Brent

NHS
Brent Clinical Commissioning Group

MINUTES OF THE HEALTH AND WELLBEING BOARD
Held as a hybrid meeting on Thursday 30 July 2026 at 6.00 pm

Members in attendance: Councillor Grahl (Chair), Councillor Butt (Brent Council), Councillor Chadha (Brent Council), Councillor Rubin (Brent Council), Councillor Dixon (Brent Council), Dr Radhika Balu (GP & Clinical Director – Mental Health, WNL ICB), Simon Crawford (Deputy CEO, LNWH) (Jackie Allain (Director of Operations, CLCH), Robyn Doran (Director of Transformation, CNWL, and Brent ICP Co-Chair), David Crawley (HealthWatch Brent), Dr Ruth du Plessis (Interim Director of Public Health and Leisure, Brent Council – non-voting), Rachel Crossley (Corporate Director Service Reform and Strategy, Brent Council), Nigel Chapman (Corporate Director Children, Young People and Community Development, Brent Council – non-voting)

In attendance: Wendy Marchese (Strategic Partnerships Manager, Brent Council), Hannah O'Brien (Senior Governance Officer, Brent Council), Daniel Shurlock (Head of Place Leadership, Brent Council), Anita Silberbauer (Skylight Director, Crisis), Dr Debbie Frost (LGA), Subash Jayakumar (GP Partner – The Stonebridge Practice / Clinical Director – Harness PCN South), Eleanour Maxwell (Senior Programme Officer, Better Care Fund, Brent Council)

Councillor Grahl opened the meeting as the newly appointed Chair and welcomed those present, including new members to the Board. She thanked the outgoing Chair, Neil Nerva, for Chairing for the previous three years.

1. Apologies for absence and clarification of alternate members

Apologies for absence were received from the following:

- Kim Wright (Chief Executive, Brent Council)
- Tom Shakespeare (Brent Integrated Care Board Director)
- Claudia Brown (Director of Adult Social Care, Brent)
- Dr Rammya Mathew (Vice Chair, ICP)

2. Declarations of Interest

None declared.

3. Minutes of the previous meeting

RESOLVED: That the minutes of the previous meeting, held on 16 April 2026, be approved as an accurate record of the meeting.

4. Matters arising (if any)

None.

5. Neighbourhood Health - National Guidance and Brent's Approach to 'Working in Neighbourhoods'

The Board received a report from the Brent Integrated Care Partnership (ICP) Executive setting out the goals and expectations of the NHS Neighbourhood Health Framework and how it will be delivered as part of Brent's overall approach to 'Working in Neighbourhoods' (WIN), highlighting progress to date in neighbourhood working in Brent and outlining the role of the Health and Wellbeing Board in shaping, overseeing and championing neighbourhood working. Robyn Doran began the presentation and highlighted the following key points:

- She highlighted the importance of neighbourhood work both because Brent had been passionately working towards this for several years and because it was now part of a framework in terms of the NHS 10-Year Plan which cited the importance of Health and Wellbeing Boards in the shaping of neighbourhood geographies and overseeing how the work was implemented locally.
- The framework set out how local areas should move away from the hospital-based treatment that had been traditionally delivered for many years to a community-based model, towards prevention and away from treatment, and towards a digital approach, away from analogue. The principle should be care as close to home as possible, wrapping services for health and social care, and the voluntary sector, around where people lived.
- In recognising those aims, the ICP also acknowledged the differences across neighbourhoods in Brent. Neighbourhood working had been piloted in Harlesden for the past 18 months which she had advised had been a successful way of working, asking the community what mattered most to them.
- As the ICP had tested and learned from that model, it would look to roll it out wider across the whole borough, with a programme overseeing that and neighbourhoods agreed by the Health and Wellbeing Board. The ICP would report regularly to the Board on the progress of the programme.

Dan Shurlock then outlined the Health and Wellbeing Board's role in supporting working in neighbourhoods, highlighting the following key points:

- There were some significant decisions and roles for the Health and Wellbeing Board in supporting the implementation of Working in Neighbourhoods, including to confirm the neighbourhood geographies.
- There was an expectation for an action plan to be signed off for each of the agreed neighbourhood areas in Brent, with those action plans aiming to deliver some of the key NHS targets around health services going forward. Brent should identify the local priorities specific to Brent communities that the system wanted to work together on and identify opportunities to bring in additional funding and resources to deliver those priorities.
- The ICP was opening up a conversation with key stakeholders to ask for their views on geographies. That evidence would be gathered for the Board and the ICP would return to the Board in September 2026 outlining that engagement work, the findings and recommending a way forward for neighbourhood geographies.

