MINUTES OF THE HEALTH AND WELLBEING BOARD
Held as a hybrid Meeting on Thursday 29 January 2026 at 6.00 pm

Members in attendance: Councillor Nerva (Chair), Dr Rammya Mathew (Vice Chair), Councillor Knight (Brent Council), Councillor Grahl (Brent Council), Councillor Donnelly-Jackson (Brent Council), Councillor Kansagra (Brent Council), Jackie Allain (Director of Operations, CLCH), Robyn Doran (Director of Transformation, CNWL, and Brent ICP Director), Ruth du Plessis (Interim Director of Public Health and Leisure, Brent Council – non-voting), Rachel Crossley (Corporate Director Service Reform and Strategy, Brent Council), Shirley Parks (Director of Education, Partnerships and Strategy) on behalf of Nigel Chapman (Corporate Director Children, Young People and Community Development, Brent Council – non-voting), Claudia Brown (Director of Adult Social Care, Brent Council – non-voting)

In attendance: Wendy Marchese (Strategic Partnerships Manager, Brent Council), Hannah O'Brien (Senior Governance Officer, Brent Council), Nipa Shah (Director of Brent Health Matters), Jonathan Turner (Borough Lead Director – Brent, NWL ICB), Dan Shurlock (Head of Place Leadership, Brent Council), Will Holt (Change and Improvement Programme Lead, Brent Council)

The Chair opened the meeting by highlighting this would be a themed Health and Wellbeing Board meeting focused on health inequalities and neighbourhoods in Brent.

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

Apologies for absence were received from the following:

- Kim Wright (Chief Executive, Brent Council)
- Nigel Chapman (Corporate Director Children, Young People and Community Development)
- Tom Shakespeare (Director – Brent Integrated Care Partnership)

2. **Declarations of Interest**

Personal interests were declared as follows:

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

3. **Minutes of the previous meeting (20 November 2025)**

RESOLVED: That the minutes of the previous meeting, held on 20 November 2025, be approved as an accurate record of the meeting.

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

None.

5. **Overview of Health Inequalities**

Ruth du Plessis (Director of Public Health and Leisure, Brent Council) and Dr Rammya Mathew (Vice Chair of Brent Health and Wellbeing Board) led a presentation on inequalities

in Brent, highlighting what inequalities were in terms of key data and national and regional comparators, best practice for tackling inequalities. Also how local insights and data had been used to further develop the approach to tackling health inequalities in Brent, and how Brent continued to refine efforts towards tackling inequalities. They highlighted the following key points:

- The recently published Indices of Multiple Deprivation (IMD) 2025 was used to indicate Brent's position in terms of inequalities across the 296 local authority areas. Brent was ranked 41st most deprived area in England and 12th highest for income deprivation. Within London, Brent remained the 4th most deprived borough since the last IMD in 2019. Data showed clear gaps in life expectancy at birth between the most deprived and least deprived areas in Brent, and a gender gap with males living an average of 6 years less than females in Brent.
- Brent was focused on tackling inequalities through a prevention lens, based on population health data and the wider determinants of health, using evidence-based interventions that were tailored to local need. In order to do this, health services were being asked to design services based on the wider determinants of health, using neighbourhood health as an opportunity to tackle inequalities as core business.
- Workstream one was for all partners to take a 'no wrong door' approach, taking a joined-up, system-wide approach to supporting vulnerable residents and identifying those who may need additional support.
- Workstream two focused on community connectedness, building trust, capability and connection with Brent's diverse communities, including through aligning community-based roles such as social prescribers, community connectors and health educators, and embedding VCSE partners, into the inequalities programme. This workstream would also review community grants to ensure alignment with resident-identified needs and population health priorities.
- Population health management was the third workstream, using data and insight to target resources where they were most needed, applying proportionate universalism (universal services for all with more intensive support for communities with greatest need) and aiming to reach residents with unmet needs.

