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Health Partnerships Overview and Scrutiny Committee

Tuesday, 20 September 2011 at 7.00 pm
Committee Rooms 1 and 2, Brent Town Hall, Forty Lane, Wembley, HA9 9HD

Membership:

Members Councillors:	**first alternates** Councillors:	**Second alternates** Councillors:
Kabir (Chair)	Mitchell Murray	Moloney
Hunter (Vice-Chair)	Leaman	Ms Shaw
Beck	Clues	Cheese
Colwill	Baker	Kansagra
Daly	Sheth	Van Kalwala
Hector	Aden	Al-Ebadi
Ogunro	McLennan	Mistry
RS Patel	Naheerathan	Oladapo

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The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item		Page
1	**Declarations of personal and prejudicial interests** Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.	
2	**Deputations (if any)**	
3	**Minutes of the previous meeting held on 26 July 2011** The minutes are attached.	1 - 10
4	**Matters arising (if any)**	
5	**Organisational futures: Potential merger of Ealing Hospital NHS Trust with The North West London Hospitals NHS Trust** North West London Hospitals NHS Trust and Ealing Hospital Trust are working on plans for a proposed merger. The Health Partnerships Overview and Scrutiny Committee has previously considered a report on this issue at its meeting in June 2011. An update has been provided by the two hospital trusts on the proposed merger for members to consider (see appendix 1). It should be noted that the original intention was for the committee to consider the Outline Business Case for the merger at its meeting in September 2011. However, this will not be completed until October 2011.	11 - 14
6	**Paediatric Services at Central Middlesex Hospital** Report to follow.	

7	**North West London Hospitals NHS Trust Maternity Services Update**	15 - 46

NHS London has carried out a review of maternity services across London including at North West London NHS Hospitals Trust. The chair of the Health Partnerships Overview and Scrutiny Committee has asked that this report is presented to the committee so that members are able to see how the service is viewed by NHS London.

8	**Brent Joint Strategic Needs Assessment**	

A presentation will be given to Members on the Brent Joint Strategic Needs Assessment.

9	**Brent Local Involvement Network Annual Report 2010/11**	47 - 116

The Brent Local Involvement Network (LINk) is a member based, community led network of voluntary sector organisations and individuals, which includes residents, service users, businesses and community organisations. The network aims to empower and enable people to have a stronger say in how local health and social care services are commissioned and delivered in the Brent. The Brent LINk annual report for 2010/11 is enclosed.

10	**GP Commissioning Consortia Update**	

Members will be provided with a verbal update concerning the GP Commissioning Consortia.

11	**Health and Wellbeing Board Update**	

Members will be provided with a verbal update concerning the Health and Wellbeing Board.

12	**Health Partnerships Overview and Scrutiny work programme**	117 - 124

The work programme is attached.

13 Any Other Urgent Business

Notice of items to be raised under this heading must be given in writing to the Democratic Services Manager or his representative before the meeting in accordance with Standing Order 64.

14 Date of Next Meeting

The next scheduled meeting of the Health Partnerships Overview and Scrutiny Committee is scheduled for Tuesday, 29 November 2011 at 7.00 pm.

Please remember to SWITCH OFF your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.
- Toilets are available on the second floor.
- Catering facilities can be found on the first floor near the Paul Daisley Hall.
- A public telephone is located in the foyer on the ground floor, opposite the Porters' Lodge

MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday, 26 July 2011 at 7.00 pm

PRESENT: Councillor Kabir (Chair), Councillor Hunter (Vice-Chair) and Councillors Cheese (alternate for Councillor Beck), Colwill, Daly and RS Patel.

Apologies were received from: Councillors Beck and Ogunro.

Also present: Sarah Basham (Clinical Director, Willesden Clinical Commissioning Group), David Cheesman (North West London NHS Hospitals Trust), Andrew Davies (Policy Officer, Strategy, Partnerships and Improvement), Rob Larkman (Chief Executive, NHS Brent and Harrow), Jo Ohlson (Brent Borough Director, NHS Brent and Harrow), Mansukh Raichura (Chair, Brent Local Involvement Network), Fiona Wise (North West London NHS Hospitals Trust) and Toby Howes (Senior Democratic Services Officer, Legal and Procurement).

1. **Declarations of personal and prejudicial interests**

None declared.

2. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 9 June 2011 be approved as an accurate record of the meeting.

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

Minutes

Members agreed to Councillor Hunter's suggestion that the names of NHS representatives and council officers attending the meeting be recorded in future minutes.

Burnley Practice

In reply to a request from Councillor Hunter for an update on Burnley Practice, Jo Ohlson (Brent Borough Director, NHS Brent and Harrow) advised that a number of bidders had been interviewed and a recommendation of the preferred bidder would be submitted to the Board and subject to their approval, the provider would be appointed. Councillor Hunter mentioned that the Local Medical Committee had expressed concern over proceedings and had withdrawn their observer. The

committee heard that the Board would take such a matter into account during their consideration.

4. **NHS Brent GP access update - quarter 4 results**

Jo Ohlson introduced the report which provided information requested by the committee at the previous meeting to see what improvements had been made in GP satisfaction measures for quarter four of 2010/11. She reported that overall there had been improvements with regard to the access indicator, whilst although overall satisfaction indicators had dropped in respect of patient experience, the reduction was less than that reported nationally. Jo Ohlson added that “the clean, comfortable, friendly place to be in” indicator had improved slightly overall. It was felt that the improvements recorded could be partly attributed to the Access, Choice and Experience (ACE) programme. Jo Ohlson acknowledged that more work could be undertaken to provide a summary of performance by practice, however she informed Members that the ACE team’s resources to undertake performance analysis had been diminished.

Prior to the committee discussing this item, Councillor R Moher (Lead Member for Adults and Health) was invited to comment. Councillor R Moher asked for an explanation as to why Kingsbury Consortia had performed worse in all indicators with regard to experience and what action was being taken to remedy this.

In reply, Jo Ohlson commented that the better performing consortia tended to show greater enthusiasm to ACE’s initiatives and this had not been the experience at Kingsbury. However, all consortia were expected to consider ways to improve patient satisfaction and experience. Sarah Basham (Clinical Director, Willesden Clinical Commissioning Group) added that ACE had focused on embedding systems last year and this year would focus on standardisation, whilst a process of peer reviews whereby local practices made comparisons with neighbouring ones to see how they can improve would continue.

During Members’ discussion, Councillor Hunter enquired when the results per practice would be available and in a user friendly format. In respect of large performance differences between practices, she queried whether some consortia performances was being compromised because of one particular practice performing well below the others. Councillor Hunter also expressed concern that the more detailed information previously requested and the performance improvement anticipated had not materialised to date and sought assurances in respect of these. Councillor Daly commented that almost half the patients were not satisfied in respect of the clean, comfortable, friendly place to be indicator and asked what was being done to address this. She suggested that a more helpful way of presenting the data would be to list the ten best and ten worst performing practices, as this would be particularly useful for patients. Councillor Daly felt that the customer satisfaction levels recorded overall indicated that the level of service currently being provided was not acceptable and that a more robust approach focusing on ensuring customer satisfaction needed to be taken.

Councillor Colwill commented that he personally had been content over access and experience in a recent visit to a health facility. However, he sought reasons as to why the Kingsbury and Willesden consortiums were performing below others. Councillor Cheese enquired what measures were in place to ensure that staff

behaved in an acceptable way. In respect of peer reviews, he suggested that not all neighbouring practices enjoyed good relationships and he felt that a different approach to improving practices needed to be taken.

The Chair emphasised that providing best quality of service was the highest priority and she sought details of what measures were being taken to ensure this. In respect of GPs taking responsibility to improve access to services, she enquired what support they were given to achieve this.

In reply to the issues raised by Members, Jo Ohlson confirmed that the performance results were publically accessible through the NHS Choices website. The results were compiled by consortia, however Jo Ohlson agreed to look into how to make the information more user friendly. Members were advised that practices were obliged to register and comply with the Care Quality Commission's (CQC) premises standards by April 2012. The ACE programme also encouraged staff to provide more customer support and have a friendlier approach. In the meantime, staff had contractual obligations that they were required to meet and consortia were required to provide a declaration in respect of this. From April 2012, the CQC would be checking to see if the declaration was sufficient as well as reviewing patient feedback. Each consortia was required to provide information on how it was addressing areas that were in need of improvement. Jo Ohlson advised that there was not always a direct correlation between high quality care and high patient satisfaction levels. Consideration of how to provide appropriate weight to each indicator also needed to be given, however Members heard that a traffic light system of highlighting performance results would continue to be provided. However, it was not anticipated that the measures put in place by the ACE programme would show significant improvements until quarters three and four. Jo Ohlson explained that GPs now had more support to help them improve in areas of service since the ACE programme had been launched as well as receiving advice and support from peers and neighbouring practices.

Rob Larkman (Chief Executive, NHS Brent and Harrow) added that practices across the borough would have their performances scrutinised and those performing below satisfactory levels would be challenged to raise their standards.

The Chair requested that a report providing performance information of both individual practices and the consortia be provided at a future meeting of the committee.

5. **GP list validation exercise**

Jo Ohlson introduced this item and began by stating that steps were being taken in respect of patients erroneously being removed from practice lists. Measures were being taken to ensure the smooth re-registration of patients on to the lists and prevent loss of income to practices. A complete list of patients who had been re-registered would be available within the next week and monthly updates would be available subsequently.

During Members' discussion, Councillor Cheese suggested that some GPs may already be overburdened with other tasks and that alternative staff rather than GPs and receptionists be approached to undertake such tasks. Councillor Hunter expressed interest in receiving the re-registration figures. She suggested that the

validation exercise be undertaken as a rolling programme undertaken by practices every two years. Councillor Colwill suggested that working with the council's Births and Deaths Registry may be beneficial and he enquired whether the savings targets were on schedule. Councillor Daly asked whether the number of patients removed from the lists and without a GP were known and had the appropriate risk assessments been undertaken.

The Chair enquired whether the validation exercise would become the responsibility of the North West London Primary Care Trust Cluster. She also concurred with the suggestion that validation should be carried out every two years on a rolling basis.

In reply to the comments made, Jo Ohlson stated that concerns had been raised with regard to the large number of patients involved and the six month time frame given to complete the exercise and many practices had not carried out these activities until towards the end of this period. Some practices had carried out the validation exercise in phases, such as by age group. Jo Ohlson advised that it was anticipated that a London wide validation policy would be in place by April 2012 and suggestions could be made as to what this could include. She added that it was important that such a policy was robust and the consortia would be responsible for undertaking the validation exercise. Members were informed that it was expected that the savings targets would be reached and this would be confirmed by the re-registration figures. Brent NHS would be aware of any patients who had re-registered at another practice within the borough, however in some instances they may have moved away, registered with a practice outside Brent or did not wish to be registered at any practice. Jo Ohlson confirmed that risk assessments had been undertaken and that steps had been taken in respect of ensuring vulnerable patients were not removed from lists unnecessarily.

The Chair requested that the re-registration figures be provided at the next meeting.

6. **Update on GP commissioning in Brent**

Jo Ohlson advised that the Brent Federation had been successful in its application for a delegated budget and she welcomed any questions and comments from the committee.

Councillor Hunter drew Members' attention to paragraph 2.3 of the main report which seemed to contradict paragraph 2.5 in respect of whether the proposed Clinical Commissioning Groups would actually be expected to work with local authorities and other bodies. Councillor Daly enquired about arrangements for those Clinical Commissioning Groups where patients came from more than one borough. She also requested a presentation on the relationship between the National Commission Board and GP consortia at a future meeting.

The Chair enquired when the budget would be delegated to the Brent Federation. In respect of governance, she enquired whether the Clinical Commissioning Group would be taking on lay people to serve on the governing board.

The Chair invited Councillor R Moher to comment. Councillor R Moher enquired on arrangements where an individual GP had indicated that they do not wish to be involved in the work of a commissioning group.

In reply to the issues raised, Jo Ohlson advised that the budget was due to be delegated to the Brent Federation around August/September, whilst delegation of accountability and responsibility were already in place. With regard to Clinical Commissioning Groups working with other organisations, Jo Ohlson acknowledged that the wording provided by the Department of Health on the matter needed clarifying, however currently practices were expected to work with other like-minded practices that were not necessarily their neighbours. The issue of what Clinical Commissioning Group a practice would come under depended on what part of the borough most of its patients came from. In respect of GPs not wishing to be involved in commissioning group work, the Clinical Commissioning Group concerned would deal with the situation as if felt appropriate or the GP could be allocated to a different Clinical Commissioning Group.

7. **Health and Wellbeing Board update**

Andrew Davies (Policy Officer, Strategy, Partnerships and Improvement) provided Members with a verbal update with regard to developments concerning the Health and Wellbeing Board (HWB). He reminded Members that the setting up of a HWB was required under the Health and Social Care Bill. As a precursor to the HWB that was anticipated to function from next year, a Shadow Health and Wellbeing Board had been set up and this had already met three times since February 2011. At the last meeting, the Shadow Board had reflected on changes to the Health and Social Care Bill. Andrew Davies explained that the HWB would play a formal role in developing commissioning plans and referring them back to the clinical commissioning groups or the NHS Commissioning Board, both of which would have a duty to cooperate with the HWB. The HWB could undertake Executive functions on health and social care matters on behalf of the council, whilst membership of the board was envisaged to be equally proportioned between members and officers, although there could be more elected members if this was preferred. The committee noted that the HWB was still at the developmental stage and there may be further changes as relationships between organisations developed. The matter was complicated by uncertainties with regard to the Health and Social Care Bill, however issues for further consideration included decision making, roles and responsibility, terms of reference and HWB’s relationship with other committees.

Councillor R Moher added that further clarification from the Government was awaited before seeing how the relationship with the NHS Commission Board would function.

During discussion, Councillor Cheese sought clarification with regard to clinical networks of experts. Councillor Daly asked what the composition was of the Shadow Health and Wellbeing Board, did the composition of the Boards vary nationally and if it was decided that the majority of Board members should be elected representatives, should this be on a cross-party basis. The Chair commented that the membership of the Board should reflect the terms of reference.

Mansukh Raichura (Chair, Brent Local Involvement Network) was invited to comment. Mansukh Raichura expressed a wish that the views of patients was not diluted and stressed the importance of allowing them to make contributions to the Board.

In reply to the issues raised, Andrew Davies confirmed that the current Shadow Health and Wellbeing Board's membership consisted of, from the council's side, the Leader of the Council, the Lead Member for Adults and Health, the Lead Member for Children and Families, the Director of Strategy, Partnerships and Improvement, the Director of Children and Families and the Director of Adult Social Care. Jo Ohlson, Rob Larkman and Simon Bowen represented NHS Brent on the Board, whilst the directors of the five consortia were also invited to the meetings and Mansukh Raichura attended as a patients' representative. Andrew Davies advised that the original guidance had stated that the HWB required at least one member of the Board to be an elected councillor, however the guidance had since been revised to state that HWBs may also be compose a majority of elected members and this issue could be reconsidered. Members heard that the composition of HWBs did vary nationally and for example the London Borough of Enfield had three sub-groups. Members could receive a report on how HWBs operated elsewhere if they wished.

The Chair asked for updates on the HWB at future meetings.

8. **Paediatric Services at Central Middlesex Hospital**

Fiona Wise (North West London NHS Hospitals Trust) introduced this item and advised that a review by the Clinical Team at Central Middlesex Hospital had identified that there had been a significant reduction in patient numbers at the Paediatric Assessment Unit (PAU) since Care UK's Urgent Care Unit (UCC) had opened in March 2011. This had the effect of reducing staff morale in the PAU and there was a danger of de-skilling because of the reduced activity. As a result, it was proposed to absorb the paediatric assessment function within the UCC and to de-commission the PAU, whilst the paediatric outpatient service and Brent Sickle Cell service would remain at the hospital.

David Cheesman (North West London NHS Hospitals Trust) added that PAU had experienced a number of staff resignations and it was difficult to maintain minimum staff levels and was also costing the hospital £6.5K per week because of the lack of patients. By contrast, the UCC had proven to be a big success since its opening and on average was absorbing 87% of paediatric demand. David Cheesman advised that patients requiring specialist opinion or overnight care were being transferred to Northwick Park Hospital and this arrangement had been in place since October 2010. The committee heard that the proposals did not include major service changes and under Section 2.2, an informal consultation with relevant community groups would be required. Members noted that it was intended to implement the proposals in October 2011.

During Members' discussion, Councillor Cheese expressed concern about the time delay in transferring patients who had arrived at Central Middlesex Hospital to Northwick Park Hospital. He also queried whether St Mary's agreement to accept rare, critically unwell children was sufficient and stressed that standards could not be compromised in such situations. Councillor Daly sought clarification as to whether the UCC was staffed by Care UK and was there a protocol in place. Views were sought as to whether the Care UK contract could be extended to other services. Councillor Daly also requested that a patient satisfaction survey for Care UK be undertaken.

Councillor Hunter agreed that the relevant community groups should be consulted regarding the proposals which she felt offered the benefit of reducing unnecessary overnight stays. She also sought clarification with regard to how the proposals fitted in with the overall strategy.

