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Health Partnerships Overview and Scrutiny Committee

Tuesday, 7 February 2012 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	Ketan Sheth	Van Kalwala
Hector	Aden	Al-Ebadi
Ogunro	McLennan	Oladapo
RS Patel	Naheerathan	Oladapo

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

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 29 November 2011 1 - 10

The minutes are attached.

4 Matters arising (if any)

5 North West London NHS Hospitals Trust/Ealing Hospital Trust merger 11 - 14

The report is attached. Presentation slides have also been circulated to Members.

6 North West London - shaping a healthier future 15 - 40

The report is attached and includes a presentation that will be given to Members.

7 Joint Strategic Needs Assessment consultation

A presentation will be given to the committee on the Joint Strategic Needs Assessment (JSNA) and Members will be given the opportunity to comment on its contents. The JSNA is available on the council's website at:-

http://www.brent.gov.uk/localdemocracy.nsf/JSNA/LBB-425?OpenDocument&pp=200088

8 Khat task group - final report 41 - 76

This report sets out the findings and recommendations of the Khat Task Group that are being presented to the Health Partnerships Overview and Scrutiny Committee for endorsement.

9 Diabetes task group scoping document 77 - 80

This report requests the Health Partnerships Overview and Scrutiny Committee to consider the attached scope for 'Tackling Diabetes in Brent' and agree for a task group to be set up.

10 Clinical Commissioning Group update

Members will receive a verbal update on this item.

11 Health and Wellbeing Board update

Members will receive a verbal update on this item.

12 Health Partnerships Overview and Scrutiny Committee work programme 81 - 90

The work programme is attached.

13 Date of Next Meeting

The next scheduled meeting of the Health Partnerships Overview and Scrutiny Committee is scheduled to take place on Tuesday, 27 March 2012 at 7.00 pm.

14 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.

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, 29 November 2011 at 7.00 pm

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

Also Present: Councillors McLennan and R Moher (Lead Member for Adults and Health)

An apology for absence was received from: Councillor Hector

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

None declared.

2. **Minutes of the previous meeting held on 20 September 2011**

RESOLVED:-

that the minutes of the previous meeting held on 20 September 2011 be approved as an accurate record of the meeting.

3. **Matters arising**

GP list validation exercise

Councillor Hunter acknowledged that information on the GP list validation exercise broken down per practice had been provided. However, whilst the overall average percentage of return was within 6%, the Wembley Park Drive Medical Centre was around 60% and she sought reasons for this. In reply, Jo Ohlson (Brent Borough Director, NHS Brent and Harrow) stated that this could be for a number of reasons, which may include patients not having visited the practice for a long time, or difficulties in being able to contact patients. She added that further information from Wembley Park Drive Medical Centre could be sought.

Paediatric Services at Central Middlesex Hospital

Councillor Hunter sought feedback with regard to patients' views on accessibility with regard to the sickle cell service and whether there had been any progress concerning improving transport links. David Cheesman (North West London NHS Hospitals Trust) advised that questionnaires regarding the sickle cell service had been distributed and the results would be fed back to committee and to he Mayor of London. Dialogue with the Mayor of London continued with regard to seeking improvements in public transport to the site.

North West London Hospitals NHS Trust and social enterprises

The Chair confirmed that briefing notes in respect of North West London Hospitals NHS Trust property proposals and on social enterprises had been received.

4. **Ealing Hospital Trust Integrated Care Organisation six month progress report**

Julie Lowe (Chief Executive, Ealing Hospital Trust) introduced the report and stated that the organisation was focusing on providing effective management of community services. Three community service directors had been appointed in April to oversee the operational development and strategic development of more integrated community services in Brent, Ealing and Harrow. The Integrated Care Organisation (ICO) was also working in close partnership with the council in respect of safeguarding. Members noted that the OFSTED safeguarding inspection report was now publically available and that the backlog of assessments for looked after children had been completed.

During Members' discussion, Councillor Daly enquired on the number of vacancies within senior management and had the appropriate risk assessments been undertaken. In light of the OFSTED health assessments, she enquired whether there were plans in place to improve health delivery for looked after children. Councillor Hunter asked if there any moves to ensure council representation on the ICO. The Chair acknowledged that the ICO would be taking on extra responsibilities and asked whether it had sufficient capacity and the necessary specialised equipment to do so.

In reply, Julie Lowe advised that the ICO was now an NHS organisation and that council observer status could be provided but this would not include voting rights on the board. She stated that staff resources had increased to take on the extra duties and staff transfers may also take place. It was noted that there were presently eight vacancies within senior management, however it was felt that by March 2012, these positions were likely to be filled or suitable candidates chosen. Efforts were being made to ensure that the relevant specialist equipment was in place and it was noted that the ICO had been commissioned by NHS Brent. Julie Lowe stated that community services across the three boroughs would be provided according to which areas were in most need of a particular service. The committee noted that a risk assessment had been undertaken, including in relation to child protection and the relevant care groups. Since the OFSTED health assessment, plans were being put in place to improve delivery for looked after children.

Councillor R Moher (Lead Member for Adults and Health) advised that observer status on the ICO board was yet to be offered to the council.

RESOLVED:-

that the Ealing Hospital Trust Integrated Care Organisation six month progress report be noted.

5. **Plans for the future of North West London NHS Hospitals Trust and Ealing Hospital Trust**

Simon Crawford (SRO, Organisational Futures Project) presented this item and confirmed that the outline business case for the plans had been produced following the outline strategy that had been set out in May. Although the plans included the merger of two health trusts, there were no proposals to make major changes to services. The plans followed on from a high level appraisal conducted last year which sought to explore the potential of a merger. The committee heard that the proposed merger would lead to the one of the largest integrated care services in the country and would ensure the availability of 24/7 care, better use of resources and access to equipment. Simon Crawford drew Members to the key four chapters in the report, including the commissioning strategy in North West London, the implications for the two trusts, the clinical vision for a combined organisation and the financial evaluation. He stated that under the current arrangements, Ealing Hospital Trust struggled to provide some specialist treatment, whilst North West London NHS Hospitals Trust had some issues in respect of emergency surgery. It was felt that the integration of the two trusts would address these issues and help gain foundation trust status.

Simon Crawford acknowledged that the landscape of healthcare was changing and appendix B of the report set out some potential scenarios for service change. The current proposals were to be presented to Brent Local Involvement Network (LINk) on 12 December. The next stage was to submit a final business case and more work on financial details and capital assessments were required before this could be achieved. Following this, the decision to merge would be taken in June 2012, with implementation happening from July 2012.

Mansukh Raichura (Chair, Brent LINk) was invited to comment and he stated that a public meeting involving service users was needed to gain their views and provide feedback.

During discussion by committee, the Chair advised that a joint meeting of the chairs and vice chairs of the Brent, Ealing and Harrow health scrutiny committees and the relevant staff was to be arranged to discuss the proposals in detail and she suggested that this should take place in January 2012. Councillor Cheese sought information on how the merger would benefit patients, particularly those in south Brent and expressed concern that changing locations of services could mean greater journey times for some patients. Councillor Hunter commented that clarification should be sought as to what services changes patients may expect from the merger during the joint health scrutiny committees meeting. She queried why a management level merger had been approved without public consultation and felt that the merger would inevitably lead to changes to services to at least some degree. Councillor Daly asked whether details of an equality impact assessment (EIA) could be provided at the joint health scrutiny committees meeting and suggested that the merger could lead to a monopoly in healthcare provision which, again, may raise equality issues. She added that some services needed to be accessed locally and that this too needed to be considered in the context of equality issues.

In response to the issues raised, Simon Crawford confirmed that he would be happy to organise a public meeting with service users and to prepare an evaluation of the services that would be provided. He stated that the integrated care agenda being pursued would provide a greater benefit for patients and schemes such as Brent STARRS were helping to improve services. Simon Crawford advised that any service change would be as a result of NHS commissioning plans regardless of whether the merger materialised. Furthermore, no formal consultation with regard to the management merger was necessary as this would not have a major impact on delivery of service, however consultation had taken place with Brent LINk in accordance with the NHS Act 2006. The committee noted that any service changes would be subject to an EIA, whilst equality issues had already been taken into account in respect of the merger. The Co-operation and Competition Panel was currently reviewing the outline business case to assess any potential effects on patient access and choice.

Professor Rory Shaw (Medical Director) added that services would benefit from continuing improvements to medicines and a larger trust would be more capable of providing 24/7 services and that ensuring the patient went to a location with the appropriately qualified staff and facilities was the key to providing better services.

The Chair requested that information on any areas of particular concern and an explanation of what are the benefits of being a foundation trust be presented at the January meeting of the chairs and vice chairs of Brent, Ealing and Harrow health scrutiny committees.

6. **Accident and Emergency Services at Central Middlesex Hospital**

Peter Coles (Interim Chief Executive, North West London NHS Hospitals Trust) introduced the item and referred Members to the letter from North West London NHS Hospitals Trust confirming that the Accident and Emergency (A and E) Services at Central Middlesex Hospital are to close overnight as of 14 November. He stated that this was a temporary closure made to ensure patient safety and to maintain quality of service. The closure was subject to an external review from NHS London and Peter Coles acknowledged that concerns had been raised with regard to lack of notice, however safety issues had necessitated the decision to be made swiftly.

Professor Rory Shaw added that a lot of patients arriving at A and E at night could be looked after by on-site GPs at the Urgent Care Centre (UCC), whilst there had also been a very significant reduction in patients attending A and E, particularly at night time. There was also not enough work in A and E for trainees to gain the necessary experience and it was becoming increasingly hard to find weekend and evening staff to cover. As a result, the committee heard that 40% of costs were on agency staff, with this rising to 85% at weekends in A and E and even then agency staff were becoming increasingly difficult to obtain which raised the risk of having to close the A and E ward at short notice. This had led to London NHS, the strategic authority, to recommend the temporary closure of the A and E ward whilst the situation was reviewed.

During discussion, Councillor Ogunro enquired how service standards would be maintained if there was a serious accident on a large scale in the area during the night. Councillor Cheese sought further details as to why patient numbers at A and

E had dropped so significantly and on the difficulties of acquiring staff at night time and weekends. Councillor Daly requested more details with regard to patient numbers at the UCC and what would be the impact of the changes on the Ambulance Service. In addition, she felt that the move raised equality issues, especially with regard to ill children and she asked if an EIA had been undertaken. She also sought views as to whether the GPs would be able to treat those requiring specialist services. Councillor Hunter stated that she could understand the clinical reasons concerning the A and E closure, however in view that the letter was sent on 4 November, she expressed surprise that it was not mentioned at the Hospital Trust Board meeting on 2 November.

The Chair expressed surprise that staff could refuse to work in A and E at night time and during weekends in view that an emergency service was being provided. She also expressed disappointment that the A and E closure had not been communicated at an earlier stage and commented that such a failure could affect the hospital's image.

In reply, Dr Rory Shaw confirmed that appropriately qualified GPs were available 24/7 at the UCC, whilst acute physicians were also in attendance. GPs would determine whether patients could be treated at the hospital and if the specialist treatment required was not available, they would arrange the appropriate transfer to another suitable site. The UCC had proven to be a big success and was largely responsible for the reduction in patients to A and E. Dr Rory Shaw explained that the hospital had previously thought that it could identify staff to work at the A and E, however he accepted that communication on the decision could have been made earlier. Members heard that the ambulance service had not expressed any concern about the proposals.

David Cheesman (Director of Strategy, North West London NHS Hospitals Trust) added that soon after the UCC had opened, there had also been a dramatic reduction of admissions to the Paediatric Assessment Unit (PAU) which had also been closed for the similar reasons. He advised that around 90% of all child patients at Central Middlesex Hospital were treated in the UCC.

7. **Mental Health Rehabilitation Provision in Brent**

Robyn Doran (Director of Operations, Central and North West London Foundation Trust) introduced the report and advised that there had been a healthcare needs assessment undertaken for the in-patients of Fairfield House and Rosedale Court with discussions taking place between patients, their carers and staff. Around 22 of the existing in-patients were to be moved to more appropriate levels of care, whilst the remaining patients would be moved from Fairfield House to Rosedale Court as this was a better, more modern facility for active rehabilitation recovery model style care. Members noted that this was a needs based programme being developed to improve health and wellbeing outcomes and was yet to be approved by the Central and North West London Foundation Trust Board. The committee heard that there was a great diversity of care needs in each unit and the impact and risks as set out in the report were noted. Robyn Doran advised that the anticipated financial impact to the local authority for the five patients being placed in supported care was approximately £182k per year.

Chris George (Advocate) was invited to address the committee. Chris George acknowledged the shortcomings at Fairfield House including the fact that the facilities were outdated and he broadly welcomed the proposals. However, he expressed concerns about the consultation with service users, whilst the transition arrangements were also going to be difficult and complex. He stressed that arrangements for each patient must be decided on an individual basis as the needs of each varied considerably, with some of a challenging nature and careful planning would be required.

In response, Sarah Mansuralli (Deputy Borough Director, NHS Brent) advised that a risk assessment framework had been devised and engagement with all relevant stakeholders was taking place. The risk assessment framework also addressed transitional planning and it was acknowledged that extensive consultation would be required.

Councillor R Moher sought further details concerning the timescale of the programme. She commented that Fairfield House had a very traditional, institutionalised feel to it with large mix of patients with different needs and that it was not the most suitable facility for some of them. However, there was some concern amongst both patients and carers at the speed of which the changes may be made.

During discussion by Members, Councillor Hunter stressed the importance of consulting at an early stage and she enquired whether the budget estimates for the five patients to be placed in supported care were realistic. Councillor Cheese commented that a number of patients would be reluctant to change and that careful planning was needed to address this. The Chair sought views as to whether supported housing would be available and be accepted by the users where this type of care would be proposed and she asked whether committee members could visit Fairfield House.

In reply to the issues raised, Robyn Doran advised that the next stage of the programme involved a six months consultation and it was envisaged that the next report to the committee would be presented around June 2012. Organisations would be approached with regard to the possibility of some users being placed in supported housing. She acknowledged that consultation could have begun at an earlier stage and welcomed Members to visit Fairfield House.

Alison Elliott (Director of Adult Social Care) advised that the council would work extensively with Central and North West London Foundation Trust and Brent NHS to ensure the most appropriate outcome for each patient and she indicated that the council should have been consulted earlier. She also informed the committee that there were also budgetary considerations for the council and this would present certain challenges.

RESOLVED:-

(i) that the progression of the proposal to improve patient care through a standard needs based assessment and placement process be noted; and

(ii) that the subsequent but temporary closure of Fairfield House be approved, subject to the approval of the Central and North West London Foundation

Trust's Council of Members and Board, pending a thorough options appraisal to determine its future use.

8. **Access to GP Services in Brent**

Jo Ohlson referred briefly to the report updating the committee on GP access and invited Members to ask any questions or seek clarification of any issues.

Councillor Hunter noted the large variations recorded in the report's results and asked what steps were being taken to address this. She emphasised that access and patient experience was very important and the role of receptionists, for example, was crucial. Councillor Cheese felt that an external organisation should be responsible for inspecting surgeries. The Chair commented that it was hoped that services would continue to improve, particularly in relation to patient access.

In reply, Ethie Kong (GP) advised that practices were challenged to improve themselves through peer review undertaken by each consortium. From this, practices could learn examples of best practice from each other. Consortiums were also looking at developing the appropriate services across the area covered and an example of this was the piloting of free health checks in Harlesden which was now to be launched across Brent. The timing of offering services was also being considered and services that could not be provided by an individual surgery would be provided collectively. Training was also being organised to focus on particular areas such as customer service. In Wembley, the ACE programme had helped to improve the appointments service results by 33% and all practices now had extended hours. Members also heard that a text messaging service was also available.

RESOLVED:-

that the report on the access to GP services in Brent be noted.

9. **GP Commissioning Consortia update**

It was noted that this item would be discussed at a future meeting of the committee.

10. **JSNA consultation**

Imran Choudhary (Consultant, Public Health Medicine, NHS Brent) gave a presentation on the Joint Strategic Needs Assessment (JSNA) consultation, explaining that the aims of the assessment included improving health and wellbeing and tackling health inequalities. The JSNA would involve compiling evidence to feed into key issues that would help shape the priorities of the Health and Wellbeing strategy. Members noted the particular characteristics of Brent's population regarding age, ethnicity and mental and physical health issues. The JSNA was due to be launched on the internet in the first week of December 2011 for consultation over the next two months, whilst a series of public presentations would also be undertaken.

Mansukh Raichura was invited to address the committee and enquired whether the TB programme would be commissioned on a London-wide basis, what input would

Brent provide and what resources would be available. He stressed the need for extensive public consultation on the JSNA to take place.

