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Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE AGENDA

7.00 pm	Thursday 6 November 2014	Havering Town Hall Committee Room 3A

Members 6: Quorum 3

COUNCILLORS:

Conservative (2)	Residents' (1)	East Havering Residents' (1)	UKIP (2)
Dilip Patel (Vice-Chair)	Nic Dodin (Chairman)	Gillian Ford	Patricia Rumble
Jason Frost			Vacancy

Andrew Beesley
Committee Administration Manager

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AGENDA ITEMS

Protocol for members of the public wishing to report on meetings of the London Borough of Havering

Members of the public are entitled to report on meetings of Council, Committees and Cabinet, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

AGENDA ITEMS

1 ANNOUNCEMENTS

Details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation will be announced.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

(if any) – receive.

3 DISCLOSURE OF PECUNIARY INTERESTS

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still disclose an interest in an item at any time prior to the consideration of the matter.

4 MINUTES (Pages 1 - 32)

To agree as a correct record the minutes of the meetings held on 8 September 2014 (joint meetings of all overview and scrutiny committees) 9 September 2014 and 23 September 2014 (joint meeting with children & learning overview and scrutiny committee). All minutes attached.

5 INTENSIVE REHABILITATION SERVICE AND OCCUPATIONAL THERAPY

Presentation from officers of North East London NHS Foundation Trust.

6 GP FEDERATION

Discussion with representatives from the Havering GP Federation – Havering Health Ltd.

7 CARE ACT

Presentation by Barbara Nicholls – Head of Adult Services on the impact on carers of Care Act assessments.

8 URGENT BUSINESS

To consider any item of which the Chairman is of the opinion, by means of special circumstances which shall be specified in the minutes, that the item should be considered as a matter of urgency.

9 IMPLEMENTATION OF HEALTHWATCH

Under the Council Continuous Improvement Model, to receive an update from officers on the implementation of Healthwatch in Havering.

MINUTES OF A MEETING OF THE
JOINT (ALL) OVERVIEW & SCRUTINY COMMITTEE
Council Chamber - Town Hall
8 September 2014 (7.30 - 11.10 pm)

Present:

COUNCILLORS

Conservative Group	John Crowder, Robby Misir, Garry Pain, Carol Smith and Frederick Thompson
Residents' Group	June Alexander, Clarence Barrett, Nic Dodin, Alex Donald, Gillian Ford, Jody Ganly, Linda Hawthorn, Ray Morgon, Barry Mugglestone, Stephanie Nunn, Linda Van den Hende, Julie Wilkes and Darren Wise
UKIP Group	Philip Hyde, Phil Martin, Patricia Rumble and Lawrence Webb
Independent Residents Group	Michael Deon Burton and David Durant

All decisions were taken with no votes against.

The Chairman reminded Members of the action to be taken in an emergency.

1 **MEMBERSHIP AND CHAIRMAN OF MEETING**

With the agreement of all Overview and Scrutiny Committee Members present, the Chair was taken at this special meeting by Councillor Clarence Barrett.

2 **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman advised all present of action to be taken in the event of an emergency evacuation of the town hall becoming necessary.

3 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS**

Apologies for absence were received from the following Members:

Children & Learning Overview and Scrutiny Committee:

Councillor Jason Frost (substituted Councillor Robby Misir)

Councillor Philippa Crowder (substituted by Councillor Frederick Thompson)

Councillor Reg Whitney (substituted by Councillor Stephanie Nunn)

Councillor John Glanville (substituted by Councillor Phil Martin)

Crime & Disorder Committee:

Councillor John Wood (substituted by Councillor Linda Hawthorn)

Councillor Dilip Patel (substituted by Councillor Robby Misir)

Councillor John Glanville (substituted by Councillor Phil Martin)

Environment Overview and Scrutiny Committee:

Councillor Keith Roberts (substituted by Councillor David Durant)

Health Overview and Scrutiny Committee:

Councillor Dilip Patel (substituted by Councillor John Crowder)

Councillor Joshua Chapman (substitute by Councillor Robby Misir)

Councillor Jason Frost (substituted by Councillor Frederick Thompson)

Individuals Overview and Scrutiny Committee:

Councillor Ray Best (substituted by Councillor Frederick Thompson)

Councillor Viddy Persaud (substituted by Councillor John Crowder)

Councillor Roger Westwood (substituted by Councillor Robby Misir)

Councillor Keith Roberts (substituted by Councillor David Durant)

Towns and Communities Overview and Scrutiny Committee:

Councillor Jason Frost (substituted by Councillor John Crowder)

Councillor Steven Kelly (substituted by Councillor Carol Smith)

Value Overview and Scrutiny Committee:

Councillor Philippa Crowder (substituted by Councillor Frederick Thompson)

Councillor Steven Kelly (substituted by Councillor Carol Smith)

Councillor Barbara Matthews (substituted by Councillor Stephanie Nunn)

4 DISCLOSURE OF PECUINIARY INTERESTS

There were no disclosures of interest.

5 THE COUNCIL'S FINANCIAL STRATEGY

The Leader of the Council, Councillor Roger Ramsey explained that large cuts in Council expenditure were required by Central Government and grant levels, of which Havering already received one of the lowest amounts per head in London, would therefore be cut further. The Council had not taken lightly any proposed cuts to services but it was nonetheless necessary to balance the budget.

Comments made at the meeting would be considered by Cabinet on 24 September. A period of statutory consultation would commence for approximately three months from shortly after the 24 September Cabinet meeting. Some staff consultation would not commence until after proposals had been finalised.

Confirmation of the final settlement figure from Government for 2015/16 was expected in December 2014. The final budget and level of Council Tax would therefore be set by full Council at its meeting in February 2015.

Having scrutinised the budget proposals, the Overview and Scrutiny Committees noted:

1. The financial position of the Council.
2. That the report was formally consulting them on the proposed Corporate budget adjustments and that this was the opportunity to scrutinise the budget proposals.

Answers to questions raised by Members on specific items of the budget are shown in the appendix to the minutes.

