Brent Joint Health and Wellbeing Strategy Refresh

Brent

Tackling health inequalities

Contents

Brent Joint Health and Wellbeing Strategy

A Health and Wellbeing Strategy is a plan designed to improve the health and wellbeing of the local population. It identifies key health priorities and outlines the necessary actions to address them. This document is a refresh of Brent's original Health and Wellbeing Strategy, with a renewed focus on tackling health inequalities.

The global pandemic exposed and highlighted health inequalities, prompting Brent to redefine its approach in developing a new Joint Health and Wellbeing Strategy. The current strategy represents a shift from previous health and care-focused objectives to a broader focus on the social determinants of health while adopting a more community-centred approach.

Brent's Joint Health and Wellbeing Strategy was developed in partnership with residents, health organisations, and voluntary sector organisations.

This collaborative effort established five main themes within the strategy:

- **1. Healthy lives**
  I am able to make the healthy choice and live in a healthy way, for myself and the people I care for.

- **2. Healthy places**
  Near me there are safe, clean places where I, and people I care for, can go to relax, exercise for free, meet with like-minded people, and where we can grow our own food.

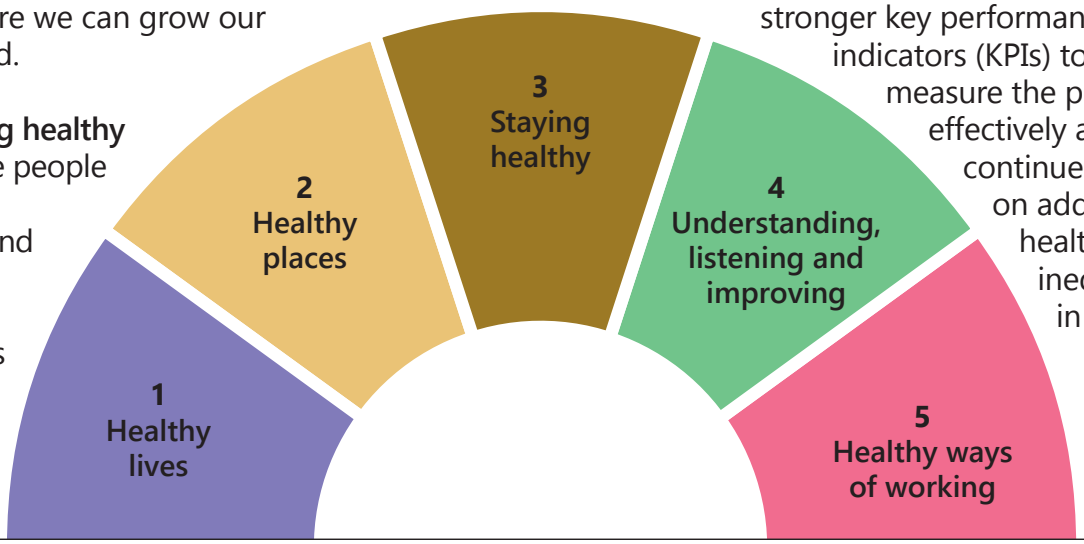
- **3. Staying healthy**
  I, and the people I care for, understand how to keep ourselves physically and mentally healthy, managing our health conditions using self-care first. We have access to good medical care when we need it.

- **4. Understanding, listening and improving**
  I, and those I care for, can have our say and contribute better to the way services are run; BHWB data are good quality and give a good picture of health inequalities.

- **5. Healthy ways of working**
  The health, care and wellbeing workforce will be happy and strong; and the health and wellbeing system will recover quickly from the impacts of the pandemic.

In January 2024, the Health and Wellbeing Board reaffirmed their commitment to these established priorities. Since most of the initial objectives have been achieved or become standard practice, all partners collaborated to propose the new commitments, which continue to be focused on addressing health inequalities.

The refreshed commitments feature stronger key performance indicators (KPIs) to measure the progress effectively and continue to focus on addressing health inequalities in Brent.



About Brent

Brent is situated in North West London. It covers an area of 4,325 hectares, making it London's fifteenth largest borough; about 22% of this is green space. It is also the capital's seventh most populous borough, with a population of 339,800. Brent is also ethnically diverse with almost two thirds of the population (64%) from Black, Asian and minority ethnic groups, the third highest in London. A further 19% of residents are from White minority groups and the remaining 16% of residents are White British, the second lowest rate in London(1).

Brent has a young population; the median age is 35, five years below the average for England (40); 21% of local people are under the age of 18. It is one of the most diverse boroughs in London – 56% of the local population were born abroad, the largest proportion of any local authority area. We are also ethnically diverse, with 34% Asian, 35% White, 17% Black, and 13% Mixed and other ethnic groups.

The largest single group is the Indian population who comprise 17% of residents. The borough has the third largest Hindu population in England and Wales, and the tenth largest Muslim population (as a percentage of the population). Over 149 languages are spoken in the borough; 34% of residents do not have English as their main language – the second highest proportion in London.

(1) Source: Brent Open Data.

Key facts(2)

16%
of residents live in income deprived households (before housing costs)

36%
of residents live under the poverty line, after housing costs

30%
of residents who work full-time earn below the London Living Wage of £11.05

42,835
residents are in receipt of universal credit

339,800
residents live in Brent

71%
of residents are in employement including 11% who are self-employed

35
is the average age of our residents

118,612
households in Brent

1,705
households are in temporary accomadation

29%
of homes are privately rented

56%
of the population were born abroad

9%
of residents have diabetes and 11% have high blood pressure (data for NHS NWLCCG)

149+
different languages are spoken by residents

(2) Data source: trustforlondon.org.uk

Who is reponsible for delivering the Joint Health and Wellbeing Strategy?

The Health and Wellbeing Board is responsible for delivering the Joint Health and Wellbeing Strategy (JHWS).