The Chair thanked colleagues for their presentation and invited contributions from those present. The following points were made:

- The Chair highlighted the importance of learning from this work in order to inform public services across Brent and future plan in relation to inequalities and neighbourhoods. He noted that working together in neighbourhoods and the Brent Health Matters Annual Report were also due to be discussed during the meeting, which all linked with the work being done to understand and address inequalities in Brent.
- Councillor Donnelly-Jackson advised that she was pleased that the Council had adopted the Socio-economic Duty, ensuring that socio-economic status was considered as a protected characteristic, and encouraged other partners to do the same.
- Noting the references in the presentation to unmet need, the Board asked for further clarity on what was meant by that. Dr Rammya Mathew explained that this referred to large and varied needs. As a GP, she saw patients coming to her attention very late in their condition with multiple chronic unmanaged conditions, which was often linked to the fact they found it difficult to access services, including screening and vaccination offers. Low uptake of screening and immunisations was found to be more common in deprived communities.
- Resource allocation was raised, with it noted that this had historically not been done proportionately across North West London and London as a whole, with outer boroughs traditionally receiving less resource, particularly around community and mental health services, and Brent not receiving an allocation that recognised it was one of the most deprived of the 8 NWL boroughs. This was an issue that Brent Integrated Care Partnership

(ICP) had raised consistently, highlighting an aim to develop and put more money into services to level Brent up, and the ICP would continue to raise that as the 8 boroughs merged with North Central London in April 2026 to become a 13 borough Integrated Care System (ICS).

- Within the new North West and North Central ICS, 4 pillars of proactive care had been set out, including creating community assets for health and wellbeing, early identification and early help. Over the last few years, particularly in children's services, Brent had started seeing new money, but this was still not the case for community services, so members felt it was important to continue to raise this and for partners to understand the population and levels of deprivation in the borough. Brent was also addressing the lack of resource through neighbourhood health, piloting approaches in areas such as Harlesden where there were more pressures and more deprivation. Members could foresee the positives of a neighbourhood health approach in this regard, where the model would depend on the individual need of neighbourhoods and could be flexible based on that.
- In relation to lack of access to health services for those in higher areas of deprivation, the Board asked what the factors leading to this were, and whether this was because there was a less equal spread of services across those areas or because families were not making use of the services. Ruth du Plessis advised that there were a number of factors affecting access, such as the system not yet having got it right in terms of putting resource where it was needed, the lack of resource in more deprived communities, and evidence suggesting that some families did not have the confidence to access services even where resources were available. Shirley Parks added that some of that was being addressed at Family Wellbeing Centres (FWCs), where referrals and signposting helped vulnerable families navigate the health system, recognising that it was a complex system, particularly for those whose first language was not English, in order to understand what was available to them. FWCs also hosted some health services within the centres to make it more accessible to families to access services in one place. In addition, the Brent Health Matters Health Inequalities Children's Programme had specific resource to address access for hard-to-reach communities and was looking to make a bid for further funding to resource people whose active role was to help connect families with services and help them understand the benefits of the services available to them. Schools also played a big role in helping families understand what services were available to them.

In concluding the discussion, the Chair encouraged partners to consider adopting the Socio-Economic Duty in the same way the local authority had done. He highlighted the opportunities with the new ICS for the Health and Wellbeing Board to communicate directly with the Integrated Care Board (ICB) around resource allocation and neighbourhood working. He recommended that he, as Chair, and Dr Rammya Mathew, as Vice Chair, wrote to the incoming ICB on the points raised during the discussion on behalf of the Health and Wellbeing Board.

6. Public Health Annual Report 2025

Ruth du Plessis (Director of Public Health and Leisure, Brent Council) introduced the report and led a presentation detailing the Public Health Annual Report and the work of Public Health in Brent in addressing health inequalities in Brent. She advised Public Health was working through community-centred approaches and emphasised the three themes for reshaping public health – Community Engagement, Social Capital, and Radical Place Leadership. She thanked those involved in the drafting of the report for their collaboration, particularly Janice Constance (Principal Public Health Strategist, Brent Council) and her team, and communities and partners who had input.

