Brent Health Matters Annual Report 2023/2024

July 2024

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Brent ICP
Integrated Care Partnership

1. Foreword

Cllr Neil Nerva, Cabinet Member for Community Health and Wellbeing

Dr Haidar Mohammad, ICP Clinical Lead

Robyn Doran, Brent ICP Director

Foreword

Brent is an incredibly diverse borough with unequal health outcomes.

The Brent Health Matters programme is improving the health experience of residents whose access to services is limited by knowledge, language, ability to access and time to access. It therefore acts a bridge between the community and mainstream services, enabling residents who have limited contact with these service to have health and care needs better met.

The programme reaches residents often with unrecognised health and care needs, which could have long-term implications if not treated on time.

A priority for system leaders is enabling health and care services to use findings from the programme to adapt and improve mainstream services.

The prevention model promoted by the programme is welcomed by residents and enables better use of valuable financial and practitioner resources. Residents value the self-help and peer supported approach promoted by the programme and enabled through its community grants programme.

Councillor Neil Nerva – Cabinet Member for Community Health and Wellbeing

Foreword

The Brent Health Matters (BHM) programme is a partnership across all stakeholders in Brent that was setup to tackle health inequalities through community engagement and outreach. The programme launched in September 2020 soon after the first wave of Covid, when the impact on the community had shone a light on the inequalities that historically existed in Brent. BHM reports into the Health Inequalities and Vaccination Executive Group, which feeds into the Brent ICP and the Brent Borough Partnership.

We continuously seek to understand the barriers faced by different communities and people that are seldom heard from, and work with them to support them to meet their health and care needs. The BHM team is made up of 5 locality teams that work in each of the 5 'Brent Connects' areas, and includes staff from teams in CNWL, Brent Council, CLCH and voluntary organisations consortium led by Brent Carers Centre.

There is a lot that we're proud of this year including our flexible approach to working in the community in response to emergency incidents, building the community's trust in services, capacity building in the community, and our work with different stakeholders. We were finalists for an MJ, HSJ, and nominated for a parliamentary award this year.

We want to thank our residents and community organisations that have worked with us in the last year and look forward to strengthening the working relationships in the coming year.

We hope you find this report interesting and helpful.

Dr Haidar Mohammad - ICP Clinical Lead

Robyn Doran - Brent ICP Director

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2. Overview

An overview of the role and approach of Brent Health Matters in supporting residents; our impact in numbers; our spending; and challenges faced in 2023/2024.

Background to health inequalities

Population

339,800
Brent population

▲9%
Increase 2011-21

Population density
7,859 people per km²

14th highest in England & Wales

Language

34%
1 in 3 Brent residents* use a main language other than English, the 2nd highest rate in England & Wales

8%
of residents have poor proficiency in spoken English – the 3rd highest rate nationally

20% of households have no-one who uses English as their main language, the highest rate nationally

Around **90** different languages spoken in Brent.

Life expectancy

Variation of 9 years between different parts of Brent

Variation of 11.7 years between different parts of Brent

Life Expectancy at Birth in Brent (2017 - 2019)

Ethnicity & Country of Birth

65%
of residents from Black, Asian & minority ethnic groups ▲ 2nd highest rate in England & Wales

56%
of Brent residents born outside the UK – the highest rate in England & Wales

Index of Multiple Deprivation (IMD)

Brent is the most deprived borough in NWL with an IMD rank of **49**, compared to the borough with the highest rank in NWL which is **199.**

COVID-19

The underlying inequality that was present in the community has been exacerbated by Covid-19. Brent had the highest overall Covid-19 mortality rate out of all regions in England from March to June, 2020. Brent saw a rate of **216.6 deaths per 100,000 people**, in that time period.

Diabetes

According to the diabetes QOF prevalence, in 2021/22, **8.6%** of patients were recorded on practice registers as having diabetes. This is higher in comparison to the England average at 7.3%.

Mental Health

According to the Mental Health QOF prevalence, in 2021/22, **1.15%** of patients were recorded on practice registers as having a mental health diagnosis. This is higher in comparison to the England average at 0.95%.

Cardiovascular Disease

In 2021, Brent's mortality rate from all cardiovascular disease (for all ages) was **267.2 deaths per 100,000 people.** This is higher than the England average at 230.4 deaths per 100,000 people in that time period.