Brent

healthwatch Brent

Brent ICP
Integrated Care Partnership

NHS
North West London

NHS
Central London Community Healthcare
NHS Trust

NHS
London North West University Healthcare
NHS Trust

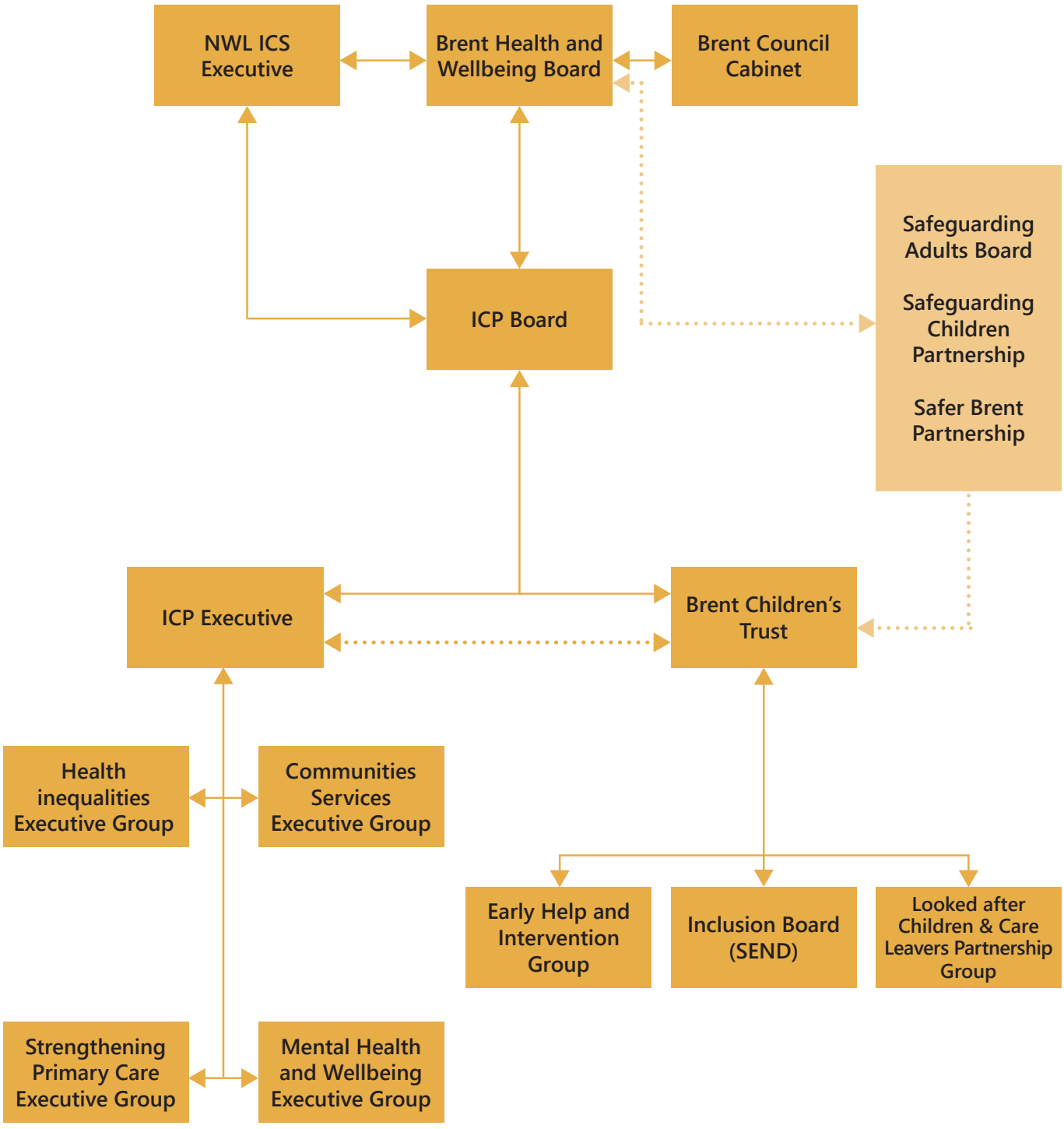
NHS
Central and North West London
NHS Foundation Trust

Health and Wellbeing Boards (HWBs) are a statutory forum where political, clinical, professional and community leaders come together to improve the health and wellbeing of their local population. Health and Wellbeing Boards have a statutory duty to produce a Joint Health and Wellbeing Strategy (JHWS) for their local population, as set out in the Health and Social Care Act 2021. All Board members must have regard for the JHWS in the delivery of their health and wellbeing services and responsibilities.

The Brent Health and Wellbeing Board (BHWB) is made up of key partners, with representatives from:

- Brent Council (including Councillors, Public Health, Adult Social Care, and Children and Young People)
- NHS Brent Integrated Care Partnership Executive Committee
  - North West London Integrated Care Board (NWL ICB)
  - Central and North West London Mental Health Trust (CNWL)
  - Central London Community Health Care (CLCH)
  - London North West University Healthcare (LNWUH)
- Nursing and residential care
- Healthwatch Brent

As well as its statutory role, the BHWB ensures system leadership across commissioners and providers working in Brent. The Joint Health and Wellbeing Strategy (JHWS) outlines the key priorities for the BHWB. Much of the delivery of the strategy sits with the Integrated Care Partnership (ICP) and Brent Children's Trust (BCT).


NWL ICS Executive
Brent Health and Wellbeing Board
Brent Council Cabinet
ICP Board
Safeguarding Adults Board
Safeguarding Children Partnership
Safer Brent Partnership
ICP Executive
Brent Children's Trust
Health inequalities Executive Group
Communities Services Executive Group
Early Help and Intervention Group
Inclusion Board (SEND)
Looked after Children & Care Leavers Partnership Group
Strengthening Primary Care Executive Group
Mental Health and Wellbeing Executive Group

What are the health and wellbeing inequalities?

Health inequalities are ultimately differences in the status of people's health, that can be related to a range of different issues that impact on the opportunities they have to lead healthy, well lives.

These can include:

- If someone has any health conditions
- If people are able to access treatment when they need it
- The quality of the care and treatment when it is needed
- Behaviours including drinking alcohol and smoking
- Wider sociol and economic determinants of health, for example where someone lives, their housing situation, the nature of their job

Often these inequalities can be experienced by different groups of people for example:

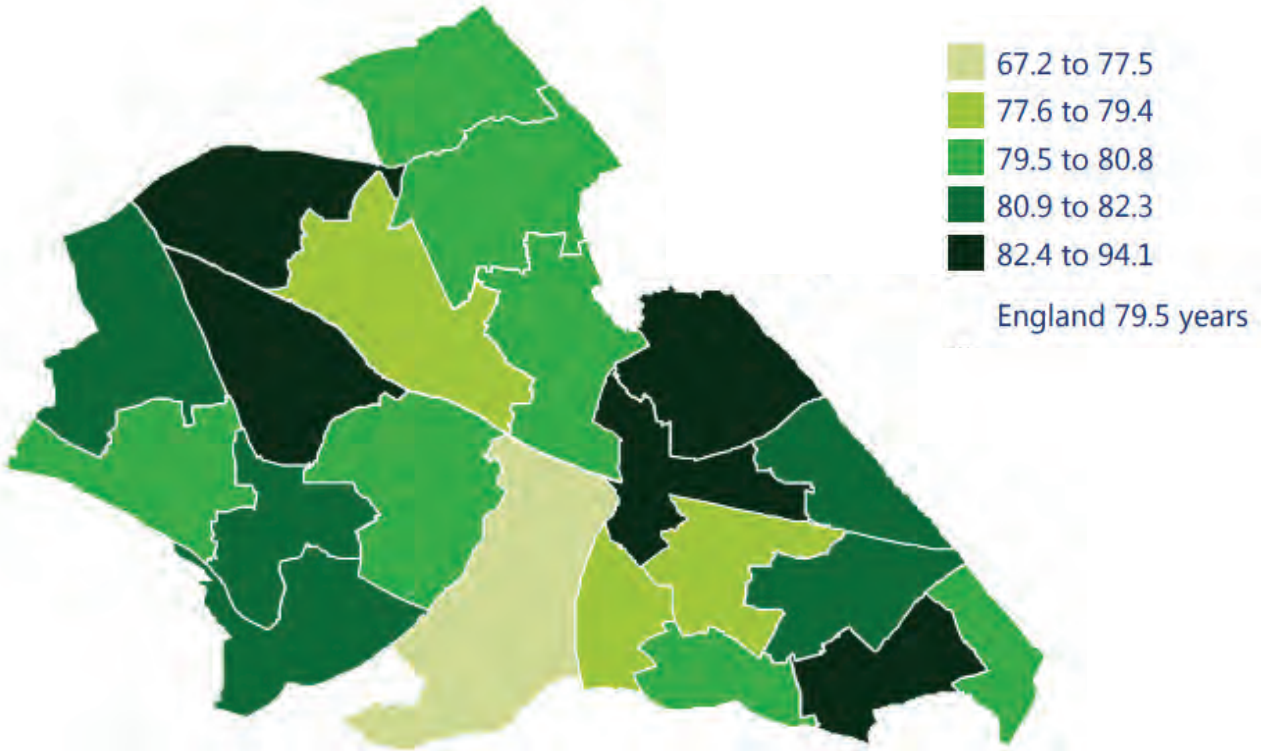
- Those living in more deprived areas and other socio-economic factors, for example those on lower incomes
- Younger and older people, those from black and minority ethnic communities and those living with a disability
- Socially excluded groups such as people experiencing homelessness

People will experience different and/or multiple combinations of these factors, and this will impact on the health inequalities they experience. A simple way of understanding the impacts of these factors is looking at the inequalities in life expectancy. Life expectancy for males at birth in Brent 2018-2020(3) is 80.4 years, female at birth is 85 years.

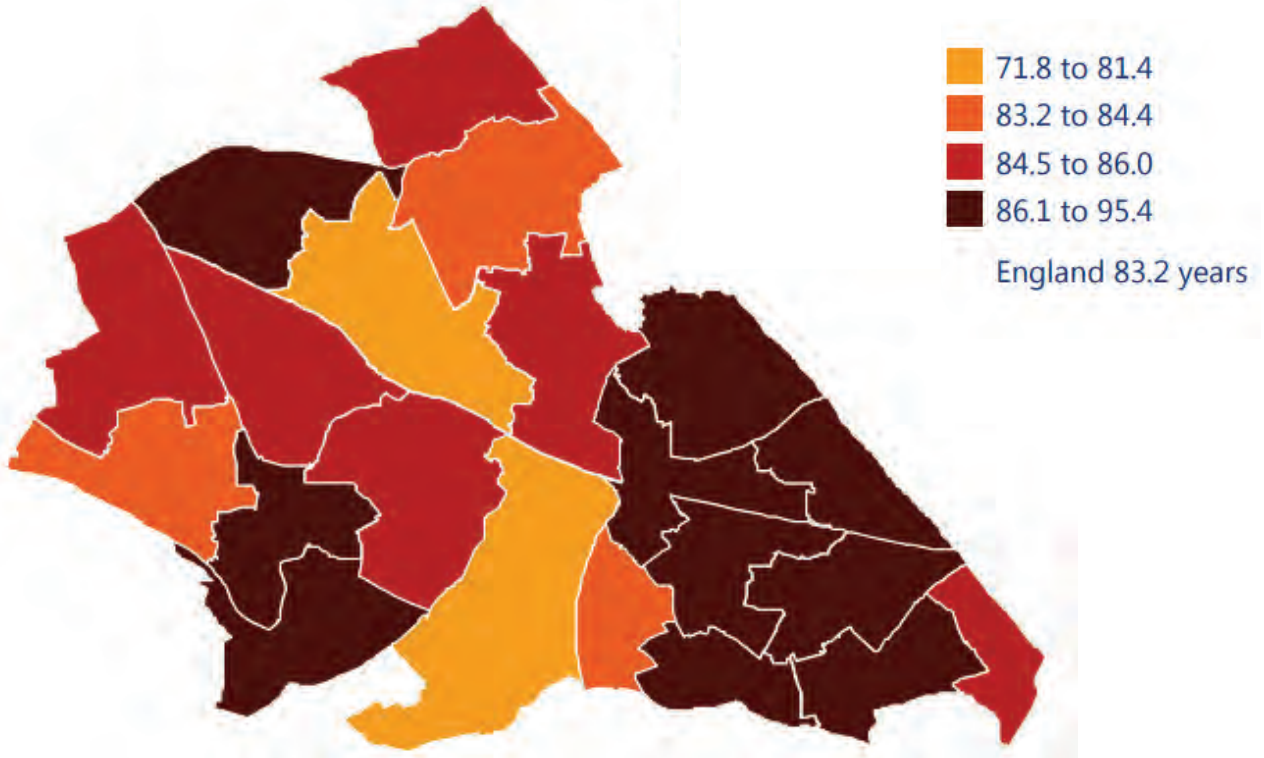
These are lower than most of our neighbouring boroughs. There are differences in life expectancy within Brent too, as shown in the following two maps.

(3) This is the latest available life expectancy data for Brent; no more recent data has been published as of July 2024.

Male life expectancy at birth (Brent 2016-2020)



Female life expectancy at birth (Brent 2016-2020)



Brent will aim to give access to healthy, affordable food for all residents with a focus on food education and sustainability.

New and Refreshed Commitments

The table below illustrates the new commitments for the Health and Wellbeing Strategy. These commitments include brand new projects as well as ongoing activities that were not previously included in the main strategy. Capturing this work is essential not only for measuring its health impact but also for receiving the Health and Wellbeing Board's approval and spotlight. This visibility may allow some of these activities to be expanded and further benefit the community.

1 HEALTHY LIVES

I am able to make the healthy choice and live in a healthy way, for myself and the people I care for.