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Chairman

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APPENDIX: JOINT MEETING OF OVERVIEW AND SCRUTINY COMMITTEES, 8 SEPTEMBER 2014, ANSWERS TO MEMBER QUESTIONS ON THE COUNCIL'S FINANCIAL STRATEGY

Questions were asked by Members on the areas shown below and answers were given by officers or Cabinet Members as follows:

1. Consultation on 2% Council Tax increase – It was not feasible to consult on this as the final decision on the level of Council Tax would not be taken until February 2015. A referendum would be required if a higher increase was wanted and there would not be the time to organise this which would also be a costly exercise. A question relating to the Council Tax increase may be able to be included in the consultation.

2. Transformation Costs – These costs were built in for the first two years only and there were no budgeted transformation costs by the end of year 4.

3. Pensions – It was not the case that an additional £40m had been paid into the Council pension scheme although there had been a large increase. This had been stipulated by the Council's actuary in order to balance the pension fund, given that both assets and liabilities had increased substantially. A one-off contribution of £10m had been made last year in order to reduce annual extra contributions and to allow the pension fund to invest in local infrastructure. The Council had to keep to its legal requirements on this issue.

4. Funding for maintained schools – It was the case that academies currently received slightly more funding than maintained schools but this gap had now almost closed. Schools were generally funded equally per pupil although there were different weightings given for each borough. Further information on the variation in schools funding between boroughs could be provided by officers.

5. Impact of change in national Government policy – The proposed cuts were for a period of two years and it was possible that the position may change after this. The Shadow Minister for Local Government had however recently indicated in a letter to the Leader that there would not be any increase in funding for Local Authorities and that money may also be transferred to more 'needy' Councils.

6. Use of reserves – Reserves had been used to for example fund the £10m contribution to the pension fund and would also be used to meet redundancy costs. Strategic reserves were earmarked for specific purposes and verified

by an auditor. The in-year contingency had been lowered from £2m to £1m and Members regularly took advice on how to best use the reserves. The current General Fund balance of £11m was not earmarked but it was felt that at least £10m of this would be needed to fund changes required under the Care Act. The Group Director was happy to discuss the use of reserves with Members further.

7. Proposed Development Company – The Council was currently working with Capita to assess the viability of this proposal. The final cost would be known in approximately two months. The cash amounts held by the Council could be used for this sort of scheme. Risks would be factored in and a report on the Development Company would be brought to Cabinet.

8. Other savings from Economic Development – The Council was supporting businesses to come into Romford. The proposed saving was a stretch target based on economic conditions and the amount of vacant office space. Members could be briefed separately on this.

9. Interest shortfall – There was not an interest shortfall of £5m as this was mixing up General Fund borrowing with Housing borrowing. Housing borrowing had increased to £200m two years ago when the Government changed the housing finance system. The Housing Revenue Account was ringfenced and maintained separately from the General Fund Account.

10. Streetcare – Non-contractable items related to recharges for support services. A full survey of lamp columns was needed to check they were suitable for LED lighting. A further risk was a change in energy prices although this could be mitigated. The current energy budget was £650k.

11. Communications – The annual cost of producing Living Magazine is approximately £60k although not all of this could be delivered as a saving as the staff involved also work on other, separately funded publications which offset the budget. A likely general fund saving from not producing Living would be around £30k. A list of events run by the Council and their cost could be provided. There is no set twinning budget as twining activity is not consistent and costs are sometimes covered by the twinning partner. There has been no twinning expenditure for some time. Reputation management referred to dealing with the press, social media and managing emerging issues related to the Council. It was planned to reduce the budget for the Havering Show by £17k through attracting more sponsorship.

12. Customer Transformation and Channel Shift – While more people were using on-line Council services, it was still proposed to retain a face to face channel.

13. Culture and Leisure – The proposed Music School saving was considered robust given the successful new model operating in the Music School. MyPlace savings could be found via increasing income and efficiencies from integrating management between MyPlace and the neighbouring sports centre. The Stubbers Centre had been leased to a charity for a peppercorn rent. Both the lease and rent level expired in two years and this would need to be renegotiated and hence produce more income.

14. CCTV – The two CCTV systems would be moved onto one site at Waterloo Gardens. There was however no reduction proposed in the CCTV hours of service. Officers would provide details of the numbers of prosecutions brought about the use of CCTV. Number plate recognition software was being introduced with the Police although the Police would not be making any financial contribution to this, they would be using personnel to work jointly with the CCTV to detect crimes associated with cars.

15. Supporting People Review – A number of options were being considered, and staff proposed to consult with tenants before deciding on the way forward. One option was proposed that support and housing management tasks could be combined in one role and that a dedicated scheme manager be provided for every two schemes. Some Members felt this was a high risk strategy. It would not be possible to run a pilot scheme as the saving needed to be made next year.

16. Private Sector Leasing – There were around 1,000 properties managed in this sector. Complaints received were responded to in the same way as for a council tenant. The proposed £500k saving over four years was based on increasing the number of units let although the market was changing. The rent paid by landlords was based on levels at the lower end of the market as seen in areas such as Harold Hill and Rainham. Several Members felt that many landlords in Harold Hill were sub-dividing properties excessively. Officers accepted this but it was noted that, for some people, a single room in a shared house was their only affordable option. A vetting system for landlords was in place for larger HMOs. Some Members felt there was a danger of ghettoisation in Harold Hill with too many people being put in the area. Officers responded that they had to procure properties where they could afford to do so, and unfortunately they did not control the market.

17. Meals on Wheels – The current provision of Meals on Wheels would be reviewed. A new staffing model would be considered in order to generate savings.

18. Care Act and Better Care Fund – More successful reablement was now seen in people's homes than at Royal Jubilee Court although Royal Jubilee Court

continued to very effective as a step-down facility following hospital care. Community Treatment Teams had demonstrated an impact and this had led to the use of pooled funding opportunities from the Better Care Fund. The performance element of the Better Care Fund would be decided later that week at the Health and Wellbeing Board. This was a new and complex area and work was progressing with the Clinical Commissioning Group (CCG) on e.g. undertaking joint assessments at Queen's Hospital. Commissioning work such as this would be taken through the Health and Wellbeing Board and Individuals Overview and Scrutiny Committee for monitoring. The proposed cap would apply to existing clients.

