Public Document Pack

Health and Wellbeing Board

Thursday 30 July 2026 at 6.00 pm
Conference Hall - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Please note this meeting will be held as an in person meeting which all Board members will be required to attend in person.

The meeting will be open for the press and public to attend. Alternatively, the meeting can be followed via the live webcast HERE.

Membership:

Councillor Grahl (Chair)	Council member
Rammya Mathew (Vice-Chair)	Primary Care
Councillor M Butt	Council member
Councillor Chadha	Council member
Councillor Dixon	Council member
Councillor Rubin	Council member
Radhika Balu	West and North London Integrated Care Board
Robyn Doran	Brent Integrated Care Partnership Executive
Simon Crawford	Brent Integrated Care Partnership Executive
Jackie Allain	Brent Integrated Care Partnership Executive
Patricia Zebiri	HealthWatch Brent
Kerry Richards	Care and Residential Sector Representative
Susana Carvalho	Care and Residential Sector Representative
Ruth Du Plessis	Brent Council - Non-Voting
Rachel Crossley	Brent Council - Non-Voting
Kim Wright	Brent Council - Non-Voting
Nigel Chapman	Brent Council - Non-Voting
Claudia Brown	Brent Council - Non-Voting

Substitute Members (Brent Councillors)
Councillors: Amadi, Johnson, Kelcher and Knight

Councillors: Chowdhury and Kansagra

recycle for Brent

For further information contact: Hannah O'Brien, Senior Governance Officer
Tel: 020 8937 1339; Email:hannah.o'brien@brent.gov.uk

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit: **www.brent.gov.uk/democracy**

Notes for Members - Declarations of Interest:

If a Member is aware they have a Disclosable Pecuniary Interest* in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent and must leave the room without participating in discussion of the item.

If a Member is aware they have a Personal Interest** in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent.

If the Personal Interest is also significant enough to affect your judgement of a public interest and either it affects a financial position or relates to a regulatory matter then after disclosing the interest to the meeting the Member must leave the room without participating in discussion of the item, except that they may first make representations, answer questions or give evidence relating to the matter, provided that the public are allowed to attend the meeting for those purposes.

***Disclosable Pecuniary Interests:**

(a) **Employment, etc. -** Any employment, office, trade, profession or vocation carried on for profit gain.

(b) **Sponsorship -** Any payment or other financial benefit in respect of expenses in carrying out duties as a member, or of election; including from a trade union.

(c) **Contracts -** Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.

(d) **Land -** Any beneficial interest in land which is within the council's area.

(e) **Licences-** Any licence to occupy land in the council's area for a month or longer.

(f) **Corporate tenancies -** Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.

(g) **Securities -** Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:

- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party of trade union).

(b) The interests a of a person from whom you have received gifts or hospitality of at least £50 as a member in the municipal year;

or

A decision in relation to that business might reasonably be regarded as affecting the well-being or financial position of:

- You yourself;
- a member of your family or your friend or any person with whom you have a close association or any person or body who is the subject of a registrable personal interest.
-

Agenda

Introductions, if appropriate.

Item Page

1 Apologies for absence and clarification of alternate members

For Members of the Board to note any apologies for absence.

2 Declarations of Interest

Members are invited to declare at this stage of the meeting, the nature and existence of any relevant disclosable pecuniary or personal interests in the items on this agenda and to specify the item(s) to which they relate.

3 Minutes of the previous meeting 1 - 12

To approve as a correct record, the attached minutes of the previous meeting held on 16 April 2026.

4 Matters arising (if any)

To consider any matters arising from the minutes of the previous meeting.

5 Neighbourhood Health - National Guidance and Brent's Approach to 'Working in Neighbourhoods' 13 - 36

This report sets 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), highlights progress to date in Brent, outlines the role of the Health and Wellbeing Board in shaping, overseeing and championing neighbourhood working, and provides timelines and next steps.

6 LGA Independent Review of Brent Health Matters and Brent's Response 37 - 60

This report presents the LGA peer review report and action plan in response to the findings and recommendations.

7 Better Care Fund Overview and Forward Planning

a) Overview of the Better Care Fund — Verbal

To provide an overview of the Better Care Fund (BCF) and the Health and Wellbeing Board's role in ratifying the BCF.

b) Better Care Fund Year-End Position 2025-26 — 61 - 64

This report presents the End of Year (EoY) report for the Better Care Fund (BCF) 2025-26, which was submitted to the BCF Team at NHSE on 5 June 2026, and seeks formal ratification from the Health and Wellbeing Board for the Corporate Director Service Reform and Strategy to sign off the report to meet the national submission deadlines.

c) Better Care Fund Proposed Plans for 2026-27 — 65 - 70

This report provides an update on the planning process for the Better Care Fund (BCF) Plan for 2026-27 and seeks formal ratification for the BCF 2026-27.

8 Forward Planning

To discuss and agree any future agenda items for the Health and Wellbeing Board.

9 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Deputy Director – Democratic and Corporate Governance or their representative before the meeting in accordance with Standing Order 60.

Date of the next meeting: Wednesday 9 September 2026

Please remember to turn your mobile phone to silent during the meeting.

- The meeting room is accessible by lift and seats are provided for members of the public on a first come first served basis.

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Brent

NHS
West and North London

MINUTES OF THE HEALTH AND WELLBEING BOARD
Held as a hybrid meeting on Thursday 16 April 2026 at 6.00 pm

Members in attendance: Councillor Nerva (Chair), Dr Rammya Mathew (Vice Chair), Councillor Knight (Brent Council), Councillor Grahl (Brent Council), Councillor Kansagra (Brent Council), Jackie Allain (Director of Operations, CLCH), Simon Crawford (Deputy CEO, LNWH), Patricia Zebiri (HealthWatch Brent), 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), Claudia Brown (Director of Adult Social Care, Brent Council – non-voting)

In attendance: Wendy Marchese (Strategic Partnerships Manager, Brent Council), Hannah O'Brien (Senior Governance Officer, Brent Council), Tom Shakespeare (Director – Brent Integrated Care Partnership), Charlene Santos (Community Engagement Lead, Brent Council), Rita Nath-Dongre (Elders Voice), Fay Austin (Elders Voice), Tony Burch (Age-Friendly Champion), Sarah Nyandoro (Head of Place, Mental Health & Wellbeing (All Age), Brent ICP), Shadi Ambrosini (Public Health Strategist, Brent Council) (online), Aisling Rogers (Health Improvement Delivery Specialist, Brent Council), Alex Colas (Co-Chair of the Food Partnership Steering Group)

1. Apologies for absence and clarification of alternate members

Apologies for absence were received from the following:

- Kim Wright (Chief Executive, Brent Council)
- Robyn Doran (Director of Transformation, CNWL, and Brent ICP Director)
- Councillor Donnelly-Jackson

2. Declarations of Interest

Personal interests were declared as follows:

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

3. Minutes of the previous meeting

RESOLVED: That the minutes of the previous meeting, held on 29 January 2026, be approved as an accurate record of the meeting.

4. Matters arising (if any)

None.

5. Age Friendly Group Progress Update

The Board received a presentation from Rita Nath-Dongre (Elders Voice), Fay Austin (Elders Voice) and Tony Burch (Age-Friendly Champion) which provided an update on the

development of Age-Friendly Brent, a borough-wide, resident-led initiative aimed at improving the quality of life of older people. In presenting the update, the following key points were raised:

- To date, Age-Friendly Brent had undertaken engagement with older residents and allies through conversations and focus groups, and joined the UK Network of Age-Friendly Communities. A Part-time Age-Friendly Project Co-ordinator had been recruited in July 2025 to help drive the agenda forward, and supported the launch of an Age-Friendly Survey which was circulated in September 2025. Age-Friendly Brent had then successfully officially launched in November 2025 and recruited Age-Friendly Ambassadors made up of local residents championing the voice of older people. An Age-Friendly Brent Newsletter had been developed to keep key stakeholders informed of the movement, and the Action Strategy and Action Plan for 2026-2028 had been drafted and included in the agenda papers alongside the report.
- Some of the remaining challenges Age-Friendly Brent hoped to address were; accessible and reliable transport; GP, Care and support service access; digital exclusion and; outdoor safety including uneven pavements and lack of public toilets and resting spots on high streets.
- The Strategy focused on creating more opportunities for older people to take part in cultural activities, physical activities, lifelong learning and community life in order to support both mental and physical wellbeing and enable older adults to stay active, connected and independent as they aged.
- The project was guided by principles of co-design with older people, equity and inclusion, accessibility, prevention and independence and partnership delivery. Priorities were around accessible transport, outdoor spaces and buildings, community support and health services, social participation and housing. Underpinning all activity would be digital inclusion and communication.
- Some of the actions due to be undertaken to achieve those priorities by March 2027 included; digital skills sessions delivered across the borough; pavement walkabout audits completed and reported; rest and toilet community pilot scheme launched; campaign launched for the removal of restrictions affecting travel concessions; audit of bus stopping and boarding practice piloted; Age-Friendly features in local publications and events; and an Age-Friendly councillor representative identified.
- The Board was asked to support the strategy implementation and ensure support across Council departments and partners for an Age-Friendly approach in Brent, identify an Ageing Well Champion within the Council to work with the Cabinet, Chief Executive, Leader and other councillors on Age-Friendly initiatives, and consider ways to embed this approach into business as usual for all relevant partners going forward.

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

- The Chair expressed that he was pleased by the nature of the priorities identified by Age-Friendly Brent, which he described as viable, practical and representative of the voice of older residents in Brent. He recognised that many priorities were not unexpected, and there would now be a real expectation for implementation of the objectives. As such, he emphasised the importance of public bodies working together, listening to residents, and demonstrating that some of those reasonable expectations laid out could be delivered by public bodies. He cautioned there was a risk of losing trust in public organisations and the system if some of these asks were not taken

forward, as residents saw this as an opportunity for a true partnership between less heard groups of people and the wider system. He added that the newly elected administration would be putting together a new Borough Plan which would be a good opportunity to ensure the work of the Age-Friendly Network was prioritised within that.