In reply, Fiona Wise advised that patients were already being transferred to Northwick Park Hospital for emergencies, specialist care and overnight stays. Children who arrived at Central Middlesex Hospital would initially be treated by UCC who would determine whether a transfer was necessary. Presently PAU was only treating around 30 patients a week on average.

David Cheesman advised that there was a robust system with regard to patient arrangements which ensured that patients were receiving the most appropriate treatment at a suitable hospital. Central Middlesex Hospital would continue to provide a 24 hour accident and emergency service.

Jo Ohlson advised that a number of other services, such as sickle cell treatment and safeguarding were also being looked at and it was possible that Care UK may have further involvement in future. The committee noted that the UCC was also staffed by a paediatric trained nurse or GP on a 24 hour basis. With regard to PAU, Jo Ohlson explained that it had been anticipated that it would treat much more children when it was originally established, however the creation of UCC had proven to be more successful than had been imagined. Jo Ohlson advised that a patient satisfaction survey regarding Care UK could be undertaken as part of the customer engagement process.

Sarah Basham confirmed that the UCC was staffed by Care UK and stressed that there was a robust system in place with regard to referring patients to other hospitals. She advised that St Mary’s Hospital had been treating critically unwell children from across West London for a number of years and that this arrangement was robust and effective and that this offered the best treatment in the area for such situations.

The Chair thanked the presenters and requested that there be an update on this item at the next committee meeting on 20 September.

9. **North West London NHS Hospitals in patient survey results**

Fiona Wise introduced the report and explained that the 2010 patient survey results were based on a very small sample number, with 333 respondents representing 41% of survey forms distributed. Members noted that the survey was not weighted in terms of ethnicity. In terms of comparisons with other Health Trusts, Fiona Wise stated that although general observations could be made, the individual results of each Trust were private to that Trust. The committee heard that although results were better than in previous years, there was room for further improvement and the Trust was committed to improving the patient experience.

During discussion by committee, Councillor Hunter commented on the need to make a concerted effort to improve in the three areas identified in the survey, these being nurses, care and treatment and operations and procedures. She suggested it would be beneficial to look at how the best performing Trusts operated and use this to identify best practice methods. Councillor Daly sought further reasons as to

the relatively poor results for nurses and what action was being taken to address this, in particular on how to overcome barriers between nurses and patients. She also enquired whether nurses were still routinely doing 12 hour shifts.

Councillor Colwill asked for more information with regard to hospital cleanliness and whether positive comments could be included in the survey results. Councillor Cheese asked what arrangements were available in terms of patients' relatives, particularly when they received bad news and he suggested that staff should be available to direct them to an appropriate facility.

The Chair enquired whether an improvement in patient survey results was anticipated for 2011. She commented that standards may not be as high in certain respects for agency staff and she felt more work was needed in terms of staff loyalty to the Trust. She noted that there would be a follow-up report in 12 months.

In reply to the issues raised, Fiona Wise began by explaining that specialist hospitals tended to perform better nationally in patient surveys and their results were helped by not having an Accident and Emergency unit. She advised that the Trust sought to learn how to improve by considering how similar organisations that had made significant improvements operated. Fiona Wise felt there was a reasonable chance that the 2011 patient survey results would indicate an improvement as the areas identified for improvement were being worked upon, however she warned that the format of the survey would remain the same. The committee heard that agency nurses were more likely to be the subject of complaints with regard to customer care issues and they were being given customer care training. Patients were also being encouraged to complete their surveys during their hospital experience so that better feedback could be received for staff to reflect on. A patient charter had also been developed and a strategy had been agreed by the Board to improve staff interaction with patients. It noted that all staff had the required professional training and qualifications, however agency staff faced additional challenges such as working in a new environment and needed time to get use to a particular hospital's procedures. It was noted that it was normal practice for nurses to work 12 hour shifts, however this was also the case with all other Trusts. However, Fiona Wise agreed to provide information in respect of this through Andrew Davies.

Fiona Wise advised that the survey only briefly touched on hospital cleanliness as this was covered by other inspection processes, whilst Brent Local Involvement Network and the Care Quality Commission also undertook checks. Whilst positive comments could not be inserted into the survey results, such observations could be reported to the committee. Fiona Wise acknowledged that most hospitals did not have a private area for patients' relatives, however there was a Bereavement Officer available to help in such matters.

10. **North West London Hospitals NHS Trust Budget and Annual Plan**

Fiona Wise began by advising that the budget and plan was yet to be formally agreed by the Department for Health. An underlying deficit remained and the report explained why the budget gap had widened in 2010/11 compared to 2009/10, with the deficit now at £11.6m. This was partly attributable to the loss of non-recurring funding, including Urgent Care Centre funding. Fiona Wise drew Members' attention to the savings proposed to reduce the deficit as set out in the report.

During discussion, Councillor Hunter asked if service delivery could be maintained in the face of the savings that were proposed. Councillor Daly sought further details of what kind of efficiency savings would be made and commented that reducing in-patient time may increase the risk of patient admissions. Councillor Cheese also felt that this was a risk and that such a measure may be rendered a false economy. Councillor RS Patel enquired whether consideration had been given to merging the Trust with Ealing NHS in order to help achieve savings. Councillor Colwill suggested that Government funding for frontline health services had been offered and he enquired why it was not being used for this purpose.

The Chair enquired how certain was the Trust that it could achieve £9.7m savings through the Annual Plan and she asked for an update on this item at the 29 November meeting.

In response, Fiona Wise stated that it was not intended to make all the savings required in one year as a balance needed to be maintained between maintaining service delivery and achieving savings. Efficiency savings measures included shortening the length of hospital stay for patients, re-organising staff rotas and reducing management overheads. Every effort was being made to minimise redundancies. Fiona Wise acknowledged that reducing patients' length of stay could increase the risk of re-submissions, however consideration needed to be given as to what the optimum length of stay is for each patient and many patients in any case wanted to return home at the earliest opportunity. She cited developments in best medical practice with regard to this issue, such as patients who had knee operations whose recommended length of stay in hospital had been reduced from ten to four days. The STARS scheme also addressed the issue of reducing the number of beds to increase efficiency and effectiveness whilst also reducing costs. Strict rules were in place with regard to administrating medication, ensuring patients were appropriately supervised and carrying out patient checks. In addition, comfort rounds were conducted every two hours to ensure patients' needs were being met. Fiona Wise was confident that the £9.7m Annual Plan savings could be achieved providing the conditions set down were adhered to.

Rob Larkman added that consideration of more radical ways of working was needed to both increase efficiency and achieve the required savings. In addition, the ever changing population of the area needed to be taken into account.

Alison Elliott (Director of Adult Social Care) advised that in relation to the Government funding referred to by Councillor Colwill, the pot of money was not ring fenced and that £3.24m had been allocated to Adult Social Care from Health to help address the council's priorities. The council was working with NHS Brent and Harrow to introduce preventative measures to reduce the number of patients requiring hospital treatment. Adult Social Care and NHS Brent faced huge challenges and Alison Elliott stated that the committee would be informed of how the discussions between the two organisations were progressing.

Members noted that informal discussions were taking place with regard to the possibility of considering a merger with Ealing NHS and update on this would be presented at a future meeting.

11. **Health Partnerships Overview and Scrutiny work programme**

Andrew Davies drew Members' attention to the work programme and welcomed any requests for future topics. Councillor Daly suggested that information be provided on property and land owned by NHS Brent and Harrow in the context of preparing for GP commissioning. Rob Larkman replied that work in respect of this was taking place across the entire North West London and information would be provided to Councillor Daly through Andrew Davies.

12. **Any other urgent business**

None.

13. **Date of next meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled for Tuesday, 20 September 2011 at 7.00 pm.

The meeting closed at 9.40 pm

S KABIR
Chair

Health Partnerships Overview and Scrutiny Committee
20th September 2011

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected:
ALL

Organisational futures: Potential merger of Ealing Hospital NHS Trust with The North West London Hospitals NHS Trust

1.0 Summary

1.1 North West London Hospitals NHS Trust and Ealing Hospital Trust are working on plans for a proposed merger. The Health Partnerships Overview and Scrutiny Committee has previously considered a report on this issue at its meeting in June 2011. An update has been provided by the two hospital trusts on the proposed merger for members to consider (see appendix 1). It should be noted that the original intention was for the committee to consider the Outline Business Case for the merger at its meeting in September 2011. However, this will not be completed until October 2011.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to note the update on the proposed merger between North West London NHS Hospitals Trust and Ealing Hospital Trust and question officers from the trusts on how this work is progressing.

Background Papers:

Organisational futures: Potential merger of Ealing Hospital NHS Trust with The North West London Hospitals NHS Trust – report from Fiona Wise and Simon Crawford – Appendix 1 to this paper.

Contact Officers:

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Appendix 1

Wednesday 31 August 2011

Brent Health Partnership Overview and Scrutiny Committee

Update for meeting held on 20 September 2011

Organisational futures: Potential merger of Ealing Hospital NHS Trust with The North West London Hospitals NHS Trust

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The following provides an update for members of the Brent Health Partnership Overview and Scrutiny Committee regarding the potential merger of Ealing Hospital NHS Trust with The North West London Hospitals NHS Trust.

1. Developing an Outline Business Case

After discussion with NHS London, we have extended the timetable for the development of the Outline Business Case (OBC) and now anticipate that this will be completed in October, rather than the end of August.

We believe that extending the timetable will allow us to articulate more clearly the benefits of integration, the vision for the new organisation and how it will operate from 'day one'. It will also allow us more time to develop the clinical case for change and to conduct further work with local GPs and other key stakeholders on the vision for the future integration of acute and community services.

We have also had further guidance from NHS London regarding the level of financial detail required for the OBC and will be extending the financial modelling up to 2015/2016. The extended timetable will also enable us to take into account NHS North West London's emerging Quality, Innovation, Productivity and Prevention (QIPP) plans. QIPP is a programme across the NHS designed to improve efficiency and quality, as well as reduce costs.

Finally, this additional time will enable further engagement with our stakeholders as we move forward with the development of the OBC.

We are working through how this extension in the OBC timetable will impact on the overall timescale for merger and, if approved, what the timeline would be for the new organisation to become an NHS Foundation Trust.

At the moment we anticipate the Full Business Case (FBC) being produced between March and May 2012 with the merger potentially occurring between July and October 2012.

The OBC will make the case for merger and organisational change. Any potential service change highlighted within the OBC would be subject to the full separate statutory public consultation and scrutiny process which would be led by commissioners.

2. Deliberative events

As members will be aware we held three deliberative events (across Brent, Harrow and Ealing) for local stakeholders at the end of May and beginning of June this year. The events were an opportunity for local stakeholders to find out more about why we are considering a merger and to express their views at an early stage.

A company called Participate Ltd were commissioned to design, and facilitate these events, and pull together a report detailing the main findings, themes and issues raised. This report is on our website and was distributed to participants and other stakeholders in July. This report and its recommendations have been accepted by the Programme Board (established to oversee the potential merger process).

The views expressed at the events are also being used to help inform the development of the Outline Business Case (OBC) and any future communication and engagement plans. We would also like to take this opportunity to thank people for attending. Given that the events were held in the evening, many people gave up their own personal time and for this we are very grateful.

Fiona Wise
Chief Executive
The North West London Hospitals NHS Trust

Simon Crawford
SRO, Programme Board

Wednesday 31 August 2011

Health Partnerships Overview and Scrutiny Committee
20th September 2011

Report from the Director of Strategy, Partnerships and Improvement

For Action

Wards Affected:
ALL

North West London Hospitals NHS Trust Maternity Services Update

1.0 Summary

1.1 NHS London has carried out a review of maternity services across London including at North West London NHS Hospitals Trust. The chair of the Health Partnerships Overview and Scrutiny Committee has asked that this report is presented to the committee so that members are able to see how the service is viewed by NHS London.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to note the update on the North West London NHS Hospitals Trust maternity service and question officers from the trust on the performance of the service.

Background Papers:

Contact Officers:

Phil Newby, Director of Strategy, Partnerships and Improvement
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The North West London Hospitals NHS NHS Trust	Agenda Item	
Brent **Overview & Scrutiny Committee**	Paper	
Meeting on: 20th September 2011	Attachment	2 appendices

Subject: Benchmarking against National and Pan London reports on Maternal Death July 2011

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Summary:
The purpose of this paper is to provide Brent Overview and Scrutiny Committee with assurance that recently published reports relating to National and Pan London maternal deaths have been reviewed by NWLH Trust and appropriately benchmarked for compliance against the recommendations.

The Trust Maternity Services have reviewed the following reports, all published between March to June 2011:

- Centre for Maternal and Child Enquires (CMACE) Report 'Saving Mothers' Lives 2011 (confidential maternal death enquiry 2006-8).
- CMACE 2011 A Review of Maternal Deaths in London Jan 2009-June 2010
- CMACE London Maternal Death Review Trust Specific Feedback Report Jan 2009- June 2010

These reports outline in all 19 recommendations, against which the Trust has benchmarked a positive achievement of 79% compliance. Where gaps in service are identified appropriate actions are being undertaken to address these issues.

Areas for further action to meet the recommendations are:

Two areas of non- compliance with the recommendations have been identified:

- Provision of pre-pregnancy counselling. This is primarily undertaken by the woman's General Practitioner (GP) and local community services. The Trust will work in partnership with commissioners and support community healthcare providers to work towards this recommendation.

- Consultant Obstetricians and Clinical Leadership. This recommendation reflects the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines on the number of Obstetricians recommended per number of births (1:500), continuity of care by a named obstetric consultant and proposed obstetric staffing targets for consultant presence on the labour ward (98hrs). The Trust provides consultant cover to the labour wards; however it is not always possible to provide continuity of care by the same consultant due to their other responsibilities e.g. operating and out-patient clinics. Additional consultant obstetricians would be required to meet this recommendation; a business case is currently being developed for consideration.

Three areas of partial compliance have been identified:

- Women with potentially serious medical conditions require immediate and appropriate multidisciplinary specialist care. . Multidisciplinary specialist care is provided in the majority of areas e.g. diabetes, HIV, obesity, however joint perinatal mental healthcare provision needs to be strengthened.
- Training in recognition and management of the sick and/or deteriorating woman. This training is provided but not currently in a multidisciplinary format as recommended. A new multidisciplinary training programme will be commenced from August 2011 and scenarios will also be included in the mandatory simulation skills and drills programme.
- Interpretation services. Professional interpreters are available 24/7 and parent education classes in eight different languages. However following an annual language profile review a DVD has also been developed to support the provision of maternity care information in the top ten languages, this should be available in the next two months.

The report provides a summary of the National and Pan London reports and Trust position when benchmarked against the recommendations within an action plan template.

The Brent Overview & Scrutiny Committee is asked to:

- Note the Maternity Services benchmarked position August 2011 against national and pan London reports which demonstrate high levels of compliance overall - 79%
- Support the ongoing actions to improve compliance with the recommendations.

Benchmarking against National and Pan London reports on Maternal Death July 2011

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1. Purpose

The purpose of this report is to provide Brent Overview & Scrutiny Committee with assurance that all relevant recently published reports relating to maternal death have been reviewed and appropriately benchmarked for compliance against recommendations. In view of the organisational history of the Trust, in relation to maternal mortality, it is important that Brent Overview & Scrutiny Committee is given assurance that the Trust maternity services have implemented the recommendations and that processes are monitored in a robust and systematic manner. Where gaps in service are identified the Women's management team are taking action to address these issues.

The three publications relevant to this paper are:

- CMACE Report 'Saving Mothers' Lives 2011 (confidential maternal death enquiry 2006-8).
- CMACE 2011 A Review of Maternal Deaths in London Jan 2009-June 2010
- CMACE London Maternal Death Review Trust Specific Feedback Report Jan 2009- June 2010

2. Definition of a Maternal Death

A maternal death is a death occurring during pregnancy or within 42 days of delivery, miscarriage, termination of pregnancy or ectopic.

- *Direct* – as a direct result of pregnancy
- *Indirect* – as a result of pre-existing or new medical or mental health conditions aggravated by pregnancy, such as heart disease or suicide
- *Coincidental (*fortuitous) – are unrelated to pregnancy
- *Late (*between 42-365 days after delivery) – are those occurring between 6 weeks and 1 year after delivery, and can be direct, indirect or coincidental causes

3. CMACE Report ‘ Saving Mothers’ Lives (published March 2011)

The overwhelming strength of successive CMACE {Centre for Maternal and Child Enquiries} Enquiry Reports has been the impact their findings have had on maternal and neonatal health in the UK and further afield. Over the years there have been many impressive examples of how the implementation of their recommendations and guidelines have improved policies, procedures and practice and saved the lives of more mothers and babies.

Encouraging results are given in this report, in particular the reduction of *Direc*t causes, especially thromboembolism. Another example is the increasing number of women booking for maternity care by 12 completed weeks of pregnancy, a key recommendation in earlier reports and which has been chosen to be a cornerstone of maternity-care provision in England. However, in other areas, improvements remain to be seen, and therefore some recommendations have been repeated from the last Report.