19. Social Care Agency Staff – Officers were looking to retrain permanent staff to take on new roles and make processes more effective. Eight new children's social workers had started work that week. The allocation of admin work would be looked at as part of the review but it was also important that social workers took ownership of their assessments. Modelling of the impact of the Care Act was continuing but this had been factored into the proposals as far as possible. It was important to get the balance right in the use of agency staff.

20. Social Care Staffing – It was not possible to guarantee that serious incidents seen in areas such as Rotherham would not occur. The implications of the Rotherham inquiry for Havering would be looked at shortly by the Crime & Disorder Committee. Services were however scrutinised by Members. Social worker pay was benchmarked and a recruitment & retention strategy was in place. Havering social workers were more interested in support, career progression and a manageable caseload than they were in money.

21. Younger Adults – While current users would be affected, the assessment criteria for younger adults was not going to be altered. It was aimed to deliver services in the most appropriate way and appeal procedures would be in place.

22. OneSource – It was planned to change the Council's job evaluation scheme and avoid any negative impact on lower paid staff. A new pay line for lower paid staff would be introduced if necessary. A new job evaluation scheme for the highest paid staff was also likely to be introduced. There were approximately 2,500 staff that may be affected but the proposed saving was only £500k from a £95, total wage bill. It was hoped to introduce a consistent set of practices and to agree these with the unions.

23. Council Tax Support – The GLA precept made up 20% of Council Tax bills and it was also necessary to consult with the GLA on changes to the Havering scheme. The second person rebate normally applied to households that were

not eligible for other Council Tax support and the Council's preferred option proposed therefore to abolish this. It was emphasised that the proposal only applied to working age applicants, not retired people.

24. Parking – The proposals had been amended but it was wished to allow a period of free parking for everybody. A breakdown of expenditure on parking could be supplied to Members. It was not possible to be certain of the impact of the proposed new tariffs. The additional schemes referred to related to the introduction of a broader parking strategy. Officers would look at the impact of a 40p rather than £1 charge after the free first 30 minutes in order to assess whether this would reduce parking in side streets. It was proposed to introduce charges for car parking in parks but a free period for the first 30 minutes was under consideration. The 10 minute grace period applied to any duration of parking ticket. It was noted that revenue gathering was not the purpose of parking enforcement. It was planned to introduce parking at football pitches and some Members felt this could result in people parking in nearby streets. Officers agreed to consider this.

25. Moving Traffic Offences Powers – These had now been adopted by all but six London Boroughs. Once adopted, decisions would be made on how these powers would be applied. Details could be provided to Members on the advantages of using these powers. A report on adopting the powers would also be brought to full Council. Some Members felt that taking on these powers could make the Council unpopular with local residents.

26. Trading Standards – Savings could be made via a restructure and no longer undertaking some of the non-statutory functions carried out by Trading Standards. While enforcement of underage alcohol sales would continue it was felt that e.g. the training of shop staff did not need to be carried out by Trading Standards officers. The banking protocol also no longer needed to be led by Trading Standards. Enforcement work would not be affected and there was not felt to be a risk to revenue generation from the proposals. Officers wished to move the service to a more intelligence-led way of working. Officers would supply details of the income recovered from proceeds of crime.

27. Voluntary Sector Review – The reduction of the grant to HAVCO was due to the closure of their Community Accountancy Service. Rate relief for charities would be unaffected by any of the proposals. It was clarified that Council grants were often given to not for profit organisations in order to employ people so it was not simply a matter of increasing volunteer numbers. Other Members felt that most volunteers in Council services did come from charities. It was also possible that some extra work could be commissioned from charities in connection with the requirements of the Care Act.

28. Libraries – All libraries, including the four most strategically important libraries, would have reduced opening hours compared to the current position. Officers could provide further details if necessary. There was no suggestion that any libraries would close. Officers had thought seriously about the viability of the proposals which were based on library service models that ran successfully elsewhere. The local studies library was a valuable service and efforts would be made to recruit more volunteers to help operate it. Officers would supply details of library footfall. The new Rainham and Harold Hill libraries would continue to operate. There were a total of 93 people currently employed in Council libraries although as many of these were part-time staff, this equated to 53.1 FTE posts.

29. Health and Wellbeing – This category related to leisure centres and 'Policy, Marketing and Administration' referred to expenditure on support services. Services provided by the Health and Wellbeing Team included the arts service and sports development, as well as the leisure services role.

30. Queen's Theatre – Officers met on a quarterly basis with the Queen's Theatre and had discussed the budget options. Full details of options would be shared with theatre management once the consultation had started. The grant figure of £400k was not correct and the total grant to the Queen's Theatre for this year was £546k.

31. Youth Service – It was proposed to no longer provide discretionary services. All youth services provided by the Council would be mapped by officers. Work with vulnerable young people such as dealing with any gangs in Romford town centre would be protected. It would also be possible to signpost to other youth provision. Some Members felt that Overview and Scrutiny should look at this area. An initial proposition had been received from staff to form an employee led mutual to take on aspects of the service and this would need to be worked through. Some staff would transfer to the over 12 service which would be combined with Early Help & Troubled Families. The Youth Service had direct contact with more than 200 young people but did a lot of other work with young people in addition.

32. Troubled Families – Savings in this area, after the first year, would be challenging and officers accepted there was a lot of work to do.

33. Children's Centres – There would be more reliance on volunteers to run Children's Centres but there were no current plans to involve the private sector. It was hoped to retain five or six of the current Children's Centres but this could not be guaranteed at this stage.

34. Equalities Impact Assessments – All compulsory assessments had been completed and the complete set would be appended to the next Cabinet report on the budget. These would remain in draft as final decisions would not be taken until February 2015.

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MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY COMMITTEE
Havering Town Hall
9 September 2014 (7.30 - 9.50 pm)

Present:

Councillors Nic Dodin (Chairman), Dilip Patel (Vice-Chair), Patricia Rumble, Gillian Ford, Joshua Chapman and Jason Frost.