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

- The Board were pleased that Social Capital was a key theme for Public Health and that the report encapsulated the importance of relationships and networks through warm welcome spaces and the library exercise project, where over 270 residents had taken part.
- The Board commended the work in the report, particularly the integration of sports, culture and libraries, school-based oral health assessments, translation of letters into community languages and bigger policy campaigns such as treating gambling harm as a public health issue.
- The Board asked for more detail on how Public Health would ensure a joined-up, system-wide approach was in place to support vulnerable residents who may be using warm spaces. Ruth du Plessis advised that Public Health wanted to make every contact count, whichever way people presented to services. To do that, there was a need to upskill the workforce, and she highlighted that library staff had been very keen to support this approach and willing to learn these skills. Public Health wanted to build more on that with the neighbourhoods workstreams, and there was also the new Joy app that supported that join-up. Robyn Doran added that she had attended Willesden library recently and witnessed people using the blood pressure machines that were available, and in her local library there had been vaccinations being provided by CLCH, showcasing that approach towards making every contact count and bringing healthcare into the community.
- The Board raised concerns that 43.4% of 5-year-olds in Brent had obvious dental decay, compared to 22.4% nationally. They recognised the work Public Health were doing in that space, particularly with the oral health bus and its impactful visits to schools, but asked whether any more resource could be put in to make bigger improvements, raising concerns that this could affect the quality of life of those children and the number of children attending A&E. Ruth du Plessis acknowledged the concerns raised and advised that Public Health were putting more resource into oral health having secured more funding, and were pulling together dental packs and looking to expand the work particularly for children in school.
- The Board highlighted that progress with the Food Strategy had been challenged at a recent scrutiny meeting and asked for an update on where that was. Ruth du Plessis highlighted that the Food Strategy had been drafted and the Steering Group had reviewed it and fed back. The Public Health team was now reviewing that feedback and would send the draft strategy out for wider engagement before bringing it to the Health and Wellbeing Board.
- The Board queried where the data outlining ethnicity and language in the report had been obtained, and heard that some data would be from the Office for National Statistics (OFS) and some would be census data. Officers agreed to look into this and provide a response on where the data was obtained.

As no further issues were raised, the Board welcomed the report and thanked those involved, including Dr Melanie Smith as the predecessor of Director of Public Health who had overseen the report, and highlighted the need for sustained focus on oral health, particularly in children. The Board noted that the Food Strategy was coming to a future meeting, and asked for both the Public Health Annual Report and upcoming Food Strategy to be published prominently on the Council website.

7. Brent Health Matters Impact and Learning

Nipa Shah (Director of Brent Health Matters) welcomed two Brent Health Matters (BHM) Community Champions, Viorica and Bee, to the meeting, who provided an outline of their role within the community. Viorica explained that her role was to promote health education and prevention, and provide information and resources to people to improve their health. She had

a specific focus on educating people about diabetes, expanding people's knowledge and facilitating them to take care of their own health and view their health as a priority. She highlighted that it was a very active role, attending many different events and speaking with many different communities, particularly as she spoke 4 languages. She had also had the opportunity to translate for the clinical team when needed. Bee volunteered as a Brent Family Help Parent Champion, doing outreach in nurseries, largely with under 5-year-olds such as through rhythm and singing exercises, ensuring a physical presence in spaces where parents gathered in order to provide information on the services provided in Brent. This also included attending libraries, schools, events and functions to promote Brent's services, focusing on vaccinations and oral hygiene with an early year's focus. She added that she had benefited from volunteering as she had learned more about the breadth of services available in Brent which she could then share with others. She worked closely with BHM co-ordinators in Kilburn, and she had connected Oxford University to Brent parents who had undertaken a study to understand the impact of social media on vaccination uptake. That study had been complimentary to Brent's work on vaccinations and outreach during covid.