3.1 ‘Top Ten’ recommendations:

The CMACE report states that over time, as the evidence base for clinical interventions has grown, and with the expansion of the enquiry into other professional areas, the wider social and public-health determinants of maternal health, the number of recommendations made in this Report has increased. However this has made it difficult for commissioners and service providers, in particular at Trust level, to identify those areas that require action as a top priority. Therefore this report contains a list of ‘Top Ten’ recommendations which all stakeholders involved in providing maternity services are advised to introduce, and audit as soon as possible.

Upon receipt of the CMACE report, Maternity services provided a report to the Patients Safety and Quality Committee in March 2011. The Top Ten recommendations have been reviewed and a benchmarked position determined with an action plan incorporated (Appendix 1). The action plan provides assurance to the Trust Board of compliance with the recommendations and will be performance managed through the Maternity Governance Board and Patients Safety and Quality Committee.

CMACE Report ' Saving Mothers' Lives

	'Top Ten' Recommendations	RAG Status
1.	Pre-pregnancy counselling	
2.	Professional interpretation services	
3.	Communications and referrals	
4.	Women with potentially serious medical conditions require immediate and appropriate multidisciplinary specialist care	
5.	Clinical skills and training	
6.	Specialist clinical care: identifying and managing very sick women	
7.	Systolic hypertension requires treatment	
8.	Genital tract infection/sepsis	
9.	Serious Incident Reporting and Maternal Deaths	
10.	Pathology	

4. CMACE 2011 Review of Maternal Deaths in London Jan 2009-June 2010

During 2010 London Local Supervising Authority (LSA) and NHS London became concerned that there was an apparent increase in the number of the maternal deaths occurring in London. CMACE was therefore commissioned by the LSA and NHSL to:

- Investigate an apparent increase in the number of maternal deaths in London during 2009 and 2010;
- Identify trends and themes associated with these maternal deaths;
- Identify learning points specific to London;
- Ensure the continuing provision of safe maternity services in London

The World Health Organisation (WHO) definition of maternal death was used for the review: " the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes".

4.1 Results

It was found that between the dates above there were 42 maternal deaths notified to CMACE meeting the case definition.

Direct	Indirect	Coincidental	Late	Unknown	Total
17	19	2	2	2	42

During this period for NHS London the maternal mortality rate (the number of maternal deaths per 100,000 maternities) was calculated as 19.3 and demonstrates a statistically significantly increased rate compared with the (provisional) national rate for this time, 8.6.

4.2 Clinical and socio- demographic factors

Haemorrhage and sepsis were the most common causes of *Direct* maternal deaths, and diseases of the central nervous system and infectious diseases were the most common cause of *Indirect* deaths.

There was an increased risk identified for younger and older women, a higher number had their ethnicity classified as 'Other', more had been born in Asia, compared with the maternal death populations for the 2006-8 Maternal Death Enquiry. The deprivation profile for this group was broadly similar to that found in the MDE report. 36 % had previous pregnancy complications with previous Caesarean Section being the most common, followed by mental health (17%), gastro-intestinal(14%), respiratory (12%), sepsis (12%).Just under half of the women (43.7%) were overweight, obese or very obese. 55% of the women booked for antenatal care by 12 weeks, 30% in second trimester and 5% in the third trimester. 31of the maternal deaths occurred in the first six weeks postpartum.

NWLH NHS Trust maternity population have a 44% high risk category.

Gestation of pregnancy at which women died:

1st trimester 0-12 weeks	12-24 weeks	25-29 weeks	30-37 weeks	>37 weeks	Total
2	5	6	12	17	42

4.3 Conclusion

The report concluded that it had highlighted several interdependent themes contributing to maternal mortality in London, some of which have featured in previous confidential enquiries into maternal death.

Specific challenges were identified in relation to the management of haemorrhage and sepsis which should be addressed along with the need to ensure training in a number of particular areas which have been identified in the report. At a systemic level, the report concludes, there are clear challenges for consultants and senior midwives in delivering their leadership role which requires attention. The need for timely recognition of serious illness was an important recurrent theme.

4.4 Recommendations

Appendix 2 contains the benchmarked position in relation to the nine recommendations and details actions to be taken to achieve compliance.

Review of Maternal Deaths in London Jan 2009-June 2010

	Recommendation	RAG Status
1.	SUI Reports for maternal deaths	
2.	Senior Midwifery Support	
3.	Consultant Obstetricians and Clinical Leadership	
4.	Training in recognition and management of the sick and/or deteriorating woman	
5.	Additional training to address apparent deficits in knowledge	
6.	Haemorrhage	
7.	Sepsis and Viral Infection	
8.	Seasonal influenza vaccination	
9.	Post-mortem examination	

5. CMACE London Maternal Death Review Trust Specific Feedback Report Jan 2009- June 2010

This report was provided to individual Trusts as part of the Pan London report commissioned by LSA and NHSL. The panel ascribed 3 maternal deaths to the Trust in this period and it has not been possible to challenge this as CMACE has ceased to function earlier in 2011. The third women referenced was booked at a neighbouring maternity unit and delivered there, being transferred to NWLH NHS Trust for ITU and St Mark's specialist care and died of her original surgical problems. The cause of death in these three cases is:

1. **Sepsis** :
   This woman had a normal vaginal delivery with third degree tear in her second pregnancy. She was discharged from hospital and then readmitted with abdominal pain and feeling unwell. Her care was complicated by late diagnosis of a ruptured caecum by the surgical team at the London hospital where she delivered.

2. **Diseases of the central nervous system**:
   This woman was in her first pregnancy at Northwick Park Hospital, low risk at booking who presented at term in a collapsed state, an Emergency Caesarean Section was performed and mother diagnosed with a subarachnoid haemorrhage, she subsequently died at a tertiary hospital. Baby was born in a poor condition and transferred to a tertiary Neonatal Unit and died.

3. **Categorised as 'other'** :
   This woman had delivered her fourth baby at Northwick Park Hospital and at 11days postnatal, self-referral to A&E having collapsed at home, complaining of right sided abdominal/groin pain followed by reduced power and numbness in her right leg and then 'blacked out'. - impression ?DVT ?Sepsis. Seen on Delivery Suite and referred for a CT, patient collapsed, surgical intervention was on-going, noted to have a right Common Iliac Artery tear/rupture 3cm below the aortic bifurcation. The iliac artery was repaired, however complete haemostasis was not achieved and patient was transferred to ITU and died subsequently.

5.1 Learning points

There were six learning points highlighted for NWLH Trust in this report and are addressed in the two appendices attached and also form part of the action plan from the last maternal death SUI action plan which is currently being implemented.

1. The Labour Ward co-ordinator should be supernumerary
2. Adherence to the 4 hour discharge target in A&E meant an inappropriate transfer to the obstetric unit. The patient should be treated at the most appropriate place regardless of targets.
3. Critically ill postpartum women who have no obstetric cause for their illness should not be treated on the Labour Ward.

4. Training is needed in the identification and treatment of a critically ill patient
5. There should be early escalation and involvement of senior staff.
6. Always reconsider differential diagnoses and review management plans if a patient remains unwell.

6. Conclusion

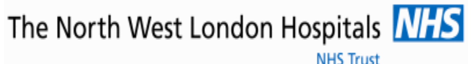
The CMACE national maternal death confidential enquiry 2006-8, the CMACE Pan London Maternal Death Review January 2009-June 2010 and the individualised Trust report on maternal deaths occurring in that period have been reviewed by maternity services in a timely and appropriate manner. These reports have been reviewed and benchmarked by the multidisciplinary team to assess the maternity service in terms of robust clinical governance arrangements, workforce, leadership and compliance with quality standards which optimise patient safety. Overall in 19 recommendations 79% compliance was achieved.

These reports acknowledge the challenges of providing maternity care in London which is one of the most diverse cities in the world, which has experienced a rapidly growing population, with ever increasing numbers of births. Obesity, diabetes, and the age at which women give birth and the use of fertility treatment are all increasing. These factors increase the risk of medical complications, making thorough risk assessment and early management of complications essential.

Areas of non-compliance by the Maternity services with recommendations in the reports have been assessed and RAG rated and action plans with appropriate monitoring arrangements agreed. Where appropriate these risks are recorded on the Maternity Risk register with mitigating actions.

The Brent Overview and Scrutiny Committee can be assured that the Trust has a robust clinical governance framework in place with a clear escalation process to the Trust Board. The actions contained in the benchmarked action plans will be performance managed through the Divisional Governance framework and reviewed and monitored regularly by the Trust Patient Safety and Quality Committee within agreed time scales.

Colette Mannion, Head of Midwifery and Gynaecology
Carole Flowers, Director of Nursing
27th August 2011



Appendix 1

The North West London Hospitals NHS Trust
Women and Children's Directorate: Maternity Services,
Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008 (Supplement to BJOG)

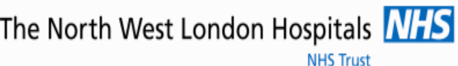
The Maternity Services National Recommendation and Guidelines Review Team	
Initials	**Clinical Specialisation**
CM	Head of Midwifery and Gynaecology
OL	Clinical Director of Obstetrics
BD	Obstetric Lead for Risk Management
GU	Public Health Development Lead
TM	Consultant Midwife
GL	Matron Inpatient Services
GN	Matron Community Midwifery Services
LS	Matron Delivery Suite
PM	Maternity Clinical Risk Manager
NR	Anaesthetic Lead for Obstetric Risk Management
RN	Neonatology Lead for Obstetric Risk Management
SP	Radiology Lead for Obstetric Risk Management

Compliance Matrix: Fully Compliant Partially Compliant Non-Compliant Non Applicable

The North West London Hospitals NHS Trust Women and Children's Directorate: Maternity Services Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008 (Supplement to BJOG)					
Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
Planning Local Maternity Services					
1 Pre Pregnancy counselling 1.1 Women of childbearing age with pre-existing medical illness, including psychiatric conditions, whose conditions may require a change of medication, worsen or otherwise impact on a pregnancy should be informed of this at every opportunity. This is particularly important since 50% of pregnancies are not planned. They should be proactively offered advice about planning for pregnancy and the need to seek pre-pregnancy counselling whenever possible. Prior to pregnancy, these women should be offered specific counselling and have a prospective plan for the management of their pregnancy developed by clinicians with knowledge of how their condition and pregnancy interact . 1.2 Pre-pregnancy counselling services, starting for women with pre-existing medical illnesses, but ideally for all women planning a pregnancy, are a key part of maternity services and should be routinely commissioned as an integral part of the local maternity services network. They could be provided by the GP practice, specialist midwives or other specialist clinicians or obstetricians, all of whom should be suitably trained and informed. General practitioners should refer all relevant women to the local services if they do not provide such counselling themselves.	Develop robust pre-conception counseling services in Brent and Harrow. Locate current commissioning source for preconception care and re-direct funding to maternity services where preconception care will be well managed and established.	Working in collaboration with PCTs & GP to develop a preconception service model especially for women with pre-existing medical diseases or condition. Maternity services will work in conjunction with , PCTs and Local Authorities to ensure that: Local multi-agency health promotion arrangements are available for women in groups and communities who under-use maternity services or who are at greater risk of poor outcome (Vulnerable women) Maternity records should include section on plans for preconception care in subsequent pregnancies for women with pre-existing medical conditions Develop a preconception care strategies	CM/GU/P CT Leads	Review September 2011	**Non-Compliant**

The North West London Hospitals NHS Trust
Women and Children's Directorate: Maternity Services
Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008 (Supplement to BJOG)

Recommendations	Local Provision/ Evidence of Implementation	Actions	Lead	Time Scale	Compliance
Planning Local Maternity Services					
2 Professional Interpretation Services Professional interpretation services should be provided for all pregnant women who do not speak English. These women require access to independent interpretation services, as they continue to be ill-served by the use of close family members or members of their own local community as interpreters. The presence of relatives, or others with whom they interact socially, inhibits the free two-way passage of crucial but sensitive information, particularly about their past medical or reproductive health history, intimate concerns and domestic abuse.	Professional interpreters available 24/7 and language	Conduct an annual language profile in maternity services to improve communication barriers for servicer users in the high priority language groups. Parent Education classes in 8 different languages	**GU**		**Fully Compliant**
	Developing maternity information DVD in 10 languages.	Complete DVD production		Review September 2011	**Partially Compliant**
3 Communications and referrals 3.1 Referrals to specialist services in pregnancy should be prioritised as urgent. In some specialities, routine referrals can take weeks or months, or even be rejected because of local commissioning rules. This is unacceptable for pregnant women. The referral must clearly state that the woman is pregnant, and its progress must be followed up. Trainee doctors and midwives should have a low threshold for referral "upwards" and just receive an immediate response. Referral between specialities should be at a senior level. When rapid referral is required, the senior doctor should use the telephone. 3.2 Good communication among professionals is essential. This must be recognised by all members of the team looking after a pregnant woman, whether she is "low risk" or "high risk". Her GP must be told that she is pregnant. If information is required from another member of the team, it is not enough to send a routine request and hope for a reply. The recipient must respond promptly, and if not, the sender must follow it up. With a wide variety of communication methods now available, including e-mail, texting and fax, teams should be reminded that the telephone is not an obsolete instrument.	Guideline is in place and Implemented. Implementation a new inter-professional communication tool (SBAR) used during handover and referral process. A standard letter is sent to the GP when a woman is high risk				**Fully Compliant**

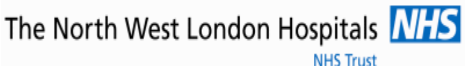


The North West London Hospitals NHS Trust
Women and Children's Directorate: Maternity Services
Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008 (Supplement to BJOG)

Recommendations	Local Provision/ Evidence of Implementation	Actions	Lead	Time Scale	Compliance
Planning Local Maternity Services					
4 Women with potentially serious medical conditions require immediate and appropriate multidisciplinary specialist care Women with pre-existing disease at the start of pregnancy: 4.1 Women whose pregnancies are likely to be complicated by potentially serious underlying pre-existing medical or mental health conditions should be immediately referred to appropriate specialist centres of expertise where both care for their medical condition and their obstetric care can be optimized. Providers and commissioners should consider developing protocols to specify which medical conditions mandate at least a consultant review in early pregnancy. This agreement should take place via local maternity networks. Pregnant women who develop potential complications: 4.2 Women whose pregnancies become complicated by potentially serious medical or mental health conditions should have an immediate referral to the appropriate specialist centres of expertise as soon as their symptoms develop. 4.3 In such urgent cases, referral can take place by telephone contact with the consultant or their secretary (to make sure they are available or identify an alternative consultant if not), followed up by a fax if necessary. 4.4 Midwives and GPs should be able to refer women directly to both an obstetrician and a non-obstetric specialist – but must inform the obstetrician. The midwife should, wherever possible, discuss this with, or alert, the woman's GP.	Conjoint Diabetic and Medical High Risk, FGM, Fetal medicine, Guideline in place. Haematology, Obesity and HIV clinics in place, with specialist input from Anesthetist, Neurologist and other patient specific consultant input. Specialist Midwives are in place to support: Infectious diseases (HIV), Diabetes, FGM, Haemoglobinopathies, Safeguarding, Teenage pregnancy, antenatal & newborn screening and pregnancy loss. New perinatal mental health midwife recruited due to start in September 2011	Require joint perinatal mental health care provision with North West and Central Mental Health Trust.	CM/GU/PCT Leads	Review September 2011	**Partially Compliant**

The North West London Hospitals NHS Trust Women and Children's Directorate: Maternity Services Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008 (Supplement to BJOG)					
Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
Planning Local Maternity Services					
5 Clinical skills and training 5.1 Back to basics. All clinical staff must undertake regular, written, documented and audited training for the identification and initial management of serious obstetric conditions or emerging potential emergencies, such as sepsis, which need to be distinguished from commonplace symptoms in pregnancy. 5.2 All clinical staff must also undertake regular, written, documented and audited training for: The understanding, identification, initial management and referral for serious commoner medical and mental health conditions which, although unrelated to pregnancy, may affect pregnant women or recently delivered mothers. These may include the conditions in recommendation 1, although the list is not exclusive. The early recognition and management of severely ill pregnant women and impending material collapse. The improvement of basic, immediate and advanced life support skills. A number of courses provide additional training for staff caring for pregnant women and new-born babies.	Mandatory training for doctors and midwives in recognition of deteriorating patient and care escalation process				**Fully Compliant**

The North West London Hospitals NHS Trust Women and Children's Directorate: Maternity Services Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008 (Supplement to BJOG)					
Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
Planning Local Maternity Services					
6 Specialist clinical care: identifying and managing very sick women 6.1 There remains an urgent need for the routine use of a national modified early obstetric warning score (MEOWS) chart in all pregnant or postpartum women who become unwell and require either obstetric or gynaecology services. This will help in the more timely recognition, treatment and referral of women, who have, or are developing, a critical illness during or after pregnancy. It is equally important that these charts are also used for pregnant or postpartum women who are unwell and are being cared for outside obstetric and gynaecology services e.g. Emergency Departments. Abnormal scores should not just be recorded but should also trigger an appropriate response. 6.2 The management of pregnant or postpartum women who present with an acute severe illness, e.g. sepsis with circulatory failure, pre-eclampsia/eclampsia with severe arterial hypertension and major haemorrhage, requires a team approach. Trainees in obstetrics and/or gynaecology must request help early from senior medical staff, including advice and help from anaesthetic and critical care services. In very acute situations telephoning an experienced colleague can be very helpful. The recent RCOG guideline of the duties and responsibilities of consultant on call should be followed. 6.3 Pregnant or recently delivered women with unexplained pain severe enough to require opiate analgesia require urgent senior assessment/review.	Mandatory training for doctors and midwives in recognition of deteriorating patient and care escalation process The national modified early obstetric warning score (MEOWS) chart guideline is in place implemented.				**Fully Compliant**