During Members' discussion, Councillor Cheese sought an explanation for the increase in TB cases and was sufficient care being provided. Councillor Hunter felt that there needed to be more ways of consulting with regard to the JSNA in addition to the internet. Mental health was a big concern in Brent, whilst female genital mutilation was also an issue. Councillor Daly suggested that JSNA could also be presented at the Area Consultative Forums, whilst every effort should be made to look at the broader picture.

In reply, Imran Choudhary advised that TB had been on the increase since the 1980s, particularly amongst black and minority ethnic groups. The reasons could be attributed to a number of factors, including lifestyle, state of health and long working hours. Action was being taken to help those with TB and reduce any stigma attached to the condition and new immigrants were being screened for TB. It was noted that the TB programme was likely to be London-wide, however work also needed to be undertaken locally, whilst the London model would direct the service overall. With regard to consultation, Imran Choudhary explained that the JSNA would be taking on board the responses received which would then feed into the Health and Wellbeing strategy which would also be subject to a further consultation.

Andrew Davies (Policy and Performance Officer, Strategy, Partnerships and Improvement) advised that there would be detailed briefs of both the JSNA and the Health and Wellbeing strategy. The JSNA document had around 30 chapters and the consultation would seek to identify what areas were of most interest and of highest priority. The JSNA would also be presented to the Shadow Health and Wellbeing Board. Phil Newby (Director of Strategy, Partnerships and Improvement) added that the JSNA would be bought back at the 7 February 2012 meeting where there could be further discussion to contribute to the JSNA consultation.

11. **Health and Wellbeing Board update**

Andrew Davies provided an update with regard to the Shadow Health and Wellbeing Board which was meeting on 21 December 2011 to discuss the process involved in delivering the Health and Wellbeing strategy, including the consultation that was to be undertaken. The strategy would build from the JSNA and efforts would be made to ensure the language used would be clearly understood by the general public.

Councillor Hunter stated that representation from opposition political groups on the Health and Wellbeing Board was common with other local authorities and this should also be the case for Brent. The Chair commented that feedback in respect of the JSNA and the Health and Wellbeing strategy was provided at the One Community, Many Voices event on 10 October 2011.

The suggestion with regard to opposition political group representation on the Health and Wellbeing Board was noted and the committee heard that clarification of this would be sought.

12. **Health Partnerships Overview and Scrutiny Committee work programme and feedback from the One Community, Many Voices event**

The Chair reminded Members to send any suggestions for the work programme to Andrew Davies. She then drew Members' attention to the feedback from the One Community, Many Voices event and commented that valuable feedback had been received.

13. **Date of next meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled to take place on Tuesday, 7 February 2012 at 7.00 pm. The Chair added that a pre-meeting would take place at 6.30 pm.

14. **Any other urgent business**

Progress report on the proposed closure of the paediatric assessment unit at Central Middlesex Hospital

The committee noted an update with regard to this item that was circulated at the meeting.

The meeting closed at 9.45 pm

S KABIR
Chair

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	Health Partnerships Overview and Scrutiny Committee 7th February 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Proposed merger of Ealing Hospital and North West London Hospitals NHS Trusts

1.0 Summary

1.1 Members will be aware that Ealing Hospital and North West London Hospitals NHS Trusts are working towards a merger. The chair and vice chair of the Health Partnerships Overview and Scrutiny Committee met with their counterparts from Ealing and Harrow Councils in November 2011 to discuss the proposed merger and the implications for each borough. Following that meeting the councillors wrote to the two hospital trusts outlining a number of concerns. They were –

- Patients could be required to travel longer distances to access services once service changes have taken place after the merger is complete. This could be compounded by poor public transport connections between areas such as Ealing and Harrow.
- Northwick Park Hospital's ability to cope with the additional patients it is likely to receive, especially in the Accident and Emergency Unit. On occasion it struggles to meet demand and it is not unknown for it to be closed to ambulances because of a lack of beds to admit people.
- Will GPs and Community Services receive the necessary support and investment to take on the additional responsibilities needed to deliver services closer to peoples' homes, in the community?
- How will changes be communicated to residents and is there a Communications Plan in place for the merger and also subsequent service changes?
- Why is formal consultation not taking place on the merger but only on service changes? Can you explain how people have been able to let you know what they think about the merger proposal, and how these views have been taken into account?

1.2 A follow up meeting with Harrow and Ealing chairs and vice chairs was held on the 24th January 2012. Representatives from Ealing Hospital Trust and North West London Hospitals NHS Trust were at this meeting to respond to the concerns set out above and discuss specific aspects of the merger. The slides attached as an appendix to this report were presented to members at the meeting and address the points set out above.

1.3 The main issues to emerge at the second meeting were –

- Increased investment in community services is crucial for the success of the merged organisation. The new organisation will deliver integration between community and acute care to help achieve the vision for the new trust of fewer visits to hospital for patients, and shorter visits when they are necessary. The investment in community services will be funded by commissioners from savings made in hospital services.
- The new trust will look to expand the services delivered from Central Middlesex Hospital in order to relieve pressure on Northwick Park. It was noted that planned care should not have to compete for resources with emergency care and that CMH could become a planned care centre, with emergency care provided at Northwick Park. The new trust will look to deliver this split in the delivery of services.
- Feedback from the LINk deliberative events on the merger has varied, but the LINks responses will be included in the Full Business Case when it is published in March 2012. Brent LINk is yet to respond; Ealing LINks event was attended by over 100 people, many of whom were opposed to the merger; Harrow LINk accepts the clinical argument for the merger, but has some concerns for the future of the new trust – will it be less personal and more remote as a result of its increase in size?
- Back office functions will be merged once the merger goes through, but no decisions have been taken on where the new organisation will be based. Back office services are expected to deliver a 15% saving once the new organisation is up and running.
- The work on the merger is taking place independently of NHS North West London's work on service change. The trusts had to model four service change scenarios in the Outline Business Case to demonstrate that the merged organisation would be clinically and financially sustainable if service changes take place and it loses income. This was the reason behind the scenario planning. NHS North West London will be leading consultation on service change intentions later this year.
- NHS trusts need to of sufficient scale to employ specialist teams and consultants to deliver services – by working in specialist teams services improve as practitioners carry out more procedures than non-specialists. The stand alone trusts would struggle to achieve the necessary scale and as a result services would be commissioned elsewhere – probably in central London trusts. The benefits of local integration between acute and community services would be lost if this happened.
- There are no guarantees that NHS North West London will want to continue commissioning the range of services it does from a merged trust. But, commissioners have endorsed the Outline Business Case and the trusts are confident that the Full Business Case will be endorsed when it's published. The trusts will be working with commissioners to sell the benefits of integrated community and acute services.

1.4 The chair and vice chair of the Health Partnerships Overview and Scrutiny Committee are keen that the views of the committee on the merger are sent to the

two hospital trust boards. Although a formal consultation on the merger isn't taking place, the councillors believe that it is important that the views of the local health overview and scrutiny committee are known by the trust boards and made public. It is proposed that the committee writes to the trust boards following a discussion of the merger plans at the meeting on the 7th February. Officers from North West London Hospitals and Ealing Hospital Trust will be at the committee to answer members questions on this issue.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to discuss the proposed merger between Ealing Hospital and North West London Hospitals NHS Trusts and agree that the chair of the committee writes to the Hospital Trust board's setting out members views on the proposal.

Background Papers – Slides from the informal meeting on 24th January 2012

Contact Officers

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	Health Partnerships Overview and Scrutiny Committee 7th February 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL
North West London – Shaping a healthier future	

1.0 Summary

1.1 NHS North West London has begun pre consultation work on its commissioning plans for health services in the cluster area. The North West London cluster covers eight boroughs – Brent, Ealing, Harrow, Hillingdon, Hounslow, Hammersmith and Fulham, Kensington and Chelsea and Westminster. The health scrutiny chair person from each council was invited to a briefing held by NHS North West London on the "North West London – Shaping a healthier future" project on the 16th January. The slides from this meeting are included in the agenda pack.

1.2 The chair of the Health Partnerships OSC was keen that as well as engaging with health scrutiny chairs, representatives from NHS North West London were invited to the Health Partnerships OSC to outline their plans for health services in Brent. NHS North West London will be represented at the committee meeting to do this.

2.0 Recommendations

2.1 It is recommended that members consider the slides from NHS North West London, attached at appendix 1 to this report, and question officers from NHS North West London on the "Shaping a healthier future project".

Background Papers – Slides from the North West London Health Scrutiny Chair's briefing on the 16th January 2012.

Contact Officers

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Shaping a healthier future

NHS North West London

North West London

Shaping a healthier future

Overview and Scrutiny Briefing
16 Jan 2012

Welcome and introduction

Anne Rainsberry
Chief Executive

Shaping a healthier future

NHS
North West London

Agenda

▪ **Welcome and introduction**	**18:30 – 18:40**
▪ **Context**	**18:40 – 18:50**
▪ **Case for change**	**18:50 – 19:15**
▪ **Outline of programme**	**19:05 – 19:20**
▪ **Next steps**	**19:20 – 19:30**
▪ **Questions and discussion**	**19:30 – 20:30**

Healthcare provision in North West London

- 1 A&E department for every 200,000 people
- 423 GP practices
- 1,187 GPs

Mental Health Trusts

Central and North West London
(Hillingdon, Harrow, Brent, K&C, Westminster)

West London Mental Health
(Hounslow, Ealing, H&F)

Community Providers

- Central London Community Healthcare
- Hounslow & Richmond Community Healthcare
- Central and NWL NHS FT
- Ealing ICO

8 Clinical Commissioning Groups

Brent CCG
Ealing CCG
Hammersmith & Fulham CCG
Harrow CCG
Hillingdon CCG
Great West CCG (Hounslow)
Central London CCG
West London CCG

NWL – host commissioner for London Ambulance Service

Shaping a healthier future

NHS North West London

Over the past year we have made good progress. Patient journeys have helped us clearly articulate the quality of care we are aiming to deliver

Several pathways were reviewed

- Acute services (focusing on emergency surgery, A&E, inpatient paediatrics, and maternity services)
- Planned care and the management of Long Term Conditions (standards for high-level clinical pathways with two illustrative in-depth pathways)
- Primary care, when it is part of an integrated care pathway (illustrated for diabetes) or as part of an end-to-end pathway including care in an acute setting (illustrated with emergency care and paediatrics)
- A mental health care pathway
- A complex patient at the health and social care interface

For each pathway, we captured the patient journey

Patient journey in emergency surgery

Shaping a healthier future

NHS North West London

The impact on providers of the Commissioning Strategy Plan

Three overarching principles underpin our models of care

1. **Centralising** most specialist services means better clinical outcomes and safer services for patients
2. **Localising** routine medical services means better access closer to home and improved patient experience
3. Where possible, care should be **integrated** between primary and secondary care, with involvement from social care, to ensure seamless patient care

Shaping a healthier future

NHS North West London

Centralise: We have centralised key specialist services and improved patient outcomes

- Hyper Acute Stroke unit
- Major Trauma Centre
- Vascular surgery centre
- Heart attack centre

Shaping a healthier future

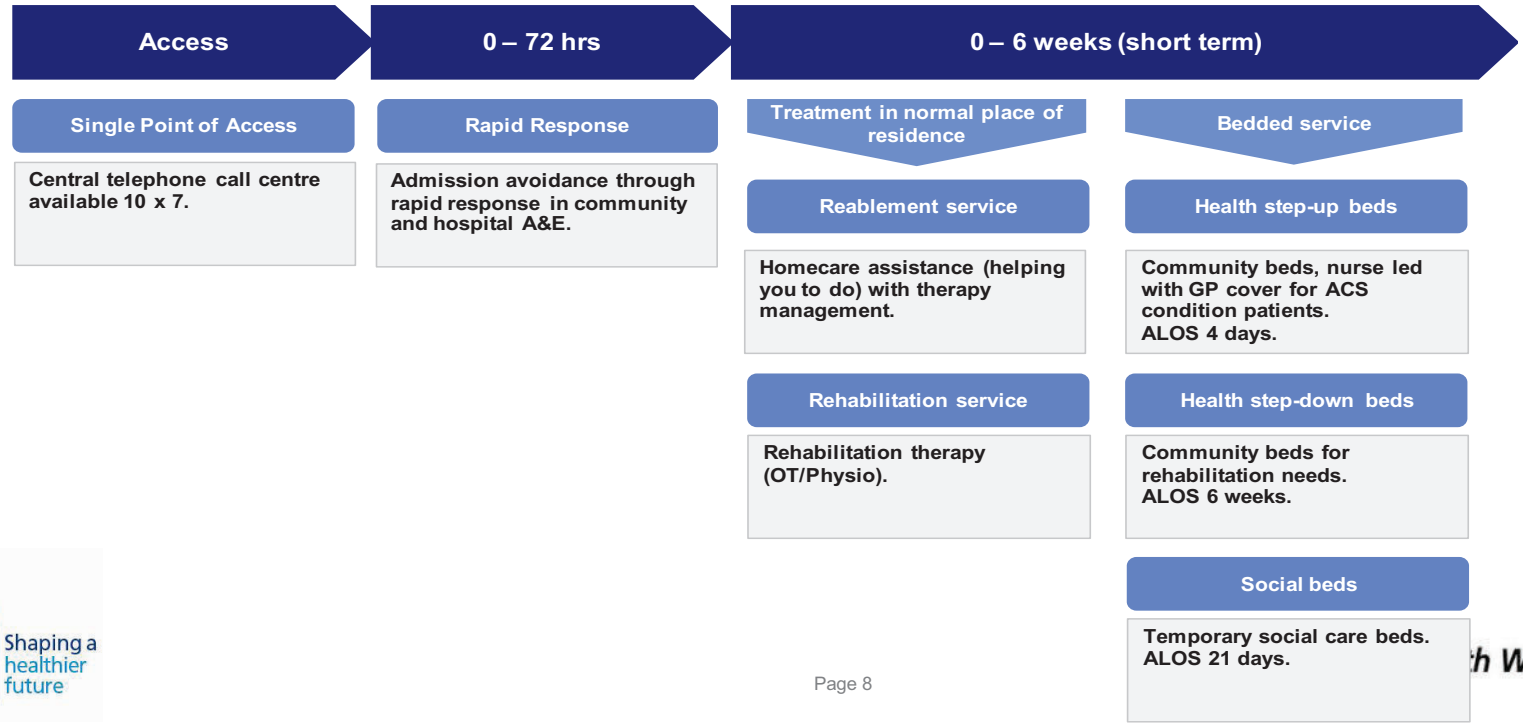
NHS North West London

Localise: We launched a successful Short Term Assessment, Rehabilitation and Re-ablement Service (STARRs) in Brent

Early supported discharge
Following a spell in acute hospital spell, STARRS supports patients to return to their normal place of residence more rapidly than would otherwise be possible.

