MINUTES OF A MEETING OF THE
CHILDREN & LEARNING OVERVIEW & SCRUTINY SUB-COMMITTEE
Town Hall
8 October 2015 (7.00 - 8.55 pm)

Present: Councillors Gillian Ford (Chairman), Carol Smith (Vice-Chair), Jason Frost, Nic Dodin and John Glanville

Co-opted Members: Phillip Grundy, Jack How and Julie Lamb

Apologies for absence were received from Councillors Joshua Chapman and Philippa Crowder. Co-opted member Lynda Rice

11 CHAIRMAN'S 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:
Councillor Joshua Chapman, Councillor Philippa Crowder and Lynda Rice.

Councillor Fredrick Thompson was present - substituting for Councillor Joshua Chapman

13 DISCLOSURE OF PECUNIARY INTERESTS

There were no disclosures of pecuniary interest.

14 PROVISIONAL ITEM: 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 re-attendance 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.

15 GP COMPETENCE, CONFIDENCE AND 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 health-check. 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.

16 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.

17 TRANSFER OF 0-5'S 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.

18 **BRIEFING NOTE**

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.

19 **URGENT BUSINESS**

There was no urgent business raised.

Chairman