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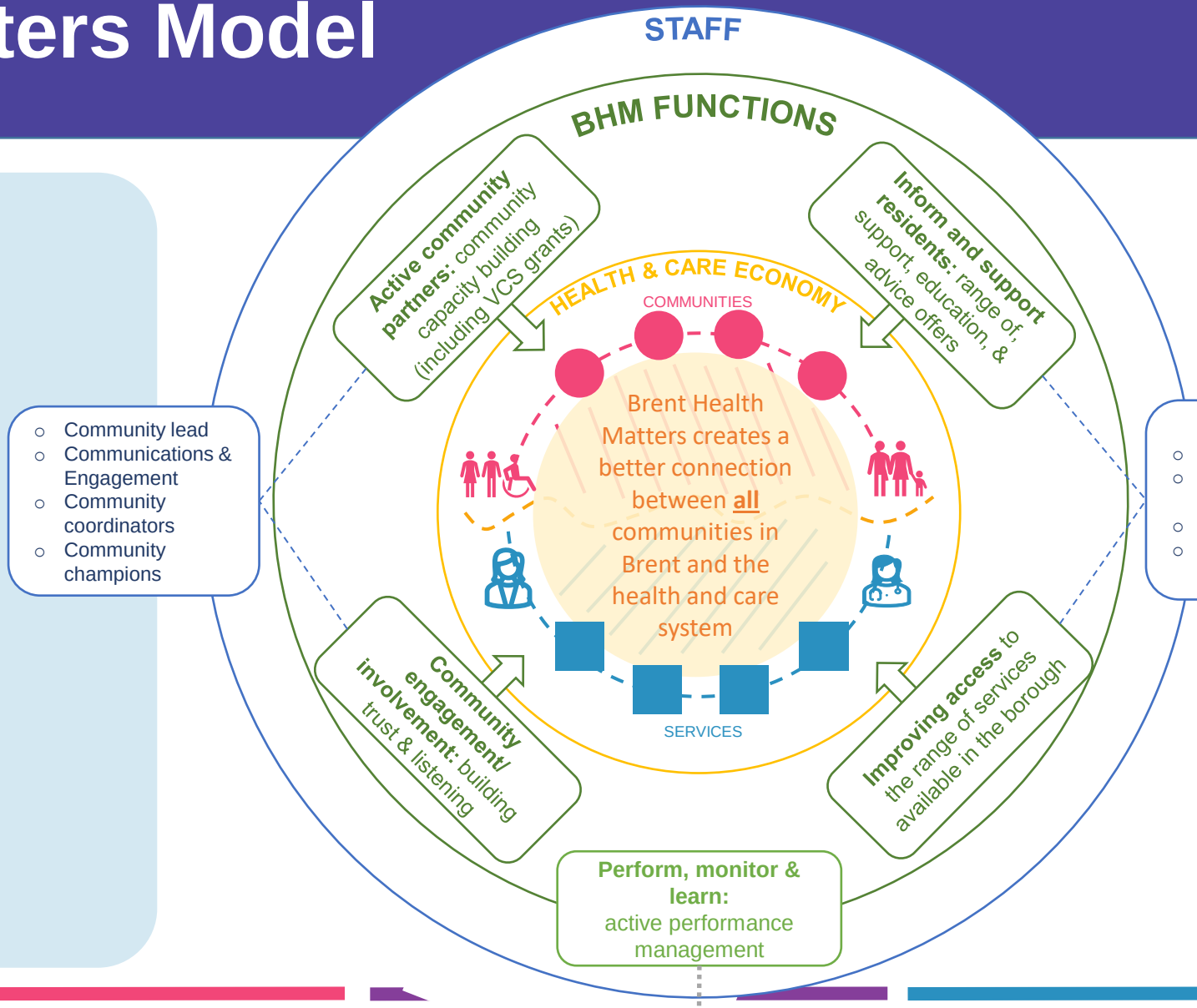
Brent Health Matters Model

- **Brent Health Matters is both a model to tackle inequalities and a team supporting that model.**
- The model recognises that very often the way in which we provide health and care services and engage with our residents, does not make it easy for people to access the care they need, or encourage the behaviours that would support healthier happier lives.
- Brent Health Matters is a partnership across all stakeholders in Brent setup in 2020 to understand the barriers faced by some communities and people who are seldom heard from and support them to improve the management of long-term conditions and quality of life.