Admission avoidance
STARRS is designed to work with patients who are identified as being at risk of a hospital admission, by providing a time-bound, intensive service involving a range of practitioners. The service is designed to treat a patient in their normal place of residence, supporting people to live independently

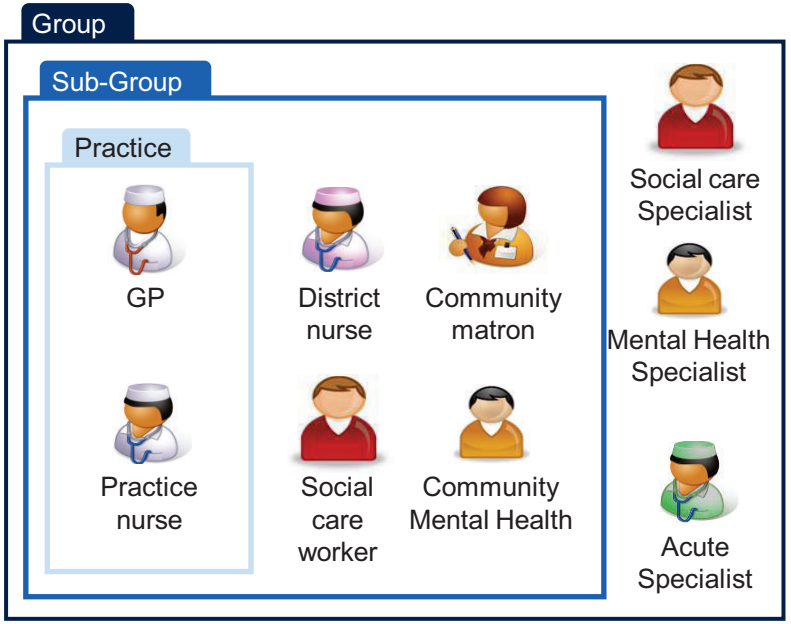
Short term crisis prevention
Working with community services STARRS is designed to help patients through a short-term crisis. STARRS has strong links with other community services, enabling patients' medium-long term health and social care needs to be met



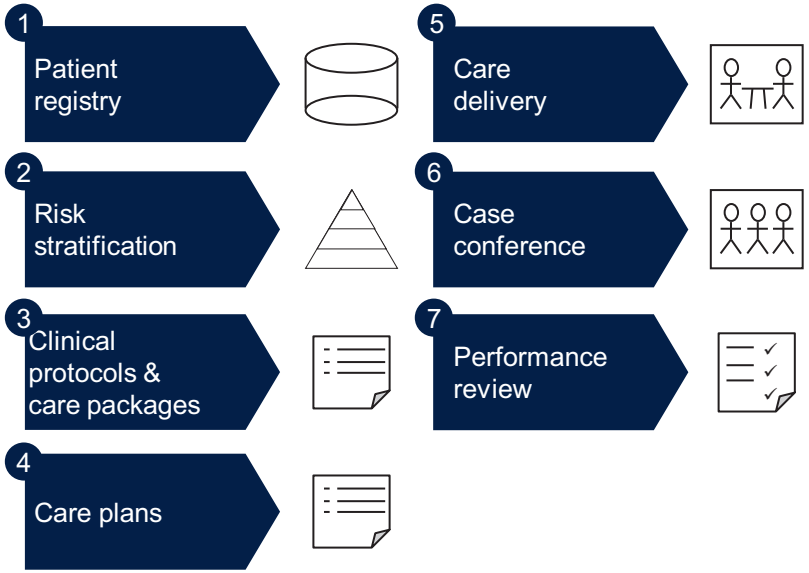
Integrate: We have launched an ambitious Integrated Care Pilot to improve the care of the frail elderly and diabetic patients across 5 boroughs

Improve the quality of patient care for patients with diabetes and the elderly

Local Multi-Disciplinary Groups…



…working in a Multi-Disciplinary System



What are we trying to achieve in NWL?

1) Improve patient outcomes and experience through collaboration and coordination care across providers (4 hospitals, 3 community providers, 93 GP practices, 5 social care organisations) with shared clinical practices and information
2) Over 5 years decrease hospital usage including emergency admissions by 30% and nursing home admissions by 10% for diabetics and frail elderly through better more proactive care
3) Reduce the cost of care for these groups by 24% over 5 years

Shaping a healthier future

NHS North West London

A large number of providers taking part in this pilot

NHS North West London

Ealing CCG
Great West CCG (Hounslow)
West London CCG (K&C)
Westminster CCG
Hammersmith and Fulham CCG

age UK

Diabetes UK

City of Westminster

Imperial College Healthcare NHS Trust

Chelsea and Westminster Hospital NHS Foundation Trust

THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA

Imperial College Healthcare Charity

h&f hammersmith & fulham

Central London Community Healthcare NHS Trust

Barnet ▮ Hammersmith and Fulham ▮ Kensington and Chelsea ▮ Westminster

Central and North West London NHS Foundation Trust

London Borough of Hounslow

Ealing www.ealing.gov.uk

West London Mental Health NHS Trust

Ealing Hospital NHS Trust

Shaping a healthier future

NHS North West London

The case for change

Dr Mark Spencer
Medical Director

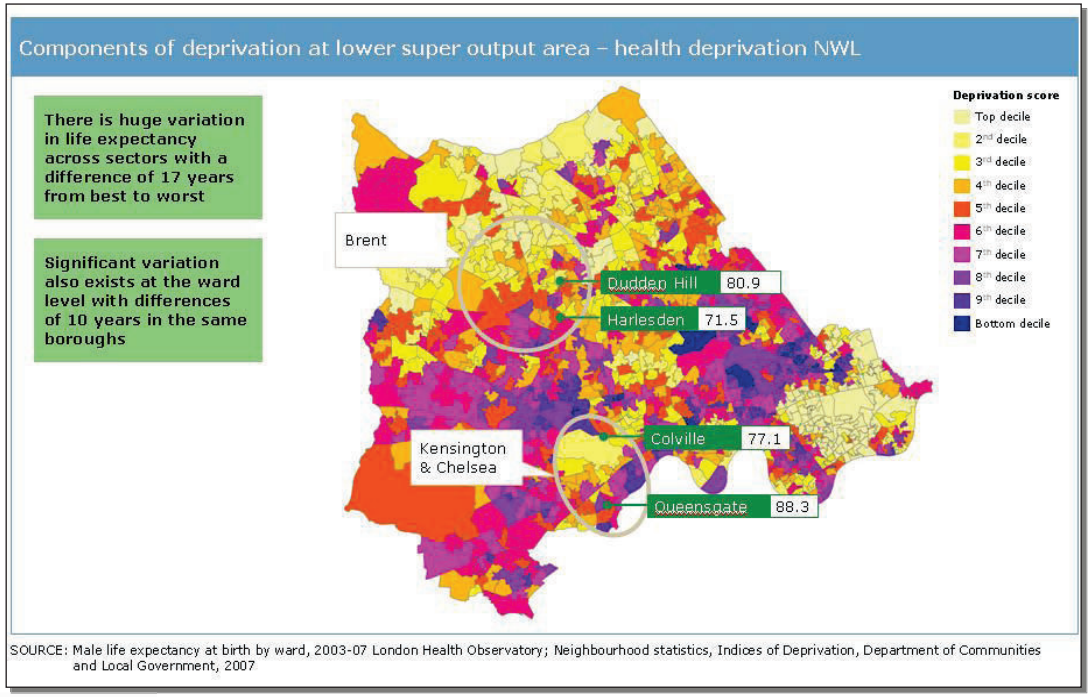
Shaping a healthier future

NHS North West London

Context for the NHS in North West London

The North West London (NWL) cluster is one of the largest PCT clusters in England.

- 8 PCTs/Clinical Commissioning Groups
- Budget of £3.5 billion
- Covering a population of 1.9 million



- Since 2000 life expectancy has improved by 2 years but gap across the cluster is still 16 years.
- We have some of the best provision of primary and acute care in London, but also some of the least good.

Summary of the Case for Change (1/3)

DRAFT

1. Our healthcare needs are changing and demand is increasing

- The population is getting **older**
- Current **lifestyle** is creating an epidemic of obesity, diabetes, cancer, heart disease and stroke
- The numbers of patients living with **chronic disease** are increasing
- **Science and technology** offer new ways of tackling old problems
- Internet, mobile communications and telehealth are opening up **new channels for delivering care** and providing health information, increasingly **supporting patients to care for themselves**

2. As a result we have made changes over the last few years

- Changes have been made in Community, Primary and Hospital care **increasing quality and localisation of services**
- **Coordination and integration** of care across the boundaries of providers has been improved reducing non-elective admissions for diabetic and elderly patient groups
- **Some specialist services have been centralised** into single networked centres, improving clinical outcomes
- NWL continues to deliver excellent **education** opportunities developing the next generation of clinicians alongside nationally and internationally recognised **research** that brings the latest treatments to patients

Summary of the Case for Change (2/3)

DRAFT

3. But there is still more to do

- The NHS could and should do more to **prevent ill health** in the first place
- When people are concerned about their health, the first point of call is **primary care**. We should do more to provide high quality easy access to physicians who can treat and help patients navigate the health care system
- For the increasing number of patients who suffer from **long term conditions**, we could be doing more to support them to manage their condition and maintain their independence
- More can be done for north west London's increasingly **ageing population** to enable them to live independently and to not be reliant on so much care
- Despite delivering good outcomes from hospital care, we are failing to provide consistently good **patient experience** for people
- As a result of **medical specialisation**, the need for clinical practitioners to treat a minimum number of patients to learn and maintain their skills and the need to provide increasing numbers of hours of consultant delivered care, it is challenging for all sites to provide **urgent surgery, paediatrics, obstetrics, critical care and A&E services**
- A number of **providers[1] in NW London are already facing significant challenges** in meeting key access targets, have significant financial challenges or have estate which is not fit for delivering modern standards of health care in.

1 Providers who fit into some or all of these categories include North West London Hospitals (Northwick Park and Central Middlesex), Imperial College (Charing Cross, Hammersmith and St. Mary's), Ealing Hospital and West Middlesex Hospitals

Summary of the Case for Change (3/3)

DRAFT

4. Delivering the best patient experience and clinical outcomes are the organising principles for how services should be delivered in North West London. **There are specific actions we need to take to deliver this commitment, which will require us to reconfigure our services. We need to:**

- More actively engage patients in taking personal responsibility for staying healthy and helping them manage their own health conditions.
- Work together with our health and social care partners in an **integrated** and seamless way to coordinate each individual patient's care
- Deliver more consistent high quality community and primary care and dramatically improve **access to local care**
- Support clinicians to become experts in specialist areas and increase the success rates of their treatments by **centralising and specialising services** into fewer hospitals, consistently delivering high quality care
- Make the best use of our good estate and improve or dispose of poor estate
- Facilitate the delivery of **high quality, coordinated care** through having well motivated and highly trained staff and better using technology to share information

Across the CCGs we have heard a set of five core themes on how to transform out of hospital care in NWL

What we want the future to look like…

1) **Easy access** to **high quality**, **responsive primary** care to make out of hospital care first point of call for patients

2) **Simplified planned care pathways** that allow hospital care to be delivered in a community setting

3) **Rapid response to urgent needs** by primary care for so that patients don't need to access hospital A&E

4) **Providers working together**, with the patient at the centre to effectively manage the **elderly and LTCs** out-of-hospital

5) **Minimal time in hospital** when admitted, with **early supported discharge** into well organised community care

…and how we propose to deliver it

a) **Organise** into relevant **local general practice networks**[1]

b) **Use networks to co-ordinate** a multidisciplinary group of social workers, community staff, district nurses and consultants (e.g., ward/localities)

c) **Ensure accountability for both health and social care**, with a named lead the patient knows is responsible for their care, prevents needless admission, speeds discharge and acts as single point of contact to organise OOH response

d) **Deliver care in settings of sufficient scale** to realise clinical and economic critical mass, optimising space utilisation

e) **Employ** a future workforce with a different **skill mix**, appropriate to the care delivered

f) **Agree consistent quality standards** for delivery of OOH care

g) **Establish enablers** to support the system:
- **Shared information** and communication to support core processes i.e., risk stratification, care planning, care delivery
- **Incentive/contractual alignment** to incentivise additional activity for proactive care, extended hours and reduced cost
- **Transparent performance management** on access, quality, referrals and cost across all providers

1 Harrow (Peer groups); Brent (Localities); Hounslow (Mentoring cells); H&F (Practice networks); Ealing (Practice networks); Hillingdon (Practice networks); CLH (MDGs); K&C (Learning Sets)

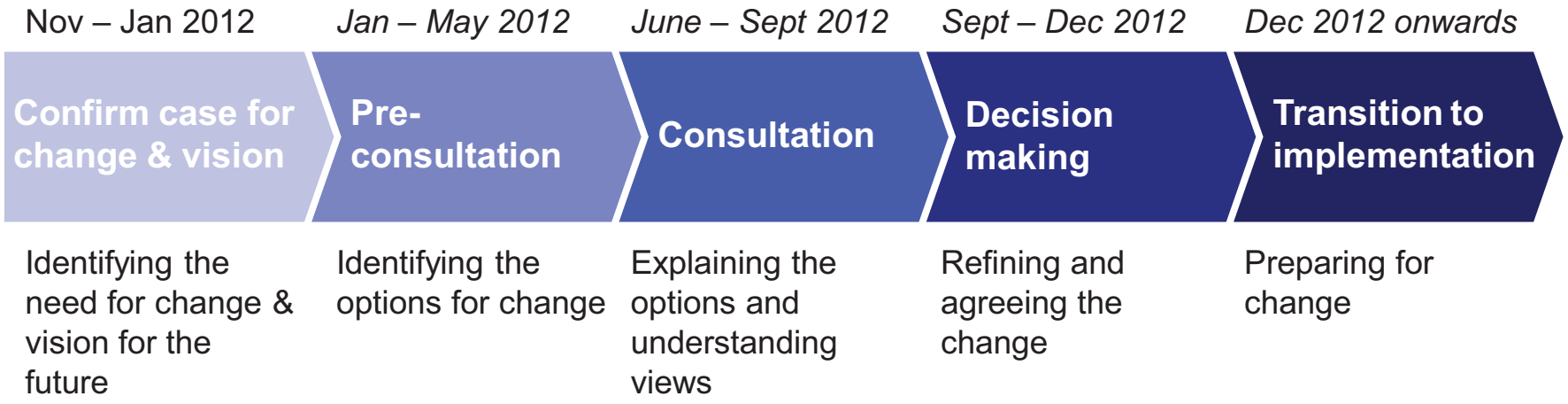
Shaping a healthier future

Daniel Elkeles
Director of Strategy

Shaping a healthier future

NHS
North West London

Current programme timeline



- Local clinicians are working together to confirm the quality standards and service models that will help NWL to address these challenges
- Local clinicians will subsequently lead a process to identify, appraise and shortlist options to deliver these standards
- We have a governance structure designed to obtain input from a variety of key stakeholders (see later slide)
- We are currently planning two pre-consultation engagement events to give local stakeholders specific opportunities to input to the identification of options

The options generation process will create a long list of options initially and gradually narrowing these down based on an agreed set of criteria

Mid February

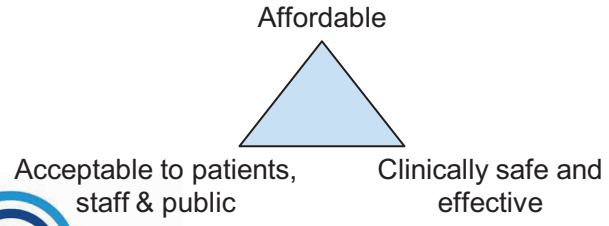
- Start with defined delivery models based on service configurations grounded in understanding of best clinical practice, standards and interdependencies
- Identify long list of options for role that each site could play

Mid March

- Test implications of long list of options (taking into account capacity requirements and fixed points)
- Discard groups of scenarios where significant challenge to implementation is likely (e.g. >50% under capacity at a given site)

Start April

- Identify short list of feasible scenarios and undertake more detailed modelling where necessary to support final decision-making on options for consultation



Key drivers:
- Clinical quality and interdependencies
- Capacity requirements
- Fixed points

We will ask for input to determine the detailed criteria for evaluating the options

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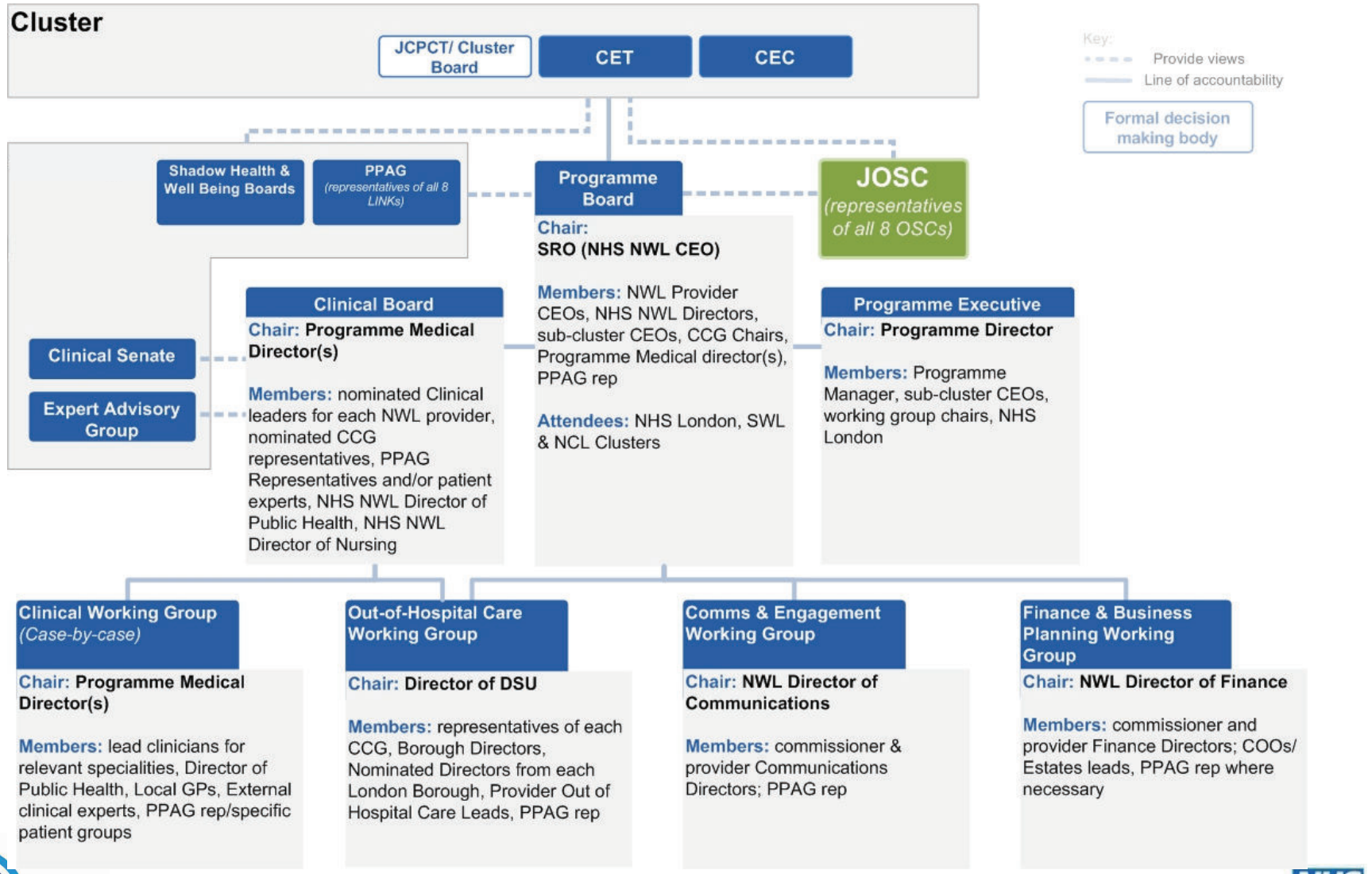
Programme Governance



Shaping a healthier future

NHS North West London

Issues to consider

1. How would you like to continue to be engaged with the programme?
2. What support do you need from us to set up a NW London JOSC?
3. What are your thoughts on the timing of the public consultation?
4. What advice would they give us on how to run a successful public consultation?