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.1	We will coproduce Brent's first food strategy in collaboration with community groups and other local organisations. This strategy will improve access to healthy, affordable food for all residents with a focus on food education and sustainability.	By improving access to nutritious food and improving understanding through education, we aim to bridge health gaps and foster equality in health and wellbeing across our communities.	The number of organisations involved in coproducing the strategy. Additional KPIs might be considered once the strategy is developed.	Currently, there is no formal food strategy in place for Brent. So far, we have engaged with 37 local organisations during the Visioning Workshop, who have contributed to developing the provisional scope of the strategy.	Public Health

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.2	We will deliver health and wellbeing community events throughout the Borough, including health checks and health promotion.	We monitor how we are reaching our more deprived communities and track the ethnicity of those taking up our offer. Some of our events will have a specific focus, such as those aimed at factory workers or particular faith settings. Additionally, we will coproduce community events to ensure they meet the needs of our diverse population. We will also provide targeted interventions at a community level, focusing on conditions such as CVD to Cardiovascular Disease (CVD), diabetes, and mental health.	Carry out at least 40 community events per month across five localities in Brent.	Public Health and Brent Health Matters currently organise and carry out health and wellbeing events throughout the borough. On average, they hold around 35 events per month, focusing on general health promotion, immunisation, and specific conditions like CVD, diabetes, cancer, and mental health issues.	Public Health

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.3	We will distribute a minimum of £250,000 in community grants to support projects aimed at improving the health, wellbeing, and development of children and young people.	All grant recipients will identify specific groups of children and young people who currently face health inequalities. By targeting these vulnerable populations, we aim to reduce health disparities and contribute to more equitable health outcomes within our community.	The number of community organisations supported.	The number of community organisations who were supported last year is: 46	Brent Health Matters
1.4	We will address inequities in access to NHS services through targeted communication activities.	By promoting access to NHS services through social media and flyers, we aim to reach people who currently do not access NHS services in a timely manner. This approach will help raise awareness and provide information to underserved populations, thereby reducing barriers to healthcare and addressing health inequalities.	Promote communications for at least three NHS services through social media and flyers, ensuring a reach of at least 6,000 people per month.	Work has started in collaboration with NHS colleagues. We have promoted the COVID spring booster campaign, the Pharmacy First campaign, and childhood immunisations (MMR), reaching approximately 36,000 people through social media and distributing 500 flyers.	Communication

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.5	We will provide Diabetes peer support and Digital inclusion programmes.	These initiatives aim to provide crucial support and resources to underserved populations, improving their health outcomes and access to digital health information.	Deliver at least six Healthy Educators programmes in the community, targeting Black, Asian, and Minority Ethnic (BAME), emerging communities and deprived neighbourhoods.	In 2023, we delivered five digital inclusion programmes, each consisting of six sessions, with 48 people graduating from the course. Additionally, we provided three diabetes peer support programmes, also with six sessions each, which 33 people completed.	Brent Health Matters
1.6	We will tackle period poverty through the rollout of Period Dignity Brent initiative, ensuring that residents have access to free, eco-friendly period products in publicly accessible council buildings across Brent and addressing stigmas and taboos that surrounds menstrual health.	Period Dignity Brent addresses health inequalities by ensuring accessible menstrual products for all, including disadvantaged groups such as asylum seekers, refugees, homeless people, or food bank users, by targeting distribution where we have identified the greatest need, in that way promoting period dignity and improving menstrual health outcomes.	This commitment will be measured by the number of sites providing the Period Dignity offer. We will track whether the offer is available at all the sites we initially targeted.	Currently there are six council buildings that can provide free period products. We have identified a further 10 locations to expand the offer.	Public Health Communications, Insight and Innovation

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.7	We will tackle tooth decay in children in Brent by delivering the mobile dental assessment and intervention programme (oral health bus) directly to primary schools with high rates of overweight and obesity.	We will target areas with high obesity rates, focusing on children living in the most deprived areas (deciles 1-3).	The number of oral health outreach events delivered at primary school: the target is 20. The number of children provided with dental assessments and interventions.	Last year the oral health bus visited 17 locations in close proximity to primary schools. 627 children from these locations were assessed last year.	Public Health
1.8	Further increase the uptake of Healthy Start Vouchers and vitamins	We will target all mothers, especially those from deprived areas, to ensure they have access to dental care and education. This focus will help reduce tooth decay in children by addressing the root causes and providing necessary resources and support to those most in need.	Increase the uptake of the Healthy Card Scheme among eligible Brent families by up to 5%. Up to 80% uptake of vitamin drops by residents from Family Wellbeing Centres and up to 30% uptake of pregnancy vitamins by residents in Family Wellbeing Centres.	Currently, the uptake of Healthy Start Card scheme among eligible families is 57% in Brent and the uptake of the healthy start vitamins among Brent families was not being reported.	Public Health

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.9	We will implement the BHM CYP team to tackle Health Inequalities in children and young people.	Our initial focus will be on increasing uptake of immunisation, improving asthma care and increasing awareness for mental health conditions. By targeting these areas, we aim to reduce health disparities among children and young people, particularly in underserved communities.	Total number of vaccinations given by the team. Number of children who received asthma reviews and management plans as a result of the team's outreach efforts.	This is a new initiative, so the baseline is 0.	Public Health Brent Health Matters
1.10	We will improve the mental health of school pupils through evidence-based interventions. Our skilled mental health practitioners liaise with teachers to identify children experiencing distress, increased absences, or social isolation.	By integrating mental health practitioners into schools and focusing on early, evidence-based interventions, we aim to provide equitable mental health support to all children, thereby reducing health disparities and promoting overall well-being.	The number of referrals. Percentage of referrals that progressed to interventions.	From September 2023 to March 2024, we received 98 referrals, of which 83 (approximately 85%) progressed to interventions.	Mental Health and Wellbeing Executive Group

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.11	We will continue providing tailored and accessible resources to most vulnerable residents through Community Hubs.	All Hub staff have received basic neurodiversity training, improving their flexible approach and enabling better support for residents with additional needs. This will improve residents' well-being and may reduce disparities between them and those without additional support needs.	The percentage of enquiries resolved at point of contact. The number of residents accessing Community Hubs.	The percentage of enquiries at the Community Hubs resolved at point of contact was 82% at the end of Q4 2023/24. The number of residents accessing Community Hubs was 5,510 in Q4.	Resident Services
1.12	We will address tobacco related inequalities in Brent via the government smokefree initiative. We will ensure our most vulnerable tobacco users such as pregnant smokers and smokers in drug & alcohol services are given the opportunity to quit.	By identifying areas of need, and engaging with underserved communities, such as the newly arrived communities and Paan consumers, to address barriers and co-produce a stop tobacco service that is accessible and culturally appropriate.	Number of organisations/ individuals (i.e. community champions) that engage with the initiative. Stop tobacco service activity as measured by number of referrals, those setting a Quit Date, or those that have Quit successfully using the programme.	We currently run a public health specialist stop tobacco service, with varying referral pathways into communities/ partner organisations. In 2022/23, 33 smokers joined the stop tobacco service, 45% of these managed to quit.	Public Health

