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*Republished on 5 November 2026 to include items 4, 5 and 8

# Health and Wellbeing Board

## Monday 9 November 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.
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# Agenda

Introductions, if appropriate.

| Item | | Page |
|---|---|---|
| **1** | **Apologies for absence and clarification of alternate members**<br><br>For Members of the Board to note any apologies for absence. | |
| **2** | **Declarations of Interest**<br><br>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**<br><br>To approve as a correct record, the attached minutes of the previous meeting held on 17 September 2026. | 1 - 16 |
| **4** | **Matters arising (if any)**<br><br>To consider any matters arising from the minutes of the previous meeting. | |
| **5** | **Best Start Family Hubs Annual Report**<br><br>To provide an overview of the Best Start Family Hubs Annual Report, highlighting key achievements, challenges and priorities. | 17 - 52 |
| **6** | **Brent Gambling Harms Prevention Strategy**<br><br>To present the Draft Brent Gambling Harms Prevention Strategy for endorsement before progression to Cabinet. | 53 - 88 |
| **7** | **Child Death Overview Panel Annual Report**<br><br>To present the Child Death Overview Panel Annual Report, including key themes, learning and recommendations. | 89 - 110 |
| **8** | **Winter Planning 2026-27**<br><br>To discuss key priorities and planned activity for winter 2026. | 110 - 117 |

## 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: Thursday 21 January 2027**



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 17 September 2026 at 6.00 pm

**Members in attendance:** Councillor Grahl (Chair), Councillor Knight (Brent Council - alternate), Councillor Chadha (Brent Council), Councillor Rubin (Brent Council), Councillor Johnson (Brent Council - alternate), Dr Rammya Mathew (Vice Chair / Brent ICP), Dr Radhika Balu (GP & Clinical Director – Mental Health, WNL ICB), (Jackie Allain (Director of Operations, CLCH), Robyn Doran (Director of Transformation, CNWL, and Brent ICP Co-Chair), Katherine Shaw (CEO, HealthWatch Brent), Dr Ruth du Plessis (online) (Interim Director of Public Health and Leisure, Brent Council – non-voting), Claudia Brown (Director Adult Social Care, Brent Council – non-voting), Nigel Chapman (Corporate Director Children, Young People and Community Development, Brent Council – non-voting)

**In attendance:** Wendy Marchese (Strategic Partnerships Manager, Brent Council), Hannah O'Brien (Senior Governance Officer, Brent Council), Tom Shakespeare (Brent ICP Director), Shivani Dhrona (Neighbourhood Transformation Manager, Brent ICP), Mai Stafford (Head of Health Evidence and Insight, Brent Council), Nicola Brownjohn (Independent Chair, Brent Safeguarding Adults Board)

1. **Apologies for absence and clarification of alternate members**

Apologies for absence were received from the following:

- Kim Wright (Chief Executive, Brent Council)
- Councillor Muhammed Butt (substituted by Councillor Knight)
- Councillor Dixon (substituted by Councillor Johnson)
- Patricia Zebiri (Healthwatch Brent)
- David Crawley (Healthwatch Brent)
- Daniel Shurlock (Head of Place Leadership, Brent Council)
- Simon Crawford (Deputy CEO, LNWHT)
- Rachel Crossley (Corporate Director Service Reform and Strategy, Brent Council)

2. **Declarations of Interest**

Dr Rammya Mathew declared a personal interest as GP at King's Edge Medical Centre, part of Kenton North Primary Care Network (PCN).

3. **Minutes of the previous meeting**

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

4. **Matters arising (if any)**

None.

5. **Safeguarding Adults Board 2025-26 Annual Report**

The Board received the Brent Safeguarding Adults Board Annual Report for 2025-26 from Nicola Brownjohn (Independent Chair of the Brent Safeguarding Adults Board), who highlighted the following key points from the report:

- She highlighted the importance of her independence in the role of Safeguarding Adults Board (SAB) Chair, bringing all key agencies and partners together to support safeguarding in the local area.
- The Board was required to work to a strategic plan, which for 2024 until the start of 2026 had focused on three main priorities; self-neglect; substance misuse and housing and; strengthening the learning from Safeguarding Adult Reviews (SARs).
- In relation to self-neglect, a toolkit had been developed for practitioners, and the SAB was now testing the impact of that and whether it was useful for staff. Whilst no longer a priority for the next year, self-neglect and the toolkit would be monitored over the next few years.
- The housing and substance misuse priority had been established following two SARs that had themes around housing and substance misuse and the complexities of that. Due to some of the needs of those who misused substances, the focus going forward for the next year would be around monitoring the learning from the deaths of those who misused substances.
- The final priority around implementing learning from SARs was now completed, with new governance arrangements for that.
- The annual report also presented the new strategic priorities identified at the SAB development day in January 2026; safeguarding those with complex care and support needs and; mental health and suicide prevention, particularly through a homelessness and substance misuse lens, working with the Public Health Team.
- In relation to the new priority around safeguarding those with complex care and support needs, Nicola Brownjohn explained that this included reviewing cases of those who did not meet the threshold for a Section 42 Safeguarding Enquiry, how partners worked together to understand what was going on for that person to prevent that case from becoming a Section 42 Enquiry in the long-term.
- Alongside the two priorities, the SAB would have ‘golden threads’ around community engagement, digital inclusion and monitoring the workforce.

The Chair thanked Nicola Brownjohn for her introduction and invited contributions from those present. The following points were made:

- The Board asked why the SAB had moved away from the priority around substance misuse and housing for the next year. Nicola Brownjohn advised that Public Health was already working with the Substance Misuse Team and the Housing Team within the Council to look at the housing needs of those who misused substances and it was felt that the SAB had gone as far as possible with that priority without duplicating existing workstreams. In addition, because a national requirement to review all deaths of those who misused substances had been established, it was felt that work was being captured through those different areas and if there was any learning to be had it would come through those workstreams.
- The Board asked whether the SAB was satisfied there was sufficient joined up working between the Homelessness Prevention Team, other housing services, Adult Social Care and safeguarding teams. Nicola Brownjohn advised that a Task and Finish Group, chaired by Crisis, was looking at how well those partnerships were working, particularly as housing was a consistent issue coming up in SARs. Peabody, a social housing

provider, was also taking part in SAB now and helping with issues around private housing. Claudia Brown added that there was a Housing and Mental Health Subgroup in Adult Social Care that had a very good relationship with housing, particularly for vulnerable residents. Adult Social Care also worked closely with housing through CMARAC, such as whether it was appropriate to move individuals involved in cuckooing which needed housing input.

- The Board asked if the SAB did any work around cuckooing. Nicola Brownjohn advised that the second year of the current strategic plan had a golden thread focused on cuckooing and exploitation. The SAB had recently given endorsement to the Community Safety Protocol for Cuckooing and monitored cuckooing and other elements of exploitation through the multi-disciplinary CMARAC ensuring those individuals were seen as vulnerable and in need of safeguarding. A Task and Finish Group would be established in January 2027 around cuckooing and exploitation and the SAB podcast was due to publish a discussion around cuckooing, raising awareness of the new legislation and linking that with the children's partnership and its links with county lines. The Board welcomed the cuckooing safety protocol and that the SAB would be learning from data gathered around that.
- Robyn Doran confirmed that, whilst the restructure within the health system saw the ICB stepping back from the local position, it had been felt important that the SAB had a local ICP representative, particularly given the overlap on inequalities work, which had been agreed. She felt that having a local seat would ensure the ICB remained in touch with the trends and challenges within safeguarding.
- The Board asked whether the SAB had received reassurance that partners were working effectively with other local areas where there were individuals or cases involving more than one local authority, such as vulnerable adults who may move house or access services in more than one borough. Nicola Brownjohn advised that the SAB had identified a real strength in Brent in terms of taking individuals from other boroughs and sometimes continuing to work with individuals when they were no longer living in the borough. When people came through the Front Door and it was unclear who they were or where they were from, and she felt the investigation that took place was very good and the Front Door was very good at helping to connect individuals with services, including in other boroughs. Claudia Brown emphasised that Adult Social Care took a risk first approach, where individual cases were taken on without prejudice until that person was made safe, and once that had taken place, the local authority then worked to ensure the person was receiving services from the right place.
- In relation to self-neglect, the Board asked about wider communications or community engagement and how the community could play a role in identifying those who needed help. Nicola Brownjohn advised that the self-neglect toolkit had been launched a year ago, and the SAB was now reviewing how that was being implemented. The next step would be around community engagement work and developing easy read versions of the annual report for the lay person. She added that the self-neglect policy was published on the website, with clear descriptions around the stages in which to make a referral. Adult Social Care had recognised that this was not being utilised as much as it could so work was being done to promote that.
- As Cabinet Member for Housing, Homelessness and Renters, Councillor Johnson had recently met with Crisis, who had advised that they often dealt with individuals who did not want to access or receive help. He asked what support and guidance was provided in those circumstances to try to encourage individuals who were reluctant to engage to access services. Claudia Brown advised that Adult Social Care could still work with

those individuals as much as possible. She provided a recent example where a man had been living in his car and did not want to engage with services, but by building up a relationship the Council had now provided temporary accommodation for that person. Adult Social Care often worked with people when they were homeless or rough sleeping, visiting them on a regular basis, escorting them to appointments if needed and helping to move them off the street.

- In relation to domestic abuse and violence against women and girls, the Board asked whether the SAB had any focus on those issues. Nicola Brownjohn advised that this was overseen by the Community Safety Partnership and the Violence Against Women and Girls (VAWG) Panel, which did report to the SAB but the SAB did not oversee that work. Claudia Brown added that there was also a Vulnerable Adults Chairs Board where Chairs came together to discuss cases and referred cases to each other's Board's for advice where appropriate.
- Claudia Brown advised that all staff had now been trained on shared care planning and the service was building on the use of that.
- In relation to the timetable for a single patient record where all relevant services could access the same record, Dr Rammya Mathew advised that this was a national programme that was still a work in progress. Tom Shakespeare explained that this had been delayed because the national programme had subsumed the London Care Record implementation, and there was not yet a timetable for that. He agreed to provide an update on progress at a future meeting.

In concluding the discussion, the Chair thanked representatives for their responses and asked members to note the report.

6. **West and North London 10-Year Strategy**

The Board received a report and presentation from Radhika Balu introducing the emerging West and North London (WNL) 10-Year Strategy, developed following the creation of the new WNL Integrated Care Board (ICB) and aiming to improve population health outcomes, reduce inequalities, and make better use of the £12bn health and care budget. She sought the Health and Wellbeing Board's views on how the proposed strategic direction could be translated into local priorities, partnerships and delivery plans, which would ensure that the strategy reflected local priorities, supported delivery at borough level, and contributed to improving outcomes for residents across the system. Specific areas in the strategy focused on; population health and health inequalities, with emerging population priorities around early years and family support, children and young people, adults living with serious mental illness, people at risk of, or living with, long-term conditions, adults with complex health and social needs, healthy ageing and end-of-life care; prevention and early intervention; neighbourhood health and integration and; financial sustainability. The Health and Wellbeing Board's role within the strategy was around anchoring the strategy in borough priorities and JSNAs, aligning shared delivery across partners, defining local commitments, actions and ownership, and providing a clear route for feedback into the ICB. The presentation included as an Appendix in the agenda pack outlined some of the actions that would be undertaken and the expected outcome for residents and services.

The Chair thanked Radhika Balu for her presentation and invited comments and questions from Board members, with the following points raised:

- The Board echoed the aims and ambitions of the strategy, which councillors in particular highlighted was what the Council wanted to happen in the borough, with an area-based strategy. Dr Mathew agreed that the priority areas did chime with what partners were working towards in Brent, particularly around early years and

early intervention, and that approach had been adopted in Brent through family clinics and child friendly practices which had been shared as good practice with WNL ICB.

- The Board asked whether staff had been engaged on what they believed should change or be included in the strategy. Radhika Balu responded that the workforce felt that, whilst they did a lot for patients, many aspects of residents' lives impacting their health was outside of health staff's control such as housing and employment. From a management point of view, it had been recognised that there was a need to educate the workforce further about the wider determinants of health and to come together with other partners and services to find solutions for patients.
- The Board acknowledged that the figures on tooth decay for young people aged 1-3 years old were not where they hoped, and asked what the ICB wanted to see in the next ten years in terms of improving that figure. Radhika Balu advised that tooth decay was not solely a medical issue but also about how health services came together with public health, early years, and parents and carers to address the issue, such as through supervised tooth brushing or working in nurseries. Work in Harrow had shown that the number of hospital admissions relating to tooth decay could be reduced.
- In relation to the 1% left shift investment into neighbourhoods, the Board asked whether the need to reduce hospital admissions of adults with complexity living with multiple long-term conditions would deter partners from doing that prevention work. Radhika Balu responded that the 1% investment would most likely be allocated to early years and the core offer across the WNL area, including for CAMHS and the children and young people model. There was a lot of focus looking at how the ICB could deliver neighbourhoods well for children.
- Nigel Chapman advised that he and other Directors of Children's Services across the 13 boroughs were meeting regularly with the ICB around the children's workstream, with a priority focus on SEND. There was a full SEND reform programme being delivered which improved the way children's services worked with health and other partners around prevention and managing demand in early years. This connected to Best Start in Life which formed another priority, and there was also a mental health priority. He had recently met with the ICB and emphasised the need for equity in levelling up funding across the piece, and he felt there was a commitment from the new ICB to look at the data around that. The final area of priority for the children's workstream was around safeguarding the Family's First Partnership Programme which introduced a different approach to safeguarding and the role of health in multi-agency child protection teams.
- Ruth du Plessis welcomed the report and assured the Board that Public Health had been given the opportunity to contribute to the strategy. She welcomed the wider perspective on the social determinants of health which it was hoped would be backed with investment and funding. Public Health had also started work on Brent's Joint Health and Wellbeing Strategy and had been consulting with NHS colleagues to ensure there was alignment and joint learning.
- The Board asked whether the work would rely on AI and digital to succeed. Radhika Balu made the point that Imperial College Healthcare NHS Trust had recently ran a survey of 600 young people across North West London asking about AI and digital tools, and she had been surprised that the findings showed 75% of young people who responded did not prefer digital and AI tools and wanted more face-to-face interactions. However, digital tools were needed for primary care, secondary care

and community services in order to help healthcare services speed up and improve productivity and efficiency, so the ICB was planning to invest there, particularly with primary care where a Primary Care Digital Lead had been appointed.

- The Board was pleased to see a focus on inequalities in the Strategy but raised doubts over whether that priority would succeed. For example, they expressed that maternal healthcare had worsened, with the maternal mortality rate the highest it had been for over 20 years and disproportionately impacting Black and Asian communities. Despite this, the Royal Free Hospital Maternity Provision was being closed despite opposition from residents, the Council and local MPs. They also highlighted that healthy life expectancy had decreased by 3 years in the last decade, and therefore asked what this strategy would do differently to tackle inequalities and whether local areas should expect more frontline services to close. From a Strategy point of view, Radhika Balu advised that the strategy promised equity of care that was proportionate to the needs of the patient and the community which would support tackling inequalities in a hyper local way. Black and Asian populations were seeing worse health outcomes and therefore the strategy recognised the need to deliver services in a different way, asking residents how they needed their care delivered according to their needs. Access was also an important aspect of the work, ensuring the information was correct and easily available and that services were flexible and responsive to needs. As such, the strategy focused on equal outcomes across communities which may not necessarily mean each community received the same services.
- Having heard the response to how the strategy would look to tackle inequalities and reduce service closures, the Board highlighted that it would be useful to see a stronger commitment to maintaining some of the core services that residents already had access to embedded within the strategy, reporting that people were genuinely worried about their frontline services and hospitals closing. They called on the NHS to provide more assurance to residents. Radhika Balu acknowledged the points and confirmed that WNL ICB would listen to residents around what services, including core services, they wanted and base the offer around residents needs and wishes. Following a request from the Board, she confirmed that this could be made more explicit in the strategy.
- The Chair highlighted that privatisation was a concern for residents, which had accelerated in recent years, and more residents were identifying this as a cause of services becoming harder to reach, less accessible and less efficient due to the need to tell their stories to multiple different companies and input data into multiple websites. She asked whether there would be a focus on keeping services in house. Radhika Balu responded that the commitment was to keep NHS services within the NHS and she would ensure the feedback regarding privatisation was taken into account and fed back into the Strategy.
- Noting that the Strategy was being developed making use of particular datasets, the Board asked whether officers felt that they had the right data to build the strategy on. Radhika Balu responded that the data the WNL ICB received was very rich from multiple sources including primary care, secondary care and social care, which informed the ICB what was happening with residents, who was presenting often at hospitals and who had long-term conditions. Service user feedback had also been used to inform the strategy. Wider stakeholders, including Directors of Children's Services, had also been consulted in the creation of the strategy.

However, she highlighted that the same data platforms were not available across the whole footprint, and establishing that was a work in progress.

- The aim was for the strategy to be in mobilisation by November 2026.
- Tom Shakespeare echoed the previous comments, particularly around the 1% left shift of investment. He added that there was still work needed on the common core offer, particularly around mental health and CAMHS.
- The Board acknowledged the significant period of change the ICB had recently underwent and the hard work by colleagues.

As no further issues were raised, the Board resolved to note the emerging WNL ICB 10-year strategy and its proposed direction of travel.

## 7. NHS Neighbourhood Health Framework: Confirming Neighbourhood Geographies

The Board received a report from the Brent Integrated Care Partnership (ICP) providing an update on the review to determine the most appropriate geographical footprints for NHS neighbourhood health in Brent, summarising the evidence and stakeholder feedback, outlining the different geographical options considered and recommending that Brent adopted four NHS neighbourhood footprints covering Harlesden, Wembley, Kingsbury and Kenton, and Kilburn and Willesden. The report detailed the rationale for that recommendation to support sustainable integrated neighbourhood working.

Tom Shakespeare advised that the aim of bringing the report to the Health and Wellbeing Board was to agree a way forward regarding neighbourhood geographies in Brent, which Health and Wellbeing Boards were legally required to do. He reinforced the notion that neighbourhoods were a critical part of the future operating model, as outlined in the NHS 10-Year Plan, and therefore it was important a decision on a way forward was made as soon as possible to ensure the operation of healthcare services continued to be delivered smoothly. Brent currently operated a 5 neighbourhood model and there had been different views around the geography and alignment of those, particularly Cricklewood and Mapesbury ward and Willesden and Kilburn, with extensive work done to engage stakeholders and come to a resolution on those areas. A workshop a year ago had looked at the different options and there had been engagement through multiple primary care partnership forums. The ICP had also engaged LMC to support the reaching of a resolution. The detail of responses and proposals received during consultation was outlined in the report, which showed that there was no overall consensus on the way that neighbourhoods should be configured. The options put forward by different groups had been considered by the ICP's Neighbourhoods and Inequalities Exec Group who now recommended Option A within the report, which was a shift from five to four neighbourhoods, bringing Willesden and Kilburn together into one neighbourhood. He added that if the Board did not agree to that approach, the ICP recommended staying as is, with five neighbourhood areas.

Robyn Doran added that, from an operational point of view, the recommendation was focused how the ICP supported neighbourhoods, and it was felt that four neighbourhoods was operationally the most deliverable option without diluting the teams delivering care across neighbourhoods.

Jackie Allain commented from a CLCH perspective that CLCH had followed an internal governance process to review the options, with all clinical service managers proposing what they thought the best configuration of neighbourhoods was. All clinical leads had agreed that the four neighbourhood model would be the best way for them to provide focused delivery of care.

From an ICB perspective, Radhika Balu advised that it was important for the neighbourhood boundaries to be agreed as soon as possible so that they could be operationalised and the WNL strategy could be mobilised.

The Chair advised Board members that she had received several requests to make representations and she had agreed that they could have three minutes each to make their remarks, with the following representations made:

- Dr Mohammed Najim from Willesden Green Surgery spoke on behalf of the GP practices in Cricklewood and Mapesbury and Kilburn neighbourhoods in support of the ICP Exec's recommendation to bring Willesden and Kilburn neighbourhoods together. He highlighted that the local communities of Willesden and Kilburn were very similar, with the average Kilburn resident aged 37 and the average Willesden resident aged 36.5. Approximately 75% of both neighbourhoods were ethnic minorities, and both Willesden and South Kilburn had areas of both severe deprivation and relative affluence. As a lifelong resident in what he believed was Willesden, Dr Mohammed Najim was surprised to see his home placed in Kilburn neighbourhood on the neighbourhoods map. He advised that the line between Willesden and Kilburn ran through Gladstone Park, alongside Melrose Avenue and Lydford Road, with the North Circular dividing Willesden from Kingsbury communities and Willesden High Road separating Willesden from Church End communities. However, residents did not live by those boundaries. In addition, he highlighted that every GP practice across Cricklewood and Mapesbury Ward had formally written to the ICP asking to join the Kilburn neighbourhood, which the Board paper recognised and which reflected over 10 years of joint working, with both neighbourhoods built on the historic Council boundaries serving 85,000 patients and with shared workforce, leadership and services. Whilst that option had been discounted, he felt that this merger was a fair and practical compromise preventing the breakdown of staff and services and building on work done across the neighbourhoods including the coming together of practices to vaccinate thousands during the Covid-19 pandemic, having the borough's only breast cancer screening pilot for women in collaboration with Royal Free Hospital, and having the highest uptake of any neighbourhood for the new innovative cervical cancer cell swap pilot. He felt that without the merger of Willesden and Kilburn, Kilburn would be left below viable scale, and therefore its patients would be left behind, and the merger enabled an established workforce to be kept whole at a sustainable scale.
- Dr Amanda Craig, Kilburn PCN Clinical Director and Kilburn Integrated Neighbourhood Team Lead, then addressed the Board to outline her thoughts on the proposed neighbourhood model. In addressing the Board, she advised that she had been a clinical leader in Brent for many years and had established the first locality commissioning pilot over 30 years ago with what now formed Kilburn and Mapesbury and Cricklewood. She advised that those areas had worked together delivering and designing services and arranging the commissioning of services for over 30 years. She felt it would be a shame not to build on that historic relationship and split Mapesbury and Cricklewood from Kilburn. She highlighted that the two PCNs in Kilburn and Mapesbury and Cricklewood had very strong leadership which was clinically and managerially majority female and delivering well for children and women. Due to the strong joint working of the practices, which she advised formed the only group of practices based on localities, she felt it important that these areas were not split.

- Dr Azhar Hawa, Co-Clinical Director of Harness South PCN and Co-Leader of Willesden Integrated Neighbourhood Team spoke on behalf of the Harness South PCN. He advised that Harness South PCN had worked in partnership and collaborated with all organisations in the neighbourhoods programme and would continue to do so to ensure services for patients continued to get better. He advised the Board that, in July, the ICP Exec wrote to Harness South PCN with two questions – where Cricklewood and Mapesebury should sit and whether Wembley PCN should split into two. The response from Harness South PCN took no position on where the wards should sit, but made one ask that any boundary change was considered collectively across all neighbourhoods together and against the same criteria to ensure alignment. He advised that the merger of Willesden and Kilburn into one neighbourhood was never put to Harness South PCN and clinicians only heard of the proposals at a partnership forum in September where it appeared the decision had already been made. The assessment made by the ICP Exec in July showed that Kilburn and Willesden's population alignment were rated as strong and the neighbourhood needing further consideration was identified as Wembley, however several months later the recommendation now left Wembley unchanged and merged the neighbourhoods that the ICP had rated as strong. He urged the Board to review the evidence in Appendix B in terms of population needs, which identified the differences in the two populations in terms of deprivation, children's health, language and housing, which he felt did not support averaging them into one neighbourhood. In concluding his remarks, Dr Azhar Hawa added that the recommendation noted the need to agree a new leadership and representation arrangements for the merged neighbourhood, but cautioned that this would be a decision taken regarding primary care leadership with no primary care member involved in that discussion. As such, he urged the Board to decline recommendation one.
- The final representation was from Dr Nigel de Kare-Silver, Principal GP at Gladstone Medical Centre and Clinical Director for K&W (S) PCN / Co-Clinical Director for Willesden Integrated Neighbourhood Team. In opening his statement, Dr Nigel de Kare-Silver informed the Board that he had been a GP for over 30 years, serving the community against the backdrop of multiple NHS reforms, and he very much welcomed the neighbourhood approach that the country was moving towards, which he felt was based on localism and co-design instead of the traditional top-down directives from central offices. The neighbourhood approach offered health services and partners the chance to look at unique sub-populations and their distinct ethnicities, disease patterns and attitudes to health, and support people at a hyper local level. He highlighted that Willesden had been recognised as one of only two mature Brent neighbourhoods, where the team had been meeting fortnightly for 2-3 years, building strong professional and community relationships and developing a shared learning programme.
- Dr Nigel de Kare-Silver advised Board members that Willesden neighbourhood had been able to engage with parts of Brent with the highest deprivation, and he felt that going forward the Willesden neighbourhood needed to be ready to apply top-down directives from central government in the future. Currently, 90% of elite group membership had voted against changing the boundary. At the most recent K&W South PCN meeting there had been zero support expressed for the proposed merge between Willesden and Kilburn, and he called on the ICP Exec to invest in Willesden to maximise healthcare without further delay.

- Further detailing the work happening in Willesden, Dr Nigel de Kare-Silver advised that he worked closely with Dr Azhar Hawa as co-Chairs of Willesden INT as well as public health analysts to map out priorities, with data showing Willesden had a high number of people with serious mental illness, the largest number of children aged 0-5 years old as well as older adults, and pollution caused by the North Circular Road identified as a cause of illness amongst the most deprived groups in the area. Willesden had also pioneered the new health hub paediatric model that was now being adopted across NWL and had delivered targeted children's services where most needed. He highlighted that, in his view, Kilburn and Willesden were distinct neighbourhoods with different geographies, population needs and disease profiles and he felt that each area needed localism. He stated that creating a large, merged neighbourhood between Willesden and Kilburn risked diluting that localism and would result in conflicting priorities on a limited budget.
- In concluding his remarks, Dr Nigel de Kare-Silver advised that Willesden was operationally ready to deliver, and asked the Health and Wellbeing Board to vote against a merge between Kilburn and Willesden to allow for a hyper-local approach reflecting the distinct needs of each of the populations, instead of further administrative delays to implement what he described as unnecessary and unwanted organisational change.

The Chair thanked those who had attended the meeting to represent their views and the views of their patients and organisations, and invited comments and questions from the Board. The following points were raised:

- In noting the proposal to move to a four neighbourhood model by merging Kilburn and Willesden neighbourhoods, and in hearing the representations made during the meeting and the written submissions received, the Board asked how two merged neighbourhoods with potentially different health needs would account for health disparities. Tom Shakespeare acknowledged that there were differences between each neighbourhood as well as differences in need within neighbourhoods. The suggested model put forward had been a weighing up of many different factors that the ICP Exec had made a judgement on, but he acknowledged that there was no perfect solution. Dr Rammya Mathew further explained that there was a balance to be had in relation to neighbourhood populations, where the aim was for the model to feel very local but there was also a need for neighbourhoods to be operational and able to deliver for residents. This required a certain amount of capacity from a primary care perspective as well as provider organisations who delivered care to communities. She explained that with the 5 neighbourhood model, Kilburn had the smallest population of around 34k registered patients, and Wembley had the highest number of registered patients at around 250k, which she expressed was a significant variance. The proposal to merge Kilburn and Willesden reduced that variance to some extent.
- The Board asked whether there were any reputational or financial risks if Brent Health and Wellbeing Board was unable to reach an agreement. Tom Shakespeare reminded the Board of the proposed 1% left shift in funding which would go to each WNL borough, which he anticipated would increase over the years, which was reliant on mobilising the agreed neighbourhood model. As such, he advised it was essential to have a settled position on the neighbourhood geographies. If the Health and Wellbeing Board was unable to reach a decision, the recommendation was that the default current neighbourhood position would remain.

- The Board asked what the staffing implications were with the proposed change. Jackie Allain advised that CLCH, as a provider of community services, had a variety of different teams with different numbers of staff, where some teams were much larger such as the community nursing teams who were able to manage the 5 neighbourhoods and some teams were much smaller such as the respiratory teams, heart failure teams and some children's teams where they struggled to cover the neighbourhoods because they consisted of only 5-6 people. As such, working within the 4 neighbourhoods gave those staff the ability to focus on a smaller number of neighbourhoods. Further explaining, she advised that the more neighbourhoods that were established, the more multi-disciplinary meetings clinicians were required to attend, which reduced the time clinicians had available to provide care. A reduction in neighbourhoods reduced the number of meetings clinicians were required to attend, meaning more time would be available to care for patients. Robyn Doran added that, operationally, the merging of the two neighbourhoods would make it easier for CNWL to align staff with patients.
- In terms of what patients wanted for their neighbourhoods, Tom Shakespeare advised that direct patient engagement had not taken place for these proposals because they were operational in nature and based on how health services organised around patients. Whilst direct engagement exercises with patients had not been undertaken, he understood that patients felt smaller areas were better to enable more direct engagement, accessibility and visibility, which was counter to what providers had fed back around how staff were arranged. As such, there was a need for a balanced position.
- Further discussing the impact of the changes on patients, the Board asked whether patients would see any difference in the service they received. Tom Shakespeare advised that in many ways the proposals were around how services were organised operationally and therefore the impact on patients should be relatively minimal. As an example, a patient attending a GP practice in Cricklewood and Mapesbury would remain with the same GP practice and would likely have very little awareness of how services and staff were commissioned and organised.
- Whilst it was recognised that the decision was operational, the Board asked what structures would be in place going forward so that local residents could have a say in the delivery of neighbourhood healthcare services. Tom Shakespeare responded that a lot of infrastructure for feedback had already been built, such as through community forums. A number of neighbourhoods already had established leadership teams with routes to ensure patient voices were heard, and those existing mechanisms would continue to be utilised. There were well established and deep connections with hard-to-reach communities and faith groups through the work of Brent Health Matters that could also be harnessed. The ICP Exec also wanted to ensure all partners were represented as part of the governance arrangements, including primary care, providers, voluntary and community sector organisations and others to ensure they were being heard across all parts of the system.
- Board members agreed with the sentiment that Cricklewood and Mapesbury did not easily fit into one neighbourhood or another, and understood the rationale for merging the two neighbourhoods together to enable Cricklewood and Mapesbury residents to benefit from the innovative work of both neighbourhoods, particularly Willesden's work around child health and Kilburn's work on frailty. Dr Rammya Mathew added that it was recognised that the merge was contentious, with a

strength of feeling from both those who supported the merger and those who opposed the merger, but from a primary care perspective it was important for all parties to see the opportunities in the decision made and not see the decision as a barrier for what primary care could do for residents.