Next steps

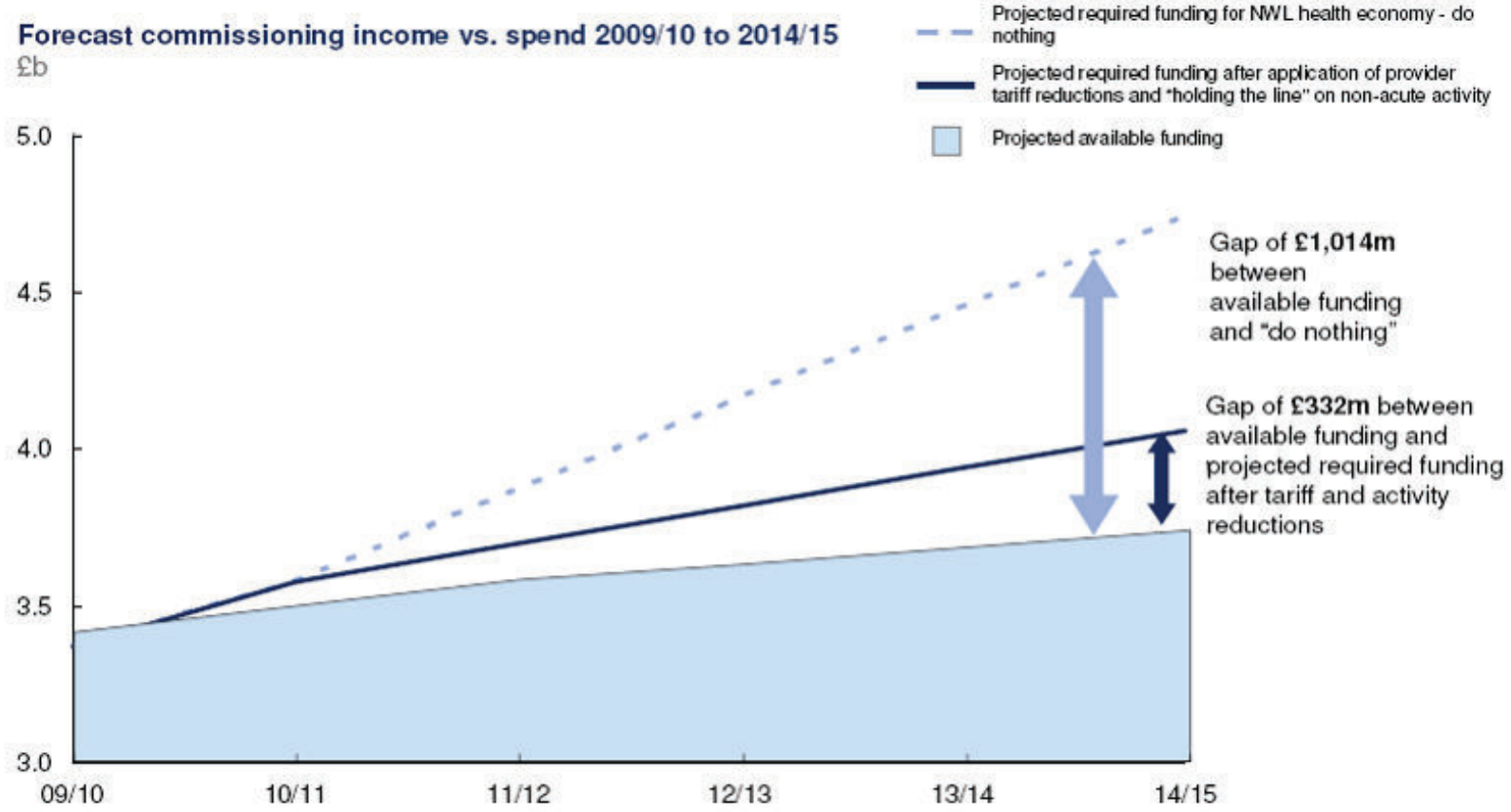
Shaping a healthier future

NHS North West London

We developed a 5 year Commissioning Strategy in 2010 and identified nine key issues which form the basis of our case for change

1	**Reducing variation in life expectancy**
2	**Improving patients' perceptions of our services (especially GP and maternity)**
3	**Improving care for patients with long term conditions (especially diabetes)**
4	**Improving primary care (access and outcomes)**
5	**Improving quality of hospital care (specialisation and decreasing length of stay)**
6	**Listening and responding to our staff (staff satisfaction)**
7	**Making better use of our buildings**
8	**Achieving £1bn of savings**
9	**Mental Health**

North West London health system needs to close a **£1bn** funding gap



We achieved the required savings in 2010/11

We have updated the analysis to take account of the most recent allocations and have confirmed that the financial challenge remains

	Health Partnerships Overview and Scrutiny Committee 7th February 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL
Khat Task Group – Final Report	

1.0 Summary

1.1 This report sets out the findings and recommendations of the Khat Task Group that are being presented to the Health Partnerships Overview and Scrutiny Committee for endorsement.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to endorse the Khat Task Group's recommendations for them to be passed to the council's Executive for approval.

3.0 Details

3.1 The final report of the Khat Task Group is attached at appendix 1. The task group was established because members were concerned about khat use amongst members of Brent's Somali community. Some of this concern came directly from the community, whilst non-Somali residents have also been affected in some way by the increase of khat use in the borough and reported this to councillors.

3.2 The task group wanted to better understand the health and social impacts of khat because of the concerns raised by members of Brent's community about the drug. There were three main issues that the task group investigated:

- The perceived impact of khat use on the community in Brent, particularly the health and social consequences of khat use.
- Anti-social behaviour associated with khat cafes or *mafrish*
- The perceived lack of treatment services and diversionary activities in Brent aimed specifically at khat users.

3.3 The task group worked to the following terms of reference:

The task group will:

(i). Consider the social implications of Khat use to determine whether there are significant problems within user communities, especially Brent's Somali community.

(ii). Consider whether the health of Khat users in Brent has suffered as a result of their use of the drug.

(iii). Consider the impact that Khat use has had on families in Brent, particularly for women and children.

(iv). Determine whether the Khat cafes in Brent are the cause or contributor to antisocial behaviour and health problems and whether there are any steps that can be taken to address these issues.

(v). Consider whether more effective treatment services can be put in place in Brent aimed specifically at Khat use.

(vi). Identify good practice already happening in Brent (such as the Help Somalia Foundations khat outreach work) and see what can be done to assist community organisations working with khat users.

(vii). Work with the local community to develop possible recommendations and solutions that can be implemented and lead by the Somali community in Brent.

3.4 The members of the task group were:

- Councillor Ann Hunter (chair)
- Councillor Eddie Baker
- Councillor Helga Gladbaum
- Councillor Krupesh Hirani
- Councillor Roxanne Mashari
- Councillor Margaret McLennan

3.5 The task group has developed nine recommendations that it hopes can be endorsed by the Health Partnerships OSC. The members of the task group are of the view that these recommendations can make a positive contribution to those affected by khat, either because they are taking it or their friends or members of their family are taking it. The recommendations address the following subject areas:

- Resolving immigration problems
- Training, employment and diversionary activities
- Treatment services
- Regulation
- Raising awareness of khat, its possible negative side effects, and promoting positive health messages

3.6 Above all other issues, tackling unemployment is the one thing that the task group believes would go a long way to reducing khat use. Employment is crucial for health and wellbeing and to improve peoples' self esteem. Brent's Somali community has been fully involved in the review and happy to give their time to help members investigate this issue. There are some excellent organisations and impressive individuals working within the community to help people improve their lives in the UK.

But time and again members heard that unemployment was a major problem, from people who were unemployed as well as others within the community and this issue should be given top priority for those who are working with Brent's Somali community.

Background Papers – Khat Task Group report – Appendix 1 to this covering report

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The health and social impacts of khat use in Brent

January 2012

Task Group Membership:

Councillor Ann Hunter (chair)
Councillor Eddie Baker
Councillor Helga Gladbaum
Councillor Krupesh Hirani
Councillor Roxanne Mashari
Councillor Margaret McLennan

Contents

Chair's Foreword

Since the beginning of time, human beings have found or made mind-altering drugs for their recreational use. From rainforest tribes to the Romans, every society has had stimulants and narcotics to drink, smoke, eat or chew, and each society has had to decide what is socially and culturally acceptable and what to ban, or attempt to ban/regulate, because of its harmful effects on individuals and/or the community.

In countries in the Horn of Africa, Ethiopia, Yemen and Somalia, one of these mood-altering drugs which has become popular is khat, the chewing of which is the focus of this report. Brent is fortunate to have a vibrant Somali community, some of whom have brought to the UK the practice of chewing khat.

There has already been a government report into the practice in 2005, and a review of the literature relating to khat research in 2011.We have referred to both of these in some detail, as well as consulting several more local reports, such as the one in the borough of Hillingdon. There is also currently an on-going government review of khat. We will send a copy of this report to them.

Our primary concern was to look at the social and health implications of khat, both for those who chew, their families and neighbours, and the communities in which they live.

We have listened to a wide cross-section of views over the last seven months, and have come up with what we think are practical and useful recommendations. Views range from a desire for a total ban on the import and chewing of khat, to those who see it as a cultural and harmless practice.

It is not in our remit to classify the drug; that is for the government to decide. What we propose are a series of practical recommendations to regulate its use, and most importantly to raise awareness of the key issues surrounding its use.

Some of these we, the Council, can implement, but some can only be actioned by the Somali Community themselves, and many of the conclusions we have reached have been as a result of listening to their various concerns. We need to work together, Council and community, to address these issues.

We want to see our recommendations implemented, and the Council and the Somali community working together to deal with the khat issue in Brent. We believe it can be done through a range of measures, spelt out in detail in the recommendations: better employment opportunities, awareness raising among both the Somali community itself, health and educational professionals and local police, and by ensuring that the local mafrish (khat cafes) comply with existing legislation in terms of health and safety and other criteria, and a voluntary agreement in terms of not selling khat to those under the age of 18.

I trust that the implementation of these specific recommendations will have a real impact on the issues of khat use and abuse in Brent.

In conclusion, I would like to thank all the contributors and interviewees, particularly Harbi Farah and all at the Help Somalia Foundation and Hussein Hersi and his colleagues at the Red Sea Foundation, who have facilitated our meetings with so many members of the Somali community here in Brent. I have been impressed by the participants' openness and willingness to engage with us, and we thank them for that.

Thanks too to the enthusiasm and zeal of the other members of the task group, Councillors Eddie Baker, Helga Gladbaum, Krupesh Hirani, Roxanne Mashari and Margaret McLennan. On behalf of them all, I would also like to thank Andrew Davies from Brent Council's Policy and Regeneration Unit; his efficiency and stamina have been a great support to us and all the other participants.

Councillor Ann Hunter
Chair of the Khat Task Group
January 2012

Executive Summary

Khat is used mainly by people from the Somali, Ethiopian, Kenyan and Yemeni communities in the UK[1]. Brent has a significant Somali population and it is use of khat amongst this group that has been of concern to councillors and to some members of the Somali community. Some believe that there are negative consequences associated with taking khat, most of which were repeated to the task group during the course of their investigations. Khat is said to:

- Contribute to family breakdown and violent behaviour
- Effect employment prospects if users spend too much time taking khat
- Encourage men to spend household income on the drug, rather than on food and paying bills
- Prevent immigrant communities from integrating with wider society
- Contribute to the onset of psychosis
- Lead to sleeping problems, loss of appetite, tiredness and a depressed feeling the day after use.

However, there are also people who regard khat as an important part of the culture of user communities, particularly at social occasions such as weddings, funerals and parties.

The khat task group was set up as members wanted to better understand the health and social impacts of khat on Brent's communities and to determine which of the opposing views on khat was closest to the truth in Brent. There were three main issues members wanted to investigate:

- The perceived impact of khat use on the community in Brent, particularly the health and social consequences of khat use.
- Anti-social behaviour associated with khat cafes or *mafrish*
- The perceived lack of treatment services and diversionary activities in Brent aimed specifically at khat users.

It is impossible to know how many Brent residents use khat. To begin with, we are unsure how many people of Somali origin live in the borough (assuming that the majority of khat users in Brent are of Somali origin). This is because the main source of information on ethnicity is the Census, which does not have a "Somali" category. But, irrespective of the number of people in Brent who use khat, what has become a concern is the pattern of use amongst some people. In Somalia, khat is an important part of the culture, but something that is normally taken in moderation, either at a celebration or after a meal. It is used, mainly by men, to stimulate conversation and as a way of relaxing. It does not normally interfere with working life, nor does it dominate lives as it can do in the UK. A number of the people who the task group spoke to during the review were concerned that the pattern of use had changed dramatically in the UK and that in the absence of anything else to do, men in particular, were spending their time with friends chewing khat.

The task group believes that the pattern of use is the key determinant of how big an impact khat had on a user's life. Khat is not physically addictive, but those who abuse khat do show signs of psychological addiction and it becomes a habit that some clearly find difficult to stop. The task group considered why the pattern of use may have changed in the UK and heard powerful opinions on this issue, many of which came back to one issue – the erosion of the traditional male role for Somali men in the UK. What was clear to people the task group spoke to, particularly women, was that the traditional societal roles are not as clearly defined in the UK as they are in Somalia. The task group was told that it is possible that men have questioned themselves as a result of this. The alienation they feel because of their

[1] Khat: Social Harms and Legislation – A literature review. Home Office, July 2011.

displacement, coupled with the trauma of war and loss of status, may have led some to seek a form of escape by taking khat to excess.

Unemployment was cited throughout the task group's work as a reason why people chew khat to excess. Khat is seen as a barrier to employment by members of the Somali community, as people who overuse khat are unable, or unwilling to work. There is little doubt that employment improves an individual's self-esteem and health and wellbeing. It is also the case, that at this current time an increasing number of people are unemployed in Brent and that jobs are scarce. Benefit dependence was raised as an issue during the review. A logical conclusion to draw is that if someone is unemployed they will have more time to take khat during the day than if they were in work.

The task group heard of numerous reasons why people in the Somali community may be unemployed, in addition to the "khat factor". These included:

- Immigration status
- Language barriers
- Skills barriers
- Lack of confidence caused by long term unemployment

The task group was told by people in the Somali community that they are concerned that those who abuse khat are able to sustain their habit because they are claiming benefits, including JSA and housing benefit and that this is acting as a disincentive to work. The task group does not buy into the theory that all khat abusers are relying on benefits to sustain their habit, and that if benefit was withdrawn people would find work. This is too simplistic and there are many ways to sustain a habit without claiming benefits. Additionally, khat use is not restricted to the unemployed or those claiming benefit and it would be wrong to promote this view. Many use it after work as a legitimate way to relax and socialise. The task group believes that unemployment is not the only reason why people take khat to excess. Nor is khat the only reason why some people from Brent's Somali community are unable to find work.

