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Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
AGENDA

7.00 pm	Thursday 19 November 2015	Havering Town Hall

Members 6: Quorum 3

COUNCILLORS:

Conservative (3)	Residents' (1)	East Havering Residents'(2)	UKIP (0)
Dilip Patel (Vice-Chair) Jason Frost Carol Smith	Nic Dodin (Chairman)	Gillian Ford Linda Hawthorn	

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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.

What is Overview & Scrutiny?

Each local authority is required by law to establish an overview and scrutiny function to support and scrutinise the Council's executive arrangements. Each overview and scrutiny sub-committee has its own remit as set out in the terms of reference but they each meet to consider issues of local importance.

The sub-committees have a number of key roles:

1. Providing a critical friend challenge to policy and decision makers.

2. Driving improvement in public services.

3. Holding key local partners to account.

4. Enabling the voice and concerns to the public.

The sub-committees consider issues by receiving information from, and questioning, Cabinet Members, officers and external partners to develop an understanding of proposals, policy and practices. They can then develop recommendations that they believe will improve performance, or as a response to public consultations. These are considered by the Overview and Scrutiny Board and if approved, submitted for a response to Council, Cabinet and other relevant bodies.

Sub-Committees will often establish Topic Groups to examine specific areas in much greater detail. These groups consist of a number of Members and the review period can last for

anything from a few weeks to a year or more to allow the Members to comprehensively examine an issue through interviewing expert witnesses, conducting research or undertaking site visits. Once the topic group has finished its work it will send a report to the Sub-Committee that created it and will often suggest recommendations for the Overview and Scrutiny Board to pass to the Council's Executive.

Terms of Reference:

Scrutiny of NHS Bodies under the Council's Health Scrutiny function

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 DECLARATIONS OF INTEREST

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

4 MINUTES (Pages 1 - 16)

To agree as a correct record the minutes of the meetings held on 8 September 2015 and 8 October 2015 (joint meeting with Children and Learning Overview and Scrutiny Sub-Committee) and to authorise the Chairman to sign them (attached).

5 PRIMARY CARE UPDATE

Discussion with Sarah See, Primary Care Director, Havering Clinical Commissioning Group on Primary Care issues in Havering.

6 JOINT STRATEGIC NEEDS ASSESSMENT

The Interim Director of Public Health will give a presentation on the Joint Strategic Needs Assessment.

7 HEALTH AND WELLBEING STRATEGY

Presentation by the Interim Director of Public Health on the Health and Wellbeing Strategy.

8 HEALTHWATCH HAVERING

A representative of Healthwatch Havering will present to the Sub-Committee on the organisation's 'Tell us what you think' campaign.

9 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 shall be considered as a matter of urgency.

Andrew Beesley
Committee Administration Manager

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MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
8 September 2015 (7.00 - 8.50 pm)

Present:

Councillors Nic Dodin (Chairman), Dilip Patel (Vice-Chair), Jason Frost and Linda Hawthorn

Also present:

Dr Susan Milner, Interim Director of Public Health
Anne-Marie Dean, Chairman, Healthwatch Havering
Caroline O'Donnell, Integrated Care Director – Havering, North East London Foundation NHS Foundation Trust (NELFT)
Carol White, NELFT
Alan Steward, Chief Operating Officer, Havering Clinical Commissioning Group (CCG)
Anthony Clements, Principal Committee Officer

11 **ANNOUNCEMENTS**

The Chairman gave details of the arrangements in case of fire or other event that should require the evacuation of the meeting room.

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

Apologies were received from Councillors Gillian Ford and Carol Smith.

13 **DISCLOSURES OF PECUNIARY INTEREST**

There were no disclosures of interest.

14 **MINUTES**

On minute 6 – Havering Access Hubs and Weekend GP Provision, it was clarified that the Urgent Care Centre at Queen's Hospital was run by the GP Federation and the Urgent Care Federation at King George Hospital was run by the Partnership of East London Cooperatives (PELC).

The minutes of the meeting held on 24 June 2015 were otherwise agreed as a correct record and signed by the Chairman.