- In terms of the wider benefits of neighbourhood working, Tom Shakespeare advised that the vision behind neighbourhood working was to wrap care around the patient by providing more integrated services closer to home to deliver better outcomes. Having a settled decision on neighbourhood geographies was an essential building block to enable that to happen.

As no further issues were raised, the Chair thanked officers for their responses and those who had attended to make representations regarding the proposals, as well as those who had provided written submissions during the process, and led a vote on the proposal to adopt four NHS neighbourhood health footprints for Brent. By a simple majority, the Board **RESOLVED:**

i) To agree the adoption of four NHS neighbourhood health footprints for Brent, comprised of the following wards:
   a. *Harlesden:* Harlesden and Kensal Green, Roundwood, Stonebridge
   b. *Wembley:* Northwick Park, Sudbury, Wembley Central, Alperton, Preston, Wembley Hill, Wembley Park, Tokyngton
   c. *Kingsbury and Kenton:* Kenton, Queensbury, Kingsbury, Barnhill, Welsh Harp
   d. *Kilburn and Willesden Green:* Kilburn, Queens Park, Brondesbury, Willesden Green, Dollis Hill, Cricklewood and Mapesbury.

ii) To confirm that support be provided by the ICP to the merged Kilburn and Willesden area to establish effective collaborative leadership and representation arrangements.

iii) To request a further update on neighbourhood health implementation is presented to the Health and Wellbeing Board.

## 8. Cancer Health Needs Assessment

The Board received a report from Mai Stafford presenting the Cancer Health Needs Assessment, outlining the statistics on cancer in Brent and the work being done to reduce cancer and its impact on Brent residents. In introducing the needs assessment, she advised that the report had been prepared in collaboration with public health, NHS services and insight from residents. The focus of the assessment was on the four most common cancers in the UK; breast, prostate, lung, and bowel, as well as the national screening programme for cervical cancer, and head and neck cancer where Brent's population had a high level of risk factors. She then highlighted some of the key statistics regarding cancer screening in the borough:

- Brent was underperforming on screening across the board, tracking below the NWL average for all three national cancer screening programmes (cervical, breast and bowel). HPV vaccinations were in decline and substantially lower than London and national averages. A substantial age gap in screenings was present with younger eligible cohorts having a lower screening uptake than older age groups. A low screening take up rate correlated with higher deprivation, and there were varying take up rates of screenings by ethnic groups.
- There was rising incidence in total cancer cases in Brent, with overall prevalence highest among white ethnic groups and individuals living in more deprived areas.

Those highest at risk of prostate cancer were Black ethnic groups which mirrored national trends, but she highlighted local qualitative research revealed a critical lack of awareness regarding prostate cancer symptoms and when/how to seek medical support among Black African and Black Caribbean residents. Head and neck cancer was a specific local concern due to higher than average rates, disproportionately affecting men and individuals form South Asian ethnic groups. Tobacco use, and specifically smokeless tobacco, was highly prevalent among men and South Asian communities and was identified as a major contributing factor to Brent's elevated rate of head and neck cancer.

- Diagnosis via national screening programmes or GP referrals led to significantly more timely diagnosis and better treatment outcomes compared to emergency routes. Brent was successfully moving away from emergency diagnoses, with the proportion of total cancers diagnosed via non-optimal pathways dropping by 11% between 2017 and 2024. Despite this, some cancers were more likely to show delayed diagnoses, and lung, bowel and cervical cancers were less commonly diagnosed through screening or GP referrals compared to total cancers.
- Both 3-year and 5-year survival rates were statistically significantly lower in Brent compared to NWL averages for cancers overall, specifically lung cancer, and survival rates were notably lower for head and neck cancer.
- Some of the cancer initiatives being provided in Brent focused on leveraging community assets through working with community champions to improve the reach and trust of cancer prevention services, and successful localised outreach models included the 'man van', providing prostate cancer screening for Black men, and Brent Health Matters outreach work and cancer screening awareness events. Public health and the ICP also delivered cancer programmes including Brent Stop Tobacco which provided digital support for the Smoke Free App, a culturally appropriate chewing tobacco cessation initiative, and proactive targeting of registered smokers by primary care with current tobacco users invited for lung cancer screenings, a non-responder bowel cancer screening call project, rollout of HPV self-sampling through primary care, and bespoke support for those in CORE20 most deprived communities to access cancer prevention and early diagnosis through Brent Health Matters.
- Brent and WNL ICB had detailed data for bowel, breast and cervical cancer screening that supported inequalities monitoring and improvement.
- Public Health aimed to integrate cancer prevention into other strategies, including a Men's health strategy and Food strategy.
- The Board was asked to acknowledge the findings of the needs assessment and advocate wherever possible for cancer services to keep services focused on cancer prevention and ensure cancer featured prominently in the new Joint Health and Wellbeing Strategy being drafted.

The Chair thanked Mai Stafford for her report and invited comments and questions from those present, with the following points raised:

- Ruth du Plessis made the point that almost half of the population would be affected by cancer in their lifetime, and so there was a need to ensure a focus on cancer and cancer prevention and garner as much support as possible to promote screenings and encourage people to come forward earlier for diagnosis and treatment. She

confirmed that cancer prevention would feature as one of the priorities of the new Health and Wellbeing Strategy.

- Board members advocated for the ‘man van’ and asked whether there would be a national screening programme for prostate cancer. Dr Rammya Mathew explained that there had been a significant national review conducted where the UK National Screening Committee decided against recommending a national screening programme for prostate cancer. During that review, a separate question asked whether a screening programme should be offered for particular communities, such as Black men in particular, and again the Committee stated that the evidence did not support recommending that. She confirmed that this had been a controversial decision amongst campaign groups who felt very differently and it was still a live topic of discussion. The message she and other primary care providers were giving in practice was that if someone felt they had risk factors, a family history of prostate cancer or felt concerned about their prostate cancer risk then they should come forward, and she reassured the Board that primary care was a lot more open to offering prostate cancer screening than it had been several years ago.
- Noting the national decision taken on prostate cancer screening, the Board asked whether there was any mechanism to undertake a local initiative on prostate screenings or whether Brent was bound by that decision. Radhika Balu advised that if a particular community was disproportionately affected by prostate cancer she would suggest the local partnership considered the option to undertake a pilot programme for specific communities, and that there was nothing preventing primary care going into the community to talk about screenings. Ruth du Plessis confirmed that a pilot to promote prostate cancer screening in particular areas would be possible, and she was pleased to hear the passion of the Board on this topic.
- Radhika Balu cautioned that vaccination rates were reducing. She reminded Board members that there was now significant evidence that the HPV vaccination prevented cancer, and therefore if the HPV vaccine uptake reduced in Brent then this would result in more cervical cancer rates in Brent in the future compared to other areas. As such, she emphasised the need to engage residents about vaccination and asked the Board to consider other options to prevent an increase in cervical cancer rates in the future. Dr Rammya Mathew advised that the HPV vaccination was delivered through schools rather than primary care through a commissioned service which was currently being reviewed by Public Health as it was felt that the delivery of the programme could be improved. She confirmed that there was a national target to eliminate cervical cancer by 2040 through screening and vaccination and therefore it was important to target those who were not taking up the screening and vaccination offer. Ruth du Plessis advised that there were early signs that uptake was increasing from the work Public Health was doing in schools to improve uptake, but highlighted the challenges in terms of the negativity and hesitancy towards vaccination from the Brent population. There was often misinformation around vaccinations and therefore deep engagement work was needed with communities in innovative ways to talk about the importance of vaccination in order to improve uptake.
- In relation to the statistic that the 3 and 5-year cancer survival rates in Brent were lower than the NWL average, the Board asked if there was any clear reason that might be. Ruth du Plessis advised that the national data showed people were not getting screened or coming forward for support when they got symptoms. Public Health and primary care encouraged anyone with a cough lasting longer than 3

weeks to see their GP and to see their GP if they discovered a lump in their breast. The preference amongst health professionals and Public Health was for people to come forward for a check and get a negative diagnosis rather than miss getting checked, particularly as the evidence suggested that the sooner someone came forward then the more effective their treatment and outcomes. She suggested the survival rates may also be affected by poor underlying health, smoking, pollution and lifestyle factors. Public Health continued to encourage people to live healthy lives as much as possible.

- The Board commended the bowel cancer self-screening test that had been sent to people over 60 and asked for an update on the outcome of that programme at a future meeting.

The Chair thanked officers and members for their input on this report and asked for a report back to the Board in the future outlining the different preventative health initiatives being undertaken in local communities to help prevent cancer, including the outcome of the bowel cancer screening programme and a proposal on taking forward a pilot on prostate cancer screening for specific communities. She asked Board members to continue to advocate for cancer prevention and early detection services and affirm that cancer prevention and care should be included in the new Health and Wellbeing Strategy in development.

9. **Forward Planning**

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

10. **Any other urgent business**

None.

The meeting was declared closed at 8:00pm

COUNCILLOR GWEN GRAHL, CHAIR

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| Brent<br>NHS West and North London | **Brent Health and Wellbeing Board**<br>9 November 2026 |
| | **Report from the Corporate Director, Children, Young People and Community Development** |
| | **Lead Cabinet Member for Children's Services, Employment and Climate Action – Cllr Jake Rubin** |

# Best Start Family Hubs update 2025-26

| | |
|---|---|
| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | N/A |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **List of Appendices:** | Appendix 1 - Family Wellbeing Centre Annual Report (2025-26) |
| **Background Papers:** | 0 |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Palvinder Kudhail<br>Director Early Help and Social Care<br>Palvinder.kudhail@brent.gov.uk<br><br>Serita Kwofie<br>Head of Early Help<br>Serita.kwofie@brent.gov.uk |

## 1. Executive Summary

1.1. This report provides an update on the progress of the Best Start Family Hubs (previously known as Family Wellbeing Centres) (BSFHs) for the 2025-26 financial year. The DfE requested the name change from Family Wellbeing Centres to Best Start Family Hubs to comply with the national branding from 1 April 2026. The BSFHs delivery model has continued to evolve through new partnerships and the expansion of services across all Hubs. The BSFH annual report 2025-26 is attached as Appendix 1.

## 2. Recommendations

2.1 The Health and Wellbeing Board is asked to note the progress and impact of the Best Start Family Hubs in improving access to integrated early help, health and wellbeing services, and their contribution to prevention, early intervention and reducing health inequalities for children, young people and families.

2.2 The Health and Wellbeing Board is asked to support strengthened system-wide partnership working through the Best Start Family Hubs and to identify opportunities for closer alignment of health, local authority and voluntary and community sector resources, with a focus on improving reach to underserved communities and evidencing measurable improvements in population health and wellbeing outcomes.

## 3. Detail

### 3.1 Contribution to Borough Plan Priorities and Strategic Context

3.1.1 The BSFH offer a wide range of support to families and link to the Borough Plan priorities:

- Prosperity and Stability in Brent
- Thriving Communities
- The Best Start in Life
- A Healthier Brent.

3.1.2 The BSFH also support the Digital Inclusion strategy and help to address the impact of cost-of-living challenges and childhood poverty.

### 3.2 Background

3.2.1 Brent has a well-established Early Help service that BSFHs are an integral part of. The BSFHs provide a universal 'front door' for families to access a wide range of early help and preventative services, including some targeted support.

3.2.2 There is a core service offer across all the BSFHs and some variation depending on local needs and what other services are delivered in the community. A description of the BSFH service offer is detailed in appendix 1 and includes health and wellbeing, education and childcare, parenting and relationship, and activities for children of all ages and stages.

3.2.3 BSFHs are at the heart of Brent's Early Help community-based offer and are a priority in the Borough Plan (2023-27). The BSFHs provide an integrated 'whole family' (for children aged 0-18 years old, and up to 25 for those with SEND), bringing together a wide range of services and support into a single offer. This arrangement helps the co-ordination and delivery of services for more vulnerable children using contextual safeguarding approaches.

3.2.4 BSFHs are open full time with several centres offering early evening youth activities. There is some Saturday opening on rotation across the BSFHs to facilitate additional sessions including for families / children with SEND. Each BSFH is shaped by a Local Steering Group (LSG) of stakeholders and there is integrated working across Brent's Early Help network to efficiently and effectively respond to the needs of local families using a holistic approach. The LSG link to the BSFH Family Hub and Start for Life Steering Group which has multi-agency representation at senior officer level.

3.2.5 The Willow BSFH is predominantly a SEND hub providing support services to families of children with SEND using an approach to identify children's needs early and putting in place interventions to prevent an escalation of need. All BSFHs have SEND navigators promoting and signposting families to Brent's Local Offer and other relevant support.

3.2.6 The Willow BSFH is co-located with a nursery for children aged 9months - 4yrs. The nursery is registered to provide full-time care for 98 childcare places. The places are managed flexibly to accommodate the needs of the community. The nursery offers 27 enhanced places for complex SEND children and 28 part-time places for Children in Need (CiN).

3.2.7 BSFHs work closely with Brent Community Hubs to ensure there are effective working relationships in place to support Brent's residents. Managers from the respective services meet periodically to review service delivery, update on current developments, and address any partnership working challenges.

3.2.8 The BSFHs focus is on prevention and early intervention, using a whole family approach to stop problems escalating and requiring higher tier and more costly support. An early help approach achieves better outcomes for families and reduces the impact of Adverse Childhood Experiences, enabling families to thrive.

***Outcomes***

3.2.9 The outcomes and impact achieved for families through the BSFHs is wide ranging and dependent on what services families are accessing, how well they engage, and the length of the intervention. For example, some families access ad-hoc stay-and-play sessions, whereas others receive targeted family/led professional support lasting up to 1 year and, as part of this work, multiple agencies may be involved. The full range of support on offer that improves family outcomes is detailed on page 30 of the annual report attached as appendix 1. Outcomes and impact are evidenced through contract monitoring data from commissioned services, case studies, case files, direct work tools, service user feedback, outcome/impact reports following the completion of interventions, assessment tools, and bi-annual parent satisfaction surveys. During the 2025-26 financial year 19,490 families were supported to achieve positive outcomes in the following 10 key areas:

1. Improved family finances and reducing the impact of the cost-of-living crisis
   - CAB supported 1,262 families to achieve financial gains of £1,019,214
2. Improved family nutrition, weight management and access to fresh fruit and vegetables
   - The Felix Project donated food items equivalent to over 50,000+ meals including fresh fruit and vegetables supporting families with the cost-of-living crisis and improved health and wellbeing
3. Improved parenting capacity leading to better relationships between parents and their children, reducing children's behavioural problems and better communication
   - 709 parents attended accredited parenting programmes and workshops
   - 51+ families participated in HENRY parenting programmes
4. Reducing health inequalities for the most vulnerable families
   - 400+ families participated in Busy Feet and other family fitness related programmes
   - Health and BSFH staff engaged with 4,000+ families regarding the risks of smoking during pregnancy and the importance of smoke free environments at home
   - 1,755 families were triaged and connected into appropriate support including Talking Therapies, Kooth, Health and Wellbeing Workshops and Counselling services
5. Improving children's school readiness
   - 4,000+ mums benefited from activities for under 2's
6. Increasing refugee and asylum seeker engagement with early help and preventative services
   - A specialist Triage Officer engaged with 200+ refugee and asylum seeker families, some families are given Oyster cards with regular credit to enable access to the BSFH, families also benefit from vouchers for clothing during winter
7. Preventing family problems becoming more complex and entrenched by intervening earlier and providing the right support at the right time
   - 1,755 families were triaged and connected into appropriate support, 159,000+ contacts were made with 19,490 families engaging with universal and some targeted services

8. Reducing the risk of domestic abuse and improving outcomes for families impacted by domestic abuse
   - Advance Independent Domestic Violence Practitioners (adults and children's) are co-located at the BSFH and supported over 100 families and women accessed the Freedom programme
9. Supporting parents and young people into employment and to access educational and work experience opportunities
   - Family Work Coaches are collocated at the BSFH and helped 150+ parents into employment
   - Connexions PAs are collocated at the BSFH and helped 100+ young people into education, employment or training
10. Reducing the impact of caring responsibilities on children and improved understanding by schools/partners regarding the issues that impact young carers leading to better educational outcomes
    - 132+ Young Carers were identified and supported during the year

***Outcome of the key priorities for 2025-26***

3.2.10 A summary of the BSFH key priorities for 2025-26 are detailed below including an update on the outcome achieved:

1. **Deliver the final year of the Start for Life programme and exit planning** - the Start for Life delivery plan was successfully implemented across all strands, and regular updates were provided to the DfE who visited a BSFH during the year to review progress. The Start for Life programme transitioned to the Best Start Family Hub and Healthy Babies programme in April 2026. The programme has created an integrated one-stop shop of family support services to prevent developmental issues escalating into more complex needs. This includes for example improved school readiness outcomes, integrated neighbourhood health services, reducing inequalities and simplified access to support.

2. **Increase the number of families registering** – the number of families registering has decreased by 1,146 (13%) from last year. Following further analysis this was an expected position, following the transition to the BSFH delivery model in 2021 and the initial spike with more families being eligible to register given the expanded service user criteria. The reduction this year is partially due to Key Workers transitioning into the new Family Support Teams and Granville BSFH being temporarily closed while it decanted to new premises. There was also a technical issue with the registration portal which temporarily prevented families from registering online which has since been resolved.

   To note, even though registrations have fallen the number of contacts with families has increased and the number of unique families worked with has also increased. This means that whilst registrations have fallen, more families currently registered are being supported to achieve positive outcomes and impact as detailed in section 3.2.9 above. An active communication and outreach plan is in place with the aim of ensuring registrations continue to be maintained. Work continues with all partners to promote BSFH registration and take-up of services, ensuring that partners recognise this as a shared responsibility.

3. **Develop the BSFH youth offer linked to the refreshed Youth Strategy and delivery plan** – the BSFH youth offer has continued to grow at some BSFHs. Activities have included for example Arts and Crafts, Homework Clubs, Mixed Martial Arts, Teen Space, Gaming, Hair and Beauty and girls only sessions. More CVS partnerships have been established, such as hosting Ansar at Preston Park BSFH who are funded externally to deliver activities. The impact on CYP includes for example: improved physical and mental wellbeing, reducing isolation, expanding social network, build essential life and employability skills, creating a sense of community and belonging, to help reduce the risk of involvement with crime and anti-social behaviour by providing safe spaces and access to trusted adult mentors.

4. **Supporting the development of the new Early Help and Social Care family support model to ensure the service is fit for purpose and works effectively in partnership with the BSFH** – the new Family Support Teams are now in place and embedding. Family Support Workers are linked to their respective geographical BSFH. However, further work is needed to ensure that Family Support Workers continue to use the BSFH to meet families, promote registration and service take-up. Guidance has been issued requesting that Family Support Workers are present at the BSFH at least 1 day per week. The impact of the changes means that families only need to tell their story once, the number of handover points for families has reduced and there is greater consistency for families with a single practitioner being involved.

5. **Supporting the development of the new Targeted Prevention Hub ensuring BSFH are a key partner with strong links** – the Targeted Prevention Hub has been established and links are in place with the BSFH to refer young people and parents into the support offer. Targeted Prevention Hub staff can hot desk at the BSFH to encourage co-location and service integration. The Targeted Prevention Hub is still in development but outcomes for young people include reducing anti-social behaviour, lowering youth reoffending, increased mental health and wellbeing, improve school attendance and connect at-risk youth with education and employment.

6. **Capitalising on the redeveloped outside play areas to deliver a greater range of environmental projects and activities** – the aim is to encourage more outdoor play and learning. A range of outdoor activities and environmental projects take place across the BSFH and the outside play areas are well used. Outdoor activities include for example: gardening clubs, growing vegetables/herbs, composting, stories and exploring mini beasts. Childminding networks also use the BSFH resources, including the outside play areas. Being outdoors is crucial for children's development and improves their mental health/wellbeing, physical fitness and social skills. Exposure to nature helps to reduce stress and build resilience and self-esteem through safe, adventurous and stimulated play.

***Challenges***

3.2.11 To ensure continuity of service delivery across the BSFH estate, work is progressing to ensure that links between the new Family Support Teams and BSFH remains strong and families are connected into the wider early help offer. New posts, such as Best Start Inclusion Practitioners, at the BSFH will be created using Best Start Family Hub funding and this will help to increase staffing numbers.

3.2.12 The high number of partnerships involved increases the complexity of the operational delivery model. This includes at times for example resource limitations, time lags, communication issues or conflicting agency agendas. Strong governance arrangements at strategic and operational levels help to ensure that multi-agency partnership working is effective, issues are addressed as and when they arise and escalated for more senior input when necessary.

3.2.13 Families continue to present at the BSFH significantly impacted by the cost-of-living crisis. Families are triaged and connected into appropriate support as quickly as possible. The Triage service piloted a new Crisis Response fund (Brent Council funded) to provide one off payment to support families in financial crisis. Payments are received promptly. The pilot was successful and will be embedded across the BSFH.

***Forward planning***

3.2.14 The BSFH improvement priorities for 2026-27 are:

1. Deliver year 1 of the Best Start in Life, Family Hub and Healthy Babies programme and rebrand the BSFH to Best Start Family Hubs. Working in partnership with multi-agency stakeholders towards achieving the DfE targets of 76% Good Level of Development and 79% take-up of Early Years Free Entitlement by 2029
2. Expand the out of hours delivery model, including access to support via telephone and video appointments, using a hybrid delivery approach
3. Support the development of wider system reforms including the Family First Partnership programme, SEND, Early Years and Working in Neighbourhoods (WiN)
4. Expand the Family Financial Resilience programme and deliver Financial First Aid training to multi-agency front line practitioners
5. Complete capital transformation works to St Raphaels, Preston Park and Willow BSFH. Develop plans for the new Granville BSFH that is being constructed as part of the South Kilburn regeneration programme.

## 4. Stakeholder and ward member consultation and engagement

4.1 Significant consultation has taken place during the reporting period, including with the then Lead Member for Children, Young People and Schools. Various focus groups were delivered during the design and consultation period with multi-disciplinary staff, stakeholders, partners and parents.

4.2 Well established governance arrangements are in place with multi-agency representation at strategic and operational levels. Parents are involved with governance at the operational level via the BSFH Local Steering Groups.

4.3 A Parent Carer Voice Forum was established to ensure there was a strong parent voice in shaping the offer. Parents were recruited with children at different ages and stages, children with SEND, dads and pregnant parents to ensure a diverse group and a wide range of views were captured.

4.4 A Youth Panel is used to co-produce and develop the CYP offer.

4.5 Feedback mechanisms are in place to capture the views of service users, and this is used to improve the BSFH model to help ensure services and support offered, actively engages families and meets their wide-ranging needs. Overall service user satisfaction rates are high across the BSFH, as evidenced by the autumn term 2024 parent/ carer survey which had over 2,000 responses, and demand for services continues to grow. Another service user satisfaction survey is due to be completed spring term 2027.

## 5. Financial Considerations

5.1 There are no direct financial implications as a result of this report being considered by Health and Wellbeing Board.

5.2 The Best Start Family Hubs delivery is supported through existing Family Hubs funding, Public Health grant, early years budgets and resources within the wider system.

## 6. Legal Considerations

6.1 The statutory obligations in the Childcare Act 2006 ("the 2006 Act") concern "young children", which essentially are those aged between 0-5. Section 1 of the 2006 Act imposes on local authorities a general duty in relation to the well-being of young children to:

a) improve the well-being of young children in their area, and
b) reduce inequalities between young children in their area in relation to:
- Physical and mental health and emotional well-being
- Protection from harm and neglect.
- Education, training and recreations.
- The contribution made by them to society
- Their social and economic well-being.

6.2 Section 3 of the 2006 Act sets out specific duties the council has in relation to early childhood services which includes early years provision and provides that the council must make arrangements to secure that early childhood services in their area are provided in an integrated manner which is calculated to facilitate access to those services, and maximise the benefit of those services to parents, prospective parents and young children. In discharging its duties, the council must have regard to any guidance given from time to time by the Secretary of State.

6.3 Section 5A ("Arrangements for provision of children's centres) requires arrangements to be made by the Council so that there are sufficient children's centres, so far as reasonably practicable, to meet local need.

6.4 Section 5D (Children's centres: consultation) requires the Council to undertake such consultation as it thinks appropriate before making arrangement for the provision of a children centre or before any significant change is made in the services provided through a children's centre or before anything is done that would result in a children's centre ceasing to be a children's centre.

## 7. Equity, Diversity & Inclusion (EDI) Considerations

7.1 The public sector equality duty, as set out in section 149 of the Equality Act 2010, requires the Council, when exercising its functions, to have "due regard" to the need to eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act, to advance equality of opportunity and foster good relations between those who have a "protected characteristic" and those who do not share that protected characteristic. The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

7.2 Having due regard involves the need to enquire into whether and how a proposed decision disproportionately affects people with a protected characteristic and the need to consider taking steps to meet the needs of persons who share a protected characteristic that are different from the needs of persons who do not share it. This

includes removing or minimising disadvantages suffered by persons who share a protected characteristic that are connected to that characteristic.

7.3 There is no prescribed manner in which the Council must exercise its public sector equality duty but having an adequate evidence base for its decision is necessary.

7.4 An Equality Impact Assessment (EIA) in relation to BSFHs was completed as part of the Cabinet report submitted in October 2019. A further Equality Impact Assessment was completed as part of the Family Hub and Start for Life programme in 2023.

**8. Climate Change and Environmental Considerations**

8.1 A range of services are provided from BSFHs that include consideration of climate initiatives.

**9. Human Resources/ Property Considerations (if appropriate)**

9.1 N/A

**10. Communication Considerations**

10.1 A communications plan is in place detailing who, how, when and where we publicise information regarding the BSFHs. This includes posters, leaflets, social media, partnership forums, a video, the website, multi-agency meetings, schools, health, VCFS and Police. Most families are connected into BSFH support services via a professional they are working with, or via word of mouth from another service user. Work continues across the BSFH partnership to promote registration and take-up of services. Improved communications have resulted in an increase demand for services.

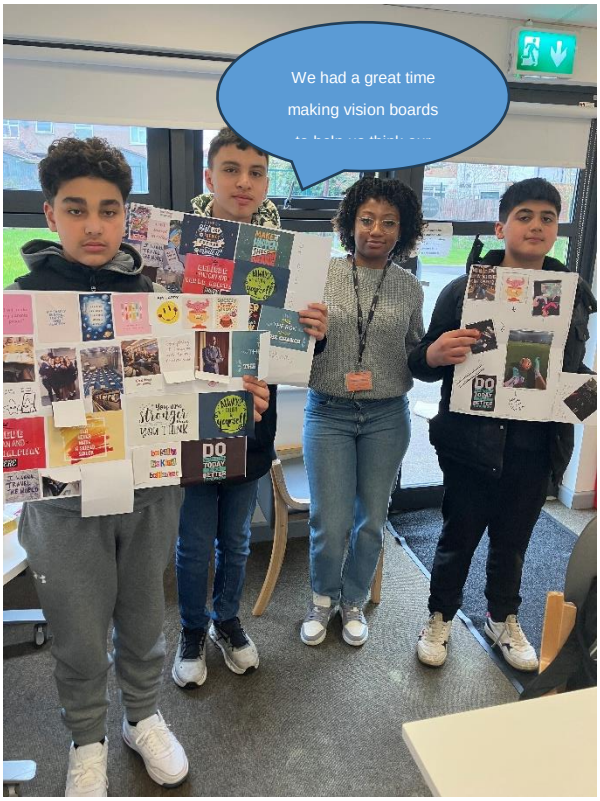
10.2 A focus continues to improve communication with schools and this has included attendance at school cluster meetings and Designated Safeguarding Lead / SENDCo forums, publicising the offer in the Headteachers bulletin / Schools Extranet / Governors termly newsletter, via Family Support Workers linked to schools, joint outreach to schools to attend coffee mornings, parent programmes/ workshops and the CYP Wellbeing Alliance network (a termly meeting that brings together statutory and non-statutory partners to share information/ new service developments and provide a forum for agencies to connect, with a focus on early intervention and prevention).

10.3 Public Health implemented an enhanced promotional campaign including print, digital and social media to raise awareness of breastfeeding and peri-natal mental health services and promote access to and use of BSFHs by more disadvantaged communities. This includes attending community meetings, videos (with translated subtitles), digital ads (with translated versions), printed flyers, posters and promotional maternity packs.