Nipa Shah then took the Board through the presentation included with the agenda pack, highlighting the following key points:

- She thanked Viorica and Bee for their remarks, highlighting their contributions as live examples of champions acting as the voice for services, helping to build trust amongst communities.
- She reminded members that BHM had been set up following the first wave of Covid, where Brent had been disproportionately impacted by the number of cases and deaths.
- BHM was funded by NWL Integrated Care Board (ICB), with the Council employed team and Health Educators funded through the Public Health Grant.
- NWL ICB had also funded the focused work on children and young people through the health inequalities pot, but that would come to an end in March 2026. A business case was being put forward for continued funding for the children and young people workstream.
- Post-covid, she felt that trust in the system had been at a minimum, and it had taken time and focus talking to communities to understand what was important to them and how they could be supported to be in charge of their own health to improve their health and wellbeing outcomes.
- BHM was in contact with around 500 community organisations in Brent and was slowly trying to get from an informing stage to a co-creation and empowering stage, where BHM was only there to support the community to take responsibility for health and wellbeing in their own communities.
- Part of that empowerment work involved community grants, and, in the past 5 years, three rounds of community grants had been allocated. There was now commitment through the Public Health grant for community grant funding to continue for the next three years, and she felt it was noteworthy that the number of grassroots organisations had increased each year, with applications received from over 120 organisations. BHM supported the community in applying for those grants and monitoring their outcomes so that they could use those outcomes as evidence when applying to other grants available across the country. She added that there were some good examples of Brent organisations being successful in grant applications following the monitoring support provided by BHM.
- One of BHMs unique key aspects of the approach included the outreach events that had been done, which included visiting faith centres, factories, community centres, schools, libraries and high streets. To date, 351 events providing health checks had been held, with other events also held for health promotion. From that, over 15,000 residents had been seen and over 14,000 health checks completed.

- Around 28% of attendees for health checks were from the Indices of Multiple Deprivation levels 1 and 2, which were the most deprived levels, but she felt that more work was needed to reach residents from those areas where it was known inequalities were higher.
- When BHM clinical team did health checks, if there was a need to escalate health issues to GPs then the team would do that. Data covering the previous 9 months showed that, of the 102 people escalated due to high blood pressure, 15 were subsequently diagnosed with hypertension, which would not have happened if BHM had not done those checks. Similarly, 10 people had been subsequently diagnosed with diabetes following escalation to their GP by BHM.
- Clinical focused work had looked at improving the percentage of people with diabetes completing their 9 key care process, which had increased from 47% in 2022 to 70% in 2025. She attributed this success to the collective work of the community teams, GP colleagues and BHM.
- There had also been focused work on bowel cancer screening, looking at those living in the most deprived areas of the borough, as the uptake of bowel cancer screening in those areas was significantly lower than more affluent areas of the borough. The number of people receiving bowel cancer screening in the most deprived boroughs had increased by 3.4% across 2 years as a result of those efforts.
- The mental health team had done additional outreach events, co-produced with communities, and engaged with a large number of residents including 1 to 1 consultations.
- Health educator work was provided by a consortium of volunteer organisations and had supported 170 people in just one year, including providing healthy lifestyle advice and digital upskilling, helping residents to register with a GP and for the NHS app. She thanked frontline Council staff, including library staff, for the support they had provided people in signing up to the app.
- The children and young people team had focused on 3 workstreams – asthma, immunisations and mental health – with a priority to reduce attendance at A&E in children under 18. She confirmed that there was now a positive trajectory with lower attendance at A&E in 2025 compared to 2023, and thanked the various community teams, GPs and BHM for that collaborative work. In relation to asthma, local residents such as Bee had been trained to become Asthma Champions, enabling them to have proactive conversations with the community about asthma and services. A particular focus for immunisations had been to improve uptake of the MMR vaccine in the Somali community, where uptake was lowest, and an Oxford professor of Somali heritage had supported that work. There was an action plan for improving that uptake and the clinical team now had approval to vaccinate in the community. A directory of services based on the thrive model had been created in relation to mental health for children and young people, and chat and chill sessions had also been introduced at 2 Family Wellbeing Centres.