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Brent Health Matters workstreams

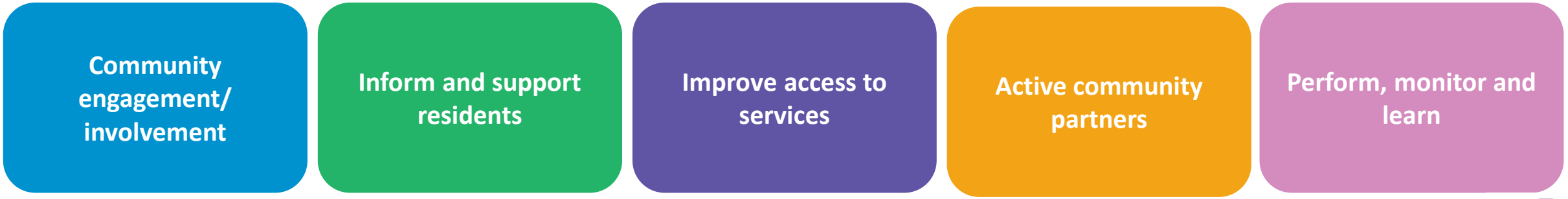
Brent Health Matters works to tackle health inequalities in Brent.

We work with residents and local organisations from diverse communities who don't normally access health and care services**.** For example, specific BAME communities, homeless people, emerging communities, people with disabilities, people with mental health issues, deprived areas, and night shift workers. **Demand for our services is growing** – largely because we have increased our visibility and presence in the community.

Our approach seeks to understand residents' needs and challenges around health and care, and to work with them to improve their health and wellbeing. Support offered via Brent Health Matters includes developing localised action plans with communities, health checks and mental health support in the community, health education and awareness (on Diabetes, Bowel Cancer screening and Hypertension), supporting people to register with a GP, Diabetes digital inclusion classes, Diabetes peer support groups, and linking the community with Council and NHS services.

We learn as we deliver and adapt our approach. We've started running smaller events and activities in target areas which has increased uptake of our offer in specific communities. We're providing more 1-to-1 support to our community grants recipients.

Brent Health Matters plays an integral part in realising the Council and Brent ICP's ambitions to build a healthier Brent.



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Brent Health Matters: the community approach

We build and maintain networks of community contacts focussing on untapped communities

Our community engagement staff and volunteer Community Champions are recruited locally and reflect the diverse populations in Brent. They work with community organisations, residents and groups to co-produce and co-deliver local actions plans in each of the 5 Brent Connect areas (Wembley, Kingsbury & Kenton, Kilburn, Willesden, and Harlesden). We currently have 40 volunteer Community Champions supporting the work of BHM.

We acknowledge the time it takes to build the community's trust in statutory services, which is why we gradually build relationships with people, often progressing from informing to consulting, involving, co-creating and empowering levels of interaction. The table below highlights the levels of participation we achieved in 2023/24.

	Brent Connect area					
Level of interaction with organisations and groups	Harlesden	Kilburn	Kingsbury & Kenton	Wembley	Willesden	Total
Informing	53	46	63	46	23	231
Consulting	9	8	17	12	15	61
Involving	10	8	9	7	11	45
Co-creating	3	3	1	11	12	30
Empowering	16	10	12	13	10	61
Total	91	75	102	89	71	428

We co-produce outreach events, taking health and care into the community at various locations including factories (day and night shifts), high streets, foodbanks, homeless shelters, places of worship, community centres, leisure centres and libraries. We held 119 events attended by 4261 people in 2023/24.

We co-produce communication assets in different languages to suit our diverse audiences, including translated leaflets and posters and videos and voice-notes recorded in community languages. We communicate with residents and stakeholders through a variety of channels including different social media platforms, WhatsApp groups, newsletters, videos, webpages and much more, including programmes on two local community radio stations.

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Our relationship with VCS providers in 2023/24

We have built and maintained relationships with local voluntary organisations

- **We linked with 428 community organisations and groups –** our locality teams have connected with new organisations to focus BHM's in-reach to untapped communities, to ensure that their voices are heard too. For example, we held consultations with organisations and their resident groups focusing on themes such as digital exclusion, cancer screening, diabetes and mental health, to co-produce action plans.