***Report sign off:***

***Nigel Chapman***
Corporate Director
Children, Young People and Community Development

**Family Wellbeing Centre**
**Annual Report 2025-26**




The annual report was authored by:
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# 1. Overview

## 1.1 Introduction and Context

1.1.1. The Family Wellbeing Centres (FWCs) form a central part of the borough's universal and preventative offer. FWCs act as an accessible 'front door' for families, providing a broad range of services, including health, local authority, parenting and targeted family support.

1.1.2. There is a consistent core offer across all centres, complemented by locally tailored provision to meet community need. Collectively, FWCs deliver a diverse and extensive programme of support, as detailed in appendix 1.

1.1.3. FWCs are a key priority within the Borough Plan (2023–2027) and underpin Brent's integrated, whole-family approach for children and young people aged 0–18 (up to 25 for those with SEND). By bringing together services such as health visiting, school nursing, early years provision, and family support, FWCs strengthen coordination, early identification, and targeted intervention, particularly for vulnerable families.

1.1.4. The model is community-led and partnership-based, shaped through local steering groups and key stakeholder partners within Brent. FWCs operate full-time, with extended and weekend access to improve reach, and maintain a strong focus on inclusion, including dedicated SEND support and specialist provision at Willow FWC.

1.1.5. The FWC are open at weekends, 9am to 1pm, during term-time. 1 FWC is open in the West and 1 in the East, and centres are rotated each half-term to ensure they are accessible to families across Brent. The weekend offer focuses on supporting parents with under 5's as working parents feedback was the Monday to Friday offer during core business hours was not accessible. The weekend service offer has expanded and now includes for example: Citizens Advice Brent, Dads activities, infant feeding support, immunisation catch-up clinics, etc.

1.1.6. The FWC model supports delivery of the Governments Best Start in Life, Family Hubs and Healthy Babies programme. As part of this programme the DfE required a national rebranding to Best Start Family Hubs and moving into the 2026/27 reporting year the FWC will be rebranded to Best Start Family Hubs and reporting will be aligned to national programme requirements.

1.1.7. Government Minister (Alison McGovern, Minister of State DWP), the Mayor's Office (Debbie Weekes-Bernard, Deputy Mayor) and the Child Poverty Unit visited Brent in May 2025 to review the FWC delivery model and how this supports families with the cost-of-living crisis, see figure 1. There is national and regional interest in Brents' partnership and community-based approach used to reduce the impact of poverty including:

- FWC at the heart of communities providing access to food via food donation programmes, toy libraries, providing advice on health lifestyles and cooking lessons for example to Feed Your Family for £5 with nutritious food
- Co-locating services at the FWC such as Citizens Advice, Housing, etc, providing family support via a holistic approach at settings that can be easily accessed and families have trusted relationships with staff
- Bringing together Community Voluntary Faith and Statutory partners into an early help 'village of support' for families to be connected into.

**Figure 1: Government Minister, Mayor's Office and Child Poverty Unit visit to Curzon Crescent FWC**



1.1.8. This report details the outcomes of the key priorities for 2025/26, provides a comprehensive report on service delivery and sets out the targets for 2026/27.

## 1.2 Key Priorities and Progress from 2025/26

During the reporting period 19,490 families have been supported to achieve positive outcomes against key priorities:

1.2.1 **Deliver the final year of the Start for Life programme and exit planning** - the Start for Life delivery plan was successfully implemented across all strands and regular updates were provided to the DfE who visited a FWC during the year to review progress. The Start for Life programme transitioned to the Best Start Family Hub and Healthy Babies programme in April 2026. The programme has created an integrated one-stop shop of family support services to prevent developmental issues escalating into more complex needs. This includes for example improved school readiness outcomes, integrated neighbourhood health services, reducing inequalities and simplified access to support.

1.2.2 **Increase the number of families registering** – the number of families registering has decreased by 1,146 (13%) from last year. However, on reflection registrations should have plateaued since the transition to the FWC delivery model in 2021 and the initial spike with more families being eligible to register, given families with children up to 18 and not just under 5s, met the expanded service user criteria. The reduction this year is partially due to Key Workers transitioning into the new Family Support Teams and Granville FWC being temporarily closed while it decanted to new premises. There was also a technical issue with the registration portal which temporarily prevented families from registering online which has since been resolved.

To note, even though registrations have fallen the number of contacts with families has increased and the number of unique families worked with has also increased. This means that whilst registrations have fallen, more families currently registered are being supported to achieve positive outcomes and impact as detailed in section 1.3 below. An active communication and outreach plan is in place with the aim of ensuring registrations continue to be maintained. Work continues with all partners to promote FWC registration and take-up of services, ensuring that partners recognise this as a shared responsibility.

1.2.3 **Develop the FWC youth offer linked to the refreshed Youth Strategy and delivery plan** – the FWC youth offer has continued to grow at some FWCs. Activities have included for example Arts and Crafts, Homework Clubs, Mixed Martial Arts, Teen Space, Gaming, Hair and Beauty and girls only sessions. More CVS partnerships have been established, such as hosting Ansar at Preston Park FWC who are funded externally to deliver activities. The impact on CYP includes for example: improved physical and mental wellbeing, reducing isolation, expanding social network, build essential life and employability skills, creating a sense of community and belonging, to help reduce the risk of involvement with crime and anti-social behaviour by providing safe spaces and access to trusted adult mentors.

1.2.4 **Supporting the development of the new Early Help and Social Care family support model to ensure the service is fit for purpose and works effectively in partnership with the FWC** – the new Family Support Teams are now in place and embedding. Family Support Workers are linked to their respective geographical FWC. However, further work is needed to ensure that Family Support Workers continue to use the FWC to meet families, promote registration and service take-up. Guidance has been issued requesting that Family Support Workers are present at the FWC at least 1 day per week. The impact of the changes means that families only need to tell their story once, the number of handover points for families has reduced and there is greater consistency for families with a single practitioner being involved.

1.2.5 **Supporting the development of the new Targeted Prevention Hub ensuring FWC are a key partner with strong links** – the Targeted Prevention Hub has been established and links are in place with the FWC to refer young people and parents into the support offer. Targeted Prevention Hub staff can hot desk at the FWC to encourage co-location and service integration. The Targeted Prevention Hub is still in development but outcomes for young people include reducing anti-social behaviour, lowering youth reoffending, increased mental health and wellbeing, improve school attendance and connect at-risk youth with education and employment.

1.2.6 **Capitalising on the redeveloped outside play areas to deliver a greater range of environmental projects and activities** – the aim is to encourage more outdoor play and learning. A range of outdoor activities and environmental projects take place across the FWC and the outside play areas are well used. Outdoor activities include for example: gardening clubs, growing vegetables/herbs, composting, stories and exploring mini beasts. Childminding networks also use the FWC resources, including the outside play areas. Being outdoors is crucial for children's development and improves their mental health/ wellbeing, physical fitness and social skills. Exposure to nature helps to reduce stress and build resilience and self-esteem through safe, adventurous and stimulated play.

## 1.3 Outcomes and Impact

1.3.1 The outcomes and impact achieved for families through the FWC is wide ranging given the verse range of services on offer. During the year 19,490 families, making over 150,000 contacts with the FWC, have been supported to achieve outcomes in the following areas:

- Improved family finances and reducing the impact of the cost-of-living crisis
  - CAB supported 1,262 families to achieve financial gains of £1,019,214
- Improved family nutrition, weight management and access to fresh fruit and vegetables
  - Felix donated food items equivalent to over 50,000+ meals including fresh fruit and vegetables
- Support to stop smoking improving family health and wellbeing

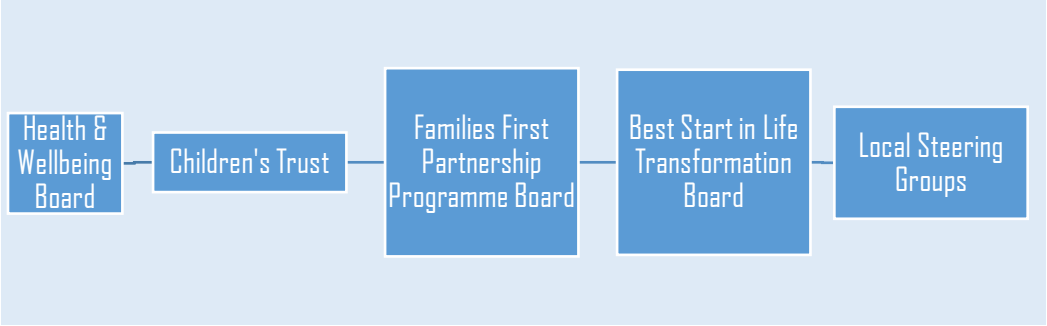
  - Health and FWC staff engaged with 4,000+ families regarding the risks of smoking during pregnancy and the importance of smoke free environments at home
- Improved oral health and reducing teeth extraction for under 5's
  - Oral health promotion sessions were delivered to over 1,000 families
- Improved parent/carer and CYP mental health and wellbeing
  - 1,755 families were triaged and connected into appropriate support including for example Talking Therapies, Kooth, Health and Wellbeing Workshops and Counselling services
- Improved parenting capacity leading to better relationships between parents and their children, reducing children's behavioural problems and better communication
- Improving CYP and parent/carers emotional literacy
- Reducing negative discipline practices such as smacking and providing parents with alternative approaches
- Reducing parental conflict and the negative impact on families
  - 709 parents attended accredited parenting programmes and workshops
- Reducing substance misuse and its impact on families
  - Where families are identified with substance misuse issues they are referred to Via New Beginnings. Via also refer families to the FWC for wrap around support
- Improved family fitness leading to better wellbeing outcomes
  - 400+ families participated in Busy Feet and other family fitness related programmes
  - 51+ families participated in HENRY parenting programmes
- Increasing refugee and asylum seeker engagement with early help and preventative services
  - A specialist Triage Officer engaged with 200+ refugee and asylum seeker families, some families are given Oyster cards with regular credit to enable access to the FWC, families also benefit from vouchers for clothing during winter
- Preventing family problems becoming more complex and entrenched by intervening earlier and providing the right support at the right time
- Preventing family breakdown and children going into care
  - 1,755 families were triaged and connected into appropriate support, 159,000+ contacts were made with 19,490 families engaging with universal and some targeted services
- Reducing the risk of domestic abuse and improving outcomes for families impacted by domestic abuse
  - Advance Independent Domestic Violence Practitioners (adults and children's) are co-located at the FWC and supported over 100 families and women accessed the Freedom programme
- Improving parents' literacy, numeracy and ICT skills
  - Brent Start delivered ESOL and Numeracy workshops and 100+ parents attended
  - FWC staff helped 3,000+ families with ICT to register, book online and complete online forms such as school applications etc
- Supporting parents and young people into employment and to access educational and work experience opportunities
  - Family Work Coaches are collocated at the FWC and helped 150+ parents into employment
  - Connexions PAs are collocated at the FWC and helped 100+ young people into education, employment or training

- Reducing the impact of caring responsibilities on children and improved understanding by schools/partners regarding the issues that impact young carers leading to better educational outcomes
  - 132+ Young Carers were identified and supported during the year
- Reducing social isolation, particularly for new mums
  - 4,000+ mums benefited from activities for under 2's
- Improving a range of outcomes for families of children with SEND
- Improving children's school readiness
- Improving school attendance, punctuality, attainment and engagement with school activities.
- Reducing health inequalities for the most vulnerable families.
- Reducing the impact of Adverse Childhood Experiences and trauma
- Increasing family's resilience to the impact of multiple disadvantages.

## 1.4 Governance arrangements

1.4.1 The FWC East and West Local Steering Groups (LSGs) meet termly, with the exception of Willow and Curzon/ Fawood, which have different governance arrangements. The LSG are neighbourhood forums for sharing information, identifying need, support requirements for families and service gaps/pressures, challenging performance and quality of delivery, acting as local agents for integrating services and drawing in additional resources. The LSG Chairs are elected from the group membership and are currently voluntary sector partners. The FWC governance arrangements will change in the new reporting period to align with new Best Start Family Hub and Family First Partnership programmes.

**Figure 2: FWC governance and reporting arrangements**




## 1.5 Headline data for 2025-26

1.5.1 Table 1 gives a summary of the FWC key performance indicators for 2025-26 (The full data report is included as appendix 2).

**Table 1: Key Performance Indicators 2025-26**

| No. | Area | Measure | Period | | | No. Difference | % Change | Comments - 2025/26 |
|---|---|---|---|---|---|---|---|---|
| | | | 2025/26 | 2024/25 | 2023/24 | 2025/26 and 2024/25 | 2025/26 and 2024/25 | |
| 1 | Registrations | Number of children and young people and adults registering with Family Wellbeing Centres | 7,516 | 8,662 | 12,486 | - 1,146 | -13% | Registration reports are not picking up all carer registrations. This is being investigating (May-26) |
| 2 | Reach - Contacts | Number of registered services users that have had a contact with Family Wellbeing Centres | 19,490 | 18,079 | 15,849 | 1,411 | 8% | |
| 3 | Volume - Contacts | Number of recorded contacts with registered service users at Family Wellbeing Centres | 159,004 | 151,613 | 124,302 | 7,391 | 5% | Total volume figures include online/offsite events recorded as 'Out of Area' |
| 4a | Reach - Dads | Number of registered dads/male carers contacted | 2,901 | 2,568 | 2,323 | 333 | 13% | |
| 4b | Volume - Dads | Number of recorded contacts with registered dads/male carers contacted | 17,771 | 14,461 | 14,563 | 3,310 | 23% | |
| 5 | Triage | Total number of families supported by Triage | 1,755 | 1,674 | 2,135 | 81 | 5% | |
| 6a | Parenting Support | Number of parents completing accredited parenting programmes/workshops | 709 | 374 | 447 | 335 | 90% | These totals include parents that have attended more than one programme/workshop within the period. Excluding duplicates, totals are given below in the notes |
| 6b | | Percentage of parents completing accredited parenting programmes/workshops | 85% | 76% | 79% | 9% | 12% | |
| 6c | | Number of parents attending accredited parenting programmes/workshops | 833 | 494 | 567 | 339 | 69% | |
| 7 | School Readiness | Number of attendances at the universal Speech & Language Communication Let's Talk sessions | 1,497 | 2,457 | 2,207 | - 960 | -39% | 2025/26 data is from eStart - Event Volume for Let's Talk. Data for previous years is from SLT commissioned service |
| 8 | Public Health - Reach - Healthy Start Vitamins | Number of people that have received Healthy Start Vitamins | 3,661 | 3,498 | 2,396 | 163 | 5% | |
| | Data extration date - Registrations / Reach / Volume Contacts | | 08-Apr-26 | 09-May-25 | | | | |

**Notes:**
Registrations, Reach and Volume Contacts - The YTD figure is calculated seperately and will include any data that's been added since the previous quarter data was extracted. The sub totals are not added manually to get the YTD total
Parenting Support - The figure includes parents that have attended more than one programme/workshop within the period

1.5.2 Where there is a significant variance in performance, these are explained below:

- Registrations – the number of families registering has decreased by 1,146 (13%) from last year. However, on reflection registrations should have plateaued since the transition to the FWC delivery model in 2021 and the spike with more families being eligible to register, given families with children up to 18 and not just under 5's, meet the service user criteria. The reduction this year is partially due to Key Workers transitioning into the new Family Support Teams and Granville FWC being temporarily closed while it decanted to new premises. There was also a technical issue with the registration portal which temporarily prevented families from registering online which has since been resolved. Work is progressing to ensure that links between the new Family Support Teams and FWC remains strong and families are connected into the wider early help offer.
- Dads – there has been a 13% increase in Reach and Volume data as a result of the Dads worker being in post and the dads programme embedding across the FWCs.
- Parenting – there has been a significant increase in the number of parents attending accredited parenting programmes due to the take up of the Triple P Group workshops and the Parents As First Teachers Group connections sessions. These workshops are 2 hours in duration and focus on specific topics that parents with which parents' may be struggling with.
- School Readiness – There is a reduction in the number of children accessing universal Speech and Language sessions as the contract with LNWHT to provide Speech and Languages services ended 31 March 2025 and the service was mainstreamed within existing FWC resources. A new speech and language support model, WellComm, has been piloted at St Raphael's FWC and some early years settings. The aim is to identify children with speech, language and communication needs earlier and provide support strategies to parents. The programme has needed some adapting for FWC use. Early indicators show positive impact on children's speech and language development and some children have also been identified for

funded nursery places and benefited from attending nursery provision. The programme will be rolled out across all FWCs and some early years settings in the new reporting year.

## 1.6 Strategic Context

### 1.6.1 Best Start in Life (Early Years strategy)

1.6.1.1 The Brent Early Years Strategy and Best Start in Life (BSiL) Local Plan 2026–2029 was developed in spring term 2026 and responds to the significant opportunities and challenges facing families with children from conception to age five and beyond. They recognise the lifelong impact of experiences in the earliest years, including the first 1,001 days and the crucial period from age three to five. The aim is to enable the youngest children to grow, learn and develop the skills needed to thrive in school and beyond.

1.6.1.2 The strategy focuses on 6 priority areas:

1. A joint commitment to system change
2. A seamless experience for families, jointly owned and delivered
3. Data that works for families and for professionals
4. A welcome from the start for every child and family, with a focus on early years inclusion
5. A clear Best Start in Life pathway for every Brent baby and family
6. High quality sustainable early education and childcare that supports all children to thrive.

1.6.1.3 Dedicated work streams will be developed around the key priorities. The FWC will be linked to the work streams and will support delivery of the strategy. This work links to the national Family Hub and Best Start for Life programme as detailed in section 2.4.3 including the Best Start in Life local delivery plan 2026-2029.

### 1.6.2 Inclusion strategy

1.6.2.1 The Inclusion Strategy 2026-2029 was developed over the last reporting year and following extensive consultation with stakeholders the three priority areas in Brent for children and young people with SEND are:

1. Improve support
2. Improve safety in the community
3. Improve preparation for adulthood.

1.6.2.2 Each priority has many agreed actions linked to it, so multi-agency partners know what they need to do to achieve the things that matter to the community. The FWC are linked to the work streams and will support delivery of the strategy. The new Best Start Family Hub programme has a requirement that all Family Hubs have Best Start Inclusion Practitioners that will support SEND families to increase engagement and participation with FWC services and identify children with additional needs early, connecting them into specialist support where necessary.

### 1.6.3 Youth Strategy

1.6.3.1 The refreshed Brent Youth Strategy 2025-28 and action plan have been delivered during the year, supporting young people's priorities of:

1. Being Heard and Taking Part
2. Reaching Goals and Enjoy Yourself
3. Feeling Good
4. Staying Safe.

1.6.3.2 The Brent Youth Strategy Action Plan outlines Brent's 2025–26 priorities for improving outcomes for children and young people across four strategic pillars:

1. Engagement and Participation
2. Skills and Opportunities
3. Health and Wellbeing
4. Safety.

1.6.3.3 Each section focuses on deepening partnerships, expanding youth voice, improving access to spaces and services, and integrating multi-agency working. There is significant overlap between the Youth strategy action plan delivery and the FWC, such as providing safe spaces for young people to meet, delivering diversionary activities, providing access to Connexions PA Advisors and mentors.

1.6.3.4 CYP being visible and heard is a strategic priority within the Borough Plan, SEND strategy, CYP Participation and Engagement Strategy, and Brent Youth Strategy. The co-production of activities and the creation of a Youth Panel enabled CYP to take an active part in improving youth services and influencing strategic decisions. CYP have been involved in the process of creating strategies that improve their childhood experiences and future life chances.

# 2. Delivery

The narrative below gives a summary of the provision delivered by key stakeholders working in partnership across the FWC network.

## 2.1 Local Authority delivery

### 2.1.1 Triage

2.1.1.1 The Triage service helps to achieve positive outcomes for children and families who require light touch interventions or short-term pieces of work with families who meet the criteria for Universal (Level 1) and Level 2 support. The common presenting issues to the triage service include:

- Families re-locating from other areas with no resources (i.e. household goods, lack of finances, etc)
- Debt - including utilities, rent, council tax, etc
- Children not in school
- Cost of living related issues
- Housing - overcrowding/ evictions/ disrepairs
- New arrivals - including Ukrainian families, other asylum seekers
- Parents with children who have undiagnosed additional needs who require help to access specialist services.

2.1.1.2 The nature of the support required by families often spans across many areas at once e.g., Housing, Education, Financial instability and as such the length of time (initially approximately 4-6 weeks) that workers are involved with families has increased to 10-12 weeks, or in some cases longer with a small cohort.

2.1.1.3 Triage intervention continues to help prevent needs from escalating and requiring higher level and more costly interventions and achieves positive outcomes for families linked to the presenting issues identified above.

2.1.1.4 Other support via the Triage service includes:

- Helping Ukrainian, asylum and refugee families, who have newly arrived in the UK and require support to integrate in the community
- Travel Access scheme - funded by the Asylum Dispersal Grant, assists those families who are seeking asylum and have limited income to travel to FWCs, maintain appointments with partner agencies or get to health appointments and is made available to families through the FWCs
- Winter and Warm scheme – vulnerable families are given a £50 shopping voucher to buy clothes/ winter related items
- Crisis Support Fund – fast tracking families to access Brent and Barnardo's Crisis Support funds
- Baby Bundles - a partnership with Little Village to provide vulnerable new birth families with access to items for newborns and in some cases a Moses basket for baby to sleep in
- Too Good to Go – food vouchers worth £15 were given to vulnerable families to enable them to access food via the Too Good to Go app. Approximately 200 vouchers were given out bi-monthly. Note, this support offer has ended.

### 2.1.2 Children and Families Information and Outreach Service

2.1.2.1 The Children and Families Information and Outreach Service for 0 – 19 (up to 25 for young people with SEND) are co-located at the FWC. The CFiS provides information, advice and outreach, offers a brokerage service to families struggling to access early education and childcare. CFiS also offers a range of community facing support services, including in partnership with Inclusion Services and Public Health, promoting the importance of the first 1001 days to families and partner organisations in the borough.

2.1.2.2 In addition, Chrysalis deliver a monthly online drop-in session for families impacted by domestic abuse. Chrysalis is funded by the LA to bridge the gap between professionals and survivors of domestic abuse. The following services are available:

- Bowling & Co. – Solicitors
- Brent Housing – DA housing officers
- Asian Women's Resource Centre
- PLIAS resettlement (Phoenix project) – IDVA support for African/ Caribbean women and girls.

### 2.1.3 Parenting support

2.1.3.1 Parenting support is an integral part of the FWC service offer and focuses on equipping parents with the skills, knowledge and confidence to support their CYP wellbeing and development. The FWC deliver a diverse suite of accredited parenting programmes and support ranging from universal through to more specialist provision to support parents at differing ages and stages of their children's development and level of need.

2.1.3.2 Parents who have English as an additional language are supported through translation services, facilitators who speak community languages, and resources i.e. parenting manuals

being available in different languages. A creche also runs alongside the programme to enable access for parents with young children.

2.1.3.3 The FWCs offer workshops that provide parents with a 'taster' session in advance of attending the full programme and is a good way of generating interest. These workshops focus on topics suitable for parents of toddlers right through to parents of adolescents. The main issues parents request support with and where positive outcomes are achieved include setting boundaries, behaviour management, conflict between parents and/ or CYP (particularly teenagers), positive approaches to discipline, poor communication, having unrealistic expectations of their CYP (high or low), parent self-care and emotional literacy.




**Figure 3: Dads completing SFSC parenting programme at Willow FWC**

2.1.3.4 During the year the parenting offer expanded to meet the increased demand for Cygnet programme delivery. The co-facilitation of the programme with school partners on school sites has been a particular success.

2.1.3.5 The Generation Parent Management Training Oregon (GEN PMTO), delivered by Barnardo's, continued during the year. The programme (typically delivered over 14 weeks) is aimed at parents where children aged between 8-14 years old are at risk of serious youth crime or developing a behaviour problem and/ or where these have already begun. The programme provides parents with effective tools to reduce coercive interactions with the aim that this will lead to improved children's mental health and wellbeing and reduce crime, violence, and anti-social behaviour. Recruitment to the programme was slower than anticipated despite ongoing promotion and outreach to universal and targeted providers which had minimal impact at increasing numbers. Funding for the programme came to an end 31 March 2026 and will not continue in the new reporting period.

### 2.1.4 Dads programme

2.1.4.1 The dads programme was relaunched in February 2025 and has successfully expanded during the year and includes:

- Fathers Fun Fridays - provides a relaxed space for dads to bond with their children through fun activities and positive shared experiences

- New Dads parenting programme - builds new fathers' confidence and skills, helping them feel more supported and engaged in their parenting role
- Dads' activities/ trips - offers opportunities for dads to connect with their children and create positive experiences while reducing isolation
- Dads peer-to-peer support network - enables dads to share experiences, offer support, and build a sense of community with one another
- Dads WhatsApp messaging group - keeps dads connected, informed, and supported through regular communication and shared opportunities.




**Figure 4: Dads Fun Fridays at Willesden Sports Centre**

2.1.4.2 The Dads Programme recognises the key role that Dads play in their children's upbringing and development. Dads can often be less heard from, an overlooked group when working with families due to for example systemic biases, workplace pressures and social stereotypes. The Dads programme aims to engage more dads to access activities and support across the FWC network and be a champion for dad's inclusion in family support work.

2.1.4.3 Feedback from Dads

*'I really enjoy special time with my daughter and taking her to activities at the centre, which she really enjoys.'*

*'I was reluctant to attend a parenting course, but I'm glad I did as I learnt a lot and met other dads going through the same issues'*

### 2.1.5 Toy Library

2.1.5.1 Each FWC has a toy library where families can borrow up to 3 toys for 2 weeks at a time at zero cost. The offer expanded to address local needs and include more toys for SEND and older age CYP.

### 2.1.6 BookTrust Storytime

2.1.6.1 In partnership with the Library Service the Booktrust Storytime programme is delivered across the FWC giving out free books to families, encouraging parents to read with their children and registering with the libraries and FWC. Families are signposted to events at the libraries and FWC.

### 2.1.7 Parents As First Teachers (PAFT)

2.1.7.1 The PAFT programme is now well embedded and supports parents with children pre-birth to 5-years with home learning environments. The research-based home-visiting programmes aims to enhance child development, parent to child interaction, family wellbeing and achievement through weekly planned activities. The programme supports FWC and families with school readiness outcomes including for example toilet training, speech, language, communication needs, social and physical development. The 3 PAFT practitioners deliver group sessions at the FWC and jointly co-facilitate some sessions with FWC staff. The PAFT programme has supported 323 families to achieve positive outcomes and impact as evidenced by the pre and post intervention questionaries (data available upon request), including for example:

- School ready – more children are ready when they go to school or nursery equipped with the skills to help them learn and engage with the curriculum
- Secure attachment – more children have improved emotional regulation, resilience and know healthy ways to interact with others
- Improved children's physical development and wellbeing
- Improved parenting capacity – leading to children's better sleep, independent toileting and fine motor coordination and reducing stress for parents
- Early detection – educated parents are better equipped to identify changes in their children's development, leading to the early identification of potential SEND and/ or other issues
- Improved partnership working with schools, nurseries, health services, who refer families into the programme, leading to improved engagement and take-up with wider FWC support services.

### 2.1.8 Raising Early Achievement in Literacy (REAL)

2.1.8.1 REAL is a research-evidence based programme designed to support children's early literacy development by buildings parents' confidence at home. It uses everyday activities to foster a lifelong love of reading and writing aimed at families with children 3-5 years old from disadvantaged backgrounds. There is 1 REAL practitioner, and training has been delivered to early years settings including the FWC. The REAL programme has supported families to achieve many positive outcomes and impact, including for example:

- School readiness outcomes
- Children's improved cognitive development
- Children's speech, language and communication
- Children's social skills
- Narrows the achievement gap for socio-economic disadvantaged children
- Leading to better academic achievement, improved emotional well-being, increase in problem-solving skills and greater socioeconomic success later in life.

### 2.1.9 SEND support

2.1.9.1 The centres are inclusive to families with SEND children and specialist support and services include for example:

- CAMHS under 5s service
- PAIRs 0-2s service

- Specialist parenting programmes – Cygnet/ Plus and Stepping Stones
- Supporting Assessment for Autism Route (STAAR) – this service ended March 2026
- Deaf and Hearing Impairment service
- Visual Impairment service
- Parent peer-support group on Saturday mornings
- Deaf parent peer support group
- Family sign class
- Brent Parent Carer Forum.

2.1.9.2 The wider FWC service offer is also accessible and for example CAB, targeted early help, and the triage service all support SEND families. The FWC promote the Brent local offer and SEND navigators connect families into appropriate support and/ or refer onto other agencies depending on need. FWC staff identify children with potential SEND issues early who are then supported and/ or signposted to specialist services.

### 2.1.10 Young Carers Support

2.1.10.1 Brent Carers Centre are the commissioned provider for Young Carers support in Brent and there are strong links with the FWC. The service offers a range of support for Young Carers including young carers activities at Family Hubs and holiday activities. In the last twelve months this has included trips to Gordon Brown outdoor centre and arts activities with a voluntary sector provider.

2.1.10.2 Brent Carers Centre, in partnership with Early Help offer outreach events at schools to increase identification of young carers. In response to feedback from young carers, a pilot series of sessions were held at Harlesden library to offer a study space for young carers.

2.1.10.3 A training offer is delivered through the Brent safeguarding partnership to support multi-agency practitioners to understand the importance of safeguarding young carers. Brent Carers Centre identified 132 new young carers during 2025-26.