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.13	In partnership with the London Ambulance Service, the Brent Rapid Response team will deploy clinicians alongside senior paramedics to provide urgent community care. This initiative aims to prevent avoidable hospital admissions and alleviate pressure on emergency services by managing Category 3, 4, and 5 patients directly in the community.	This service addresses health inequalities by providing quicker response times for Category 3, 4, and 5 patients, who typically wait longer for care. In Brent, where chronic conditions like diabetes and hypertension are common, timely and multidisciplinary care is crucial. The collaboration between BRR and LAS ensures these patients receive holistic and individualised treatment, improving health outcomes and reducing disparities.	The number of A&E attendances prevented by this pathway. The number of residents benefiting from this pathway.	This project is in the pilot phase. Currently, the pathway prevents approximately 30 A&E attendances every month. Data collected from the last six months suggests 5-6 patients a day benefit from this service.	Brent Integrated Care & Delivery Team, NWL ICB CLCH – Brent Rapid Response Team

1 HEALTHY LIVES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
1.14	We will appoint two Admiral Nurses to provide emotional care and support for families and patients at the pre-diagnosis stage or those already diagnosed with dementia. These nurses will offer skills and techniques to help families stay connected, manage fear and distress, advise on financial benefits and available support services, and ensure that both carers and patients receive the best possible additional care.	This commitment will tackle health inequalities by ensuring families and patients affected by dementia receive specialised, personalised support. Admiral Nurses will provide essential skills and techniques to manage emotional and practical challenges, reducing stress and improving quality of life. By advising on financial benefits and support services, they will help families access necessary resources, ensuring equitable care for all, regardless of socioeconomic status.	Each Admiral Nurse to have a minimum of 15 patients per case load of which at least 46% should have a BAME background. 75% of patients to remain at home rather than being admitted to a care home within a 12 month period. Reduction in GP visits commencing Admiral Nurse involvement. Reduction in Hospital admissions commencing Admiral Nurse involvement. 85% of patients/ carers/families to feel less isolated and feel that they can cope better following the support of the admiral nurse.	These are new posts, so no baseline yet.	Integrated Care & Delivery Team, NWL ICB

We will develop the programme of accessible activities in community spaces and parks, working with community organisations.

2 HEALTHY PLACES

Near me there are safe, clean places where I, and people I care for, can go to relax, exercise for free, meet with like-minded people, and where we can grow our own food.

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.1	We will organise regular social events for Ukrainian guests.	By improving access to nutritious food and improving understanding through education, we aim to bridge health gaps and foster equality in health and wellbeing across our communities.	This will be twofold; it will ensure Ukrainians will be able to meet other Ukrainians who are in the same situation as them, maintaining good mental health. The health inequality addressed is ensuring the Ukrainian community, which could otherwise be marginalised, remains included and supported.	At least one social event a month on average.	Communities and Partnerships

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.2	We will work with partners to create Sport England Place Based Expansion programme and Football Foundation Playzones initiative.	We will focus on residents in agreed locations (Stonebridge, Church End and Roundwood). By conducting consultations and data collection to identify community needs and gaps in provision, we aim to create inclusive spaces that promote physical activity and community engagement. This will address health inequalities by providing equitable access to sports and recreational facilities.	• Amount of funding secured from Sport England. • Number of community steering group established. • Numbers of people engaged in new activities. • Numbers of people new to Physical Activity.	Currently, there is no coordinated programme in the targeted locations (Stonebridge, Church End, and Roundwood). Initial consultations and community needs assessments are pending, and no funding has been secured yet.	Public Health London Sport Community Organisations

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.3	We will develop the programme of accessible activities in community spaces and parks, working with community organisations, for example walks programme, Our Parks, support to use outdoor gyms.	We will target residents, particularly those from priority groups such as children and young people, individuals with long-term health conditions, and inactive populations. By providing accessible activities, we aim to improve physical health, foster community engagement, and reduce health disparities among these groups.	• Number of programmes offered. • Number of participants. • Number of referrals made from health professionals.	Currently, there is no coordinated programme in the targeted locations (Stonebridge, Church End, and Roundwood). Initial consultations and community needs assessments are pending, and no funding has been secured yet.	Public Health London Sport Community Organisations
2.4	We will improve the quality of housing in Brent across the private sector though borough wide licensing of the private rental section and an adaptations programme that makes sure that disabled residents live in homes that meet their needs.	Poor quality PRS housing is a significant contributor to health inequalities as is housing which is unsuited to residents with disabilities.	Number of properties licensed; the target is 12,000. Amount spent on adaptations.	In 2023/24, 9,500 properties were licensed. In 2023/24, we have allocated £8.1m on adaptations.	Housing Services

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.5	We will develop Ealing Road library garden for community use and leisure, programming, plant growth, support health and wellbeing.	A lack of access to green space contributes to health inequalities.	Outdoor Programming: Number of Family Learning/Adult Events – 12	Current number of events from Spring 2024: 3 Family Learning/ Adult events, with 32 adults and 51 children participating.	Resident Services
2.6	We will review and refresh our approach to climate community engagement and encourage local green action through our Together Towards Zero grants.	Grants are allocated boroughwide to address all key themes in the climate strategy but applications from seldom heard groups and those particularly impacted by the adverse effects of climate change are particularly encouraged.	Number of community grants, target: minimum of 15.	In 2023/24 we allocated 23 grants.	Communities and Partnerships
2.7	We will further increase sign up to the Healthier Catering Commitment.	This initiative aims to promote healthier eating habits, particularly benefiting residents in deprived areas where access to healthy food options is limited.	• Number of businesses signed up to the Healthy Catering Commitment. • Aim for 20 new sign-ups in 2024. • Additional 10 new sign-ups each subsequent year.	Current number of businesses signed up: 0.	Public Health

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.8	We will work with partners from Kilburn State of Mind, Brent Council, networks, and volunteers to implement The Music Mile: Mental Health Support Programme, which aims to improve the mental health and wellbeing of residents from underserved groups and to revitalise Kilburn as a music destination.	This commitment will address health inequalities by focusing, but not limiting to, residents from Black, African, and Caribbean backgrounds. It will engage delivery partners who are musicians with prior experience in mental health support and will reach local residents attending the festival, thereby promoting mental health and wellbeing within underserved groups.	Number of individuals receiving music lessons and performance training: Target 20-30 participants. Number of semi-professional musicians who previously accessed mental health support delivering the lessons: Target 10 musicians. Number of local residents attending the festival, particularly those struggling with mental health issues and isolation: Audience target will be determined based on venue capacity.	This is a new project, so the baseline is 0.	Resident Services