The North West London Hospitals NHS Trust Women and Children's Directorate: Maternity Services Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008 (Supplement to BJOG)					
Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
Planning Local Maternity Services					
7 Systolic hypertension requires treatment 7.1 All pregnant women with pre-eclampsia and a systolic blood pressure of 150-160 mmHg or more require urgent and effective anti-hypertensive treatment in line with the recent guidelines from the National Institute for Health and Clinical Excellence (NICE) 3. Consideration should also be given to initiating treatment at lower pressures if the overall clinical picture suggests rapid deterioration and/or where the development of severe hypertension can be anticipated.	Guideline in place and implemented. Daily clinical review meetings with teaching.				**Fully Compliant**

The North West London Hospitals NHS Trust Women and Children's Directorate: Maternity Services Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008 (Supplement to BJOG)					
Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
Planning Local Maternity Services					
8 Genital tract infection/sepsis 8.1 All pregnant and recently delivered women need to be informed of the risks and signs and symptoms of genital tract infection and how to prevent its transmission. Advice to all women should include verbal and written information about its prevention, signs and symptoms and the need to seek advice early if concerned, as well as the importance of good personal hygiene. This includes avoiding contamination of the perineum by washing hands before and after using the lavatory or changing sanitary towels. It is especially necessary when the woman or her family or close contacts have a sore throat or upper respiratory tract infection. 8.2 All health care professionals who care for pregnant and recently delivered women should adhere to local infection control protocols and be aware of the signs and symptoms of sepsis in the women they care for and the need for urgent assessment and treatment. This is particularly the case for community midwives, who may be the first to pick up any potentially abnormal signs during their routine postnatal observations for all women, not just those who have had a caesarean section. If puerperal infection is suspected, the woman must be referred back to the obstetric services as soon as possible. 8.3 High dose intravenous broad-spectrum antibiotic therapy should be started as early as possible, as immediate antibiotic treatment may be lifesaving. It should be started within the first hour of recognition of septic shock and severe sepsis without septic shock, as each hour of delay in achieving administration of effective antibiotics is associated with a measurable increase in mortality. [4,5] 8.4 There is an urgent need for a national clinical guideline to cover the identification and management of sepsis in pregnancy, labour and the postnatal period and beyond. This should be available to all health professionals, maternity units, Emergency Departments, GPs and Community Midwives. Until such time as a national guideline is developed, the principles for the management of acute sepsis as detailed in Chapter 16: Critical Care of this Report should be adopted. These are derived from those developed and updated by the Surviving Sepsis Campaign. [4] 8.5 Consideration should be given to adopting a more rational system for classifying maternal deaths from sepsis, as suggested in Annex 7.1	Sepsis care bundle guideline in place and implemented				**Fully Compliant**

The North West London Hospitals NHS Trust Women and Children's Directorate: Maternity Services Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008 (Supplement to BJOG)					
Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
Planning Local Maternity Services					
9 Serious Incident Reporting and Maternal Deaths All maternal deaths must be subject to a high quality local review. In England and Wales the framework for such serious incidents (previously known as Serious Untoward Incidents/SUIs) is set out in the NPSA's "National Framework for Reporting and Learning from Serious Incidents Requiring Investigation" issued in March 2010. The results of such high quality reviews must be disseminated and discussed with all maternity staff and their recommendations implemented and audited at regular intervals.	Guidelines are in place. All SUI are monitored and reported appropriately. SUI and maternal deaths are critically reviewed and lesson learnt actively disseminated	Conduct a Trust specific CMACE seminar facilitated by CMACE organization			**Fully Compliant**
10 Pathology The standard of the maternal autopsy must be improved. The numbers of locations where they are performed should reduce, with specialist pathologists taking them on as part of agreed job plans. More clinical discretion over reporting maternal deaths to coroners is required, and there should be a complementary major input by clinicians into obtaining more consented hospital autopsies.	Sector wide approach adopted with the perinatal pathologist at Hammersmith hospital or recognized credited perinatal pathology				**Fully Compliant**

References

3 National Collaborating Centre for Women's and Children's Health. Hypertension in pregnancy: the management of hypertensive disorders during pregnancy. National Institute for Health and Clinical Excellence Guideline 107. London: RCOG, August 2010 (http://guidance.nice.org.uk/CG107/]. Accessed 5 October 2010

4 Dellinger RP, Levy MM, Carlet JM, Bion J, Parker MM, Carlet JM, et al. Surviving Sepsis Campaign: international guidelines for management of severe sepsis and septic shock. Crit Care Med 2008; 36:296-327.

5 Royal College of Pathologists, Guidelines on Autopsy Practice. Scenario 5: Maternal Death. London: Royal College of Pathologists: 2010.

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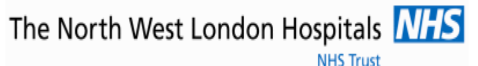

Appendix 2

The North West London Hospitals NHS Trust
Women and Children's Directorate: Maternity Services
CMACE Review of Maternal Deaths in London January 2009- June 2010 Commissioned by NHSL

The Maternity Services National Recommendation and Guidelines Review Team	
Initials	**Clinical Specialisation**
CM	Head of Midwifery and Gynaecology
OL	Clinical Director of Obstetrics
BD	Obstetric Lead for Risk Management
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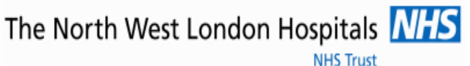
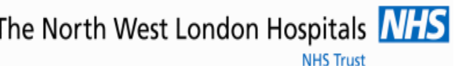
RN	Neonatology Lead for Obstetric Risk Management
SP	Radiology Lead for Obstetric Risk Management

Compliance Matrix: Fully Compliant Partially Compliant Non-Compliant Non Applicable



The North West London Hospitals NHS Trust Women and Children's Directorate: Maternity Services CMACE Review of Maternal Deaths in London January 2009- June 2010 Commissioned by NHSL					
Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
1 Serious Incident Requiring Investigation (SIRI) Reports for maternal death investigation 1.1 A standard template, such as the one provided by NPSA, should be adopted and completed in full for all maternal deaths. SIRI reports for maternal death should include substantial involvement from a senior clinician and /or senior manager external to the Trust	Maternity Services use the NPSA template for all SUI reports. External reviews are commissioned as required as part of the SUI process. Executive Director chairs the SUI panel All SUI are monitored and reported appropriately. SUI for maternal deaths are critically reviewed and lesson learnt actively disseminated		Head of Midwifery, Clinical Director, Maternity Clinical Risk Manager		**Fully Compliant**

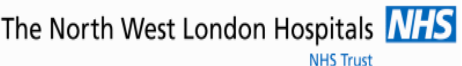


The North West London Hospitals NHS Trust
Women and Children's Directorate: Maternity Services
CMACE Review of Maternal Deaths in London January 2009- June 2010 Commissioned by NHSL

Recommendations	Local Provision/ Evidence of Implementation	Actions	Lead	Time Scale	Compliance
2 Senior Midwifery Support 2.1 The Labour Ward coordinator must be supernumerary. There must be an escalation process to address exceptional instances where due to low staffing or high clinical activity, this is not feasible, to ensure high quality care and best use of resources at all times.	Crewing on Delivery Suite to reflect supernumerary status of coordinator with robust escalation process in guidelines. Annual staffing and acuity audit to inform business planning process. Achieved CNST Level 1 December 2010		Head of Midwifery & Matrons		**Fully Compliant**
2.2 Early involvement of Supervisors of Midwives must be sought when the maternity service is regarded as becoming unsafe or when staff feel that need an enhanced level of support, eg when a woman is critically ill.	Supervisor of Midwives rota in place ensuring 24/7 access to on call Supervisor. SoM to midwife ratio monitored on Maternity Dashboard against NMC standard 1:15 SoM involvement in clinical risk monitored	To continue to nominate midwives to the role to achieve NMC standard as currently 1:18 To monitor calls to the SoM to ensure escalation of unsafe conditions	SoM team & Head of Midwifery		**Fully compliant**

3 Consultant Obstetricians and clinical leadership					**Non compliant**
Recognising the importance of senior obstetric involvement in the care of women with medical and obstetric complications;				September 2011	
3.1 Each unit should have a recognized Labour Ward Lead Consultant	Labour Ward Lead in post with clear outline of role and responsibilities	Business case to be presented to the Executive Committee to consider increase in consultant obstetrician establishment from 9 to ideally 12 to ensure 98 hour presence on DS	Clinical Director, Divisional General Manager, Head of Midwifery		
3.2 Consultants should be present on Labour Ward during all rostered sessions	60 hours presence only provided, non-compliant with RCOG guidelines				
3.3 Consultants should be proactive in leading, planning and reviewing the care of women with complicated medical, antenatal, intrapartum or postnatal care.	I post vacant, 2 locum Consultants in post, shortage of manpower.				
	Guideline in place for care plans for management of high risk women.				
3.4Particular attention should be paid to continuity of care each day and throughout a woman's admission, ensuring adequate arrangements are in place for the transfer of clinical information.	Continuity of care not achievable due to shortage of consultants and Obs/Gynae split in job plans.				
3.5 Women with complex co-existent clinical conditions require continuity of care from their named obstetric consultant (or designated colleague) regardless of their place of admission	Not achievable with current obstetric establishment. Consultants cover DS and wards as part of a rota				

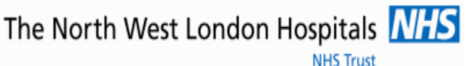
4. Training in recognition and management of the sick and/or deteriorating woman					Partially Compliant
4.1 Maternity services providers should provide training to all clinicians to ensure that they are competent and confident in the recognition and management of the sick and/or deteriorating woman.	Training provided to midwives and nurses separately from doctors.	Training Needs Analysis to be updated to include this topic as mandatory for midwives, nurses and doctors.	Head of Midwifery, RCOG Tutor and Consultant Midwife for Normal Birth& Education team	September 2011	
4.2 Training should be multidisciplinary, regular and attendance should be audited	Annual training for midwives and nurses and monitored and audited				
4.3Training should emphasize early involvement of anesthetists in the care of sick women	Compliant and Reinforced on HDU study day				
4.4 Consideration should be given to running real time drills in the clinical area	Currently not part of Drills and Skills	To be added to the mandatory Drills and Skills programme commence in August 2011			



The North West London Hospitals NHS Trust Women and Children's Directorate: Maternity Services CMACE Review of Maternal Deaths in London January 2009- June 2010 Commissioned by NHSL					
Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
5 Additional training to address apparent deficits in knowledge. **Maternity Service Providers should implement regular training to address deficiencies in the following areas of care, highlighted within the review:** • Recognition of shock • Recognition of abnormal test results including ECG's • Management of PPH including potential side effects of treatment • The use of blood transfusion and preparedness when atypical antibodies are present • Haematological conditions • Fluid balance management • Management in delay in 2nd stage of labour • Signs of and presentation of acute neurological conditions including subarachnoid haemorrhage • Recognition of non-obstetric illness including influenza (seasonal and H1NI)	Mandatory training for doctors and midwives in recognition of deteriorating patient and care escalation process				**Fully Compliant**

The North West London Hospitals NHS Trust
Women and Children's Directorate: Maternity Services
CMACE Review of Maternal Deaths in London January 2009- June 2010 Commissioned by NHSL

Recommendations	Local Provision/ Evidence of Implementation	Actions	Lead	Time Scale	Compliance
Planning Local Maternity Services					
6 Haemorrhage **When managing massive obstetric haemorrhage, clinicians should:** a) Consider the early use of blood products b) Have access to and use near patient haemoglobin testing c) Always ensure accurate measurement of revealed blood loss, acknowledge the inherent inaccuracy of estimated blood loss and recognize the possibility of concealed haemorrhage d) Formally initiate the local major obstetric haemorrhage protocol early during ongoing haemorrhage e) Consider all potential causes rather than focus solely on uterine atony. Clinicians should receive regular education about the clinical signs and symptoms of hypovolaemia (see also recommendation 5)	Mandatory training for doctors and midwives in recognition of deteriorating patient and care escalation process in place The national modified early obstetric warning score (MEOWS) chart guideline is in place implemented.				**Fully Compliant**



The North West London Hospitals NHS Trust Women and Children's Directorate: Maternity Services CMACE Review of Maternal Deaths in London January 2009- June 2010 Commissioned by NHSL					
Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
7 Sepsis and Viral Infection Sepsis and acute viral infection should be considered in the differential diagnosis of all sick women during pregnancy and postpartum period. Appropriate treatments and infection control measures should be adopted where infectious illness is suspected.	Sepsis bundle implemented and monitored.		Clinical Director and Head of Midwifery		**Fully Compliant**

The North West London Hospitals NHS Trust
Women and Children's Directorate: Maternity Services
CMACE Review of Maternal Deaths in London January 2009- June 2010 Commissioned by NHSL

Recommendations	Local Provision/ Evidence of Implementation	Actions	Lead	Time Scale	Compliance
8 Seasonal Influenza vaccination All pregnant women should be strongly recommended to have the seasonal 'flu vaccine. Maternity service providers should reinforce the current DOH recommendation regarding vaccination of staff.	Vaccination programme developed and implemented in primary and secondary care in conjunction with Brent & Harrow PCT with aim of 60% vaccination uptake. OH policy in place recommending vaccination of all front line staff		Consultant Midwife in Public Health , PCT PH Leads & Chief Pharmacist DoN		**Fully Compliant**

The North West London Hospitals NHS Trust Women and Children's Directorate: Maternity Services CMACE Review of Maternal Deaths in London January 2009- June 2010 Commissioned by NHSL					
Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
9 Postmortem examination Postmortem examinations by a specialist pathologist should be performed following all maternal deaths. This may include asking the next of kin to consent to a post mortem if the coroner has not pursued this. When clinicians are certain of the cause of death, they should still contact a specialist pathologist for advice.	All maternal death postmortems are conducted by an accredited perinatal pathologist appointed by HM Coroner				**Fully Compliant**

<table>
<tr><td> </td><td>Health Partnerships Overview and Scrutiny Committee
20th September 2011

Report from the Director of Strategy, Partnerships and Improvement</td></tr>
<tr><td>For Action</td><td>Wards Affected:
ALL</td></tr>
<tr><td colspan="2">Brent Local Involvement Network Annual Report 2010/11</td></tr>
</table>

1.0 Summary

1.1 The Brent Local Involvement Network (LINk) is a member based, community led network of voluntary sector organisations and individuals, which includes residents, service users, businesses and community organisations. The network aims to empower and enable people to have a stronger say in how local health and social care services are commissioned and delivered in the Brent.

1.2 The remit of Brent LINk includes:

- Promoting and supporting the involvement of people in the commissioning, provision and scrutiny of local care services
- Enabling people to monitor the standard of provision of local health and social care services
- Obtaining the views of people about their needs for, and their experiences of, local health and social care services
- Making reports and recommendations about how local care services could or ought to be improved to people responsible for commissioning, providing, managing or scrutinising local services

1.3 By the 30th June each year, the LINk has to produce an annual report. The annual report is a useful mechanism for the Health Partnerships Overview and Scrutiny Committee to consider the work done by the LINk, and decide whether there any issues that could be followed up by members.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the Brent LINk annual report and decide whether it wishes to follow up any issues raised by the LINk in its work programme.

Background Papers:

Brent LINk Annual Report 2010/11

Contact Officers:

Phil Newby, Director of Strategy, Partnerships and Improvement
Email - Phil.newby@brent.gov.uk
Tel - 020 8937 1032

Andrew Davies, Policy and Performance Officer
Email – Andrew.davies@brent.gov.uk
Tel – 020 8937 1609

Brent Local Involvement Network Annual Report

1st April 2010 – 31st March 2011

Cover Photo: Wembley Stadium and the Welsh Harp/Brent Reservoir

Used with kind permission of Welsh Harp Conservation Group

The Welsh Harp Conservation Group was formed in 1972 to protect the Welsh Harp/Brent Reservoir area, not only as a habitat for a variety of birdlife and rare species of flora, but in the interests of public recreation.

http://www.brentres.com/

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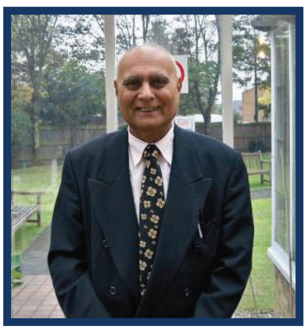
SECTION ONE: *INTRODUCTION*

MESSAGE FROM THE CHAIR



Welcome to Brent Local Involvement Network's 2010/11 Annual Report.