### 2.1.11 Housing

2.1.11.1 During the year a pilot took place with Housing Services to introduce housing surgeries across the FWC. The purpose was to provide accessible, housing related information and advice in community settings, to help ensure families are better informed about housing processes, application pathways and available support services. Intended outcomes are to strengthen families understanding of housing pathways, support earlier intervention of need/ risk, reduce the number of families approaching housing without the appropriate information and reducing potential homelessness. The housing surgeries are now embedded and delivered across the FWC network. An external evaluator has been commissioned by Housing Services to explore the impact of this work on reducing homelessness and will be reported in the next period.

### 2.1.12 Youth Justice Service (YJS)

2.1.12.1 YJS can meet with young people/ families at the FWC, subject to appropriate risk assessments, and refer family members to the wider service offer, including for example parenting support, mentors, health services and CAB. FWC also host young people for reparation activity and this has been successful at some centres and plans are to extend this offer next reporting year.

### 2.1.13 Early Help Resource Panel

2.1.13.1 Lead Professionals, including, EYWs, FSAs, Key Workers and Social Workers can present cases to a monthly multi-agency Early Help Resource Panel to request additional services for a family and/ or benefit from a multi-agency discussion regarding the case.

2.1.13.2 The purpose of the Early Help Resource Panel is:

- to support Lead Professionals to provide effective preventative early help to families
- for member agencies to agree and commit resources on behalf of their agency to respond to the needs of families
- to inform the commissioning of goods and services, such as counselling, mentoring, befriending, within the early help service to support families
- to monitor and agree services commissioned within the early help service to target services appropriately and ensure there is sufficient provision through-out the year.

2.1.13.3 Responsibility for the Early Help Resource Panel moved to Family Support Teams from April 2026.

### 2.1.14 Family Financial Resilience programme

2.1.14.1 The Family Financial Resilience Partnership is a Greater London Authority-funded programme designed to help low-income families with children access free, high-quality social welfare advice so that their income meets their everyday needs. The programme has three main objectives:

- supporting low-income families with children to maximise their income by accessing their benefit entitlements
- supporting low-income families with children to access emergency financial support when they cannot afford essentials
- supporting low-income families with children to reduce their financial hardship and material deprivation by addressing advice on wider social welfare issues – such as immigration, employment, childcare support and housing.

2.1.14.2 Brent was one of twelve London boroughs to receive funding and is delivered through the FWC. The programme works in partnership with two leading advice networks -London Legal Support Trust and London Citizens Advice to provide expert income maximisation advice covering themes such as welfare, debt, housing, childcare, disability, immigration, and employment.

2.1.14.3 Advisors focus on what matters most to families experiencing financial hardship, offering tailored support to improve financial resilience. Given this reporting period is to March 2025, only 2 months of delivery had taken place, but early indicators have shown a positive outcomes and impact on families, including:

- Increasing/ maximising income
- Reducing debt
- Securing immigration status
- Securing housing
- Improved engagement with other FWC support services
- Improved mental health and wellbeing
- Reduced stress related to financial worries/ pressures.

2.1.14.4 Phase 1 of the programme is now well established at some FWC and will expand across the FWC in 2026-27. It is expected that the programme will continue until December 2027, subject

to funding confirmation. The programme launched mid-February 2026 and at the time of writing had supported 179 families, which is the 3rd highest of the 12 Local Authority's participating. The next phase will include delivering training to front line practitioners on Financial First Aid. Plans are developing to expand the service as advice capacity increases with CAB and improve access to Harrow Law Centre

## 2.2 Community/Voluntary/Faith Sector delivery

### 2.2.1 Barnardo's partnership

Barnardo's are commissioned to provide several support services that support the FWC delivery model, including crèche provision, volunteering programme, Family Support Assistants and Early Years workers. Barnardo's bring added and social value benefits to vulnerable families including for example, the donation and distribution of white goods, mobile devices and data, gifts for children, food donations, access to social trips, a crisis support fund, and support for refugees.

#### 2.2.1.1 Early Years Workers

Early Years workers plan and deliver targeted early years focused interventions and group work, such as accredited parenting programmes, Let's Talk sessions supporting children's language development, and advice on infant feeding. Early Years workers help to identify children with additional needs early and quickly, connecting them into appropriate support services. They work closely with the rest of the FWC team to ensure there is a seamless service for vulnerable families. They make welfare calls to identified vulnerable families to check-in on them, promote FWC registration and encourage take-up of services and support.

#### 2.2.1.2 Family Support Assistants (FSA)

FSA work closely with the Triage Officers and Key Workers to support vulnerable families to access universal services. They offer family befriending and support, facilitate group work, and deliver accredited parenting programmes and other interventions. They complete outreach and home visits to vulnerable families who are not able to access FWC services on site. They make welfare calls to identified vulnerable families to check-in on them, promote registration and encourage take-up of services.

#### 2.2.1.3 Volunteer programme

Barnardo's delivers a volunteer programme that includes a Volunteer Coordinator. There are over 20 volunteers that support the work of the FWC. Most volunteer during term-time. Volunteers support FWC with for example administration, the crèche, promoting activities and services, registering families, English conversation groups, delivering parenting programmes and other interventions. The aim is for each FWC to have a minimum of 3 volunteers allocated to provide additional support, including a Parent Champion.

#### 2.2.1.4 Parent Champions

The Violence Reduction Unit (VRU) funded a Parent Champions programme using volunteer parents on the premise they are best placed to support other parents to find out about childcare choices and services for families with children of all ages, but particularly focused on families with children over 10 years old.

The Parent Champions have been supporting the FWC with outreach to refugee new arrivals, homeless families, those in temporary accommodation in local hotels to promote FWC registration and take-up of services. During the year there were on average 10 active Parent

Champions who reached over 750 parents. Using this approach can be an effective way to build trust, bridge gaps, and empower families. Parent Champions lived experience and community knowledge are key to reaching families who might otherwise remain disengaged.

The Parent Champion programme has achieved many positive outcomes including for example:

- helping to strengthen community relationships
- increasing families awareness around key safeguarding and wellbeing issues such as gang, knife crime, and online harm/ safety
- reducing isolation and creating peer-to-peer support networks via WhatsApp groups
- accessing 'hard to reach' families and connecting them FWC support services
- volunteer development - Parent Champions gain personal confidence, improve their skills and access to training, helping them to progress into employment.

The Parent Champion programme ended on 31 March 2026 with cessation of the funding from the VRU. Parent Champions were incorporated within the Barnardo's volunteer programme detailed above and will continue to support the FWC as part of this programme.

#### 2.2.1.5 Crèche provision

Barnardo's delivers a crèche service including a crèche coordinator and as and when staff to provide crèches to support programme delivery. For example, crèches are run alongside parenting programmes and other group work to increase accessibility to parents.

### 2.2.2 Felix food programme

The majority of the FWC receive food donations via the Felix project and food items were donated to families equating to 50,000+ meals during the year. The number of families accessing the offer is not known given how the food and items are distributed. Some FWC also receive non-food items from Felix such as toys, clothes and household items which are donated to families. The impact is that families are supported with the cost-living crisis and lead healthier lifestyles by having access to fresh fruits and vegetables. The project runs during school holiday periods supporting low-income families who would otherwise have access to free school meals during term time.

### 2.2.3 Little Village

Little Village supports families with babies and children under five living in poverty across Brent. They run a baby bank network, collecting, sorting and passing on pre-loved clothes and equipment. Parents are also supported by a dedicated signposting and guidance team, who offer advice and links to other services including the FWC. FWC refer families to Little Village and vice-versa, FWC collect and donate clothes and equipment to Little Village and refer families with new babies to receive Baby Bundle packs which includes items such as sleeping baskets, blankets, bibs, muslin cloths, nappies, changing mats, wipes and toiletries.

**Table 2: Little Village work in Brent**

| Project | What's on offer? | No. |
|---|---|---|
| Wembley Central Hub | Referred families choose items from LV Brent shop | 581 |
| Direct delivery | Referred families receive items delivered to their door | 552 |
| Bundles in Partnership | Clothing & essentials via FWC and other specialist settings | 197 |

| | | |
|---|---|---|
| Emergency newborn packs | Available in all maternity units serving Brent families | 20 |
| Signposting | Signposting families to FWC and other support service | 215 |
| Play Packs | Age matched toy and book packs delivered to families via FWC & CFiS<br><br>Play Pack Events | 320<br><br>4 |

The project has many positive outcomes and impact on families, including for example:

- Reducing poverty-related barriers to development
- Supporting parents as first educators
- Increasing engagement with FWC
- Improving school readiness Good Level of Development (GLD)
- Increased engagement and take-up of service e following the practical support offered.

### 2.2.4 Brent Parent Carer Forum (BPCF)

The FWC have strong links with BPCF and include for example:

- FWC staff attend workshops held by BPCF to promote the FWC and Early Help offers
- FWC via Start for Life funding provided resources to BPCF to set-up a toy library with specialist SEND toys to support families impacted by the cost-of-living crisis and to expand the reach of the FWC toy libraries
- FWC supported BPCF to run day trips to the seaside over the summer so SEND families could get away from the city and give children new experiences, network with other families and find out about other services and support
- FWC host SEND themed stay and play/ peer support sessions on rotation on Saturday mornings during term-time
- FWC host yoga for young children, including SEND children, and families have reported positive outcomes regulating children's behaviour.

### 2.2.5 Holiday Activities and Food (HAF)

Some FWC host providers funded by HAF to deliver diversionary activities to CYP over Easter, Christmas and summer school holiday periods. The FWC would like to host more HAF providers, however in general the FWC buildings/ rooms do not lend themselves to sports activities or large groups.

### 2.2.6 Advance

Advance supports women and CYP affected by domestic abuse and sexual violence.

Independent Domestic Violence Advisors (IDVAs) x2 Children's and x2 Adult workers receive referrals from Early Help practitioners and are co-located at the FWC. represent their voice at a Multi-Agency Risk Assessment Conference (MARAC), helping them to navigate the criminal justice process, and work with different agencies to provide wraparound support. They support domestic abuse victims to:

- become safe and rebuild their lives
- improve mental health and wellbeing
- address the impact of trauma and ACES

- improve family dynamics and communication
- reduce demand for more costly statutory support.

### 2.2.7 Shaw Trust - Connexions

Shaw Trust Connexions (Brent Youth Futures) service is collocated at the FWC and supports vulnerable young people 16 to 18 years (up to 25 for those with SEND) with:

- One-to-one careers guidance to help define personal interests and career paths
- Employability training, such as CV writing, application support, and interview preparation.
- Access to opportunities by making referrals for apprenticeships, traineeships, and training programmes.
- Intensive Mentoring, including confidence building, cognitive behavioural mentoring and resilience coaching.

The impact is to reduce the number of young people NEET leading to better futures.

### 2.2.8 Citizens Advice Brent (CAB)

CAB advisors are present at each of the FWC one day per week via an appointment-based system. Families can be seen at any of the FWC and can access support via telephone and webchat. CAB has achieved many positive outcomes and impact on families, including for example:

- Income maximisation
- Reducing debt
- Securing immigration status
- Supporting with employment matters
- Securing accommodation and avoiding homelessness
- Connecting families into other support services
- Reducing the impact of the cost-of-living crisis.

### 2.2.9 Faith sector

Work has progressed to develop stronger partnerships with the faith sector. This has included for example working with Daniel's Den, a Christian VCFS provider, who delivers parent and toddler groups in community settings across Brent. FWC promote Daniel's Den activities and vice-versa. Staff from the FWC have attended Daniel's Den sessions to promote FWC engagement, deliver key public health messages and strengthen partnerships.

Other work with the faith sector has included for example training practitioners from faith groups to deliver accredited parenting programmes, co-facilitating programmes with faith group and council staff and faith groups distributing publicity and other information.

As part of the Start for Life programme small grants were given out to VCFS partners to promote the FWC and Start for Life programmes to encourage take-up of services and support.

Plans are progressing to map the faith sector, who offer a wider range of family support services in community-based settings across Brent, and link these services into the wider early help support network. This work links to the Gather Movement bringing together 8,000 churches and charities who are working in partnership to transform local communities.

## 2.3 Health delivery

### 2.3.1 Public Health

There is effective integrated working with Public Health and the FWC who are involved in the front-line delivery of many public health projects and health messaging including:

- Healthy Start - distribute vitamins and £20 food vouchers to vulnerable families. This programme will stop moving into the new reporting period.
- UNICEF – FWC are Level 3 Bably Friendly accredited, there are breast feeding champions and clinics at each FWC, breastfeeding is promoted including access to specialist support
- Parenting programmes – FWC staff and Health Visitors co-deliver the HENRY Antenatal and Getting It Right (0-5) programme
- Period Dignity – FWC distribute period products from Hey Girls
- WellComm – St Raphael's FWC has piloted the new WellComm model to improve speech, language and communication and the model will be rolled out across all FWC
- Support play and child development – via stay and play activities, outdoor play areas, environmental projects, Busy Feet, using musical instruments
- School Readiness – supporting outcomes in this key area – SLT, toilet training, self-feeding
- Vaccine Clinics – FWC host vaccine catch-up clinics and are involved in joint promotional work in areas where there is low vaccine take-up
- Oral Health – promote good oral health and Harlesden Dentist access pilot project to encourage more families to register young children with a dentist.
- Obesity - promote healthy lifestyles, host Busy Feet and BeeZee families, link families to the Weight Management Service
- Healthy Eating – delivered in partnership with Brent Start, give out free fruit and vegetables via the Felix programme
- Health Review/Safeguarding Clinics are hosted at the FWC
- Maternal Early Childhood Sustained Home Visiting (MECSH) and Infant 2 school programmes are promoted by the FWC staff and the programmes are delivered in the FWC
- CAMHS and PAIRS services are hosted at the FWC
- Sleep – FWC promote safe sleep environments, baby sleep needs by age, tips for better sleep, Developing Good Bedtime Routines workshop, Being With Your Baby workshop, parenting programmes, Stay and Play sessions, link into Safer Sleep Week (March), PAFT practitioners, promote online sleep resources.
- Asthma Community Coaches – FWC staff have been identified as Asthma Community Coaches, training for staff is to take place, staff are to signpost families to appropriate support where applicable
- Screen Time – FWC promote government guidelines regarding screen time for under 5's
- Parenting support – including access to specialist SEND programmes
- Early Years Free Entitlement – FWC and Early Years staff call eligible families to promote take-up
- New Births – FWC staff make calls to new birth families to promote FWC registration, service offer and engagement
- 019 Services are co-located at the FWC
- 0-19 Service - offer an antenatal support clinic – FWC staff attend the monthly online workshops to promote the FWC offer, registration and service engagement
- Integrated 2-year checks – plans are developing for FWC staff to complete the integrated 2-year checks in partnership with Health Visitors

- Early Help (including FWC and Early Years staff) contribute to Public Health outreach across Brent (i.e. community days, oral health bus, etc).

### 2.3.2 Infant to School programme

FWCs connects families into the Infant to School programme and vice-versa. Infant to School is delivered by Nursery Nurses from the Health Visiting team who are co-located at the FWC. The evidence-based programme targets vulnerable children from 3 months to 4-years and brings specialist knowledge in child and family health to help support children's development and their physical and emotional wellbeing, as well as parents. Nursery Nurses give guidance on practical issues and link families to other useful health and family support services, parenting groups and other activity at the FWC.

Infant to School has supported families to achieve positive outcomes by improving:

- Parenting capacity
- Children's cognitive development
- Children's speech, language and communication
- Children's social skills and physical development

The impact is more children are school ready and parenting capacity and family wellbeing are improved.

### 2.3.3 Maternal Early Childhood Sustained Home Visiting (MECSH)

MESCH evidence-based programme is part of the health visiting service and is offered to vulnerable families during pregnancy up to the child's 2nd birthday. A Health Visitor is paired with a family to build a strong and trusted relationship. MESCH includes regular home visits, personalised support, practical guidance and connecting families into local community services including the FWC.

MESCH has supported families to achieve positive outcomes by improving:

- parental mental health and confidence
- child development, communication and oral health
- creating safer home environments.

The impact is more children are school ready and parenting capacity and family wellbeing are improved.

### 2.3.4 Infant Feeding

Infant feeding clinics have been delivered across all FWCs during the year. The clinics are free and available to all families living in Brent. The clinics are supported by Health Visitors and a Lactation Consultant who can tackle more serious concerns. The Health Visiting service has trained twelve peer-to-peer breastfeeding champions who support breastfeeding work across the FWCs. This and other work to promote breastfeeding has led to an increase in breastfeeding rates across Brent. The FWC were reaccredited to November 2027 with the NICEF Baby Friendly Initiative (BFI) Stage 3. Accreditation confirms that health services (maternity, neonatal, health visiting and children's centres) have fully implemented sustainable standards to support breastfeeding and relationship building.

### 2.3.5 Period Dignity

The FWC give out free period products to women and girls via a Public Health funded project with Hey Girls. Hey Girls, are a social enterprise who aim to eradicate period poverty in the UK, improve access to quality products, and increase education around period health and eliminate shame.

### 2.3.6 GPs

Partnership working with GPs has progressed significantly this year and some of the new initiatives in development with the FWC are outlined below:

- Child Health Hubs - clinics run by paediatricians and GPs from local surgeries which see children face-to-face. We have ensured that the Child Health Hub GPs are aware of the FWCs offer, so that suitable patients can be referred directly and we have mapped FWCs against the Child Health Hubs, so every GP knows which FWC covers their area.
- FWC staff representatives now attend the Child Health Multi-Disciplinary Teams (MDTs) and GPs report their input on often complex cases has been invaluable. FWCs are made aware of vulnerable families who may not typically register with the FWC, or take-up services or support, and can use the information from MDTs to reach out to families, helping to reduce barriers to accessing services. Parent Champions were used to contact less heard from families and complete outreach in specific communities with the aim of increasing take-up of FWC services.
- The work and role of the FWCs are promoted to GPs in lunch and learn sessions, primary care network (PCN) meetings and in GP training. We have created an easy referral route via email and have piloted the Joy App to onboard the FWCs to make referrals simpler.
- We have collated all children's services in the Brent Happy and Healthy Child Directory, which has been distributed to patients and GPs and includes contact details for all FWC.
- GPs have developed a new Locally Enhanced Service a comprehensive biopsychosocial health check for children aged 6–10, screening for mental and physical health concerns as well as social factors (using WWHAM questions: household, finances, food security, etc). GPs are encouraged to refer families identified through this check to the FWC.
- CYP community link workers have been recruited who operate across the Brent and support families facing social determinants of health. They have been helping to register more families with the FWCs.

Additional initiatives in the pipeline include:

- A GP trainee is leading a quality improvement project to identify and support young carers, using GP records to flag potential carers and invite them to support events at their local FWC which the GP will also attend
- Local paediatricians have expressed interest in running clinics for children and families who are frequent A&E attenders for non-urgent issues with the aim of hosting these clinics within FWCs
- FWC are keen to offer some services resources permitting at GP Surgeries where space permits, for example such as accredited parenting programmes, stay and play sessions, registering families for FWC services, with the aim of strengthening partnership working between GP and FWC.

Neighbourhood working in health hubs will continue to develop in the new reporting year.

### 2.3.7 Brent Health Matters

The FWC work in partnership with Brent Health Matters, including Community Connectors. The aim is to tackle health inequalities by bringing healthcare and wellbeing support into local communities, targeting residents who traditionally struggle to access health services due to language or cultural barriers. Brent Health Matters service include:

- Asthma Community Coaches – FWC Community Champions have been trained to help families manage childhood asthma and use inhalers correctly.
- Community Champions - A network of local volunteers who help design public services and spread vital health messages among the borough's diverse communities. The volunteer programme has been promoted families accessing the FWC.
- Outreach & Advice - They employ dedicated health inequalities pharmacists and provide community grants of up to £10,000 to local charities and organizations to support residents
- Community Health Pods - Self-service pods in local libraries and community centres where residents can check their blood pressure, weight, and heart rate, with abnormal results sent directly to their GP. These could be hosted at FWC during the next reporting period.

The impact of the service has been to help reduce health inequalities across Brent and improve health outcomes for families.

### 2.3.8 Parent and Infant Relationship Service (PAIRS) and Child and Adolescent Mental Health Service (CAMHS)

The PAIRS has expanded across the FWC network and is now well embedded reaching more families in need. The PAIRS team offers support for families with mild to moderate perinatal mental health and parent-infant relationship concerns. The service covers pregnant women and families at risk of mild to moderate mental health problems, who are receiving support via maternity, health visiting, school nursing and council services. The service extends to fathers and co-parents and the overall familial relationship with the infant, with the infant remaining the focus of the work. PAIRS supports families with 0–2-year-olds and works seamlessly with CAMHs who focus on families with 3–5-year-olds. There is a single point of referral and families are triaged and connected into the appropriate service depending on need.

### 2.3.9 Midwifery Services

Midwifery services from Imperial College Healthcare Trust and London Northwest Healthcare Trust (LNWH) are collocated at the FWC. The midwives provide comprehensive antenatal and postnatal care to families at the FWC. Having families attend the FWC for antenatal appointments is key to engaging parents early, breaking down barriers to access and developing trusted relationships with staff at the centres so they continue to access support after the cessation of midwifery services.

## 2.4 National initiatives

### 2.4.1 Family First Partnership Programme

The Early Help and Social Care department embarked on a new redesign programme to better support more holistic, joined up working and ensure we have a modern, fit-for-purpose service model, in line with the Government's Families First reform programme. A set of key design principles underpinning the development of the model were adopted as follows:

- Ensure that Children and Young People are at the centre of everything we do

- Reduction in silo-working between departments
- Minimising and streamlining handover points between teams
- Minimise assessments and duplication for children and families
- Create greater opportunities for shared learning and experience building between teams
- Greater consistency for children and families
- Increase practitioners' capacity to build strong relationships with children and families
- Supporting the recruitment and retention of Key Workers and Social Workers
- Improving the experience of Children and Families engaging with the Early Help and Social Care services.

The new delivery model went live on 2 June 2025. Key Workers moved from the FWC to form new teams at the Civic Centre and Willesden Library but retain links to their respective FWC.

### 2.4.2 Reducing Parental Conflict

Funding for the DWP Reducing Parental Conflict programme provides relationship support for families ranging from universal to specialist interventions. Brent received £38k during the financial year and this was used to:

- raise awareness of the negative impact of intense and sustained parental conflict on child outcomes via a multiagency training programme
- online resources are available from the Council's parenting website to support families and practitioners with parental conflict
- Triage workers deliver the Triple P Family Transitions parenting programme and use this in their day-to-day work with parents in conflict
- 1-to-1 support is also available for parents having challenges with co-parenting related issues.

### 2.4.3 Family Hubs and Best Start for Life

The Start for Life programme puts Family Hubs as the key delivery point for integrating support services from maternity through the early years. Local Family Hub networks consist of both physical and virtual places where services to support families come together, from birth registration to midwifery, health visiting, to mental health support, and parenting courses, to infant feeding advice, parent/ carer forums and promoting the offer. This work links to the Brent Early Years Strategy and Best Start in Life local delivery plan 2026-2029 as detailed in section 1.6.




**Figure 5: Baby Massage at Church Lane FWC**

This Government programme helps to ensure the best support is available to families in the first 1,001 days, identified within the report as 6 priority action areas, has made significant progress in Brent and met delivery plan targets as agreed with the DfE. The programme was funded until March 2026 and transitions into the new Best Start Family Hub and Healthy Babies programme from 2026, with funding committed until March 2029.

### 2.4.4 Neighbourhood Health

The government aims to put a 'neighbourhood health service' at the heart of its vision for the NHS. The programme aims to help people live well in their local communities and reduce their need for care delivered in hospitals. It involves multi-disciplinary teams across health social care and CVFS working together to promote prevention, manage long-term conditions and keep communities independent. In Brent this has included establishing Child Health Hubs and Child Health Multi-Disciplinary Teams. An overview of how the FWC link to this work is detailed in section 2.3.6.

## 3. Current Challenges and Key Priorities 2026/27

3.1 Families continue to present at the FWC significantly impacted by the cost-of-living crisis. Families are triaged and connected into appropriate support as quickly as possible. The Triage service links families into Brent's Crisis Response Fund and Barnardo's Poverty and Cost of Living Crisis Fund that provides direct, practical relief to vulnerable families. This includes for example supermarket vouchers, gas/electricity top-ups, and essential household items like beds and bedding.

3.2 To support sustainable staffing arrangements within hub settings work is progressing to ensure that links between the new Family Support Teams and FWCs remains strong and families are connected into the wider early help offer. New posts, such as Best Start Inclusion Practitioners, at the FWC will be created using Best Start Family Hub funding and this will help to increase staffing numbers.

3.3 Given the high number of partnerships involved increases the complexity of the operational delivery model. This includes at times for example resource limitations, time lags, communication issues or conflicting agency agendas. Strong governance arrangements at strategic and operational levels help to ensure that multi-agency partnership working is effective, issues are addressed as and when they arise and escalated for more senior input when necessary.

3.4 The FWC improvement priorities for 2026/27 are:

1. Deliver year 1 of the Best Start in Life, Family Hub and Healthy Babies programme and rebrand the FWC to Best Start Family Hubs. Working in partnership with multi-agency stakeholders towards achieving the DfE targets of 76% Good Level of Development and 79% take-up of Early Years Free Entitlement by 2029
2. Expand the out of hours delivery model, including access to support via telephone and video appointments, using a hybrid delivery approach
3. Support the development of wider system reforms including the Family First Partnership programme, SEND, Early Years and Working in Neighbourhoods (WiN)
4. Expand the Family Financial Resilience programme and deliver Financial First Aid training to multi-agency front line practitioners

5. Complete capital transformation works to St Raphaels, Preston Park and Willow FWC. Develop plans for the new Granville FWC that is being constructed as part of the South Kilburn regeneration programme.

## 4. Building and Resources

4.1 There are ongoing low level maintenance issues with the FWC buildings that are addressed via the contract with Facilities Management and capital funding. Cleaning, gardening and window cleaning services are included as part of the Facilities Management contract. Separate arrangements via the school partnership MoU are in place for Curzon Crescent and Fawood FWC. The FWC building priorities for 2026/27 are:

- The plant room at St Raphael's FWC will have a heat pump installed and this will require temporary closure of the FWC to accommodate the works.
- In July 2026 Granville FWC moved into temporary accommodation, the old adjacent Brent Start building. A new permanent site for Granville FWC will be built linked to local area regeneration plans in South Kilburn. It is anticipated the FWC will be hosted at the temporary site for at least 2 years.
- The outside play area at Preston Park FWC will be upgraded and officers are aiming to secure additional space to maximise the garden footprint
- Willow Nursery will have an awning installed to enable greater access to outside space by the children. Some internal reconfiguration of rooms is required to facilitate an increase in childcare places. Air conditioning needs to be installed in first floor rooms subject to sufficient capital funding being available.

## 5. Service user feedback

5.1 Service user feedback and engagement with families is used to co-produce the FWC delivery model to ensure that services and support offered actively engages families and meets their wide-ranging needs.

5.2 A Parent Carer Voice Forum meets regularly to ensure there was a strong parent voice in shaping the offer. Parents were recruited with children at different ages and stages, children with SEND, dads, and pregnant parents to ensure a diverse group and a wide range of views are captured.

5.3 Parents are involved with FWC local governance arrangements and are represented on the LSG.

5.4 A management board has been established at Willow Nursery and FWC including parent representatives.

**Appendix 1**

<table>
<tr><th colspan="2">FWC core service offer</th></tr>
<tr>
<td>

**HEALTH**

- Antenatal and maternity care
- Infant feeding support
- Health visiting
- School nursing
- Oral health improvement
- Speech and language development
- General health, registering with GP, information on local hospitals
- Keeping fit and active
- Nutrition, weight management, healthy cooking
- Information on common childhood illnesses
- Immunisations
- Parent-Infant Relationships and Perinatal Mental Health Support
- Mental health services (beyond Start for Life parent-infant mental health)
- Healthy Start vitamin project
- Stop smoking support

**PARENTS AND CARERS SUPPORT**

- Dads/ Male Carers support
- Employment, including getting ready for work, (CV writing, job searches)
- Adult education i.e. ESOL and Maths courses
- Debt and welfare advice (claiming benefits, debt management, budgeting)
- Housing advice (homelessness, renting)
- Legal advice (immigration, employment, marital)
- Parent / Carer emotional wellbeing

</td>
<td>

**EDUCATION**

- Early Childhood Education and Care (ECEC) and financial support (Tax-Free Childcare, Universal Credit childcare)
- Early Language and the Home Learning Environment
- Applying for a school place
- Starting school
- Transitions
- Improving school attendance
- Homework clubs
- Education, employment support for young people (13-16, 16+)
- Activities for early years/ primary and secondary
- Support for families with children with Special Educational Needs and/ or Disabilities (SEND)

**FAMILY SUPPORT**

- Parenting programmes
- Workshops on setting routines and boundaries
- Staying safe on computers, phones and at home
- Relationship support
- Support for separating and separated parents and their children
- Intensive targeted family support services, including those funded by the Supporting Families programme
- Substance (alcohol/ drug) misuse support
- Youth Justice services
- Youth services - universal and targeted
- Domestic abuse support (adults and children)
- Parents as First Teachers (PAFT)

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| | |
|---|---|
| Brent NHS West and North London | **Brent Health and Wellbeing Board**<br>9 November 2026 |
| | **Report from the Corporate Director of Service Reform and Strategy** |
| | **Cabinet Member for Community Safety and Public Health** |

# Brent Gambling Harms Prevention Strategy 2026-2030

| | |
|---|---|
| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | Key |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **List of Appendices:** | Appendix A - Brent Gambling Harms Prevention Strategy 2026-2030<br>Appendix B - Equality Impact Assessment |
| **Background Papers:** | Gambling Needs Assessment 2024<br>High streets at stake: The rise of Adult Gaming Centres |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Ruth du Plessis<br>Interim Director of Public Health and Leisure<br>Ruth.du-Plessis@brent.gov.uk<br>020 8937 3411<br><br>Katie Shevas<br>Change and Improvement Officer- Policy<br>Katie.Shevas@brent.gov.uk<br>020 8937 1040 |

## 1.0 Executive Summary

1.1 This report shares the draft Brent Gambling Harms Prevention Strategy 2026-2030 for comment and endorsement by the Health and Wellbeing Board. This strategy will also go to Cabinet for approval.

