APPENDIX A

Working in Neighbourhoods - Health and Wellbeing Board Background Briefing

30th July 2026

Purpose

This presentation introduces the NHS Neighbourhood Health Framework and how it forms part of a Brent's overall Working in Neighbourhoods (WIN) approach which aims to improve health, wellbeing and reduce inequalities.

The following slides:

- Set the context for neighbourhood working and why it matters for Brent residents (slides 3-6)
- Explain Brent's approach to Working in Neighbourhoods, including principles and delivery model (slides 7-8)
- Clarify the role of the Health and Wellbeing Board in shaping, overseeing and championing neighbourhood working (slide 9)
- Present Brent's proposed neighbourhood geography and timeline for further development (slides 10-11)
- Highlight progress and key achievements since the last update to the Board (slides 12-15)
- Set out timelines and next steps (slide 16)
- Invite discussion on how the Board can support and champion the continued development of neighbourhood working across Brent (slide 17)

What Is Neighbourhood Working

Neighbourhood working brings together health, local government, voluntary sector partners and communities to improve outcomes for local people.

It is based on the principle that health and wellbeing are shaped by more than healthcare alone.

NHS Neighbourhood Health Guidance

- The framework is part of the wider NHS 10 Year Plan transformation:
  - **hospital → community**
  - **treatment → prevention**
  - **analogue → digital**
- Care should happen:
  - **at home if possible**
  - **in neighbourhood settings if needed**
  - **in hospital only when necessary**
- HWBs (Health and Wellbeing Boards) to set geographies for neighbourhoods and will have a role in neighbourhood development
- Three types of contracts (Single Neighbourhood, Multiple Neighbourhoods and Integrated Health Organisations) – these are being consulted on now till September.
- The National Framework suggests that council (and other) initiatives such as Pride in Place etc are considered when defining priorities and setting geographies.

- The three-reform priorities are:

- There are 5 goals in the framework, with boroughs being asked to deliver set metrics against each one, and plans being developed for each. The HWB will be sighted on these plans for oversight and agreement.
- Funding is not defined but will be commissioned from active prioritisation through Integrated Care Boards (ICBs), led locally.

Goals and Metrics (Goal 1: Improve Health Outcomes)

Priority Cohort	Desired Outcome by 2029	Current Brent Position
Frailty, Care Home Residents, Housebound	10% reduction in non-elective admissions and bed days >1 day	New neighbourhood frailty service with proactive identification, risk stratification, integrated multidisciplinary response, care coordination and support to maintain independence at home
End of Life Care (EoL)	10% increase in identification of people approaching end of life and 10% reduction in admissions and bed days >1 day	Compassionate Care for All model; 8am-8pm 7-day specialist palliative care support; additional enhanced EoL beds; wider hospice access; Universal Care Plan (UCP) implementation
Cardiovascular Disease, Diabetes, COPD (Chronic Obstructive Pulmonary Disease)	10% improvement in evidence-based clinical outcomes; 10% increase in diabetes patients receiving all 8 care processes	Cardio-Renal-Metabolic (CRM) model being developed with focus on diagnosis, risk segmentation and proactive management; respiratory specification in development
Dementia & Mental Health	Improved diagnosis, treatment and access	Admiral Nurses recruited; redesigned mental health crisis pathway being launched
Children & Young People (CYP)	Reduced acute appointments and community waits; improved access and quality	Child Health Hubs, Family Wellbeing Centres, targeted healthy child checks, dental access pilot, Happy & Healthy Child Directory, LYRA emotional wellbeing service
Locally Identified Priorities	Neighbourhood-specific outcomes based on population need	Population health analysis informing neighbourhood plans

Goals and Metrics (Goals 2-5: Access to General Practice; Experience of Planned Care; Urgent and Emergency Care; Patient and Staff satisfaction)