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

- The Board was encouraged by the positive outcomes of the Brent Health Matters programmes, particularly around bowel cancer, agreeing that routine screening saved lives. They particularly highlighted the positive that over 15,000 residents had attended BHM events and health checks.
- The Board asked how BHM streamlined their programme to fit with primary care and address issues with access, noting the case study included in the report which detailed the difficulties a patient had in getting a primary care appointment. Nipa Shah advised that was a work in progress, and whilst BHM worked to empower residents in accessing services, sometimes it was appointment times that caused barriers. Where those issues arose, BHM worked to support individuals to work with GP practices to

tackle those barriers, such as supporting someone to use a phone app to book an appointment if they were not digitally literate.

- From a primary care perspective, Dr Rammya Mathew advised that it had been challenging to integrate BHM with primary care. For context, she highlighted that primary care capacity was limited and services were stretched, and a strategic approach was needed to align the local primary care provision with the work BHM were doing to ensure synchronicity. She advised that the strain on GPs was increasing, with around 2,000 patients per GP. Funding was constrained and she clarified that GPs were not incentivised to put patients on prescriptions and were not receiving additional allowances to do that.
- Noting the slide showing the number of people escalated to primary care for high blood pressure compared to the number of people subsequently diagnosed, the Board asked why there was that discrepancy. Nipa Shah advised that the data provided had only been tracked for 9 months, so whilst BHM may have been escalating people, there had been no mechanism to track that back to GP notes previously. There were also some people seen by BHM who lived in Brent but did not have a GP in Brent, meaning BHM did not have access to their medical notes. In addition, one reading of high blood pressure could not be taken in isolation, and there was a need for a 24-hour measure in order to diagnose someone with hypertension. The readings helped to make people aware, and their GP aware, that there had been a high blood pressure reading, in order to continue to track that and make lifestyle changes where necessary to reduce blood pressure.
- The Board noted that the number of people engaged by the mental health team was high, particularly the number of people signposted, but noted that mental health was a wide bracket and asked for a further breakdown of that data. Nipa Shah advised that the figures were a result of conversations happening out in the community at outreach events, so covered a range of mental health conditions including stress, anxiety and severe mental health conditions. A wide variety of conversations were happening where the team would refer individuals on, including to talking therapies or specialists if needed. She added that having those personal conversations in community spaces presented challenges.
- The Board noted from the data provided that some ethnic communities were attending BHM events more compared to others, and asked whether that reflected the percentage of ethnicities within the community. Nipa Shah confirmed that on the whole, the figures did reflect the community. She felt that the figures also reflected BHM making progress with some communities. There were some communities that BHM still struggled to engage, such as some Eastern European communities, whereas some Asian communities were very willing for BHM to conduct health checks, so BHM had started with communities that were willing to have them in their spaces, and was then slowly using those examples to reach the communities it struggled to engage.

As no further issues were raised, the Chair drew the discussion to a close, celebrating the good work being done and highlighting the challenges patients faced when seeking services. He advocated for discussions involving BHM, social prescribers and GPs to do some learning, acknowledging that BHM planned to align services to the neighbourhood work and work much closer with primary care colleagues to join work up. In closing the item, he noted that the funding for BHM for children's services was due to conclude but endorsed the business case for continued funding.

8. **Working Together in Neighbourhoods**

Dan Shurlock (Head of Place Leadership, Brent Council), Jonathan Turner (Borough Lead Director – Brent, NWL ICB) and Will Holt (Change and Improvement Programme Lead, Brent Council) introduced a paper providing an update on progress in developing a coordinated

approach to neighbourhood working between Brent Council and the Integrated Care Partnership (ICP). In presenting, they highlighted the following key points:

- It was felt that Brent had some pieces of neighbourhood working in train already, with some parts more mature than others, such as Brent Health Matters (BHM) and Public Health campaigns. There was also work being done to implement additional parts of the model, including Integrated Neighbourhood Teams with campus-style health hubs and more proactive prevention alongside local voluntary sector organisations (Radical Place Leadership), and a focus on piecing those workstreams together.
- Jonathan Turner highlighted some areas of achievement, including the Child Health Hubs, which had now been set up in all 5 neighbourhood areas with a standardised approach and appropriate referral pathway across all neighbourhoods. There was consultant and GP collaboration with other parts of the community system as well, with consultants out in the community, sometimes virtually, doing appointments for common child health conditions such as asthma and epilepsy. He advised that this was helping to upskill the GP population so that some of those issues that might otherwise have been referred to hospital could now be seen in the community. Links with Family Wellbeing Centres had also been built into referral pathways.
- The mental health pilot had been running across NW10, NW2 and HA9 postcodes, which had been an area of particular focus based on evidence. Community connectors, community psychologists and the Home Treatment Team Outreach Service had all been working together to pilot this outreach approach, and there had been significant activity with over 3,000 residents involved through training, workshops and co-production.
- Some of the neighbourhood health enabler workstreams were around digital infrastructure, estates optimisation, workforce, operational development and leadership. Estate optimisation was progressing with a new hub at Gladstone Park and a further hub in the pipeline in Alperton, and additional investment secured from the ICB to expand GP rooms at Wembley Centre for Health and Care. There had also been estate planning around the neighbourhood campus model, identifying possible sites for each of the 5 neighbourhoods that could be linked together to have Multidisciplinary team meetings and wider contributions from the voluntary sector within that, as well as Council services where appropriate. That was a developing piece of work which would need further input from estates teams to cost options for future bids.
- In relation to Radical Place Leadership (RPL), there was now a dedicated team of people working alongside residents in Harlesden, providing new 1 to 1 relational support and working in a much more preventative way ahead of crises presentations, particularly with people who might be at risk of financial hardship or homelessness.
- A strong presence had also been built to support community settings and build connections, and the team was working with those who might be getting turned away from different settings or who might be engaged with community groups but not Council or NHS services.
- Through cross-partnership working, residents were being connected to holistic support at the right stage, and around 20 residents were currently receiving dedicated support from the wider neighbourhood prevention team.
- Officers were working in a different way alongside community organisations and key community partners in Harlesden to establish the role they could play in neighbourhood prevention work, establishing strong pathways and ways of working for organisations to be a part of the prevention effort, including in areas such as homelessness prevention.
- Another focus was enabling the voluntary sector to better understand Council services to provide support and advice to the residents they worked with day to day, helping to break down barriers between the Council, NHS and voluntary sector.

- The aim of the working together in neighbourhoods approach was to pull all the different programmes together into a consolidated framework, including BHM, INTs and RPL. One of the risks of moving to a neighbourhood approach was that different organisations and stakeholders all developed their own neighbourhood approaches, so it was important to find a way of working that all partners wanted to adopt and commit to in an interconnected way across the different programmes, that brought all services and community assets together as one. Some of these strands of work would be done through Task and Finish Groups who would work to get this right in practice, focused on using data and insights collectively and ensuring community bridging roles were working effectively.
- The Joint ICP Executive on Neighbourhoods and Inequalities would be receiving further reports on this work in February 2026 and officers recommended a future update at a Health and Wellbeing Board meeting following that. It was also noted that further national guidance on the NHS Neighbourhood Health model was awaited and that this would likely include more detail on the role of Health and Wellbeing Boards.

The Chair thanked colleagues for their introduction and invited input from those present, with the following issues raised:

- The Board were encouraged by the presentation and looked forward to having further details in April 2026.
- The Board were encouraged by the work being done to engage with housing colleagues, and asked for more detail about the integration with housing at the next update.

As no further issues were raised, the Chair drew the discussion to a close and asked members to note the report. He thanked officers for presenting and showing the partnership work being undertaken and looked forward to further details in the future.

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

The Chair gave members the opportunity to highlight any items they would like to see the Health and Wellbeing Board consider in the future, adding that there was one more meeting of the municipal cycle.

8. **Any other urgent business**

None.

The meeting was declared closed at 7:55 pm
COUNCILLOR NEIL NERVA, CHAIR