The task group was not unanimous on whether khat should be banned as some within the Somali community believe that it should. As a result it has not made a recommendation in relation to this. It is for Government to decide whether khat should be banned and the issue has to be seen in a nation-wide context, not just the experience of our borough. However, the task group would advocate the regulation of khat in some form. Among the views it heard during the review with regards to this were:

- It should not be sold to those under 18.
- Limiting the hours of sale could make it harder for people to stay up all night chewing.
- Owners of mafrish should ensure that they complied with legislation relating to:
    - Health and safety / building regulations
    - Smoking
    - Hygiene
    - Ventilation
    - Noise nuisance
    - Protect the wellbeing of staff who work in the mafrish

Working on the khat task group has been an enlightening experience for councillors. It is clear that, for some, khat is a problem. But for many people it is not and this report has tried to present a balanced view on the issue. This is why members haven't felt able to recommend banning khat – not all believe that the evidence is there to support this. It also isn't clear whether banning khat would lead to a reduction in its use, or whether it would

simply lead to the criminalisation of a section of our community that is already among our most disadvantaged in terms of deprivation, employment and educational attainment.

The task group has made nine recommendations which can be broadly split into five categories:

- Resolving immigration problems
- Training, employment and diversionary activities
- Treatment services
- Regulation
- Raising awareness of khat, its possible negative side effects, and promoting positive health messages

It is hoped that through the implementation of these recommendations real differences can be made amongst Brent's communities affected by khat. But, above all other issues, tackling unemployment is the one thing that the task group believes would go a long way to reducing khat use. Employment is crucial for health and wellbeing and to improve peoples' self esteem. Brent's Somali community has been fully involved in the review and happy to give their time to help members investigate this issue. There are some excellent organisations and impressive individuals working within the community to help people improve their lives in the UK. But time and again members heard that unemployment was a major problem, from people who were unemployed as well as others within the community and this issue should be given top priority for those who are working with Brent's Somali community.

Task Group Recommendations

The task group's recommendations are listed in the order in which they appear in the report, rather than because of the priority given to them by the task group members.

Recommendation 1 – The task group recommends that local Somali community groups, Brent Council and Job Centre Plus work with Brent's Somali community to signpost them when necessary, to refugee and immigrant support services in Brent so that they are able to resolve their immigration problems.

Recommendation 2 – The task group recommends that Job Centre Plus, BACES and the College of North West London works with local Somali organisations to advertise the ESOL courses and work-specific courses that are available in Brent to local Somali people in the most appropriate way.

Recommendation 3 – The task group recommends that a full evaluation of the CRI khat outreach project is carried out by NHS Brent and CRI prior to the end of the six month contract in March 2012, to determine whether there is enough demand to continue the project.

Recommendation 4 – The task group recommends that the Council and Somali community groups work with the owners of mafrish (khat cafes) and shops in Brent selling khat, to develop a voluntary agreement to prevent the sale of khat to those under the age of 18, as originally recommended by the Advisory Council on the Misuse of Drugs.

Recommendation 5 – The task group recommends that the Council runs a targeted enforcement campaign to ensure that the mafrish (khat café) owners are complying with various pieces of legislation with regard to:

- Health and safety / building regulations
- Smoking
- Hygiene
- Ventilation
- Noise nuisance
- Refuse disposal – that the cafes have trade waste contracts in place
- Payment of business rates
- Improvement of shop fronts

This is to ensure the immediate environment in and around the cafes is improved and to protect the wellbeing of staff who work in the mafrish.

Recommendation 6 – The task group recommends that NHS Brent works on raising awareness of khat with health professionals, including GPs, and the police, especially the Safer Neighbourhood Teams, as advocated by the Advisory Council on the Misuse of Drugs, so that users can be offered any help and support they may need.

Recommendation 7 – The task group recommends that NHS Brent and drug treatment agencies in the borough consider a campaign aimed at khat users to advise them on where to go if they wish to stop using khat, as well as drawing to their attention some of the issues associated with the drug, such as lack of sleep and lack of appetite. Efforts should be made to engage Somali community organisations in this work.

Recommendation 8 – The task group recommends that steps are taken to involve Somali young people in the One Council Review of Youth Services in Brent, so that their views can be taken into account.

Recommendation 9 – The task group recommends that Brent Council's Communications Team works with local Somali community groups to publicise positive achievements within the community more widely, using methods such as the Brent magazine. This would raise the profile of the community in Brent, and help to celebrate successes.

1. Introduction – What is khat?

1.1 Khat is a herbal product consisting of the leaves and shoots of the shrub *Catha edulis*. It is cultivated primarily in East Africa and the Arabian Peninsula, harvested and then chewed to obtain a stimulant effect. There are many different varieties of *Catha edulis* depending upon the area in which it is cultivated.

1.2 Khat is currently imported and used legally in the UK. Until 1997, khat was traded into the UK as a "vegetable" and so was exempt from VAT. From the 1st February 1998, Her Majesty's Revenue & Customs (HMRC) reclassified khat and it has become standard-rated for VAT at 20%[2]. In 2010 HMRC established that nearly 58 tonnes of khat are being imported into the UK each week, primarily from Kenya. This compares to around seven tonnes per week in the late 1990s, reflecting the rise in the number of immigrants to the UK from khat-consuming countries. Fifty eight tonnes equates to over 9,000 boxes of khat. The total amount of VAT collected on khat was £2.9m[3].

1.3 Khat arrives at Heathrow and is taken to a warehouse in Southall. From here it is distributed across the UK for consumption. Retailers pay £35 to £40 for a box of khat, but can sell it on to consumers at £3 to £6 a bundle. The retail value of a box of khat is around £120[4].

1.4 In February 2005 the Minister responsible for drugs asked the Advisory Council on the Misuse of Drugs (ACMD) to advise the Government as to the current situation in the UK and the risks associated with khat use. At that time the ACMD decided that it would be inappropriate to classify khat under the Misuse of Drugs Act 1971. They reported that the prevalence of khat in the UK is relatively low and isolated to the Somali and Yemeni communities. They found there was no evidence of khat use in the general population. Furthermore, the evidence of harm resulting from khat use was not sufficient to recommend its control. In 2010 the ACMD was asked again to review the available evidence on Khat by the coalition Government. However, this review did not start until 2011 and is currently ongoing.

1.5 Although khat is not controlled under the Misuse of Drugs Act 1971, its two main psychoactive component chemicals, cathinone and cathine, are classified as Class C drugs under the Act. An offence is committed if cathinone or cathine are extracted from the plant[5]. There have been no successful prosecutions for this offence to date.

1.6 Drugs that have a fast onset of action have a high addictive potential. Although chewing Khat is an efficient way to extract the active ingredients, it takes a long time to reach maximal plasma levels (around 2 to 2 ½ hours) and hence khat has less reinforcing properties than other stimulants such as amphetamine and cocaine. That said, some heavy users do display the symptoms of addiction.

2. Why set up a task group?

2.1 Khat is used mainly by people from the Somali, Ethiopian, Kenyan and Yemeni communities in the UK[6], although use in these communities varies considerably. Brent has a significant Somali population and it is use of khat amongst this group that has been of concern to councillors and to some members of the Somali community.

[2] Khat: Social Harms and Legislation – A literature review. Home Office, July 2011.
[3] Khat: Social Harms and Legislation – A literature review. Home Office, July 2011
[4] Khat: Social Harms and Legislation – A literature review. Home Office, July 2011
[5] Khat (Qat): Assessment of Risk to the Individual and Communities in the UK. ACMD, 2005
[6] Khat: Social Harms and Legislation – A literature review. Home Office, July 2011.

2.2 Councillors wanted to better understand the health and social impacts of khat because of concerns raised by members of Brent's community about the drug. There were three main reasons for peoples' concerns:

- The perceived impact of khat use on the community in Brent, particularly the health and social consequences of khat use.
- Anti-social behaviour associated with khat cafes or *mafrish*
- The perceived lack of treatment services and diversionary activities in Brent aimed specifically at khat users.

3. Terms of reference

3.1 The task group agreed to work to the following terms of reference.

The task group will:

(i). Consider the social implications of Khat use to determine whether there are significant problems within user communities, especially Brent's Somali community.

(ii). Consider whether the health of Khat users in Brent has suffered as a result of their use of the drug.

(iii). Consider the impact that Khat use has had on families in Brent, particularly for women and children.

(iv). Determine whether the Khat cafes in Brent are the cause or contributor to antisocial behaviour and health problems and whether there are any steps that can be taken to address these issues.

(v). Consider whether more effective treatment services can be put in place in Brent aimed specifically at Khat use.

(vi). Identify good practice already happening in Brent (such as the Help Somalia Foundations khat outreach work) and see what can be done to assist community organisations working with khat users.

(vii). Work with the local community to develop possible recommendations and solutions that can be implemented and lead by the Somali community in Brent.

4. Methodology

4.1 To begin the review the task group organised a meeting with representatives from Brent's Somali community, working for groups providing advice and support to people within the community. As well as getting to know the "community leaders", the task group also wanted to better understand the community's views on khat, what they consider the problems to be and how they would tackle the issue. The task group was also looking for guidance on how to conduct the review, as it was clear that it would require the help and cooperation of members of the Somali community. The people present at this meeting were:

- Harbi Farah and Ilham Gasser – Help Somalia Foundation
- Hussein Hersi – Red Sea Foundation
- Abukar Awale – Khat campaigner
- Ahmed Farah and Ahmed Gure – Hornstars

- Ali Awes – Khat campaigner
- Abdi Rahman

4.2 Other evidence was gathered by interviewing people working with khat users, local residents and other stakeholders. Interviews were held with:

- Simon Green, Shamsul Islam and Bill Bilon – Brent and Harrow Trading Standards
- Andy Brown, Head of Substance Misuse – NHS Brent
- Louisa Pavli and Abdul Gureye – CRI Brent
- Abdi Mahamud – Universal TV
- PCSO Martin Wells plus four members of the Welsh Harp SNT Panel
- Dr Liban Ali, North West London NHS Hospitals Trust
- Terry Dackombe, Partnership Manager – Brent Job Centre Plus

4.3 The task group held two focus groups with members of the Somali community. One was held at the Unity Community Centre with a mixed group of men and women, some of whom were khat users, some of whom weren't. Nine people attended this focus group. A second, women only, focus group was held at the Help Somalia Foundation. 16 people attended the second focus group.

4.4 The task group made two visits to Church Road during their research. The first visit was during the day time, where local people and traders were asked for their views on khat and in particular the khat cafes, or mafrish, in the area. The second visit was in the evening specifically to visit one of the mafrish and speak to khat users so that they had an opportunity to contribute to the review.

4.5 Finally, a literature review was carried out to look at work that has already been done in this area by the Home Office, the Advisory Council on the Misuse of Drugs, other scrutiny reviews (such as Hillingdon), khat research projects and best practice examples.

5. How many people use khat in the UK?

5.1 Research suggests that khat use is limited to the diaspora communities from East Africa and the Red Sea and that very few people in the wider population use the drug. In the UK, research has primarily looked at consumption amongst the Somali community. A 2005 research project interviewed 602 Somali people and found that 204 were khat chewers. They had a mean age of 39, which was an older mean age than those people who had not chewed khat, suggesting it was more popular amongst older Somalis. There was also a marked gender difference – 51% of males had chewed khat in the recent past, but only 14% of females. The majority of those that chewed considered themselves "moderate chewers"[7]

5.2 The British Crime Survey started to ask questions about khat use in October 2009, so a picture is emerging with regard to khat use amongst the general population. Preliminary results from the October 2009 survey suggest that 0.2% of the population reported using khat in the previous year.[8]

[7] Khat: Social harms and legislation – A literature review. Home Office, July 2011
[8] Khat: Social harms and legislation – A literature review. Home Office, July 2011

6. Common perceptions of khat use

6.1 There are many negative consequences associated with taking khat, most of which were repeated to the task group during the course of their investigations (see main findings below). Khat is said to:

- Contribute to family breakdown and violent behaviour
- Effect employment prospects if users spend too much time taking khat
- Encourage men to spend household income on the drug, rather than on food and paying bills
- Prevent immigrant communities from integrating with wider society
- Contribute to the onset of psychosis
- Lead to sleeping problems, loss of appetite, tiredness and a depressed feeling the day after use.

6.2 However, there are also people who do not consider khat use to be a problem and regard it is an important part of the culture of user communities, particularly at social occasions such as weddings, funerals and parties. The task group wanted to find out which of these opposing views was closest to the truth in Brent.

7. Local Context

7.1 Brent's Somali population has grown significantly over the last 20 years following the arrival of migrants fleeing the civil war. As immigrant communities have grown, consumption of khat in the UK has also increased. In Brent there are khat cafes, or mafrish, in the Church Road area, Kilburn High Road, Wembley Central, Harrow Road near Stonebridge Park Station, Neasden Lane and in Harlesden – there may also be other areas where there are cafes. There are a number of convenience shops that sell khat for consumption off the premises. The increase in outlets selling khat reflects the growing demand for the drug in Brent.

7.2 It is impossible to know how many Brent residents use khat. To begin with, we are unsure how many people of Somali origin live in the borough (assuming that the majority of khat users in Brent are of Somali origin – there aren't significant numbers of people from Yemen or Ethiopia in the borough). This is because the main source of information on ethnicity is the Census, which does not have a "Somali" category. We do know that the number of pupils in Brent schools that record Somali as their first language is increasing year on year, suggesting that the overall number of Somali people is increasing. Somali is now the 3rd most common first language spoken by Brent school children, after English and Gujarati. It also increased in greater numbers than any other language between 2009 and 2011.

7.3 Irrespective of the number of people in Brent who use khat, what has become a concern is the pattern of use. In Somalia, khat is an important part of the culture, but something that is normally taken in moderation, either at a celebration or after a meal. It is used, mainly by men, to stimulate conversation and as a way of relaxing. It does not normally interfere with working life, nor does it dominate lives as it can do in the UK. A number of the people who the task group spoke to during the review were concerned that the pattern of use had changed dramatically in the UK and that in the absence of anything else to do, men in particular, were spending their time with friends chewing khat.

7.4 In Brent there are a number of organisations that work with Somali people, some of whom try to help khat users wanting to stop. Some community members believe passionately that khat should be banned in the UK. It should be noted that the council has no power over this decision. It is a matter that has to be decided by the

Government, usually following advice from the Advisory Council on the Misuse of Drugs.

8. Task Group Findings

8.1 The task group's findings have been split into sections, reflecting the key issues raised by people that contributed to the review. There were a number of recurring themes, but opinions on them weren't uniform and the task group has tried to reflect that in presenting its findings.

8.2 Family breakdown

8.3 The task group heard on numerous occasions that khat use (normally by men) leads to family breakdown, or at the very least, problems between husbands/fathers and their wives and children. On a site visit to Church Road the task group spoke directly to three women about their experiences of being married to men who used khat. They reported that:

- Two of the women said that their husbands were chewing khat every day and not working. They had no time for their kids as a result of using khat. One reported that her husband was working, but that he was also abusing khat.
- The men have health problems. They have little time for their families. Arguments are frequent and relationships are breaking down.
- The men sleep during the day and often don't come home during the night. When they are chewing khat they switch off their phones so they can't be contacted by their wives.
- The men are agitated as a result of their khat use and lack of sleep.
- The impact on the children is significant. The men don't have much of a relationship with their children. They are unable to help with homework, and as the women spoke little English, their children were struggling at school. They can't afford extra tuition for their children. The women feel like single parents.
- Whilst the women said that their husbands used khat when they were living in Somalia, they also worked, which meant they used less.
- The women felt that khat should be banned to restrict its use in the UK.

8.4 These were powerful testimonies and it was clear to the task group that there is genuine concern amongst some people that khat is the cause of family breakdown or relationship difficulties. Those who attended the women only focus group spoke in similar terms about families they knew that had broken up because of the man's khat use (none said they were in this position personally).

8.5 Experiences like this were reported to the task group and it is a concern that khat abuse may be causing detrimental impact on family life. However, the task group also heard differently from khat users and other non users who felt that when it's used in moderation khat use doesn't impact on family or working life. It is the abuse of khat that can contribute to problems. What isn't clear is whether khat abuse is causing family breakdowns, or whether it is a convenient scapegoat and that there are other influential factors.

8.6 Patterns of use

8.7 It became clear to the task group that the pattern of use was the key determinant of how big an impact khat had on a user's life. Khat is not physically addictive, but those who abuse khat do show signs of psychological addiction and it becomes a habit that some clearly find difficult to stop. Khat use was discussed in two focus groups, one with khat users and a women's focus group (all of whom were non users). Many

female non users that spoke to the task group felt that khat wasn't an issue when taken in moderation at appropriate times of the day. However, perhaps not surprisingly, all felt that taking khat on a daily basis for hours at a time, late into the night or all night was wrong and would have an impact on a person's ability to work and maintain stable relationships.