System Objective	Success Measure	Brent Progress
Reduce avoidable hospital utilisation	10% reduction in non-elective admissions	Frailty and EoL (End of Life) pathways established to support residents in community settings
Reduce hospital bed utilisation	10% reduction in bed days >1 day	Proactive frailty model and expanded palliative care provision expected to reduce avoidable hospital stays
Improve urgent care utilisation	Fewer avoidable ambulance call-outs and increased use of community alternatives	Further work required to understand ambulance usage and urgent care pathways
Improve discharge effectiveness	Better coordinated discharge and capacity planning	Opportunity identified for closer system-wide planning with acute and community partners. Further work required.
Improve planned care efficiency	Reduced outpatient referrals through Single Point of Access and MDT models	Further work required to understand referral variation and opportunities for diversion
Shift follow-up care closer to home	10% reduction in secondary care follow-ups	Further work required regarding appropriate transfer of follow-up activity into community settings
Improve GP access	Same-day access for clinically urgent patients; improved patient satisfaction	New GMS (General Medical Service) requirements and West and Noth London (WNL) access specification supporting resilient access models
Improve patient experience	Patient-reported experience and outcome measures	Awaiting national guidance; opportunity to strengthen shared care planning
Improve staff experience	Neighbourhood staff satisfaction measures	National measures expected; neighbourhood model expected to improve multidisciplinary working

Brent's Approach

Progress so far…

- To test out new approaches to neighbourhood working, Brent Council and key partners (including the NHS and local VCSFE organisations) have launched a new Integrated Neighbourhood Team (INT) test and learn in Harlesden, focussed on community support and prevention. In July, the new INT was launched in Harlesden, with dedicated full-time capacity for relational working alongside residents, supporting those at risk of homelessness, financial hardship and providing stronger support around school readiness.

- The INT hosts a multidisciplinary case discussion every Tuesday afternoon, with colocation at Brent Crisis Skylight on Harlesden High Street, allowing for joined-up discussion and decision-making. The Multidisciplinary Team (MDT) brings together colleagues from across Council services alongside partners from the NHS, Crisis, Sufra and grassroots organisations (Sport at the Heart, Jason Roberts Foundation). This ensures that the INT is well connected into the local community and can work effectively alongside residents who may not be known to statutory services, while also enabling coordinated planning across partners to support residents most effectively.

- In parallel, we are working to establish Child Health Hubs across our neighbourhoods and learning from the models in 2025/26 will shape how we do this, there is a vision to integrate these closely with existing Family Wellbeing Centres. These Child Health Hubs will be closely integrated with Integrated Neighbourhood Teams focussed on health and community support and prevention, building strong local networks of integrated professionals to provide the best holistic support.

Where do we want to go…

- As we reflect on the learning emerging from the Harlesden test and learn and progress in developing our approach to Neighbourhood Health, we are now building our Neighbourhood Operating Model, with a view for wider roll-out across Brent. This presents an exciting opportunity to deliver effective, community-level support in partnership with local organisations, with ward members positioned to play a pivotal role in shaping work in their neighbourhoods.

How will we get there...

- The programme executives for Health Inequalities and Neighbourhood Working have merged, this also includes membership from the previous Radical Place Leadership team, to form the Working in Neighbourhoods programme of work. Resource is being aligned to maximise impact in our neighbourhoods to reduce inequalities.

- Learning from the Harlesden model will be used to scale across the other neighbourhoods in Brent.

Brent's Approach

Role of the Health and Wellbeing Board

Must Dos	Description of the Ask	Timeframe in Framework
Lead development of the neighbourhood health plan	HWBs must jointly lead and approve a locally owned neighbourhood health plan with ICBs and partners.	Plan developed during 2026–27 Implementation from 2027–28 financial year.
Define neighbourhood outcomes & metrics	HWBs must ensure that these are developed with partners and communities to set local outcomes covering the whole life course.	During 2026–27 as part of developing plans for 2027–28.
Agree neighbourhood geographies ("footprints")	HWBs must ensure that geographies are set for INTs and neighbourhood planning (aligned with natural communities).	By end of 2026–27 (listed as a "minimum basic requirement").
Embed community engagement and co-design	HWBs must ensure neighbourhood plans are co-designed with communities.	Throughout 2026–27 and 2027–28 planning period.