Subash Jayakumar then provided further details of the pilot work conducted in Harlesden, highlighting the following key points:

- Subash Jayakumar began by introducing himself as a GP based at the Stonebridge practice and the PCN Clinical Director and Clinical Lead for the

Harlesden neighbourhood, supporting 10 practices within the Harlesden and Stonebridge area and covering a population of around 60,000 patients.

- The PCN had found that, for an increasing amount of time, many residents had been finding health organisations difficult to manoeuvre. Residents reported having to repeat their stories multiple times on a practical basis due to being moved around the system, which he highlighted was despite some important work going on within each organisation.
- As a GP, whilst his focus was on health, he could see that residents had challenges much wider than health and struggled with housing, benefits, financial strain, crime, violence and alcohol and drugs on top of their health. As such, much of what was happening for residents was intersectional and multi-faceted, resulting in residents reaching a crisis stage.
- Looking to address that, the Harlesden pilot looked to build new models and ways of working that broke down some of the organisational barriers residents were experiencing, with a strong Neighbourhood Team in place involving health, Council services, and community and voluntary sector organisations.
- The work over the last 18 months had been strong in identifying the key pressures and priorities within organisations and what residents were attending those organisations for, and the relationships that had been built during that time were equally powerful.
- He was pleased to have worked with Crisis Skylight during the pilot phase who he would not normally have worked with if it had not been for this workstream, and that relationship was equally powerful.
- The work had confirmed that many residents and service users had the same overlapping problems, and from that learning a Harlesden neighbourhood action plan had been established focusing on priorities intentionally addressing community challenges such as safety, housing, finance and employment, recognising that wellbeing was much wider than health alone. These priorities would be delivered across partners collaboratively, avoiding the need to send residents back to another front door. Social Prescribing Link Workers from Brent Mencap had helped to facilitate that as well as Care Co-Ordinators and other multi-disciplinary colleagues who were not traditionally health focused.
- The pilot had also looked to develop strong IT tools and tools for communication and officers were looking to develop that further.
- The main areas of focus were; tackling complex needs; communicating between providers; working towards opportunities for earlier intervention and proactive care within the community and; working collaboratively across organisations to move forward the aims and objectives of neighbourhood working.

Anita Silberbaur then presented the work Crisis was doing in Skylight in Harlesden, highlighting the following key points:

- Crisis was commissioned to provide support to people who were homeless or at risk of homelessness who were owed the prevention or relief duty by the local authority. Through non-commissioned work which took place at Skylight in Harlesden, work took place with rough sleepers and people with multiple exclusion with complex needs.

- Through the work in Skylight, links had been made with health, social care and other providers and the work in neighbourhoods had enabled Skylight to use its experience and knowledge to work together to develop preventative solutions.
- Working in neighbourhoods presented the opportunity to look at neighbourhood planning and health planning together, with one plan for tackling those range of issues. Pride in Place was also a new opportunity that could contribute to this workstream.
- It was clear through the pilot in Harlesden that it was best to work in a joined-up way which improved the customer experience, and those involved were trying to find creative ways to do that and avoid working in siloes or duplicating work.
- To do that, effort was required and there was a need to have backing and commitment from senior levels which trickled through all levels, which she thought was the case in Brent. There had been shared learning opportunities and impactful results already from that approach.
- There was now more connectedness between different teams, statutory services, voluntary sector organisations and health partners, and the multidisciplinary team helped to pull together the various knowledge and resource across partners with one person holding onto a case and feeding back.
- One of the key successes to the pilot had been co-locating services in Skylight, which had made services available and accessible, bringing services outside of their teams and comfort zones into different places and working with different people to develop new ways of working and a new culture with more streamlining and less isolation of services and teams.