- Councillor Knight commended the work and in particular highlighted the success of the first senior digital hub session held in Harlesden Library, which had been well attended. She added that a significant number of attendees had also joined the library that day and had looked to learn more about e-learning resources in the library.
- The Board asked whether any specific locations had been identified for the high street toilet project. Tony Burch explained that KOVE – Kilburn Older Voices Exchange – had been trailblazers in this area, encouraging 15 businesses in Kilburn high streets to sign up to allow local residents use of their toilets with posters in windows offering toilet use. Age-Friendly Brent had met with KOVE who had provided advice and guidance on the toilet scheme, and Brent was now using that model to introduce a similar scheme, beginning with Harlesden and then looking to expand that wider following the learning of that pilot. He advised that the project was concentrated on high streets because lack of toilet facilities was a reason people stayed away from high streets, and this was a way for the whole community to come together and consider what added value to the high street and build communities.
- Board members asked whether there had been any outreach to retired branch members of local trade unions who were often active in the campaigning space, such as the campaign against the ending of winter fuel allowances. Tony Burch agreed it would be useful to reach out to Brent Trade Union colleagues, and Fay Austin added that one of the Age-Friendly Ambassadors was a member of a trade union.
- Board members emphasised the importance of digital inclusion and asked whether those involved in the project and those who had been engaged had raised issues in that space. Tony Burch confirmed that those they had engaged predictably raised digital exclusion as an issue and that the strength of feeling was apparent across all stakeholders they had spoken to. Age-Friendly Brent had advised Council services to include a phone number as well as digital contact information wherever possible. The digitisation of the NHS was also a cause for concern for many older people, particularly as face to face contact and continuity of care was very important for older people. He added that there were several reasons older people may not have access to technology, including lack of broadband and equipment. The Hubs were a good resource for teaching people how to access digital services and helping with particularly critical issues. The strength of feeling around digital exclusion was why Age-Friendly Brent had included digital inclusion and access as a priority running through all the various workstreams.
- The Board challenged partners present and other public bodies as to how they would listen to what had been said by older people in Brent, particularly in relation to supporting digital access. Simon Crawford (Deputy Chief Executive, LNWH) offered to arrange a session for older people and other digitally excluded individuals on using the NHS app and how that could be used to book appointments, access records and review outcomes of consultations. Rachel Crossley (Corporate Director Service Reform and Strategy, Brent Council) advised that she would be happy to meet with Age-Friendly Brent to nominate leads for each of the different priorities and themes and convene a workshop around this. She added that it would be important to consider how future arrangements aligned with the new administration and Borough Plan.

In concluding the discussion, the Chair thanked representatives from Age-Friendly Brent for their presentation and welcomed the early priorities produced. He hoped public services at the appropriate level learned from those priorities and considered how they were incorporated into future planning, ensuring older residents were considered in everything they were delivering.

6. Children and Young People Services Updates

6.1 Brent ICP Mental Health and Wellbeing Exec Group Progress Update

Sarah Nyandoro (Head of Place, Mental Health & Wellbeing (All Age), Brent ICP) introduced the report, which provided an update on specialist CAMHS arrangements, and plans for a neurodiversity profiling tool, a children and young people's crisis safe hub, and a newly designed and commissioned emotional wellbeing and mental health support offer for Brent's children and young people known as the Local Young People Resources and Advice Service (LYRA). In presenting the update, she highlighted the following key points:

- She asked the Board to note the increase in demand for mental health services in Brent and the work being done to reduce the neurodiversity assessment waiting list as well as the work to develop a neurodiversity profiling tool. She highlighted the new crisis safe hub being developed in Brent and the pilot for children and young people focused on early intervention and prevention.
- In relation to specialist CAMHS, she confirmed that services continued to see an increase in the number of children being referred for support and treatment. The CAMHS caseloads in Brent had increased by 22% in only the last 12 months, making up 1/3 of the overall CAMHS caseload of the 5 CNWL boroughs. Around 13 referrals a day were being received and, in the last 4 months, 1,096 new referrals to specialist CAMHS had been received, with a projected continued increase in caseload in the coming years.
- In addressing the CAMHS demand, there had been some non-recurrent funding allocated in 2025-26 to Brent CAMHS to support in clearing the backlog of children and young people waiting, but she highlighted the challenge in receiving funding at the end of March that was required to be used by the end of March. As a result, it was unlikely that the non-recurrent uplift would decrease demand to an equal level with other CNWL boroughs, as the demand within Brent for specialist CAMHS was unsustainable.
- She had previously signalled to the Board that there were also backlogs in the neurodiversity assessment waiting list. NWL ICB had provided non-recurrent funding to support clearing the assessment waiting list, in terms of numbers and length of wait time. This had helped reduce the assessment waiting list from 900 in December 2025 to 199 in March 2026, and reduced the waiting times from 34 months in December 2025 to 12 months in March 2026. She highlighted that 12 months was still a long time to wait for children and young people, and she had not been advised of any plans at an ICB level to provide additional resources to manage that level of demand for neurodiversity assessments.
- In Brent, a neurodiversity profiling tool was being designed which would be a needs-based tool that could be used whilst children and young people waited for a diagnosis. This did not remove the need for a diagnosis for children and young people but helped identify need at an early stage prior to assessment, allowing schools and health providers to make adjustments and put in place care and education packages of support ranging from Speech and Language Therapy to

specialist mental health support. The tool would typically assess speech and language, attention, sensory processing and emotional regulation. She hoped this would provide parents with help managing children and young people while they waited. In order to progress this, funding had been identified by CNWL and NWL ICB, but the ICP was still looking for additional funding to pilot the tool across Brent and Ealing.

- Work was also underway on a Brent Crisis Safe Hub, offering an alternative space for children and young people to go. Currently, the largest numbers of children attending A&E in mental health crises were from Brent, presenting with suicide ideation, self-harm and emotional distress. The ICP was looking to develop this safe hub to act as a crisis intervention service for children and young people in Brent to receive clinical and non-clinical support, which would be based in the community. The hub would be open to children, young people, and their parents, who could self-define what the crisis was for them with no need to meet a particular criteria to attend the space. The ICB had worked with parents, carers, children and young people to develop a service specification for the safe hub and were now looking to go out to tender, with a view to bring in a provider by late summer 2026. A similar hub had been developed in Ealing which officers had been learning from.
- Members were also given details of the new Local Young People Resources and Advice Service (LYRA), which had been developed in consultation with children and young people. The purpose of the service was to provide early intervention and prevention for children and young people, responding to the increased mental health needs of the young population in Brent. The new service was in line with the THRIVE model of care, focused on ensuring advice, advocacy and support was provided, a 'get help' offer was available, a 'get more help' offer was available, and that help was being provided for children and young people presenting with risk. LYRA would have a partnership approach with 4 providers working in collaboration with each other and a single front door, so all referrals went through the same single point of access within CNWL.

The Chair thanked Sarah Nyandoro for the introduction and invited contributions from those present, with the following points raised:

- Dr Rammya Mathew expressed that she hoped LYRA would be transformational for children and young people. The service had been presented across primary care forums and well received by GPs who saw the service as a good way to provide support to those who did not meet the criteria for specialist CAMHS.
- The Board was pleased that the neurodiversity waiting times had reduced dramatically over the past few months from 24 months to 12 months, which they felt was clear had been achieved by the non-recurrent uplift in funding received to reduce those waiting lists. They expressed the need to be able to deliver the transformational changes required to reduce waiting lists and deliver care without being reliant upon uplifts each time. Sarah Nyandoro confirmed that there would be no additional investments into the neurodiversity waiting list, but the ICB was working with a provider, Helios, to provide online assessments to clear the backlog where possible and maintain the shorter waiting times. Some children and young people required a face-to-face assessment which Helios would not be able to provide. Tom Shakespeare highlighted that the assessment waiting times were a national challenge and lobbying was taking place at a national level to ensure consideration of the challenges and different ways services could be delivering in

this space. Whilst that ongoing national work took place, he felt that the prevention space that was being developed would be essential to maintain a 'waiting well' approach and help navigate children away from the need for specialist CAMHS.

- Further considering the one-off funding provided to reduce waiting lists, the Board asked how long that funding would last and whether it was expected demand would rise quickly once that had been used. Tom Shakespeare responded that it was expected demand would start to increase again, but he hoped that the preventative interventions being developed, as outlined in the report and presentation, would start to have an impact on the level of that increase. He expressed hope that the new West and North London ICB would recognise the challenges and put additional investment in to prioritise CAMHS and neurodiversity. The one-off funding was allocated for the previous financial year, so CAMHS was working through the case list of those who had already been on the waiting list before the end of March 2025.
- Simon Crawford (Deputy CEO, LNWH) advised of the recent comments by Dr Nick Broughton (National Director for Mental Health, NHSE) at the National Health Conference regarding the rise in demand for children's mental health services and the need for greater investment. As such, Simon Crawford emphasised that the demand being seen across services for children's mental health support was not unique to Brent, although it was particularly acute in the borough. From an acute hospital perspective, he welcomed the crisis hub and LYRA as potential avoidance of attendance at A&E, which was not the appropriate environment for children and young people in crises. He asked how LYRA would link with A&E services. Sarah Nyandoro advised that LYRA would be part of the acute pathway for mental health, which would ensure those children were being redirected from A&E towards the appropriate services. Tom Shakespeare added that the neighbourhood model approach and work within the Family Wellbeing Centres would also be essential to ensure a coherent mental health offer was provided to reduce the number of paediatric admissions. This would require combined efforts across the Council, primary care, CAMHS, the voluntary sector and community services.
- The Board asked what other local areas were doing in this space and whether best practice was being shared across areas. Sarah Nyandoro highlighted that the work Brent was doing was broadly in line with what other outside boroughs were doing to develop alternative ways to support children and young people.
- In response to queries about how children and young people would access the front door, Sarah Nyandoro explained there would be a single point of access through CNWL, which GPs had direct access to. Work was underway to give parents the same direct access to the front door rather than going through GPs.
- In relation to the neurodiversity profiling tool, the Board asked what data would be collected through that to show its impact. Sarah Nyandoro explained that this was being tested as a pilot in Brent and Ealing for up to 18 months, with the impact evaluated after that to enable the new West and North London ICB to make a decision on future investment into the tool.
- Nigel Chapman (Corporate Director Children, Young People and Community Development, Brent Council) signalled the recently published government white paper on SEND, with an expectation for local areas to produce a plan around preventative approaches to SEND and additional learning needs and return that to the DfE by June 2026. The new expectations came with funding attached and an 'experts at hand' offer to be developed by each local area to support schools more effectively. He would provide updates on this to the Board as the work progressed.

As no further issues were raised, the Board thanked officers for their presentation and commended the work done to reduce the neurodiversity waiting list and times over a 4-month period. The Board looked forward to receiving an update on sustainable resourcing for service models in the future.

6.2 Brent Children's Trust Progress Update

Nigel Chapman (Corporate Director Children, Young People and Community Development, Brent Council) thanked Wendy Marchese (Strategic Partnerships Manager, Brent Council) for drafting the Brent Children's Trust (BCT) update report and outlined the key headlines as follows:

- Neighbourhood working was a key priority for the BCT which was looking at how to bring together all neighbourhood initiatives across Brent Health Matters (BHM), Family Wellbeing Centres (FWCs) and Radical Place Leadership (RPL) into one 'working in neighbourhoods' approach.
- Early work in Harlesden on a neighbourhood approach had focused on reaching underserved families and reducing inequalities.
- The report made reference to Early Years and the approach partners were taking to support the new Early Years Strategy which had been published in March 2026, focused on a Best Start in Life approach.
- Mental health was a top concern discussed by BCT, and some useful workshops with partners had taken place in February 2026 to consider the system response to mental health, with a follow up scheduled in March 2026 which had set and agreed priority themes for the next two years.
- Agreed priorities for the next two years were; children's mental health and wellbeing; health inequalities and neighbourhood working; Best Start in Life and; inclusion support and pathways. Based on these priorities, an action plan would be developed, and he emphasised the energy and enthusiasm amongst BCT members to take forward those areas in a thematic, cross-cutting way.