Brent Local Involvement Network (LINk) is an independent network made up of individuals, community groups, voluntary sector organisations and local businesses. We work together to improve local health and adult social care services in Brent.

We do this by:

- *Finding out what people think of their local health and social care services;*
- *Giving people a chance to suggest ideas to care professionals about improving services;*
- *Looking into specific issues of concern to the community;*
- *Making recommendations to the people who plan and run services;*
- *Asking for information about services;*
- *Carrying out visits, when necessary, to see if services are working well.*
- *Referring issues to Brent Council's Overview & Scrutiny Committee if it seems that action is not being taken.*

We are steered by a Management Committee, made up of 11 individuals and voluntary sector organisations. We also have four action groups, covering:

- *Adult Social Care*
- *Primary and Community Care*
- *Mental Health*
- *Hospital Based Issues*

In October 2010, we held our Annual General Meeting. There, we presented our 2009/10 Annual Report and noted major achievements. Key note speaker, Marcia Saunders, NHS Brent Chair, was able to provide a perspective on (the then) new NHS reform proposals and how services would be maintained and improved.

About This Report

This report highlights how Brent LINk has listened to local people over the past year and used this information to help improve local health and adult social care services.

It also demonstrates "*impact through action*": highlighting case studies where we have engaged & participated in the planning, commissioning, delivering and monitoring of health and adult social care services in Brent.

These case studies include Brent LINk's Wellbeing Event held in August 2010. This allowed local people to find out more about promoting mental and physical wellbeing. Voluntary sector organisations and healthcare providers were also on hand to provide expert advice. Thanks to Family Mosaic Housing Association for funding this event.

This year, we also highlight our commitment to community involvement, by including a section called "*Inspiring Others to Get Involved".*

This recounts the story of one of our active participants and how our activities helped build his capacity to have a say in the shaping of health and adult social care services.

We hope his inspiring example will encourage other individuals and groups to get involved.

As with previous years, this year's Annual Report contains a section on who we have engaged over the past year and also a section on where we get our money and how we spent it during 2010/11.

For the coming year, in addition to helping plan, commission and monitor health and adult social care services, our main focus will also be on preparing for *Local Healthwatch:* the new "consumer champion" being introduced as part of the Heath and Social Care Bill.

At the time of writing, it is expected that October 2012 will see LINks undertake the role of Local Healthwatch. This means an increased role for Brent LINk in areas like commissioning health & social care and devising local health profiles.

Over the next 12 months, we will be working to ensure that Brent LINk is ready for the opportunities and challenges presented by Local Healthwatch.

This transitional work will include reviewing existing structures and the training needs of Management Committee members.

Brent LINk is committed to empowering local people to have a voice in how their health and adult social care is designed and delivered.
Details of how to get involved are outlined on the back page of this Annual Report. Please remember - there are different ways to get involved and different levels of involvement. It can vary from simply joining our newsletter mailing list through to attending one of our Open Forum events or joining a Project Steering Group.

I wish to conclude by thanking my fellow Brent LINk Management Committee members for working collectively for Brent LINk and, as a Management Committee, we would like to thank Brent Council's LINk contract management staff, as well as Hestia host management for the support, expertise & resources which have enabled us to make this last year a success.
I would like to also thank the many local health and social care providers who have worked with us over the last year.

Final special thanks to the people of Brent for drawing our attention to their concerns and working in partnership to effect positive changes for all.
I believe that over the past year, Brent LINk has responded to their concerns and successfully worked to help ensure their voice is heard during the planning, commissioning and monitoring of health and social care in our borough.
Mansukhlal Gordhamdas Raichura
Chair Brent LINk 2010/11

PARTNER FEEDBACK

London Borough of Brent

Public services across the board are going through a period of unprecedented change and reorganisation. Notwithstanding, Brent Council is very pleased to have been able to develop a positive and constructive working relationship with Brent LINk during the last three years. Working with the LINk has enabled the Council and its partners to gain greater insight into the views of local people on health and social care issues.

The Council recently took the decision to extend the contract with Brent's host organisation, Hestia Housing & Support. We are now looking forward to developing an even stronger relationship with Brent LINk. Working closely with the LINk Management Committee, the Host Organisation and our local partners to steer the LINk through its final year and develop a robust model for the creation of Local HealthWatch.

Alison Elliott – Director Adult Social Care (Acting)

Owen Thompson - Head of Consultation

Andrew Davies – Policy and Performance Officer

NHS Brent

NHS Brent, including Brent Community Services, has continued to collaborate with Brent LINk. This collaboration extends to: regular Chairs meeting from both organisations, attendance at each others Board meetings and Annual General Meeting, membership of the Patient and Public Engagement Steering Group and the Brent Health and Social Care Forum and membership on the emerging Patient Participation Groups for the GP Commissioning Consortia. These are all true partnerships between NHS Brent, Brent LINk and the local community, where key themes are mutuality and respect for the strengths that each party brings to the table.

In 2010-11, Brent LINk supported a number of NHS Brent initiatives including: engagement in a workshop to improve the patient experience of primary care (leading to improvements in appointment booking in GP surgeries), sitting on the contract panel to help choose a new provider for the Urgent Care Centre at Central Middlesex Hospital, supporting workshops to improve local mental health services and consulting on the Short Term Assessment, Reablement and Rehabilitation (STARRs) Service to protect people from unnecessary hospital admissions, long hospital stays and long term residential care.

The NHS, and our partners, are going through a period of unprecedented change. Organisations are reducing the size of their staff numbers, whilst still being expected to deliver financial efficiencies and improve health outcomes. This makes our partnerships even more precious. A range of evidence shows that the results from collaboration often outweigh the outputs you would get from each individual organisation. As such, Brent LINk has an important role to play in championing the health and adult social care issues that are

important to local people - particularly those who are seldom heard. NHS Brent, working with our local GPs, still has an important role in translating these issues into improved local health services. We look forward to holding true to these values and partnerships over the coming months and beyond.

Marcia Saunders - Chair of NHS Brent

Isabelle Iny - Non Executive Director: Brent Community Services

Jo Ohlson - Brent Borough Director: NHS Brent

Marco Inzani, Assistant Director: NHS Brent

Care Quality Commission (CQC)

Involving people is central to CQC's work and Brent LINk is a very important source of information about the performance of health and social care, from the point of view of people who use services. The views and experiences of local people help to inform CQC's work in a number of ways: whether it is information about newly registered services or more established providers of health and social care services. For example, it can help us decide whether to trigger a review of compliance for a provider or to bring forward a planned review.

We would like to continue to encourage Brent LINk to send us information about local health and social care services. Local groups can send us information at any time using the online feedback form on the CQC website. We look forward to continuing to develop our relationship with Brent LINk and explore ways of working together more closely in the future.

Judith Edwards

Compliance Inspector - Care Quality Commission London

North West London Hospitals NHS Trust

We are grateful to Brent LINk for its joint working with North West London Hospitals NHS Trust and to Mansukh Raichura, the Brent LINk representative who participates in our Board meetings each month.

Mansukh also sits on the Programme Board advising on and developing the business case for our potential merger with Ealing Hospital NHS Trust. We believe merger and service reorganisation will offer a number of benefits for patients, such as high quality specialist care, larger clinical teams, investment in medicine and equipment, savings in shared management, fewer unnecessary hospital referrals and reduced duplication.

We are also grateful for Brent LINk's participation in our recent public consultation on children's services in Brent and Harrow, which resulted in strong support for the case for change and the proposals to establish two Paediatric Assessment Units at the Central Middlesex and Northwick Park Hospitals and to centralise all overnight inpatient care at Northwick Park.

Finally, we welcome LINk's support for our Quality Account, which includes information about the quality and safety of our services and our priorities for the year ahead. We particularly applaud the role Brent LINk plays as a "critical friend" that is happy to advise us on areas in which we might improve, as well as complimenting us on our efforts and initiatives.

David Cheesman

Director of Strategy - North West London Hospitals NHS Trust

SECTION TWO

BRENT LINk: VISION, STRUCTURE & VALUES

Brent LINk
Unit 56, The Designworks
Park Parade, NW10 4HT

Tel: 020 8965 0309
Fax: 020 8838 0917
Email: brentlink@hestia.org
Website: www.yourbrentlink.co.uk

Host Organisation Details

Local Involvement Networks are facilitated and supported by Host Organisations.

In Brent, the Host Organisation is Hestia Housing and Support.
Hestia is a registered charity, established in 1970. Hestia's vision is ***Empowering People, Changing Lives*** and their mission is to provide high quality services in partnership with users and local communities. Hestia is also the LINk Host organisation for Ealing, Kensington and Chelsea and Hammersmith and Fulham LINks.

Hestia's Role

Hestia's role is to work with the elected Management Committee and wider LINk membership in designing and delivering its work programme. This includes, but is not limited to:

- Capacity building and training of LINk participants in order to allow them to carry out the work of the LINk
- Working with voluntary sector and community organisations to promote and enable participation in the LINk
- Acting as a point of contact for the public, service providers and commissioners
- Carrying out effective administration of the LINk including writing reports and letters in consultation with the Management Committee on behalf of the LINk
- Financial management of resources
- Servicing meetings and facilitating workshops

Hestia Housing & Support, 3rd Floor, Sovereign Court
15 – 21 Staines Road, Hounslow, Middlesex TW3 3HR
Tel: 020 8538 2940 Fax: 020 8572 5617
Email: info@hestia.org

HOST CONTACT: Carla Julien - Director of Operations

The Brent LINk Office (details on page 12) should be the first point of contact if you want to find out more about Brent LINk projects, how to join our network etc.

Brent LINk Organisational Structure

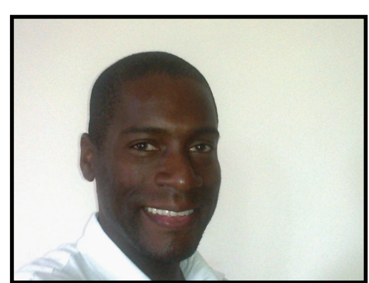
Brent LINk has a Management Committee dedicated to ensuring that individuals, organisations and communities can exert influence and affect positive change in health and social service provision in Brent. Our committee is diverse – reflecting Brent's diverse profile - but also brings expertise in areas such as mental health, learning disability, older people and adult social care.

The Management Committee attended a workshop in 2009 to identify priority areas of work and to decide on what Action Groups would reflect and address community concerns and needs.[1]

Four Action Groups were identified: Adult Social Care; Community and Primary Health Care Services, Hospital Based and Mental Health.

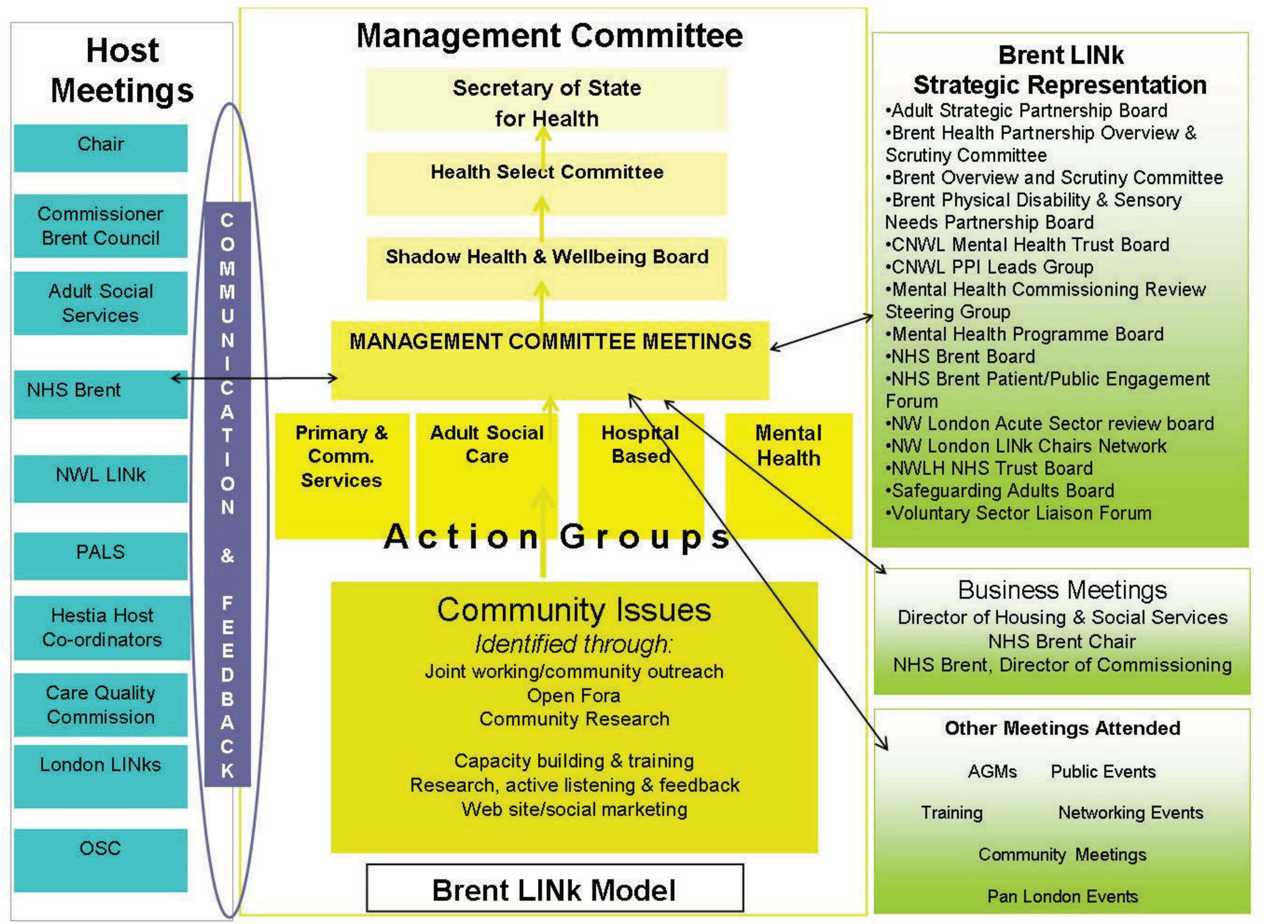
Staffing Arrangements

Brent LINk is supported by two staff members:

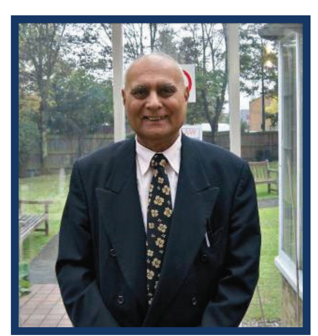


Colin Babb - LINk Co-ordinator   Carol Sealy – LINk Officer

[1] It was decided that Action Group Leads would be selected from the Management Committee.


Host Meetings
Chair
Commissioner Brent Council
Adult Social Services
NHS Brent
NWL LINk
PALS
Hestia Host Co-ordinators
Care Quality Commission
London LINks
OSC
COMMUNICATION & FEEDBACK
Management Committee
Secretary of State for Health
Health Select Committee
Shadow Health & Wellbeing Board
MANAGEMENT COMMITTEE MEETINGS
Primary & Comm. Services
Adult Social Care
Hospital Based
Mental Health
Action Groups
Community Issues
Identified through:
Joint working/community outreach
Open Fora
Community Research
Capacity building & training
Research, active listening & feedback
Web site/social marketing
Brent LINk Model
Brent LINk
Strategic Representation
•Adult Strategic Partnership Board
•Brent Health Partnership Overview & Scrutiny Committee
•Brent Overview and Scrutiny Committee
•Brent Physical Disability & Sensory Needs Partnership Board
•CNWL Mental Health Trust Board
•CNWL PPI Leads Group
•Mental Health Commissioning Review Steering Group
•Mental Health Programme Board
•NHS Brent Board
•NHS Brent Patient/Public Engagement Forum
•NW London Acute Sector review board
•NW London LINk Chairs Network
•NWLH NHS Trust Board
•Safeguarding Adults Board
•Voluntary Sector Liaison Forum
Business Meetings
Director of Housing & Social Services
NHS Brent Chair
NHS Brent, Director of Commissioning
Other Meetings Attended
AGMs
Public Events
Training
Networking Events
Community Meetings
Pan London Events

Our Management Committee



Mansukhlal Gordhamdas Raichura M.Sc Dip.Chem. Eng - Chair

Mansukhlal always seeks to promote community health objectives. He has many years experience working with health care providers to highlight community health and social care issues. Mansukhlal has also been a Voluntary and Community Sector representative on Brent's LSP Board and currently attends Brent's Health Select Committee meetings, as Brent LINk representative.

Jimmy Telesford – Vice – Chair

Jimmy has lived his life as a disabled person. This has given him insight into the difficulties and barriers that disabled people face. Jimmy has worked with disabled people as a representative, advocate and campaigner. Jimmy believes dignity is everyone's human right.