15 ST GEORGE'S HOSPITAL

The Chief Operating Officer of Havering CCG explained that the CCG had submitted an outline business case for the development of a health and wellbeing centre on part of the St George's site. Possible facilities that could be incorporated on the site included primary care, NELFT community services, outpatient clinics currently based at Queen's Hospital, voluntary and community sector facilities and a training centre. Given the demographics of the local population, the overall facility would have a focus on frail elderly patients.

NHS England had asked the CCG to provide further detail in their business case on the predicted activity levels at the new facility and on the economic case for the proposals. This was currently in progress and it was planned to resubmit the outline business case to NHS England by early October. It was emphasised that the CCG was committed to making the St George's scheme happen.

It was possible that NHS England could require empty space in existing NHS buildings to be utilised rather than building a new facility but the CCG did not feel there were any existing alternative local health facilities that were not already being fully used.

It was hoped to receive a decision on the Outline Business Case from NHS England by December with a detailed business case to be submitted within six months of approval. Final approval was hoped to be received within a further six months of submission of the final business case. Plans would be brought to the Sub-Committee as the project progressed.

X-ray services would be made available on the St George's site if it was felt these were required. The CCG was aware of the increasing and changing nature of the local population and wished to modernise primary care accordingly. The CCG had noted with interest the results of a survey carried out by the local ward Councillors on what services people wished to see at St George's. The CCG representative felt that the results indicated a wish for a similar group of services to that which the CCG was proposing.

The Sub-Committee **NOTED** the update.

16 INTERMEDIATE CARE

It was explained that the CCG wished to move more care closer to home and have less reliance on hospital-based services. To this end, two new services – the Community Treatment Team (CTT) and Intensive Rehabilitation Service (IRS) had been introduced and proven a major success.

The NELFT representative confirmed that the CCT provided a rapid response to patients in crisis or to facilitating discharge. The CCT comprised doctors, nurses, physiotherapists and occupational therapists who provided short-term support to patients in their own homes. The service was available 8 am – 10 pm, 7 days per week.

The IRS offered support from physiotherapists, occupational therapists and nurses in people's homes 7 days per week, 8 am – 8 pm. The service normally responded to a referral within 24 - 48 hours.

The CCT dealt with around 1,600 Havering referrals per quarter. This was approximately 55% of the tri-borough service and reflected the older population within Havering. 93% of referrals to the service were seen in their own homes and patient feedback on the service had been very good. The service had also reduced levels of demand on A & E. It was confirmed that a care plan was established for each patient and this was referred to by staff each time a patient was visited.

The IRS received 280-300 Havering referrals per quarter, around 50% of the total service. 98% of patients had been found to improve during this treatment and length of stay with the service had increased from 7 to 15 days on average. Regular surveys of patient experience were undertaken and patient feedback had been very positive for both services.

As regards system resilience, both services contributed to winter planning. The CCT had established with the London Ambulance Service a falls car whereby a paramedic and CTT nurse visited people who had fallen at home. It was considered that one falls car was currently sufficient to cover the three local boroughs but any increase in the service would be considered by the system resilience group. The service was currently available 7 days per week, 12 hours a day.

The services had received national recognition, being shortlisted for the Health Service Journal awards and requests to view the work undertaken had been received from Finland and the Netherlands. Future plans included the integration of services at the front door of A&E such as older persons' services and ambulatory care. It was planned to co-locate beds at King George Hospital but this was still being finalised with BHRUT and would be brought to the Sub-Committee in due course. Concerns about the change of services that had been raised in Redbridge were being addressed.

Seven per cent of patients seen were not able to be treated at home, often because their conditions were too complex. Patients would be admitted to hospital if this was found to be the situation.

It was noted that the services did not cover the neurological pathway and were for more routine conditions rather than specialist areas e.g. multiple sclerosis. Time spent with patients was not limited and CTT and IRS staff stayed with patients as long as was necessary, depending on a patient's need.

There were approximately 43 WTE staff on each team but officers would confirm this. There were currently four vacancies at the CTT and none at the IRS. While five locums were used overall, there was little staff turnover in either service.

The Chairman of Healthwatch Havering confirmed that the organisation strongly supported both services, feeling they provided excellent treatment and gave a voice to the elderly and most vulnerable people in the community.