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

- The Chair recognised that bringing healthcare back into the community from hospitals had been a mainstay of the work between the Council and NHS for many years and acknowledged the level of demand on services. She asked to what extent it was believed that the reorientation of services would deliver results and whether it would be limited by that demand. Robyn Doran responded that there had been too long a focus on having people in hospitals, which cost money and was resource intensive. By shifting the focus and co-designing services with the community, such as with the work that had been done in Harlesden recognising there was an overrepresentation of young Black men subject to a Section under the Mental Health Act as their first interaction with services, CNWL had been able to reduce admissions and had already started to see that shift in demand. There was a need to put resource behind the work in order for that shift to work, and she encouraged senior officers to do that. Jackie Allain advised that CLCH were investing in the Urgent Community Response Teams providing hospital at home to prevent people going into the hospital in the first place, providing more complex care in the community. There was a lot of work being done to keep patients at home where possible including with the London Ambulance Service. As such, neighbourhood work was recognised as a solution to the increased acute demand.
- Radhika Balu confirmed that the WNL Strategy was presented to the Integrated Care Board (ICB) the previous week. That Strategy looked to shift 1% of funding

into neighbourhoods across the 13 boroughs. The Strategy also looked at how to make a difference at the front door through more preventative and proactive approaches. The Strategy focused on the communities with the most complex health conditions in the most deprived boroughs and preventative measures.

- Noting that neighbourhoods had different population volumes, the Board asked how that might be resourced. Ruth du Plessis advised that, together, partners had put a lot of thought into neighbourhoods, such as whether having a different make-up of teams for each neighbourhood depending on need would work, or different weightings. For example, where there was a younger population with families, the focus would be ensuring services around housing, family support and debt advice were available. Where there were older populations, the approach would look to have more input from Adult Social Care and services for the elderly. Some services would need to be provided in every borough, such as mental health services. Partners were working hard to develop datasets in order to ensure the work was data led and consulting with residents to ensure it was community led. Dan Shurlock confirmed that population size would be factored into the development of neighbourhood teams.
- David Crawley advised that Healthwatch was awaiting guidance on how the patient experience would be improved in the neighbourhood team model, as the mechanisms that had existed through Healthwatch were now being centralised and abolished. He asked whether any thought had been given into the new model of patient data. Ruth du Plessis thanked Healthwatch for the work it had done across Brent in highlighting areas for improvement and areas of good practice. Brent had been building a skill base around community engagement and were training neighbourhood managers to do that quality engagement. She added that having community leaders as part of the infrastructure for engagement would be key to enable co-design. Brent was trying to move to an approach where community leaders were taking the lead in implementing improvements. It was important to work with community leaders and keep those conversations going to ensure that Brent was getting it right.
- Noting that work had previously been done with Somalian communities around vaccine hesitancy, the Board asked whether any other work had been done specifically with the Somali community. Robyn Doran advised that there had been multiple workstreams working alongside the Somali community, including mental health, which she advised was not something that was talked about amongst the community. Brent had done a lot of listening, bringing in people from the Somali community who were mental health professionals and trusted to help educate people about mental health. There was also the current project being delivered for young Black men sectioned under the Mental Health Act who were overrepresented and of Somali heritage, which had led to good relationship building and trust. The next area of work would be around vaccination and dispelling certain myths around vaccination and the false claim it caused autism, using the community to impart those messages alongside health colleagues. Funding had now been agreed for the next stage of that project, with clear targets to improve vaccination rates for that community.
- The Board asked if officers were confident that they could match the target timelines and progress the work to achieve positive outcomes within that time, highlighting that some areas would not be in place until 2029. Dan Shurlock advised that Brent had undertaken a self-assessment with a long set of requirements and expectations to fill, and having reviewed with all relevant stakeholders where Brent was currently, felt that this presented a realistic progress chart. Overall, the NHS Plan was over 10-years, and 2029 was a

staging post within that time. As Brent was still at the start of the journey, 2029 was felt to be fair and accurate. He advised he was 'cautiously optimistic' about the delivery of the programme, advising that some priorities might shift based on what was learned over the coming years and any further national directives. With the investment set aside for the work, he felt that gave a better chance at success than simply good will and collaborative working, with all people around the table committed to the work and making the case for additional investment to support these targets wherever possible. He made a request that the Board asked how partners were progressing against targets as a standing question. Robyn Doran added that the fact this work was being done in an integrated way alongside communities, including the community and voluntary sector, was another reason it was more likely to be sustainable and make a difference.

