# HEALTH COMMITTEE

## Thursday, 11 February 2021

**Democratic and Members' Services**
Fiona McMillan
Monitoring Officer

**13:30**

Shire Hall
Castle Hill
Cambridge
CB3 0AP

## COVID-19

**During the Covid-19 pandemic Council and Committee meetings will be held virtually for Committee members and for members of the public who wish to participate. These meetings will held via Zoom and Microsoft Teams (for confidential or exempt items). For more information please contact the clerk for the meeting (details provided below).**

# AGENDA

**Open to Public and Press**

**CONSTITUTIONAL MATTERS**

| | | |
|---|---|---|
| 1 | **Apologies for absence and declarations of interest**<br>*Guidance on declaring interests is available at* [http://tinyurl.com/ccc-conduct-code](http://tinyurl.com/ccc-conduct-code) | |
| 2 | **Health Committee Minutes 3rd December 2020** | **3 - 14** |
| 3 | **Health Committee Minute Action Log** | **15 - 18** |
| 4 | **Petitions and Public Questions** | |

**DECISIONS**

| | | |
|---|---|---|
| **5** | **Healthy Child Programme - Service Delivery During the COVID-19 Pandemic** | **19 - 48** |
| **6** | **COVID-19 Issues Report**<br>*To follow.* | |
| | **SCRUTINY** | |
| **7** | **NHS Dental Services** | |
| | **OTHER DECISIONS** | |
| **8** | **Health Committee Agenda Plan and Appointments to Outside Bodies** | **49 - 52** |

The Health Committee comprises the following members:

Councillor Peter Hudson (Chairman) Councillor Anne Hay (Vice-Chairwoman)Councillor David Connor Councillor Lorna Dupre Councillor Lynda Harford Councillor Linda Jones Councillor Lucy Nethsingha Councillor Kevin Reynolds Councillor Mandy Smith and Councillor Susan van de Ven

*For more information about this meeting, including access arrangements please contact*


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# Health Committee: Minutes

Date: 3rd December 2020

Time: 1.30 p.m. – 3.45 p.m.

Present: Councillors: L Dupré, L Harford, A Hay (Vice-Chairman), P Hudson (Chairman), L Jones, L Nethsingha K Reynolds, M Smith and S van de Ven

District Councillors, D Ambrose-Smith, S Clark, Geoff Harvey N Massey and S Wilson (substituting for Councillor Tavener)

## 356. Apologies for Absence and Declarations of Interest

Apologies were received from Councillor Tavener (substitute Councillor Sarah Wilson).

Declarations of Non-statutory disclosable Interests were received from:

Councillor Susan van de Ven as being Member of Rail Future (declared during discussion on agenda Item 5)
Councillor Nicky Massey as a governor at Addenbrooke's Hospital;
Councillor Sarah Wilson as an employee of Cambridgeshire Community Services employed by the Schools Immunisation and Covid Working Teams.

## 357. Minutes – November 2020

The minutes of the meeting held on November 2020 were agreed as a correct record.

## 358. Health Committee Action Log

The Minutes Action Log was noted.

## 359. Petitions and Public Questions

There were no public questions or petitions by the Council Constitution deadlines.

## Scrutiny

## 360. Addenbrooke's 3 Update Report

The Chairman welcomed Roland Sinker the Chief Executive, Hugo Ford Oncologist and Divisional Director, Claire Stoneham Director of Strategy and Major Projects and Sarah Vincent Head of External Affairs Cambridge University Hospital CUH to the meeting.

In the introduction there was a brief summary of the current status of Cambridge University Hospitals, Addenbrooke's and the Rosie. This included updates in three areas: caring for patients, keeping staff safe and an update on the building for the future plans.
In terms of caring for Covid-19 patients it was highlighted that CUH currently had around 30 or so patients of which a small number were in a critical condition. With the numbers at the time of the meeting remaining relatively flat. The numbers referenced were relatively small when compared with other areas of the Country where other NHS Trusts

such as Manchester and Birmingham had around 400 -500 patients. Addenbrooke's Hospital was currently progressing well in re-starting up its pre-Covid, specialist and planned care services with up to 93% operating capacity, as well as other areas such as diagnostics. There were current challenges around long emergency department compounded by the loss of 10% of the hospital beds base, through reconfiguration around social distancing as well as keeping covid and non covid patients safe. They were working very hard with staff regarding the flow of patients and their discharge.

The second priority of keeping staff safe was through measures such as providing support for mental health and psychological well-being and ensuring there was sufficient space to allow staff to be socially distanced . There had been a huge drive on staff flu vaccinations and a large scale asymptomatic testing programme was in operation with 4700 of the 11,000 staff tested the previous week. They were now planning [for the rollout of the Covid-19 vaccine.

On Building for the Future, CUH had been engaging with partners and the community to ensure improved partnership working with general practitioners, community care and other health professionals, voluntary organisations and the third sector through work on the Sustainable Transformation Plan (STP) and liaison work on the future proposed hospital builds. Regarding the Addenbrooke's 3 programme the aim was to ensure a coherent strategic direction and clear set of proposals on the prioritisation for construction on the site and to be able to clearly show the benefits when seeking additional Government and partner funding.

Phase 1 of the Addenbrooke's modernisation programme was dealing with current operational challenges to ensure: there were enough beds to deal with Covid patients, Ensuring that the emergency department was fit for purpose, and to reduce long waits for elective treatment. As part of the Regional Surge Centre, building was being undertaken on site, to be able to accommodate more patients. There were 60 temporary beds going onto site, with 60 more permanent beds, to ensure sufficient capacity for all patients should there be a further surge. The next stage would be to strengthen the emergency department and ensure sufficient capacity for those requiring emergency care.