8.8 The task group was informed that traditionally khat was used at weddings and other social occasions by Somali people. When Somalis get together with friends to discuss politics or events back home they use khat – it's an ingrained part of the culture. What became clear to members is that the pattern of use amongst some people appears to have changed since Somali people have come to live in the UK. In Somalia men took khat in social situations, but women would often be present – cooking a meal for instance, as part of a larger gathering. Khat would be taken for a couple of hours, at which point people would go home, or back to work but it wasn't normally used for hours on end. The normal circumstances of taking khat in the UK are different – men will go to *mafrish* (khat cafes), to chew khat and socialise. These, as far as the task group is aware, are only open to males. Its use in male only environments could have led to some of the family and relationship issues that the task group was informed about.

8.9 Members heard that as a rule older Somali people will only use khat and although some may smoke cigarettes they are unlikely to use other drugs or alcohol. Younger people do take khat but they are more likely to mix it with other substances such as alcohol and cannabis. People who participated in the review felt it was the result of a meeting of cultures and that as younger Somalis were more integrated into the UK, their behaviour reflected this. Participants in the khat user focus group felt that khat wouldn't necessarily become less of a problem in the UK as the Somali community became more settled and second and third generations became more integrated. Young Somalis are aware of khat and they'll use it because it helps them to socialise and it's cheap.

8.10 An important point was made to the task group by a female focus group participant - that in order to become a habitual user of khat, an individual will normally start by taking it socially – the habit develops. That said it is also worth considering the problem with khat in context. As the task group was told by the same female participant, there are people who are khat abusers, but compared to problem drinkers, or the number of deaths caused by alcohol abuse, it is a much smaller issue. Any response to khat has to be seen in this context and be proportionate to the scale of the problem.

8.11 The changing role of Somali men in the UK

8.12 It is important to consider why the pattern of use may have changed in the UK. The task group heard powerful opinions on this issue, many of which came back to one issue – the erosion of the traditional male role for Somali men in the UK.

8.13 In Somalia men were the breadwinners, they went out to work in order to support their families. Women were responsible for the home, for looking after children, cooking, cleaning and other domestic chores. In the UK, where Somali men haven't always been able to work (because of immigration status) or have been unable to find a job, or a job that they want to do (loss of status is an issue) their role as the "breadwinner" is no longer a given. At the same time, Somali women in the UK have become more independent, sometimes through necessity (for instance, they may have arrived here before their husbands) but also because they've been able to work and earn a living for themselves. Several women felt it was too easy for families to be provided with benefits and accommodation without the man having to work. This

results in the erosion of the male role, which may be alien to western cultures, but which the task group was told is an issue. What was clear to people the task group spoke to, particularly women, was that the traditional societal roles are not as clearly defined in the UK as they are in Somalia.

8.14 The task group was told that it is possible that men have questioned themselves as a result of this. The alienation they feel because of their displacement, coupled with the trauma of war and loss of status, may have led some to seek a form of escape by taking khat to excess. As well as taking khat, solace is sought through talking about Somalia and the desire to go home – not many people felt that they would still be in the UK after 20 years and many still hope to return to Somalia on a permanent basis. People aren't able to articulate their feelings or problems and so turn to khat and discussions with friends about Somalia and Somalian issues.

8.15 Whether this is the case or not is hard to demonstrate, but it was a strongly held view at the focus group with Somali women that some men are struggling more than others to adapt to life in the UK. They also referred to the civil war, which continues. Many Somali people in the UK still have relatives and friends in their homeland and this must be difficult and stressful and could explain why some choose to abuse khat.

8.16 Unemployment

8.17 Unemployment was cited throughout the task group's work as a reason why people chew khat to excess. Khat is seen as a barrier to employment by members of the Somali community, as people who overuse khat are unable, or unwilling to work. Although there are 10,000 people in Brent claiming Job Seekers Allowance, the number of people of Somali origin who are claiming JSA is unknown as Job Centre Plus doesn't collect this information, i.e. the relevant ethnic category, as with the census is Black African, not specifically Somali.

8.18 There is little doubt that employment improves an individual's self-esteem and health and wellbeing. It is also the case, that at this current time an increasing number of people are unemployed in Brent and that jobs are scarce. Benefit dependence was raised as an issue during this work. A logical conclusion to draw is that if someone is unemployed they will have more time to take khat during the day than if they were in work.

8.19 The task group heard of numerous reasons why people in the Somali community may be unemployed, in addition to the "khat factor". These included:

- Immigration status
- Language barriers
- Skills barriers
- Lack of confidence caused by long term unemployment

8.20 Job Centre Plus in Brent work with the Somali community to help them into employment. For example, in partnership with the Help Somalia Foundation, Job Centre Plus organised a jobs fair at Brent Town Hall in 2010 aimed at the community. This was attended by around 400 people and was considered a success. Courses are run from the College of North West London and BACES in subjects related to industries where there are vacancies in Brent's "travel to work area". ESOL courses are provided, which are accessible to people from the Somali community (or any other individual wanting to take English lessons). The task group was informed that Somali women often seek jobs in the care industry. Free courses in this sector are currently running at CNWL, with guaranteed interviews at the end of the course.

8.21 Job Centre Plus in Brent acknowledged that language can be a barrier for some job seekers (not just Somali job seekers) as English is required for virtually all jobs as are basic IT skills. ESOL classes are provided for free to people on benefit through BACES and the College of North West London to complement the job specific courses on offer. ESOL courses are offered at pre entry level (which is rare), level 1, 2 and 3. 500-600 places are available at BACES for 10 week courses. Funding is provided through successful completion of courses by the student, so BACES are able to offer more courses if scheduled classes are full. All courses have to have an outcome, and they're run on subjects for which there are vacancies in Brent's travel to work area – usually in areas such as administration, retail, hospitality etc. Courses are 10 weeks long and include complementary activities such as updating CVs and interview practice. Employment advisers also provide one to one support to help people find work when they are approaching the end of their course.

8.22 The group is keen that these courses are advertised within the Somali community. Job Centre Plus used word of mouth and the support of community groups to advertise the 2010 jobs fair. This approach seems to work with the Somali community rather than through leaflets or posters. The community groups working with Somalis in Brent should be sent up to date course details to ensure their availability is known within the community. The task group would also encourage other efforts to better market the courses available.

8.23 The task group was told by people in the Somali community that they are concerned that those who abuse khat are able to sustain their habit because they are claiming benefits, including JSA and housing benefit and that this is acting as a disincentive to work. Whilst the task group didn't meet anyone who was in this situation (or would admit to being in this situation) it is possible that some are able to sustain themselves in this way. The task group met with representatives of Job Centre Plus who felt that such supposed abuse of the system was unlikely – clients are regularly challenged to show that they are looking for work and there are penalties for those who persistently do not.

8.24 The task group does not buy into the theory that all khat abusers are relying on benefits to sustain their habit, and that if benefit was withdrawn people would find work. This is too simplistic. There are many ways to sustain a habit without claiming benefits. The task group was told that there is a culture of lending money to people for khat, and that there are often arguments about money as a result. People may be working informally, earning cash in hand and using this money to pay for khat. The task group also met 12 people in a mafrish, most of whom said they were in work. Khat use is not restricted to the unemployed or those claiming benefit and it would be wrong to promote this view. Many use it after work as a legitimate way to relax and socialise.

8.25 The task group also does not believe that khat is necessarily the cause of peoples' unemployment. Proving cause and effect in relation to khat and unemployment would be difficult. Are people abusing khat because they're unemployed? Are they unemployed because they're abusing khat? This isn't a straightforward issue but once someone has got into the habit of taking khat all day, every day, it can be difficult to break that cycle. But whether this is the cause of unemployment or a symptom of it is unclear.

8.26 The task group was informed by Job Centre Plus that in their experience it becomes much harder for an individual to find work if they are unemployed for longer than 13 to 26 weeks. Confidence gradually drops, lifestyles change and people become accustomed to benefits. There are people in Brent's Somali community who are long term unemployed – the task group met one man who informed the group he'd been

unemployed for nine years. Some in the community may also be unable to work because their immigration status has not been resolved. This may result in people seeking an outlet for their frustrations by taking khat, but unemployment is not the only reason why people take khat. Nor is khat the only reason why some people from Brent's Somali community are unable to find work.

Recommendation 1 – The task group recommends that local Somali community groups, Brent Council and Job Centre Plus work with Brent's Somali community to signpost them when necessary, to refugee and immigrant support services in Brent so that they are able to resolve their immigration problems.

Recommendation 2 – The task group recommends that Job Centre Plus, BACES and the College of North West London works with local Somali organisations to advertise the ESOL courses and work-specific courses that are available in Brent to local Somali people in the most appropriate way.

8.27 Mafrish - Antisocial behaviour

8.28 One of the main reasons for members setting up the task group was concern about the impact that mafrish are having on local communities. The task group was keen to visit a mafrish to see for themselves what happens there, the environment within the café, and to get a sense as to whether some of the problems attributed to the cafes – ASB, crime, litter and noise was accurate.

8.29 Accessing a mafrish took some negotiating, as members were keen to do this without having to use formal routes, such as through Environmental Health or Trading Standards, in order to engage customers on their experiences of using khat. In October 2011 members of the task group visited a mafrish on Church Road. The visit took place in the evening, after 6pm, and there were around 12 people using the café at that time. The mafrish was fairly small, with a number of benches around the outside of the room forming a circle within which there were desks for people to put their khat, water and soft drinks. There was a TV showing a Somali channel although most of the men there were waiting for the Champions League football to come on later that evening. The atmosphere was jovial, the communal nature of chewing khat was obvious – unlike in a pub, where people tend to talk to their friends, everyone in the room was sitting in a circle talking.

8.30 The main issues to arise from the visit to the mafrish were:

- Most of the men using the mafrish were working and tended to drop in after work in the evenings. Some of the customers were cab drivers, one was a gas engineer. Most spoke good English – some spoke perfect English, although they tended to speak to each other in a mixture of Somali and English.
- The men using the mafrish were a mixture of ages. Although no one was asked how old they were, three or four of the customers were probably under 25, whilst nobody appeared to be over 55-60.
- The customers explained that people who come to the mafrish are able to discuss their problems. This included family difficulties, but also some of the practical issues that come with living in the UK. The gas engineer explained he was the "go-to" man if his friends had problems with their plumbing or heating, and they would come to speak to him in the mafrish.
- It wasn't clear how long the men would be staying in the mafrish. The shop keeper suggested it would be 2 to 3 hours, but the men who were chewing avoided the question.

- One person felt that the Somali community in Brent needed a forum to come together to discuss the main issues affecting them, and to talk about solutions to these problems. This didn't just concern khat, but other social issues such as unemployment, gangs and education. At the moment there isn't anywhere for the community to do this and so people look to resolve their problems in the mafrish.
- By the end of the meeting any initial suspicions from the mafrish users about the task group had gone and one person remarked it was good that people from the council had taken the time to come and see them.

8.31 The experience that the task group had at the mafrish was a positive one. The people using khat were very welcoming, happy to talk to members and let them experience the mafrish. There weren't any problems linked to ASB when the councillors were present and there were people coming and going at regular intervals without incident. But it has to be acknowledged that this experience is not shared by others in Brent who live side by side with khat cafes.

8.32 Members have received complaints from constituents that the areas around the cafes are often unkempt, that rubbish is dumped on the streets and shop fronts are badly maintained. They're reported to be open all hours, meaning that they can be the source of night time disturbances. Reports of violence emanating from the cafes have been received by councillors.

8.33 The task group spent much of its time focussing on the Church Road area where there is a large concentration of mafrish, but it is also an area where there have been problems with antisocial behaviour and criminal activity. It is difficult to pinpoint the single cause of antisocial behaviour in an area like Church Road, which has a number of issues which cumulatively have contributed to its problems. As a result, members met with representatives of the Welsh Harp Safer Neighbourhoods Panel to discuss the situation at Blackbird Hill, where there is a concentration of cafes.

8.34 The main issues raised by the Welsh Harp SNT Panel members were:

- There are as many as five khat cafes in the area around Neasden Lane / Braemar Avenue. The shopping area is quite run down, there is often litter and detritus on the streets from the local businesses (including the cafes – discarded leaves and khat paraphernalia), broken glass is a common problem. Tensions in the area have been exacerbated by gang problems, and the cafes are being targeted because they are owned and used by Brent's Somali community. This is contributing to the concerns of local residents, who feel that the cafes are the cause of the problems in the area.
- Anti-social behaviour is an issue. At different times of the day the area can be affected by:
  - Double parking
  - Parking in front of driveways
  - Noise nuisance from café customers
  - Men have been seen staggering away from the cafes, high, and there have also been fights amongst customers.
  - People have been seen urinating in public.
  - At times, local people have been intimated by customers and left feeling uneasy by what they have seen.
  - The local residents believe other drugs are being dealt and used in the area.
- Deliveries of khat have a direct impact on Braemar Avenue. Deliveries happen at any time of the day, usually in private cars which stop on Braemar Avenue. Rubbish is often discarded after the deliveries have finished. The deliveries can also attract large numbers of people to the street.

8.35 These problems are acknowledged by the Safer Neighbourhoods Team in Welsh Harp and the task group hopes that they can be resolved. The task group believes that negotiation with the café owners would help, so that they can be made aware of the problems and the way the neighbours feel about the cafes.

8.36 The task group also visited Church Road in July 2011 to speak to shop keepers and local people about their perceptions of their local area, and in particular whether they felt that khat was contributing to anti social behaviour. Among the comments the group heard were:

Shopkeeper – The shop keeper was keen for khat to be banned. He had known youngsters in the area before they had taken khat and after and the effect had been clear. Young men who were normal, well behaved people are now "mad" and in his view this is the result of their khat use.

Local man – A local man said that many of the fights on Church Road are connected to money. Because many of the people abusing khat are receiving benefits, they often do not have enough money to buy their supply and so can get into debt. This is the cause of some of the tension on Church Road.

Shop keeper – One shop keeper said that the problems on Church Road, including khat, affected his business. ASB was an issue; groups of men hanging around put off shoppers, people don't feel safe in the area. Everyday there are issues, but Tuesdays and Fridays, when khat is delivered, it is particularly bad. There are arguments over khat and fights. This isn't helped by the larger number of people in the area on a Friday for prayers as those attending the mosque and those using khat come into conflict. He felt that something needed to be done to change the atmosphere in the road.

Barber shop customer - He didn't feel that khat use was a problem in Church Road. In his view, people currently using khat would probably be in a pub, if khat wasn't available.

Café owner – A Church Road café owner didn't feel that khat use was causing a problem to his business. He said that people do sometimes fight in Church Road, but that it was the same everywhere and not necessarily attributable to khat use.

8.37 From the small sample of people that the task group spoke to, there was a mixture of views. All felt that Church Road had its problems including ASB. Some believed that khat was contributing to this, others didn't.

8.38 Mafrish – licensing and business rates

8.39 The issue of mafrish licensing and business rates was raised during the review. At present there is no licensing regime for khat cafés. It is not even known how many khat cafes there are in the borough. They are often concealed, in premises that deliberately appear closed, or boarded up. There is rarely a sign to indicate that they're open for business. Sometimes people operate cafes from domestic premises, away from high streets where they are harder to find.

8.40 Khat is considered a food product so in theory café operators have to comply with food standards legislation. However, the task group was told that Trading Standards have other priorities rather than the small number of khat cafes and they will normally only investigate if there is a complaint. This is a sensible and proportionate approach. There are hundreds of legitimate food premises in the borough that need inspecting to protect the public's health. There are also difficulties in securing a successful prosecution on a khat café because:

- Demonstrating that a café is a trading premises is difficult – people can claim they bought their own khat to a "meeting place" rather than purchased it on site
- Knowing where the cafes are – Trading Standards rely on intelligence; they do not have the resource to pro-actively go and find them.

8.41 The task group was told that the most effective way to close a suspected café in domestic premises is through planning legislation. For example, if a business is trading from domestic premises there is legislation to deal with it. Similarly, if a building has been erected without permission and is being used as a cafe (as was the case in an example from Harrow), planning enforcement can be used to close it.

8.42 For cafes that are operating in business premises, ensuring they pay business rates is also an option that can be used to close the cafes. The task group was told of one former café site – 197 Church Road. This had been closed but business rates hadn't been paid for a year. The management company had been tracked down, but there were still business rates outstanding. The task group was informed by a number of people during the review that it was unlikely that business rates were being paid by café operators.