- The Board asked for assurance that the funding for this work would come through from the ICB, highlighting that Brent now sat within a much larger ICB spanning 13 boroughs and there would be much more demand for that resource. If priorities changed or the ICB wanted to move in a different direction, the Board asked what that would mean for Working in Neighbourhoods. Radhika Balu explained that the ICB's role had moved back into strategic commissioning, no longer delivering services in each borough. The model of delivery going forward would be based around neighbourhoods, based on the NHS 10-Year Plan. She provided assurance that the ICB would do a 1% left shift of about £120m to each of the boroughs depending on the population and needs of each borough. The focus of those allocations would be addressing health inequalities and addressing the life expectancy gap between the different ICB boroughs. It was recognised that there were also life expectancy gaps within individual boroughs as well, and she felt that the only way to address that was by focusing on the wider determinants of health. As such, she assured Board members that the ICB was working towards this, recognising that health outcomes were determined by a multitude of factors not limited to a GP consultation.
- The WNL ICB Strategy was due to be shared with all members of the Board and she asked that everyone commented on the draft when they received it. The Integrated Health Needs Assessment for Brent would be included in that strategy, identifying Brent as having the highest asthma admission rates for childhood asthma, promoting the MMR vaccination, and reflecting on poverty in the borough.
- In terms of how this would be different from previous commitments made around joint and neighbourhood working, Rachel Crossley highlighted that the contributions from stakeholders and the new ICB already felt different with very mature conversations around the 1% left shift. She confirmed that Brent officers were at the table in those conversations and she could feel that relationship changing.
- The Board requested that the ambitions of Brent Health Matters (BHM) were considered and incorporated both into neighbourhood working and the ICB Strategy to ensure that tackling health inequalities remained a central part of the work being done in neighbourhoods.
- The Board asked what the plans were for data sharing and IT systems for neighbourhood working. Rachel Crossley highlighted the intention to have one care record across the NHS, bringing together one full picture of a patient and allowing Adult Social Care to have read-only access to those records. There was still work needed on the Council side to ensure the right toolkits were in place and information governance training had been delivered to do that, but

there was a commitment there, and in particular she was keen to do the work at scale across services where possible to ensure systems were talking to each other.

- Simon Crawford provided a perspective from acute services, welcoming any community initiatives designed to prevent admissions and support patients in the community. He recognised the work that had taken place in Brent over the last 18 months to test a range of different initiatives. He also welcomed the intention for the 1% left shift, and hoped for more clarity around how much would be coming in and when, as well as what specifically it would target to help prevent admissions, as at the present moment he was still seeing a rising demand in acute services with a record summer period in terms of ambulance attendances and admissions.

In concluding the discussion, the Chair thanked representatives for their presentation and for responding to the Board's questions, and the Board approved the recommendations set out in the report.

6. LGA Independent Review of Brent Health Matters and Brent's Response

Councillor Liz Dixon (as Cabinet Member for Community Safety and Public Health) introduced the item, which presented the LGA independent review of Brent Health Matters (BHM), and Brent's response to the review. In introducing the report, she commended the work of BHM and was pleased that the review had recognised the success of the programme and what it had achieved in practice. The health checks in factories and health events in community spaces such as the Pakistani Community Centre were particularly emphasised as good practice in community engagement and tackling health inequalities. She provided a brief history of the establishment of BHM in response to COVID-19 and its now ongoing programme tackling health inequalities and thanked all who contributed to the review. She then invited Dr Debbie Frost to present further information who highlighted the following points:

- Dr Debbie Frost had been asked to facilitate reviews by the LGA as a retired Deputy Medical Director at NHSE, a Barnet GP and Chair of the then Barnet CCG, and she had been facilitating reviews for around 10 years. The LGA attended reviews as a group of multiple professionals to discuss the delivery of health programmes with local stakeholders. The feedback that the LGA gave came from local people.
- In Brent, the LGA spoke to over 30 people and then presented the report at a workshop of senior stakeholders in April. She presented the positive comments heard about BHM which was treasured within the community and did well in reaching communities that were often not engaging with services.
- Within the feedback received from the review, respondents felt that BHM was running alongside the system rather than within it and it was clear that not enough integration between mainstream primary care and BHM was happening. There was also a feeling that some of the activity was already being commissioned in primary and community care. She advised that a relationship was essential between BHM and primary care so that when BHM made successful interventions the practical steps, such as booking an appointment for a vaccination at the GP, could be undertaken quickly and seamlessly.
- Feedback also highlighted that the real impact of BHM's work was not being captured and it was not clear that some of the outcomes, which were very clinical in nature, were as the result of BHM interventions. For Dr Debbie Frost, the most