The second phase was the proposed cancer and children's hospitals which were moving forward at a great pace in order to achieve the aim of integrated clinical and research facilities. The Cancer Hospital was very much about research facilities combined with improved NHS patients treatment spaces, with the Children's Hospital aiming to look at the whole child without differentiating between physical and psychological needs. Both when opened would help the plans to make changes in the main hospital.

Phase three involved further developments, such as an acute hospital, with the main aging estate being in increasingly poor condition, even with ongoing maintenance repairs. Any new developments would seek to be fully integrated with both community services and primary care. A map of the site, showing the main locations, was set out in a presentation slide included as an appendix to these minutes.

Hugo Ford introduced the details of the proposed new cancer hospital which aimed for both cutting edge clinical excellence at CUH and world leading Cambridge Research and Industry with a target date of opening in 2025-26.

Key issues that needed to be addressed included that the existing cancer wards were in the oldest part of the hospital and were not fit for purpose. Speaking on cancer outcomes while they were relatively good in Cambridgeshire, nationally cancer outcomes were poor compared to other European countries and other international

comparators. One way to address this was through early diagnosis of cancer and the Hospital have one of biggest groupings of research scientists in the country who specialise in the early detection of cancer. In addition to the primary objective of improving outcomes for patients, improved early detection would also help reduce costs, as late diagnosis treatments were very expensive, especially as cancer treatment costs were rising at a far greater rate than inflation and needed to be at affordable levels.

It was explained that Cambridge University, a partner in the new Cancer Hospital project, was planning to create two new research institutes within the new hospital as described in more detail in the relevant slide. The National Institute for the Early Detection of Cancer was one of only two or three early detection centres in the world. The second, the Institute for Integrated Cancer Medicine would concentrate on finding the most accurate and appropriate treatments. To bring them together should ensure research outputs were quick, safe and could be widely disseminated. This would help provide much better care for patients while the research would benefit the whole country and the wider global community. There would be real focus on patients that were well and bringing together mental and psychological help which had not been possible before.

Issues raised included;

- Asking whether CUH had input into the discussion and consultation on the potential location of the Cambridge South Station. It was confirmed CUH had contributed, with the response having been led by Astra Zeneca on behalf of all the partners on the biomedical campus. There had been three options discussed and the option chosen was that nearest to the Guided Bus bridge.

- Asking what were considered the main reasons for the Country falling behind others in cancer diagnosis and successful treatment. In reply while no one could say the exact reason, factors included:
    - The culture of people in this country who were less likely to seek early diagnosis from doctors which could be linked to a lack of awareness and education on the symptoms of cancer
    - Fewer scanners per capita than most other developed countries
    - Delays in treatment and fewer treatments available for advanced cancer.

  Early diagnosis was however still the most important factor in the successful treatment of patients. The Member who had asked the question suggested the gateway into services was also still an important issue.

- Following on from the above, asking what the County Council and the Health Committee could do to help assist in ensuring people sought early diagnosis. With the help of the local authority, more education was required in schools on recognising the symptoms and seeking an early diagnosis. There also needed to be more outreach work from the Hospital to the community, plus increased screening programmes and greater linking up between the Local authority and Public Health England.

- The pandemic had resulted in a much greater use of virtual consultations at primary care and some at secondary level, which had suited some, but not all people. In that the intention going forward was to make greater use of virtual media to reduce the number of face to face consultations, how would this be taken forward to ensure some people were not further disadvantaged? The Member who raised it was particularly thinking of many elderly people who did not have access to IT equipment. In respect of the risk of digital discrimination, it was explained that 35% of consultations were currently being undertaken virtually through either video or telephone calls but it was highlighted that all patients were

given the choice of consultation method, which included face to face meetings. The Government target was currently 25%. The officer's view was that many of the follow up consultations could be undertaken virtually, while recognising that it had to be what the individual person wanted. Feedback on its increased use has been very good on balance. The intention was however not go back to pre-covid levels of face to face consultations.

- With regard to the decarbonisation agenda, while CUH were already using the Clean Air Hospital Framework, asking whether was a Clean Air Plan for sustainability. This was confirmed and included, waste, energy use, and how people accessed the site as well as the construction materials to be used in the new buildings. They were seeking to meet the national directive to be zero carbon enabled in due course. The big issue going forward was the integration measures required to keep people well and avoid them having to visit hospital and GP surgeries which was all linked to the prevention agenda a key vision of the STP.

- One Member highlighted that one of the problems with Public Health having moved out of the NHS was that it tended to be forgotten and one of few benefits of Covid was realising how important it was having health in all policies and through preventative measures and education avoiding people having to go to hospital.

- It was highlighted that at Rail Future meetings one of issues that a Member had picked up on had been capacity issue around the proposed Cambridge South Station. The Department of Transport were estimating 1.8m potential passengers with the bio-medical campus's own estimate being nearer 4-5m and some were putting the figure as high as between 7-8m. Her concern was that Network Rail might not be future proofing the plans for the station. It was important to take into account staff movements, not just estimated patient numbers and asked that that Biomedical campus should reassess the estimates to consider staff not just patients, as staff could with this transport facility could travel in from a lot further from the south of the County. Roland Sinker undertook to go back to the Biomedical Campus Team to look at what their estimates were. He highlighted that other benefits from Covid apart from virtual consultations had been staff being able to work remotely from other locations and therefore not everyone having to come to the Campus. Another big question would be to consider where would be living and working in the future and this could involve looking at links with East West Rail linking to Oxford Milton Keynes. Also the hospital was expanding the apprenticeships programme and these could be offered more across the Eastern Region.