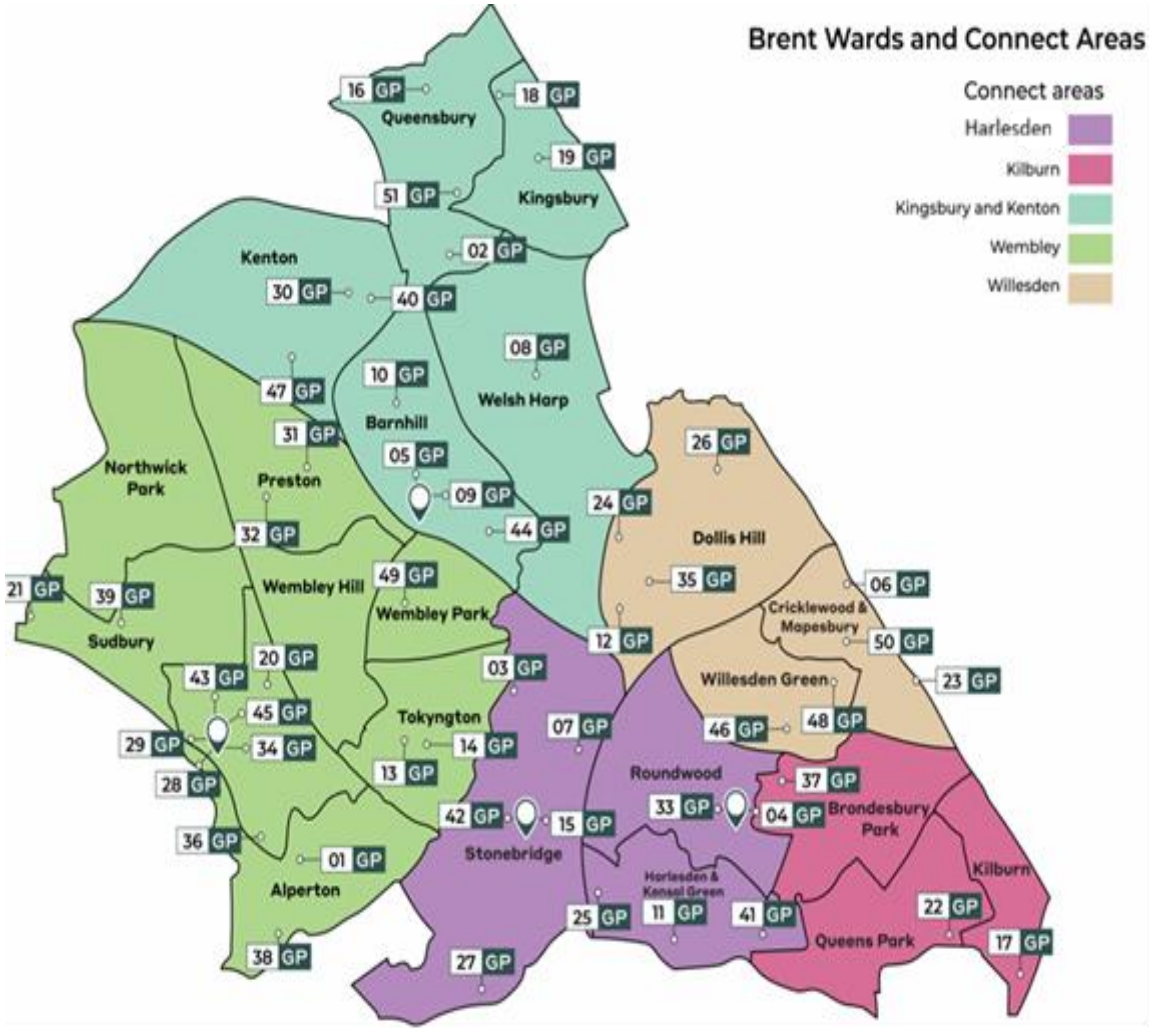
Neighbourhood geographies

- A foundational requirement to enable further implementation of the NHS Neighbourhood Health Framework is the confirmation of the geographic footprints for Brent's Neighbourhood areas.
- There is a policy expectation and convention that Health and Wellbeing Boards (HWBBs) are the natural place for these geographies to be discussed and agreed.
- While this specific decision-making role is not formally set out in legislation, it flows logically from the role of HWBBs set out in legislation (Local Government and Public Involvement in Health Act 2007, as amended) to produce a Joint Strategic Needs Assessment (JSNA) and Local Health and Wellbeing Strategy, and set the strategic direction for population health.
- An open process for NHS and service stakeholders to present evidence for any potential changes is currently taking place (noting this is not a public consultation). The evidence and options will be brought to a future HWB for decision on neighbourhood geographical footprint.