Officers present:

Matthew Hopkins, Chief Executive, Barking, Havering and Redbridge University Hospitals NHS trust (BHRUT)
Rachael Royall, BHRUT
Dr Gurdev Saini, Director, Havering Clinical Commissioning Group (CCG)
Alan Steward, Chief Operating Officer, Havering CCG
Ilse Mogensen, North East London Commissioning Support Unit
Ian Buckmaster, Director, Healthwatch Havering (part of meeting)
Carole Howard, Healthwatch Havering
Mark Ansell, Consultant in Public Health, London Borough of Havering

One member of the public was also present.

11 **ANNOUNCEMENTS**

The Chairman gave details of action in the event of fire or other event requiring evacuation of the meeting room.

12 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS**

There were no apologies for absence.

13 **DISCLOSURE OF PECUNIARY INTERESTS**

There were no disclosures of interest.

14 **MINUTES**

The minutes of the meeting held on 24 June 2014 were agreed as a correct record subject to an amendment submitted by the Chief Operating Officer of Havering Clinical Commissioning Group and were signed by the Chairman.

15 **HEALTHWATCH ANNUAL REPORT**

A Director of Healthwatch Havering presented the first annual report of the group to the Committee.

The Committee was informed that Healthwatch Havering was part of a new national concept which gave every individual in every community their own local independent consumer champion for health and care. The umbrella body for the organisation was Healthwatch England, a part of the Care Quality Commission. During its first year Healthwatch Havering had made a difference working with local partner organisations to improve services.

The Director of Healthwatch Havering explained that Queen's Hospital had been placed in special measures. Although not directly involved in that decision, Healthwatch Havering had submitted preliminary evidence to the inspection team and were also present by invitation at the meeting at which the CQC announced the findings of the inspection team.

It was also noted that the Healthwatch Havering social care team had been paying close attention to the borough's care homes and, in particular, those identified by the CQC as being in need of significant improvement.

Although Healthwatch Havering had no direct remit to represent, or act as advocate for, individuals or to investigate individual complaints, people in distress did not always understand exactly who to approach for help and contacted Healthwatch Havering "because we are here". Healthwatch Havering had taken the view that they had a general duty of care to help those in distress and carried out that duty by referring people on to those best placed to help them.

The Chairman of Healthwatch Havering explained how it was making a difference influencing official bodies and others by being formally represented at meetings of the Council's Health, Individuals and Children's Services Overview & Scrutiny Committees and at a wide range of other relevant bodies, both local and regional to North East London**.**

Healthwatch Havering had developed an ambitious work programme for 2014/15, which would include an investigation of patient-related activity at GP practices

The Director of Healthwatch Havering added that Healthwatch Havering was making a difference in developing a role in public consultation and encouraging participation in health and social care issues.

In September, Healthwatch Havering had commissioned the Film Unit of the Media Studies Group of Sixth Formers of a local school - the Coopers' Company & Coborn School, Upminster, to produce a short film of local peoples' thoughts about local health services. This film was available on the

Youtube website. Some Healthwatch Havering volunteers also provided a stand at Havering's National Women's Day in March, at Havering College and were represented at Havering's Over-Fifties Forum on a regular basis.

Healthwatch Havering was making a difference by participating actively at all meetings of the Health & Wellbeing Board which was a key provision of the Health and Social Care Act 2012. The Committee was informed that Healthwatch Havering had presented an end of year report on its progress to the Board which included their work plan for 2014/15.

Following the presentation Members of the Committee received the following answers to their questions:

- Healthwatch Havering gave care homes a two weeks warning before a visit. The Committee was also informed that Healthwatch Havering reserved the right to make an unannounced visit if there was a concern. Healthwatch Havering viewed its role as working closely with the CCG as a critical friend.
- Healthwatch Havering was working closely with its partners to identify and understand why young people who were supposed to attend a GP surgery instead turned up at Accident & Emergency.
- The organisation had a forward plan to consider issues around mental health provision for young people who were moving to Adult Health Care.
- Healthwatch Havering was working with St Francis Hospice to provide its volunteers with Gold Standard training on end of life care.

The Committee **noted** the annual report.

16 **BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST IMPROVEMENT PLAN**

The Committee received a presentation from the chief executive of BHRUT on the Improvement Plan for 2014/15 at the Trust.

The Committee was informed that following Queen's Hospital being placed in special measures the Trust had taken various steps to address the issues.

The Trust had an Improvement Director allocated by the Trust Development Authority (TDA) to oversee and support the Trust's improvement plan. The Trust had to produce a plan and deliver improvements over a period of time whilst receiving support to make improvements. The Trust also had to report progress monthly which was overseen by the TDA.

The Committee was informed that the improvement plan for the hospital had five key themes to address the findings of the Chief Inspector of Hospitals'

review. Each theme had important objectives and supporting improvement actions:

- **Workforce**: recruiting, retaining, developing and deploying the right numbers of permanent staff needed to provide high quality care 24/7.
- **Emergency Care Pathway**: making sure patients were assessed and treated promptly and were supported to return home as soon as they were medically fit to leave hospital, and to ensure that patients were cared for in the right place with the right follow up care.
- **Clinical Governance**: supporting all care with effective management of patient notes and information, and systems which quickly alerted to problems.
- **Outpatients**: ensuring effective management of outpatient services so appointments ran on time, every time.
- **Leadership and Organisational Development**: putting the right systems, structures, checks and balances in place to make sure the Trust was properly managed from board to ward.

The Trust's hotel services were being retendered in order to improve the quality of hospital food.

The new BHRUT IT system had the flexibility to meet hospital needs. Work was in progress with suppliers in order to get the system working for patients and it was agreed that the chief executive should report back in two months' time on progress with the IT system.

The chief executive felt that there were not enough trainee doctors nationally. This was also an issue with emergency consultants due to the competitive nature of recruitment and it was emphasised that the Trust wanted to recruit more doctors.

There were already some outpatient services that ran from non-hospital sites such as the Victoria Centre in Romford. The chief executive was mindful of clinic capacities with for example ophthalmology outpatients being very busy.