The Sub-Committee **NOTED** the update and the work of the two services.

17 **CCG UPDATE**

Vanguard Programme – It was confirmed that the CCG, with partners, had successfully bid to develop a Vanguard programme, the only such project in London dealing with urgent and emergency care. The CCG had organised a conference on these issues in July 2015 which had concluded that new technology needed to be used more in urgent care. There were too many unnecessary patients at both A & E and GPs and it had also been found that it was necessary to join up relevant pathways and invest in the workforce.

The CCG had jointly bid for the Vanguard programme as part of the System Resilience Group and in conjunction with the GP Federation, NELFT and Barking, Havering and Redbridge University Hospitals NHS Trust. The bid was based around a concept of 'click-call-come in' whereby people could firstly use technology to self-care or to book appointments direct. NHS 111 was seen as a gateway to the system and would have a directory of services available that could be used by its staff and other health professionals. More serious cases would still be asked to attend A & E or an Urgent Care Centre where necessary.

The bid formed a two-year programme for the local health economy. It was planned to develop a new care model by March 2016, involving both residents and local clinicians in this work. Work to move to the new system was planned to begin by October 2016 and new contracts and pricing would be developed by March 2017. Full implementation of the new system was anticipated by October 2017. This work would be funded by the award of a share of a National Transformation Fund.

A local launch of the Vanguard was planned for mid-October 2015 which would be open to stakeholders. It was accepted that more promotion of this area was needed with, for example, use of Facebook to promote the 'Not Always A&E' message. You Tube and mobile phone applications could also be used. The Healthwatch Havering Chairman added that it was important

to ensure that the Vanguard contracts fully reflected what people wanted from services before messages were publicised in the community.

Richmond Fellowship services – It was confirmed that the CCG had decided to reprovide some employment support services provided to mental health services users. Meetings were held quarterly with the new provider – Richmond Fellowship and feedback from service users had been positive. The service target had been to give support to 300 service users in the first year but 254 service users had been assisted in the first six months alone. Officers would supply details of the numbers of service users who had gone on to employment, education, training or volunteering and it was also agreed to seek to set up a visit to the Richmond Fellowship Havering base in order that the Sub-Committee could discuss the services offered directly. More information would also be given on the indicators used to assess the performance of the Richmond Fellowship.

Everyone Counts – The CCG had been encouraging this programme to develop GP services for the over 75s. Sixty schemes had been approved by GPs which would be monitored by the CCG. Examples included schemes introducing health assessments at home by GP practice staff.

Other issues – The CCG and Health & Wellbeing Board had been nominated for an APSE award for their system resilience work and the CCG's work on end of life care had also been recognised. The CCG's work on co-commissioning of GP services was also progressing.

The Sub-Committee **NOTED** the update.

18 HEALTHWATCH HAVERING ANNUAL REPORT 2014/15

The Healthwatch Havering chairman explained the organisation was an individual consumer champion for every individual in the community. Healthwatch had a direct line of accountability to Healthwatch England and the Care Quality Commission.

Healthwatch Havering had a team of around 30 volunteers most of whom had a background in either the NHS or social services. Volunteers undertook enter and view visits and determined the selection criteria and priorities for these themselves. Notice was usually given of enter and view visits as Healthwatch was keen to work in partnership with the NHS and social care facilities. All enter and view reports were published on the organisation's website. In 2013/14, nine elderly care homes and seven nursing homes had been visited.

Healthwatch members sat on the Council's Quality and Safeguarding Board, Health & Wellbeing Board and the Primary Care Commissioning Board. Healthwatch had established a positive and supportive relationship with both NELFT and BHRUT.

Views of local residents were collected by Healthwatch Havering via 'have your say' events, meetings with carers and relatives of vulnerable groups and attending meetings of groups such as the Havering Over 50s Forum. The content of the Healthwatch Havering website had also recently been expanded.

Healthwatch's work on learning disabilities had seen a higher number of Havering people with learning disabilities having GP healthchecks and receiving health action plans. Registered patients with learning disabilities were now flagged up on arrival at local hospitals, hospital passports had been introduced for this group and 80 learning disability champions had been trained at the Hospitals Trust.

