**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.

Chairman