There were a number of reasons why clinics might be cancelled. These included their not being set up properly on the system or the relevant doctors being on other duties or on leave. Action was being taken to enforce the Trust policy that no clinics could be cancelled within six weeks of their scheduled date.

The JONAH computer system for patient discharge was followed by some wards but not by others and the chief executive accepted that this needed to

be addressed. It was felt that, in order to have an effective patient flow, 10 patients at each hospital should be discharged before 10 am with 20 discharged from each site by 12 pm. 85.5% of patients had met the four hour treatment rule in A&E in August, some 4.5% short of the Trust's target in this area.

Shifts had been altered at the Trust's call centre to match demand levels which had allowed more calls to be answered. More modern phone technology was also being introduced. The chief executive would look into why the ear, nose and throat department only had an answerphone and was unable to be contacted via the switchboard.

All tablets to take home could be dispatched from the hospital pharmacy within four hours but this required doctors to transcribe medication forms earlier. Funding had been allocated for extra staff to ensure this was done.

Trainee doctors were expected to undertake clinical audits and there was a programme of monitoring of this. This would produce changes in the way the hospital worked. Named management staff would follow up on changes and the chief executive felt there was a need to employ more clinical governance staff.

It was felt that more GP appointments should be made available via NHS 111 as this would reduce pressures on A&E. It was important to make alternatives to A&E more accessible but the chef executive accepted there was a challenge in this as people were often used to going to A&E.

It was noted that urgent care services were due to be retendered and that both money and the quality of service would be considered equally during the tendering process.

The chief executive wished to implement the Trust improvement plan before expanding A&E at Queen's. The A&E would however be expanded in order to create space for the Urgent Care Centre. A target date for the A&E works would be set once progress on the improvement plan had been achieved.

As regards the Francis Report, the chief executive felt that this had shown a tolerance by staff in mid-Staffordshire of poor standards. There had been a lack of accountability and little use of clinical audit etc. The report had said that people needed to understand a Trust's values. Non-compliance should be tackled and a culture of openness and transparency should be developed.

The response to the Francis Report from BHRUT had been to understand the current quality of care and create a culture where staff could report problems. The focus would be on putting patients first.

The director of quality and safety at the Trust wanted clinical services to check if patients were safe and that care was effective. There were also priorities to improve the patient's experience and ensure that the workforce

was engaged. Trust complaints and compliments were analysed and the chief executive signed off all responses to complaints. The Trust also had an Independent Patient Experience Group which included representatives from Healthwatch.

The Trust whistle blowing and raising of staff concerns policy had been updated. 'Meet the chief executive' sessions were held for staff who were encouraged to have a duty of candour. The Trust vision had been refreshed and it was accepted that the Trust needed to be financially viable in order to improve care for patients.

A PRIDE programme – passion, responsibility, innovation, drive, empowerment had been introduced for staff and the chief executive agreed that staff training and development were very important.

Other initiatives included walkabouts by Trust directors who completed a template about wards they had visited. Walkabouts were held at least once a week. The next steps for the Trust were to seek to improve public confidence in their services.

The chief executive wished to promote a culture where staff believed it was safe to speak up. He wanted staff to take ownership of processes but accepted this was a culture shift that would take time to implement. Progress had been seen with for example the friends and family test for in-patients which had recorded a 71% approval rate in August and 73% in July.

The Trust's guardian services scheme to allow staff to discuss concerns confidentially had been working well and had been used by approximately 110 staff thus far. Junior managers needed to follow through on these commitments however in order for the programme to work fully.

The Trust was keen for staff to resolve complaints on the spot and to focus more on the patient experience. Matrons were expected to be visible on wards and photographs of staff were displayed at ward entrances. It was also important that board members talked to patients direct. It was felt essential that nursing staff adopted themes such as care and compassion in their work.

The Committee **NOTED** the position.

17 BREAST CARE SERVICES

The Committee had been asked by the Joint Health Overview and Scrutiny Committee to consider whether the proposed changes to breast cancer services required formal consultation.

BHRUT officers explained that they wished to move breast cancer services from the Victoria Centre in Romford to King George Hospital. Some of the Victoria site was already vacant and NHS Property had earmarked the site

for disposal. It was explained that breast screening was carried out at a number of centres and that all breast surgery was now done at King George Hospital. The proposals were therefore consistent with the development of specialist women's services at King George.

The Trust was working with Transport for London on improving public transport to King George. It was uncertain if taxi fares to or from the hospital could be reimbursed or if patient transport covered screening services.

A quality assurance group had overseen the process of developing the breast services proposals and engagement had taken place on the plans with service users. It was hoped to open the new unit at King George in June 2015. BHRUT officers were happy to report back on progress both before and after the opening of the new unit.

Members felt effective communication of the changes was important, both to the Havering and joint overview and scrutiny committees and to the public as a whole. It was noted that a local representative panel was also being set up.

The chief executive agreed to look into the lack of parking at breast care facilities at both King George Hospital and the Harold Wood polyclinic.

The Committee **AGREED** that the proposals to relocate breast cancer services did not require formal consultation.

18 **INTERMEDIATE CARE CONSULTATION**

A director of Havering CCG explained that intermediate care referred to specialised services to avoid or reduce stays in hospital. Two new services had recently started. A community treatment team (CTT) consisting of doctors, nurses, social workers and other professionals and an intensive rehabilitation service (IRS) where therapists visited people in their homes up to four times a day.

Both services were available seven days a week and the maximum wait to commence treatment would be five days for the IRS and two hours for the CTT. Feedback for both services had been good. Four thousand patients had been seen from Havering compared with only seven hundred in a similar timescale under the old system.

There were currently 104 rehabilitation beds across Havering, Barking & Dagenham and Redbridge but 49 were not used. As such, it was considered that a total of only 40-60 beds was now needed. The proposal was that these beds would be based at King George Hospital.

Officers reported that the proposals had been well received in Havering and Barking & Dagenham while some concerns had been expressed in the Wanstead area of Redbridge.