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.9	We will tackle air pollution in Brent by recruiting Air Quality Champions to improve local understanding of air quality issues and provide practical advice on reducing exposure to air pollution.	Cleaner air benefits everyone, especially people living in areas with high pollution levels, which are often linked to lower income. This helps reduce health differences among different communities.	Number of Air Quality Champions recruited. Number of vulnerable or disadvantaged individuals reached and supported by the Air Quality Champions. The number of people involved in Air Quality projects that attend the associated workshops.	No Air Quality Champions have been recruited yet, so the baseline is 0.	Public Health
2.10	We will engage with school children to educate them and raise their awareness about air quality issues through interactive maps showing high and low pollution routes within a 5–10 minute walking radius of schools, and by organising educational air quality events.	By educating children about air quality and providing them with practical tools, we help protect their health, particularly those who are most vulnerable. This initiative promotes equal access to important health information, helping to reduce the disparity in health outcomes among different communities.	We will collect data through a survey to measure the number of children who have changed their travel habits to use lower pollution routes to school. The number of educational events organised related to air quality and pollution awareness.	We are currently supporting schools to submit their travel plan for this academic year and will use this years' data as the baseline. The data will be available by the end of July.	Public Realm

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.11	We will increase participation in active travel by creating safe environments where people can confidently walk, cycle, and use other forms of active transportation. Through the implementation of the Active Travel Implementation Plan, we aim to promote these activities to improve public health, reduce traffic congestion, and lower environmental impact.	Active travel, such as walking and cycling, boosts physical activity, which reduces the risk of chronic diseases. It also improves mental health by lowering stress and anxiety, particularly benefiting underserved communities with limited access to recreational facilities. Reducing car use cuts pollution and traffic, creating a healthier environment and lowering transportation costs for low-income families, allowing more resources for other needs.	We aim to reduce traffic levels to 994 million vehicle kilometres by 2027 by having fewer vehicles on Brent's roads or vehicles travelling shorter distances. We aim to increase the proportion of residents engaging in at least 20 minutes of active travel to 41% by 2026/27.	The targets were set pre-pandemic with Brent's baseline traffic at 1,098 million vehicle kilometres annually. The proportion of Brent residents doing at least 20 minutes of active travel a day is 31% as of 2022/23 data.	Inclusive Regeneration and Employment

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.12	We will equip Brent schools with the Climate Action Guide and Plan Template, support them through regular webinars and Climate Champions Network meetings, and provide Carbon Literacy Training. Additionally, we will participate in the "Our Schools Our World" programme to improve sustainability education and initiatives, ensuring every school has a trained sustainability lead to drive effective climate action.	By integrating sustainability into the curriculum and school activities, we foster a sense of environmental stewardship and provide equal opportunities for students to engage in green careers. Additionally, schools in disadvantaged areas will receive targeted support, helping to bridge the gap in environmental education and empowering all students to contribute to a sustainable future.	The number of schools actively using the Climate Action Guide and Plan Template. The attendance at the regular climate action webinars. The number of sustainability leads trained through the "Our Schools Our World" programme. The number of schools that have successfully created and implemented a climate action plan.	There are approximately 10 schools that use the guide. There were two webinars organised so far with the attendance of 13. This is a new programme, so the baseline is 0. This is a new project, so the baseline is 0.	Communities and Partnerships

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.13	We will distribute the SCIL Youth Provision Grant to fund structural changes and improvements to premises used by youth organisations, enabling better access and increasing facilities and activities for young people in the London Borough of Brent.	We are especially targeting highly deprived areas to tackle health inequalities and ensure that young people have access to a range of facilities and places where they feel safe and at ease.	The number of successful applications.	19 EOI's have been submitted out of which 12 have been progressed to application stage.	Early Help and Social Care

Funds from the SCIL Youth Provision Grant will help structural changes and improvements to premises used by youth organisations, enabling better access and increasing facilities and activities for young people in the London Borough of Brent.

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.14	We will continue providing early multi-agency intervention and support through our Family Wellbeing Centres (FWC). By working with partners, we offer services including health, education, and wellbeing, taking a holistic approach to family needs. We will continuously analyse data from families to ensure our services meet their needs, preventing escalation to more specialist services.	By analysing data and collecting feedback from families, we ensure our FWCs offer services tailored to Brent's families' needs. This approach aims to equip FWCs with the ability to address issues before they become serious problems, which may prevent health disparities. Continuously analysing family data allows us to respond dynamically, ensuring services remain effective and relevant. Tailoring FWC offer based on family feedback reduces the risk of health inequalities.	The number of families supported by FWCs.	In 2023/24 a total of 18,113 families accessed FWCs.	Early Help and Social Care

2 HEALTHY PLACES continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
2.15	We will support school with the introduction of a school street zone (Pedestrian and cycle zone) where feasible to restrict vehicle access and encourage active travel.	By introducing a school street zone, we can help improve air quality and road safety by reducing parking and congestion issues, and enhancing the environment around the school, which contributes towards a cleaner and greener Brent. School streets also support active travel within the school community, and children and parents will benefit from walking and cycling to and from school.	The number of schools with a school street zone, with a target of implementing three new zones per year, subject to consultation with stakeholders. In addition, we can measure the success of modal shift towards active travel by using the annual travel plan survey data for the individual schools.	The current number of school street zones is 31.	Public Realm

We will promote bowel cancer screening services in communities high at risk through awareness presentations and communications in different languages.

3 STAYING HEALTHY

I, and the people I care for, understand how to keep ourselves physically and mentally healthy, managing our health conditions using self-care first. We have access to good medical care when we need it.

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.1	We will provide mental health services in Ukrainian, Russian, and English for Ukrainian guests and all hosts.	This will ensure that residents who are affected by the war in Ukraine either as Ukrainians or hosts who are providing a home for Ukrainian guests have access to suitable mental health services in their own language (Ukrainians only).	Commission providers to provide: • face-to-face mental health support • 24/7 virtual mental health support	We have mental health provision for hosts, and face-to-face for guests. We are in the process of commissioning 24/7 virtual mental health support for guests.	Communities and Partnerships
3.2	We will promote bowel cancer screening services in communities high at risk through awareness presentations and communications in different languages.	This commitment will focus on communities with high risk of developing cancer such as people living in deprived areas, Pakistani, Black African, Black other ethnicities, and people with Severe Mental Illness (SMI).	Deliver 10 engagement events with target communities.	Delivered 9 bowel cancer screening awareness presentations to communities between December 2023 and April 2024. Working with the bowel cancer screening service at St Marks Hospital to arrange ordering of test kits for eligible people.	Bent Health Matters

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.3	We will deliver targeted work on hypertension in black communities.	We will focus on Black communities and individuals, aiming to reduce health disparities related to hypertension.	Support at least 100 patients with hypertension who haven't had a recorded blood pressure measurement in last 18 months.	Recorded blood pressure of 237 hypertensive patients and updated this on their GP records in 2023/24.	Brent Health Matters
3.4	We will deliver education and awareness sessions on healthy eating to local communities via our Health Educator contract.	People who don't normally access health care services such as those from BAME and emerging communities, as well as residents from deprived neighbourhoods. This initiative aims to reduce health disparities by providing essential health education and promoting healthy eating habits.	Deliver at least 50 health education and awareness sessions via our Health educator contract, targeting BAME communities. Successfully support at least 50 people with or at risk of developing Diabetes (or other conditions) to achieve their lifestyle/healthy eating goals.	Provided case management support to 66 people with or at risk of developing Diabetes in the last year (April 2023-2024).	Brent Health Matters
3.5	We will improve mental health awareness in Brent through coproduction of community engagement sessions.	We will target people with common mental health conditions, aiming to reduce disparities by providing essential mental health education and support.	Deliver at least 50 Mental Health awareness sessions. Co-produce at least 50% of sessions.	Mental Health team within Brent Health Matters delivered 20 workshops for communities in 2023/24.	Brent Health Matters