- Asking about the progress and challenges regarding raising funding, due to the reliance on match funding to finance the projects? For the cancer hospital Government funding of £150m was being requested alongside a broader funding package from partners including the University of Cambridge and they were also looking at bringing in other partners. For the Children's Hospital £100m Government funding had been received and the plan was to raise a further £100m through the University and other partners. There was still the need to be clearer about the level of funding that would be required and being able to show the benefits to potential funders. This would include discussions with regional and national NHS, while recognising that the capital funding environment for the NHS was currently very tight.

- One Member expressed concern regarding being able to recruit the appropriately qualified staff especially following Brexit and concerns she had heard from the

BMA regarding staff recruitment and asked how confident were they of being able to staff the proposals. She highlighted that the Nightingale hospitals had not been as successful as hoped, as a result of a shortage of qualified staff especially as it took 4-5 years to train specialist doctors and nurses. Hugo Ford replied that with regard to the Cancer hospital, there was a good Workforce Plan and for most staff requirements, these would not be much greater than the current staffing levels. The general point about staffing was however, well made. It was highlighted that the Hospital was lucky to be able to attract good quality staff and had worked very hard to achieve this, while acknowledging that scaling up to 120 beds would be a challenge. He also acknowledged that as they recruited internationally, Brexit could be an issue. Claire Stoneham further explained that as a Trust there had been a focus on recruitment and vacancy rates and the Hospital had been very successful as a result. They were also doing well with apprenticeships and providing their own staff with development opportunities and would be seeking to do more in the area through local recruitment

- In reply the Member while pleased to hear about the good progress being made but as they were more long term in nature, still believed that there could still be serious short term staffing problem

Roland Sinker concluded the presentation by stating that they would all be concerned about the new developments if it was not also the intention to undertake radical measures along with partners with to aim of keeping people well and working with Public Health to help keep people out of care hospitals through the prevention programmes. On recruitment the aim would be to make the jobs attractive, as while they involved a great deal of work, the professionals involved would find them very rewarding in what would be a cutting edge, innovative, working environment.

The Chairman thanked the presenters and also on behalf of the Committee, wished to convey to all their staff at the hospital their sincere thanks for the fantastic work they were doing under extremely challenging conditions.

It was resolved unanimously to:

Note the Strategy of Cambridge University Hospitals to make the case for investment in the redevelopment of their aging estate to enable them to provide facilities that are fit for modern health care delivery, and for the Committee to work with them to ensure they engage with the public in the development of their plans.

## 361. Re-commissioning Integrated Sexual and Reproductive Health Services

The Health Committee had previously approved the commissioning of integrated Sexual and Reproductive Health (SRH) Services by Cambridgeshire County Council (CCC) as a collaborative arrangement with Peterborough City Council (PCC), Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and NHS England (NHSE).

Due to the impact of COVID-19, the re-commissioning of integrated Sexual & Reproductive Health Service (SRH) across Cambridgeshire and Peterborough was paused between March and October 2020. The process had recommenced in order to meet the requirement of a new contract from the 1st April 2021 and had included an assessment of the procurement and contractual options for commissioning the service undertaken by consultants using criteria to help eliminate any inherent bias. As SRH services were clinical providers were usually NHS organisations and due to the current Covid-19 crisis with NHS services being extremely stretched, it was considered unlikely that the current

provider CCS and other NHS organisations would have the capacity and focus to participate in a full a competitive tender exercise, which would result in less competition.

Additionally, it had been planned to secure savings from the re-commissioning of the SRH Treatment Services Contract to help contribute to the funding of the separate, Prevention of Sexual Ill Health contract which had commenced in September. Those savings would be critical from April to help fund and continue to deliver the contract's agreed level of services. Another important factor that was looked into was that it was not considered appropriate to just extend the current contract for further longer period without the opportunity of having the flexibility to undertake the procurement exercise and test the competitive when conditions became more favourable.

Six options for re-commissioning integrated SRH services were considered as follows:

1. Continuing the current contract.
2. Negotiating a section 75 with the current provider CCS for 7 years as planned in the original procurement exercise.
3. Negotiate a section 75 with the current provider, CCS, for a limited period (to be agreed with commissioning partners). This would cover the period until COVID 19 demands had decreased and ensure providers had the capacity to tender for the contract.
4. Soft Market Test to determine approach.
5. Formal procurement for a 2 years plus 1 contract.
6. Formal procurement for a 7-year contract.

The options were then assessed and scored against a set of risks and benefits criteria set out in paragraphs 2.6 and 2.7 of the report. Appendix 1 provided the detail of this assessment. The only options that had received a positive score in the rankings (where the positive benefits outweighed the current risks) was for the implementation of a shorter Section 75 agreement with CCS, the current NHS provider of the services. (Options 2 and 3). The option of securing a Section 75 for the shorter period then proceeding to a competitive procurement had the following key advantages:

- It would ensure that a new Service was established within 2021/22 timeline that reflected the vision for an integrated SRH service and new delivery model.
- Create certainty for service users and staff within a difficult environment.
- Ensure that the two local authorities were able to achieve the financial savings that had been allocated to the prevention service.
- Allow the potential bidders within the wider market place an opportunity to develop bids that offered innovative service models when the COVID pressures become less acute.

In discussion the following issues were raised:

- Querying the difference between the benefit scores given for options 2 and 3 in terms of what the 1 plus 5 referred to for option 2 and for option 3 which was showing 1 plus 4. In reply this was explained as being for stability and the absolute assurance that a service would be in place by April 2021. The worst case would not to have a service in place at April 2021.
- It was suggested that showing the scores in the appendix would have been helpful for absolute clarity.
- Querying the recommendation to negotiate a section 75 with the current provider, CCS, for a limited period (to be agreed with commissioning partners) but not providing any detail on what a limited period constituted. In reply it was indicated that this could be between 12 months to three years.