compelling narrative was successful individual stories, such as when the BHM team visited a family who needed help for asthma and also supported that family in applying for benefits and school places for three children who were not in school and arranged a dentist appointment all within the same visit, which was not possible to quantify but which made a big difference to that family. She felt that some of this community working could be better communicated when reporting the impact of BHM.

- Further feedback suggested that upstream prevention ambition was unfinished and that the programme had focused too much on health access and clinical interventions instead of the wider determinants of health, such as housing, employment, poverty, education and place.
- There was no shared infrastructure enabling organisations to collaborate. Several interviewees pointed to organisations already functioning as neighbourhood anchors such as the Jason Roberts Foundation, Ashford Place and Harlesden Collaborative as examples of what was possible when community energy was properly resourced and connected, and the report advocated for putting people at the centre of what BHM was doing instead of statistics.
- BHM had no dedicated Programme Board to achieve a common vision from all partners, with no obvious body that brought together the stakeholders to own the outcomes framework for BHM.
- The recommendations from the workshop were then presented and focused on moving towards prevention, moving care into the community, and moving from analogue to digital. The LGA recommended BHM supported more community-based or community-led actions, repurposed the BHM grant programme, ensured a stronger focus on children, young people and families for early support and prevention, aligned relationships to Integrated Neighbourhood Teams, introduced a small flexible budget that could be drawn on, made links to the wider enablers for neighbourhood working and integrated BHM with primary care.

Dan Shurlock then presented Brent's responses to the review, highlighting the following key points:

- The work to align BHM closer to the wider neighbourhoods agenda was underway with a detailed action plan.
- There was now a Joint Partnership Leadership Group established with key stakeholders, including two GPs, to help link BHM with primary care. That group was 100% committed to taking forward the recommendations and actions from the review.
- He felt that the review provided a balanced view of BHM that celebrated the successes and achievements of the team and identified ways BHM could develop further.
- Following the outcome of the review, BHM had looked to reprioritise the resource available based on the learning, putting it towards the areas that would make the most difference and deliver the biggest impact.

Ruth du Plessis summed up the presentation by quoting the review which had found that BHM had achieved something genuinely hard to replicate. She thanked the Programme Director, Nipa Shah, for the work she had done with BHM over the years since it had been established and thanked the LGA for producing their peer review. She felt that the

programme had built real trust in communities above and beyond what statutory services had previously been able to do.

The Chair thanked officers for their presentation and invited comments and questions from Board members, with the following points raised:

- The Board echoed the compliments for BHM which they felt was an asset to Brent and truly valued in the community. They thanked the LGA for conducting the review and were pleased to receive external validation for what was being done and how that could be improved.
- Noting that there were recommendations to further develop work with children and families, the Board asked what partners thought would make the most impact there, particularly in relation to immunisations and oral health. Ruth du Plessis advised that BHM had agreed it would shift resource to ensure a bigger focus on children and families, linked with Brent hubs and wider teams such as the 0-19 service. She agreed that there was a need to focus on dentistry and immunisations and added that mental health was also a top priority she would want to see resource go towards. She advised that BHM could do more in that preventative space for children and young people on mental health. Partners were also looking to shift clinical resource into those areas as well. Robyn Doran highlighted childhood asthma as another area to focus on, and she had seen a shift with BHM working with GPs delivering children's hubs which had made a big difference in identifying the social determinants of health.
- In response to whether BHM worked with housing colleagues, officers confirmed this was the case.
- The Board asked whether BHM delivered any work specifically related to addiction. Ruth du Plessis confirmed work was delivered through VIA New Beginnings, Brent's service user-led drug and alcohol service, who had used the opportunity through BHM to break down some of the stigma towards addiction and raise awareness of the services available to help and support those experiencing addiction. She added that often services may see someone with a mental health issue who did not then get treated by the drugs and alcohol service and vice versa, so the mental health and addiction team was trying to invest in those services by creating some combined posts across mental health and addiction. Slightly wider, better links with housing were being made in relation to mental health with a dedicated housing post within the service and bringing in community connectors who could relate to different communities and the different understandings of mental health from different cultural backgrounds.
- The Board was pleased that one of the recommendations was to focus on community grants and ensuring more trusted voices around the table.
- Noting the comments around the lack of demonstrable outcomes using the current reporting mechanisms, the Board asked what data collection would need to take place in order to capture the work and outcomes in more detail. Robyn Doran responded that one of the questions being asked was how the programme could measure social value and the difference it was making. There were measures out there to capture that and the level of community engagement which BHM was now looking at. Dan Shurlock responded that it was an important challenge to the team. Going forward, the ICP was going to support BHM with more practical next steps to work with individuals and families to navigate their individual situations which would have some measures of the positive impact by helping those families avoid a crisis