Dr Yoginder S Maini – Vice Chair

Dr Maini is a regular user of NHS services which, he maintains, has given him a wide knowledge of services available to patients. A qualified accountant and fellow of the Life Insurance

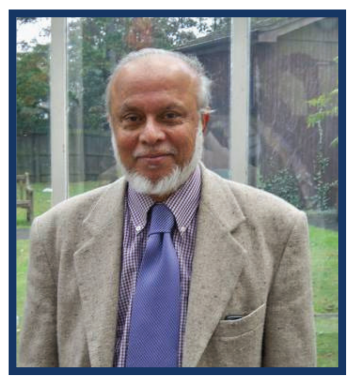
Association, Dr Maini was awarded a PhD in Theology in 2008. He is also Founder Group Secretary of Brent Heart of Gold.

Robert Esson

Robert was born in Willesden Green, Brent. He is a Civil Engineer by profession and holds a BSc and E.Mec. An original member of NW Patients Parliament, Rob is an insulin dependent diabetic and has had both knees replaced. Rob was a part-time carer for his wife and feels he can be an advocate for groups that do not traditionally take part in community activity. Rob is also a member of Brent Association of Disabled People (BADP).

Michael Adeyeye

Michael has been actively involved in Brent's Community/Voluntary sector for nearly 30 years. He is also a Trustee of BADP and Brent African Association. Michael is also a qualified Health and Safety practitioner, with interests in promoting health and safety management in environment.



Dr Golam Ahmed

Joined the NHS in 1973 as a trainee Doctor and obtained a PGDip in ENT (ONT) from London

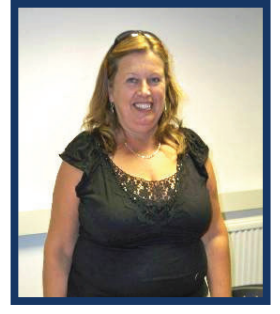
University and a FRCS from Glasgow University. Dr Ahmed has worked in medicine globally and is an advocate for both equitable access and quality of treatment.

Dr Tony Ogefere

Dr Ogefere is Executive Director of SIRI Behavioural Health, providing holistic therapeutic service for disadvantaged people suffering psychosocial and emotional difficulties. Dr Ogefere is also an international Counselling Psychologist and Social work Practitioner in addition to being Governor of CNWL NHS Foundation Trust.

Maurice Hoffman

Maurice is the Work Placement Advisor at Alperton Community School. He has extensive knowledge of NHS commissioning and finances. Maurice wants to contribute to Brent LINk by working with the people of Brent and providers of health and social care.



Ann O'Neill

Ann has worked for Brent Mencap for over 8 years: campaigning for better lives and opportunities for people with learning difficulties. Ann's strengths lie in her knowledge of strategic planning, strategic documents and public speaking. She sits on many strategic boards

and is a former Chair of BRAVA. Ann understands strategic issues and what they might mean in practice to Brent.

Dharampal Kaur / Mrs Singh

Mrs Singh has extensive experience of working in statutory and voluntary services. At present, Mrs Singh is a Brent Age Concern Champion for Older People and a Health Trainer. Over the years, Mrs Singh has worked as a Teacher, Governor, Volunteer Tutor (Expert Patient Programme) and Peer Mentor Volunteer. She has also attended extensive training courses in Health and Social care matters. Mrs Singh is a Life member of the Sikh Missionary Society and has also worked at Amnesty International.

Wendy Quintyne

Wendy is a Brent resident with extensive knowledge of the voluntary and community sector. She understands the vital role the sector plays in providing services: particularly to vulnerable and 'hard to reach' communities. In her, role Wendy strives to promote the well being of older people and works to make later life a healthy, fulfilling and enjoyable experience.

Brent LINks Values

Brent LINk's mission is *'to give communities a stronger say in how their health and social care services are delivered.'* To make this happen, we have adopted a set of values which govern our work and the way in which we engage Brent's diverse communities. These values can be summarised as:

- openness and inclusivity;
- accessibility to all, including people who feel excluded, people who might need support to participate, people with caring responsibilities and people with full time jobs;
- reaching out to all communities: collecting evidence of their views and making those views known to the appropriate bodies;
- recognising that addressing the wider determinants of health (such as income and housing) are central to our role
- communicating information we receive in a constructive way to service planners, commissioners and providers;
- feeding back responses and outcomes to the wider community on a regular basis

Brent LINk

In addition, Brent LINKs recognises that local involvement networks are about whole communities having opportunities to influence health and social care services. To facilitate this, we apply the following values to our governance arrangements:

- adopt shared principles and work together to change things for the better;
- demonstrate values by working with others for everyone's benefit;
- act responsibly and play a full part in the work;
- help people to help themselves;
- take responsibility and answer for actions;
- give everyone a say in how things are done;
- act fairly and in an unbiased way;
- share interests and common purpose with others;
- be open – don't hide it when you are not perfect;
- be honest about what you do and how to do it;
- encourage people to work together to improve their community;
- support similar work that others are doing;
- make a commitment to allow anyone to take part;
- look for opportunities to work together to strengthen accountability locally and beyond; and
- recognise that some people and groups find formal structures daunting and find ways to accommodate their needs.

Names Of Authorised Representatives (For Enter & View):

Mansukh Raichura - Chair	Jimmy Telesford - Vice Chair
Dr Yoginder S Maini - Vice Chair	Robert Esson
Michael Adeyeye	Dr Golam Ahmed
Dr Tony Ogefere	Ann O'Neill
Dharampal Kaur/Mrs Singh	Wendy Quintyne
Carol Sealy – Host	

Names of individuals involved in making relevant decisions[2]

Mansukhlal Raichura	Shadow Health & Wellbeing Board Health Overview Scrutiny Committee NHS Brent & Harrow CNWL Mental Health Trust Board NWL LINK Chairs Network NWLH NHS Trust Board meeting
Mr Maurice Hoffman	CQC Link Advisory Group
Ann O'Neill	Safeguarding Adults Board
Dharampal Kaur/Mrs Singh	Brent Disabled Users Forum

[2] *as defined in Section 2 (1) (a), 2 (2) (a)-(h) and 2 (3) (c) (i) and (ii) of the Local Involvement Networks Regulations 2008.*

Key Strategic Meetings Attended:

- Adult Strategic Partnership Board
- LB Brent Health Partnership Overview & Scrutiny Committee
- LB Brent Overview and Scrutiny Committee
- Brent Physical Disability & Sensory Needs Partnership Board
- CNWL Mental Health Trust Board
- CNWL PPI Leads Group
- Mental Health Commissioning Review Steering Group
- Mental Health Programme Board
- NHS Brent Board meeting
- NHS Brent Patient and Public Engagement Forum
- North West London Acute Sector review board
- NWL LINK Chairs Network
- NWLH NHS Trust Board meeting
- Safeguarding Adults Board
- Voluntary Sector Liaison Forum

SECTION THREE: *BRENT PROFILE*[3]

THE PEOPLE OF BRENT

Brent is one of only two local authorities serving a population where the majority of people are from ethnic minorities, and these groups are increasing faster than any other. Our population is growing and dynamic. Brent's population forecast by the Greater London Authority (GLA) in 2010 was approximately 280,000, although Council-commissioned research suggests that this figure could be over 15,000 higher and is growing steadily.

Almost a quarter of residents are under 19 years old. The GLA predict that Brent's population will increase by roughly 10,000 people every ten years. Brent's population is predicted to be 284,412 by 2014. The highest growth is expected to occur in Tokyington as a result of the Wembley stadium development which is projected to increase by 10,000 by the year 2031.

HEALTH AND WELLBEING IN BRENT

Over the last ten years, rates of deaths from all causes have decreased for both men and women and are lower than the England average. Circulatory diseases, including heart disease and stroke, and cancers are the most common cause of death in Brent. There are significant health inequalities, linked to location, gender, level of deprivation and ethnicity. The most deprived wards in the South of the borough have a

[3] Source: NHS Brent Public Health Annual Report 2009/10

higher death rate, and lower life expectancy than the less deprived wards in the North of the borough.

Colleagues from Brent Community Services attending Brent LINk Wellbeing Event August 2010

Brent has one of the highest rates of diabetes (5.16%) and TB (93.6 per 100,000) in London and in England. Smoking is the single greatest cause of preventable illness and premature death. Obesity is the second most significant contributory factor to ill health and preventable disease. Brent has one of the lowest adult physical activity rates in England with 56% reporting they do not participate in any sporting or physical activity and only 18% taking exercise on 3 occasions a week for 30 minutes.

ACCESS TO SERVICES

There were 359,115[4] patients registered with Brent GPs as at June 2011. Patient turnover at approximately 20% per annum is high. The number of WTE GPs per 100,000 population weighted by age and need was 68.8 per 100,000 in 2006.This is higher than the England rate of 61.8 per 100,000 and the 15th highest in London. Analysis of primary care within Brent shows a higher percentage of smaller practices as compared with national averages.

70% of Brent Practices are one and two handed practices compared to 54% in London and 42% in England. Satisfaction with access to a GP is below the national average. Brent ranks 135th out of 150 PCTs with respect to patient satisfaction of opening hours and for overall satisfaction, Brent ranks 142nd out of 150 PCTs. In a recent survey conducted by IPSOS MORI 83% of respondents said that they were able to get an appointment with a GP within 48 hours compared to 86% nationally and 77% said they were satisfied with opening hours compared with 84% nationally. Many patients would welcome increased opening hours. However, the GP Patient Survey response rate is low compared to the national average.

[4] Source: *"Update on GP Commissioning Report"* LB Brent Health Partnership & Overview Committee, June 2011

SECTION FOUR: *OUR MEMBERSHIP*

Sign up of Participants

By the end of the reported year, we had **668** signed up participants to Brent LINk and reached out to many more people through our outreach work and public events. We have also met with statutory and voluntary agencies that have expressed an interest in becoming involved.

What follows is an analysis of the Brent LINk participant demographics. It illustrates the diverse spread of participants and Brent LINk is proud to have reached out to so many different groups of people in our diverse borough.

Participant Analysis:

Gender	**%**
Number of Females	44
Number of Males	39
Declined to answer	17

Age Group	**%**
16-21	2
22-29	6
30-44	19
45-59	24
60-74	26
75+	7
Declined to answer	16

Disability	**%**
Yes	17
No	57
Declined to answer	26

Sexual Orientation	**%**
Heterosexual	51
Gay	0.5
Lesbian	0
Bisexual	0
Declined to answer	45.5
Other	3

Religion/Faith	**%**
Buddhist	0
Christian	26
Hindu	18
Jewish	1.5
Muslim	12
Sikh	9.5
Other	4
Declined	25
None	4

Ethnicity	**%**
Asian or Asian British- Indian	31.2
Asian or Asian British – Pakistani	4.7
Asian or Asian Other	1.8
Black or Black British- African	9.4
Black or Black British- Caribbean	12.4
Black or Black British- Other	1.2
Chinese	0
Mixed White & Asian	0.2
Mixed White & Black African	0.93
Mixed White & Black Caribbean	0.93
Mixed Other	0.93
Other	1.61
White British	10.9

White Irish	3.1
White Other	2.5
Declined to answer	18.2

Interested Groups

By the end of the reported year, we had **222** participants belonging to interested groups.

Interested Group Monitoring Information Analysis:

Gender	%
Number of Females	43
Number of Males	37
Declined to answer	20

Age Group	%
16-21	4
22-29	6
30-44	19
45-59	23
60-74	25
75+	7
Declined to answer	16

Disability	%
Yes	17
No	56
Declined to answer	27

Sexual Orientation	%
Heterosexual	50
Gay	0.5
Lesbian	0
Bisexual	0.31

Declined to answer	45.69
Other	3.5

Religion/Faith	**%**
Buddhist	0.31
Christian	28.7
Hindu	16.3
Jewish	1.5
Muslim	11
Sikh	8.8
Other	4.2
Declined	24.99
None	4.2

Ethnicity	**%**
Asian or Asian British- Indian	31.2
Asian or Asian British – Pakistani	4.6
Asian or Asian Other	1.8
Black or Black British- African	9.4
Black or Black British- Caribbean	12.4
Black or Black British- Other	1.2
Chinese	0
Mixed White & Asian	0.15
Mixed White & Black African	0.93
Mixed White & Black Caribbean	0.93
Mixed Other	0.93
Other	1.6
White British	10.9
White Irish	3.12
White Other	2.50
Declined to answer	18.34

SECTION FIVE: *DEMONSTRATING IMPACT THOUGH ACTION*

ACTION GROUPS

In order to focus resources on specific issues, Brent LINk has established four Action Groups. These cover: Adult Social Care, Community & Primary Care Services, Hospital Based issues and Mental Health. Key activities are outlined below.

Adult Social Care Action Group

Group Aims:

- Help and improve Adult Social Care provision in Brent
- Make Social Care services more user focussed, by feeding back the views of social care service users to people who deliver those services
- Work strategically with Commissioners and Providers of Social Care services

The Action Group have been working on the following issues:

- Direct Payments
- Centre for Independent Living
- Social Care Charges
- Personalisation and Transformation of Services
- Waiting time for assessments
- Freedom Passes
- Public sector cuts and effects on services
- Support for Carers and Families
- Adult Social Care Customer Journey
- “One Stop Shop” closures
- Stonebridge Day Centre
- Changes to Safeguarding Team

Management Committee Member at a Group Workshop, Brent LINk Well Being Event August 2010

Future Plans

The Action Group aims to provide briefing, seminars and information in partnership with Brent Social Services and other agencies on Personalisation and conduct *Enter and View* visits. Ann O'Neill, Action Group Lead will be the Brent LINk representative on the Adult Strategic Partnership Board, so as to increase strategic involvement in designing and commissioning services.

Primary and Community Care Action Group

Group Aims:

- Communicating Primary Health and Social Care service user issues to relevant service providers & Commissioners;
- Use *enter and view* powers, where appropriate, to collate service user perspective views and experiences;
- Seek the best ways of working with lead officers & Commissioners of Primary Health & Community Care services providers;
- Assist or advise in communication between services users and providers.

The Action Group have been working on the following issues:

- Urgent Care Centre at Central Middlesex Hospital
- Surgeries closure & patient dispersion
- NHS Health Check programme
- GP List validation programme
- Clusters' Patients & public participation group - development work
- Separation of Brent Community Service and into an Integrated Care Organisation
- NHS-Reform Bill – Development of GP Consortia

Future Plans

Monitor impact of reduced PCT staffing levels on the quality of care commissioned & provided. Continue voicing service user concerns and views to commissioners and service providers. Facilitate patient and public participation and involvement in planning, development, commissioning of NHS services.

Hospital Based Action Group

Group Aims:

- Discuss and take action on issues pertaining to Hospital Services i.e. Northwick Park, Central Middlesex or any Hospital Based Service commissioned by NHS Brent;
- Work closely with North West London Trust Board and Care Quality Commission.

The Action Group has been working on the following issues:

- Monitoring changes to Children's Services
- North West London Trust's 2009/10 Quality Accounts
- A&E targets
- Low levels of patient satisfaction
- Merger of Ealing Hospital & NWLH Trusts.

Future Plans

Continue monitoring quality of care provided. Also, lobbying to raise service user issues with health care providers. Ensure that service user concerns and aspirations are integral to any future Trust mergers. Contribute to acute care reconfiguration and NWL Sector's saving plans.

Mental Health Action Group

Group Aims:

Discuss and take action on Mental Health issues in Brent and help improve the quality of Mental Health provision within Brent. This includes:

- Establishing a working relationship with service providers to ensure that service users needs are being met;
- Gaining understanding of the link between Local Authority service providers and Commissioners;
- Interfacing between enhancement services such as Improving Access to Psychological Therapies (IAPT) and Community Development workers (CDW); working to ensure that any such services meet the needs of service users;
- Influencing the design of IAPT and CDW services in partnership with Commissioners;
- Conducting Research;
- Promoting Positive Mental Health in the Community.

The Action Group has been working on the following issues:

- Belvedere House: Successful lobbying to ensure that patient consultation was integral to service reconfiguration plans;
- 2009/10 Quality Account for NWLHT and CNWL;
- Establishing working relationships and partnerships with mental health service providers.

Future Plans

- To continue positive working relationship with current and new service providers;
- To engage with service users, service providers and other stakeholders: mapping out, identifying and addressing gaps in service provision;

- To work in partnership with mental health service providers in the development of a Mental Health Network.

CASE STUDIES

The following case studies highlight how Brent LINk has worked to empower local people to have a say and/or influence health and adult social care services in Brent.

CASE STUDY: Community Consultation Exercise on the Liberating the NHS White Paper, September - October 2010

Summary:

During September - October 2010, Brent LINk engaged local communities in Brent: seeking views on Government's plans for the future of the NHS, outlined in the *Equality and Excellence: Liberating the NHS,* White Paper.

To ensure representation from Brent's diverse communities, Brent LINk organised a range of local community based events. These included:

- *Coffee mornings on 2nd, 16th & 30th September 2010*
- *'Street Talk' – street outreach and listening to the public*
- *Management Committee meeting 1st October 2010*
- *White Paper Information and Public Consultation Event in partnership with NHS Brent 23rd September*

A number of speakers attended the *Information and Public Consultation Event* including Chief Executive NHS Brent, London Borough of Brent Director of

Social Care, GLA Assembly Member for Brent/Harrow and Hestia Chief Executive.