As no further issues were raised, the Chair drew the discussion to a close, thanking officers for a detailed report.

7. Brent Food Strategy

Shadi Ambrosini (Public Health Strategist, Brent Council), Aisling Rogers (Health Improvement Delivery Specialist, Brent Council) and Alex Colas (Co-Chair of the Food Partnership Steering Group), presented the first draft of a new Food Strategy for Brent, which was commitment 1.1 of the Joint Health and Wellbeing Board Strategy. The report and presentation provided an update on the development of the Food Strategy and its related Food Action Plan and highlighted core themes, with a proposed plan for implementation. In presenting the strategy, they highlighted the following key points:

- The Food Strategy presented a long-term plan bringing together statutory organisations, voluntary and community sector partners, the private sector and residents to improve the way food was produced, accessed, consumed and disposed of, setting out key priorities and actions around health, sustainability and equity.
- The Strategy was based on shared values around food such as equity, dignity, partnership and community.
- In terms of why Brent needed a food strategy, it was highlighted that Brent faced significant challenges with rising food insecurity, diet-related ill-health and

environmental pressures. Poor diet contributed to obesity, diabetes and cardiovascular disease which placed strain on services and reduced residents' quality of life. Additionally, the cost-of-living crisis and unequal access to healthy food deepened health inequalities. As such, it was seen that a co-ordinated approach was essential to address these issues and create a food system that worked for all.

- Figures were provided to demonstrate those points; the prevalence of type 2 diabetes amongst Brent residents was at 8.1% for 2024-25 compared to the London average of 7.2%; the hypertension rate in Brent for 2026 was at 13.3% compared to the London average of 10.6% and; in 2024-25, 38.1% of year six pupils had been diagnosed as obese/overweight compared to a London average of 24.8%. This correlated to other measures of inequality, for example, 33% of people in Brent lived in poverty, with 1,855 visits to Brent Hubs for food related supported between 2025-2026, 21.8% of pupils receiving Free School Meals in 2025, 57% of eligible families receiving cash support through the Healthy Start scheme to support the purchase of fresh fruit and vegetables in 2025, and around 17% of Brent residents in receipt of Universal Credit.
- Brent's Food Strategy was built around six Food Missions seeking to address the most pressing food-related challenges and highlighted a deeply interconnected food system with shared values. Each of the six missions had three core objectives with three distinct solutions. Those missions were; to improve access to healthy and affordable food and tackle diet-related health inequalities; to help reduce insecurity and ensure everyone could access affordable and healthy food with dignity; to support the development of food literacy and skills in schools and communities; to promote good food jobs, skills, training and opportunities within the local food economy; to encourage growing food in the community and at home and support access to resources and; to empower residents and institutions to reduce food waste, cut carbon emissions and support more sustainable food choices.
- The strategy was developed through a long process working with residents. Starting in 2021, Brent launched the Right to Food Campaign. In 2023, a Food Visioning Workshop took place, engaging 55 people and 37 organisations, which led to the development of seven strategic themes which informed initial priority setting and established a Food Partnership Steering Group. In 2024 the Brent Food Partnership identified core priorities which later helped inform the development of key objectives and recommended areas for action. 2025 saw Brent Council appoint a Public Health Strategist to work on the strategy and undertake a further Food Strategy Workshop, engaging 67 people and 28 organisations, which used the initial seven strategic themes to develop the six Food Missions now identified in the Strategy. In 2026, Task and Finish Groups were undertaken in March to finalise a draft Food Action Plan, engaging 41 stakeholders. It was added that there had already been grassroots work taking place around food, so the process had been sensitive and looked to facilitate what was already being done. There were several national initiatives and officers had been mindful of the political environment being operated in.
- In terms of governance, it was proposed that the Food Strategy was strategically overseen by the Health and Wellbeing Board to ensure that the commitments remained anchored to Brent's broader ambitions around health equity, climate action, community cohesion and economic resilience. The Steering Group would offer strategic direction for delivery and co-ordinate work across Food Missions,

oversee performance, assess risks, and share learnings, with strong links into the Health and Wellbeing Board. Food Action Working Groups would lead operational delivery for each Food Mission, delivering mission-specific interventions and monitoring progress. The Food Partnership would act as the borough-wide convening body that worked to strengthen the local food system through collective actions.

- It was highlighted that Brent Public Health was committed to exploring resourcing options with relevant stakeholders to support the delivery of the proposed actions and an allocation from the Public Health Grant would be made, as appropriate, with other funding streams explored where available.
- For year one delivery of the Strategy, focus would be on high-impact actions that strengthened food security, improved diet-related illness, boosted food literacy and skills, expanded food-growing opportunities, enhanced good food jobs and accelerated Brent's transition to a more sustainable, climate-friendly food system.
- Cross-cutting themes for year one prioritised actions the Council and partners could directly deliver or influence. The themes aimed to embed poverty alleviation principles by recognising financial insecurity as a major barrier to healthy food access, strengthened cross-sector collaboration, build education and workforce capacity, advance climate and sustainability goals by promoting plant-rich diets and reduced food waste, and ensure cultural relevance and dignity through adopting inclusive, community-led approaches that reflected Brent's diverse cultures.
- The Brent Food Partnership was contributing to other food movements locally and nationally, including the Brent Sustainable Food Places Network and Sustain. Based on the Good Food Local London Report, which tracked Council action on food in London, Brent had received an overall score of 82% in the 2026 publication, an improvement from the score of 79% received in 2025.
- Next steps would be to finalise the Food Action Plan, including the KPIs, roles and resourcing considerations, to continue to seek meaningful engagement with residents, organisations and stakeholders, to identify strategic partners to support in realising the vision, to establish Food Action Working Groups (FAWGs) to support the governance of the strategy, to establish a borough-wide Food Partnership, to work with the Steering Group to allocate resources appropriately, and to work towards achieving Bronze Status in the Sustainable Food Places Award.

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

- The Board were encouraged by the presentation and the amount of work that had gone into creating a robust Food Strategy that truly reflected the residents in the borough and their priorities around food. They felt it important for the Health and Wellbeing Board to add value where possible and stay involved in the process.
- The Board emphasised the importance of the work being meaningful with funding and resources attached to it, and asked what resourcing had already been set out to carry this forward. They also asked for this to be incorporated into the document so that everyone who read the strategy were aware of what was being committed towards this. Ruth Du Plessis (Director of Public Health, Brent Council) advised that funding was likely going to be put towards the development of a Food Network to learn from other areas and models. She added that there were some things that could be done that did not cost money but created dignity by doing things slightly

differently. Shadi Ambrosini agreed to be more explicit in the documents regarding funding.

- The importance of collecting good quality data in order to understand the impact of the strategy was highlighted. Shadi Ambrosini agreed that it was important the work was grounded in local insights, and work would be taken forward to conduct a food system analysis to collate local insights around food as well as understand the good practice happening in Brent. Over the next few months, that would be contextualised in documents that would sit alongside the Food Strategy.
- The Board hoped for buy-in from all partner organisations in a meaningful way to support the implementation of the strategy objectives and actions, including NHS provider partners.
- Councillor Knight asked for the co-location of services at the New Horizons Centre to be referenced in the document, highlighting the good relationship of the Centre with Sufra. She added more generally that additional tangible case studies would be useful to include in the strategy. Shadi Ambrosini agreed to incorporate that into the documents that related to the Food Strategy.
- The Board suggested further reference was made to working with parents and carers to encourage home cooking and provide education around that where necessary. Shadi Ambrosini took the comment on board, advising that conversations had started with Early Years colleagues to ensure food literacy, education and intervention that not only targeted children but brought their parents into the conversation as well.
- The Board highlighted that the Action Plan should be clearer about who was expected to implement those particular actions.

As no further issues were raised, the Chair drew the discussion to a close and asked members to note the Food Strategy and Food Action Plan whilst taking on board the comments made to further improve the documents related to the Food Strategy. He highlighted the desire to be explicit about investment and resource and where that would be put, identify firm metrics to demonstrate the impact of the Strategy, explicitly state who was expected to implement the actions outlined, and include tangible examples and case studies of what had already been achieved. He thanked colleagues for the work undertaken on the Food Strategy and expressed that the Health and Wellbeing Board placed value on this work. He hoped that by bringing these documents forward, the priorities would be incorporated moving forward with the new administration and Borough Plan.

8. Proposal to refresh the Brent Health and Wellbeing Board Terms of Reference

Wendy Marchese (Strategic Partnerships Manager, Brent Council) introduced the report, which set out an initial proposal to amend the Brent Health and Wellbeing Board Terms of Reference to allow relevant Council Directors to be included as voting members. In outlining the rationale behind this proposal, she advised that the proposal was to ensure that all members could participate in the Board in equal partnership and ensure governance arrangements reflected current legislation and evolving system expectations, bringing Brent more in line with practice across other local Health and Wellbeing Boards. In concluding her introduction, she advised that the report was intended as an initial step to ensure the Board's arrangements were up to date and ready for inclusion in the refreshed Constitution. A wider review of the Terms of Reference was expected as the system evolved and the Integrated Care Board became a 13 borough West and North London ICB. As such, the Board was requested to agree in principle to the initial change to voting

membership and agree for amendments to the Terms of Reference to reflect that change to be brought forward through the appropriate governance processes.

The Chair thanked Wendy Marchese for her introduction and invited comments and questions from those present, with the following points raised:

- Councillor Board members felt that the report did not detail the advantages on a practical level of expanding voting rights to senior officers of the Council, expressing that they felt it would reduce their own democratic voice on the Board, and confuse the operations of the Board when officers who presented reports were also voting members.
- In response to a query in relation to section 3.1.2 of the report detailing a number of local authorities whose membership arrangements included senior officers as voting members, Wendy Marchese advised that the list detailed examples of where this was done and not the entirety of local authorities who had those arrangements in place.
- Councillor Nerva provided further context behind the proposal, referencing the Health and Wellbeing Act 2012 which specified who the relevant members should be on a Health and Wellbeing Board, which he described as a unique body in the public sector bringing together partners on an equal basis from the local authority, various parts of the NHS, HealthWatch, and other organisations the Board wished to invite, such as the care sector representatives Brent's Board currently included. There had been an assumption within the 2012 legislation that local authority statutory officers, in this case the Director of Adult Social Care, Corporate Director of Children, Young People and Community Development, and Director of Public Health, were members of Health and Wellbeing Board in their own right. Rachel Crossley (Corporate Director Service Reform and Strategy, Brent Council) further added that the Health and Wellbeing Board was not a traditional Council Committee but a partnership Board focused on the wider health and wellbeing system rather than on executive decisions.
- The Board were not minded to agree to the recommendations of the report at this stage, and suggested that the report be noted and Terms of Reference passed to the Director of Law to review, in terms of their compliance with relevant legislation, as part of the constitutional review taking place.
- As a further suggestion to the membership, Councillor Donnelly-Jackson proposed a housing representative from Crisis was included. This would also be taken forward as part of the constitutional review.