or a cost avoidance in the system. The methods of capturing that were not straightforward but were possible. As a practical example, Ruth du Plessis advised that BHM had recently attended a factory night shift where they learned that the factory catering system had been changed as a result of the education from BHM, showing the wider impacts that had not been measured or reported. As such, BHM was looking to understand some of those wider impacts further. Radhika Balu added that it would be useful for the ICB to receive feedback when BHM and Brent ICP measured social value so that could be fed into the overall WNL strategy.

As no further issues were raised, the Board thanked BHM for all the work they do, particularly the work around early detection of bowel cancer which had saved lives.

7. Better Care Fund Overview and Forward Planning

7.1 Overview of the Better Care Fund

Eleanor Maxwell provided an overview of what the Better Care Fund was and its mechanisms to new Board members before they were asked to ratify the end of year position and plan for 2026-27. In outlining the purpose of the Better Care Fund, she highlighted that it underpinned the services residents relied on, particularly in relation to the move between hospital and the place the patient called home. There were many strands of governance to the Better Care Fund (BCF), for which the Health and Wellbeing Board provided strategic oversight and democratic accountability. Every area in England was required to produce a BCF which then acted as a joint agreement between the local authority and ICB and was supported by a Section 75 Agreement. Whilst based on guidance, every BCF was local to the area it sat within, meaning Brent had the ability to chose how BCF funds were spent in the borough and there was a good amount of flexibility within that. In terms of the purpose of the BCF, she advised that it enabled the local authority and ICB to jointly plan services by bringing funding together to focus on shared priorities based on the needs of residents.

Over the last three years, she had helped to significantly strengthen the way Brent managed the BCF with stronger monitoring of metrics and stronger governance. A full corporate audit had been undertaken with all recommendations now implemented and a dedicated BCF Board had been established to improve financial monitoring and scheme management. The stronger, more robust approach to measuring performance and outcomes had strengthened partnership working, giving greater visibility of where the investment was having the greatest impact and enabling partner to move much faster where gaps needed to be addressed.

Eleanor Maxwell flagged that, over the next two years, there would be a need to respond to significant national changes, including the ICB restructuring, the development of a system integrator role, and the transition following the abolition of NHSE who currently owned the BCF. Whilst this would present challenges, she felt that there would also be opportunities to strengthen local partnership working to further align services around neighbourhoods.

Looking ahead, the BCF would continue to play a central role in supporting the shift towards neighbourhoods, and the key existing metrics were likely to remain unchanged. Whilst reducing hospital admissions and improving discharge were still priorities, there was an increasing focus on prevention, early intervention and supporting people to remain independent in their own communities. The BCF would increasingly align with the development of neighbourhood working, meaning using shared resources and flexibility, designing services around people’s needs rather than organisational boundaries and making greater use of shared data and joint decision making. Success would increasingly be measured not only by how quickly people leave hospital but whether they were able to

live healthier and more independent lives and avoid unnecessary escalation into intensive services. In practical terms, she flagged that the greatest challenge would be balancing the need to sustain existing services with the expectation to invest in new models of care, which would be difficult if the funding did not keep pace with inflation, or if there were demographic changes or rising demand where Brent was expected to do more with less.