8.43 To test this, Revenues and Benefits were asked to check on a further two suspected cafes on Church Road. Both of these premises were, as of November 2011, paying business rates – one occupied rates, the other unoccupied rates. The amount of money the council receives is the same for both occupied and unoccupied premises. This was an interesting development and perhaps wasn't what the task group was expecting. It was felt that the mafrish owners were unlikely to be paying business rates because their businesses are deliberately low profile. The task group heard from numerous witnesses who felt similarly.

8.44 Health problems

8.45 Previous research into khat by organisations such as the Advisory Council on the Misuse of Drugs have commented on the health risks of taking the drug. Among the consequences attributed to taking khat are:

- Depression
- Insomnia
- Eating disorders, such as anorexia
- Infectious disease, such as TB or pneumonia, contracted as a result of taking khat in confined, poorly ventilated spaces in mafrish.

8.46 Although khat isn't physically addictive, heavy users can develop psychological dependency. Mental health issues can be exacerbated by khat chewing sessions that can last up to three days, where users get little or no sleep. But, what isn't clear to the task group and what hasn't been demonstrated in other studies is whether the mental health problems some khat users suffer have been caused by khat, or whether users were already suffering some mental health problems when they started taking khat, or whether it is coincidence that some khat users have developed mental health problems. Proving cause and effect has not been possible to date.

8.47 The task group spoke to a Somali doctor who has worked with people who have taken khat and developed health problems. What wasn't clear to the doctor is whether people suffered from mental health problems, before they started taking khat. People from Somalia in the UK have a number of issues that they are facing and their mental health problems could be attributed to other factors, not necessarily khat. The language barrier, the trauma of war, isolation, sense of displacement and

blurring of traditional roles are all factors the task group was told could contribute to poor mental health.

8.48 The Advisory Council on the Misuse of Drugs cites two different research projects on the link between khat and psychiatric morbidity. The results from both were inconclusive. One study looked at people in the Somali city of Hargeisa, which found a link between khat and psychiatric symptoms, but it also found an association between the experience of traumatic events, amount of khat use and psychosis. The study concluded it was not possible to determine cause and effect. The second study in Yemen found that there could be an inverse association between khat and psychiatric symptoms – that people using khat were less likely than others to develop psychiatric symptoms.[9]

8.49 Another issue, raised by one of the female participants at a focus group, was the effect that pesticides present on the khat have on the health of those who chew it. Khat grown in Kenya or other parts of East Africa is treated with pesticides that are banned in the UK, and yet it is ingested without washing in many cases. The female participant felt that this was the most dangerous issue connected to khat and that the Food Standards Agency should do more to monitor this. It should be noted that the Somali doctor the task group spoke to had not come across anyone suffering from the adverse impact of ingesting pesticides, although anecdotally it is said to contribute to liver problems amongst the Somali community.

8.50 A research exercise has been carried out looking at 15 khat-related deaths in the UK between 2004 and 2009. However, as the report acknowledges, the contribution of khat was varied. In more than 50% of cases the individual died in traumatic circumstances with external causes of death (such as car crash or suicide). The common feature among all of the deaths was that the individuals had either been known khat users, or traces were found in their blood stream during their post-mortem (along with other drugs and in many cases alcohol). Some of the individuals also had mental health problems. Khat toxicity was possible in two of the cases, but it isn't clear that khat was the sole cause of any of these deaths, but its use was a common factor amongst the victims.[10]

8.51 Views of khat users

8.52 It was important to the task group that the views of khat users were included in this project. The anti-khat lobby in Brent is loud and more than capable of ensuring their message is heard. What must not be forgotten is that khat is a legal product and those who take it have as much right to make sure their views are known and heard by decision makers as those who are calling for it to be banned.

8.53 The task group's findings from its visit to the mafrish are set out above. In addition to that visit, a focus group was held which khat users attended. Among the benefits of khat explained to the group were:

- The mafrish are places where the community can go to resolve problems and catch up on news. They're a good way for people to keep in touch with events in the community and also in Somalia.

[9] Khat: Assessment of Risk to the Individual and Communities in the UK - Advisory Council on the Misuse of Drugs, 2005

[10] Assessing Khat Related Death with special reference to the UK situation – John Corkery, St George's University of London. 2011

- There are economic benefits to khat. Shopkeepers run mafrish as a way of supplementing their income during difficult times economically. People work in the khat industry and this brings jobs and income to Brent.

- Abusing khat (i.e. chewing more than three bundles a day) was problematic. Using it in moderation didn't normally cause the user or their families any issues.

8.54 The experiences of people who had used khat attending the focus group are set out below:

One man told the group he was a daily khat user and had been for 20 years, since he had been in Europe. He said that he did not use khat to excess and that his level of use did not cause him any harm. He works, lives a normal family life helping his children with their school work, is able to sleep, eats normally and did not think that khat had a negative impact on him or his family. He chewed up to one bundle each day, but he believed using more than two or three bundles a day was problematic and could be classed as misuse. He compared use in Somalia and in the UK – in the UK people are more likely to be habitual and chronic khat users than they are in Somalia. Taking khat all night is not a good thing.

A second man, who was much younger than most of the group, had only taken khat once, with his friends. He took it because his friends were taking it and he wanted to see what it was like. In his words, it was like "chewing grass" and it did nothing for him. He's aware of the problems it can cause and the pesticides that can be present on the plants and he does not plan to use it again.

A third man uses khat occasionally, but he says that it has little effect on him. However, he has friends who are regular users, who spend their time taking khat when he is at work. Some of his friends are problem users, others take it at the weekends without any issues. Those who take it daily are bored – they have nothing else to do.

The fourth man used to chew khat twice a week – on the days it was delivered, so it was fresh. He used it when socialising with friends, although he has not chewed for 10 years

8.55 Time and again, the message that the task group heard about khat use, from users and many non-users was that moderation is crucial. Used to excess, khat can cause problems. Used in moderation, some believe that khat is a harmless stimulant people use when they socialise and relax.

8.56 ***Services in Brent***

8.57 One of the concerns that members had when beginning the review was the lack of specialist khat treatment services in Brent. Somali community members had told the task group that khat users would be highly unlikely to use mainstream drug treatment services if they wanted to give up khat because of the stigma this could cause within their community. They felt that users would not even regard khat as a drug, let alone something they would need treatment for.

8.58 However, in 2010/11 and 2011/12 (the period for which figures are available) khat users have been receiving treatment services from CRI, Brent's drug outreach service provider. It should be noted that the majority of service users are also using other substances as well as khat and may have sought treatment as a result of their abuse problems linked to these substances, rather than khat. See table 1 below:

Table 1 – CRI Drug Outreach – Khat users

Year	Number of clients	Nationality	Drug Use	Discharge reasons
2010/11	14	13 Somali 1 Ugandan	8 – khat, crack, alcohol and cannabis 3 – khat and alcohol 3 – khat, alcohol and cannabis	7 – completed treatment and occasionally use drugs (but not heroin or crack) 2 – completed treatment and are drug free 1 – completed treatment and is alcohol free 1 – in prison 1 – dropped out 2 – remain on caseload
2011/12 – Q1 only	2	2 Somali	1 – khat and alcohol 1 – heroin and alcohol (female client)	Both are still on caseload

8.59 Since the task group started its work, Brent's substance misuse service has funded CRI to provide a khat outreach service to specifically target khat users in a pilot project that will last until March 2012. If demand for services materialises, it could be extended beyond that date. The task group welcomes this development and is encouraged that NHS Brent has made an initial investment into khat-specific services. CRI has provided information on the number of khat users receiving treatment in the first six weeks of the khat outreach services, which started in September 2011. Six out of nine service users for whom the information is known are using substances other than khat. Two clients are female and one has mental health problems.

Table 2 – CRI khat outreach service – Client information for first six weeks of operation

Age	Gender	Nationality	Marital Status	Mental Health Issues	Parental Status	Substance Use
63	Male	Somali	Divorced	No	None of the children live with the client	Alcohol and khat
51	Male	Somali	Single	No	Not a parent	Crack, khat, alcohol and cannabis
21	Male	Somali	Single	No	Not a parent	Khat
38	Male	Somali	Married	No	All of the children live with the client	Heroin, cannabis and khat
43	Male	Somali	Single	No	Not a parent	Alcohol and khat
57	Male	Somali	Single	No	Not a parent	Khat

26	Male	Somali	Single	No	Not a parent	Khat, cannabis and alcohol
63	Female	Somali	Single	No	Not a parent	Khat
52	Male	Somali	Single	No	Not a parent	Alcohol and khat
39	Male	Somali	Single	No	Not a parent	Unknown
37	Male	Somali	Single	No	Unknown	Unknown
59	Female	Somali	Single	Yes	Unknown	Unknown

8.60 It is too early to judge the success of this service, or whether Somali khat users are reluctant to use it because it is provided by a mainstream drug treatment provider. The task group was very impressed with the commitment that CRI are making to this project, using one of their existing drug workers who is Somali, to lead this work. One point that is worth noting is that those people opposed to khat use often argue that its abuse can lead to family breakdown. However, of the clients using CRIs services, only one was divorced and the majority were not parents, which contradicts this view.

Recommendation 3 – The task group recommends that a full evaluation of the CRI khat outreach project is carried out by NHS Brent and CRI prior to the end of the six month contract in March 2012, to determine whether there is enough demand to continue the project.

9 Solutions

9.1 The task group held a meeting at the start of the review with representatives from organisations in the borough that work with the Somali community. The clear message from that meeting was that ultimately it should be the community that resolves the problems connected to khat abuse – moralising or lecturing from officials, be it from health or the local authority was likely to fall on deaf ears or result in outright suspicion and hostility. Solutions have to come from the community if they are to succeed.

9.2 The task group has been mindful of this throughout, and has based its recommendations on the views of the community. It is crucial that it is the community agrees with the recommendations and supports their implementation. This will rely on the support of the organisations that work so hard to improve the lives of people in Brent.

9.3 *Regulating khat*

9.4 The task group was not unanimous on whether khat should be banned or not and as a result has not made a recommendation in relation to this. It is for Government to decide whether khat should be banned and the issue has to be seen in a nation-wide context, not just the experience of our borough. However, the group heard from a number of people who felt khat should be banned, or at the very least, regulated in some way. The task group does support the regulation of khat.

9.5 Those in favour of banning khat believe that the health and social problems attributed to its use warrant stricter controls. Because khat is mainly used by immigrant communities and knowledge of it amongst the wider population was limited, its impacts are down played. A common comparison was made with the reaction to

deaths attributed to legal highs, which had widespread media attention. The Government has moved quickly to ban some legal highs. Khat receives nothing like the publicity – is this because its popularity doesn't extend beyond the Somali, Ethiopian and Yemeni communities in the UK? It certainly hasn't been adopted as a "cause celebre" by the tabloid press, in the way that legal highs were.

9.6 Others arguments in favour of a ban were

- It's the only way to bring its use under control
- A ban would make people think twice about chewing and reinforce the point that it is a drug that can have negative side effects. Because it's legal some people view it as harmless and don't appreciate the consequences of using it to excess.
- Women may also be reluctant to allow their husbands to chew at home if it was banned, to avoid criminal activity taking place in their home.

9.7 It is clear that some members of Brent's Somali community are passionate campaigners for the banning of khat. On the 28th October 2011 the Wembley Observer ran a front page story on this very issue featuring Abukar Awale, a prominent campaigner from Brent who advocates the banning of khat in the UK. He participated in the task group and was among the more vociferous advocates for banning khat.

9.8 The main arguments against banning khat that the task group heard were:

- Banning khat will drive up the price, causing further economic difficulties to those who use it
- It would be a waste of public resources to prosecute people for khat possession or selling. Resources should be used to tackle more serious crimes
- Khat users, who otherwise would never / have never committed a crime, shouldn't be criminalised because of their khat use.
- If khat was banned then users would look to other substances, such as alcohol, to replace it
- Banning khat would make little difference – men would continue chewing, even if it was more expensive and harder to obtain.

9.9 The Home Office publication "Khat: social harms and legislation – a literature review", refers to the situation in Norway and Sweden, both of which prohibited khat in 1989 without any research into its harms. The report says that "demand remains high in Norway and it is estimated that out of 9,000 Somalis in Oslo, 1,000 are consumers".[11] The report also says that "khat is still chewed by 30% of Somali men in Sweden"[12] (20 years after the ban was introduced). The suggestion from the report was that banning khat does not necessarily lead to a reduction in its use.

9.10 When the Advisory Council on the Misuse of Drugs carried out its khat review in 2005, it decided against banning khat. But it did make a number of recommendations that it suggested should be voluntarily implemented. Those relating to regulation were:

> ***"ACMD Recommendation 4***
> The (Advisory) Council recommends that the Government/local relevant authorities explore the possibility of a voluntary agreement among retailers of khat on excluding sale of khat to those under 18 years old.

[11] Khat: Social harms and legislation: A literature review
[12] Khat: Social harms and legislation: A literature review

ACMD Recommendation 5
Furthermore, the (Advisory) Council recommends an awareness raising campaign of the health and safety implications of chewing Khat in Mafreshi (e.g. – health implications from poorly ventilated, smoky environments), and a voluntary undertaking from community leaders and Mafreshi owners adhere, wherever possible to current health and safety regulations on ventilation, lighting, fire escapes etc."[13]

9.11 The task group advocates the regulation of khat in some form. Among the views it heard during the review with regards to this were:

- It should not be sold to those under 18.
- Limiting the hours of sale could make it harder for people to stay up all night chewing.
- Owners of mafrish should ensure that they complied with legislation relating to:
    - Health and safety / building regulations
    - Smoking
    - Hygiene
    - Ventilation
    - Noise nuisance
    - Protect the wellbeing of staff who work in the mafrish

9.12 Of course, implementing a system of regulation and licensing would not be cheap or easy to do on a borough only basis. It would require enforcement and would be unpopular amongst those who work in the khat trade and khat users. But it is something that the task group would ask the Advisory Council on the Misuse of Drugs to consider recommending to Government, to see if a national scheme can be put in place. A voluntary code is unlikely to succeed and would be hard to implement.

9.13 It should be noted that scrutiny reviews have been carried out in other boroughs looking at the health and social impacts of khat, specifically Hillingdon. Councillors there have also recommended a system of regulation for khat should be introduced in the UK, and opted against specifically recommending that khat should be banned.[14]

Recommendation 4 – The task group recommends that the Council and Somali community groups work with the owners of mafrish (khat cafes) and shops in Brent selling khat, to develop a voluntary agreement to prevent the sale of khat to those under the age of 18, as originally recommended by the Advisory Council on the Misuse of Drugs.

Recommendation 5 – The task group recommends that the Council runs a targeted enforcement campaign to ensure that the mafrish (khat café) owners are complying with various pieces of legislation with regard to:

- Health and safety / building regulations
- Smoking
- Hygiene
- Ventilation
- Noise nuisance
- Refuse disposal – that the cafes have trade waste contracts in place

[13] Khat: Assessment to the risk of the individual and communities in the UK – Advisory Council on the Misuse of Drugs, 2005

[14] What problems are posed to Hillingdon, and beyond, by khat and what can we do to tackle them? – Hillingdon Overview and Scrutiny Review report , 2010/11

- Payment of business rates
- Improvement of shop fronts

This is to ensure the immediate environment in and around the cafes is improved and to protect the wellbeing of staff who work in the mafrish.

9.13 *Educating people on the dangers of khat*

9.14 Making sure people know the impact that khat can have on users was a common call from people contributing to the review. Although the cause and effect of many of the perceived side effects haven't necessarily been proven beyond doubt, those people who contributed to the review (including khat users) were clear that using khat repeatedly to excess had consequences for health and wellbeing. There are calls for these messages to be communicated to people so that they are aware of the risks of khat abuse, possibly on khat packaging in a similar way to cigarette packaging. The task group acknowledges the impracticalities of this. Khat is sold out of boxes, normally wrapped in blue carrier bags. Stamping a warning message on the bags would be hard to organise. It is also not clear what the message should be. Unlike with cigarettes for example, the links between khat and ill health are not as clear.

9.15 Raising awareness is considered particularly important amongst younger people who may be getting into khat. Somali TV would be a useful way of doing this, but programmes have to be targeted at different age groups – logically young people watch different programmes from older people. Outreach in mafresh would also be helpful, as would outreach in mosques and the use of role models to talk to people about the dangers of khat.

9.16 The Advisory Council on the Misuse of Drugs in 2005 felt that there "was a need to educate primary health care professionals and others directly involved with members of (khat using) communities about the health and social problems associated with khat use.

9.17 The need for education was in the following areas:

- The health risks associated with Khat use
- The dangers of Khat use
- Risk reduction and safer Khat use
- Treatment options for Khat use
- Prevention of Khat use"[15]

9.18 The Advisory Council acknowledged the need to focus education, at least partly through local communities, by introducing peer education models. The task group would endorse this approach. The Help Somalia Foundation already does peer mentoring work with khat users and it is hoped that this can be continued. Primary care services will also have a role in educating users. It is clear to the task group that despite the good work of CRI, education should not be the exclusive role of drug treatment service providers if it is to be effective. Ideally it should be community led.

