Appendix 2: Progress tracker

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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