1.2 Brent is already leading from the front on gambling harms prevention. We conducted a gambling Joint Strategic Needs Assessment in 2024, which gave a clear insight into the high level of gambling and gambling harm within the borough and highlighted the need for intervention. In response, the Council has spearheaded a national campaign to lobby government to grant local authorities greater powers to prevent the proliferation of gambling venues on our high streets- this campaign has led to the government recently announcing a series of key changes.

1.3 The purpose of this strategy is to build on this strong foundation of leadership and set out a clear programme of action for the coming years. The strategy seeks to continue our role in driving change nationally, and to bolster our local approach to preventing and tackling the harm caused by gambling. The strategy is focused on strengthening our local offer of prevention, early intervention and support and challenging the wider systems and environments that contribute to gambling-related harm. It seeks to establish stronger partnership working, recognising the role we all must play in tackling gambling harm.

## 2.0 Recommendation(s)

2.1 The Health and Wellbeing Board is asked to endorse the Gambling Harms Prevention Strategy 2026-2030, which will also go to Cabinet on 7 December 2026.

## 3.0 Detail

### 3.1 Contribution to Borough Plan Priorities & Strategic Context

3.1.1 The new Council Plan, which will be considered by Cabinet on 9 November 2026 and Full Council on 16 November 2026, sets out three priorities that will guide everything Brent Council does as an organisation. Subject to the Plan being approved by Council, this strategy will directly support delivery of two of these priorities.

3.1.2 Under ‘A borough to be proud of’, the strategy will contribute to the ‘Thriving town centres and high streets’ focus area. The strategy directly ties into one of the commitments set out in this focus area; to continue to take strong action to reduce the concentration of premises that undermine community wellbeing, including gambling arcades. By strengthening our commitment to preventing the proliferation of gambling premises and creating stronger mechanisms to do so, we will contribute to high streets that better meet the needs of our communities and increase pride in our high streets and town centres.

3.1.3 The strategy will also support ‘A borough where people thrive’, particularly the ‘Healthy and active communities’ focus area. Within this focus area, the Council commits to work to reduce health inequalities and make it easier to access early support. The strategy adopts a public health approach, recognising that gambling harm can have significant and far-reaching impacts on the health and wellbeing of individuals, families and communities. We will strengthen pathways into appropriate support for those experiencing gambling harm, while taking action to prevent harm from occurring in the first place.

### 3.2 Background

<u>Context</u>

3.2.1 We know that Brent residents are disproportionately affected by gambling harm. Brent is among the areas with the highest number of gamblers who experience the most negative consequences as a result of gambling. 17.1% of people in

Brent are considered to be gambling with a low-level of risk (vs 13.4% in the rest of the country), while 6.2% are considered to be gambling with the highest level of risk (compared with 2.9%). The economic cost of gambling in Brent was estimated at £14.3 million in 2022 – a sevenfold rise from £2 million in 2012 – ranking it among the most affected boroughs for fiscal gambling related-harm. Brent also has one of the highest number of gambling premises in London.

3.2.2 Brent's demographic profile matches many of the risk groups most likely to gamble and/or experience harms from gambling. Brent has a younger than average population, high numbers of ethnically diverse communities, and is ranked the fourth most deprived borough in London.

3.2.3 In recognition of the impact of gambling in Brent, work has been ongoing to get a better understanding of gambling in the borough. To build a clearer picture of gambling harms in Brent, we conducted a Joint Strategic Needs Assessment, drawing on evidence and qualitative research to demonstrate the extent and impact of gambling in the borough. Brent also commissioned a report by the Social Market Foundation on the impact of Adult Gaming Centres (AGCs), which explored the rise of AGCs and recommended ways local authorities could be empowered to tackle gambling-related harm on our high streets.

3.2.4 Alongside this, we established a sustained public affairs campaign, lobbying decision makers to strengthen local powers and to take action to reduce the harm gambling causes our communities. In 2025, the Leader of the Council wrote an open letter to the government on gambling harms. Signed by 39 other local authorities, mayors and campaign groups, the letter called for stronger local powers. We have consistently raised the issue of gambling harm, creating and sustaining a national conversation about the challenges people are facing and the need for change. On 11 August 2026, the government announced its intention to revoke the 'Aim to Permit' rule, giving councils stronger power to refuse applications for new gambling premises. The government also announced its intention to require planning permission for AGCs, making it harder for new venues to open. These changes are due to come into effect in early 2027.

Funding

3.2.5 The Office for Health Improvement and Disparities has awarded Local Authority Public Health Teams some funding to support the delivery of needs assessment and strategy development. The national programme covers 2026/27 and 2027/28. The strategy will guide the prioritisation of this funding in line with local need and the agreed programme requirements.

Developing the strategy

3.2.6 The strategy was developed through the use of existing data and insight, and a series of engagement exercises designed to identify and refine the key strategic priorities.

3.2.7 Key engagement exercises included a Gambling Strategy workshop which brought together partners, including Betknowmore UK, B3 (Brent's peer support and advocacy drug and alcohol service), staff and residents with lived experience of gambling harm. The workshop provided an opportunity to explore local priorities, experiences and perspectives, helping to inform the overall direction of the strategy and identify emerging priorities.

3.2.8 A series of focused priority scoping meetings were then held with key staff, with each session centred on an emerging strategic priority. These meetings were used to further develop the priorities, clarify the intended ambitions and identify the actions required to support their delivery.

3.2.9 The strategy has also been informed by:

- Brent's Gambling Joint Strategic Needs Assessment
- Published evidence and research on gambling and gambling harms
- The Social Market Foundation's report commissioned by Brent on Adult Gaming Centres
- National guidance, including from the Office for Health Improvement and Disparities

3.2.10 The draft strategy was shared for feedback with a range of key stakeholders, including gambling charities, local organisations who support residents with lived experience of gambling harms, all members of the Health and Wellbeing Board and key officers.

The strategic priorities

3.2.11 Our ambition is for Brent to be a borough where fewer people experience gambling-related harm, support is available early and without stigma, and organisations work together to prevent harm before it occurs. The strategy takes a public health approach. This means looking beyond individual gambling behaviour to the wider factors that influence harm, including gambling products and industry practices, local availability and exposure, socioeconomic circumstances and national and local policy.

3.2.12 Below are the 4 strategic priorities proposed in the draft strategy, with a brief description of what this means:

**Priority 1: Raising awareness and driving change**

We will raise awareness and understanding of gambling-related harms across Brent through communications and educational campaigns and help those impacted by gambling harms via support pathways. Alongside this, we will continue to advocate for stronger government legislation and local powers to reduce gambling-related harm in our communities.

**Priority 2: Embedding a data-led approach**

Data will be at the core of our approach to tackling gambling harms. We will build a robust local evidence base on gambling related harm in Brent to guide

decisions for future interventions and support. This will also strengthen our ability to refuse planning and licensing applications for gambling presences in the borough.

**Priority 3: Regulation, planning and enforcement**

To reduce the harms caused by gambling, we also need to reduce one of the causes – gambling premises. We will make robust, lawful and proportionate use of the Council's available planning, licensing and enforcement powers to address gambling-related risks and support safe, diverse and sustainable high streets.

**Priority 4: Improving pathways to support**

We will work with partners, support services, and colleagues across the Council to strengthen our processes for earlier identification of individuals at risk of experiencing gambling harms. Anyone at risk will have access to newly developed clearer, and more effective pathways to support.

Delivering the strategy

3.2.13 To support the successful delivery of the strategy, the following activities are initially planned:

**Action plan**

A detailed action plan will be developed, setting out the specific activities that will take place to achieve each priority. This will include lines of responsibility and set clear timescales for delivery.

**Gambling Harms Partnership**

Tackling tackle gambling harm in Brent will require strong partnership working, with organisations across the borough, coming together to coordinate activity, share expertise and take collective action. The draft strategy proposes establishing a Gambling Harms Partnership, bringing together Council services and key partners, including the NHS and VCFSE sector. Its role will include providing local leadership, supporting effective partnership working and monitoring progress against the strategy.

Next steps

3.2.14 Subject to endorsement by the Health and Wellbeing Board, the strategy will be considered by Cabinet on 7 December.

## 4.0 Stakeholder and ward member consultation and engagement

4.1 Engagement with stakeholders took place throughout the process for developing the strategy. As detailed in section 3.2.6 a workshop with various

stakeholders was held to establish the key themes that the strategy could address. Subsequent scoping meeting with staff were then conducted to refine these themes into focused priorities.

4.2 The draft strategy was shared for consultation with a range of key stakeholders, including gambling charities, local organisations who support residents with lived experience of gambling harms, partners on the Health and Wellbeing Board and key officers.

## 5.0 Financial Considerations

5.1 This report seeks endorsement of the Gambling Harms Prevention Strategy 2026-2030.

5.2 Brent has been awarded funding through the Office for Health Improvement and Disparities (OHID) Gambling Harms Prevention Grant for 2026/27. A spending plan has been submitted to OHID with the grant progress update, covering expenditure to date and forecast expenditure for the remainder of 2026/27.

5.3 Funding will be used for eligible gambling harms prevention activity, with payments made within 2026/27 in accordance with the memorandum of understanding. Funding is not transferable between financial years, and unspent or ineligible funding may be recovered.

5.4 The national funding programme covers 2026/27 and 2027/28. Brent's allocation for 2027/28 is not confirmed, and funding is not secured for the full strategy period. Continuing staffing and contractual commitments will require confirmed funding and will be reflected in the Council's medium-term financial forecast.

## 6.0 Legal Considerations

6.1 The Council has power to adopt and implement the Gambling Harms Prevention Strategy as part of its public-health, community-wellbeing, licensing, planning, safeguarding and partnership functions. The Strategy is a high-level policy framework. Its adoption does not alter the statutory tests applying to individual planning, licensing, enforcement, social-care or safeguarding decisions, each of which must continue to be taken in accordance with the relevant legislation, statutory guidance and the particular evidence available.

6.2 Brent Council is the licensing authority for the purposes of the Gambling Act 2005. Under the legislation currently in force, the Council must exercise its gambling premises-licensing functions in accordance with relevant Gambling Commission codes and guidance, the statutory licensing objectives and the Council's published Statement of Principles. Section 153 of the Gambling Act 2005 presently requires licensing authorities to "aim to permit" the use of premises for gambling where the statutory requirements are satisfied. Accordingly, general concerns about gambling-related harm, the concentration of premises or local opposition cannot, without relevant supporting evidence

connected to the statutory licensing objectives, automatically justify refusal of an application. Each application must be considered fairly and on its individual merits, without predetermination.

6.3 On 11 August 2026, the Government announced its intention to revoke the “aim to permit” rule and to introduce planning controls requiring Adult Gaming Centres to obtain planning permission. These are proposed reforms and, pending the necessary consultation, legislation and commencement arrangements, do not change the law currently applicable to the Council’s decisions. The Council will monitor the development of the reforms and review its Gambling Statement of Principles, planning policies, local evidence base and decision-making procedures once the final legal framework is known.

6.4 Actions taken under the Strategy must represent a lawful, evidence-based and proportionate exercise of the Council’s powers. The Strategy must not be applied as a blanket policy against gambling operators or premises, and planning, licensing and enforcement powers should not be used for an improper purpose or as a substitute for powers available under another statutory regime. Decisions should identify the relevant legal power, take account of all material considerations, disregard immaterial considerations and be supported by adequate reasons and evidence.

6.5 The proposed collection, linkage and sharing of information about gambling-related harm may involve personal data and, in some circumstances, special category data concerning health, ethnicity or other sensitive matters. Before new collection or information-sharing arrangements are implemented, the Council and its partners must identify the applicable lawful basis and, where relevant, a condition for processing special category data; ensure that processing is necessary, proportionate, fair and transparent; apply data-minimisation, retention and security requirements; and put appropriate information-sharing agreements and privacy information in place. A Data Protection Impact Assessment must be completed where the proposed processing is likely to present a high risk to individuals. Wherever practicable, monitoring and evaluation should use anonymised or appropriately aggregated information.

6.6 In approving and implementing the Strategy, the Council must comply with the Public Sector Equality Duty under section 149 of the Equality Act 2010 by having due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. The accompanying Equality Impact Assessment should remain under review as the action plan and individual interventions are developed. Communications, engagement and pathways to support should be accessible, avoid stereotyping particular communities and include reasonable adjustments where required.

6.7 The Strategy does not itself create an entitlement to specific care, support or safeguarding intervention. Where gambling-related harm becomes apparent, the Council must consider whether duties are engaged under the Care Act 2014, children’s safeguarding legislation or other relevant statutory frameworks. Any assessment, safeguarding enquiry or service provision will

remain subject to the applicable statutory criteria, individual circumstances, professional assessment and lawful commissioning arrangements. Gambling behaviour or an apparently unwise financial decision does not, without more, establish that a person lacks capacity under the Mental Capacity Act 2005.

6.8 Any commissioning, grant-funding or partnership arrangements arising from the Strategy must comply with the Council's constitutional and financial procedures and all applicable procurement, subsidy-control, contractual and information-governance requirements. The proposed Gambling Harms Partnership should operate under clear terms of reference setting out its membership, remit, accountability, decision-making and reporting arrangements. It should not fetter the discretion of the Council's statutory decision-makers or be treated as having authority to determine individual licensing, planning, safeguarding or service-entitlement matters.

## 7.0 Equity, Diversity & Inclusion (EDI) Considerations

7.1 The Public Sector Equality Duty, as set out in section 149 of the Equality Act 2010, requires the Council, when exercising its functions, to have "due regard" to the need to eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act, to advance equality of opportunity and foster good relations between those who have a "protected characteristic" and those who do not share that protected characteristic. The protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. The council also internally recognises care experience and socio-economic status as protected characteristics.

7.2 The strategy has been subject to an EIA (Appendix B) and officers believe that there are no adverse equality implications. The strategy is expected to have positive impacts on all residents who are affected by gambling. In particular it is expected to have positive impacts on groups most vulnerable to the harm caused by gambling, including young people, men, multiethnic groups and those experiencing socio-economic disadvantage and poverty

## 8.0 Climate Change and Environmental Considerations

8.1 There are no climate change and environmental considerations for this report.

## 9.0 Communication Considerations

9.1 Communications will play an important role in supporting the delivery of the Gambling Harms Prevention Strategy, particularly through Priority 1: Raising awareness and driving change. A borough-wide communications campaign will be developed to increase awareness and understanding of gambling-related harms, challenge stigma and ensure residents know where they can access help and support. This will bolster our existing public affairs work, expanding our communications focus beyond lobbying. Work is ongoing with the Communications Team to develop the approach.

***Report sign off:***

***Rachel Crossley***
Corporate Director of Service Reform and Strategy

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# Brent Gambling Harms Prevention Strategy

2026-2030

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# Foreword

I am proud to introduce Brent's first Gambling Harms Prevention Strategy, which sets out our vision for a borough where fewer people experience harm from gambling, where people can access support early and without stigma, and where we work together to prevent harm before it happens.

The harm caused by gambling is a significant public health issue, and one that can too often remain hidden. Its impact can be devastating, affecting people's mental and physical health, financial security, relationships, employment and housing. The consequences can also reach far beyond the individual, affecting families, children and our wider communities.

We know that people in Brent are affected by gambling-related harm, and we are determined to do more. We have already taken a stand, calling on government to give councils greater powers to prevent the proliferation of gambling premises and better protect our high streets and communities. In July, councillors for all political groups unanimously passed a motion declaring a gambling harms emergency in Brent and committing to develop a Gambling Harms Strategy. This strategy delivers on that commitment, setting out how we will strengthen prevention, improve access to support and take stronger action to reduce gambling-related harm across Brent.

We cannot tackle this issue alone. We will work alongside residents, communities, the NHS, voluntary, community, faith and social enterprise organisations, and other partners to make sure people know where to turn for help and feel able to ask for it. We will work together to reduce inequalities, challenge stigma and make support easier to access.

Our ambition is simple: a Brent where people can enjoy their lives without experiencing gambling-related harm, where those who need help can get it early, and where no one affected by gambling feels they have to face it alone.



Councillor Liz Dixon

Cabinet Member for Community Safety and Public Health

# Introduction

This is Brent's first Gambling Harms Prevention Strategy. The strategy provides the high-level framework for our approach to tackling gambling harms in Brent, setting out our vision and priorities. It sets out our commitment to adopting a public health approach to preventing and reducing gambling-related harm across the borough. It describes how we will work to reduce risk, intervene earlier and make the best use of the powers and resources available to us across the Council to improve outcomes.

We've already led national efforts to lobby the government to grant local authorities more control over the gambling establishments in their area. In 2025, the Leader of the Council wrote an open letter to the government. Signed by 39 other local authorities, mayors and campaign groups, the letter called for reform to the powers councils have to prevent the proliferation of gambling venues on our high streets. We have consistently raised the issue of gambling harm, creating and sustaining a national conversation about the challenges people are facing and the need for change. Brent's work contributed to the national debate about the powers available to councils to address the concentration and impact of gambling premises. In August 2026, the Government announced proposals to strengthen licensing and planning controls.

Alongside this work, we have begun to build a picture of gambling harms in Brent, including through a Joint Strategic Needs Assessment, and commissioning a report by the Social Market Foundation on the impact of Adult Gaming Centres.

This strategy builds on this strong foundation of leadership and sets out a clear programme of action for the coming years to both continue our role in driving change and create a more coordinated local approach to tackling the harm caused by gambling. It builds on the Council's commitments to take action on the proliferation of gambling premises in the borough and to adopt a preventative approach to tackling health inequalities.

We recognise that gambling harms are a complex, and often a taboo subject, meaning that many harms remain hidden. It is therefore essential that we change the narrative around the harms that gambling cause and shift blame away from individuals. Our ambition is for Brent to be a place where gambling-related harm is reduced and people have timely access to appropriate support, with Council services, partners and residents working collectively to support individuals without stigma.

This strategy covers four key priorities for addressing gambling harms in Brent:




We have developed this strategy using the best available evidence alongside the experiences of people who live and work in Brent. We have brought together findings from our Joint Strategic Needs Assessment, engagement with residents, workshops with partners and staff, published research, guidance from the Office of Health Improvement and Disparity (OHID) and conversations with people who have lived experience of the harms of gambling. This has built a clear picture of gambling and gambling-related harm across the borough and gives us a strong case for change.

# What are gambling-related harms?

Gambling is an activity which involves risking money or something of value on an uncertain event or outcome, with the hope of winning more. This includes gaming (for example slot machines, card games and casino games), betting, bingo and lotteries. The risk of harm varies according to the product, its design and accessibility, patterns of participation, marketing and the circumstances of the individual and community.

Gambling harm is the negative impact that gambling has on the mental, physical and financial health and wellbeing of individuals, families, communities and society. Research shows that 2.7% of UK adults, around 1 in 37, experience problem gambling[i]. This means that they have experienced severe negative consequences as a result of gambling.

Research shows that the harms associated with gambling can be wide-ranging. **Gambling harms don't just affect the person who gambles**. They can impact their families, friends and wider society (known as 'affected others'). Affected others can experience the same types of harm at the same severity as those experienced by the individual who is gambling.

## Types of harm include:

| | |
|---|---|
| Health | Studies show that harms to health for an individual who gambles can include sleep problems, neglecting proper personal care, and experiencing emotions such as guilt, shame, loss of self-esteem and loneliness. Heavy gambling is associated with over 35% increased mortality rates[ii]. Deaths from suicide are significantly higher among adults with gambling disorder[iii]. |
| Financial | This is the most direct form of harm experienced by gamblers and their affected others. Financial difficulties due to gambling can result in bankruptcy, relationship problems, mental health issues and homelessness[iv]. |
| Relationships | It is estimated that, for every person who is directly affected by their own gambling, there is, on average, six more people indirectly affected[v]. Evidence shows that those engaging in problem gambling experience lower levels of family functioning, including arguments, relationship strain and domestic abuse. |
| Employment and education | Performance at work, school or university can be affected by gambling. Children of gamblers can experience difficulties at school due to a chaotic home life. Gambling has been shown to increase the risk of absenteeism, job turnover and withdrawal from education. |
| Crime | There is low to moderate evidence that links gambling with criminal activity. This data is extremely hard to quantify as the crime is often recorded for what it is, but rarely includes what motivated the crime. Crimes committed by gamblers often involve theft or fraud – usually as a way to pay off accumulated debts.[vi] |

Gambling harms do not always present as an obvious or immediate problem. They can develop gradually, may be difficult to recognise and can remain hidden until they become more serious. Sometimes people are not aware themselves of how harmful their gambling has become until they are experiencing severe harm and even then, some people are unable to stop. Gambling is also not always the presenting cause of a person's difficulties. Someone may initially seek support for issues such as financial problems, debt, relationship difficulties, poor mental wellbeing or housing insecurity, with gambling only identified as an underlying or contributing factor later.

## People more likely to be affected by gambling harms[vii]

Though gambling harms can affect anyone, they are most strongly experienced by men and those living in areas with higher levels of deprivation. Experiences of gambling harms often coexist alongside other difficulties like mental health issues and substance misuse.

**Gender**

Numerous studies have shown that men gamble at a higher rate than women. Research also shows that men are more likely to gamble as a habitual activity. However, while women are less likely to gamble than men, the gender gap is shrinking as the number of women who gamble, particularly online, is on the rise. Women with online gambling accounts were recently found to spend more time on each session than men. Nearly half of women who gamble say they do so in the hope of winning money to help with the cost of living. There are also differences in how men and women are targeted by gambling companies (men through sport and women through bingo for example) but always with the aim of getting people into high risk fast paced forms of gambling.

**Ethnicity**

Some research indicates differences in the prevalence and severity of gambling-related harm between ethnic groups. Some research shows that people from ethnic minority groups are more likely to experience gambling harm than white populations.

**Deprivation**

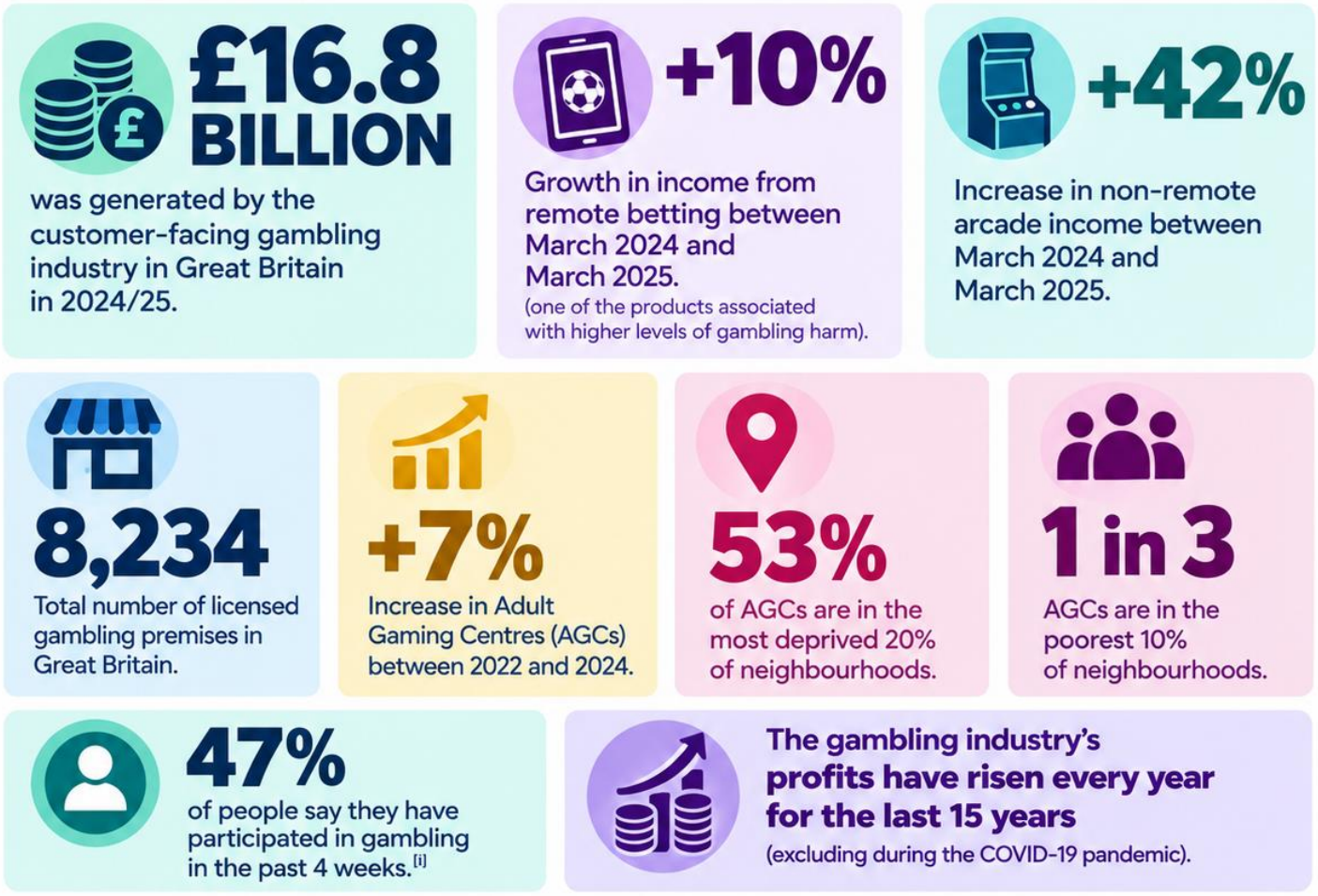
Studies have shown that many gambling premises are often located near potentially vulnerable populations in the most deprived areas. A 2020 report[viii] found that 21% of the UK's gambling premises were based within the most deprived decile in the country, while just 2% were in the least deprived decile. People living in the most deprived areas are more likely to gamble compared to those in the least deprived, and more likely to experience gambling problems. Their gambling activities also differ – those living in more deprived areas are more likely to gamble on faster-paced games such as scratch cards or slot machines, while those living in less deprived areas are more likely to bet on sport activities.

**Age**

Age is another factor associated with the likelihood of experiencing gambling harms. While participation in gambling is lowest amongst 16-24 year-olds, they are more than three times as likely to experience the most extreme levels of gambling-related harm.

# Where we are now

## The national picture[ix]




## Regulation and licensing of gambling in the UK

Around 28% of gambling is done in-person rather than on digital platforms. The Gambling Act 2005 regulates gambling in Great Britain. Under the Act, local authorities are responsible for issuing licences for land-based gambling premises (including bookmakers, adult gaming centres and bingo halls). The Gambling Commission regulates commercial gambling at national level, while local licensing authorities exercise premises-licensing, compliance and enforcement functions under the Act.

Under the Gambling Act 2005, Brent Council is the licensing authority for gambling premises in the borough. In exercising its premises-licensing functions, the Council must apply the statutory licensing objectives, relevant Gambling Commission codes and guidance, and its published statement of principles. The current legislation requires licensing authorities to 'aim to permit' premises use where the statutory criteria are met. General public-health concerns or local opposition are not, by themselves, freestanding grounds for refusal, although robust local evidence may be relevant where it demonstrates a connection with the statutory licensing objectives, including protecting children and other vulnerable persons from harm or exploitation.

On 11 August 2026, the government announced its intention to revoke the statutory 'aim to permit' rule and proposed that Adult Gaming Centres should require planning permission. At the date of this strategy, the detail and timing of these measures remain subject to consultation, legislation and commencement arrangements. The Council will monitor developments and review its approach when the final legal framework is confirmed.

## Gambling in Brent

### What we already know[x]

Brent's demographic profile matches many of the risk groups most likely to gamble and/or experience harms from gambling. Brent has a younger than average population, high numbers of ethnically diverse communities, and is ranked the fourth most deprived borough in London; all of which are risk factors which could result in experiencing increased gambling harm. These characteristics may intersect with other social, economic and individual factors associated with gambling-related harm, but experiences and levels of risk are not uniform within or between communities.

Available estimates indicate that Brent may have comparatively high levels of gambling-related harm as measured using the Problem Gambling Severity Index (PGSI), a screening tool used to assess gambling behaviour and associated risk in the general population. 17.1% of people in Brent are considered to be gambling with a low-level of risk (vs 13.4% in the rest of the country), while 6.2% are considered to be gambling with the highest level of risk (compared with 2.9%). The economic cost of gambling in Brent was estimated at £14.3 million in 2022 – a sevenfold rise from £2 million in 2012 – ranking it among the highest boroughs for fiscal gambling related-harm.