As no further issues were raised, the Chair drew the discussion to a close, noting the following resolutions:

i) To refer the report and proposed amendments to the Terms of Reference to the Director of Law to review as part of the constitutional review, with a view to ensuring the Terms of Reference and membership were compliant with the current relevant legislation.
ii) To incorporate a housing representative from Crisis into the membership as part of the Terms of Reference Refresh that would be undertaken as part of the constitutional review.

9. Health and Wellbeing Board Forward Look

The Chair gave members the opportunity to highlight any items they would like to see the Health and Wellbeing Board consider in the future, adding that this would be the final meeting of the current Council administration.

In terms of future items, it was proposed that a SEND update would be brought to the Board once the Council had submitted its SEND plans to the DfE. The Neighbourhood Plan would also be brought forward with proposals on governance for that going forward.

10. **Any other urgent business**

None.

The meeting was declared closed at 8:00 pm

COUNCILLOR NEIL NERVA
Chair

Brent NHS West and North London	**Brent Health and Wellbeing Board** 30 July 2026
	Report from Head of Place Leadership

Neighbourhood Health - National Guidance and Brent's approach to "Working in Neighbourhoods"

Wards Affected:	All
Key or Non-Key Decision:	Non-key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
List of Appendices:	Appendix A – Briefing Slides on NHS Neighbourhood Health Framework
Background Papers:	
Contact Officer(s): (Name, Title, Contact Details)	Robyn Doran* Director of Transformation and Brent ICP Director, Central and North-West London NHS Foundation Trust robyn.doran@nhs.net Dr Rammya Mathew* GP, Kings Edge Medical Centre, Borough Medical Director – Brent rammya.mathew@nhs.net Daniel Shurlock Head of Place Leadership, Brent Council daniel.shurlock@brent.gov.uk **Joint Chairs of the Integrated Care Partnership Neighbourhoods and Health Inequalities Executive*

1.0 Executive Summary

This report:

1.1. Sets 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).

1.2. Highlights progress to date in neighbourhood working in Brent.

1.3. Outlines the role of the Health and Wellbeing Board in shaping, overseeing and championing neighbourhood working.

1.4. Provides an overview of timelines and next steps.

2.0 Recommendation(s)

2.1 The Board is asked to:

a. Note and confirm the role and responsibilities of the Health and Wellbeing Board in overseeing the delivery of the NHS Neighbourhood Health Framework (as a component of Brent's overall Working in Neighbourhoods approach) and the development of local neighbourhood action plans (Appendix A, slide 9).

b. Note the current position on Brent's neighbourhood geographies (Appendix A, slides 10-11) and timelines for development of neighbourhood action plans (slide 16).

c. Note progress in developing the Working in Neighbourhoods approach since the last update to the Health and Wellbeing Board in January 2026, including the key enabling workstreams (slides 13-15).

3.0 Contribution to Borough Plan Priorities & Strategic Context

3.1 The NHS Neighbourhood Health Framework and wider Working in Neighbourhoods (WIN) Programme directly support the delivery of Brent's Borough Plan by strengthening partnership working across health, local government, voluntary, community, faith and social enterprise (VCFSE) organisations and local communities to improve health outcomes and reduce inequalities.

3.2 It contributes to several of the Borough Plan priorities, including:

- **A Healthier Brent:** by shifting care towards prevention, early intervention and proactive neighbourhood-based support, enabling residents to remain healthier and more independent for longer.
- **The Best Start in Life:** through the continued development of Child Health Hubs, integration with Family Wellbeing Centres and coordinated support for children, young people and families.

- **Thriving Communities:** by strengthening community capacity, improving access to local services, increasing resident participation and addressing the wider social determinants of health through integrated, place-based partnership working.

3.3 The WIN programme also supports co-ordinated delivery across a number of wider strategic priorities and policies, including:

- **Brent Joint Health and Wellbeing Strategy**, through its focus on prevention, reducing health inequalities and partnership working.
- **Brent Joint Strategic Needs Assessment (JSNA)**, by using population health intelligence to identify local priorities and inform neighbourhood action plans.
- **NHS 10-Year Health Plan**, supporting the three strategic shifts from hospital to community, treatment to prevention, and analogue to digital.
- **NHS Neighbourhood Health Framework**, which establishes neighbourhood working as the operating model for integrated health and care and identifies Health and Wellbeing Boards as key partners in neighbourhood development.

3.4 The proposals within this report therefore align both local and national policy objectives by supporting the development of Integrated Neighbourhood Teams (INTs), neighbourhood action plans and the governance arrangements required to deliver neighbourhood health across Brent.

4.0 Background

4.1 Neighbourhood working is recognised nationally as the principal delivery model for improving population health, reducing inequalities and providing more integrated care.

4.2 The NHS Neighbourhood Health Framework forms a central part of the NHS 10-Year Plan and sets out a shift from hospital to community, treatment to prevention and analogue to digital services. It aims to bring together health, local government, voluntary and community partners to provide coordinated, person-centred support closer to home, recognising that health and wellbeing are shaped by wider social determinants. In Brent, the framework is being delivered through the Working in Neighbourhoods programme, using population health data, integrated neighbourhood teams and community insight to reduce inequalities, improve access and outcomes, and support residents to remain healthy and independent for longer.

4.3 For NHS services specifically, it will change how key services are funded, contracted, organised and delivered, including emerging Single Neighbourhood, Multi-Neighbourhood and Integrated Health Organisation contracting models (currently being consulted on). It also signals an intention to shift resources and activity from acute hospital care into neighbourhood-based prevention and community services, bringing care closer to home. There is an expected 1% “left-shift” from acute services to enable this to happen.

4.4 Brent has already established strong foundations through the Working in Neighbourhoods programme. This includes:

- establishment of neighbourhood leadership arrangements;
- early development of draft neighbourhood action plans;
- introduction of Community Support and Prevention team (Harlesden)
- launch of Child Health Hubs;
- neighbourhood population health dashboards;
- digital improvements including the Universal Care Plan and London Care Record;
- continued development of neighbourhood workforce, estates and organisational development programmes.

4.5 Harlesden has been established as Brent's neighbourhood test-and-learn site, where partners are trialling new approaches to integrated multidisciplinary working, with a focus on community support and prevention. The learning developed from Harlesden will inform the wider roll-out of the model across other Brent neighbourhoods.

4.6 Alongside neighbourhood delivery, work has commenced to review Brent's neighbourhood geographical footprints. In line with national guidance, the Health and Wellbeing Board is recognised as the appropriate strategic forum to oversee this process, ensuring neighbourhood boundaries align with local population need, wider public service reform and national expectations.

4.7 A phased decision-making process is proposed during Summer and Autumn 2026, culminating in formal Board approval of neighbourhood geographies alongside emerging neighbourhood action plans.

5.0 Stakeholder and ward member consultation and engagement

5.1 As the WIN Programme develops, we will continue to engage with relevant ward members to ensure that they have the opportunity to support in shaping the services delivered in their wards.

5.2 Briefings with relevant ward members, including invites to visit and observe neighbourhood working in practice will be scheduled over the coming months.

6.0 Financial Considerations

6.1 There are no direct financial implications arising from this report.

6.2 Implementation of neighbourhood action plans will utilise both existing organisational resources and additional investments through business cases. For example, business cases will be developed over the next two years to the West and North London Integrated Care Board (ICB) to draw funding into Brent as part of the”1% shift” of NHS resources from acute spend into neighbourhood level prevention.

6.3 More broadly, the Working in Neighbourhoods programme seeks to maximise all existing and future investments through greater integration, partnership working and alignment of resources across organisations.

7.0 Legal Considerations

7.1 There are no direct legal implications arising from the recommendations within this report.

8.0 Equity, Diversity & Inclusion (EDI) Considerations

8.1 Reducing health inequalities is a core objective of the Working in Neighbourhoods programme.

8.2 Neighbourhood action plans are informed by population health intelligence, the Brent JSNA and resident insight to ensure resources are targeted towards communities experiencing the greatest inequalities.

8.3 The programme adopts a place-based approach that aims to improve access to services, strengthen prevention and address the wider determinants of health through collaborative working across organisations and communities.

8.4 Equality considerations will continue to be incorporated into future neighbourhood delivery and service redesign.

9.0 Climate Change and Environmental Considerations

9.1 Neighbourhood working supports more local delivery of services, reducing unnecessary travel for residents and enabling greater use of community-based facilities.

9.2 Co-location of services and increased digital working are expected to improve operational efficiency whilst contributing to wider sustainability objectives.

10.0 Human Resources/Property Considerations

10.1 Delivery of the Working in Neighbourhoods programme is supported through ongoing workforce and organisational development alongside strategic estates planning. Any specific staffing changes are and will be managed through the appropriate organisation's change policies and processes.

Current work includes development of neighbourhood workforce plans, leadership development, co-location opportunities and progression of Neighbourhood Health Centre proposals.

No immediate Human Resources or property decisions are required as part of this report.

11.0 Communication Considerations

11.1 A coordinated communication and engagement approach will continue to support implementation of the Working in Neighbourhoods programme.

This includes:

- engagement with residents and communities;
- communication with system partners;
- updates through Health and Wellbeing Board governance;
- sharing learning from neighbourhood delivery;
- supporting consistent messaging regarding neighbourhood health across Brent.

11.2 Future communications will accompany the confirmation of neighbourhood geographies and development and delivery of neighbourhood action plans.

Report sign off:

Rachel Crossley
Corporate Director, Service Reform and Strategy, Brent Council

APPENDIX A

Working in Neighbourhoods - Health and Wellbeing Board Background Briefing

30th July 2026

Purpose

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

The following slides:

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

What Is Neighbourhood Working

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

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

NHS Neighbourhood Health Guidance

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

- The three-reform priorities are:

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

Goals and Metrics (Goal 1: Improve Health Outcomes)

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

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

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

Brent's Approach

Progress so far…

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

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

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

Where do we want to go…

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

How will we get there...