- In reply to the answer provided above, the Member who had raised the question expressed surprise that it could be as long as three years, as this maximum potential length gave it the same time span as the worst scoring option. In reply this was to potentially take into account the period when community organisations who could be potential bidders where likely to be assisting with the vaccination programme and therefore would not able to bid for some time. It was explained it was not just for one service, the new contract was being designed for but would be seeking to combine three to four services currently commissioned by different organisations. It was e very complicated and officers were seeking the benefits of a current joint commissioned service for a short period of time, which would also help with staff certainty until a procurement exercise could be undertaken at a time when more potential bidders would be able to take part.
- The Chairman's opinion was that the period was more likely to be in the region of 12-18 months rather than 3 years until the Covid crisis had abated. Officers indicated that the initial risk assessment had been estimated on three years, but a shorter timescale should be feasible. At the current time it was not possible to predict what would happen in 12 months' time.

It was unanimously resolved to agree to support:

a) The Establishment of a section 75 Agreement for Re-commissioning Integrated Sexual and Reproductive Health Services with the current provider Cambridgeshire Community Services.

b) A section 75 Agreement for a short period (to be agreed with commissioning partners) to allow the opportunity for a formal procurement when the Covid-19 challenges are reduced.

## 362. Public Health Response to Covid-19

Given the rapidly changing situation and the need to provide the Committee and the public with the most up to date information possible, the Chairman accepted this as a late report on the following grounds:

1. Reason for lateness: To allow the report to contain the most up to date information possible.

2. Reason for urgency: To enable the committee to be briefed on the current situation in relation to the Council's response to Covid-19 for those services for which it was responsible.

Key highlights from the report included:

- That in the previous report which had only been two weeks earlier, for the reporting week 4th November to 11th November, the new lab-confirmed Covid-19 cases with addresses in Cambridgeshire had been 908, a rate of 139 cases per 100,000 population. While cautioning that Covid figures could be very volatile and could change very quickly, the latest figures showed a steep decline, with new lab-confirmed Covid-19 cases in Cambridgeshire in the week ending 26th November 2020 showing 397 diagnosed cases a rate 61 cases per 100,000 population. The earlier higher figure related to the activities in the week before the lockdown period characterised by more socialising and highlighted the danger going forward following the relaxation of the lockdown and moving to Tier 2.

- Within Cambridgeshire County, the rates were highest in Fenland at 90 cases per 100,000 population and lowest in South Cambridgeshire at 45 cases per 100,000.
- There had been 436 Covid-19 related deaths in Cambridgeshire in the period from March to 20th November 2020 (registered to 28th November). There were seven Covid-19 related deaths in the week to 20th November, one in Cambridge, one in Fenland, three in Huntingdonshire and two in South Cambridgeshire. All deaths having occurred in hospital.
- The highlight was the new local enhanced contact tracing service which launched in Cambridgeshire on November 19th, building on the success of the service running since August in Peterborough. This service followed up Covid-19 positive cases, who the national Test and Trace Service has not been able to contact in the first 24 hours. (normally about 20% of cases). The service in Peterborough had successfully followed up 85% of all cases referred to them. The person was then interviewed to find out who they have been in close contact with, and those contacts were then referred back to the national Test and Trace system.
- In Cambridgeshire working as a collaborative effort with all five District and City Councils, and Peterborough City Council, the success rate had been good with over 230 cases (83%) successfully followed up. The Director of Public Health placed on record her thanks to all the staff involved in this excellent effort.
- Work has also continued with both universities in Cambridge and Covid-29 case rates among Cambridge University students have fallen significantly and in the most recent reporting week from 23rd-29th November, only six cases were reported. This compared with 234 cases two weeks previously, reported in the week from 9th-15th November.
- Anglia Ruskin University would be using rapid lateral flow tests, as part of a national programme to test university students before they returned home for the Christmas period
- She highlighted the very hard work undertaken by Val Thomas through a Department of Health and Social Care pilot project in helping improve access to Covid-19 testing for some of the most vulnerable residents, including work with homeless hostels, refuges, and drug and alcohol services to supply swabs which could be used immediately with anyone who reported Covid-19 symptoms.
- Work-load had continued to be very high among the various officer cells, as had the amount of communications activity undertaken.

Issues raised in discussion included:

- Councillor Nethsingha placed on record her huge congratulations to all those who had worked so hard to bring the number of cases down and getting the local Tracing Service working so effectively which was echoed by other Members, as well as highlighting having communities behaved well which was helping to stop the spread of the virus.
- Responding to queries raised regarding the recently announced news of a vaccination programme, it was highlighted that this would be a huge undertaking and would take time to roll out. To clarify, the Vaccination programme would be led by the NHS and not Public Health, but the latter were offering their support. The essential message was that while there was still hope for the spring, it was vital to continue with safety measures such as maintaining social distancing until enough of the population had been vaccinated as the virus would be around for a long time.
- One Member highlighting that there had been a story in the national news regarding care home inspectors not being tested between visits to care homes and whether this had been recognised locally and if so, what measures were being taken. In reply, the Director stated it was recognised that if professional

staff visited several homes there was an increased risk. She had not seen the story and would be happy to receive more details but would also find out what local safeguarding measures were being taken. Action Councillor Dupre / Liz Robin