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.6	We will assist residents to register with a Brent GP.	This initiative aims to reduce health disparities by connecting residents with essential health and care services.	Aim to assist at least 150 residents in registering with a GP or accessing health services.	Public Health and Brent Health Matters supported 114 to register with GP last year.	Brent Health Matters
3.7	We will provide mental health outreach and raise awareness in our most impacted neighbourhoods through events and workshops. Additionally, we will recruit mental health Community Connectors to educate and empower these communities.	We have identified three areas in the borough with the highest number of A&E admissions due to mental health crises, with the vast majority of these admissions being from Black and Asian communities. This illustrates significant health inequalities in these areas, which we aim to address through targeted approach.	Reduced number of A&E admissions from people in mental health crisis and decreased percentage of approaches from Black and Asian communities. The number of mental health awareness events and workshops organised. Number of people engaged through awareness events and workshops and proportion of attendees from Black and Asian communities.	In 2023/24, 176 people presented to A&E with a mental health crisis, with 85% of these admissions being from Black and Asian communities. In 2023/24, we organised 129 events and 114 workshops and training sessions. In 2023/24, we engaged with 5,326 people.	Mental Health and Wellbeing Executive Group Brent Health Inequalities Team (CNWL) Brent Health Matters

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.8	We will improve the accessibility and appropriateness of the library service for Brent residents living with dementia.	This commitment addresses health inequalities by ensuring Brent residents with dementia have better access to tailored library services. Improved publicity, home delivery, dementia-friendly materials, and accessible cultural venues ensure these residents can engage with library resources. Additionally, seeking funding for specialised programmes supports their cognitive and social needs, promoting overall wellbeing and inclusion.	Increase the number of homes receiving deliveries to 15. Provide 6-8 boxes of dementia-friendly items, each containing 35 items, to homes. Successfully apply for and receive designation status for Brent Libraries under the Arts Council England Designation Scheme. Submit a successful Arts Council England (ACE) funding application by March 2025 (only one ACE application can be submitted at a time).	Current delivery: 10 Homes. Current stock: 15 items. This will be our first time applying for the ACE Designation Scheme and funding.	Resident Services

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.9	Pilot the introduction of social prescribing into ASC.	The pilot will help to support people who are on the cusp of adult social care and have been referred to Brent Customer Services. Referrals come from other services such as the social prescribers in the primary care networks and other such as self-referrals to adult social care. Referrals include groups from all communities many of whom will be experiencing health inequality.	Activity data and outcomes data: Number of referrals Types of referral/support requested Number of allocations to social prescriber coordinators Cases opened and cases closed Average length of intervention Outcomes Survey data –service user experience	No current baseline.	Adult Social Care

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.10	We will improve the information, advice, and guidance accessed by informal carers by implementing the Brent Carers' Strategy, which was co-produced with them.	Becoming a carer often has a negative impact, especially on young people. It affects their work, education, and mental health. Carers' wellbeing often deteriorates as soon as they take on caregiving responsibilities. Any additional support given to them could positively impact their wellbeing and reduce health inequalities between carers and those without such responsibilities.	The number of carers accessing services and resources. The number of young identified through the Early Help Assessment and Child and Family Assessment. The number of young carers being identified by their schools or health services.	Approximately 35 new young carers referrals to Brent Carers Centre. 924 adult carers accessed services and resources in the financial year 2023/24. Approximately 50 young carers identified through the combined Early Help Assessment and Child and Family Assessment. Approximately 60 young carers identified via schools.	Adult Social Care Early Help and Social Care

Improved information, advice, and guidance will be available for informal carers by implementing the Brent Carers' Strategy, which was co-produced with them.

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.11	Develop a Prevention strategy and implementation plan based on the Care Act principles of preventing, delaying and reducing the need for care.	The strategy and delivery plan is underpinned by the principle of reducing health inequalities. Part of the delivery plan will involve data analysis, scrutinising cohorts who we know to be at risk of developing or exacerbating health conditions and developing interventions which will reach them earlier.	As part of the plan a set of outcome measures will be developed. These are likely to include but not limited to; Increased uptake of support measures for carers Decreased number of people accessing social care services for the first time through a hospital admission Increasing number of people accessing Reablement services Increasing number of people accessing information and advice through the Brent website	Current there is no strategy or plan which brings together preventative interventions across health and social care.	Adult Social Care

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.12	We will reduce emergency hospital admissions for patients with Chronic Obstructive Pulmonary Disease (COPD) through delivering disease education, support self-management and techniques to manage their condition independently at home.	A disproportionate burden of COPD occurs in people of low socioeconomic status due to differences in health behaviour such as tobacco smoking, social and physical environment which play leading roles in lung disease development and is also associated with worse COPD outcomes. An effective intervention is to target and educate this cohort of patients.	5% reduction in unplanned admission from the previous year.	The number of NEL from Nov 2022 (M8) to October 2023: 347	Brent Integrated Care & Delivery Team, NWL ICB

We will deliver disease education, support self-management and techniques to help patients manage their condition independently at home.

3 STAYING HEALTHY continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
3.13	We will reduce hospital admissions through the 'Step-Up Pathway', a service that utilises a dedicated bed to provide immediate care, accessible directly from community health services or via the A&E.	This approach reduces the need for hospital admissions. By optimising the use of hospital resources, the pathway improves access to healthcare for everyone, including the most at-risk populations, therefore reducing health disparities.	The number of residents receiving care within two hours	This is a new project, so the baseline is 0.	Brent Integrated Care & Delivery Team, NWL ICB

CLCH had introduced a 'step-up' pathway from rapid response into a community bedded unit, improving the utilisation of beds, reducing hospital admissions and freeing up hospital beds.

We will provide work opportunities via our community champions and Health educators programme for local communities.

4 HEALTHY WAYS OF WORKING

The health, care and wellbeing workforce will be happy and strong; and the health and wellbeing system will recover quickly from the impacts of the pandemic.