Brent has one of the highest numbers of gambling premises in London. In some wards, it is easier to find a place to gamble than a major supermarket. In 2025, Brent Council commissioned a report from the Social Market Foundation which explored the rise of Adult Gaming Centres and made recommendations on ways local authorities should be empowered to tackle gambling-related harm on our high streets. The report found that some professionals supporting vulnerable people in Brent believe that clusters of gambling venues in the borough have a detrimental impact on the community

In Brent, gambling premises tend to be clustered in more deprived areas, particularly around Harlesden, Kensal Green, Kilburn and Wembley Central, which all boast busy high streets and good transport links. In Harlesden, there are seven betting shops within 600m, and ten in a mile stretch in Willesden.

# Our approach to change

The evidence is clear: stronger action is needed to prevent and reduce gambling-related harm in Brent.

Our ambition is to create a borough where fewer people experience gambling-related harm, support is available early and without stigma, and organisations work together to prevent harm before it occurs.

A public-health approach recognises that gambling carries differing levels of risk and that harm is shaped by the interaction between products, industry practices, availability, marketing, social and economic conditions and individual circumstances. Prevention should therefore include proportionate population-wide, targeted and individual interventions.

Brent recognises that gambling-related harm can arise from a complex interplay between gambling products, industry practices, government policy, local conditions, and individuals' circumstances and exposure, rather than from individual behaviour alone.

# Our priorities




Our priorities for tackling gambling-related harms in Brent have been developed through engagement with partners, staff and peer workshops, data analysis, conversations with people who have lived experience and published research, and guidance from OHID. They set out our commitment to making Brent a place where people understand the risks associated with gambling and where those experiencing gambling harms get the right support, at the right time.

Detailed actions, responsibilities, timescales and measures supporting each priority will be set out in the action plan and reviewed through the Gambling Harms Partnership.

## Priority 1: Raising awareness and driving change

We will raise awareness and understanding of gambling-related harm across Brent through communications and educational campaigns and support people affected by gambling harms through appropriate pathways. Alongside this, we will continue to advocate for stronger national legislation and local powers to reduce gambling-related harm in our communities. To achieve this, we will:

1. **Coordinate a borough-wide communications campaign** to increase awareness of gambling harms and the help available for both those gambling, and their affected others. Focused on Brent communities and targeted to specific groups where the data points to increased prevalence of gambling harm, we will work with our communities to raise awareness and understanding.
2. **Work with schools, colleges and youth services** to promote and provide sessions and resources which teach children how to understand and identify the risks and harms associated with gambling and what to do about it.
3. **Make clear our strong opposition to new gambling premises operating in Brent**, continuing our public affairs and communications activity to challenge the proliferation of gambling premises and highlight the harms gambling can cause to our communities.
4. **Continue to advocate for stronger powers for councils to tackle gambling harms**, including lobbying Government to deliver on its commitment to revoke the ‘Aim to Permit’ rule and to give councils greater powers to prevent the proliferation of gambling premises and challenge gambling providers.
5. **Take action on online gambling** where we can, including restricting access to online gambling sites when individuals are using council assets.

## Priority 2: Embedding a data-led approach

Data will be at the centre of our approach to tackling gambling harms. We will build a robust local evidence base to guide decisions for future interventions and support. This will support proportionate, evidence-based interventions and strengthen the evidence available to the Council when exercising relevant planning, licensing, public-health and enforcement functions. To achieve this, we will:

1. **Conduct a comprehensive review of our existing data** and insight to better understand what data is currently available, where gaps exist and where additional data may be required.
2. **Explore opportunities to strengthen our data collection** on gambling-related harm in our existing assessment, referral and recording systems.
3. **Strengthen data sharing arrangements** between internal services, organisations engaged by the council to provide service and external partners to improve the availability of data and insight.
4. **Use data to map geographic hotspots of harm** within the borough, to help us to better target interventions, demonstrate where gambling premises cause harm and to strengthen the decisions we make when considering planning and licensing applications for gambling premises.
5. **Use strengthened evidence and insight** to inform decision-making, target interventions and evaluate impact, including establishing robust baselines of data on gambling in Brent and enhance refusals to gambling premise applications.

Note: Data collected or shared in connection with this strategy will be handled lawfully, fairly, transparently and proportionately. Wherever practicable, monitoring and evaluation will use anonymised or appropriately aggregated information. Appropriate privacy, information-sharing and data-protection arrangements, including Data Protection Impact Assessments where required, will be completed before relevant activity is implemented.

## Priority 3: Regulation, planning and enforcement

To reduce the harms caused by gambling, we also need to reduce one of the causes – gambling premises. We will make robust, lawful and proportionate use of the Council's available planning, licensing and enforcement powers to address gambling-related risks and support safe, diverse and sustainable high streets. To achieve this we will:

1. **Review our planning policies**, with a particular focus on the ongoing review of the Brent Local Plan, which is a key mechanism to enable stronger powers to control the number and location of gambling venues.
2. **Review licensing policies** to maximise the powers we have to reduce the concentration of premises and take effective action against existing providers.
3. **Explore ways to improve how our planning policies and licensing policies work together** to strengthen our powers to refuse new gambling premises applications.
4. **Strengthen enforcement** of our policies, through increased monitoring of and where necessary intervention at gambling premises in the borough. This is with the aim of ensuring that operators are complying with our policies and the law and taking action where required to reduce harm to residents.

### Priority 4: Improving pathways to support

We will work with partners, support services and colleagues across the Council to improve early identification of gambling-related harm and establish clearer and more effective routes to appropriate support. To achieve this, we will:

1. **Work with partners, including through a new Gambling Harms Partnership, to review current support services** to identify where any gaps exist in meeting the support needs of people in Brent and where stronger partnership working may help to strengthen provision in these areas.
2. **Where gaps are identified, work with partners to develop, and where appropriate commission, a clearer and more comprehensive pathway of support**
3. **Map existing contact points** where gambling harm may become visible to the Council **and refine processes to better target intervention at the first opportunity**. This includes working to increase awareness in residents and partners of the range of support available, so that the right support can be sought and provided at the right time
4. **Ensure staff across the council**, including those working in housing, debt advice, social care and public health **receive robust training** on how to recognise gambling harms and where to signpost residents for support.

## How we'll get there

To support the delivery of our priorities, we will develop a detailed action plan setting out the specific actions, responsibilities and timescales needed to achieve the ambitions set out in this strategy. The strategy provides the high-level framework for our approach to tackling gambling harms in Brent, setting out our vision and priorities. The action plan will translate these ambitions into practical activity.

We know that we can't do this alone. The Office of Health Improvement and Disparities (OHID) has provided a framework of recommended approaches and will provide support to local areas in developing their plans. Delivery will take account of the respective responsibilities of the Council, NHS commissioners and voluntary-sector providers and will remain subject to relevant grant conditions, commissioning arrangements and available resources.

Delivery of this strategy will require strong partnership working, with organisations across Brent coming together to coordinate activity, share expertise and take collective action. To support this, a Gambling Harms Partnership will be formed, with membership from across the Council and key partners, including the NHS and VCFSE (Voluntary, Community, Faith and Small Enterprise sector). The primary purpose of this partnership will be to provide local leadership and ensure effective partnership working to address and reduce the impact of gambling harms in Brent. One of their key roles will be to monitor progress against this strategy.

### How we'll measure success

To evaluate the effectiveness of this strategy, we need ways to measure success. We know that there is limited local data available on gambling in Brent at present. This makes it challenging to establish an initial baseline of evidence from which to measure progress. One of the goals of Priority 2 is to establish baselines of data to enable future monitoring of gambling in Brent, and the effectiveness of the actions we take against it. We will continually update appropriate outcome measures within the action plan as data improves.

At the highest level, the outcomes we want to see are:

- **A reduction in gambling-related harm-** A reduction in the number and proportion of people in Brent experiencing gambling at levels associated with the most negative consequences, measured by the Problem Gambling Severity Index (PGSI)
- **Earlier access to support for residents at risk of or experiencing gambling harm**
- **Improved understanding of gambling-related harm**- amongst both staff and residents
- **Stronger regulation and compliance-** Improved compliance by gambling premises with their regulatory responsibilities, supported by an increased programme of targeted, risk-based and proportionate inspections.
- **Stronger management of the local gambling environment**- A stronger evidence base for assessing the number, location and concentration of gambling premises, particularly in areas experiencing higher levels of deprivation or gambling-related harm, and the lawful and proportionate use of the Council's planning, licensing, and enforcement powers where appropriate.

[i] Gambling Survey for Great Britain (Annual Report 2025): Official statistics
[ii] A-Public-Health-Approach-Responsible-Safer-Gambling.pdf
[iii] Gambling-related harms evidence review: summary - GOV.UK
[iv] Gambling-related harms evidence review: summary - GOV.UK
[v] Gambling Needs Assessment 2024
[vi] Gambling Harms in Greater Manchester – Strategic Needs Assessment
[vii] Gambling Needs Assessment 2024
[viii] The geography of gambling premises in Britain | School of Geographical Sciences | University of Bristol
[ix] Industry Statistics - Annual report - Financial year April 2024 to March 2025 - Official statistics

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**EQUALITY IMPACT ASSESSMENT (EIA)**

| | |
|---|---|
| **POLICY/PROPOSAL:** | Brent Gambling Related Harms Strategy |
| **DEPARTMENT:** | Service Reform & Strategy |
| **TEAM:** | Public Health |
| **LEAD OFFICER:** | Katie Shevas |
| **DATE:** | 07.10.2026 |

*EIA Guidance is available online, please reach out to equality@brent.gov.uk for any further support.*

**SECTION A – SCREENING**

1. Briefly and clearly describe the policy, proposal, change, or initiative, and what it is trying to achieve.

Brent is among the areas with the highest number of people gambling with the most negative consequences. We have over 80 licensed premises, one of the highest numbers in London. In some wards, it is easier to find a place to gamble than it is to shop in a major supermarket. Brent's demographic profile matches many of the risk groups most likely to gamble and/or experience harms from gambling – in particular, with its younger than average residents, high numbers of ethnically diverse communities, and being ranked the fourth most deprived borough in London. These factors all mean that stronger action needs to be taken to tackle gambling in Brent, to reduce the risk of harm to residents.

The Brent Gambling Harms Strategy 2026-2030 sets out our commitment to adopting a public health approach to preventing and reducing gambling-related harm across the borough. It describes how we will work to increase awareness of harms, reduce risk, intervene earlier, and make the best use of the powers and resources available to us to improve outcomes for those at risk of and experiencing harm from gambling.

2. Are there any groups who may be impacted by your proposal? For reference, Q4 lists all protected groups.

This strategy will impact all Brent residents affected by gambling harm, including those who gamble, and their affected others (someone who experiences negative personal, financial or emotional harm as a result of another person's gambling). Some people with protected characteristics, as evidenced in section 4, may be more susceptible to experiencing gambling harm and may therefore experience a greater impact as a result of the strategy. All Brent residents will be impacted by the general public awareness efforts included in the Strategy.

3. If no groups are affected, explain why.

N/A

4. Mark with an "X" the potential impact of the policy or proposal on different groups. You can mark more than one box for each group.

| Characteristic | IMPACT | | |
|---|---|---|---|
| | Positive | Neutral/None | Negative |
| **Age** - People of different age groups. | X | | |
| **Care Experience** - People who have been in care for any period of their childhood. | | X | |
| **Disability -** People with physical, sensory, learning, and mental health disabilities, long-term conditions, and non-visible disabilities. | | X | |
| **Gender reassignment** - Transgender and non-binary people, including anyone who is proposing to, started, or who has completed a process to change their gender. | | X | |
| **Marriage and Civil Partnership -** Applies mainly in the workplace, people who are married or in a civil partnership. | | X | |
| **Pregnancy and Maternity -** People who are pregnant, on maternity leave, or new parents. | | X | |
| **Race and Ethnicity -** People of different ethnicity, nationality, and skin colour. | X | | |
| **Religion or belief -** People of all faiths, and those with no religious belief. | | X | |
| **Sex -** Differences between men and women, including disparities in pay, career progression, and health outcomes. | X | | |
| **Sexual Orientation -** People who identify as lesbian, gay, bisexual, queer, asexual, or any other non-heterosexual identity. | | X | |
| **Socio-Economic Status –** People who are experiencing poverty or socio-economic disadvantage. | X | | |

| | | | |
|---|---|---|---|
| **Other relevant groups*** *[replace this text and specify where appropriate]* | | | |

* Other relevant groups could include Carers, Refugees or Asylum Seekers, Veterans, among others. Review the EIA Guidance for more information.

5. Complete **each row** of the checklist with an "X".

| **SCREENING CHECKLIST** | | |
|---|---|---|
| | **YES** | **NO** |
| Does the policy or proposal have implications for eliminating discrimination, advancing equality of opportunity, or fostering good relations among different groups? | **X** | |
| Does it relate to an area with known inequalities? | **X** | |
| Would it add, change, or remove services used by any groups listed in Q4? | **X** | |
| Does it have negative or positive equality impacts on any groups listed in Q4? | **X** | |
| **If you have answered YES to ANY of the above, proceed to section B.**<br>**If you have answered NO to ALL the above, proceed straight to section C.** | | |

**SECTION B – IMPACTS ANALYSIS**

6. What data and evidence have you used to understand potential impacts? This could include service user data where relevant. If there is little or no evidence, explain why, and note any plans to improve data collection in future, adding this to the Action Plan in Section E.

| |
|---|
| The development of the Gambling Harms Strategy has been informed by a range of qualitative and quantitative evidence. Evidence used to inform this assessment includes:<br>• Brent Joint Health Needs Assessment on Gambling<br>• Brent Open Data and other relevant local intelligence sources<br>• Conversations with those who have lived experience of gambling harm<br>• Engagement with partners, including Betknowmore |

7. For each characteristic:
    a. Provide detail for the impact listed in the response to Q4 in the left-hand box.
    b. Provide data and evidence to explain how you reached your conclusion in the right-hand box.

   Relevant data sources for Brent and its residents can be found in the EIA Guidance document.

| **Age** | |
|---|---|
| Provide detail for the impact listed in Q4. | Provide supporting data and evidence. |
| The Strategy is expected to have a positive impact on people across different age groups, with particular benefits for children, young people and young adults, who can be more vulnerable to gambling-related harms.<br><br>The strategy's focus on prevention, early identification, improving awareness and access to appropriate support will help to reduce the immediate and longer-term impact of gambling, with particular benefits for groups where evidence indicates a greater vulnerability to gambling harm. | The Joint Strategic Needs Assessment indicates that while participation in gambling is lowest in 16-24 year olds, they are more than 3 times as likely to experience severe harm as a result of gambling.<br><br>Brent is a relatively young borough. According to the 2021 census, the median age of Brent residents is 35 years, lower than the England average of 40 years. Around 24% of residents are aged under 20, while approximately 12% are aged 65 and over.<br><br>Gambling Needs Assessment 2024<br><br>2021 Census - First release \| Brent Open Data |

| **Care Experience** | |
|---|---|
| Provide detail for the impact listed in Q4. | Provide supporting data and evidence. |

| | |
|---|---|
| We do not have data to show that people with care experience are more likely to experience gambling harms. No specific impacts relating to care experience have been identified from this strategy. The Gambling Harms Strategy's commitments are intended to improve outcomes for all residents affected by gambling, regardless of care experience. | |

| **Disability** | |
|---|---|
| Provide detail for the impact listed in Q4. | Provide supporting data and evidence. |
| We do not have data to show that those with disabilities are more likely to experience gambling harm. No specific impacts relating to disability have been identified from this strategy. The Gambling Harms Strategy's commitments are intended to improve outcomes for all residents affected by gambling, regardless of disability. | |

| **Gender Reassignment** | |
|---|---|
| Provide detail for the impact listed in Q4. | Provide supporting data and evidence. |
| We do not have data to show that transgender or non-binary people are more likely to experience gambling harm. No specific impacts relating to gender reassignment have been identified from this strategy. The Gambling Harms Strategy's commitments are intended to improve outcomes for all residents affected by gambling, regardless of whether they are transgender of non-binary. | |

| **Marriage and Civil Partnership** | |
|---|---|
| Provide detail for the impact listed in Q4. | Provide supporting data and evidence. |
| We do not have data to show that people in a marriage or civil partnership are more likely to experience gambling harm. No specific impacts relating to marriage or civic partnership have been identified from this strategy. However, it is worth noting that gambling harm can have a particular effect on families, with the harm from one member of the family gambling being felt by the wider family as | |

| | |
|---|---|
| well. The Gambling Harms Strategy's commitments are intended to improve outcomes for all residents affected by gambling, regardless of relationship status. | |

| **Pregnancy and Maternity** | |
|---|---|
| Provide detail for the impact listed in Q4. | Provide supporting data and evidence. |
| We do not have data to show that people who have experienced pregnancy and maternity are more likely to experience gambling harm. No specific impacts relating to pregnancy or maternity have been identified from this strategy. The Gambling Harms Strategy's commitments are intended to improve outcomes for all residents affected by gambling, regardless of pregnancy or maternity. | |

| **Race and Ethnicity** | |
|---|---|
| Provide detail for the impact listed in Q4. | Provide supporting data and evidence. |
| The strategy is expected to have a positive impact on people of all races and ethnicities, with particular benefits for multiethnic communities. Evidence indicates that people from multiethnic communities experience higher levels of potential and severe adverse consequences from gambling than white people.<br><br>The strategy's focus on prevention, early identification, improving awareness and access to appropriate support will help to reduce the immediate and longer-term impact of gambling, with particular benefits for groups where evidence indicates a greater vulnerability to gambling harm. | Gambling Needs Assessment 2024<br><br>The Joint Strategic Needs Assessment indicates that multiethnic groups gamble less than white groups, yet experience higher levels of harm. The impact of gambling on these groups intersect with other areas of disadvantage as well, including high deprivation and financial vulnerability.<br><br>Brent Census Atlas 2021 - Ethnicity \| Brent Open Data<br><br>Brent is one of the most ethnically diverse boroughs in England and Wales. According to Census 2021, approximately 64% of residents identified with Asian, Black, Mixed or Other ethnic groups, while around 36% identified as White.<br><br>Nomis - 2021 Census Area Profile - Brent Local Authority |

| Religion or Belief | |
|---|---|
| Provide detail for the impact listed in Q4. | Provide supporting data and evidence. |
| We do not have data to show that those with a religion or belief system are more likely to experience gambling harm. No specific impacts relating to religion or beliefs have been identified from this strategy. The Gambling Harms Strategy's commitments are intended to improve outcomes for all residents affected by gambling, regardless of religion or belief. | |

| Sex | |
|---|---|
| Provide detail for the impact listed in Q4. | Provide supporting data and evidence. |
| The strategy is expected to have a positive impact on all people, regardless of sex. However, there may be particular benefits for men. Evidence shows that men are likelier to have higher rates of gambling than women, are more likely to gamble as a habitual activity and are more likely than women to spend money when gambling online.<br><br>There is also early data which suggests that women may be more likely to take part if particular forms of gambling such as bingo, which are being targeted at this group. Women are also more likely to gamble with the hope of improving their financial situation.<br><br>The strategy's focus on prevention, early identification, improving awareness and access to appropriate support will help to reduce the immediate and longer-term impact of gambling, with particular benefits for groups where evidence indicates a greater vulnerability to gambling harm. | Gambling Needs Assessment 2024<br><br>In Brent, our qualitative data supports this quantitative trend. Men were likelier to take part in all types of gambling activity compared to women, whereas women – and in particular, women of Asian ethnicity - were more likely to say they had never gambled or taken part in any form of gambling. |

| Sexual Orientation | |
|---|---|
| Provide detail for the impact listed in Q4. | Provide supporting data and evidence. |

| | |
|---|---|
| We do not have data to show that sexual orientation impacts likelihood of experiencing gambling harm. No specific impacts relating to sexual orientation have been identified from this strategy. The Gambling Harms Strategy's commitments are intended to improve outcomes for all residents affected by gambling, regardless of sexual orientation. | |

| **Socio-Economic Status** | |
|---|---|
| Provide detail for the impact listed in Q4. | Provide supporting data and evidence. |
| The strategy is expected to have a positive impact on people, regardless of economic status. However, there will be particular benefits for those living in deprived areas. Evidence indicates that people experiencing higher levels of deprivation, experience higher levels of potential and severe adverse consequences from gambling than those living in the least deprived areas.<br><br>Studies have shown that many gambling premises are often located near potentially vulnerable populations in the most deprived areas. People living closer to gambling venues (less than 0.7km away) were twice as likely to be 'problem gamblers' than individuals living further away (more than 3.1km away). With 81 licensed premises, Brent has one of the highest numbers of gambling premises in London.<br><br>The strategy's focus on prevention, early identification, improving awareness and access to appropriate support will help to reduce the immediate and longer-term impact of gambling, with particular benefits for groups where evidence indicates a greater vulnerability to gambling harm. The strategy also priorities work to take a more robust approach to reducing the number of gambling premises in the Borough- especially in the most deprived areas. | Poverty & Inequality Data Brent \| Trust For London \| Trust for London<br><br>Brent has comparatively high levels of socio-economic disadvantage and poverty.<br>Data on poverty and inequality indicate that around 33% of Brent residents live in poverty, compared with 22% across England, and the child poverty rate is estimated to be 42%, significantly above both the England and London averages.<br><br>Evans and Cross, "The Geography of Gambling Premises in Britain" |

| **Other Relevant Groups** | |
|---|---|
| Provide detail for the impact listed in Q4. | Provide supporting data and evidence. |

| | |
|---|---|
| N/A | N/A |

8. Summarise any engagement activities with relevant groups (this may replicate some of the information listed in Q7). State whether those involved represent the people affected by your proposal, or whether more engagement is needed, which should be added to the Action Plan in Section E.

We have developed this strategy using the best available evidence alongside the experiences of people who live and work in Brent. We have brought together findings from our Joint Strategic Needs Assessment, engagement with residents, workshops with partners and staff, published research, guidance from the Office of Health Improvement and Disparity (OHID) and conversations with people who have lived experience of the harms of gambling. This has built a clear picture of gambling and gambling-related harm across the borough and gives us a strong case for change.

9. Provide more detail on any areas identified as requiring further data or detailed analysis.

N/A

**SECTION C – CONCLUSIONS**

10. Summarise your overall conclusions based on the analysis:
    - If there are no impacts, state that here, and **do not complete sections E or G.**
    - If you decide not to move forward, explain why, and **do not complete sections E or G.**
    - If there are negative impacts, explain what you'll do to reduce them. If you choose to continue despite negative impacts, or if negative impacts remain following your action plan, provide a justification for your decision.
    - If there are positive impacts, explain how these could be strengthened, where possible.

This strategy is expected to have positive impacts on all residents who are affected by gambling, with particular positive benefits on groups most vulnerable to the harm caused by gambling:

- Young people
- Men
- Multiethnic groups
- Those experiencing socio-economic disadvantage and poverty

**SECTION D - RESULT**

| *Select one of the following options with an "X".* | | |
|---|---|---|
| **A** | **CONTINUE WITH THE POLICY/PROPOSAL UNCHANGED** | **X** |

| | | |
|---|---|---|
| **B** | **JUSTIFY AND CONTINUE THE POLICY/PROPOSAL** | |
| **C** | **CHANGE/ADJUST THE POLICY/PROPOSAL** | |
| **D** | **STOP OR ABANDON THE POLICY/PROPOSAL** | |

**SECTION E - ACTION PLAN AND MONITORING**

Unless your proposal has no equality impacts or you are not moving forward, complete the table below to track specific actions to:

- Reduce negative impacts and increase positive outcomes.
- Monitor actual or ongoing impacts.
- Record plans to improve data collection.
- Plan any further engagement or analysis that may be required.

Use the 'Status' column on the right to indicate whether the action is yet to start, is in progress, or has been completed.

| Issue Identified | Action | Lead Officer | Completion Date | Status |
|---|---|---|---|---|
| Positive impacts are anticipated for young people, those from multiethnic backgrounds, men and those experiencing poverty. These impacts will be dependent on successful implementation of the various priorities as set out in the strategy. | Review the EIA once implementation of the strategy has begun, updating the action plan to ensure that the anticipated impacts are felt, and that if any new equality impacts or evidence is identified it is reflected in the EIA. | Gambling Harms Strategy Delivery Officer | At first EIA review | Not started |
| Improve data collection | Use data collection methods to map geographic hotspots of harm to understand where gambling harms are most prevalent in the borough, and compare this with other data sets such as indices of deprivation. This will enable us to build a data backed picture of gambling harms across the borough. | Gambling Licensing Enforcement Officer | By the end of the strategy term | Not started |

11. Describe how you will monitor the actual, ongoing impact of the policy or proposal?

| |
|---|
| An action plan will be developed to deliver the strategic priorities. One of the goals the strategy is to establish baselines of data to enable future monitoring of gambling in Brent, and the effectiveness of the actions we take against it. We will continually update appropriate outcome measures within the action plan as data improves.<br><br>At the highest level, the primary outcome measure we will use at this early stage is to see a reduction in the number of people gambling with the most negative consequences in Brent (according to the PGSI scale). We will also hope to see a reduction in the number and concentration of gambling premises across the borough, which should result from stronger licensing enforcement measures and successful refusals against licensing and planning applications. |

**SECTION F – SIGN OFF**

| | Signature | Date |
|---|---|---|
| **Officer:** | Katie Shevas | 06.10.2026 |
| **Reviewing Officer or Head of Service** | Ruth du Plessis  | 07.10.2026 |

**SECTION G – REVIEW**

EIAs are live documents and should be reviewed regularly, especially if there are actions still to be completed or if the proposal has significant equality impacts.

When to review

- Review every 6 months until all actions in the Action Plan above are complete.
- If new data, feedback, or changes to the service arise, revisit the EIA to make sure it's still accurate.

Who should review

- The same officer who completed the EIA should carry out the review. If there's been a staffing change, the new lead officer should take over.

What to update

- Use the Status column in the Action Plan above to show progress (e.g. Not Started, In Progress, Completed). Add comments and updates in the table below — include any new data, evidence, or feedback.

When reviews can stop

- Once all actions are complete and no further equality impacts are expected, you can stop reviewing the EIA.
- Add rows to the table below as necessary until all actions are completed.

| **Date of 1st Review:** | |
|---|---|

| | |
|---|---|
| Officer: | |
| Comment on progress toward specific actions, and provide any data and evidence updates: | |
| Reviewing Officer or Head of Service: | |
| **Date of 2nd Review:** | |
| Officer: | |
| Comment on progress toward specific actions, and provide any data and evidence updates: | |
| Reviewing Officer or Head of Service: | |
| **Date of 3rd Review:** | |
| Officer: | |
| Comment on progress toward specific actions, and provide any data and evidence updates: | |
| Reviewing Officer or Head of Service: | |

| | |
|---|---|
| Brent<br>NHS<br>West and North London | **Brent Health and Wellbeing Board**<br>9 November 2026 |
| | **Report from Independent Chair of the Child Death Overview panel** |

# North West London Child Death Overview Panel Annual Report

| | |
|---|---|
| **Wards Affected:** | All |
| **Key or Non-Key Decision:** | N/A |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | OPEN |
| **List of Appendices:** | Appendix 1 – NWL Child Death Panel Annual Report |
| **Background Papers:** | None |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Chris Miller<br>Independent Chair of the Child Death Overview Panel<br>chris.miller@nhs.net |

## 1.0 Executive Summary

1.1 The rate of child and infant mortality in Nort West London has fallen by 9.7% since 2019.

1.2 The fall is not evenly distributed across the age range of children or the categories of death. Peri natal cases (children less than 28 days old) and chromosomal impacted deaths now account for 57% of NWL CDOP cases – this has risen from 44% four years ago.

1.3 25 cases involving Brent children were reviewed in 2025-2026. Up from 23 in the previous year.

1.4 Child deaths are not evenly spread across the population and some small communities have higher numbers than others. The link with deprivation is complicated , but may be real. However there are pockets of child death that may lead to further local analysis and action.

1.5 NWL analysis has identified a number of issues that apply across all eight boroughs of NWL.

## 2.0 Recommendation(s)

2.1 To note the NWL CDOP report

2.2 To see to what extent local specific action can be undertaken to combat future child death.

## 3.0 Detail

### 3.1 Contribution to Borough Plan Priorities & Strategic Context

3.1.1 The NWL CDOP report helps understand issues that haver an impact on the council priorities of

- Best Start in Life and
- Healthier Brent.

### 3.2 Background

3.2.1 There is a rich seam of data collected over a number of years which , if interrogated ,could enable Brent Partners to further contribute to the reduction in child mortality across the ICB footprint by tackling those issues and locations identified in the NWL that are susceptible to local action.

## 4.0 Stakeholder and ward member consultation and engagement

4.1 None

## 5.0 Financial Considerations

5.1 None.

## 6.0 Legal Considerations

6.1 None.

## 7.0 Equity, Diversity & Inclusion (EDI) Considerations

7.1 Child mortality is not evenly spread across communities and locations evenly. The CDOP annual report identifies where differences lie. Local responses to those differences will further reduce child mortality.