- With the national lockdown coming to an end, asking what could be done to tackle complacency, especially in terms of ensuring targeted messaging to school children and university students. The message from the Council and the Communications team was to emphasis that indoor areas not well ventilated and where it was hard to social distance were the highest risk areas. The family home needed to be viewed as a high risk area and that they should also still avoid mixing indoors in other people's homes, restaurants and pubs. Who was giving the message was important, as they did not always trust authority but also recognising that it was more difficult in multi occupation households and in some employment settings Action: The Director was happy to bring details of the Communications undertaken to the next meeting
- On the above, the point was made that it was not just children the message needed to be directed to, but also parents and the whole population. The Member raising it highlighted that there still seemed to be a widespread belief that families could observe a normal Christmas, or have children from different households mixing indoors and therefore it was important to emphasis that the virus did not differentiate just because it was Christmas. The Director agreed and stated that the safest way of meeting was by virtual family meet ups or meeting outdoors or postponing some celebrations until later into the next year.
- Highlighting that unpaid carers caring for the most vulnerable were not included in the list of the proposed first round of priority vaccinations and asking if the Committee could do anything to lobby Government to highlight this important but often neglected group to seek to add them to the list. The Director was happy to take this suggestion forward through the appropriate local routes who could then escalate the suggestion to national government. She did however highlight that while not taking away the importance of this particular group, who were often undervalued, there was still the case for vaccinating first those whose potential risk was much higher due to them being in contact with more than one person, such as health workers and care home workers. Action: Liz Robin Director of Public Health.
- With regard to the vaccination programme asking whether Public Health and councils generally through redeploying staff would be asked to participate? While Councils and voluntary organisations were ready to help there was no guidance as yet on how the offer might be taken up. The Director suggested that role could be in terms of providing communications messages but they could also assist with marshals and providing transport.
- There was a request for sharing guidance on what was available on how testing would be undertaken for those visiting relatives in Care Homes. The Director undertook to circulate this to the Committee when it became available Action: Liz Robin
- Asking for clarification on the role of local testing compared to national testing . It was explained that local testing was important, but limited part of the process. The National Test and Trace Service provided details of who had tested positive if they could not follow them up in within 24 hours, which was about 20% of the cases. Once passed to the local level, action was taken to contact the person by phone etc and to ask who they had been in contact with. The national IT system was then used to feedback the contact details to the national service who undertook all the work with the contacts.
- On a question of the staff resourcing implications of the local contact service, additional staff had been obtained from redeployed County Council and District Council staff and through additional recruitment measures.

- On University testing asking was it was still continuing and was it contributing to the figures? The Director stated that the local Univeristies had managed their positive cases very well and the number of positive cases had fallen rapidly from 234 cases at the peak to only six in the previous week.
- Referencing the spike in positive cases in Fenland there was a request for more details regarding whether it was a community or a factory spike? The main cases were concentrated in Whittlesey and Wisbech but there was not one specific reason. As while there were a greater number of higher risk workplaces such as factories and refrigerated areas in buildings, there had also been a rise in the number of cases in the older population. The cases were however now coming down. Raj Lakshman was able to confirm that part of the rise was from an outbreak in a Fenland School which accounted for 14 cases. Val Thomas indicated that seven were in workplace settings and they had also contributed in a large part to the total figures.

It was resolved unanimously:

a) to note the progress to date in responding to the impact of the Pandemic and

b) note the public health response.

## 363. Business Planning proposals for 2021-26 Current position

The Business Planning paper was included in the agenda pack with the appendix circulated to the Committee and published a day later.

The report which was received by all Service Committees asked them to consider:

- the current business planning position and estimates for 2021-2026
- The impact of COVID-19 on the 2021-2022 financial position
- The principal risks, contingencies and implications facing the Committee and the Council's resources
- The process and next steps for the Council in agreeing a business plan and budget for future years.

However as sections 1-6 of the report detailed the corporate and overall position of the County, what was more relevant to the Health Committee was section 7 providing the overview of Public Health Services' draft Revenue Programme.

It was highlighted that:

- No announcement had been made on any uplift or saving on the 2021/22 Public Health Ring-fenced Grant allocation and therefor it was assumed that the grant would be the same as in 2020/21 i.e. £27.2m an uplift of £1.7m

- The uplift had enabled the County Council core budget previously allocated to support Public Health Directorate programmes, to be replaced with grant funding and was a welcome boost. Of this, a total a total of £568,349 grant funding was required to fund the NHS pay increase over the past three years, for local NHS providers of public health programmes and £47K required for internal inflation pressures, within the Directorate.
- After allowing for the allocation of grant set out above, this left £928,000 of recurrent funding for investment in public health programmes in 2021/22. The proposed investments of the Public Health Grant in 2021/22 was listed as follows:

| Investment - description | Investment - amount £k |
|---|---|
| Child and adolescent mental health counselling this had been approved at the last meeting | 70 |
| Healthy weight and obesity programmes - already agreed as the priority area for action | 400 |
| Public health staffing – to fund the additional staff that had been required for communications and support work to other directorates taking account of what had been learned from Covid on what was required around the County to provide and sustain services along with District colleagues and which officers would want to continue going forward such as support to the Adults Positive Challenge and Best Start in Life Programmes. | 300 |
| Provider sustainability - this was to provide additional financial support which had not been possible in previous years where services had been required to make savings and particularly to help support the Drug and Alcohol Service. | 128 |
| Healthy Fenland Fund Team - the proposal was to make this a recurrent contribution | 30 |
| Total | 928 |

Issues raised in the discussion included:

- One Member expressed her delight at the additional monies that were proposed, including strengthening the Public Health Team, which was recognition of the importance of Public Health across all the Council's activities, and also the increased money monies to help the sustainability for providers
- Corporate section on Benchmarking - One Member commented on the opening wording in paragraph 2.2.2, reading "Whist delivering excellent outcomes for its residents, Cambridgeshire ……" suggesting that the statement did not tally with the table later, in the same paragraph, showing benchmark performance of the County Council compared to other shire counties or its statistical neighbours.
- Querying on the Healthy Weight and Obesity programme and referencing the £80k agreed at the last meeting to undertake the proposed initiative, asking whether the £80k was included in the £400k. In reply, it was explained that the £400k was for a recurrent investment programme. The £80K agreed at the November meeting was separate and was to appoint a senior person who had experience of the systems to look at barriers and enablers to help shape the £400k programme