- **We awarded community grants to 27 community organisations –** the projects that were delivered addressed a range of concerns and various target groups including children with hearing impairment, people with dementia, parents and carers of children and young people with special needs, physical activity sessions, people with visual impairment, to mental health and green spaces. The support provided by Brent Health Matters to organisations in this process helps them become more sustainable to apply for other grant opportunities.

- **We learnt from providers** – there is a lot that we can learn from the community to ensure BHM and health and care services better support them. We received awareness sessions from various organisations to improve our understanding of the challenges faced by certain groups such as people with learning disabilities, and people from Somali, Iraqi and Romanian backgrounds.

- **We held quarterly community forums** – this provided an open space for organisations and residents to meet us and provide feedback about different themes such as community grants and our communications. The community's insights informed the programme's communications strategy and most recent community grants scheme.

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Brent Health Matters: mental health approach

The programme's mental health approach involves assertive outreach with residents and people with lived experience to improve residents' outcomes, experiences and access to mental health and emotional wellbeing services.

We recognise the importance of listening to and learning from the community to inform and shape services we provide or source. The team co-produce meaningful interventions that are culturally sensitive to suit the diverse needs of the communities we work with.

We have open and relatable conversations about mental health and emotional wellbeing with people in the community. This is tackling the stigma around mental health.

We've held forums, information sessions, co-facilitated events, training sessions, and co-produced mental and physical health workshops, such as loneliness workshops and mental health first aid training.

We have made great progress with certain communities such as the Somali community, and have had important conversations with others such as refugees, asylum seekers, homeless people, and foodbank users.

We engaged with more than 5,000 people to raise awareness of mental health and the support that they can access.

We supported 2,564 individuals with their emotional wellbeing needs, signposting to relevant services that would support their needs.

Around 250 community engagement events were held in 2023/24.

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Brent Health Matters: the clinical approach

The programme's clinical approach supports people to re-engage with healthcare services to manage their health.

The clinical service follows the ethos of taking healthcare to communities, supporting communities to improve awareness and case finding, for example identifying people with hypertension, diabetes and atrial fibrillation who aren't accessing healthcare services. The team also works with people from different ethnicities and areas of high deprivation to improve health outcomes, for example cancer screening and improving uptake of vaccinations.

Our health checks at outreach events consists of:

- Height, weight and Body Mass Index (BMI)
- Blood sugar level
- Blood pressure
- Atrial fibrillation
- Heart rate
- Diabetes risk assessment

These readings are communicated with patients' own GPs and documented on the same system as Brent GPs, with escalations as needed.

Our clinical priorities have evolved over time. The programme initially supported patients with Diabetes and Covid-19 vaccinations from GP lists. This was revised in 2023 to better target health inequalities issues in certain groups:

- Support people known to have high blood pressure from Black ethnic background who have not had any blood pressure recorded in their GP notes in the last 12 months.
- Follow-up with patients who haven't had a Severe Mental Illness (SMI) physical health check in the last year, to do home visits to understand barriers and do the check.
- Reach out to patients from GP lists who have not responded to an invite for bowel cancer screening, focussing on deprived areas, Pakistani, Black African, Black other ethnicities, and people with SMI.

In 2023/24:

- 69% of people who had health checks live in areas of high deprivation (IMD 1, 2, 3 and 4).
- We saw 79 foodbank attendees, 467 workers at factories and 76 refugees
- 27% of our health checks were provided to people from Black ethnic backgrounds.
- We provided blood pressure reviews for 148 patients known to have high blood pressure from Black ethnic backgrounds.
- We carried out physical health checks with 35 patients with SMI.
- We successfully contacted and ordered bowel cancer screening test kits for 998 patients from priority groups.

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Brent Health Matters: Health Educator Service

Our Health Educators play an integral role equipping residents to better prevent and manage long term health conditions, and access the range of services, support, education and advice available in Brent.

Our consortium of VCS providers (Brent Carers Centre, SAAFI, Community Barnet, PLIAS and Brent Mencap) deliver this service. Like many of the programme's staff, Health Educators are recruited locally to reflect the diverse cultures and languages in Brent. This allows them to have conversations with people on streets, shops and community centres. They had conversations with 16,547 people in 2023/24 alone. They also support people to register with a GP if needed.