Current Position

Neighbourhood	Population	Projected Growth (By 2041)	GP Registered Population
Kilburn	47,913	53,600	34,538
Willesden	54,787	66,800	77,803
Harlesden	56,965	74,200	83,455
Kingsbury & Kenton	75,663	92,000	89,538
Wembley	104,487	165,600	249,046

- Current footprints vary significantly in size.
- Some are already operating close to the neighbourhood model described nationally, whilst others are substantially larger.
- There are differing views on which neighbourhood the Cricklewood & Mapesbury Ward fits best
- The Wembley neighbourhood area is at the upper edge of the guidance, with a growing population



Progress so far

Neighbourhoods' Maturity Matrix

- Using the Neighbourhood Maturity Matrix, we have undertaken a full assessment across all components of the framework.
- This provides a clear baseline of current delivery, strengths, and areas needing development across our neighbourhood model.
- **The stock take shows that most components are currently at Developing (Level 1), with some pockets of Established (Level 2) progress emerging.**
- Below are some key highlights

Level	Stage	Description
0	**Not Started**	No activity or planning has begun in this area.
1	**Developing**	Early steps taken; plans forming or pilots underway, but inconsistent or limited implementation.
2	**Established**	Core elements are in place and functioning; consistent practice is evident across the neighbourhood.
3	**Mature/ Exemplar**	Model of good practice with evidence of impact; actively sharing learning and case studies locally and beyond.

Strong foundations for neighbourhood working:
• Leadership teams established in every neighbourhood; INT Executive group operating to support decision-making.
• Clear local messaging on neighbourhood health exists, with work underway to bring together the three workstreams under a single "Working in Neighbourhoods" (WIN) identity.

Estates and co-location progressing
• Mapping of community hubs completed, with refreshed local estates strategy in place.
• Harlesden identified as a priority site with active co-location plans (WIN team already co-locating).

Workforce development underway
• Training Needs Analysis completed; OD (Organisational Development) plan in development.
• Successful delivery of 21st Century Leadership Programme cohorts supporting culture and leadership within neighbourhood teams.

Information sharing and digital infrastructure advancing
• IG work underway to enable LA access to London Care Record /Universal Care Plan (UCP) (Role based access definition and local opt-out being developed).
• Promotion plans for UCP

Early operational progress in place
• Child Health Hubs launched and aligned with neighbourhood footprints.
• JOY Directory of Services now in use across primary care and being adopted by the council to strengthen single signposting.
• Population dashboard developed at neighbourhood level, including a resident-facing version.

Clear priorities established for next phase
• Alignment of frailty and CYP models of care with WNL frameworks.
• Development of neighbourhood-specific action plans as the basis for quality improvement and delivery.

Progress since last update to HWBB

Neighbourhoods

Harlesden remains the most mature neighbourhood within the programme, with its action plan now substantially complete and progressing through governance (see Slide 15). Delivery against a number of priorities is already underway, demonstrating the transition from planning into implementation.

The remaining neighbourhoods are at different stages of development and continue to use population health intelligence, resident insight and partner engagement to identify local priorities. Draft neighbourhood action plans are being developed and will be brought through governance, with the emerging priorities presented to a future Health and Wellbeing Board meeting.

Enabler Workstreams

The Workforce & Organisational Development, Estates and Digital workstreams are being refreshed to align with the emerging National Neighbourhood Health Framework and Brent's neighbourhood delivery model. Each group is reviewing its Terms of Reference and establishing a refreshed programme of work to ensure the enablers provide strategic oversight and support to neighbourhood delivery.

Digital

The Digital workstream has delivered a significant milestone by enabling Adult Social Care staff to access Universal Care Plans (UCPs). Training has now been completed, allowing staff to securely view Advance Care Plans and other shared care information for residents receiving support across organisations. This represents an important step towards more integrated, person-centred care, with further work continuing to enable full read/write functionality once national information governance requirements have been resolved.

HARLESDEN NEIGHBOURHOOD ACTION PLAN 2026–2030

Working together for better health and care

Example Action Plan

Our ambition is to improve health outcomes and reduce inequalities in Harlesden by delivering joined-up, proactive, neighbourhood-based care.
We want care to be delivered as close to home as possible.