In moving to the recommendations, the Leader of the Liberal Democrat Group Councillor Nethsingha indicated that her Group would wish to abstain as they would have their own budget proposals. The Chairman understood the position of her Group, but highlighted that the current report was only asking them to endorse the budget proposal of the Health Committee that had been discussed and agreed at earlier meetings rather than being asked to support the whole Council budget and savings proposals of which this Committee had none. He proposed which was seconded by the Vice Chairman that there should be an additional recommendation to read "We endorse the budget of the Health Committee as part of the consideration of the Council's overall business plan" to make clear that the Committee was only endorsing the Health Committee's budget proposals. On this basis,

It was resolved unanimously:

a) Note the progress made to date and next steps required to develop the business plan for 2021-2026

b) Note the impact of COVID-19 on the Council's financial planning

c) Endorse the budget proposals of the Health Committee as part of the consideration of the Council's overall Business Plan.

## 355. Forward Agenda Plan

It was resolved:

To note the agenda plan and agree that in order to keep the agenda to a manageable size that the following update reports currently listed for inclusion for the February meeting would be emailed to the Committee rather than included on the formal agenda:

- Trend analysis of the impact of the first Covid19 wave on childhood vaccinations

- Further report on the actions being taken to support young people and families during Covid-19

- Finance Monitoring Report

To include as an item on the February formal committee agenda an update on the agreed funded key projects to include details of timescales going forward.

Chairman

February 2021

# Health Committee

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising or outstanding from the previous Minute action log from the Health Committee from the meetings held on 9th July and 19th November and updates Members on progress in delivering the necessary actions.

| Item | Action to be taken by | Action | Comments | Status & Estimated Completion Date |
|---|---|---|---|---|
| Meeting of 9th July 2020 | | | | |
| 1) Minute 316 Agenda Plan - Updates on Re-opening Minor Injuries Unit (MIU) at Doddington | Kate Parker / Jan Thomas | The Chairman indicated that as this was an area of particular interest to the Committee it would be looking for updates to future meetings. | Discussion with CCG is ongoing as to the appropriate timing to bring updates back to Health Committee.<br><br>The current position is that the Doddington MIU will continue to remain closed with a phased re-opening with a further update to be provided once the date of re-opening has been confirmed. | Ongoing |
| Meeting of 19th November 2020 | | | | |
| 2. Minute 351 Aligning the Age for Counselling Services to Children and Young People across | Kate Parker | There was a request from a member that there should be a monitoring report back to Committee in due course on whether the revised arrangements / new contract was meeting demand for the services. | This will be added as a discussion item on the agenda for the next Chairman, Vice Chairman and Lead member scheduled to be held on 21st December. | Ongoing |

| | | | | |
|---|---|---|---|---|
| Cambridgeshire and Peterborough | | | | |
| 3. Minute 352 Addenbrooke's Cambridge Children's Hospital Project and Engagement Update | Kate Parker | The Committee agreed to receive further updates with the Chairman, Vice Chairman and Lead Members to discuss a timetable for follow up reports at their next meeting. Item to be added to said agenda. | This will be added as a discussion item on the agenda for the next Chairman, Vice Chairman and Lead member scheduled to be held on 21st December. | Ongoing |
| 4. Minute 353 - Public Health response to Covid-19 | Liz Robin<br>Kate Parker | In a question raised on what the Council was doing to maintain Staff morale and further to the request from the same member requesting a report back to the Committee or whichever was the relevant Committee, this request would be added as a discussion item at the next Chairman, Vice Chairman and Lead Members meeting | This will be added as a discussion item on the agenda for the next Chairman, Vice Chairman and Lead member scheduled to be held on 21st December. | Ongoing |
| Meeting of 3rd December 2020 | | | | |
| 5. Minute 362 - Public Response to Covid-19 | | | | |
| a) National News Story - Care Home inspectors | Cllr Dupre / Liz Robin | There had been a national news regarding care home inspectors not being tested between visits to care homes and questions were asked whether this had been recognised locally and if so, what measures were being taken. In reply the Director stated it was recognised that if professional staff visited several homes there was an increased risk. | Councillor Dupre passed on the article after the meeting on 3rd December. | |

| | | | | |
|---|---|---|---|---|
| | | She had not seen the story and would be happy to receive more details but would also find out what local safeguarding measures were being taken. | | |
| b) Communications to tackle complacency regarding social distancing etc. | Liz Robin | The Director of Public Health would provide details of the Communications that were being undertaken to the next meeting. | | |
| c) Unpaid Carers being treated as a high priority group for the early vaccination Programme | Liz Robin | Members highlighting that unpaid carers caring for the most vulnerable were not included in the list of the proposed first round of priority vaccinations and asking if the Committee could do anything to lobby Government to highlight this important but often neglected group to seek to add them to the list. The Director was happy to take this suggestion forward through the appropriate local routes who could then escalate the suggestion to national government. | | |
| d) Sharing Guidance on how testing would be undertaken for those visiting relatives in Care Homes | Liz Robin | The Director undertook to circulate this to the Committee when it became available. | | |

# Healthy Child Programme: Service delivery during the Covid-19 Pandemic

| | |
|---|---|
| To: | Health Committee |
| Meeting Date: | 11th February 2021 |
| From: | Dr Raj Lakshman |
| Electoral division(s): | All |
| Forward Plan ref: | Not applicable |
| Key decision: | No |
| Outcome: | This report provides an update on:<br>a) The impact of Covid-19 on the Healthy Child Programme during 2020 including impact on families and changing demand into the service;<br>b) actions taken to respond to these challenges and changes to the delivery model; and<br>c) service performance during this time and feedback from families. |
| Recommendation: | The Committee is asked to note and comment on the actions being taken to support children young people and families during covid-19 |

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# 1. Purpose of Report

1.1 The purpose of this report is to provide an overview of the 0-19 Healthy Child Programme (HCP) during the Covid pandemic to date. This report seeks to provide a richer understanding of changes to activity, demand and operational delivery of the programme within the context of working throughout the pandemic.