7.2 Better Care Fund Year-End Position 2025-26

Rachel Crossley introduced the BCF end of year report for 2025-26 which sought formal ratification from the Health and Wellbeing Board. She noted that, due to tight timescales, she had signed off the End of Year report under delegated authority from the Health and Wellbeing Board in order to meet the national submission deadlines.

In considering the report, the following points were raised:

- Councillor Butt noted the Section 75 agreement presented and agreed at Cabinet on Monday 27 July 2026, which ensured discharge and support elements were in place for residents moving out of hospital. He noted that there previously was more funding coming through in this area, and highlighted issues going forward if the level of funding was not in line with demand, need and the opportunities and commitments required of all partners.
- In response, Eleanor Maxwell agreed that there was a need for stability of funding. The previous year, local areas had only been notified of funding 2 weeks before the national deadline for completion, meaning a budget of stability was set, and this year, due to national and regional structural changes to the system, another budget of stability had been set, but every scheme had been re-costed and looked at in depth. She highlighted if the funding did not keep pace with inflation for a further year then that risked devaluing what the scheme could do and it would not be possible to deliver new innovative schemes. She expected that going forward the new merged ICB would look for consistency in funding across the 13 boroughs.

As no further points were raised, the Chair drew the item to close and the Health and Wellbeing Board approved the 2025-26 Better Care Fund End of Year report.

7.3 Better Care Fund Proposed Plans for 2026-27

Eleanor Maxwell then presented the proposed BCF Plan for 2026-27 and an update on the planning process, which had been developed jointly with the WNL ICB and submitted to NHSE by the deadline of 14 May 2026. She highlighted that the plan allocated £57m of joint funding covering 60 schemes spanning discharge, reablement, community therapies, equipment, carer support, adaptations and services for independence. £19m was set aside for community health services commissioned by the ICB, £30m for Adult Social Care commissioned services, £7m for the Disabled Facilities Grant and around £1m for some wider Council and voluntary services, which she highlighted was a reflection of the breadth of the number of partners and services in Brent. Success of the scheme would be measured through key system metrics such as fewer hospital admissions, faster hospital discharges, more people supported safely at home and fewer long term residential admissions to care homes. The performance of every scheme was closely monitored through local KPIs, financial monitoring and regular performance reviews, and the data on these metrics was reported to NHSE. Performance monitoring ensured value for money and continuous improvement. She highlighted that she had developed a good system of tracking these metrics over the three years she had been in post as the dedicated Better Care Fund Project Officer as she felt it important to have a strong hold on whether the schemes were delivering what they set out to and identify where there were gaps that needed addressing.

In considering the report, the Board highlighted the following points:

- In considering the papers as a whole, the Board highlighted it would be useful to have further financial details in the reports in future as well as the outcomes of the schemes.
- The Board asked for further details regarding the £1.3m overspend attributed to community equipment. Eleanor Maxwell highlighted that the community equipment provider had stepped back from the contract, which left boroughs where they worked in a difficult position as it meant additional costs, including legal challenges and finding alternative suppliers. Whilst the ICB funded 62% of the contract, the ownership, commissioning and management sat with the local authority which resulted in an overspend. In addition, the budget setting from the ICB was not as accurate as it could be and was limited by funds available in the BCF. She highlighted that the community equipment budget had been overspent every year and she believed the budget set by the ICB needed to be reviewed. Rachel Crossley added that the new provider were delivering much better data and stronger contractual management since mobilisation.

As no further issues were raised, the Board resolved to formally approve the BCF Plan for 2026-27.

8. Forward Planning

The Chair gave members the opportunity to highlight any items they would like to see the Health and Wellbeing Board consider in the future.

In terms of future items, it was proposed that a joint paper between the ICP and Housing on the effects of housing on healthcare and health outcomes in the borough was brought to a future meeting, including proposed actions for the new neighbourhoods model and BHM, and linking this with the Council's air quality strategy. Nigel Chapman agreed to bring an update on progress towards Best Start in Life to a future meeting. Rachel Crossley agreed to bring a progress report on the Carer's Strategy to a future meeting.

The Board also requested that, where possible, residents and service users were invited to the meeting to share their experiences.

9. Any other urgent business

None.

The meeting was declared closed at 7:50 pm

COUNCILLOR GWEN GRAHL
Chair