Members felt there was a lack of awareness of the new services and officers explained that leaflets giving details of the new services were being sent to GPs and community groups. A pilot scheme was also in operation where members of the CTT went out with ambulance crews as this could reduce the number of visits needed to hospital.

A social worker did work on the CTT and risk assessment of home conditions could be carried prior to discharge from hospital. The CTT aimed however to keep people out of hospital. Patients could access the CTT direct or be referred via the NHS 111 service.

A Member observed that the proposals were in line with the national focus on moving funding and services from acute to primary settings. Extra staff had been employed in anticipation of winter pressures and this was reviewed on a regular basis. Agency or locum staff could also be used if necessary although efforts were being made to reduce this.

The Committee **NOTED** the presentation and **AGREED** that the clerk to the committee should draft a letter for the Chairman giving the Committee's response to the consultation, based on the discussions at the meeting.

19 ST GEORGE'S HOSPITAL UPDATE

The CCG chief operating officer confirmed that the CCG was committed to having services on the St George's site such as a GP, pharmacy and possibly a community treatment base. There would be a probable focus on older people at the site. It was also possible that a voluntary sector facility could go on the site.

Approval had now been received from NHS England to develop a business case for St George's. A delivery board would therefore be re-established including NHS Property and NHS England. There would also be a steering group with wider representation. It was planned to submit an outline business case to NHS England in February or March 2015. It was confirmed that any medical facilities would be at the front of the site.

It was hoped to put forward a strong case to use the St George's site for the new facilities although it was noted that NHS Property could decide that other local facilities should be used instead.

An update on the position could be given following a meeting of stakeholders in October and monthly written updates would be given to the Committee where possible. It was noted that local residents were unhappy that the site remained empty after two years and at the annual £0.5 million cost of keeping the site secure.

The Committee **NOTED** the update.

20 URGENT BUSINESS

There was no urgent business.

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Chairman

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MINUTES OF A MEETING OF THE HEALTH OVERVIEW & SCRUTINY COMMITTEE (JOINT MEETING WITH CHILDREN & LEARNING OVERVIEW & SCRUTINY COMMITTEE)
Havering Town Hall
23 September 2014 (2.00 - 4.20 pm)

Present:

Councillors Nic Dodin (Chairman), Dilip Patel (Vice-Chair), Patricia Rumble, Gillian Ford, Jason Frost and John Crowder (substituting for Councillor Joshua Chapman).

Councillor David Durant was also present for part of the meeting.

Apologies for absence were received from Councillor Joshua Chapman

Officers present:
Mark Ansell, Consultant in Public Health, LBH
Jessica Arnold, Havering Clinical Commissioning Group (CCG)
Kathy Bundred, Head of Children's Services, LBH
Kenny Gibson, NHS England
Caroline O'Donnell, North East London NHS Foundation Trust (NELFT)
Mary Pattinson, Head of Learning & Achievement, LBH

Anthony Clements and Vicky Parish, Committee Administration, LBH

1 **ANNOUNCEMENTS**

The chairman gave details of the action to be taken in case of fire or other event that may require an evacuation of the meeting room.

2 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS**

Apologies were received from Councillor Joshua Chapman (Councillor John Crowder substituting).

3 **DECLARATIONS OF INTEREST**

Councillor Gillian Ford disclosed an interest in item 4 – healthy weight/obesity as she was a facilitator delivering the MEND programme.

4 **HEALTHY WEIGHT/OBESITY**

Officers reported that within the London Borough of Havering, one fifth of children at reception were overweight or obese while one third of children of year 6 age were obese. This followed the trend of the national average, and was marginally better than the London average. Historically, rates had been flat, but in recent years rates of obesity had been increasing with greater frequency.

Some ethnic groups were at higher risk (Black African and some Asian groups) and as the borough became more diverse, further action to address obesity may be required.

The short term impacts of obesity to children included being stigmatised and low self-esteem. The long term impacts included a risk of type-2 diabetes and cardiovascular issues, particularly within morbid obesity. Treating obesity was difficult. Havering's model within the partnership focussed on prevention, within a holistic approach, but there were a variety of factors involved which created an 'obesogenic' environment.

Some of the services provided included giving health advice to weaning mothers (including diet, nutrition and cooking information), promoting parks and green spaces healthy walking schemes for over 10 year olds, catering in schools, which met the national standards, and was now available free in infants schools including the restarted healthy schools programme, change for life clubs, leisure centres and smarter travel. Officers felt Havering had set a standard which was becoming best practice.

NICE, Public Health priorities and the MEND programme all focussed on healthy weight and obesity, and had been proven to work. MEND focussed on 4-5 year olds, but recruitment to the programme had decreased. It may have become stigmatised, and issues of being labelled as 'obese' could create obstacles.

A co-opted member posed the possibility that many families may understand nutrition, but there may be issues with specific children and their relationship with food (including eating disorders). This was within the remit of school nurses, who can provide a great deal of help and support to children and young people who required further information or medical intervention.

For parents who do not know about nutrition, or how to cook there was support available to teenage mums, but as obesity was so complex, this was an issue that ranged across departments, and further discussions needed to be completed to solidify the strategy. The MEND programme targeted most of this already, including building self-esteem, looking at cooking and targeted services as part of it, with a focus on children from 0 – 5 years of age.

Councillor Durant asked the Committee to recommend that Cabinet that Chafford School swimming pool be kept open to the public as it was a resource for health of residents in the south of the borough. Councillor Ford felt this was outside the remit of the meeting but did agree to write to the relevant Cabinet Member and head of service about the issue.

A Member asked if support for black and Asian groups had been focussed on, such as reaching out in alternative languages as these groups may include a number of second language speakers who may not understand the information given. Officers responded that, at the present time, there was not enough information to provide more specific guidance. It was possible to include ethnicity data within the borough performance statistics that were produced.

Members also asked if licensing of the number of fast food outlets could be reconsidered as the sheer quantity of junk food available may be a hindrance to the obesity reduction agenda.