This report has been co-written with service leads from the HCP provider who have also provided us with comments from local families that are included throughout this report.

1.2 Instead of just looking at sections of the HCP delivery as stand alone items (such as the Mandated Health Visitor contacts that we regularly report on), this report includes a wider look at HCP activity during this time to highlight the shifting demands and service response. Key areas to note include:

- The expansion of the 'Call Us' telephone number to improve access to a wider set of support services (section 4.1)
- The growth in families accessing support via the expanded text and online offer (sections 4.2 and 4.3)
- Maintenance throughout the period of an offer of all 5 mandated Health Visitor contacts (section 5)
- The continuity of face to face support for families where clinical triage advises this approach and the introduction of video conferencing (section 5.6)
- The significant increase in the number of families accessing support on the targeted Universal plus and universal partnership plus pathways in comparison to the previous year (section 6)
- Development of new ways to support families who have had babies during the period (section 6.2)

# 2. Background

2.1 <u>Commissioning Arrangements:</u>

A single section 75 Agreement has been in effect as of 1st October 2019 between Cambridgeshire County Council (CCC), Cambridgeshire Community Services (CCS) and Cambridgeshire and Peterborough Foundation Trust (CPFT) for delivery of an integrated 0-19 service covering Cambridgeshire and Peterborough. A separate Delegation and Partnership agreement is in place delegating commissioning functions of the HCP by Peterborough City Council to Cambridgeshire County Council to enable this collaboration to work effectively. The existing arrangements are in place until 31st March 2024.

Integration of the HCP is the first stage of the wider integration process for Children's Health and Wellbeing services in Cambridgeshire and Peterborough as part of a vision to offer a wholly integrated service based on a skill mix model across all 0-19/25 practitioners that will meet the needs of our diverse populations and will be underpinned by a range of strategies, including:

- Best Start in Life (prebirth-5 years)
- Best Start in Life Plus/Early Help and Vulnerable Adolescents (5-25 years)

- CYP Mental Health and Emotional Wellbeing (0-25 years)
- Health & Wellbeing Strategy
- Think Communities

This new contract came with a requirement to undertake a range of service and organisational changes to allow for an equitable and integrated programme of delivery between the two NHS Trusts. Achievements to date include:

- Geographical restructure into a 3-locality model; North Cambridgeshire Locality, South Cambridgeshire Locality and Peterborough Locality
- Staffing restructure of Senior Leadership team to hold joint contracts across both trusts
- Implementation of Chat Health across the geography. This text-based service aimed at 11–17-year-olds already existed in Cambridgeshire and was rolled out across Peterborough in September 2019
- Introduction of a new County-wide 'Text Us' service for parents – implemented in September 2019
- Introduction of a single point of access (SPA) 0300 number – implemented in September 2019
- Roll out of a county-wide Enhanced Young Parents Pathway to provide targeted support for young parents not eligible for the Family Nurse Partnership (FNP) programme
- Establishment of a county-wide Orthoptist-led Vision Screening programme

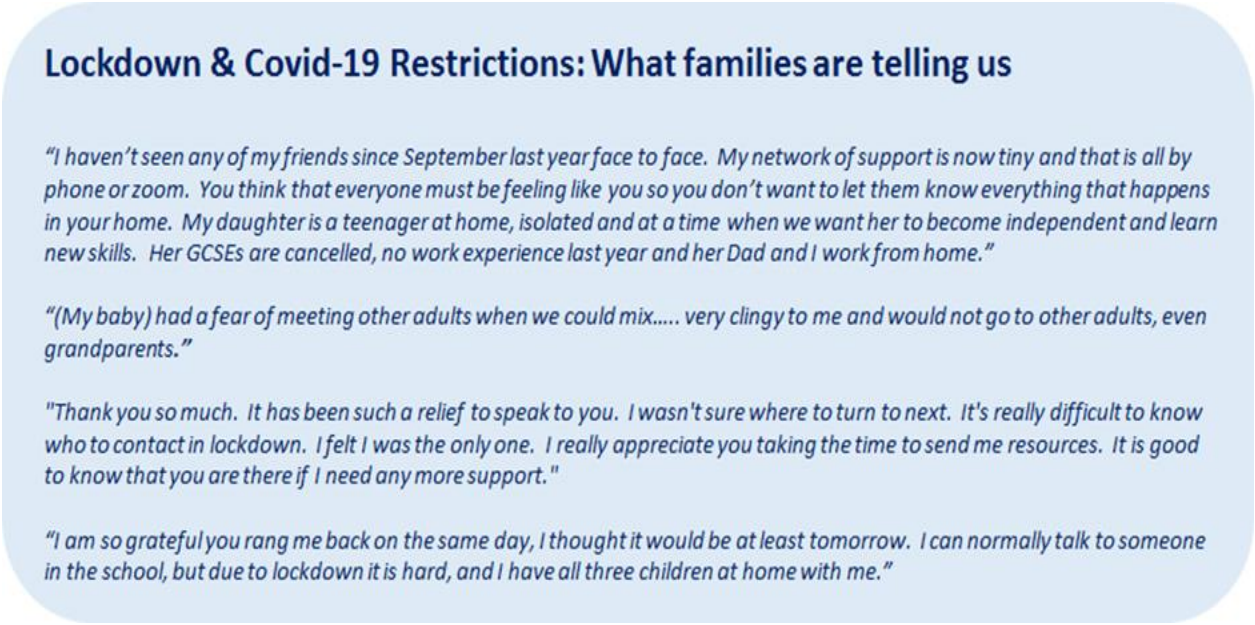
2.2 Best Start in Life strategy Implementation:

The development work of the Best Start in Life programme was paused in March as priorities across the system shifted to tackle the pandemic. The steering group reformed in August and has been focusing on moving forward with the place-based pilots in Cambridge City, Wisbech and Peterborough, with an added focus on how integrated working can help us deal with the impact of Covid-19 on families and plan for the restoration of face-to-face service provision.