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

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

Brent's Approach

Role of the Health and Wellbeing Board

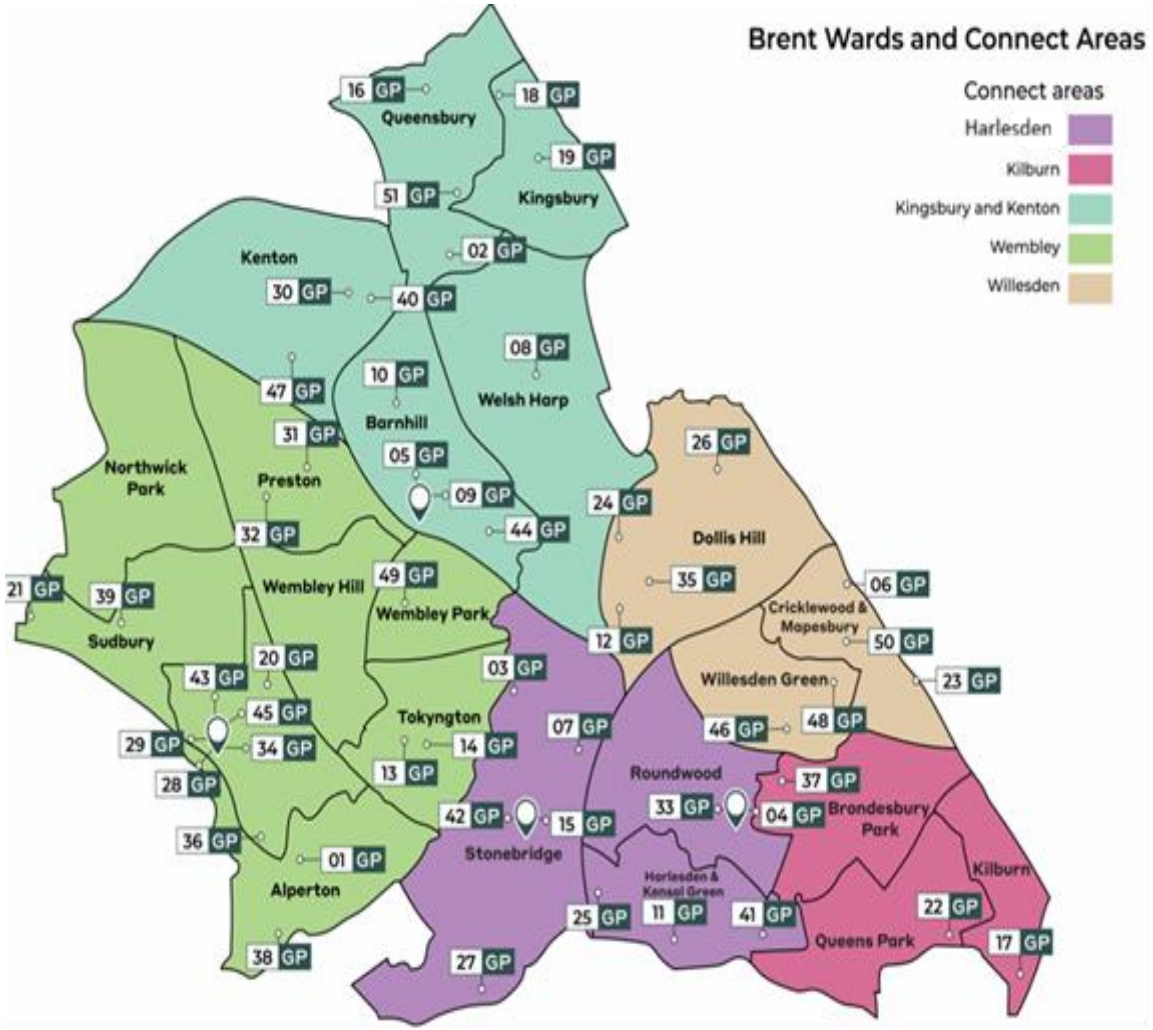
Must Dos	Description of the Ask	Timeframe in Framework
Lead development of the neighbourhood health plan	HWBs must jointly lead and approve a locally owned neighbourhood health plan with ICBs and partners.	Plan developed during 2026–27 Implementation from 2027–28 financial year.
Define neighbourhood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

Neighbourhood geographies

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

Current Position

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



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

Progress so far

Neighbourhoods' Maturity Matrix

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

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

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

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

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

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

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

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

Progress since last update to HWBB

Neighbourhoods

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

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

Enabler Workstreams

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

Digital

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

HARLESDEN NEIGHBOURHOOD ACTION PLAN 2026–2030

Working together for better health and care

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

Example Action Plan

1. OUR VISION

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

Our vision is shaped by:

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

2. OUR PRIORITIES 2026–2030

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

3. HOW IT WORKS

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

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

Enabled by data and technology

- London Care Record
- WSiC dashboards
- Care plans

Working together

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

4. WHAT CHANGES FOR RESIDENTS

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

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

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

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

Your voice matters
We listen and shape services with you.

5. HOW SUCCESS IS MEASURED

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

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

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

We care – We put people at the heart of everything.

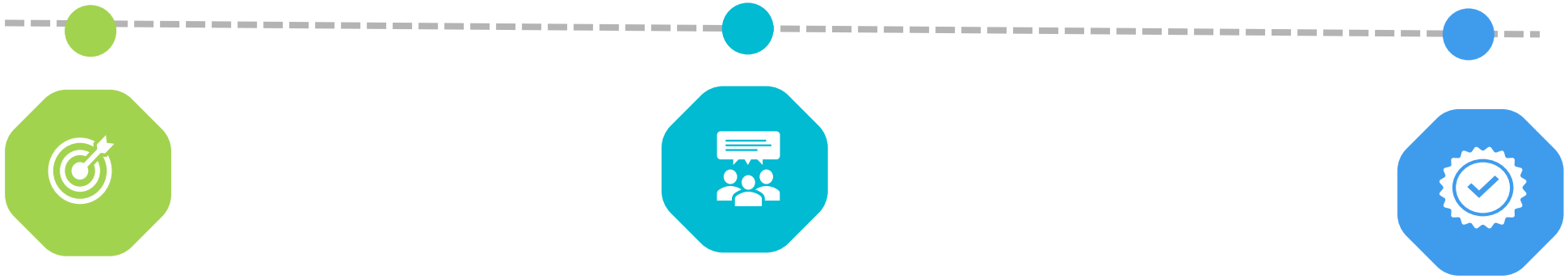
We are local – We work in our neighbourhoods and communities.

We collaborate – We work together across organisations and sectors.

We improve – We learn, innovate and keep getting better.

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

Timeline for formal agreement of action plans



JULY 2026

- HWB report on overall approach, requirements and role

SEPTEMBER 2026

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

DECEMBER 2026

- Neighbourhood action plans 27/28 formally submitted to HWB

*TBC based on HWB dates

Questions For The Board

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

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Brent NHS West and North London	**Brent Health and Wellbeing Board** 30 July 2026
	Local Government Association Peer Review of Brent Health Matters
	Cllr Liz Dixon – Cabinet Member for Community Safety and Public Health
Summary of Local Government Association (LGA) Peer Review of Brent Health Matters (BHM)	

Wards Affected:	All
Key or Non-Key Decision:	Non key
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
List of Appendices:	Appendix A: LGA Peer Review of Brent Health Matters Appendix B: Brent BHM action plan in response
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Ruth du Plessis Director of Public Health Ruth.du-Plessis@brent.gov.uk Daniel Shurlock Head of Place Leadership daniel.shurlock@brent.gov.uk Nipa Shah Interim Operational Lead - Working in Neighbourhoods nipa.shah@brent.gov.uk

1.0 Executive Summary

1.1 Brent Health Matters (BHM) was originally set up in September 2020, following the first wave of COVID-19 where Brent was disproportionately affected in terms of the number of cases and number of deaths. It subsequently formed a central part of a more community connected response to both the immediate and longstanding impacts of COVID-19.

1.2 Since then, BHM has evolved into a broader programme to address health inequalities across the Borough. Recognising the changing context and value of external perspective, Brent Public Health and the Integrated Care

Partnership (ICP) requested that the Local Government Association (LGA) carry out a peer review of BHM at the start of 2026.

1.3 After the LGA team completed their review, a workshop was held with senior stakeholders on 23 April 2026 to sense check the findings and agree key next steps. Further to this a leadership group has been set up with senior members from all the partners in Brent ICP to implement the recommendations and oversee the transition to the next phase of BHM.

1.4 The final report from the LGA and the action plan in response are attached separately (Appendix A and B). The headline conclusion from the review was that BHM continues to successfully reach residents who don't always access formal services; and that this remains a key priority for Brent as part of a strategy that rightly considers the wider determinants of health (e.g. housing, education, income, employment, behaviours, social connection, environment) not just medically diagnosed conditions.

1.5 While BHM is a well-established and trusted approach the review also identified changes that could increase its impact. This includes embedding BHM in neighbourhood working; increasing individual and family level support for residents by doing a mix of public events and case work; consolidating the existing grants programme with other grant pots across the council; involving the voluntary sector more in the design and implementation of neighbourhood support; and reviewing clinical aspects of the model to avoid duplication.

2.0 Recommendation(s)

2.1 The Health and Wellbeing Board is asked to:

a) Note the LGA peer review report and thank the external team for their input and recommendations
b) Endorse the headline action plan created in response to the recommendations and highlight any further priority issues for the next stage of Brent Health Matters

3.0 Detail

Contribution to Borough Plan Priorities & Strategic Context

3.1 Delivery of the action plan in response to the LGA peer review will support:

- Brent Joint Health and Wellbeing Strategy, through its focus on prevention, reducing health inequalities and partnership working.

- Borough Plan priorities, including:
  - A Healthier Brent: by shifting care towards prevention, early intervention and proactive neighbourhood-based support, enabling residents to remain healthier and more independent for longer
  - Thriving Communities: by strengthening community capacity, improving access to local services, increasing resident participation

and addressing the wider social determinants of health through integrated, place-based partnership working.

Background

3.2 Brent Health Matters was set up in September 2020, following the first wave of COVID-19 where Brent was disproportionately affected in terms of the number of cases and number of deaths.

3.3 Funding for the BHM Clinical and Mental Health team came from North West London (NWL) Integrated Care Board (ICB) following a business case. Meanwhile, funding for the council employed team and Health Educators (provided by a consortium of voluntary organisations) came from the Public Health grant. The offer initially focused on adults; however, some aspects have been extended to include children and young people.

3.4 Since its inception BHM has evolved into a broader programme to address health inequalities across the borough. Recognising the changing context and value of external perspectives, Brent Public Health and the Integrated Care Partnership (ICP) requested that the Local Government Association (LGA) carry out a peer review of BHM at the start of 2026.

3.5 The LGA peer review team combined expertise from different from across different disciplines. It was comprised of:

- Simon Sherbersky: Former Executive of Communities and Director of Ageing Well, Torbay
- Dr Debbie Frost: Deputy Director for Systems Improvement and Professional Standards at NHS England
- Helen Lowey: Strategic Public Health Advisor for Greater Manchester trauma responsive agenda and Walsall Council
- Cllr. Paul Warburton: Retired Nurse, Labour councillor for Warrington, Chair of HWB Board

3.6 The team carried out 30 interviews and group conversations between February and March 2026. After the review, a workshop was held with senior stakeholders on 23 April 2026 to sense check the findings and agree key next steps. The final report from the LGA can be found in Appendix A.

Action plan

3.7 Further to the workshop a leadership group has been set up with senior members from all the partners in Brent ICP to implement the recommendations and oversee the transition to the next phase of BHM. The key actions being progressed are included in Appendix B and summarised below:

a) *Neighbourhoods* - align all BHM staff and resources into neighbourhoods and boost 1to1 support to residents/families, building on the approach developed in Harlesden and extending into other areas (noting this aligns with a Council restructure underway)

b) *Workforce development* - establish relational working as core skill-set across community roles – develop career pathways, training, supervision, reflective support, action learning as part of workforce strategy
c) *Team alignment* – ensure stronger connections with other community based / focused roles such social prescribers (employed by GPs) and other case managing roles, to maximise impact and avoid any duplication
d) *Events* – target communities or populations where impact is greatest. Co-develop strategy for VCFSE (Voluntary, Community, Faith and Social Enterprise) to take on greater ownership for running events
e) *Clinical* – review the strategic priorities for BHM clinical resources in conjunction with ICB and primary care colleagues
f) *Leadership* – establish clear governance through a senior leaders partnership group to deliver the recommendations, actions and report to Neighbourhoods and Health Inequalities Executive group, ICP Board and Health and Wellbeing Board

4.0 Stakeholder and ward member consultation and engagement

4.1 The review included interviews with around 30 people from a wide range of stakeholders including statutory services, voluntary sector and council members.