Healthwatch Havering governance arrangements had been reviewed and the role of volunteer specialist advisor had been introduced to increase the volunteer knowledge base. Enter and view procedures had also been reviewed and benchmarked. All Healthwatch Havering board meeting minutes were now published on the organisation's website.

Funding for Healthwatch from the Council in 2013/14 had been £129,000 and the difficult financial climate had meant that a supplementary grant had been withdrawn, giving total funding for 2015/16 of approximately £117,000. There were a total of 2.31 full time equivalent paid staff at the organisation.

The Healthwatch Chairman clarified that, if patients or residents were felt by enter and view volunteers to be at risk, the Council would be contacted immediately. Officers present stated that both Havering CCG and NELFT had very good relationships with Healthwatch Havering and valued the work undertaken by the organisation.

The Sub-Committee **NOTED** the Healthwatch Havering Annual Report 2014/15.

19 **URGENT BUSINESS**

The Havering CCG Chief Operating Officer reported that the GP hubs service was now being used more frequently at weekends and would supply further details. Increased numbers of children were now being seen at the weekend hubs rather than going to A & E.

A Member suggested that it may prove useful to advertise alternatives to A & E in schools and the CCG officer agreed to consider this.

Chairman

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MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
(JOINT MEETING WITH CHILDREN AND LEARNING OVERVIEW & SCRUTINY SUB-COMMITTEE)
Havering Town Hall
8 October 2015 (7.00 - 8.52 pm)

Present:

Councillors Nic Dodin , Dilip Patel, Gillian Ford, Jason Frost, Linda Hawthorn and Carol Smith

There were no apologies for absence.

Officers present:

Clare Burns, Senior Locality Lead, Havering Clinical Commissioning Group (CCG)
Drs Aber Equb, Anand Shilsaker and Morgan Keane, Barking, Havering and Redbridge, University Hospitals NHS Trust (BHRUT)
Sue Milner, Interim Director of Public Health, LBH
Mark Ansell, Public Health Consultant, LBH

20 **ANNOUNCEMENTS**

The Chairman gave details of the arrangements in case of fire or other event that should require the evacuation of the meeting room.

21 **DISCLOSURE OF PECUNIARY INTERESTS**

There were no disclosures of pecuniary interest.

22 **PAEDIATRIC EMERGENCY PATHWAY AND CHILDREN'S PHLEBOTOMY**

1. Children's phlebotomy Service

Dr Shilsakar confirmed that the children's phlebotomy service at Queen's Hospital was available, by appointment, between 8.40 am and 5.10 pm, Monday – Friday. Two full time phlebotomists were available and the service sought to create a child-friendly environment. GPs could access the service but referrals were mostly from special needs schools. Referrals could also come from community paediatricians as well as from outpatients and, to some extent, patients on the hospital wards. The service was designed for children with special needs and behavioural issues.

The service saw up to 50 children per day and waiting times were not more than one working day. The service received good feedback on friends and family scores and play therapists were available to help children and give a good patient experience. Photo guides of procedures were shown to parents and cartoons had been developed to help put children at ease.

It was accepted that the Victoria Hospital did not carry out blood tests for children under 16 years of age and that the busy Queen's environment could lead to challenging behaviour in children.

Results for routine blood tests were sent to GPs in 1-3 days although this could be longer for more specialised tests.

2. Children's Emergency Pathway

Dr Equb confirmed that there were paediatric emergency units at both Queen's and King George Hospitals. The unit at Queen's saw around 36,000 children per year and King George treated approximately 16,000 children annually. The equivalent annual figure for the Chelsea & Westminster Hospital paediatric emergency unit was 22,000 - 25,000 children treated per year.

A wide range of medical and surgical services were offered at the units. Paediatric emergency medicine clinics, to check on children previously treated, were offered four days a week at Queen's and one day a week at King George. There were established links with major trauma centres, burns units and other specialist facilities.

The infrastructure of the children's A & E section had been rebuilt considerably over the past 18 months and the service was now very patient focussed. The unit had been refurbished and there were now separate registration and waiting areas for children.