Some residents were keen to get their health back on track after meeting our Health Educators, whether that's someone with a health condition such as Diabetes or Hypertension, or someone who's at risk of developing health conditions. A personalised approach is taken with individuals to support them to achieve their healthy eating and lifestyle goals in 3 months. Health Educators have case managed 66 people in 2023/24.

The 8-week Diabetes peer support programme has been creating a safe space for people with or at risk of developing Diabetes to better manage their health together.

Participants complete the programme feeling equipped with information, advice, and peers that motivates them to improve their physical health and emotional wellbeing. 62 people completed the programme in 2023/24.

The 6-week Diabetes digital inclusion programme has been equipping people with Diabetes with the skills and confidence to manage their condition online.

Participants are supported to create an email address and ask their GPs to update their records with this information. They get registered onto the Know Diabetes website and learn how to sign up and use online resources and support groups. 65 people completed the programme in 2023/24.

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3. Achievements

A summary of the programme's achievements over 2023/34, including our successes, and our areas for improvement.

Brent Health Matters 2023/24: in numbers

We held 119 events attended by 4,261 people and carried out 3,930 health checks.

We linked in with 428 community organisations and groups.

Identified 262 undiagnosed people with high blood pressure at events

Identified 182 people with non-diabetic hyperglycaemia

We supported 2,564 people for mental health and emotional wellbeing at events

We supported 65 digitally excluded people with Diabetes or at risk of developing Diabetes to create an email address and use the Know Diabetes platform.

Supported 239 residents to register with a Bent GP practice

Supported 51 people to access Housing, Adult Social Care and Employment services to resolve their social issues.

Supported 128 Diabetic/pre-Diabetic people to implement healthier eating and lifestyle changes to prevent or manage their condition.

Awarded grant funding to 27 community organisations to deliver health inequalities projects

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Brent Health Matters 2023/24: our feedback

We are always seeking feedback from the community to continually improve our approach. With this in mind, we collect feedback forms from people who have had a health check at our events, and people who complete our peer support group and digital course. We also keep an open dialogue with our stakeholders such as factories and VCS organisations, which has helped us know what to keep doing, what to stop, and what we can do differently.

We are proud of the positive feedback that we hear from those we serve

All our teams have received positive feedback from residents and service users – their efforts have made a real impact and we are proud to recognise that…

*Feedback from the **Bakkavor Factory Abbeydale Road site Senior Executive Manager***

> *By you guys coming here, we are helping employees feel more confident about their health and are finding conditions that people were unaware of, with many employees telling me they have been referred for further support.*

*Feedback on **the Healthy Cookery Programme at Brent Mencap***

> *I'm really enjoying learning how to make healthy food, I like the environment and I like to socialise with other people.*

*Feedback for our **Diabetes Digital Course***

> *Once I joined I found it very interesting, especially Know Diabetes because it gave me a lot of ins and outs of Diabetes. I joined GP online appointments and I did in just 2 hours. I was so happy I done something.*

*Feedback from **a resident***

> *This is my first time attending a health and wellbeing event, and it was great to get all this support in one place. I learned lots and feel encouraged to take charge of my health.*

*Feedback from our **Harlesden Community Champion***

> *The talks hit every nail on the head. BHM has changed my life, giving me the power to overcome challenges, and the platform to support others in the community. There is no place like Brent.*

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Brent Health Matters 2023/24: areas for improvement

We have identified the following areas for improvement in 2023/24 and have commissioned the King's Fund to help us address some of these:

- **Our events should focus on untapped and emerging communities, as well as the communities that face the highest health inequalities.**
- **We need to build closer working relationships with GPs and PCNs.**
- **We have had limited success in incorporating the BHM model with wider health and care services to make tackling health inequalities business as usual.**

We have started to develop our theory of change (Appendix A) to guide our evaluation and improvement. We need to build on this and further develop our theory of change to ensure we can demonstrate our outcomes and impact.

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4. Priorities

A summary of the programme's way forward for 2024/25

Brent Health Matters 2024/25: moving forward

Looking ahead, 2024/25 is likely to be another challenging yet rewarding year for Brent Health Matters. We are determined to continue working with the community to deliver a high-quality service that meets people's needs and influence the way health and care services are delivered too.