1. OUR VISION

A healthier, fairer Harlesden where people live well for longer and receive the right care, at the right time, in the right place.

Our vision is shaped by:

- National and system priorities
- Population health data and inequalities
- What matters to our residents and communities

2. OUR PRIORITIES 2026–2030

1. **Community Leadership**
   Communities are heard, involved and leading change together.
2. **Community Safety, Substance Misuse and Anti-Social Behaviour**
   Safer communities and strong support to reduce harm and improve wellbeing.
3. **Housing and Homelessness**
   Safe, stable homes for everyone and support to prevent and reduce homelessness.
4. **Financial Hardship**
   Support to improve financial wellbeing and reduce the impact of cost-of-living pressures.
5. **Employment Support**
   Helping people into work, access training and build skills for a better future.
6. **Obesity**
   Healthy weight, healthy lives through prevention, support and healthy environments.
7. **Sexual Health**
   Accessible, inclusive and confidential sexual health services for all.
8. **Frailty, Care Home & Housebound Residents**
   Proactive quality management to help people stay independent at home for longer.
9. **End of Life Care**
   Compassionate, personalised care that respects choices and supports families.
10. **Long-term Conditions (CVD, Diabetes, COPD)**
    Better control, strong prevention and support to live well with long-term conditions.
11. **Mental Health Conditions and Dementia**
    Proactive support, earlier help and joined-up care for better outcomes.
12. **Children and Young People (CYP)**
    Healthy starts, early support and the right help at the right time.

3. HOW IT WORKS

Our neighbourhood model puts residents at the centre of coordinated care.

1. **Identify**
   Use data and local insight to identify people at risk and in need.
2. **Connect**
   Residents are connected to the right services and support.
3. **Coordinate**
   Multi-disciplinary teams work together around the person.
4. **Care at Home & in Community**
   Care is delivered close to home, with a focus on prevention.
5. **Review & Improve**
   We learn, measure impact and continuously improve.

Enabled by data and technology

- London Care Record
- WSiC dashboards
- Care plans

Working together

- Primary Care
- Community Services
- NWL Council
- GPs
- Residents & Carers

4. WHAT CHANGES FOR RESIDENTS

Care that is coordinated around you, not services
One joined-up team.
One care plan.

More proactive support, not just reactive care
We identify needs early and act early.

Care closer to home
More support in your community and at home.

Better access to community and preventative support
Help to stay well and independent for longer.

Your voice matters
We listen and shape services with you.

5. HOW SUCCESS IS MEASURED

	WHAT WE MEASURE	OUR TARGETS BY 2030
Activity	• % high-risk patients identified • % with care plan (LCP) • % discussed at MDT	>90% >80% >80%
Health Outcomes	• Improved quality of life • Better control of long-term conditions • More people die in their preferred place	↑ 5–10% improvement ↑
System Impact	• Reduction in non-elective admissions • Reduction in A&E attendances • Reduction in ambulance conveyances	10–20% reduction 10% reduction ↓
Experience	• Improved family/carer experience • Improved patient experience	↑ ↑
£	• Better outcomes, less variation • More efficient use of resources	Sustainable improvement

We will report progress transparently and adapt based on what works for our community.

WORKING TOGETHER
across health, care and our community to build a healthier, fairer Harlesden.

We care
We put people at the heart of everything.

We are local
We work in our neighbourhoods and communities.

We collaborate
We work together across organisations and sectors.

We improve
We learn, innovate and keep getting better.

We are fair
We tackle inequalities and champion equity for all.

Timeline for formal agreement of action plans

JULY 2026

- HWB report on overall approach, requirements and role

SEPTEMBER 2026

- HWB to review headlines on provisional action plans and work in 26/27
- HWB to confirm preferred geographies

DECEMBER 2026

- Neighbourhood action plans 27/28 formally submitted to HWB

*TBC based on HWB dates

Questions For The Board

- Are there any particular opportunities, risks or local priorities that Board members would like reflected in the neighbourhood approach and action plans being developed?
- Does the Board agree the timeline for reviewing and confirming Brent's neighbourhood geographies and initial action plans in Autumn 2026?