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
4.1	We will provide work opportunities via our community champions and Health educators programme for local communities.	We will target people who are unemployed from local communities, providing them with employment opportunities and training. This initiative aims to reduce economic disparities and improve health outcomes by engaging community members in meaningful work.	Number of new work opportunities provided to residents in Brent.	Local recruitment is prioritised within BHM with 14 Health Educators and 41 Community Champions recruited in 2023. This included two new Health Educators.	Brent Health Matters
4.2	We will improve partnership working through the new Community Wellbeing Service to enable those with health needs to access the holistic support offer addressing the cost of living.	The Community Wellbeing service will be accessible to residents with physical and mental health needs through referral routes with key partners.	Number of referrals from health and public health professionals to the new service.	This is a new service so no baseline.	Communications, Insight and Innovation

4 HEALTHY WAYS OF WORKING continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
4.3	We will improve partnership working through the new Community Wellbeing Service to enable those with health needs to access the holistic support offer addressing the cost of living.	The Community Wellbeing service will be accessible to residents with physical and mental health needs through referral routes with key partners.	Number of referrals from health and public health professionals to the new service.	This is a new service so no baseline.	Communications, Insight and Innovation

By improving the partnership working through the new Community Wellbeing Service it will enable those with health needs to access the holistic support offer addressing the cost of living.

4 HEALTHY WAYS OF WORKING continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
4.3	We aim to provide pathways to employment for individuals referred by GPs, social prescribers, self-referrals, and local employment services. By integrating these diverse referral pathways, we can ensure comprehensive support for those in need. Through this initiative, we aim to support individuals with mental health conditions in securing employment, with assistance from Twinings, Shaw Trust, the Department for Work and Pensions (DWP), and Brent Works	We aim to address health inequalities by providing employment opportunities to those with mental health challenges. Through this initiative, we can help reduce economic disparities, thereby improving overall health and well-being. Employment is a critical factor in improving mental health outcomes, and by supporting individuals in gaining employment, we help enhance their financial stability, social inclusion, and overall quality of life.	We aim to assist 160 people in gaining employment.	Our current baseline is 149 people with mental health supported into employment.	Inclusive Regeneration and Employment

We will develop and embed coproduction with residents in ASC and ensure services are accessible and culturally appropriate.

5 UNDERSTANDING, LISTENING AND IMPROVING

I, and those I care for, can have our say and contribute better to the way services are run; BHWB data are good quality and give a good picture of health inequalities.

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
5.1	We will develop and embed coproduction with residents in Adult Social Care (ASC) and ensure services are accessible and culturally appropriate.	The Co-production Champions will work across a spectrum of services and community groups to engage individuals and partners in the coproduction and codesign of adult social care services. Working closely with Public Health colleagues we will identify groups who are less well served by Adult Social care e.g. Gypsy and Roma communities and develop engagement strategies and plans that are appropriate. We will review our system and practice around recording demographic groups to better reflect the communities in Brent (where we are able to make changes).	Activity data on engagements: Number of people engaged. Number of referrals to Brent Customer Services/Adult Social Care. Number of recorded service users from specific groups.	In Adult Social Care's recent self-assessment, we identified the following: 'We are also very aware that there may be groups we are under-serving. For example, over the past year, there were no service users who were identified as Roma, Gypsy and Traveller or with an LGBTQIA+ identity. This is not in line with what we know about the population composition within Brent and could reflect accessibility, disclosure and recording challenges. We recognise we have further work in this area to identify and engage with groups where there may be unmet need.	Adult Social Care

5 UNDERSTANDING, LISTENING AND IMPROVING continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
5.2	We will establish a programme of ward-level data insight sessions with elected members, including continued development of ward profiles to inform ongoing discussions between councillors and officers.(4)	Councillors will have a greater understanding around their residents, which will inform the strategic discussions and policy making process. This includes identifying trends across different wards, which often might be health or wellbeing related.	The number of sessions delivered	We have delivered four sessions in Spring 2024.	Communications, Insight and Innovation
5.3	We will continue working with service user groups, such as B3, to further embed the voices of service users in the design and delivery of treatment and recovery services.	This commitment directly addresses health inequalities by ensuring that the design and delivery of treatment and recovery services are informed by those who use them, particularly those from marginalised groups.	The number of individuals who have successfully completed the recovery champion course and are available to support and guide others through their recovery journey. The number of new attendees to BSAFE sessions.	By the end of the financial year 2023/24, there were 46 recovery champions who had successfully completed the course. In the financial year 2023/24, there were 99 new attendees at BSAFE sessions.	Public Health

(4) Pilot sessions and next steps are pending evaluation.

5 UNDERSTANDING, LISTENING AND IMPROVING continued

	New commitment	How will the new commitment address health inequalities	KPI	Baseline	Lead
5.4	We will collect information with a range of groups and individuals in Brent and use this to understand and improve health.	This will include conversations with community groups and individuals who have everyday experience of health challenges. We will focus on topics that affect groups that currently have poorer health or are less well served by public health initiatives. We will take a community researcher approach where possible so that local people are involved in the planning, delivery and learning from the research.	Include people with lived experience in 100% bespoke health needs assessments over the next year. Take a participatory research approach in at least one evidence and insight project over the next year. Prioritise including representatives from at least two new community groups.	Where appropriate in terms of methodology, we have incorporated resident's view in 4 out of 6 (66%) bespoke needs assessments in the previous year. We currently engage with communities that have some established connect with public health. We aim to hear from more people in different communities within Brent.	Public Health

By improving access to nutritious food and improving understanding through education, we aim to bridge health gaps and foster equality in health and wellbeing across our communities.

Glossary

ASC
Adult Social Care

BAME
Black, Asian, and Minority Ethnic

B3
A Group in Brent which provides peer support and advocacy to drug and alcohol service users in Brent

BHM
Brent Health Matters is a borough-wide partnership programme that aims to engage with the community on a number of wide-ranging issues to reduce the health inequalities experienced in Brent.

Brent ICP
Brent Integrated Care Partnership brings together health and care organisations from across the borough to work collaboratively with all the health, care and wellbeing organisations that serve the community of Brent.

CYP
Children and Young People

CVD
Cardiovascular Disease

FWC
Brent Family Wellbeing Centres offer a wide range of free health, education and welfare services to families.

GP
General Practitioner

ICB
Integrated Care Boards are NHS organisations responsible for planning health services for their local population.

KPI
Key Performance Indicator

LGBTQIA+
Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and other identities

NHS
National Health Service

NWL
North West London

PRS
Private Rented Sector

Reablement
Reablement is a short term and intensive service designed to help people in their recovery after an illness or disability. It helps the patient to re-learn important skills needed for daily living whilst allowing maximum independence.

SEND
Special Educational Needs and Disabilities

Social prescribing
It is an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing.

VCS
Voluntary and Community Sector

Brent

healthwatch Brent

Brent ICP
Integrated Care Partnership

NHS
North West London

NHS
Central London
Community Healthcare
NHS Trust

NHS
London North West
University Healthcare
NHS Trust

NHS
Central and
North West London
NHS Foundation Trust

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