## 8.0 Climate Change and Environmental Considerations

8.1 Not applicable.

## 9.0 Human Resources/Property Considerations (if appropriate)

9.1 Not applicable.

## 10.0 Communication Considerations

10.1 To be determined by Brent officers.

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North West London
Child Death Review Team
Brent, Ealing, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, Westminster

# NWL Annual Report 2026

Chris Miller

Brent Health and Wellbeing Board

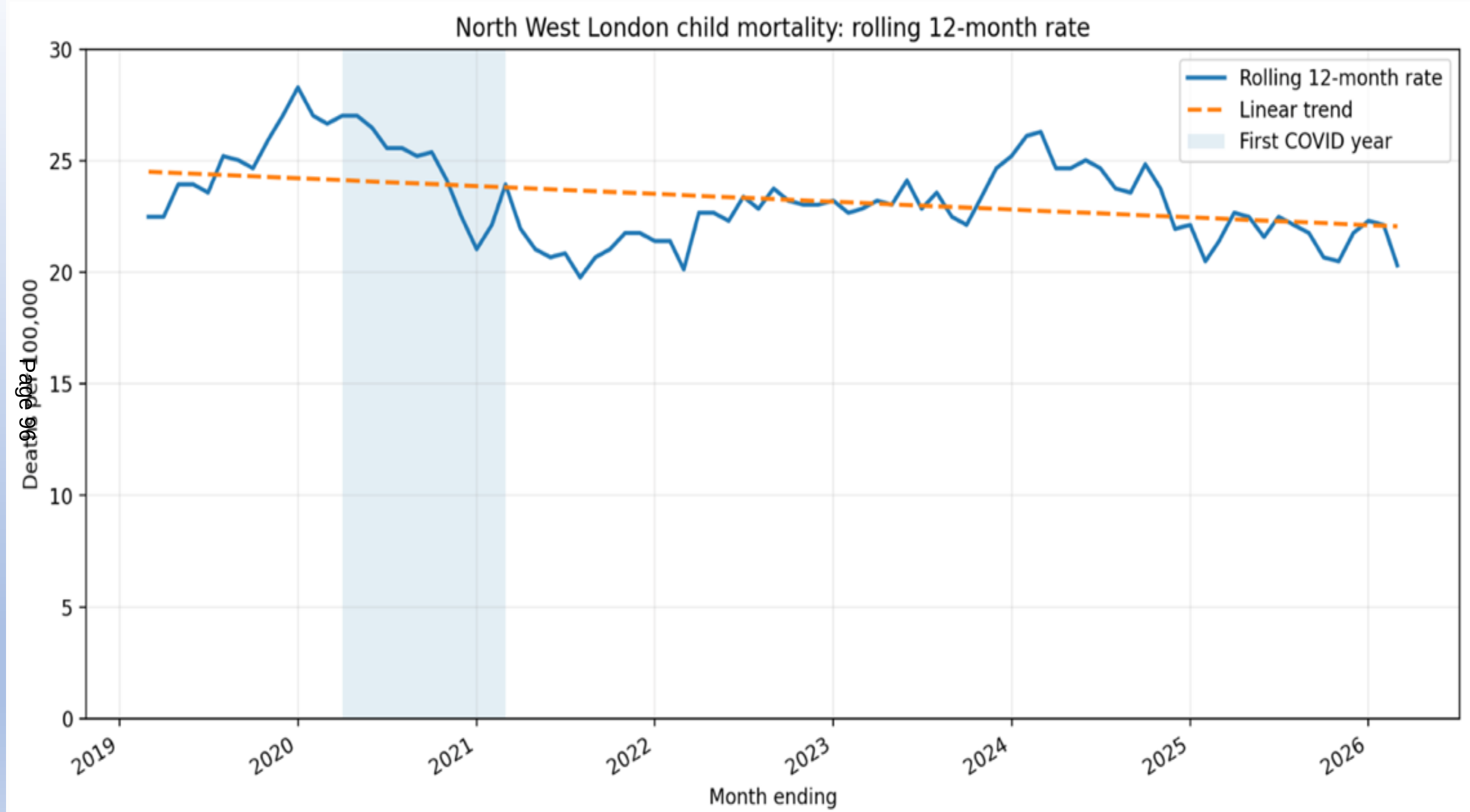
November 2026

# 2026 Annual Report – Some Headlines

- Since 2019,  child and infant mortality has declined by 9.7%.
- In 2025- 6 NWL convened 16 panels
  - reviewing  117 cases  (37 fewer than 2024-5)
- Convened a JAR in 45% of cases
- The largest group of cases involved babies under 28 days.
- More than half of all cases involve peri natal or chromosomal events.
  - These cases have increased from 44% ( 2022) to 57% (2026)

# More Headlines

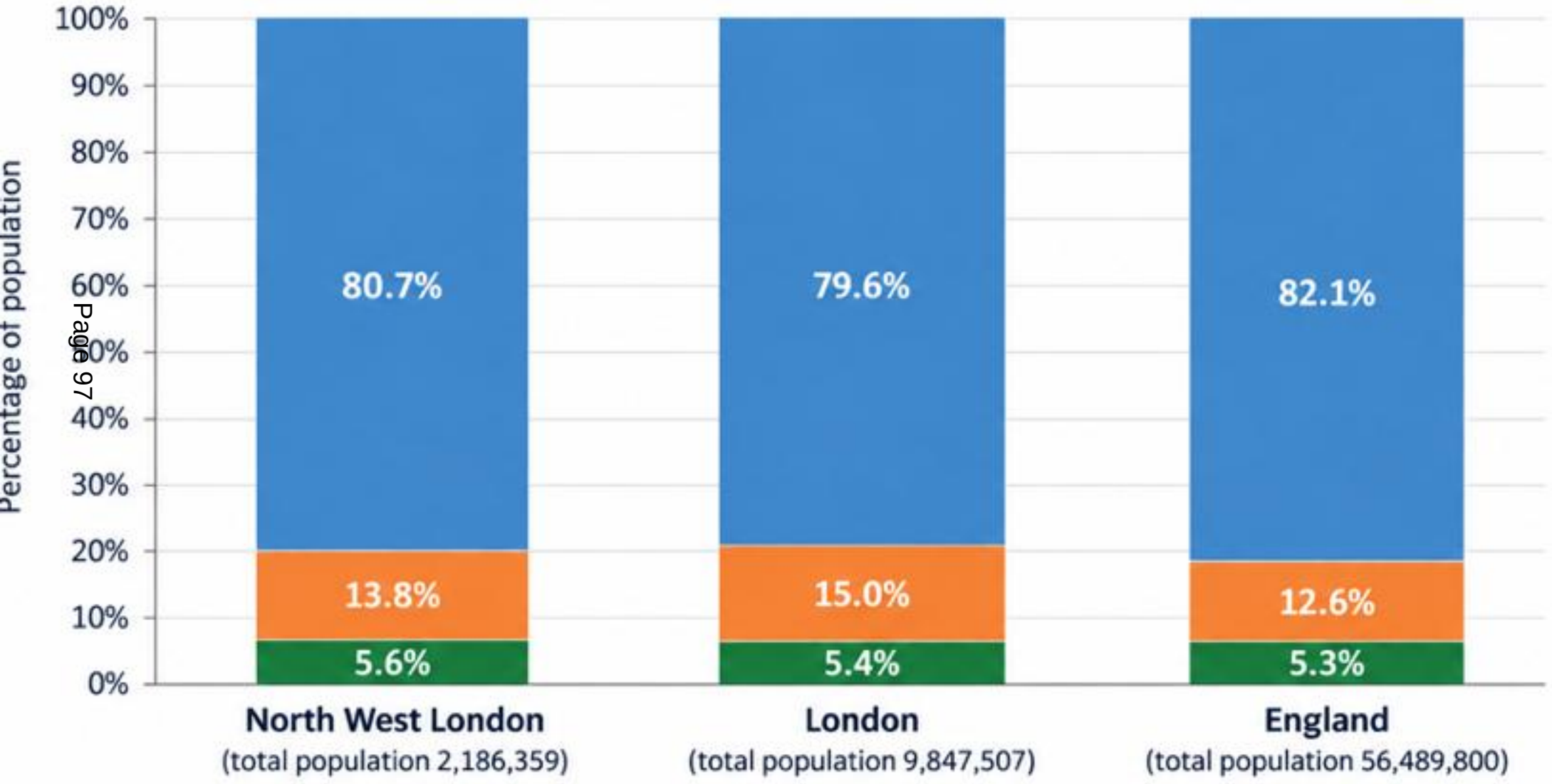
- NWL has a higher proportion of children in its population than England as a whole.
- NWL is much more diverse than England, is roughly the same as London but has a significantly higher Asian / Asian British population.
- It has more deprived communities than London as a whole
  - Slightly more children die in deprived communities than in less deprived communities
- Since 2022 there has been significant ethnicity changes in cases reviewed with  the proportion of Asian cases (up) , white (down) and mixed (up).


North West London child mortality: rolling 12-month rate
Rolling 12-month rate
Linear trend
First COVID year
Deaths per 100,000
Month ending
0
5
10
15
20
25
30
2019
2020
2021
2022
2023
2024
2025
2026

# Population by age group, 2025

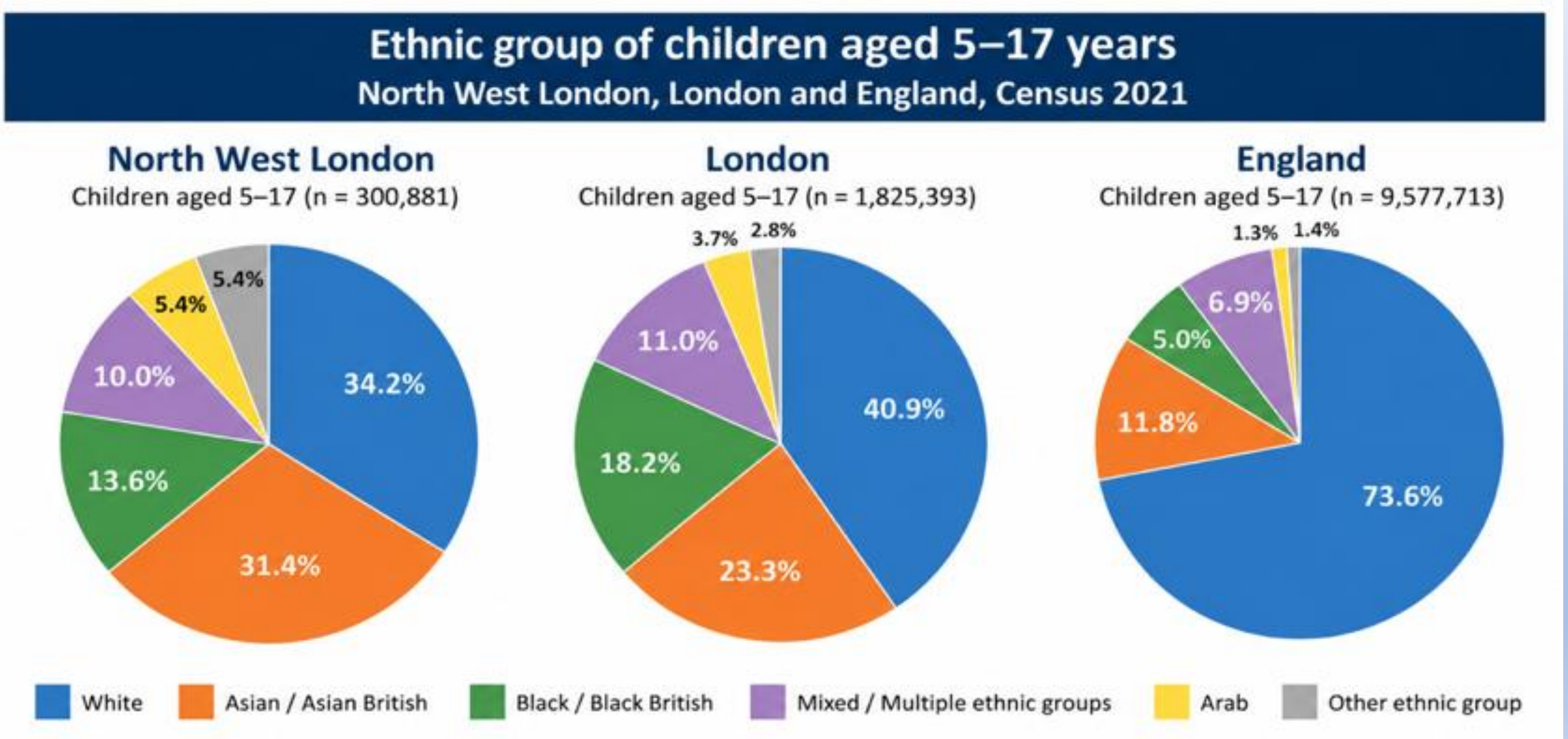
## North West London, London and England

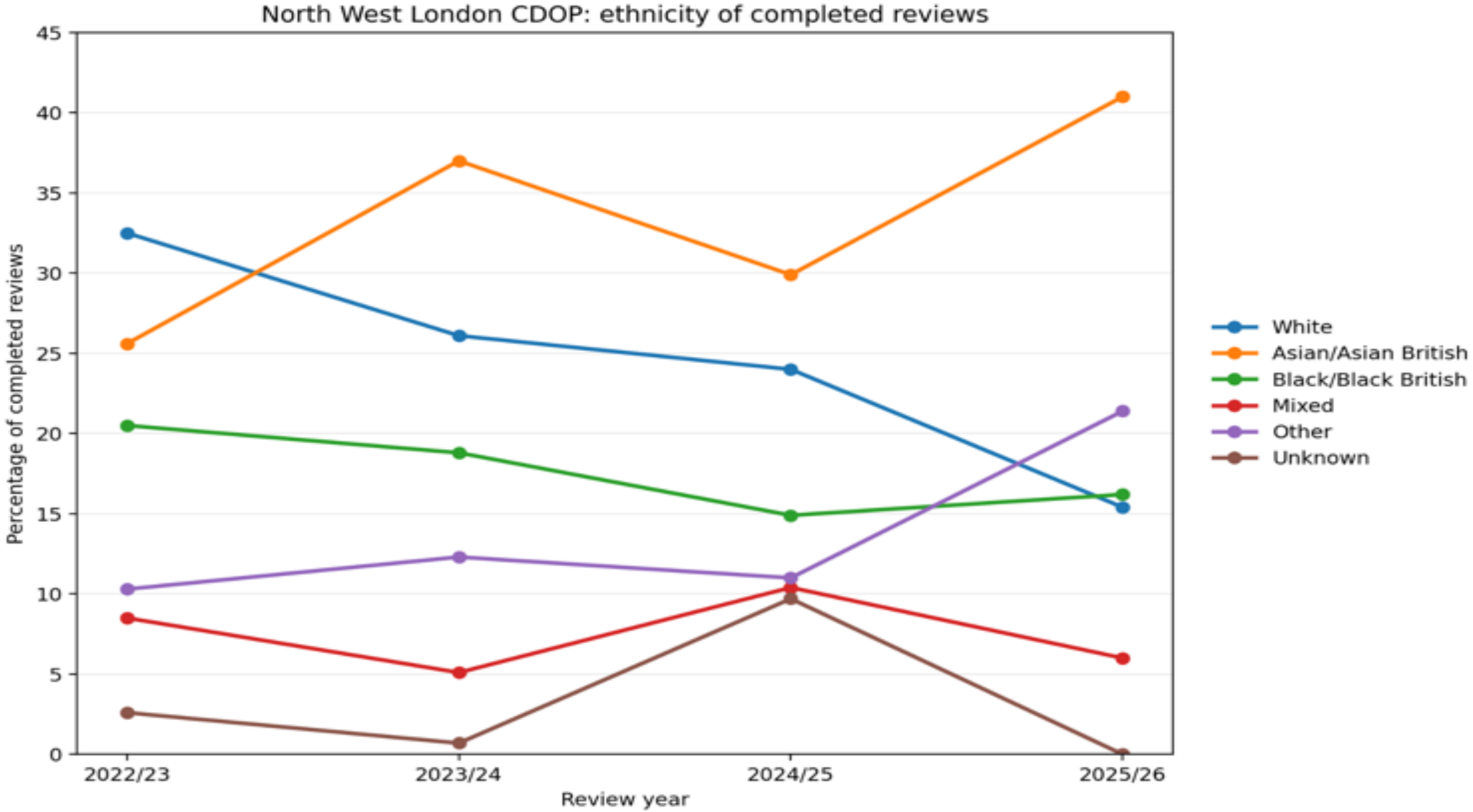
(percentage of total population)




| | | | |
|---|---|---|---|
| Total % aged | 19.3% | 20.4% | 17.9% |

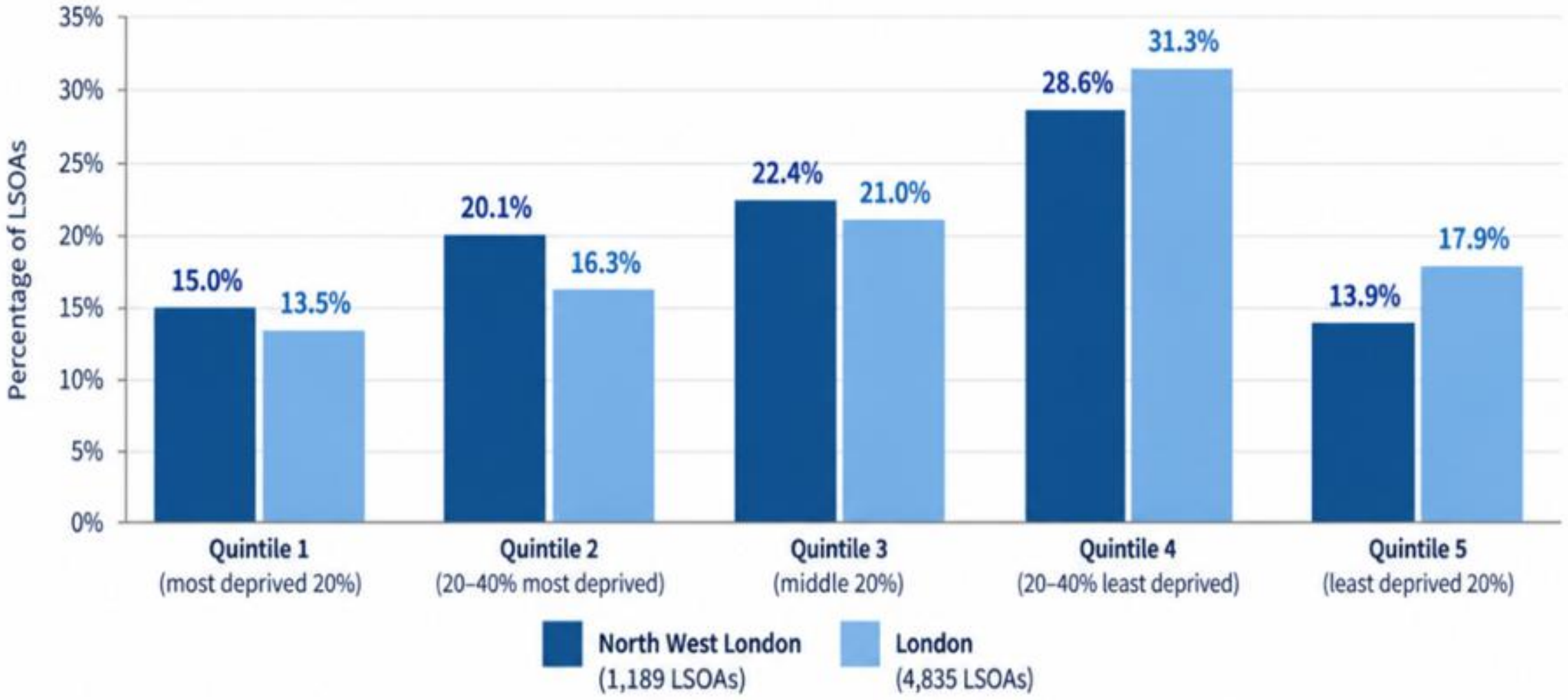
# Race and Ethnicity



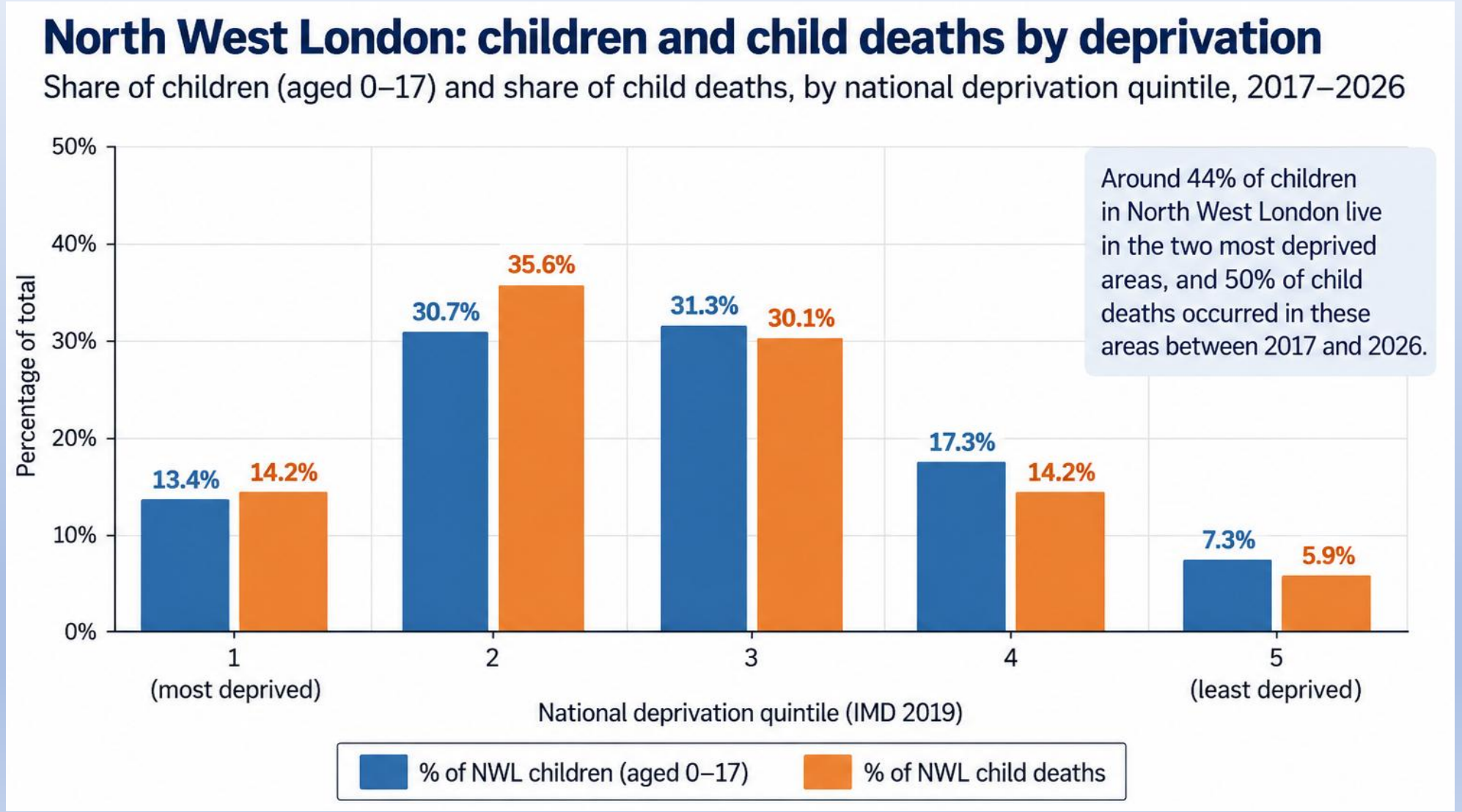

North West London CDOP: ethnicity of completed reviews
Percentage of completed reviews
45
40
35
30
25
20
15
10
5
0
2022/23
2023/24
2024/25
2025/26
Review year
White
Asian/Asian British
Black/Black British
Mixed
Other
Unknown

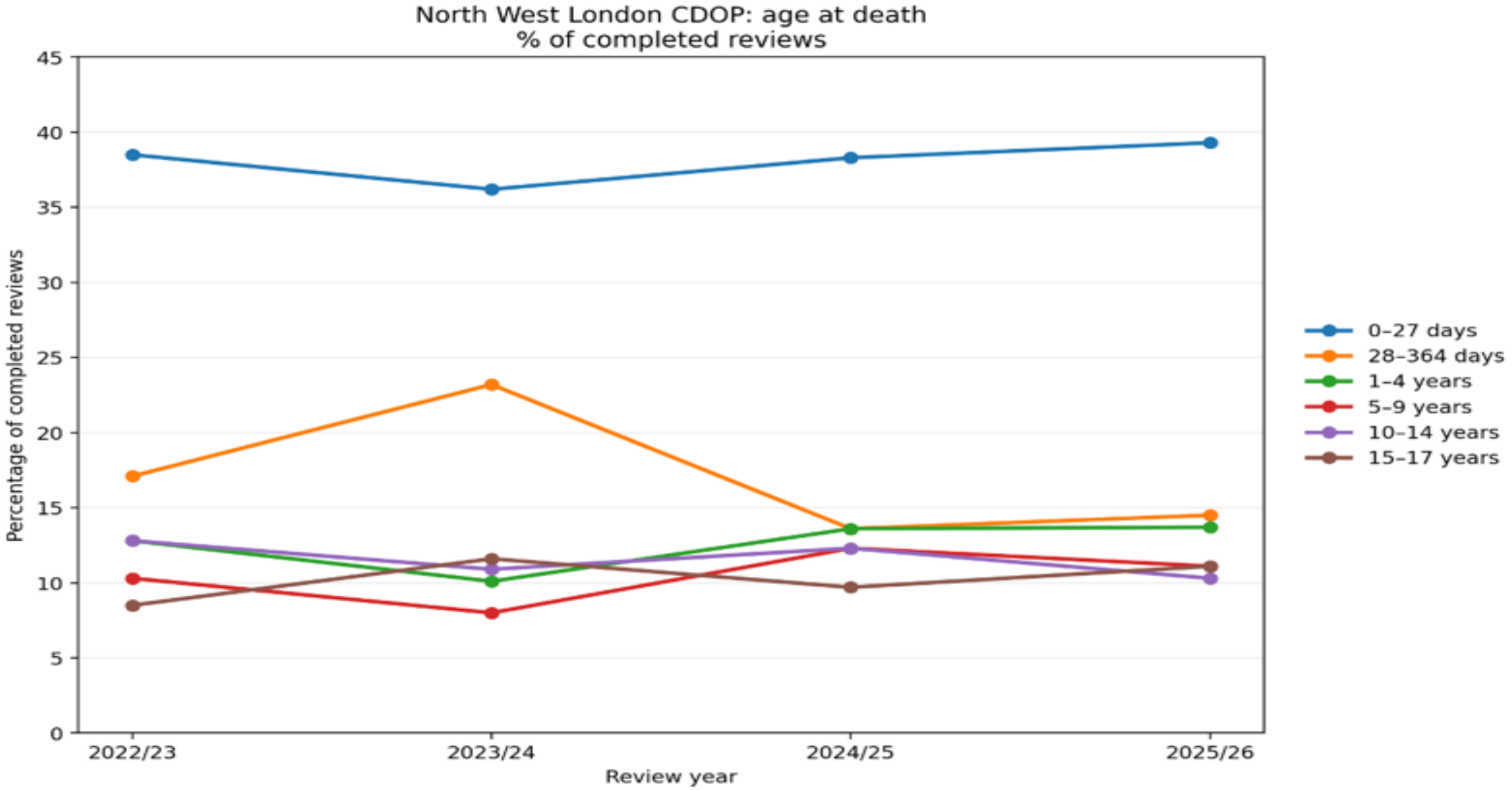
# Deprivation in North West London compared with London

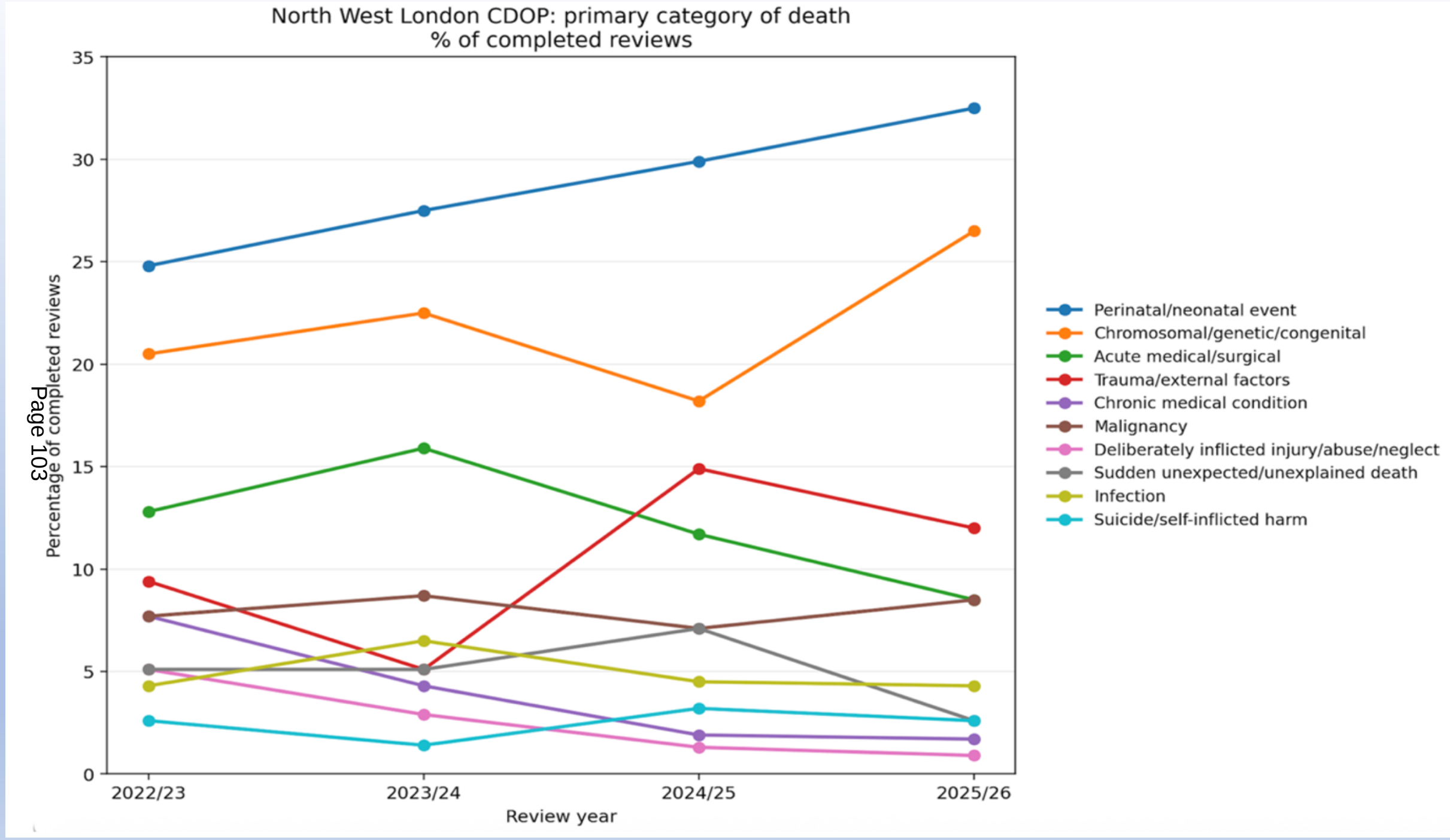
Proportion of Lower Layer Super Output Areas (LSOAs) in each national deprivation quintile, IMD 2025