A clinical nurse was stationed in the waiting area to ensure children did not deteriorate while they were waiting to be seen and cases could be escalated if necessary. Triage staff did checks for the presence of sepsis and also used a safeguarding tool to identify any potential child protection issues.

All clinical guidelines and protocols for children's A & E had been updated and these were available to junior doctors on-line, via an I-phone app and in paper format. The high staff turnover in the department was being addressed and successful recruitment day in April 2015 had recruited a total of 30 A & E nurses, 10 of whom were paediatric trained. Nurses were rotated between A & E and the children's ward and there were now full induction packs available for all staff.

A lot of resources had been invested in staff training with sessions arranged for nurses and junior doctors. Specific paediatric nurse training days had also been arranged, led by consultant paediatricians. Formal staff supervision had also increased.

As regards child protection, the safeguarding pathway had been updated and a pathway for dealing with cases of suspected child sexual exploitation had also been introduced. There was also extensive staff training in these areas.

Children exhibiting mental health issues had previously remained in A & E for 24-48 hours. A new pathway for these cases had now been developed however and most cases were now dealt with within six hours. Cases could also be referred to the Child and Adolescent Mental Health Service as needed.

The Care Quality Commission had found that children's A & E had strong clinical governance. Incidents were investigated and staff involved received regular feedback and supervision. Work was regularly undertaken with the Havering Clinical Commissioning Group on areas such as health promotion sessions and advice booklets for parents.

Children's A & E met the Royal College quality standards with 96% of patients treated within four hours at King George and 94.8% doing so at Queen's. The A & E reattendance rate for children was 1.7% compared to a UK average of 10%. The unit had only received four complaints since the start of 2015, having seen around 28,000 children in that time. The unit was scoring 80-85% on the Friends and Family test at Queen's (a significant improvement on previously) and 90-95% at King George. There had also been very positive comments received from parents about their children's treatment etc.

The children's A & E induction pack was sent to locum agencies and all clinical guidelines were also made available to locum staff. Most locum doctors returned regularly to work in the department in any case. The induction of agency nurses was the responsibility of the matron.

There was a two-month induction period for children's A & E staff nurses who also only undertook day shifts at first. The clinical director received CVs of locum doctors and reviewed what they had undertaken prior to their commencing work at the unit.

The transition time for children's A & E cases depended on each individual case. Major burns cases were stabilised and then transferred to Broomfield Hospital. Burns were photographed and e-mailed to Broomfield to enable more accurate treatment to be offered. Once stabilised, children with major trauma were transferred to the Royal London Hospital although most major trauma cases were now taken straight to the Royal London in any case.

Leaflets on domestic violence were placed in the women's toilets and nursing staff had been trained to ask subtly if a patient needed help. This area was supervised by the Trust safeguarding team. A pathway on this was being worked on and this was part of the child protection assurance group.

A pathway on Female Genital Mutilation (FGM) was also currently being worked on and the Chairman requested that the finalised pathway be brought for scrutiny to a future joint meeting of the Sub-Committees.

If there were major safeguarding concerns then children would not be released home after treatment but this only happened very rarely. Residential social workers from Barking & Dagenham were present in Queen's A & E and children's A & E staff met with social workers from all three local boroughs on a weekly basis.

Forms had also been introduced for children to complete as part of the Friends & Family test as well as graphical cards to ascertain what they thought of their treatment etc. It was also hoped to organise listening events with children.

The Community Treatment Team could send children to A & E but cases were usually managed in the community so this only happened rarely.

The Committee **noted** the position.

23 **GP COMPETENCE, CONFIDENCE & TRAINING**

The Senior Locality Lead at Havering CCG explained that the A & E paediatric consultant had recently trained local GPs on paediatric matters. This had covered children's dermatology and respiratory conditions, areas on which local GPs had requested further training. GP training on the recognition of ADHD and managing children with behavioural difficulties had also been scheduled. This would be run by community paediatricians from the North East London NHS Foundation Trust. GPs were required to revalidate every three years and these training sessions contributed to revalidation.

The CCG had received some additional Government funding for children's mental health services and was currently looking at whether this could be used to commission behavioural therapies for children. It was confirmed that the Havering CAMHS plan would be signed off and published shortly and suggested that this could be taken to scrutiny in the future. The plan included access to psychological therapies for children.