Brent LINk was able to use its local network to collate a diverse range of community responses to the Government's proposals. These were summarised and sent to the Secretary of State for Health, as Brent LINk's contribution to the overall White Paper consultation.

Key Outcomes:

- Local communities were able to have a voice in shaping future healthcare services;
- Brent LINk was able to provide fora for health & social care commissioners/ providers to engage with local communities;
- Brent LINk was able to raise its profile amongst local community health projects and local health economy;
- Brent LINk was able to engage a wide range of communities due to the flexible "menu" of community engagement options (e.g. 'Street Talk' – community outreach engaged young people and other groups typically not engaged in community engagement activity).

Case Study: Brent LINk Wellbeing Event, August 2010

Summary:

The event aimed to promote healthy lifestyles, minds and bodies and included a range of free interactive stalls including: fresh juice bar, dance workshops, "family maths workshops", free treatments,

interactive kids corner, men's health, community health promotion and free Henna designs (see picture below).

Stalls included NHS Brent, Brent Association of Disabled People, Brent Mencap, Brent Mind, Brent Community Services, British Heart Foundation, Health Promotion, Brent Dentistry and Anthony Nolan Trust.

Key Outcomes:

- Participants were able to access practical advice and tips on promoting their physical and mental wellbeing;
- Brent LINk was able to provide a forum for health & social care providers to engage with local communities;
- Brent LINk was able to raise its profile amongst local community health projects and local health economy.

Participant receives free henna design at Brent LINk Wellbeing Event

Mayor of Brent receiving shoulder massage at Brent LINk Wellbeing Event

Case study: *"Navigating Mental Health Services"* Seminar, October 2010

Summary

On 14 October 2010, Brent LINk organised a "Navigating Mental Health Services" service user event at Willesden Library. This was part of a wider strategic review of mental health services in Brent, undertaken by NHS Brent.

The "Navigating Mental Health Services" event offered service users, carers, their families and voluntary organisations an opportunity to:

- discuss experiences of – and difficulties with – accessing mental health services
- identify ways of addressing issues raised
- identify how services need to work in future to enable individuals to move towards recovery utilising a range of resources

Forty five individuals attended the event, including service users, carers, representatives from community & voluntary sector. Commissioning arms of NHS Brent and Brent Mental Health Services also attended.

To focus discussion, participants divided into three groups; addressing acute services, community services and primary care service provision.

Key Outcomes:

- A report was written and sent to mental health commissioners, outlining service user recommendations in areas such as user information, community outreach activity, improved links between GPs and mental health providers and community engagement;

- User feedback helped shape content and priorities for 2011/12 mental health commissioning intentions (including service redesign proposals);

- The event helped raise awareness amongst commissioners of practical service user issues (e.g. time taken to travel to services);

- The event also increased service user knowledge of issues and national policy.

Case Study: Brent LINk Adult Social Care Open Forum, December 2010

Summary:

On 16th December 2010, Brent LINk held an *Adult Social Care Open Forum* for service users, individuals, carers, their families, community & voluntary sector organisations.

The event provided a platform for Brent LINk to provide feedback on how London Borough of Brent was responding to proposed public sector cuts and the subsequent impact on Adult Social Care Services.

Brent LINk was also able to collate a summary of key community concerns and feed these back to LB Brent.

Key Outcomes:

Brent LINk was able to provide feedback to individuals, voluntary sector and community organisations on LB Brent's spending cuts and implications for adult social care services.

Brent LINk was also able to feedback local peoples' experience of adult social care services including: benefits, discharge from hospital, support for Carers, role of voluntary sector organisations, lack of service information/advice and the "Personalisation Agenda". This feed back was used to inform the 2011/12 commissioning cycle.

Inspiring Others to Get Involved

Dave is an active Brent LINk participant who has attended several Brent LINk events. Here, he tells his story to a Brent LINk staff member…

When did you first get involved with Brent LINk activities?

Around June 2010.

How?

I found out about the Brent LINk's community training programme.
I got in touch and signed up for some training including mental health awareness, computer training and effective meeting skills.

Have you attended any of the community engagement events organised by Brent LINk?

Yes. I attended their consultation event: allowing individuals and organisations to comment on the *Liberating the NHS* Government White paper. I also attended an Open Forum Public Meeting, discussing mental health issues.

What did you like about the community engagement events?
Three main things. Firstly, they were a great ways to find out about issues. I am Vice Chair of a local pensioner's organisation. By attending the Brent LINk events, I was able to find out about local health and social care issues and feed these back to our members - some of whom had said that they were "starved of information".

Secondly, the events allowed me to submit views and opinions to decision makers and people who shape health and adult social care service In Brent.

For example, I knew that as part of its NHS White Paper consultation, Brent LINk was collating local organisations' views and sending them to the Secretary of State for Health. I just felt that being part of a wider network increased the chance of our voice being heard.

Finally, the events were a great way to connect with Brent LINk's extensive local network and to find out about different groups and tap into networks with similar issues.

What's really made a difference?
The *Effective Meeting Skills Training* has been really helpful for my work with my organisation.

What would you like you see Brent LINk provide for the future?
More training would be great.

“WHAT YOU SAID, WHAT WE DID”

Over the past year, Brent LINk has attended many community events, fora and meetings.

The following section highlights the issues we identified through our community engagement activity and what we did in response.

What You Said	What We Did
Community Training Brent LINk members felt that targeted training in key areas would build their ability to have a voice in shaping health and adult social care	Brent LINk sought member views and subsequently developed a training programme including: • *Enter & View* • IT skills • Active Citizenship *i.e. Getting community voices heard in decision making* • Mental Health Act
Consultation Brent LINk members wanted to express their views on NHS proposals contained in the *“Liberating the NHS”* – Government White Paper	Brent LINk held a series of *“Liberating the NHS” consultation events* including: • Public consultation event • Information coffee mornings • Community outreach • Street outreach Community responses were

What You Said	What We Did
	submitted to Sec State Health, NHS Brent and other stakeholders
Cross Borough & Sub Regional Work Brent LINk members wanted information on sub-regional LINk Best Practice	Brent LINk initiated and continues to attend sub-regional NWL LINk Chairs Meetings. Subsequently, Brent LINk Chairs and Host (Hestia) meet regularly to discuss and take action on sub-regional issues.
Information LINk members wanted locally accessible and relevant information on physical and mental well being.	Brent LINk successfully bid for a £7,000 grant to host the 2010 Brent Well-being Day. This took place in August 2010 attracting 300 members. Highlights included: • Dissemination of information about health and social care service providers • Free alternative therapies. • Healthy buffet and juice bar.
Brent LINk Adult Social Care Open Forum Members of the public wanted their views, concerns and aspirations about health and social care heard by	Brent LINk held an Open Forum Event attended by over 50 people. It allowed the public to scrutinise commissioning decisions of senior commissioners from NHS Brent and LB Brent (more on page 41).

What You Said	What We Did
providers.	
Brent LINk Youth Forum Young people wanted a platform to articulate their health concerns and aspirations.	Brent LINk: • Facilitated six youth forum meetings • Held an Open Forum with young people and youth stakeholders • Encouraged and supported young people to get involved • Worked to ensure youth issues were addressed by Management Committee and Action Groups.
Targeted Outreach Local Specialist agencies expressed concern at health issues affecting local homeless people.	Brent LINk worked in partnership with St Mungos to engage with homeless people in Brent. This included: • Targeted outreach "tapping into" *St Mungos* local networks • Facilitated coffee morning allowing service users to express views and concerns about health and adult social care. Concerns were fed back to Action Groups who discussed with relevant Lead Officers and specialist GP practice serving transient

What You Said	What We Did
	communities.
Strategic Meetings with Heads of Services Members wanted Brent LINk to be more “plugged in” i.e. bringing patient perspective to strategic decision making and shaping health and adult social care in the Borough.	Brent LINk undertook a partnership development programme. Key successes included: • Invitation to join Mental Health Commissioning Review • Invitation to join Adult Strategy Partnership Board • Invitation to sit on the Commissioning Tendering Panel for Urgent Care Centre, Central Middlesex Hospital • Strategic meetings with Brent Adult Community Services
The LINk received a large number of calls from people who had concerns about elements of the “Personalisation Agenda”.	Brent LINk held an Open Forum Event attended by over 50 people. This included an opportunity for the public to pose questions and concerns to senior commissioners from NHS Brent and LB Brent about personalisation. Brent LINk members continue to bring Personalisation issues to Action Group meetings during 2011/12.

SECTION SIX
LOOKING AHEAD: THE NEXT 12 MONTHS

2010/11 was a busy and successful period for Brent LINk. For the next 12 months, we aim to build upon this success and develop activity in a number of key areas:

Youth Engagement

Brent LINks recognises the need to ensure that it reaches out to a broader range of the community and that getting them involved will be a critical success factor.

For the coming year, we will be designing and delivering a youth engagement outreach programme.

This will initially entail engaging young people and youth organisations: identifying young people's health issues and their experience of health and adult social care services – either as patient, service user, carer or family member.

As well as developing activities based upon these uses, we will also regularly feedback this information to London Borough of Brent's Shadow Health & Wellbeing Board (and other relevant partnerships). In this way, the information can influence and inform service commissioning, planning and delivery.

We will also provide feedback to the young people we consult i.e. outlining to them how their input was used. To assist this feedback (and as part of our overall youth engagement) we will also be increasing our social networking presence. We will be updating our Facebook page and creating a new Twitter account. We will also be revising our website and looking into providing information updates via mobile ‘phone SMS/text.

Improved Performance Management Systems

Another 2011/12 priority will be to improve our performance management systems. We will ensure that the activities we develop are based upon community need and that our targets are SMART *(i.e. Specific, Measurable, Achievable, Realistic and Time bound).*

To this end, we will be producing quarterly action plans based upon issues raised through engagement with our network and the wider community.

This performance management will also apply to our Action Groups. They will have quarterly action plans which will enable us to focus the energies, expertise and enthusiasm of Action Group members.

Developing Stronger Local Relationships with Care Quality Commission (CQC)

For the coming year, we will be building upon the already positive relationship we have with CQC. We will achieve this through regular partnership meetings which will ensure coordination of our respective inspection programmes and in particular, CQC compliance regarding our "enter and view" documentation and methodology.

This partnership working will include passing information about local experiences to CQC when we consider that this is the best route to achieve improvements in local services.

We will also continue to seek the advice of CQQ on our ***Enter and View*** programme: helping to ensure that, when the programme becomes operational during the first half of 20011/12, it reflects CQC best practice.

Readiness for Local HealthWatch

A main focus for Brent LINk for the coming year will be preparation for *Local Healthwatch.* Local Healthwatch is the new "consumer champion" being introduced as part of the Heath and Social Care Bill. At the time of writing, it is expected that LINks will undertake the role of Local Healthwatch from October 2012. This potentially means an increased role for Brent LINk in areas like commissioning health and social care, patient advocacy and devising local health profiles.

Over the next 12 months, we will be making sure that Brent LINk is ready for this new role by, for example, reviewing the "menu" of community involvement

opportunities that we offer and also by ensuring that our activities are based on evidence from people's views.

This will also entail closer working with London Borough of Brent and NHS Brent as we begin to map out arrangements for devising local health profiles.

We will also be reviewing existing Brent LINk structures and the training needs of our Management Committee members so that we are prepared for the opportunities and challenges presented by Local Healthwatch.

We will keep our network informed about these developments via public meetings, our newsletter, website and Twitter account.

SECTION SEVEN: *OUR YEAR IN FIGURES*

The Reach of Brent LINk & the Level of People's Participation

A member of the public can register with Brent LINk as an individual member or a group. The definition of a Brent LINk member is as follows:-

A **Brent LINk member** is a person or group that makes a commitment to take part on a regular basis in the development and implementation of the roles of the LINk, and to provide information to and collect information from a local community or a specific group within a community.

A LINk member is different from a participant:-
A **LINk participant** is a person, group or organisation that wants to influence the bigger picture through the roles of the LINk, even though they may not be in a position to participate on a regular basis. A participant may be interested in a single issue, may take an active role in specific pieces of work that relate to their areas of interest, or they may take a less active role by answering surveys or providing information or a view on behalf of an interest group.

Informed Participants: are groups or individuals who register their interest in the LINk and receive information, whether general updates and/or thematic interest.

This includes those who interact with our website and social networking sites.
Occasional Participants: are informed participants (individuals or groups) who also respond to a particular LINk issue, or attend a workshop or meeting on a specific topic. For example, someone who became involved in a task and

finish piece of work around a specific issue (such as the Brent LINk Wellbeing Event) and had no further involvement with the LINk on any other work streams and requested to revert back to receiving the newsletter only. This could also be someone who requests to receive themed information and comes along to an occasional meeting 1 -2 times a year.

Active Participants: are groups or individuals who have a high level of participation (i.e. someone who takes part in activity at least once a month), for example by attending introduction to LINk workshops, accessing training to build up skills in representation and/or visiting services, becoming involved in action group activities or representing Brent LINk externally.

Within each of these levels, **people with a social care interest** are those with experience of using social care services or a specific interest in social care. They may also have an interest in health care.
Group participants are people who are acting as a representative for one or more organisation(s) or interest group(s). **Individual participants** are those who are not acting in this way.

Level of participation	Total	Of which		
		People with a social care interest	Individual participants	Interest group participants
Informed participants	558	234	387	171
Occasional participants	89	39	50	39
Active participants	21	14	11	10

SUMMARY OF ACTIVITY

Requests for Information in 2010-11	
How many requests for information were made by Brent LINk?	11
Of these, how many of the requests for information were answered within 20 working days?	9
How many related to social care?	1
Enter and View in 2010-11	
How many enter and view visits did Brent LINk make?	0
How many enter and view visits related to health care?	0
How many enter and view visits related to social care?	0
How many enter and view visits were announced?	0
How many enter and view visits were unannounced?	0
Reports and Recommendations in 2010-11	
How many reports and/or recommendations were made by Brent LINk to commissioners of health and adult social care services?	6

How many of these reports and/or recommendations have been acknowledged in the required timescale?	4
Of the reports and/or recommendations acknowledged, how many have led, or are leading to, service review?	2
Of the reports and/or recommendations that led to service review, how many have led to service change?	1
How many reports/recommendations related to health services?	6
How many reports/recommendations related to social care?	1
Referrals to OSCs[5] in 2010-11	
How many referrals were made by Brent LINk to an Overview & Scrutiny Committee (OSC)?	0
How many of these referrals did the OSC acknowledge?	n/a
How many of these referrals led to service change?	n/a

[5] *Brent LINk regularly attends Brent Health Partnership OSC meetings and raises and makes contributions to the service user issues. This has pre-empted formal Brent LINk referrals to OSC.*

SECTION EIGHT: *OUR FINANCES*

Brent LINk Financial Summary: Hestia (April 2010 to 31st March 2011)

The following is a breakdown of the LINk and Host Accounts combined:

Brent LINk	Income	Expenditure	Variance
LINk activities	**30160.00**	**27252.00**	**2908.00**[a]
Host / Running costs	**143593.00**	**137542.00**	**6051.00**[b]
Family Mosaic Award	**6981.00**	**6981.00**	**0.00**
TOTAL	**180734.00**	**171775.00**	**8959.00**

The following is a breakdown of the LINk and Host Accounts:

LINk Summarised Statement

Description	Allocation: (£)	Expended: (£)	Variance: (£)
Development costs:			
Printing and Publication	2500.00		
Stationery and Post	900.00		
Advertising	750.00		
Library	200.00		
Sub-Total	**4350.00**	**10703.00**	**- 6353.00**
Communication and Engagement:			
Radio	1200.00		
Entertainment (music & catering)	1700.00		
Freephone	300.00		
Incentives	500.00		
Web conferencing	300.00		
Translation/Interpretation / BSL/Audio/Braille	4500.00		
Crèche Service	500.00		
Website Development	2000.00		
Sub-Total	**11000.00**	**3700.00**	**7300.00**
Consultation Research / Projects:			
Commissioning user survey	2000.00		
External Facilitators	1000.00		
Sub-Total	**3000.00**	**2625.00**	**375.00**

Expenses for LINk participants:			
Travel	1680.00		
Subsistence	1680.00		
Carer costs	500.00		
Child care	500.00		
Payments	750.00		
Sub-Total	**5110.00**	**764.00**	**4346.00**
Training for LINk Participants:	3200.00		
Sub-Total	**3200.00**	**3878.00**	**- 678.00**
Venue for activities:	3500.00		
Sub-Total	**3500.00**	**5582.00**	**- 2082.00**
Total Allocation:	**30160.00**		
Amount Expended :		**27252.00**	
Surplus on the disbursed Grant			**2908.00**

Host Summarised Statement

Description	**Allocation: (£)**	**Expended: (£)**	**Variance: (£)**
Staff costs [c]:			
Salaries, Employers NI, Pensions			
Agency and Staff Travels			
Sub -Total	**112536.00**	**106242.00**	**6294.00**
Administration Costs			
Office Costs**:**			
Office costs, Office Rental			
Phone and Post, Sundry Costs,			
Depreciation & IT Consumables.			
Sub-Total	**11208.00**	**9130.00**	**2078.00**
Building/Household Costs			
Council Tax, Portable Appliance Testing			
Cleaning Material			
Sub-Total	**0.00**	**1002.00**	**- 1002.00**
Recharged Cost			
Management Charges			
Insurance Charge			
Recruitment Charge			
Training Charge			
Sub – total	**19849.00**	**21168.00**	**- 1319.00**
Total Allocation:	**143593.00**		
Amount Expended:		**137542.00**	
Overall Surplus on the disbursed Grant:			**6051.00**

NOTES:
- This summary was extracted from the Brent LINk year-end Management Accounts which are in the process of being externally audited at the date of publication.
- Figures for expenditure are to the nearest whole number.