Priorities for 2024/25:

- **Supporting the development of Integrated Neighbourhood Teams and the Council's Change programme which has a strong focus on community empowerment and neighbourhood working.**
- **Refreshing our clinical priorities based on current data, such as hypertension in the black community and bowel cancer screening.**
- **Launching a team to tackle health inequalities in children and young people, focussing on asthma management, mental health and immunisations.**
- **Linking with other untapped and emerging communities to hear their voices and co-produce solutions to issues they face.**
- **Continuing our community grants programme and support community organisations to deliver community grants projects. Work with community organisations to collect data to understand the impact of projects and make organisations more sustainable.**
- **Using the cultural competency framework, implement and measure changes to CNWL as a result of our improved understanding of communities and their needs.**
- **Increase BHM's programme's presence at established council spaces in the community, for example hubs and family wellbeing centres.**

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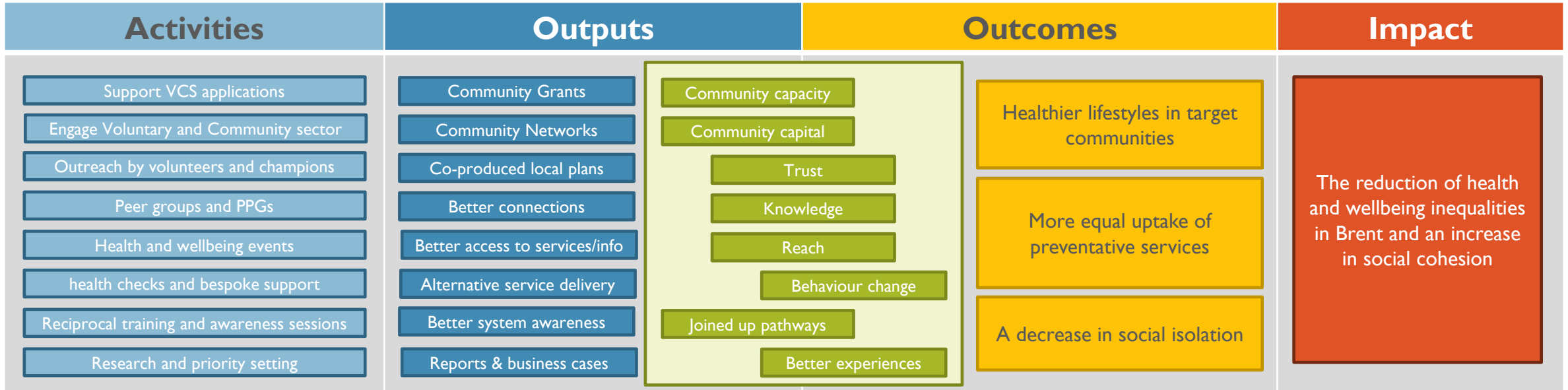
Appendix A: Our Theory Of Change



How do we measure this?

- # of events, number of people attending events
- # of people engaged, feedback from engagement
- # of organisations engaged, feedback from VCSE
- # of people attending digital courses, participants satisfaction
- # of people engaged by health educators, number of cases managed
- # of people followed up by clinical team, # of onward referrals
- # of calls received by advice line
- # of people seen by MH team for 1-1 consultations
- # of people supported to register with a GP
- # of health checks provided
- # of people supported on to pathways for statutory services
- # of reciprocal training offered/received
- Report and feedback from organisations on grants

Benefit realisation

Measures will be identified by:

1. Analysing outcomes and feedback from people supported by BHM
2. Longitudinal studies
3. Applying an external evidence base

- TBC Community Capacity
- TBC Community Capital
- TBC Trust
- TBC Knowledge
- Reach: analysis of BHM users
- Friends and Family test

- Active lifestyle questionnaires
- TBC: further Healthier lifestyle measures
- Equality of population registered to a GP
- Equality of population accessing IAPT services
- Equality of population receiving regular health checks
- TBC: Social isolation

- Reduction in life expectancy gap
- Reduction in disproportionate acute episodes
- Reduction in disproportionate diagnosis of long-term conditions
- Reduction in disproportionate diagnosis of SMI
- Social cohesion measures

Monthly | Months, to years, to decades | Months, to years, to decades | Years, to decades, to lifetimes