Appendix A

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

March 2026 | LGA Partners in Care and Health

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

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

The review team:

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

1. Context: why this review, why now?

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

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

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

2. What is genuinely working: the BHM legacy

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

Reaching communities others cannot

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

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

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

Tangible health impact

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

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

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

A trusted brand and passionate team

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

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

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

3. What we observed: the honest picture

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

Running alongside the system, not within it

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

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

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

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

The real impact is not being captured

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

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

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

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

The upstream ambition is unfinished

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

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

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

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

The VCFSE sector is underused

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

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

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

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

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

People are not always on the same page

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

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

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

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

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

"It's very siloed here in Brent."

4. Community voice

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

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

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

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

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

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

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

5. What people want to see: a vision emerging

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

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

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

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

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

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6. Questions considered at the April 2026 workshop

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

The BHM brand

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

Shared ownership and governance

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

Integration, not replication

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

Measuring what matters

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

How can data sharing and communication be enhanced?

Going upstream

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

Enabling the VCFSE

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

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Brent people matter

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

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

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

Getting on the same page

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

What will shared success look like?

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