5.0 Financial Considerations

5.1 There was no cost to the Council for the LGA review.

5.2 BHM is funded jointly in partnership. Funding for the BHM Clinical and Mental Health team is through the North West London (NWL) Integrated Care Board (ICB) following approval of a business case. Meanwhile, funding for the council employed team and Health Educators (provided by a consortium of voluntary organisations) is through the Public Health grant as is the BHM grants programme. The actions set out in this report are based on maximising the impact of current investments, rather than altering it at this stage.

6.0 Legal Considerations

6.1 There are no direct legal implications arising from the recommendations within this report.

7.0 Equity, Diversity & Inclusion (EDI) Considerations

7.1 This way of working will support tackling existing Health Inequalities in Brent.

8.0 Climate Change and Environmental Considerations

8.1 There are no direct climate change and environmental implications arising from the recommendations within this report.

9.0 Human Resources/Property Considerations (if appropriate)

9.1 To enact the recommended changes a formal staff consultation was completed with all BHM council staff from 18th June to 23rd July 2026. This has adjusted some roles and updated role profiles to reflect the priorities agreed.

10.0 Communication Considerations

10.1 The action plan has been presented at the Neighbourhoods and Health Inequalities Executive group for Brent ICP and shared with all staff group across all stakeholders. Tailored engagement with local communities will continue to be a key part of BHM.

Report sign off:

Rachel Crossley
Corporate Director of Service Reform and Strategy

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Brent Health Matters: findings and reflections from the Local Government Association (LGA) peer review

March 2026 | LGA Partners in Care and Health

This report sets out what we heard across more than 30 interviews and group conversations conducted as part of the Local Government Association peer review of Brent Health Matters (BHM) between February and March 2026. It is intended as pre-reading for the April workshop, where participants are invited to build on these findings and begin to vision the next stage of neighbourhood health in Brent.

The findings are presented as observations, not conclusions. Our aim is to hold up a mirror — to reflect back what people told us, honestly and without attribution, so that everyone in the room can have the conversation they need to have.

The review team:

- Dr Debbie Frost: Deputy Director for Systems Improvement and Professional Standards at NHS England
- Helen Lowey: Strategic Public Health Advisor for Greater Manchester trauma responsive agenda and Walsall Council
- Cllr. Paul Warburton: Retired Nurse, Labour councillor for Warrington, Chair of HWB Board
- Simon Sherbersky: Former Executive of Communities and Director of Ageing Well, Torbay

1. Context: why this review, why now?

Brent Health Matters was established in September 2020 in direct response to the disproportionate impact of COVID-19 on Brent's most deprived communities: Harlesden, Church End, Alperton and Stonebridge. These areas have some of the highest concentrations of deprivation and ethnic diversity in London and were hardest hit by the pandemic.

Five years on, the programme has accumulated significant achievements. It has also reached a point where its original design, shaped around the COVID emergency, needs to evolve. The introduction of neighbourhood health as a national policy direction creates both a challenge and a genuine opportunity for Brent to do something different — and to do it well.

The LGA was asked to provide an independent perspective on what is working, what needs to change, and what conditions would allow BHM's learning and relationships to become the foundation of a more integrated approach to neighbourhood health.

2. What is genuinely working: the BHM legacy

The most consistent theme across all our interviews was this: BHM has achieved something genuinely hard to replicate. The programme has built real trust in communities that statutory services had previously, and repeatedly, failed to reach. Trust is embodied in the staff, the community champions, the relationships, and the BHM brand itself.

Reaching communities others cannot

BHM has taken health engagement into factories, places of worship, libraries, night-time workplaces and community events across Brent's five Connect areas. The programme held 119 outreach events attended by over 4,200 people in 2023/24 alone, engaging with 428 community organisations. This reach is near-unique in the London context.

> *"Their outreach work is phenomenal. They have empowered the community and raised awareness of health through their checks, including in hard-toreach groups. BHM has near-unique skills and reputation in communities and places of worship."*

> *"Success has been when BHM worked with factories — where they went to people and met communities in a completely different way. Amazing stories."*

Tangible health impact

The programme has helped drive measurable improvements in some of Brent's most stubborn health inequality gaps. The bowel cancer screening health Inequalities gap narrowed from 13% to 9%. Hypertension identification in Black communities has improved through outreach to night-shift factory workers and places of worship. A pre-diabetic screening session at a local temple led to identification, education and lifestyle changes for residents who would not otherwise have engaged with primary care.

The children and young people team has demonstrated particular innovation. Joint home visits with housing officers on asthma outreach have been part of a picture which showed reduced hospital attendances and admissions. Community connectors and link workers are reaching outcomes that other services simply cannot. In addition, there has been help for a few of the most disadvantaged families with the wider determinants of health that will improve the children's life chances.

"BHM is reaching communities that wouldn't otherwise be contacted or attend a GP practice. Through out-of-hours and night working in places of worship and factories, it has resulted in greater identification and management of hypertension, improved GP follow-up and medication reviews, especially in the Black population."

A trusted brand and passionate team

People across the system — council members, NHS partners, VCFSE organisations and community leaders — speak highly of the BHM brand. Staff are consistently described as passionate community champions. The brand, and the relationships it embodies, are assets that must be protected through any future transition, for example, enabling another service to supporting black men to get help with mental health before crisis point.

"Following the establishment of BHM, people see the council differently. They are receptive to and appreciative of the offer."

"It is a conduit to help individuals — a unified approach to tackling health inequalities. The Met Police of health inequalities: preventing and reducing ill health and poor health outcomes, able to refer across services."

3. What we observed: the honest picture

Alongside the genuine achievements, our interviews revealed a consistent set of concerns and gaps. These are not criticisms of the BHM team — they reflect structural and systemic issues that BHM alone cannot resolve. They are the conversations that Brent as a whole system needs to have.

Running alongside the system, not within it

BHM operates substantially in parallel to the statutory system rather than being embedded within it. A telling example emerged from our interviews: a community session was being delivered next to a GP practice, and the GP practice did not know it was happening.

Some BHM activity — blood pressure monitoring, health checks — duplicates what is already commissioned across primary care and community health services. A GP practice receives £25 for a health check; the cost of BHM-delivered checks is unknown. The question is not whether BHM should deliver these activities, but whether its unique contribution — community trust, culturally competent outreach, relationship-building — is being directed at what only BHM can do.

> *"BHM is indulgent rather than target-focused. There is duplication between BHM and GP practices, for example in BP monitoring and health checks. There is a lack of output and impact data."*

> *"Don't duplicate health and care practitioner roles in BHM — they already exist across the wider system. Focus instead on being the catalyst that helps the interface between communities and existing services."*

The real impact is not being captured

BHM's greatest contribution is not clinical activity alone. It builds trust, connection, community agency and resilience: the social conditions that make better health outcomes possible. Yet these outcomes are almost entirely invisible in the programme's current reporting, which focuses on activity metrics.

Several interviewees raised a harder question: to what extent can observed improvements in clinical indicators be attributed specifically to BHM, rather than to primary care activity already under way? This points to a gap: the programme is currently reporting activity, not change in people's lives.

> *"There is a recognition that building relationships with communities is really key, but it's not being captured in the monitoring and outcomes. People like the brand and the community engagement side, but they want to see it going forward in a more meaningful and productive way, with improved health and social outcomes."*

> *"Was it BHM that made the change, or was it primary care doing the work they had been doing anyway? Who do you attribute the change to?"*

The upstream ambition is unfinished

BHM was explicitly designed to address the wider determinants of health inequality, not just its clinical symptoms. In practice, the programme's focus has remained substantially on health access and clinical interventions, with limited reach into housing, employment, poverty, education and place. People across our interviews expressed strong appetite to go further upstream.

- **Housing:** consistently cited as one of Brent's biggest drivers of poor health. BHM's community reach could connect systematically to housing improvement, damp and overcrowding interventions and homelessness prevention — but this link is not yet being made.
- **Financial insecurity and poverty:** BHM already includes financial advice capacity. Interviewees felt integration with welfare benefits support, debt advice and the Brent poverty commission agenda could be much stronger.
- **Employment and economic inclusion:** several people identified an untapped opportunity to align BHM with employment and skills programmes, particularly for communities most affected by health inequalities.
- **Education and early years:** BHM's CYP team already opens a route into schools and early years. People felt these connections were underdeveloped.
- **Structural racism and lived experience:** health inequalities in Brent are deeply racialised. People felt that more needs to be done to ensure Black, Asian and minoritised residents genuinely shape the programme, not just receive it.

> *"Housing is the single biggest issue in Brent. There is potential for greater focus on community issues and engaging with other departments to bring those services into the BHM offer, but this needs to be thought through, phased and structured."*

> *"Community groups should be better networked and collaborating and learning with each other and services. BHM has started to build these relationships."*

The VCFSE sector is underused

BHM's VCFSE consortia — five partner organisations delivering health education at £250,000 per year — is valued. But competitive tendering has fragmented the wider sector rather than building it. The Brent CVS has just three part-time staff. There is no equivalent of Harrow Together or the Hillingdon H4 Partnership: no shared infrastructure enabling organisations to collaborate rather than compete.

Several interviewees pointed to organisations already functioning as neighbourhood anchors — the Jason Roberts Foundation and Ashford Place in Harlesden, the emerging One Harlesden collaborative, the Brent Place Partnership with Sport England — as examples of what is possible when community energy is properly resourced and connected.

"There are a lot of groups but limited working together, and this has not been resourced. COVID showed the sector can collaborate when supported, but structures dissolved post-pandemic. Competitive tendering forces charities to compete rather than coordinate, eroding trust."

"I would love five organisations like the Jason Roberts Foundation in Brent."

"One Harlesden shows that if the energy and resource is put in, we can bring disparate groups and individuals together to support particular marginalised people. More attention, focus and resource is needed across Brent to build community capacity to tackle inequalities."

People are not always on the same page

BHM has no dedicated programme board and no refreshed theory of change since the COVID period. There is no obvious body that brings together the primary care, ICB, CLCH, CNWL, public health, local authority and VCFSE leads to own the outcomes framework for BHM and make commissioning decisions with proper accountability.

Plans to reinforce new Health and Wellbeing Board should be able to provide the strategic leadership for this going forward.

"There is no BHM Project Board or systemic oversight. BHM could be seen as the authority's response to COVID — doing something — but it is not embedded within primary care."

"There is non-deliberate silo working in the council and across the health system, rather than shared ownership.

"It is an excellent idea undermined by the lack of team working. It is unclear who is in charge. Autonomy of the neighbourhoods would be brilliant."

"It's very siloed here in Brent."

4. Community voice

The following is drawn from a focus group of 15 residents at a community wellbeing group hosted at Ashford Place in Brent. It is one conversation, not a representative sample, but what residents described maps directly onto the system-level themes above and gives them human texture.