5 **IMMUNISATION**

The officer from NHS England reported that The World Health Organisation (WHO) had stated that all Western countries will be without vaccine preventable diseases by 2020. Immunisation was the best chance to prevent the spread of disease.

An important change had recently been made; Hepatitis B was now a vaccination available for all of London and it was a requirement to jab three or four times before a child is 12 months old.

Havering was the national leader on flu vaccinations. Children as young as four-years-old had self-administered flu vaccines nasally. This had been received well, and put Havering at the top of the league for pilot schemes within schools.

All children in SEN schools were to be given flu vaccines, as well as all teachers, members of staff and parents of these children. Havering was unique in the UK in this respect.

Teenagers had been given ‘dovetailed’ vaccinations, having multiple vaccinations at the same time (HPV, School leavers’ vaccine and MENC). These had been available in schools, pharmacies and other locations, as opposed to doctors’ surgeries, to prevent overloading with immunisation. Records were forwarded to doctors to ensure full health records were maintained.

It had been recommended that all health care providers should have all front line staff vaccinated.

67,000 people had attended community pharmacies for seasonal flu vaccination, and pertussis (maternal whooping cough vaccination). Pharmacies had been working in collaboration with the Council, and now provided ‘at cost’ injections for flu to health and social care professionals.

Suggestions for venues for vaccinations were welcomed, as restricted opening hours of doctors surgeries had been identified as not matching the busy schedules of families, perhaps including children’s centres.

Councillor Ford queried if schools were still providing vaccinations. It was advised schools had previously, but waste management issues made this problematic, though not impossible. The administering of HPV vaccines was currently being discussed and guidance on this was expected shortly from Public Health England. Around the borough, vaccination receivers were asked if the service was good. 65% said yes within GP surgeries. Within pharmacies, this figure was 92%.

It was not possible to say at this stage if there were any specific gaps of social groups or those with specific conditions or circumstances that had not received immunisation. Officers would check if a report detailing the social groups of those immunised could be produced. At this time social groups are not analysed.

There was also an issue of availability of immunisation with for example uptake of shingles vaccinations being poor, but GPs only being allocated 5 inoculations per week. The logistics needed to be changed in order to improve the rate of vaccination.

It was advised that all SEN children aged 2 – 4 years old presently received seasonal flu vaccinations, but it had been agreed to roll this out to every child from ages 2 – 19. There was a change in progress to make these self-administered vaccinations.

Social workers and care workers were offered free flu vaccinations last year. It was confirmed that they, along with the remainder of the workforce in the Council will be also able to receive free vaccinations this year.

6 SCHOOL NURSES

School nurses were qualified nurses, specialists in public health, and provided both individual support to children and their families, but also dealt with wider issues of the school as a community and improving health across the board. Their priorities were keeping children healthy and happy, including issues of weight, ensuring sexual health, reducing the number of children requiring help, and reducing school absenteeism. Service had been variable between schools, and variable responses have been received. The Council had a mandate to measure children in the National Children’s Measurement Programme including vision and hearing checks. NELFT was the current provider, providing 17 members of school nursing staff across 84

schools in the borough. Although more resources would increase the capacity of the team, the existing resources also had capacity for improvement. Parents had the right to opt out of the service if they chose to. Members asked if a glossary of health service terms could be provided.

NELFT provided information on children's health checks, conducted at ages 4/5 and 10/11. They ensured records were transferred across areas preventing children missing inoculations if they moved areas.

School nurses did not dispense the morning-after pill, but they could advise teenagers to attend a community pharmacy to obtain this if they deemed it appropriate.

School nurses were commended as always attending any meeting regarding a child or group of children's health, providing a thoughtful and professional service.

7 0-5 TRANSITION (EARLY YEARS)

It was explained that 0-5 transition started antenatally within the midwife plan and birthing plan. Havering now had 27.5 health visitors. Twelve of the staff were not qualified health workers but were support officers or volunteers. There had been a recent boom in recruitment to local health visitation, early years commissioning, midwifery, nursery nursing and registered nursing.

Local performance data would be produced monthly from October for the London Boroughs and parts of Essex involved in NELFT. These reports will also feed in to the department of health.

There was a lack of data around resident population in some areas. At primary school age, there was a 7% difference in GP registrations and the numbers in the school cohort. At a senior level, this was a 47% difference.

NHS London would provide to Members a copy of the new mandate of what was expected of a health visiting service as well as the National Health Visiting Specification which complemented the mandate.

The Havering allocation of budget in this area was extremely small, and had not increased despite the caseloads increasing. Caseload calculation was completed in 2008, and has not been reviewed in light of the demographic churn, however it was hoped this issue, which had disadvantaged several authorities, could be overcome.

8 TEENAGE BREAKDOWN AND CAMHS ISSUES

There were four tiers of CAMHS services:

1. Primary mental health workers, via a range of providers including the CCG and NELFT.
2. Early intervention
3. The threshold for multidisciplinary help
4. Inpatient services at the Brookside unit in Goodmayes which were commissioned through NHS England (services for young people who were too at risk for community support)

Locally there was a significant growth in CAMHS and prevalence of child mental health issues. There had been a 6% increase of self-harm from 2011 (7%) to 2013 (13%). Within young people there was a 4% increase of rates of prolonged sadness or unhappiness. There were increased risks associated with this, such as sexual risk, self-harm, smoking, drinking, drug-taking, and recklessness.

Although it had been suggested that CAMHS did not work for everyone, the Tier 4 service Havering offer was nationally acclaimed; the borough's budget allocation was however small which limited the work that could be done. Communication and access to CAMHS was being worked on. A review was conducted recently to ascertain how easily the correct support was given, and the service rated well. It was accepted that CAMHS information on the relevant websites could be made clearer and more accessible.

CAMHS was generally available for 5 – 19 year olds, although some under 5's will be seen by CAMHS if deemed appropriate, and services were offered up to the age of 25 if there were more complex needs.

A Member asked why the rate of referrals had almost doubled and if this was due to an increase of reporting. Although schools, Early Years and Troubled Families teams had all become better at identifying these issues, there had in fact been an increase in prevalence as this was a growing national problem. Some of the factors included increase in pressure around exam times, general issues of teenage years, social networking, and the change of social interactions globally.

