attended the events in the Factory (before their shift or during their breaks) and 606 received a physical health check. There was considerable undiagnosed or unmet health need found:

Number of the 606 workers found to have:

- nondiabetic hyperglycaemia (pre-diabetes) 73
- untreated hypertension 83
- raised heart rate 48
- abnormal heart rhythm (possible atrial fibrillation, a treatable stroke risk) 45
- referred to their GP for follow up 168
- referred urgently to the GP in attendance at the event 34

These findings show not only the value of inreach into communities but the value of combining community engagement with a clinical intervention.

Response to a health protection risk

3.50 UKHSA (the UK Health Security Agency) identified a cluster of TB cases with an apparent link to a particular local community. Routine approaches by UKHSA and TB services to surveillance and screening failed to engage the community.

3.51 Public Health and BHM therefore engaged with the community and worked with UKHSA to bring the NHS mobile Xray unit into the local community. TB screening was offered on a walk-in basis along with blood pressure and blood sugar checks, advice and information with translation by BHM workers. UKHSA described the event as “successful beyond our wildest dreams”: 350 residents attended, 200 residents were x-rayed in a single day and a number of referrals were made to TB services and to GPs.

Progress made so far and how the programme monitors and evaluates its performance

3.52 Diabetes has been a focus of the BHM team. In the last 2 years, the proportion of patients with diabetes who are recorded as having received the 9 key care processes (a marker of good quality diabetic care) has improved significantly as follows:

- March 2021: 8.6%
- March 2022: 44.2%
- Current: 58.5%

3.53 This reflects the work of the whole ICP, but BHM have undoubtedly played a role in raising awareness of and providing education on diabetes in the community as well as actually carrying out some of the key care processes at their events.

3.54 All the *activities* undertaken by BHM are captured in a monthly dashboard. However, it has been challenging to measure *impact* of the work being done. The team is currently working with stakeholders to develop a logic model to underpin the measurement of impact of all the work streams.

3.55 When we started the programme, we were faced with high level of lack of trust and confidence in health and care provision from communities. This was evident when we approached the communities. Having worked with our communities and voluntary sector organisations, the programme has now built a rapport and relationship with a variety of community organisations. This has resulted in the team being inundated by community organisations wanting to run joint initiatives/events with BHM.

3.56 The programme has awarded three rounds of grants (total amount £600k) in the last two years to 59 organisations to support them to develop and run their own health and wellbeing programmes for their community. We are currently working with 17 organisations to support them in monitoring and evaluating the impact of these programmes which will further help them in securing grants from other resources

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3.57 BHM programme works closely with the public health team to look at locally available data on demographics and health outcomes. This helps the programme identify and prioritise communities that they proactively approach to work with them in addressing the issues. We have recently started collecting detailed demographic details of people attending BHM events and are able to link this to the clinical outcomes at the events. This will inform us further on clinical areas we need to focus on and within specific communities.

Areas of improvement identified so far

3.58 The programme has identified the following areas that we need to focus on in the coming year:

- Working with GP practices, and PCNs to identify cohorts of patients who do not normally engage with GPs
- Working with other health and social care services to ensure tackling Health Inequalities becomes BAU within all services
- Developing an impact outcomes framework for the programme

Funding

3.59 BHM programme is funded through a variety of sources:

- The clinical team (employed by CLCH and CNWL) through recurrent funding from NWL ICB (agreed by NHS CCG in 2020).
- The community team is funded through the Council's public health grant
- The Health Educators programme was initially funded from the public health grant. The current funding is through the section 256 agreement, using underspend in the clinical team last year
- The initial two grant rounds were funded by the public health grant (one round was specific for promoting Covid vaccination). The third grant round, which was distributed in summer 2022, is funded through the section 256 agreement

Next Steps

3.60 BHM and Brent public health have a busy community led intervention programme over the summer months.

3.61 Health inequalities are structured, fixed and, in our communities, intersectional. But while our inequalities are entrenched, our vulnerable populations are in a state of flux. We have the newly arrived communities notably those from Eastern and Southern Europe. We have emerging communities from Latin America and Brazil. The recent census showed our established communities are ageing which will have an impact on our long-term conditions profile. The work to counteract health inequalities therefore needs to continue both in scale and scope.

3.62 Key interventions going forward are:

- Expansion of BHM to focus on addressing inequalities in children and young people
- Expansion of the clinical team within BHM to carry out focussed work on people with long term conditions that do not engage with GPs
- Rationalisation of work around health inequalities in cardiovascular disease long term conditions and the risk assessment process

- Continued work to reduce the substantial health inequalities of emerging and newly arrived communities
- Continued work on reducing health inequalities in our refugee and asylum seeker health populations
- Influencing the NW London agenda through ongoing work on the NW London Race Inequality Steering Group and the NW Core20Plus5 Delivery Group

3.63 We are in process of submitting a business case to NWL ICB for the Brent allocation of ICB Health Inequalities funding. This business case focuses on creating a dedicated team to focus on addressing Health Inequalities in children and young people, with initial focus being on increasing childhood immunisation, supporting patients with Asthma and Mental Health conditions.

4.0 Financial implications

These are contained in the report.

5.0 Legal Implications

There are no legal implications arising from this report.

6.0 Equality Implications

These are contained in the report.

Report sign off:

Dr Melanie Smith
Director of Public Health