Recommendation 6 – The task group recommends that NHS Brent works on raising awareness of khat with health professionals, including GPs, and the police, especially the Safer Neighbourhood Teams, as advocated by the Advisory Council on the Misuse of Drugs, so that users can be offered any help and support they may need.

[15] Khat: Assessment of Risk to the Individual and Communities in the UK - Advisory Council on the Misuse of Drugs, 2005

Recommendation 7 – The task group recommends that NHS Brent and drug treatment agencies in the borough consider a campaign aimed at khat users to advise them on where to go if they wish to stop using khat, as well as drawing to their attention some of the issues associated with the drug, such as lack of sleep and lack of appetite. Efforts should be made to engage Somali community organisations in this work.

9.19 *A place for people to meet without khat*

9.20 There were two main strands to this – firstly, the mafrish act as a useful meeting place for men, to catch up with friends and to discuss community issues. Whilst it is possible that non khat chewers go to the mafrish, they are male only environments and clearly khat is present and is a significant pull factor for those going to the mafrish. The task group heard that having a meeting place where khat wasn't chewed would be beneficial to the community.

9.21 Secondly, the point was made to the task group that Somali men and women do not have a place where they are able, as a community, to meet and socialise and discuss issues affecting them. Mafrish are male only, whilst Mosques are also separated along gender lines. Having a space where families can spend time would be a positive development, where there are activities for men, women and children that they are able to do together.

9.22 The task group is especially conscious of the view that solutions have to come from within the community. Regarding this point, the task group would not support the opening of a Somali "community centre", or a similar council run building. This would almost certainly fail for the reasons identified above, possible suspicion and hostility towards organisations like the local authority. If it is a genuine community ambition to have such a space, the council and partners should assist where it can to help make it a reality. But the solution has to be community driven and community owned if it is to be a success. In some respects resources are already available. Somali groups use the Chalkhill Community Centre, the Unity Community Centre and Hornstars use community facilities in Stonebridge. Ensuring that the wider community is aware of this may help to resolve some of the issues that the task group was told about.

9.23 *Diversionary Activities*

9.24 This is related to the above point, but it was noticeable that some of the mafrish customers made a point of telling the task group that if there were other things they could do, they wouldn't be in the mafrish chewing khat. They informed the task group:

- If there was more for them to do, they would not be chewing khat. The younger customers would prefer to play football, but there wasn't anywhere for them to go to do this. They didn't feel safe going up to Hornstars in Stonebridge because of problems between groups from different parts of Brent and gang territory. However, if football sessions could be set up in the Church Road area then they may be able to play against teams from Hornstars. This could be a way of breaking down the barriers that currently exist. They were encouraged to hear about the plans for the new Roundwood Centre and thought this may be a good place for younger Somali people to try different activities.

9.25 There were a number of points raised by this statement, not least gang concerns, which are outside the remit of the task group. But, are people taking khat because of the absence of other things to do, especially younger people? Of course, the most affective diversionary activity would be employment.

Recommendation 8 – The task group recommends that steps are taken to involve Somali young people in the One Council Review of Youth Services in Brent, so that their views can be taken into account.

10. Conclusions

10.1 Working on the khat task group has been an enlightening experience for councillors. It is clear that, for some, khat is a problem. But for many people it is not and as a result this report has tried to present a balanced view on the issue. This is why members haven't felt able to recommend banning khat – not all believe that the evidence is there to support this. It also isn't clear whether banning khat would lead to a reduction in its use, or whether it would simply lead to the criminalisation of a section of our community that is already among our most disadvantaged in terms of deprivation, employment and educational attainment.

10.2 Above all other issues, tackling unemployment is the one issue the task group believes would go a long way to reducing khat use. Employment is crucial for health and wellbeing and to improve peoples' self esteem. Brent's Somali community has been fully involved in the review and happy to give their time to help members investigate this issue. There are some excellent organisations and impressive individuals working within the community to help people improve their lives in the UK. But time and again members heard that unemployment was a major problem, from people who were unemployed as well as others within the community.

10.3 At this time, when unemployment generally is rising, and unemployment in Brent is above the London and national averages, helping people to find work is challenging. But coupled with the disadvantages facing Brent's Somali community, such as language barriers, lack of qualifications and skills recognised in the UK etc, getting people back into meaningful work is no easy task. But it is the area that the task group believes deserves the biggest focus and would make an enormous contribution to reducing the numbers of people who abuse khat.

10.4 There is much good work going on in Brent's Somali community where people are striving to establish themselves in the UK and in many cases succeeding in doing this. For example, Capital City Academy pupil Suleyman Abdi securing a place at Oxford University to study engineering, the first pupil from the school to gain a place at Oxford. But more needs to be done to promote this and emphasise the positive contribution the Somali community makes to life in Brent. The task group's final recommendation will hopefully help to address this.

Recommendation 9 – The task group recommends that Brent Council's Communications Team works with local Somali community groups to publicise positive achievements within the community more widely, using methods such as the Brent magazine. This would raise the profile of the community in Brent, and help to celebrate successes.

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	Health Partnerships Overview & Scrutiny Committee **7th February 2012** **Report from the Director of Strategy, Partnerships & Improvement**
For Action	Wards Affected: ALL

Tackling Diabetes in Brent – Task Group

1.0 Summary

1.1 This report requests the Health Partnerships Overview and Scrutiny Committee to consider the attached scope for 'Tackling Diabetes in Brent' and agree for a task group to be set up.

2.0 Recommendations

2.1 That Members of the committee agree to set up a task group and that group offices are approached for membership.

3.0 Detail

3.1 The key issue is that Diabetes in Brent is increasing rapidly and is a significant health problem for the people of Brent, as well as being a huge financial burden on the NHS. There is a need to improve the preventative care measures provided by Brent PCT and to ensure that patients are diagnosed correctly.

3.2 Research carried out by the Joint Strategic Needs Assessment shows that the prevalence of diabetes registered patients in Brent is 6.7% compared to only 5.3% for London. It also confirms that there is a need to increase the provision and access to patient education and self management programmes.

3.3 There are a number of main risk factors leading to Diabetes:

- Obesity

- Lack of exercise
- Poor diet
- Ethnicity
- Deprivation
- Lack of knowledge
- Late diagnosis

3.4 Research shows that there is a clear link between Diabetes and ethnicity. People of South Asian, African, African-Caribbean and Middle Eastern decent have a higher that average risk of Type 2 diabetes. With 59 per cent of the population in Brent originating from black and ethnic minority backgrounds diabetes in Brent has become one of the biggest cost and challenges facing the NHS.

3.5 The scope for 'Tackling Diabetes in Brent' is attached.

4.0 Financial Implications

4.1 None

5.0 Legal Implications

5.1 None

6.0 Diversity Implications

6.1 None

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 None

Background Papers

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Tackling Diabetes in Brent

Why are we looking at this area?

According to Diabetes UK, there are approximately 2.9 million people in the UK that have been diagnosed with diabetes and this is on the increase. It is estimated that by 2025 almost five million people in the UK will have diabetes. Majority of these cases will be Type 2 diabetes due to the ageing population and the number of overweight and obese people increasing.

Diabetes UK[1] explains that diabetes is a common life-long health condition and develops where the amount of glucose in your body is too high because your body cannot use it properly. This happens because your pancreas does not produce any insulin, or not enough to help glucose enter your body's cells – or the insulin that is produced does not work properly (known as insulin resistance). There are two main types of diabetes, **Type 1 diabetes** and **Type 2 diabetes:**

Type 1 diabetes develops when the insulin-producing cells in the body have been destroyed and the body is unable to produce any insulin.

Type 2 diabetes develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance).

If diabetes is left untreated, it can lead to heart disease, stroke, blindness and kidney failure. The other alarming figure is that there are around 850,000 people in the UK who have diabetes but have not yet been diagnosed.

The Department of Health indicates that diabetes does not affect everyone in our society equally. Significant inequalities exist in the risk of developing diabetes, for example access to health services and the quality of those services, and in health outcomes, particularly with regard to Type 2 diabetes. The Brent borough strategy states that Brent is ranked amongst the top 15 per cent most deprived areas of the country and there are stark differences in the life expectancy across the borough. This is the result of the significant inequalities in health and well being experienced by residents in our most deprived wards compared to the most affluent parts of Brent. Across a range of health conditions such as heart disease, obesity, cancers, diabetes and respiratory conditions, communities on lower incomes are disproportionately affected. Improving outcomes for people with diabetes is one of the specific objectives in the "Improving prevention, management and outcomes for priority health conditions in Brent" work stream in the Health and Wellbeing Strategy for Brent and therefore provides an opportunity for review.

What are the main issues?

Diabetes is one of the leading diseases in Brent and the brief prepared by the Joint Strategic Needs Assessment (JSNA) clearly identifies that there is a need for increased investment in the prevention of Diabetes and clearer auditing of data from GP care in Brent. The quality of care needs improving and a more focussed and long term approach to community engagement is required.

Brent is a very diverse borough with 59 per cent of the population in Brent originating from black and ethnic minority backgrounds. Research shows that people of South Asian, African, African-Caribbean and Middle Eastern descent have a higher than average risk of Type 2 diabetes, as well as less affluent people. People of South Asian ethnicity have the highest prevalence of diabetes within the Brent community and teamed with the significant inequalities identified, diabetes in Brent has become one of the biggest costs and challenges facing the NHS.

Although Type 2 diabetes tends to affect the middle aged or older people, national statistics indicate that diabetes is now more frequently being diagnosed in younger overweight people and South Asians at a younger age. The other risk factors associated with the increased risk of developing diabetes are social exclusion, lifestyle, social deprivation and lack of physical activities or for those who have a family history of diabetes.

[1]Diabetes UK, Jan 2009, www.Diabetes.org.uk, http://www.diabetes.org.uk/Guide-to-diabetes/Introduction-to-diabetes/What_is_diabetes/

What should the review cover?

The review provides an opportunity to look into the causes of diabetes and identify ways in which the local authority and Brent PCT can break down some of the barriers to improving patient education and encouraging self management. It is evident that more can be done to highlight the importance of taking every opportunity to draw attention to the risk of developing diabetes and its accompanying complications which arise from unhealthy life-styles, and emphasise the personal responsibility which falls upon individuals to reduce those risks. Promoting effective self management can help to reduce NHS costs which arise from the onset of associated health conditions such as cardiovascular disease and renal failure. This review needs to assess the current quality of service to people with diabetes in the borough, particularly diagnostic services and help identify actions which can reduce the onset of complications.

The JSNA has reported that although the total spending per patient in Brent is in line with the national average, Brent actually has the second lowest primary care prescribing spend on diabetes patients in the country. Further investigation is required to identify the reasons and facts behind this data. Lack of early detection and prevention has contributed to the number of diabetic patients in Brent. There is evidence to support that there is opportunity to increase the prescribing spend in primary care to improve patient outcomes.

The JSNA brief Brent mentions primary prevention and the on going work to develop a new care pathway for diabetes patients to make better use of healthcare resources. Below is a summary of what is currently being offered:

- Pilot intensive lifestyle intervention for people with impaired glucose tolerance.
- The NHS Health checks programme being rolled out across Brent for adults aged 40-74 years.
- Redesigning the diabetes care pathway which aims to maximise the quality of care available.
- DESMOND programme is a patient education programme encouraging self management.
- Weight loss programme - A very new and recent initiative where patients are being referred to Slimming World by their GP's to support weight loss and healthy eating plans

What could the review achieve?

<u>Prevention and improved Patient care</u>

Diabetes can be prevented and tackling the growing number of people diagnosed with the disease is vital. With the responsibility for Public Health coming back to Local authorities a strategy and forward plan needs to be in place to ensure that relevant data is captured and recorded.

A task group would be the ideal forum for the local authority and partners to discuss how diabetes in Brent can be controlled and how to introduce a full prevention programme. There is work currently being carried out behind the scenes within the NHS and the task group could assist in advocating this within the local community. There needs to continued evaluation of the work being done to tackle this problem and checks should be carried out so that data is captured and recorded accurately so that it is of value.

[1]Diabetes UK, Jan 2009, www.Diabetes.org.uk, http://www.diabetes.org.uk/Guide-to-diabetes/Introduction-to-diabetes/What_is_diabetes/

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.

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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.	Report noted by the committee.
	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.	Issue to remain in the work programme. Outline Business Case to come to November committee meeting.
	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.	The committee agreed the two recommendations in the report: • The NWLH PAU service is decommissioned at CMH from October 15th 2011, subject to the agreement and sign off of the critical clinical pathways by Clinical leads and GPCE.

			• The paediatric outpatient service and Brent Sickle Cell service will remain at CMH.
	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.	The committee will be consulted on the JSNA at their next meeting in October.
	Brent LINk Annual Report	The Brent LINk will present their annual report to the committee for discussion and comment.	Report noted
	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.	Report noted
	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

Meeting Date	**Item**	**Issue**	**Outcome**
29th November 2011	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.	Members requested KPI information on the ICO performance. The committee also agreed that they should follow up the health assessment on LAC issue at a later date. This has been added to the committee's work programme.

	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.	Report noted. The results of the 6 month survey on GP patient satisfaction will be published in December 2011.
	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.	Noted
	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.	Noted
	JSNA Consultation	The JSNA will be presented to members to give them an opportunity to comment on the resource and contribute to the consultation.	The committee has asked for another presentation on the JSNA in February 2012, where they will respond to the consultation.
	Plans for the future of North West London NHS Hospitals Trust and Ealing Hospital Trust	Presentation of the outline business case, as agreed by the committee at their meeting on the 20th September.	The committee will continue to scrutinise this issue and comment on the merger proposal. An informal meeting with members of the Ealing and Harrow OSCs will be held in Jan 2012.
	Mental Health Rehabilitation Provision in Brent	At the request of NHS Brent, this item has been put on the agenda to give members an opportunity to comment on the consultation on Mental Health Rehabilitation provision in Brent.	The committee agreed to visit Fairfield House and Rosedale House to better understand the issues that CNWL are looking to address.
	A&E at Central Middlesex Hospital	The chair has asked for an update on the plan to close A&E overnight at Central Middlesex Hospital.	The chair will write to the Hospital Trust expressing members' disappointment with communication over the closure of A&E overnight at CMH.

Meeting Date	Item	Issue	Outcome
7th February 2012	Joint Strategic Needs Assessment Consultation	Presentation and discussion on the Joint Strategic Needs Assessment, so that members are able to respond to the consultation.	
	Khat Task Group	Final report of the khat task group for endorsement before it is passed to the council's Executive for approval.	
	North West London NHS Hospitals Trust / Ealing Hospital Trust Merger	Following the informal meeting with Harrow and Ealing councillors, the item will be added to the committee's agenda for members to finalise their response to the merger proposals.	
	North West London Commissioning Strategy Plan	Officers from NHS North West London will be invited to the committee meeting to outline their commissioning plans for the sector, the consultation for which will begin in June 2012.	
	Diabetes Task Group Scoping Document	For agreement by the Health Partnerships OSC.	
	Health and Wellbeing Board Update	The committee has asked for an update from the Health and Wellbeing Board to be reported to each meeting.	
	Clinical Commissioning Group Update	The committee has asked for an update from the Clinical Commissioning Group at each of its meetings.	

Meeting Date	Item	Issue	Outcome
27th March 2012	Role of community pharmacists in improving health	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	

	and wellbeing	borough.	
	Mental health services in Brent	Report to committee on 29/11/11 may provide basis for further enquiries about mental health services. Chair of the committee has suggested support for carers of those with mental health problems.	
	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.	
	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.	
	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.	
	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.	
	PAU accessibility	NWL are carrying out a questionnaire on the accessibility to Northwick Park of sickle cell patients. The results of this will be presented to the committee.	
	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.	
	TB in Brent	Added at the request of the committee (meeting on 20th Sept 2011).	
	GP access patient satisfaction survey results	In December 2011 the results of the six monthly patient survey will be published. Members should scrutinise the results with Brent GPs to see how their initiatives to improve access are reflected in patient satisfaction.	
	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.	
	Health needs of People with Learning Disabilities	Brent MENCAP has carried out work with NHS Brent to train GPs, hospital staff and community staff about the health needs of PWLD. The work was paid for by Brent Council Learning Disability Development fund and an independent evaluation report has been produced to highlight this key area of health care. Brent MENCAP has requested that the report be considered by the Health	

		Partnerships OSC as it relates to a task group carried out in 2010 looking at the health needs of people with learning disabilities.	