Residents were clear that what works is not clinical outreach but proximity, consistency and being known. A fleeting event does not build the trust through which real change happens.

> *"Most of us need not this fleeting intervention but a bit of hand-holding."*
>
> *"Since I've been coming here for over a year it's completely transformed my life. It gets me on the train. It's self-action."*
>
> *"If you've got a place that you can get to easily, that you're always going to be welcomed... you can phone or walk in and we'll say, we can help, or we can't. If we can't, we'll connect you to someone."*

Although there is an extensive grants programme which is part of BHM, residents and community leaders were frustrated that organisations already doing this work are poorly resourced while more expensive programmes operate around them.

> *"Brent Health Matters is a hugely expensive resource. I would rather they give us some money to employ some people to actually respond to your issues."*
>
> *"Give us a bit of money and we can continue doing actually your work. We're all adults. At times we might be less well than other times, but we're able and capable."*

What residents described is a shift in logic as much as structure: not more outreach, but investment in the hyper-local spaces and relationships that build connection, confidence, capability and control. The community and voluntary sector should be resourced to lead, with the statutory system as a genuine partner. One of the biggest epidemics in London, residents said, is loneliness. The antidote is not a programme. It is people.

> *"One of the biggest epidemics in London is actually loneliness."*
>
> *"It's people that matter."*

5. What people want to see: a vision emerging

Across all our interviews, there was a striking consistency in what people said they wanted. Nobody wanted BHM to end. Nobody wanted to lose the brand, the relationships or the community trust the programme has built. What people wanted was for BHM to become the foundation of something bigger and more connected — an approach and a set of relationships, not just a programme.

- BHM's community engagement learning embedded into neighbourhood health infrastructure across all system partners, not retained as a separate council-hosted activity
- Clinical delivery mainstreamed into existing health services and considering their place in the new Integrated Neighbourhood Teams; BHM's distinctive contribution concentrated on community-facing engagement, convening and capacity-building
- Investment in VCFSE capacity and connectivity through a community anchor model, with collaborative rather than competitive commissioning, drawing on the Brent Giving participatory model
- A shared outcomes framework capturing trust, social value, social connection, community agency and wider determinants alongside clinical indicators
- Strategic oversight through a genuinely empowered Health and Wellbeing Board or like, with VCFSE and resident voices, owning the vision for neighbourhood health
- A programme that goes further upstream: systematically connecting health engagement to housing, poverty, employment and place, so neighbourhood health connects to real neighbourhoods such as Harlesden, effectively.

> *"Move away from programme. Branding has power, but fundamentally it's about how we're working differently — how we apply working with neighbourhoods to cement BHM as a cornerstone. How do we move from programme to system?"*

> *"Really lucky to have the resources and foundations — but we need to turn them into both capacity and a way of working. The Health and Wellbeing Board's role in Brent hasn't been a system lead for a while. That needs to change."*

This vision is confirmed and grounded by what residents told us directly. The shift from Brent Health Matters to Brent People Matter is not just a change of name: it is a change of logic. It means resourcing the hyper-local spaces, relationships and community groups that are already holding people — and enabling them to do more, rather than building further statutory infrastructure around them.

6. Questions considered at the April 2026 workshop

The following questions are not ours to answer — they are Brent's. We offered them as prompts for the April 2026 workshop, to facilitate the conversations that will help Brent determine its own way forward.

The BHM brand

How do you protect what is genuinely trusted and valued, while enabling BHM to evolve? What would be lost if structural change was handled badly?

Shared ownership and governance

How can the vision of neighbourhood health in its widest sense be shared and owned by all? How does it connect to the places people call home, i.e. their neighbourhoods? Who needs to be in the room for that vision to have legitimacy? What body should hold the programme to account, and how does it need to work differently?

Integration, not replication

Where is BHM genuinely adding value that the statutory system cannot? Where is it duplicating what is already commissioned / delivered? How do you shift the balance towards the former? How do you ensure a long term, sustained, place-based approach?

Measuring what matters

If the real value of BHM is trust, connection and community agency, how do you make those outcomes visible and valued? What would a shared outcomes framework across all partners need to include?

How can data sharing and communication be enhanced?

Going upstream

BHM was designed to address the root causes of health inequality. To what extent is it doing that now? What would it take to connect health engagement more systematically to housing, poverty, employment, place and people?

Enabling the VCFSE

Are you investing in the community and voluntary sector in a way that builds collective capacity? Or are current approaches fragmenting it? What would a genuinely enabling commissioning model look like for Brent and how can BHM support this?

Brent people matter

Residents told us that what they need is not more outreach events but investment in hyper-local spaces where relationships, trust and mutual support can grow.

How does Brent shift resource and decision-making power towards community and voluntary sector organisations that are already doing this work?

What would it mean in practice to move from a programme logic to a people focused approach — from Brent Health Matters to Brent People Matter?

Getting on the same page

What needs to happen for all key partners, including communities, to share a common vision for neighbourhood health in Brent?

What will shared success look like?

This briefing report was prepared by the LGA Partners in Care and Health team as part of a peer review of Brent Health Matters, March 2026. All quotes are non-attributable and are presented to represent the range of views heard across 30+ interviews and conversations with system partners, elected members, community leaders and VCFSE organisations.

APPENDIX B

Response to the LGA peer review of Brent Health Matters

30th July 2026

Background

- Brent Public Health and the Integrated Care Partnership (ICP) requested that the Local Government Association (LGA) carry out a peer review of Brent Health Matters (BHM) at the start of 2026.
- The panel members carried out 30 interviews and group conversations between February-March 2026
- Following their draft report, a workshop was held with senior stakeholders on 23rd April 2026
- A leadership group has been set up with senior members from all the partners in Brent ICP to implement the recommendations and oversee the transition to the next phase of BHM

Local Government Association

The LGA peer review team

- Dr Debbie Frost: Deputy Director for Systems Improvement and Professional Standards at NHS England
- Helen Lowey: Strategic Public Health Advisor for Greater Manchester trauma responsive agenda and Walsall Council
- Cllr. Paul Warburton: Retired Nurse, Labour councillor for Warrington, Chair of HWB Board
- Simon Sherbersky: Former Executive of Communities and Director of Ageing Well, Torbay

Brent ICP
Integrated Care Partnership

Summary of findings

- BHM has achieved something genuinely hard to replicate. The programme has built real trust in communities that statutory services had previously, and repeatedly, failed to reach.

- The programme has held 208 outreach events attended by over 8,141 people, engaging with 428 community organisations. This reach is near-unique in the London context.

- People across the system — council members, NHS partners, VCFSE (Voluntary, Community, Faith and Social Enterprise) organisations and community leaders speak highly of the BHM brand. Staff are consistently described as passionate community champions.

- The introduction of neighbourhood health as a national policy direction creates both a challenge and a genuine opportunity for Brent to do something different — and to do it well.

Brent ICP
Integrated Care Partnership

Gaps, improvements and opportunities

- Running alongside the system, not within it
- Real impact is not being captured re community working
- Upstream prevention ambition is unfinished
- VCFSE is underused
- Changing shift to “Brent People Matter”, rather than just focusing on health
- Finalise a common vision from all partners
- Review clinical team composition and function

Brent ICP
Integrated Care Partnership

Recommendations from stakeholder workshop April 2026

1) Support more community-based and led actions e.g. building on community champions, connectors approach and capacity building
2) Repurpose BHM grants (as part of council's wider changes to grant funding) and direct more core funding to the voluntary sector rather than piecemeal bids
3) Stronger focus on children, young people and families for early support and prevention
4) More relationship-based 1to1 support approaches and giving people time and flexibility aligned to the Integrated Neighbourhood Teams
5) Identify ways to support community connected workers with access to a small, flexible budget that can be used to support residents
6) Make links to wider enablers for neighbourhood working (such as digital, estates/workplaces, training)
7) Map the roles across the wider system – neighbourhoods working gives the opportunity to bring the wider system together
8) Re-consider the strategic focus on the existing BHM clinical investment and create more flexibility to do more preventative community focused work

Brent ICP
Integrated Care Partnership

Delivering the change

- The review team recommended strengthening the cross-partnership governance that directs and oversees the next chapter of BHM as it is integrated into wider neighborhood working.

- A specific “transitions” leadership group is now set up to do this with senior leads from Brent Council, ICP, CNWL, CLCH (with VCFSE to also be added from now). It reports into the overall ICP and Health and Wellbeing Board governance via the Neighbourhoods and Health Inequalities Executive.

- It will meet monthly for the next six months of transition work and will recommend the appropriate ongoing oversight and governance.

- This group reviewed the recommendations that emerged from the review and subsequent stakeholder workshop and is now progressing the immediate actions on the following slide.

Brent ICP
Integrated Care Partnership

Key actions

Theme	Action	Time
Neighbourhoods	1. Align all BHM staff and resources into neighbourhoods and boost direct 1to1 support for residents/families, building on the approach developed in Harlesden and extending into other areas (noting this aligns with a Council restructure underway)	• July-Sept: team changes • Sept-March: extending neighbourhood working
Workforce development	2. Establish relational working as core skill-set across community roles – develop career pathways, training, supervision, reflective support, action learning as part of workforce strategy and plan	• Aug-Oct: plan agreed • Nov-March: first phase implementation
Team alignment	3. Ensure stronger connections with other community based / focused roles such social prescribers (employed by GPs) and other case managing roles, to maximise impact and avoid any duplication	• July-Sept: team changes • Sept-March: extending neighbourhood working
Events	4. Target communities or populations where impact is greatest. Co-develop strategy for VCFSE (Voluntary, Community, Faith and Social Enterprise) to take on greater ownership for running events	• Aug: Review events • Sept-Dec: Co-design VCFSE role
Clinical	5. Review the strategic priorities for BHM clinical resources in conjunction with ICB and primary care colleagues	• July-Sept: agree new strategic priorities
Leadership	6. Establish clear governance through a senior partnership group to deliver the recommendations, actions and report to Neighbourhoods and Health Inequalities Executive group, ICP Board and Health and Wellbeing Board	• In place – meeting monthly

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Brent NHS West and North London	**Brent Health and Wellbeing Board** 30 July 2026
	Report from Corporate Director of Service Reform and Strategy
	Councillor Butt - Leader and Cabinet Member for Adult Social Care

Better Care Fund - End of Year 2025-26 Reporting

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	N/A
List of Appendices:	N/A
Background Papers:	N/A
Contact Officer(s): (Name, Title, Contact Details)	Eleanor Maxwell Senior Programme Officer Better Care Fund Lead for Brent Borough Email: eleanor.maxwell@brent.gov.uk Telephone: 020 8937 2195

1.0 Executive Summary

1.1 The purpose of this report is to present the End of Year (EoY) report for the Better Care Fund (BCF) 2025/26 which was submitted to the BCF team at NHS England (NHSE) on 5th June 2025.

1.2 This report seeks formal ratification from the Health and Wellbeing Board (HWBB) for the End of Year report, it should be noted that it has been signed off, by Rachel Crossley, Corporate Director for Service Reform and Strategy under delegated HWBB authority, to meet the national submission deadlines.