Referrals often came from school nursing services, intervention support, early years, parents, GPs or even self-referral. It was necessary to simplify referral routes, as these could be quite complex and confusing.

A member queried if teachers can refer a child themselves on their own grounds, or if they required the school nurse or a parent's consent in order to be able to do so, without having to do it anonymously. It was felt that the issue of consent could be overcome but this may be one of the complicated issues that needed to be simplified.

Parenting support was offered at tier 1, to give support and guidance in dealing with mental health issues, which may help prevent future referrals. It was accepted however that more could be done to strengthen the prevention aspects.

The NELFT officer also advised that she would look at further advertising of CAMHS services, potentially including in GP's surgeries, schools and community centres. The YMCA was also suggested as a possibility for the advertising of CAMHS services

9 **SEXUAL HEALTH AND TEENAGE PREGNANCY**

Poor sexual health included sexually transmitted infections, pregnancy and sexual abuse, but also encompassed wider social implications including domestic violence, and poor mental health, amongst others.

In 2008 there was a steep decline in teenage conception rates, particularly focussed on 16 – 17 year olds. Repeat abortion rates were however increasing amongst young people.

There was a national increase in the prevalence of sexual infections. The long term consequences included risk of infertility. Havering however had the lowest rates of HIV in London, but the highest proportion of late diagnoses.

High quality treatment and prevention services were commissioned but the critical change needed to be young people taking charge of their own sexual health, including how to properly use contraception.

The sexual health service was currently being re-commissioned, focussing on treatment, but there was also a new focus on prevention including better use of GP surgeries and pharmacies in getting messages out of promoting healthy relationships in schools. Apps on mobile devices would also be used to spread awareness of the services on offer. There was presently a pilot in GP services registering a point of care HIV testing service, in an attempt to normalise the testing. When this was offered within GP's surgeries, patients tended to decline.

A request was made to attempt to identify the conception rates of under 16's more clearly, through a more thorough breakdown of the information and officers would seek to provide this.

It was confirmed that emergency and routine contraception was available to young people without the knowledge of their parents, if it was deemed appropriate.

A Member suggested that sex education in schools may need to be reviewed in line with modern social changes. It was also suggested that as young people had free access to contraception and the morning after pill, both available without parents' consent, and abortion rates had still increased there was an issue with the way children were taught in schools on these crucial matters.

Havering officers advised that there were still issues to be resolved, however good quality mandated Personal, Social and Health Education (PSHE) was already available in all Havering schools. OFSTED inspected all providers and ensured that they provided good information and support for children and young people, however due to social and media changes, the sexualisation of children and young people had been increasing.
The implications of the Rotherham Inquiry were due to be scrutinised part of the next Children's OSC meeting. The CCG was working on providing clearer information to women about effective long term contraception after an abortion. It was agreed that more details of the sexual health services available at GPs should be given to all Councillors.

10 **EDUCATION HEALTH PLANS**

Officers would provide a paper on this issue to accompany the minutes. The new legislation framework in Social Care which commenced on 1st September, and combined early years, social care, schools and colleges was working closely to put in place Children's and Young People's provision from 0 – 25 years for children with Special Educational Needs and disabilities.

There were four strands:

1. *Education:* Education health plans put parents and young people at the heart of the decision making process. Parents and young people needed to be able to see that advice, guidance and decision making methods that met their needs were all in place.

   It was important that everyone was aware of what was available within the 'local offer' of support to children, families, young people and carers, which included NELFT, leisure services and other available information. Officers would work to improve the accessibility of and information on the local offer that was available on the Havering website.

   Any corporate body or organisation was subject to 'open text response' and needed to be aware that anyone could now review

their services using this new method for review and information sharing.

The Council was keen to quality assure everything on the local offer, including the health offer. NICE (National Institute for Health and Care Institute), OFSTED and other partners were working with the Council on this.

Specialist services were not provided locally in Havering, but there were substantial links with pan-London specialist services.

2. *Education Health & Care Plans:* The Local Offer was being built into new care plans. It would take approximately two years to convert all of the current Statements over to Education Health and Care plans. The thresholds remained the same, but new processes including health, social care and education were also in the directory.

   The conversion timetable was on-going, with a parallel system in place to accommodate all of the older formats and newer formats. At a rate of 100 conversions per month, the timescale was on course to be met. All 2, 3 and 4 year olds would get the new formats first. Those 16 and over may not receive new formats, as they would not be prioritised, as they will reach the upper age-limit at the deadline.

   Joint commissioning was also being worked on. As there was one plan, there needed to be one process and one pooled budget for services for adults and children.

3. *Personal Budgets:* Parents and young people could receive the equivalent budget rather than the service that would be provided automatically by the borough (budget holding), or receive a nominal budget (to receive budgetary information only).

   Officers were keen to find a way to get as many of these people back into the standard system as possible, as this would keep costs down with more people using the services, and provide a more inclusive service if all users trusted the service provided.

   Personal budgets were too much work for many parents, who tended to avoid them as they required employing staff to fulfil the caring roles that would be provided as part of normal council and associated bodies' duties.

4. *Streamlined Services:* This included the children's disability team, and would now be known as the 'Children and Adults with Disabilities Service'. Havering would be only the second Council nationally to combine services in this way.

A co-opted member pointed out health representatives occasionally failed to attend Statement meetings. Officers advised that although there were no

particular issues, there were still limited resources. If however a number of parents sought to take up personal budgets, it would put the service under further resource pressure.

Officers felt that, whilst no one would be forced to take either option, personal budgets were not something that parents generally wanted.

There were different thresholds for Children's and Adults personal budgets. One of the reasons for streamlining the services was not to change the statutory thresholds, but to transition between the two age groups in a much clearer and more transparent way.

Each personal budget case was awarded on its own merit, and the personal budget equated to the actual cost of what the authority would have spent on that individual for the specific care that they required.

The Chairmen of the Children & Learning and Health Overview and Scrutiny Committees would meet to discuss future work plans in relation to children's health.

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Chairman