It was clarified that a GP would not diagnose ADHD, this would be carried out by a paediatrician. It was suggested that a GP could attend a future meeting to discuss ADHD and related conditions. Sessions had been run in children's centres on managing children's conditions at home and the CCG officer supply a copy of the information booklet given to parents at the six week healthcheck. This was also available as a mobile phone app that it

was hoped could be given to parents to download whilst they were still in the maternity unit.

GPs were able to refer children direct if necessary to the surgical assessment unit at Queen's or to the paediatric hot clinic.

The Committee **noted** the update.

24 HEALTHY SCHOOLS

Public health officers explained that the national healthy schools programme had ceased in 2011 and the healthy schools London programme had launched in April 2013 and had been in operation for the last 18 months. The programme sought to encourage whole schools to promote health. Schools undertook needs assessments, planned specific actions and then carried these out. There were currently 57 Havering schools registered with the programme of which 24 had gained the bronze award level.

The Council healthy schools coordinator organised workshops and published newsletters etc about the programme. A borough celebration event had also been held for schools that had delivered awards. The programme was popular with schools and fitted with OFSTED requirements to promote health and wellbeing.

There was pressure on the Council's public health allocation and the public health team would be smaller in size once a forthcoming restructure was completed. A traded service model was under consideration and it would need to be ascertained if schools were willing to pay for the healthy schools service.

Officers would circulate a list of Havering schools who were involved in the healthy schools programme. Publicity for the programme would be considered as part of the public health communications plan. The public health e-newsletter could also be used to celebrate healthy schools. One school had arranged yoga sessions for children before school started and a member added that yoga was very beneficial in Special Schools.

The Committee **noted** the position.

25 TRANSFER OF 0-5S SERVICES

Officers explained that, with effect from 1 October 2015, the Council had been responsible for the commissioning of health visiting and family nurse partnership services. It was noted that the family nurse partnership service was not currently running in Havering as there were not enough teenage mothers in the borough. Child health information systems remained with NHS England and the 6-8 week GP check was still part of the GP contract.

It was clarified that health visitors were still employed by NELFT but the service was now commissioned by the Council rather than NHS England. Funding had been received in-year from central Government to cover the transfer of health visiting of £160 per child aged 0-5 years, This equated to an additional £400,000 for Havering above the contract value. A cut in the national public health budget of £200 million had however also been announced and Havering's overall public allocation had therefore reduced by £700,000. Havering had also received only two extra posts as a result of the health visiting transfer whereas other boroughs had received significantly more posts.

Havering had a small team of health visitors which meant caseloads were larger than the national average. The health visiting contract was based on national specification and covered the universal offer of five mandated health visiting checks. More focussed care was also offered for children with greater needs.

New birth health visiting checks were taken up in 90% of cases. Checks at 6-8 weeks were more targeted but were delivered on 40% of occasions. Take-up of the one and two to two and a half year checks were around 50%. Follow up action would be taken if a child did not attend two of the mandatory checks but it was emphasised that parents did not have to engage and health visitors did not have the right of entry. Concerns could also be raised by other health professionals and safeguarding was very much a focus of the health visiting team.

Immunisations were not offered by health visitors but if a child did not attend for immunisations, this could be referred to the health visitor for follow up action. The health visiting service was not a universal offer but officers emphasised that to reach more or all families would require a lot of additional resources.

The health visiting service worked closely with children's services in order to stretch resources and had established links with children's social care. These were however usually only needed in rare cases. It was expected that more children would move into the borough and it was hoped that at risk children from other areas could be identified.

The public health funding allocation was not part of the NHS ring fence and next year's allocation would be confirmed in December 2015.

The Committee **noted** the update.

26 **BRIEFING NOTES**

It was agreed to seek to organise a topic group meeting to scrutinise the Local Offer as well as the work of the Amy Winehouse Foundation. The Committee Chairmen would meet separately with the Interim Director of Public Health in order to discuss the scrutiny in more detail.

27 **URGENT BUSINESS**

There was no urgent business raised.

Chairman

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