# Deprivation and Child Death



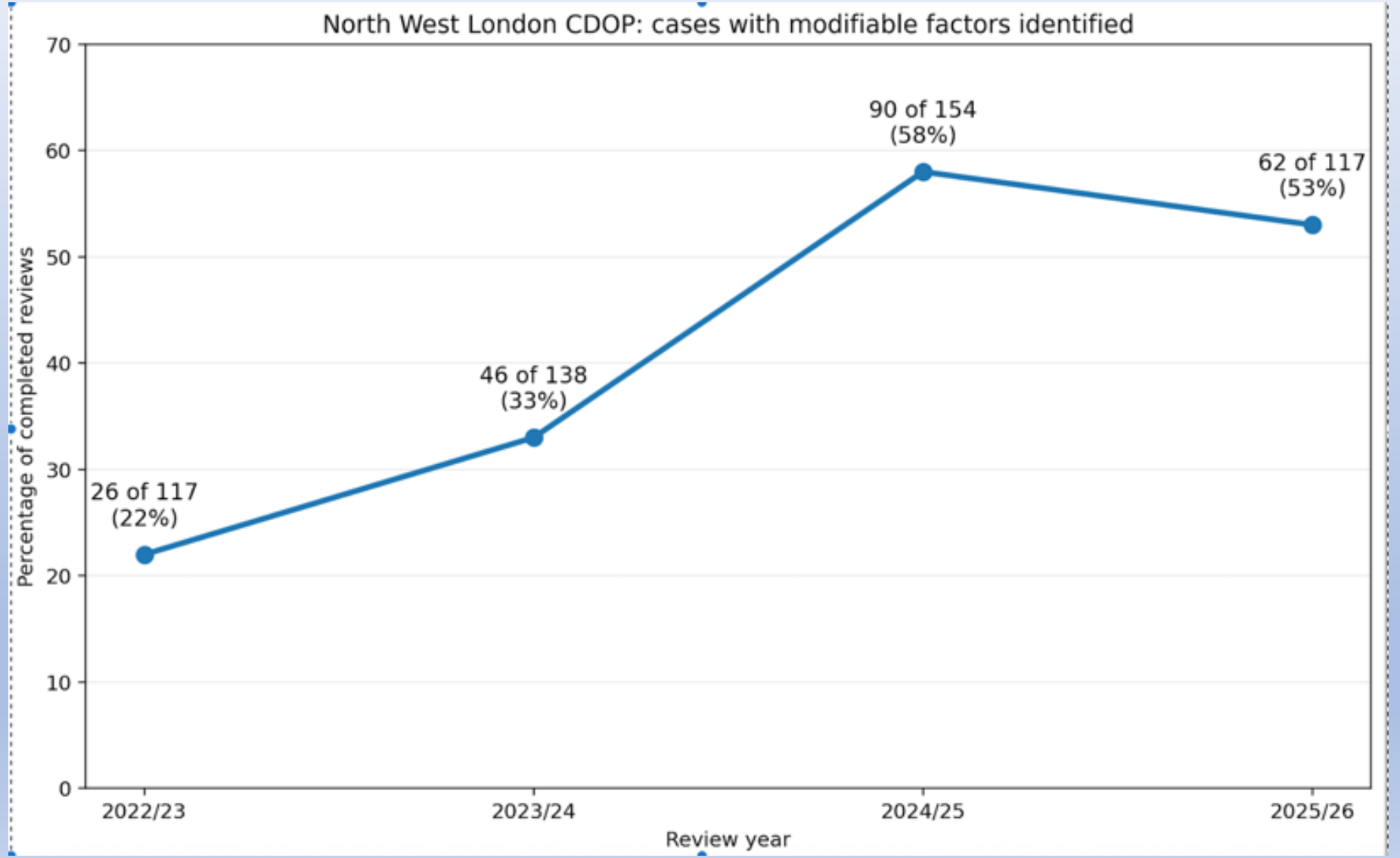

North West London CDOP: age at death
% of completed reviews
Percentage of completed reviews
0
5
10
15
20
25
30
35
40
45
2022/23
2023/24
2024/25
2025/26
Review year
0–27 days
28–364 days
1–4 years
5–9 years
10–14 years
15–17 years


North West London CDOP: primary category of death
% of completed reviews
Percentage of completed reviews
Review year
2022/23
2023/24
2024/25
2025/26
0
5
10
15
20
25
30
35
Perinatal/neonatal event
Chromosomal/genetic/congenital
Acute medical/surgical
Trauma/external factors
Chronic medical condition
Malignancy
Deliberately inflicted injury/abuse/neglect
Sudden unexpected/unexplained death
Infection
Suicide/self-inflicted harm

| Completed CDOP Reviews by Local Authority | | | |
|---|---|---|---|
| **Local Authority** | **2024** | **2025** | **2026** |
| Westminster | 17 | 10 | 14 |
| Kensington and Chelsea | 5 | 24 | 1 |
| Hounslow | 16 | 23 | 19 |
| Hillingdon | 22 | 20 | 16 |
| Harrow | 23 | 15 | 11 |
| Hammersmith & Fulham | 12 | 12 | 14 |
| Ealing | 22 | 27 | 17 |
| Brent | 21 | 23 | 25 |
| **Total** | **138** | **154** | **117** |

| Year | Death Notifications | JARs Held | Percentage |
|---|---|---|---|
| 2019-20 | 150 | 25 | 17% |
| 2020-21 | 131 | 25 | 19% |
| 2021-22 | 117 | 30 | 25% |
| 2022-23 | 145 | 58 | 40% |
| 2023-24 | 144 | 55 | 38% |
| 2024-25 | 126 | 52 | 41% |
| 2025-26 | 145 | 66 | 45% |

# Modifiable Factors



# Some Findings from CDOP Neonatal Panels (7)

- CTG Monitoring
- Use of Interpreters
- Genetic Counselling
- Thermal Management



# Medical and Palliative Panels (5)

- Communication with families.
- Healthcare engagement and treatment adherence.
- International treatment pathways and travel abroad.
- Advance care planning and RESPECT documentation.
- Supporting children with highly complex healthcare needs.



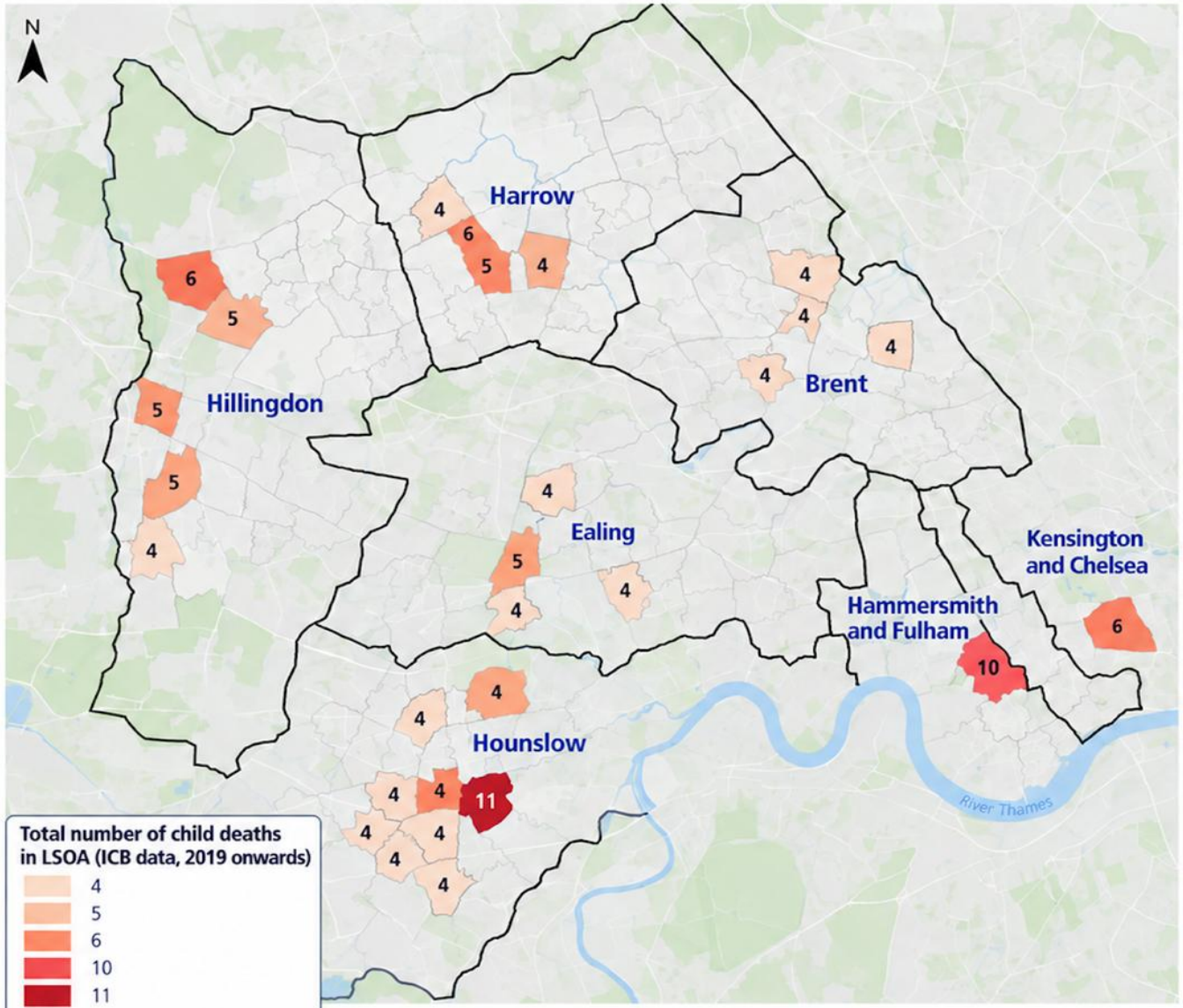
# SUDIC and Trauma Panels (4)

- Child supervision and environmental safety.
- Safer sleep and injury prevention.
- Interpreter use and effective communication.
- Serious youth violence and exploitation.
- Multi-agency information sharing.
- Investigation processes following sudden and unexpected child deaths.



# LSOAs in North West London with 4 or more child deaths

Total number of child deaths in each LSOA (NWL ICB data, 2019 onwards)




| LSOA code | Borough | Child deaths |
|---|---|---|
| E01002681 | Hounslow | 11 |
| E01001876 | Hammersmith and Fulham | 10 |
| E01002529 | Hillingdon | 6 |
| E01002912 | Kensington and Chelsea | 6 |
| E01002650 | Hounslow | 6 |
| E01002181 | Harrow | 6 |
| E01002130 | Harrow | 6 |
| E01002457 | Hillingdon | 5 |
| E01002525 | Hillingdon | 5 |
| E01002626 | Hounslow | 5 |
| E01002238 | Harrow | 5 |
| E01002401 | Hillingdon | 5 |
| E01001366 | Ealing | 5 |
| E01002662 | Hounslow | 4 |
| E01002638 | Hounslow | 4 |
| E01002615 | Hounslow | 4 |
| E01002641 | Hounslow | 4 |
| E01002620 | Hounslow | 4 |
| E01002634 | Hounslow | 4 |
| E01002629 | Hounslow | 4 |
| E01002397 | Hillingdon | 4 |
| E01002118 | Harrow | 4 |
| E01001373 | Ealing | 4 |
| E01000498 | Brent | 4 |
| E01001215 | Ealing | 4 |
| E01000549 | Brent | 4 |
| E01001326 | Ealing | 4 |
| E01000591 | Brent | 4 |
| E01002114 | Harrow | 4 |
| E01000633 | Brent | 4 |
| E01002203 | Harrow | 4 |
| E01000638 | Brent | 4 |
| E01000477 | Brent | 4 |

Map shows Lower Layer Super Output Areas (LSOAs) in North West London with 4 or more recorded child deaths, based on North West London ICB data from 2019 onwards. Numbers indicate the total child deaths in each LSOA.

Source: North West London ICB child death data (2019 onwards) | LSOA boundaries: ONS, 2021 | Map produced for illustrative purposes only.

| | |
|---|---|
| Brent<br>NHS West and North London | **Brent Health and Wellbeing Board**<br>9 November 2026 |
| | **Report from Brent Integrated Care Partnership** |

# Brent Winter Resilience and Community Flow 2026 27

| | |
|---|---|
| **Wards Affected:** | All wards |
| Report purpose: | For information and discussion |
| **Open or Part/Fully Exempt:**<br>(If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act) | Open |
| **List of Appendices:** | None |
| **Background Papers:** | None |
| **Contact Officer(s):**<br>(Name, Title, Contact Details) | Nikki Teesdale<br>Deputy Director for Community and Primary Care<br>Brent ICP<br>nikki.teesdale@nhs.net |

## 1.0 Executive Summary

1.1 This report updates the Health and Wellbeing Board on Brent's partnership response to winter pressures, including hospital capacity, discharge and the contribution of community, primary care and council services. Partners recognise the pressures facing residents and services and are working together to strengthen timely care, safe discharge and support at home.

1.2 The winter planning position includes a reported 60-bed gap. Rising demand and discharge delays are placing pressure on available hospital beds, particularly where people no longer need an acute hospital bed but require further care or support. Recent review of Brent's discharge information has highlighted Pathway 1 and Pathway 2 as priorities for closer joint attention, alongside longer stays and the concentration of Brent patients at London North West University Healthcare NHS Trust (LNWH).

1.3 The response brings together immediate winter resilience with the longer-term shift towards prevention and care closer to home. A regular ICP place-based flow forum has been proposed to strengthen shared oversight of demand, capacity and discharge, building on existing arrangements and connecting frailty, admission avoidance and

recovery. This report is for information and discussion; no approval of funding or service changes is sought.

## 2.0 Matters for Board discussion

2.1 The Board is invited to note the winter pressures, the particular focus on Pathways 1 and 2, and the partnership work described in this report.

2.2 Discussion is invited on the connection between immediate winter resilience, partners contributions, and the wider shift towards prevention, independence and community care.

## 3.0 Detail

### 3.1 Contribution to Borough Plan priorities and strategic context

3.1.1 The report supports the borough's aims for better health and wellbeing, reduced inequalities and greater independence. It connects NHS winter planning with adult social care, housing and practical support, recognising that residents' ability to remain well or return home depends on the combined contribution of services, families, carers and communities.

3.1.2 Brent ICP's role is to bring partners together around the whole resident journey. The "left shift" means preventing deterioration, identifying need earlier and enabling more care at home or in the community where this is safe and appropriate. Winter learning will inform the 2027/28 ICP strategic plan and the alignment of existing resources, including the Better Care Fund (BCF).

### 3.2 Background and hospital bed pressures

3.2.1 Brent ICP has brought together available acute and community winter plans, alongside primary care and mental health initiatives and reviewed their connections across admission avoidance and discharge. LNWH describes rising attendance and ambulance demand, continuing flow pressures and the need to sustain additional hospital capacity introduced over the summer. Its prioritisation reflects the immediate requirement to provide safe care within limited resources.

3.2.2 The submission reports a 5.6% increase in attendances in months 1-5 compared with the previous year and a 17.2% increase in Northwick Park Type 3 attendances. It also describes corridor care, length-of-stay pressures and the closure of a 34-bed ward at Ealing for infection control works. These are pressures reported in the winter plan submission, rather than a new live capacity return for this Board meeting.

3.2.3 The reported 60-bed gap is a winter planning position, rather than a verified daily shortage for Brent alone. Joint work is needed to clarify its timing, geographical coverage and assumptions, the contribution of existing services and any residual gap. A shared demand-and-capacity trajectory would help partners target the weeks and pathways where additional support would have the greatest effect.

3.2.4 Recent discussions and local review of data highlight the relationship between people no longer meeting the criteria to reside in an acute bed, extended lengths of stay and onward community capacity. Delays reduce the availability of beds for people requiring admission and can affect recovery and independence. The concentration of Brent patients at LNWH makes close coordination with the Trust and onward care providers particularly important.

### 3.3 Pathways 1 and 2 and timely discharge

3.3.1 Pathway 1 supports people to return home with additional care, rehabilitation or reablement. The local focus is on understanding the time between readiness for

discharge and the start of support, the availability of care and therapy, and practical barriers such as equipment, housing conditions or home clearance. Earlier joint planning can help identify the support needed for a safe return home.

3.3.2 Pathway 2 provides short-term bed-based rehabilitation, recovery or further assessment where a person cannot immediately return home. Capacity and timely access to suitable provision require joint attention, together with onward arrangements so that temporary care supports recovery and does not become an extended stay. Hospital and community bed capacity need to be considered together.

3.3.3 Further work is also needed for patients without a planned discharge date, people with extended stays and those whose needs span several services. Home First, bridging support and the Transfer of Care Hub (TOCH) provide an important focus for understanding how existing capacity is used and where coordinated intervention could help. More complex discharge pathways, including Pathway 3, remain within the wider oversight of flow.

### 3.4 Strengthening place based community flow governance

3.4.1 A regular ICP place-based community flow meeting has been proposed to bring LNWH, community health services, primary care, the local authority and other relevant partners together outside the Executive meeting. Its format, frequency and core membership remain to be agreed with partners, with particular attention to winter pressures and avoiding duplication of existing forums.

3.4.2 The proposed forum would develop a shared view of current and anticipated demand and available community capacity; examine Pathway 1 and 2 barriers; and review Home First, bridging services and TOCH coordination. It would connect this work with frailty and proactive care so that admission avoidance, discharge and recovery are considered together.

3.4.3 The intended approach is practical joint problem-solving, with a small number of shared priorities, named action leads and clear outcomes. Operational barriers requiring wider support would be escalated through existing borough and system arrangements. Organisational responsibilities and established clinical and statutory processes would continue to apply.

3.4.4 A shared monitoring view would include people no longer meeting criteria to reside, Pathway 1 and 2 waiting times and delay days, planned discharge dates, longer stays, community capacity and utilisation, and readmissions. Reporting would use dated baselines and common definitions to distinguish improvement in flow from pressure being transferred to another service.

### 3.5 Prevention and the 1 per cent challenge

3.5.1 Supporting safe hospital care and intervening earlier in the community are complementary parts of the winter response. For people with frailty or wider social needs, proactive reviews, rapid community responses and practical help at home may prevent deterioration or avoid a hospital attendance. Where admission is needed, early discharge planning and timely recovery support remain essential.

3.5.2 The borough's work on the 1% challenge is intended to translate a measurable contribution to reducing hospital demand into practical action across the pathway. The focus is on where collective intervention can reduce avoidable admissions, unnecessary hospital days and discharge delays while improving residents' outcomes. Partners will need to confirm the baseline, denominator and reporting period before expressing the challenge as a quantified Brent delivery commitment.

3.5.3 Potential contributions include targeted frailty reviews, Urgent Community Response (UCR), ambulance referral and diversion, Hospital at Home, and better access to appropriate primary care. Prevention also involves addressing non-clinical risks such

as cold homes and difficulties accessing support. Work on urgent treatment centre attendance should examine residents' clinical and social needs and the availability of alternatives, without assuming that attendance is inappropriate.

3.5.4 Benefits should be assessed through admissions avoided, acute bed-days released, safe return home, readmissions and resident experience, alongside the additional workload in community and social care. Released capacity should be distinguished from cash-releasing savings. This will connect winter resilience with longer-term investment in prevention and care closer to home.

### 3.6 Brent Council contribution over winter

3.6.1 The council's core adult social care contribution includes assessment and care planning, arranging support for eligible residents, safeguarding and emergency duty arrangements. These functions are central to discharge and to supporting people whose needs increase over winter. Joint attention to assessment, care availability and the practical circumstance at home is particularly relevant to Pathway 1; suitable recovery provision and onward support are important to Pathway 2.

3.6.2 Brent's existing reablement service provides short-term support to regain skills and confidence at home. It can support people leaving hospital and others who may benefit from greater independence. Its role in the winter pathway is to support recovery and reduce reliance on ongoing care where appropriate, with individual goals and subsequent needs reviewed through care planning. (1)

3.6.3 Adult safeguarding and emergency duty arrangements remain part of the council's response when residents are at risk, including outside office hours. The flow work should maintain clear links to these arrangements so that safety concerns and complex circumstances are addressed through the appropriate services. (2)

3.6.4 Alongside statutory services, Brent Well and Warm, delivered with Groundwork, offers eligible households energy advice, home visits where needed and guidance on financial support. Council information also signposts residents to warm spaces and help with energy costs. Connecting residents to this support is relevant to preventing deterioration and addressing the conditions that can make recovery at home more difficult. This is existing support, rather than a newly confirmed winter capacity expansion. [3]

3.6.5 The Public Health team and Brent Health Matters are working hard to promote winter vaccine uptake and winter well health messages. Estimates suggest indicated that, in England, the winter vaccination programme prevented an estimated 104,000 hospital admissions and 7,100 deaths. Public Health has pulled together a multiagency working group to support joint action on improving vaccination uptake. The Public Health team is arranging vaccinations for social care and care workers at a variety of community settings as well as social care and health care workers based at the Council. This includes 6 community Flu and Covid Vaccination sessions in October 2026 and 5 sessions in November 2026. The team has also arranged 3 Flu vaccination sessions for Health and Social Care Workers based at the council. The Public health team is also providing targeted flu vaccination session for the homeless in accordance with the new eligibility guidance. Additional sessions will be facilitated depending on demand, uptake and epidemiology.

3.6.6 The partnership is seeking to bring together a single borough view of existing BCF, adult social care, housing and Public Health activity alongside any additional winter provision. This will clarify available capacity, referral routes, outcomes and dependencies. Scheme-level winter commitments and additional capacity will need confirmation by the responsible leads before they are included as funded delivery assumptions.

### 3.7 Further opportunities and next steps

3.7.1 Borough planning has identified options including a falls response, stronger ambulance-to-UCR referral, practical home support, additional step-down or flexible care capacity, and primary care appointments bookable from urgent treatment services. Primary care partners have also developed options for respiratory and paediatric access, proactive frailty reviews, care-home support and vaccination outreach.

| Option | Indicative cost | Scope and intended contribution |
|---|---|---|
| Falls pick-up service | c£230,000 | Wider Outer North West London footprint; appropriate response after falls and fewer avoidable conveyances. |
| Ambulance and UCR diversion pilot | £20,000 per month | Wider footprint; £120,000 assumes six months. Brent share and period require confirmation. |
| Practical home support | c£50,000 | Handyman support linked to community health to address barriers to safe discharge. |
| Additional step-down or flexible care | c£300,000 | Indicative six-month estimate for ten beds or flexible care capacity; model and throughput to be refined. |
| UTC-bookable primary care appointments | c£350,000 | Initial assumption of 20 weeks and 15 daily appointments; operating days and additionality require confirmation. |

3.7.2 These remain options for appraisal where resources become available. Any scheme would require confirmation of additionality, capacity, mobilisation dates, delivery responsibility and measurable benefit. Proposals covering a wider geography would need an agreed Brent contribution, and overlapping proposals should be assessed together to avoid counting costs or benefits twice.

3.7.3 The immediate priorities are to develop the proposed community flow arrangements with partners, deepen understanding of Pathway 1 and 2 constraints, and connect existing provision to a shared demand-and-capacity view. Learning will support earlier joint planning for future winters and the wider programme of prevention and care closer to home.

### 4.0 Stakeholder and ward member consultation and engagement

4.1 The report draws on winter planning discussions involving acute, community, primary care and local authority partners. The proposed governance arrangements are subject to further partner discussion. This is a partnership update rather than a report of formal public or ward member consultation.

4.2 Residents and carers should be involved in individual discharge and recovery planning. Their experience should also inform pathway improvement, including whether support is accessible, culturally appropriate and coordinated around what matters to the person.

## 5.0 Financial Considerations

5.1 In response to the acute sector's immediate operational position, including increased demand, bed pressures and continuing challenges with patient flow, the Integrated Care Board (ICB) decided to allocate the additional winter funding to acute partners, with the exception of £140,000, allocated to Adult Social Care. This decision was made without borough partnership consideration of the final allocation. Brent partners recognise the rationale for prioritising safe hospital care and maintaining capacity through the winter.

5.2 Borough partners had sought to use this funding opportunity to strengthen admission avoidance and community capacity, reducing demand earlier in the pathway and supporting timely discharge. These proposals remain relevant to the wider winter response. While recognising the immediate acute pressures, the partnership has requested that the priorities and use of any further funding are considered and agreed at partnership level, through the appropriate approval arrangements, so that investment reflects the needs and potential benefits across the whole pathway.

5.3 Alongside the additional winter funding, agreement has now been reached on spend for the £1.1 million neighbourhood investment outlined in Brent's neighbourhood proposal. This supports the borough's response to the 1% challenge and the shift towards prevention, proactive care and support closer to home. The intention is to reduce avoidable hospital demand while improving residents' independence, experience and outcomes.

5.4 With agreement on spend in place, work is now focused on mobilising the neighbourhood model, initially through the Harlesden work on frailty and adults with complex needs, alongside targeted cardiovascular prevention. Mobilisation will bring partners together around the delivery arrangements, workforce and community capacity, cohort identification, referral routes and measures of impact. Brent Health Matters, resident involvement and voluntary and community sector partners are integral to developing support around people's wider needs.

5.5 The £1.1 million provides the investment basis for mobilisation; it should not be described as a realised saving or a guaranteed reduction in acute expenditure. Benefits will be tracked against agreed baselines, including avoidable admissions, hospital bed-days, discharge flow, independence and inequalities, alongside the impact on community and social care services. This will support shared oversight of the 1% ambition and inform future partnership investment decisions.

## 6.0 Legal Considerations

6.1 No new statutory powers, delegations or service changes are sought through this information report. Delivery continues through the responsibilities of the respective partner organisations. Any subsequent proposals would require appropriate legal and governance consideration, including care and safeguarding responsibilities, equality considerations and lawful information sharing.

## 7.0 Equity, Diversity and Inclusion Considerations

7.1 Winter pressures can have a greater effect on people with frailty, disability, long-term conditions, limited support networks or difficulty keeping their homes warm. Language, digital access, housing insecurity and cultural needs can affect access to services and timely discharge. Partners should use local data and resident insight to identify and respond to these differences.

7.2 Any subsequent service changes should consider equality impacts through the relevant organisational processes. Monitoring should examine who benefits and whether access or outcomes differ across resident groups. Safe discharge planning should reflect individual needs and the circumstances and capacity of unpaid carers.

**8.0 Climate Change and Environmental Considerations**

8.1 Support for warmer homes and appropriate care closer to home connects winter resilience with wider environmental objectives. Any change in travel or resource use would require assessment; no quantified environmental saving is claimed in this report.

**9.0 Human Resources and Property Considerations**

9.1 Community and social care workforce availability, appropriate recovery beds and conditions in residents' homes affect winter delivery. No new staffing establishment or property commitment is sought. Additional schemes would require a deliverable workforce and capacity plan alongside any funding approval.

**10.0 Communication Considerations**

10.1 Partners should provide clear and consistent information about access to care, discharge support and practical winter assistance. Communications should be accessible and should distinguish existing services from proposed or newly funded provision. Shared reporting through established borough and system arrangements will support oversight of pressures, actions and outcomes.

## 4 Council service references

[1] Brent Council - Reablement Short-Term Support. https://brent.gov.uk/adult-social-care/staying-independent/reablement
[2] Brent Council - Protecting adults from risk of harm and abuse. https://www.brent.gov.uk/adult-social-care/protecting-adults-from-risk-of-abuse
[3] Brent Council - Electricity gas and water bills including Brent Well and Warm. https://brent.gov.uk/cost-of-living-help-and-advice/electricity-gas-and-water-bills
Council service information checked on 20 October 2026. Winter planning figures are attributed to the October submission and are not a live Board-date position.

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