A – Any unspent income for LINk activities will be carried over into 2011/12, for use by the Brent LINk.
B- Any unspent income for Host activities will not be carried over into 2011/12.
C - Senior manager salary cost within the service group is not included.

SECTION NINE:
CIRCULATION OF BRENT LINK 2010/11 ANNUAL REPORT

Brent LINk's 2010/11 Annual Report will be circulated to signed up Brent Participants and made available to the general public on Brent LINk's website www.yourbrentlink.org

Selected achievements from the 2010/11 Annual Report will also be posted via Brent LINk Twitter account: http://twitter.com/BrentLINk# throughout 2011/12.

An "Easy read" version will be published summer 2011 for people with learning difficulties or limited proficiency in English.

A copy of the Brent LINk Annual Report will be sent to:

The Secretary of State for Health

The Care Quality Commission

The London Borough of Brent

LB Brent Health Partnership Overview & Scrutiny Committee

NHS Brent

Central & North West London Foundation Trust

NW London Hospital Trust

Copies will also be made available via:

Brent LINk Office upon request

Local Libraries and Community Centres

Brent LINk meetings, events and outreach activity

Registration Form

If you would like to join Brent LINk
Please complete the following **FREE** registration form

Return your completed forms in the **FREEPOST** envelope provided

Brent Local Involvement Network –
IT'S YOUR LINk!

How to get in touch and involved with Brent LINk

If you would like to receive information, be invited to events, get involved, join our Action Groups or help us help you to make a difference, join us. Anyone who lives or works in Brent can get involved.

Please complete the attached registration form or contact the Brent LINk Team for information on:

✉ Brent LINk
Hestia Housing and Support
Unit 56
The Designworks
Park Parade
London
NW10 4HT

☎ Main Office: 0208 965 0309

brentlink@hestia.org

www.yourbrentlink.org

Brent LINk Registration Form

London Borough of Brent Local Involvement Network –
IT'S YOUR LINk!

Please tick the boxes below (as appropriate) and complete the contact details:

I am interested in:
Registering to become involved in the LINk ☐
Volunteering for the LINk (e.g. administration and activities) ☐
I would like to be kept informed about the LINk ☐

Name:____

Contact Address:______________________________________

____

____

Tel: ____________________ Mobile: __________________________

Email: ____

How would you prefer to receive information and updates about the LINk:

Email ☐ Post ☐ Telephone ☐ Mobile ☐

If you require assistance to complete this form please telephone the Brent LINk team on 020 8965 0309 or email on brentlink@hestia.org

Please complete and return in the **FREEPOST** envelope provided

Brent LINk Registration Form (continued)

Please answer the following questions	**Yes**	**No**
Are you a user of health and/or social care services in the borough?		
Are you a carer for someone who uses health and/or social care services in the borough?		
Do you work in the borough of Brent?		
Are you a resident of the borough?		
Are you registering an interest in the LINk on behalf of an organisation or group?		

Your organisation or group name (if applicable): __________________

____

Are you interested in any particular services or issues?

- ☐ Adult Social Care
- ☐ Older People
- ☐ Mental health
- ☐ Disability
- ☐ Carers'
- ☐ Hospital services
- ☐ Health and social care issues in neighbouring boroughs
- ☐ Primary and community health services e.g. GPs, community nursing, therapies, dentists, pharmacists, optometrists

Other (please state below):

____

____

____

Signed ………………………………………………………………………………

Date ..…………………………………………………………………………….

Please complete and return in the FREEPOST envelope provided

Brent LINk VOLUNTARY MONITORING INFO*

*(This is to ensure the LINk is reaching out to everyone)

Please mark a cross in the box that describes you:

Male ☐ Female ☐

Please mark a cross in the box for your age:

16 – 21 ☐ 22 – 29 ☐ 30 – 44 ☐ 45 – 59 ☐

60 – 74 ☐ 75+ ☐

Do you consider yourself to have a disability?

Yes ☐ No ☐ Declined to answer ☐

Would you define yourself as:

Heterosexual ☐ Gay ☐ Lesbian ☐ Bi-sexual ☐

Other ☐ Declined to answer ☐

Please tick the box that describes your faith or religion:

None ☐ Hindu ☐ Sikh ☐ Muslim ☐

Christian ☐ Jewish ☐ Buddhist ☐

Declined to answer ☐ Any other religion ☐

Please state other religion here:

____

How would you describe your ethnic background?

White British ☐

White Irish ☐

White Other ☐

Mixed – White & Black Caribbean ☐

Mixed – Other ☐

Mixed White & Black African ☐

Mixed – White & Asian ☐

Asian or Asian British – Indian ☐

Asian or Asian British – Pakistani ☐

Asian or Asian British – Bangladeshi ☐

Asian or Asian British – Other ☐

Black or Black British – Caribbean ☐

Black or Black British – African ☐

Black or Black British – Other ☐

Chinese ☐

Other ☐

Declined to answer ☐

Have your say…

Please tell us about the experiences you have had as patient, service user and/or carer an issue you may have become aware of in relation to Health or Social Care Services in the London Borough of Brent

Please complete and return in the **FREEPOST** envelope provided

Have your say …

Please tell us about the experiences you have had as patient, service user and/or carer an issue you may have become aware of in relation to Health or Social Care Services in the London Borough of Brent

Please complete and return in the **FREEPOST** envelope provided

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Health Partnerships Overview and Scrutiny Committee

2011/12 Work Programme

Meeting Date	Item	Issue	Outcome
9th June 2011	Plans for the future of North West London NHS Hospitals Trust and Ealing Hospital Trust	North West London NHS Hospitals Trust and Ealing Hospitals Trust have taken the initial steps towards a merger, commissioning consultants to see if a business case can be made for such a move. The Health Partnerships Overview and Scrutiny Committee wants to be kept informed of developments as this project progresses.	Report noted. The issue will come back to the committee in Sept or Nov, during the public consultation. There may also be an opportunity to meet informally with the Programme Board during the summer. Joint scrutiny with Ealing and Harrow is also a possibility.
	North West London Hospitals NHS Trust Quality Accounts	The Quality Account from the Hospital Trust will be presented to the committee to give members an opportunity to add its comments prior to submission to the Care Quality Commission.	The committee has sent its response to NWL Hospitals on their Quality Account.
	GP Commissioning Consortia Update and Primary Care Issues in Brent	The committee has asked for an update from the Brent GP Commissioning Consortia to be presented to each meeting so that councillors can be kept informed of progress and key issues. In addition, the committee will receive reports on the following primary care issues in the borough: • An update on the Burnley Practice tender exercise • A report on the situation at Stag Lane clinic, and whether any progress has been made in securing a permanent solution to the issues regarding the building, or a replacement.	Report noted. There are a number of issues that the committee has picked up on: • Mental health commissioning – how plans for joint commissioning with the council are progressing. • Health and social care integration • A request for a report on GP commissioning plans in July 2011, including these two issues • Burnley Practice – will be reported back to the committee if list dispersal is the only option
	Khat Task Group	The terms of reference for the group will be presented to the	Agreed by the committee.

	Terms of Reference	committee for approval.	
	GP list validation exercise	Request for information on the GP list validation exercise following concerns raised by patients and GPs over the process.	Agreed to follow up in July 2011 with a report from NHS Brent setting out how the project has gone, what lessons have been learned and the number of patients that have re-registered following their removal from the GP lists.

Meeting Date	**Item**	**Issue**	**Outcome**
26th July 2011	GP Patient Access Survey Results – Q4 2010/11	The committee is keen to follow up the results of the ACE programme to see what impact it has had on patient satisfaction with access to GP services in Brent. NHS Brent has previously reported that they expected improvement by Q4 2010/11 and so members have asked to see the Q4 results, which should be available for June 2011.	The committee has asked for a report from each of the CCGs on how they will be working to improve access to their surgeries to drive up satisfaction scores. This will be presented to the committee in November 2011. This will include individual practice performance. Jo Ohlson has agreed to provide traffic light performance information for each practice.
	GP list validation exercise	Following the meeting in June 2011, the committee has requested a report from NHS Brent setting out how the project has gone, what lessons have been learned and the number of patients that have re-registered following their removal from the GP lists.	The committee has recommended to NHS Brent and NHS North West London that each practice has its list validated at least once every two years, on a rolling programme for each practice in the borough, to

			avoid the problems that the current validation exercise has encountered. Information on the number of re-registrations to practices in Brent will also be sent to committee members over the coming months. This issue maybe followed up later in the year, depending on the number of re-registrations.
	GP Commissioning Consortia Update	The committee has asked for an update from the Brent GP Commissioning Consortia to be presented to each meeting so that councillors can be kept informed of progress and key issues. For July, members have requested that the report includes information: • Mental health commissioning – how plans for joint commissioning with the council are progressing. • Health and social care integration	Report noted. Members have asked for a report on the governance of the CCGs and also the relationship between NHS Commissioning Board, CCGs and the local authority, once these become clearer.
	North West London NHS Hospitals In Patient Survey results	The results of the annual In Patient Survey will be presented to the committee in July 2011. This follows on from previous discussions on the trust's We Care Programme, which members wanted to follow up.	Report noted. This will be followed up in 12 months time.
	Central Middlesex Hospital Paediatric Assessment Unit	The North West London NHS Hospitals trust has asked to place a report on the committee's agenda on their plans for the paediatric assessment unit at Central Middlesex Hospital. They are considering a proposal to merge the unit with the Urgent Care Centre at the site. The Health Partnerships Committee should consider whether a public consultation is needed on this plan and comment on the proposals.	The committee agreed that NWL Hospitals and NHS Brent should speak to stakeholders about the proposals for the PAU at CMH and report back to the September meeting with a report on their views. At that point, the committee will decide to recommend whether formal consultation is needed on the plans

			for the PAU.
	North West London NHS Hospitals Trust Budget	The Hospital Trust has set a budget for 2011/12 which anticipates a deficit of £19m. The committee is keen to know what the implications are for the trust and patients and how the deficit is likely to be addressed through the year.	Report noted. The committee has agreed to follow up this issue with further reports on the proposed merger with Ealing Hospital Trust.
	Health and Wellbeing Board Update	The committee has asked for an update from the Health and Wellbeing Board to be reported to each committee meeting.	Report noted. This will now become an agenda item at each committee meeting.

Meeting Date	**Item**	**Issue**	**Outcome**
20th September 2011	North West London Hospitals Maternity Services	There have been widely reported issues at the maternity unit at Northwick Park Hospital in recent months and NHS London has carried out a review of maternity services across London. Officers from the trust should be invited to attend the committee to report to members on the incidents that have taken place and how they have been addressed.	
	Plans for the future of North West London NHS Hospitals Trust and Ealing Hospital Trust	The committee will have an opportunity to consider the business case and respond to the public consultation on the proposed merger. This could be deferred to November 2011, or possibly subject to joint scrutiny meeting with Ealing and Harrow.	
	Central Middlesex Hospital Paediatric Assessment Unit	The committee considered the proposal for the PAU at CMH at its July meeting, where it agreed that NWL Hospitals and NHS Brent should speak to stakeholders about the proposals and report back to the September meeting with a report on their views. At that point, the committee will decide to recommend whether formal consultation is needed on the plans for the PAU.	
	Joint Strategic Needs Assessment	The committee has asked that the JSNA is brought to a future meeting, so that members can be given an overview of the borough's key health needs. The joint health and wellbeing strategy that will be	

		developed after the JSNA will outline the council and health commissioners plan to tackle the health issues facing people in Brent.	
	Brent LINk Annual Report	The Brent LINk will present their annual report to the committee for discussion and comment.	
	GP Commissioning Consortia Update	The committee has asked for an update from the Brent GP Commissioning Consortia to be presented to each meeting so that councillors can be kept informed of progress and key issues.	
	Health and Wellbeing Board Update	The committee has asked for an update from the Health and Wellbeing Board to be reported to each committee meeting.	

Meeting Date	Item	Issue	Outcome
29th November 2011	Public Health Transfer to Brent Council	The chair of the committee has asked for a report on the work being done to prepare for the transfer of public health services to the council. A One Council project will take place to ensure the transfer happens within the Government's timetable and to ensure that the service meets Brent's specific needs once it is integrated within the council.	
	Integrated Care Organisation Report	The committee has requested a report on the progress of the ICO, since its creation in April 2011. The report should focus on how the ICO has strengthened its leadership in Brent and is addressing the issues highlighted by the council during consultation on its creation. This report should come to the committee in September 2011.	
	Health Inequalities Performance Monitoring	The Health Select Committee should make health inequalities a major focus of its work in 2010/11. As part of this, a performance framework has been developed to monitor indicators relevant to the implementation of the health and wellbeing strategy, which relate to the reduction of health inequalities in the borough. This framework	

		will be presented to the committee twice a year, with a commentary highlighting key issues for members to consider.	
	Central Middlesex Hospital Urgent Care Centre	The Urgent Care Centre has opened at Central Middlesex Hospital. The committee has asked for a report setting out progress and performance issues in the first six months of operation for the UCC.	
	Sickle Cell and Thalassaemia Services Report	The Committee has asked for a report Sickle Cell and Thalassaemia services at North West London NHS Hospitals Trust. The committee will invite sickle cell patient groups to attend for this item to give their views on services in the borough. This follows a previous report on changes to paediatric in patient arrangements at NWL Hospitals. Members are keen to know how sickle cell patients have been dealing with this change.	
	Fuel Poverty Task Group	Recommendation follow up on the task group's review.	
	Health Visitor numbers	Councillor Mary Daly has asked for an item on the way that NHS Brent is responding to the Government's commitment to increase Health Visitor numbers.	
	Breast Feeding in Brent	Following a report in March 2011 on the borough's Obesity Strategy, the committee has requested a follow up paper on the Breast feeding service in the borough. Members were particularly interested in the role of peer support workers and how mothers are able to access breast feeding services. The committee would also like to have accurate data on breast feeding initiation and prevalence in Brent.	
	GP Patient Access Survey Results	Following concerns about satisfaction with access and experience at GP practices in Brent, the committee has asked for a report from each of the CCGs on how they are working to improve access to their surgeries to drive up satisfaction scores. The report will include information on individual practice performance.	
	GP Commissioning Consortia Update	The committee has asked for an update from the Brent GP Commissioning Consortia to be presented to each meeting so that councillors can be kept informed of progress and key issues.	
	Health and Wellbeing Board Update	The committee has asked for an update from the Health and Wellbeing Board to be reported to each committee meeting.	

Meeting Date	Item	Issue	Outcome
7th February 2012	Role of community pharmacists	The chair is keen to look at community pharmacists in Brent, and how their role in delivering health services can be best utilised. She also wants to look at the way that different elements of the health system, such as GPs and social care work with pharmacists in the borough.	
	Mental health services in Brent		
	Belvedere House	Central and North West London Mental Health Foundation Trust has offered to host a visit at Belvedere House, where it provides day services for adults with mental health problems. The trust has been reviewing the services provided at Belvedere and this will be an opportunity for members to better understand those changes. A report will also be presented to the committee in April 2011 on the work that has been taking place since this issue was originally considered by Health Select Committee in March 2010.	
	Patients Association Presentation	The Patients Association has offered to give a presentation on patient experience in Brent, based on their evidence and personal testimonies. The committee should decide whether it wishes to take up this offer.	
	Brent Tobacco Control Strategy	The committee would like to follow up the Brent Tobacco Control Strategy, to check the progress of its implementation. It is also interested in specific issues, such as the licensing of shisha bars, to see how this issue is being addressed in Brent.	
	GP Commissioning Consortia Update	The committee has asked for an update from the Brent GP Commissioning Consortia to be presented to each meeting so that councillors can be kept informed of progress and key issues.	
	Health and Wellbeing Board	The committee has asked for an update from the Health and Wellbeing Board to be reported to each committee meeting.	

	Update		

Meeting Date	Item	Issue	Outcome
27th March 2012	End of life / palliative care in Brent	The committee has asked for a report on end of life care in Brent. Members are keen to look at how the End of Life Strategy is being implemented and to know what services exist in Brent and how effective they are in delivering care.	
	GP Commissioning Consortia Update	The committee has asked for an update from the Brent GP Commissioning Consortia to be presented to each meeting so that councillors can be kept informed of progress and key issues.	
	Health and Wellbeing Board Update	The committee has asked for an update from the Health and Wellbeing Board to be reported to each committee meeting.	