1.3 The EOY report was also signed off by West and North London Integrated Care Board (W&NL ICB), Brent's Chief Financer and reviewed by borough-based colleagues in Health, Adult Social Care and Finance.

2.0 Recommendation(s)

2.1 That the HWBB approve the 2025/26 Better Care Fund End of Year report.

3.0 Detail

Contribution to Borough Plan Priorities & Strategic Context

3.1 The BCF Plan aligns with both Brent Council's Borough Plan 2023–2027 and the Health and Wellbeing Strategy 2022–2027, contributing particularly to Strategic Priority 5: *"A Healthier Brent."* The plan supports efforts to reduce health inequalities and deliver integrated, place-based health and care services tailored to the needs of Brents population. BCF schemes are structured to contribute directly to the outcomes outlined in both strategic documents.

Background

3.2 Key points to note:

3.2.1 Brent Borough successfully met all National Conditions, including securing a signed Section 75 (S75) agreement.

3.2.2 A formal agreement was formally agreed by key partners W&NL ICB and Brent Council on 24th November 2025.

3.2.3 Expenditure was reported in line with the agreed plan, except for scheme 109 Contribution to Community Equipment. An additional 7 schemes, which reported either underspends or overspends balanced overall. This reflects positively on the governance and financial monitoring processes and demonstrate the system's responsiveness to local needs, a commitment to transparency with partners, and ongoing efforts to align spend with optimal outcomes for residents.

3.2.4 All spending, including variances, are tracked quarterly within the Council and subject to oversight and approval by the BCF Board.

Stakeholder and ward member consultation and engagement

4.1 All BCF End of Year reporting has been reviewed and agreed upon by the relevant stakeholders.

4.2 There are no additional stakeholder and ward member consultation and engagement comments specific to this paper.

4.0 Financial Considerations

5.1 The table below summarises the financial values reported in the End of Year submission at Funding Source level.

5.2 An overspend was reported under NHS Minimum Health contribution due to higher equipment costs in scheme 109. This was re-imbursed to the Council by W&NL ICB.

BCF End of Year 25/26 - Funding Source Tracker

Funding Source	Budget 25/26	EOY Actual	Difference	Notes
Disabled Facilities Grant (DFG)	£6,597,406.00	£6,597,406.00	£0.00	
Local Authority Better Care Grant	£16,462,867.00	£16,462,867.00	£0.00	
NHS Minimum Contribution to LA	£10,511,117.00	£10,511,117.00	£0.00	
NHS Minimum Contribution to Health Spend	£18,782,861.00	£20,059,543.46	-£1,276,682.46	Overspend is from Community Equipment funding line under the ICB. Due to the very challenging year after liquidation of the previous supplier NRS which led to additional costs for the system. The overspend is the responsibility of the ICB to fund. The Council also carried a proportion of overspend outside the BCF in line with the Borough contract for shared costs. 62% ICB and 38% LA.
NWL ICB Discharge Funding	£3,124,905.00	£3,124,905.00	£0.00	
Additional North West London (NWL) ICB Contribution	£621,072.00	£621,072.00	£0.00	
Total	**£56,100,228.00**	**£57,376,910.46**	**-£1,276,682.46**	
			Difference -ve = OVER BUDGET	

5.0 Legal Considerations

6.1 None – Section 75 for 2025-26 supports the pooled funding arrangements.

6.0 Equity, Diversity & Inclusion (EDI) Considerations

7.1 There are no additional Equality, Diversity and Inclusion considerations arising directly from this report. Individual Better Care Fund schemes continue to be delivered in accordance with the Council's equality duties and aim to reduce health inequalities across Brent.

7.0 Climate Change and Environmental Considerations

8.1 There are no specific climate and environmental considerations relating to this paper.

8.0 Human Resources/Property Considerations (if appropriate)

9.1 There are no specific Human Resources / Property considerations relating to this paper.

9.0 Communication Considerations

10.1 There are no specific communication considerations relating to this paper.

Report sign off:

Rachel Crossley

Corporate Director of Service Reform and Strategy

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Brent NHS West and North London	**Brent Health and Wellbeing Board** 30 July 2026
	Report from Corporate Director of Service Reform and Strategy
	Councillor Butt – Leader and Cabinet Member for Adult Social Care

Better Care Fund Plan Approval 2026/2027

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	N/A
List of Appendices:	N/A
Background Papers:	N/A
Contact Officer(s): (Name, Title, Contact Details)	Eleanor Maxwell Senior Programme Officer Better Care Fund Lead for Brent Borough Email: eleanor.maxwell@brent.gov.uk Telephone: 020 8937 2195

1.0 Executive Summary

1.1. The purpose of this report is to seek formal approval of the Brent Better Care Fund (BCF) Plan for 2026/27 and provide an update on the planning process.

1.2. The final Brent Better Care Fund Plan, developed jointly with West and North London Integrated Care Board (W&NL ICB), was submitted to NHS England (NHSE) by the required deadline on 14 May 2026. The Plan was approved prior to submission by the ICB and by the Corporate Director of Service Reform and Strategy, under delegated authority from the Health and Wellbeing Board. Whilst all boroughs are awaiting formal approval from NHSE, Brent's Plan has successfully completed the assurance process and was recognised by NHS England as one of the strongest submissions across the region. Work is now underway to finalise the Section 75 Agreement between Brent Council and W&NL ICB ahead of the 30 September 2026 deadline.

2.0 Recommendation(s)

2.1 HWBB members are asked to review and formally approve the BCF Plan for 2026/27.

3.0 Detail

Contribution to Borough Plan Priorities & Strategic Context

3.1. The BCF Plan aligns with Brent Council's Borough Plan 2023–2027 and the Health and Wellbeing Strategy 2022–2027, contributing particularly to Strategic Priority 5: *"A Healthier Brent."* The plan seeks to reduce health inequalities and deliver place-based health and care services tailored to local needs. It includes schemes designed to meet the outcomes of both the Borough Plan and the Health and Wellbeing Strategy.

Background

3.2. The 2026/27 Better Care Fund Plan has been developed within a national planning framework that prioritises stability and continuity ahead of anticipated changes to the health and care system. Whilst the Plan largely maintains existing investment and service arrangements, it reflects the longer-term strategic direction towards integrated neighbourhood working, prevention, and delivering more care within community settings, providing a strong foundation for future transformation.

3.3. Whilst the national approach emphasises stability, Brent has used this planning cycle to undertake a detailed review of Better Care Fund investment, particularly across Local Authority-led schemes. Funding has been realigned where appropriate to reflect changing demand, service cost pressures, value for money and demonstrable outcomes. This has ensured that investment continues to support effective service delivery, while creating capacity for a small number of targeted initiatives that address local priorities, including reducing avoidable hospital admission following attendance at A&E and supporting the longer-term strategic direction of the programme.

3.4. The Plan was developed jointly by Brent Council and W&NL ICB and required formal approval from both organisations to ensure compliance with national planning requirements and local priorities.

3.5. **Factors considered in the planning process**

- **NHS Minimum Contribution:**
  Increased by 4.4%, compared with 3.9% in 2025/26. Whilst this represents an increase on the previous year, it remains below the historic average annual uplift of 5.66%, limiting the ability to fully absorb inflationary and demand-led cost pressures.

- **Overall Funding Status:**
  The majority of Better Care Fund funding streams remain unchanged from the previous year.

- **Funding Pressures:**

Rising operational costs continue to reduce the real-terms value of available funding. As a result, the priority has been to protect existing service provision, with only limited capacity to invest in new or transformational initiatives.

- **Strengthened Governance:**
  The Brent Better Care Fund Board has continued to strengthen governance arrangements through clearer accountability, enhanced oversight and improved performance monitoring across the programme.

3.6 Overall, the 2026/27 Better Care Fund Plan maintains investment in the core integrated services that support residents to remain independent, reduce avoidable hospital admissions and facilitate timely discharge from hospital. Through targeted reprioritisation of resources, the Plan also provides limited investment in new initiatives that address emerging local priorities while preparing the programme for future system reform.

4.0 Stakeholder and Ward Member Consultation and Engagement

4.1 All BCF schemes commissioned by the local authority have been reviewed and agreed by the relevant stakeholders.

4.2 There are no further stakeholder and ward member consultation or engagement comments specific to this paper.

5.0 Financial Considerations

5.1 The table below summarises Better Care Fund income over the last four financial years, providing context for changes in funding levels.

BCF - Income - 2026/27

Category	2023/2024	2024/2025	2025/26	2026/27	Change £	2027/28	2028/29	26-27 notes
Disabled Facilities Grant (DFG)	£5,780,850	£6,597,406	£6,597,406	£6,597,406	£0			
NHS Minimum Contribution to LA	£9,572,333	£10,114,127	£10,511,117	£10,978,509	£467,392	£11,510,860	£12,057,210	Minimum contribution to LA increase 26/27 - 4.4% 27/28 - 4.8%
NHS Minimum Contribution to Health Spend	£17,726,564	£18,729,888	£18,782,861	£19,175,090	£392,229	£19,570,010	£20,000,750	
Additional North West London (NWL) ICB Contribution	£1,486,000	£1,216,000	£621,072	£621,072	£0			
NWL ICB Discharge Funding	£1,670,080	£3,124,905	£3,124,905	£3,190,160	£65,255	£3,255,860	£3,327,520	Noted separately as it funds discharge focused schemes, but included in the NHS Minimum in formal templates.
LA Discharge Funding	£1,870,905	£3,118,175	£0	£0	£0	£0	£0	Combined to create the Better Care Grant from 25/26
iBCF Contribution	£13,344,692	£13,344,692	£0	£0	£0	£0	£0	
Local Authority Better Care Grant	N/A	N/A	£16,462,867	£16,462,867	£0			
Total	£51,451,424	£56,245,193	£56,100,228	£57,025,104	£924,876	£34,336,730	£35,385,480	

Not all funding yet confirmed

	2023/24 to 2024/25	2024/25 to 2025/26	2025/26 to 2026/27	2023/24 to 2026/27 (3 years)
Total Change £	£4,793,769	-£144,965	£924,876	£5,573,680
Total Change %	8.5	-0.3	1.6	9.8

+'ve = growth
-'ve = reduction

6.0 Legal Considerations

6.1 There are no legal implications at this time. A new Section 75 agreement will be required to cover the 2026/27 period and is currently being developed.

7.0 Equity, Diversity & Inclusion (EDI) Considerations

7.1 There are no additional Equality, Diversity and Inclusion considerations arising directly from this report. Individual Better Care Fund schemes continue to be delivered in accordance with the Council's equality duties and aim to reduce health inequalities across Brent.

8.0 Climate Change and Environmental Considerations

8.1 There are no specific climate and environmental considerations relating to this paper.

9.0 Human Resources/Property Considerations (if appropriate)

9.1 There are no specific Human Resources / Property considerations relating to this paper.

10.0 Communication Considerations

10.1 There are no specific communication considerations relating to this paper.

Report sign off:

Rachel Crossley

Corporate Director of Service Reform and Strategy

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