The relationships built across system partners by the Best Start in Life programme have proved vital during this period and with a group of operational leads set up to meet weekly during this time to address Covid-19 related issues.

2.3 Covid-19:

This report seeks to outline how the HCP has responded to the effects of Covid-19 on both the lived experiences of families and the way in which the service has been impacted. The HCP has needed to adapt its delivery to ensure that families remain supported during the Covid-19 period, whilst keeping staff and families safe. This report will also explore the challenges and learning opportunities this unprecedented period has provided, in order to reflect on how this can feed into longer term service development.




# 3. Local Response to National Guidance

## 3.1 Initial Prioritisation Measures (phase 1): March-June 2020

On the 19th March 2020 NHS England & NHS Improvement wrote to all providers to outline COVID-19 Prioritisation within Community Health Services. Specific advice was also given for community child and family services. This set out guidance regarding the prioritising of services, including listing those services classed as 'essential' which needed to be protected as a priority. The essential elements for the Healthy Child Programme were identified as:

- The Antenatal and New Birth Visits
- Maintaining a single point of access
- Safeguarding work
- Family Nurse Partnership

At the beginning of the pandemic the Healthy Child programme rapidly responded to the national guidance and amended its service delivery. Essential service delivery was maintained with families able to contact the service either by telephone or text messaging throughout.

In terms of the clinical support available to families, the service has been able to maintain a more extensive offer of support than that recommended in the national guidance documents, with all the 5 mandated contacts being maintained. In Cambridgeshire and Peterborough no staff from the service were required to be re-deployed to other areas of the NHS.

During the antenatal and initial post-natal period Health visitors were supported to use their clinical judgment as to whether the contact was required to be 'in person' or delivered as a virtual contact. The decision making was based around levels of known vulnerabilities with each individual family. During these early weeks the use of video conferencing to assess and support families was implemented in order to provide staff and service users with the tools to offer a blended approach. Essential Health visitor appointment clinics were

established in order to have a place to see infants for physical assessment and review if indicated. The use of Personal Protective Equipment (PPE) was also implemented in line with guidance from the Department of Health. Since no HCP practitioners were requested to be redeployed, the service was also able to continue with the 1- and 2-year development reviews undertaken by the Community Nursery Nurses utilising the flexibility of contact methods.

Within the Enhanced Young Parents Pathway, a similar approach was implemented. However due to the higher levels of vulnerabilities for those teenage parents being supported under the Family Nurse partnership Programme a higher proportion of the contacts were delivered 'in person'. This was due to several of the teenagers finding engagement over the video platform difficult due to self-esteem issues, challenges of data usage and often more difficult social circumstances.

In the 5-19 pathway the School nurses were also supported to consider and use their clinical judgement on the most appropriate mode of engaging with young people to address their emotional and physical health needs. During this first national lock down many young people were not in education so in order to reach out to young people the service undertook a social media campaign to advertise Chathealth. During this time text messages received into the service from young people increased 3-fold (see section 4.1.3 for further information). At this time staff from the Healthy Child Programme and the Emotional health & wellbeing teams worked collaboratively to deliver Chathealth. This was in order to share expertise from the clinicians across both teams and build resilience within the service offer as the progress of the pandemic was unknown at that time.

The vision screening offer for year reception children was required to be paused at this point until an alternative delivery model could be considered and articulated. The service worked closely with the lead orthoptists and clinical experts to devise a parent led assessment and the offer of a follow up community clinic appointment to undertake the vision screening if indicated.

As the service became more aware of the increased level of vulnerability for the families across Cambridgeshire & Peterborough and the urgent requirements of amending service delivery due to the pandemic, one approach taken was to strengthen existing partnership relationships with a view to enable timely sharing of information and to update professionals regarding amended service delivery offers across the system. Monthly meetings were established with acute midwifery partners from all three providers; weekly meetings were established across health & children's social care and a similar forum set up with Child & Family centres and Early Help services. These forums have been incredibly useful in keeping up to date with partners in terms of approach and how best to work together to meet the changing demand and have also facilitated further strengthening of relationships across key partner agencies.

3.2 Recovery & Restoration (Phase 2): June - September 2020

During this time the HCP continued with its blended approach to offering health support to children, young people and their families. As the pandemic progressed the service began to experience higher levels of parental anxiety. Telephone calls and text messages into the service began to rise and requests for support to new parents increased. There were increased requests to support with infant feeding issues; more requests for health

assessment in young people; and support for families experiencing domestic abuse appeared to be on the increase.

Nationally data began to emerge that due to parental pressures there was an increase in non-accidental injuries in babies. Whilst we had not seen this increase in Cambridgeshire and Peterborough the service did conduct an audit of records of all babies born during lockdown to ensure that an assessment had been undertaken of all infants. From the cohort of infants born during the period 16 March 2020 to 31 October2020, only 9 babies out of a cohort of 5978 had not received a holistic Health Visitor assessment where the infant had been seen. The service has now contacted these families and assessed their health needs.

From September families were also able to access some in person groups support from Children's Centres that reopened for pre-booked groups and activities with a focus to support parents of babies born during the pandemic. In addition, self-weighing stations were re-opened at these sites.

3.3 Recovery & Restoration (Phase 3): October 2020 – Present

In November 2020 plans were developed to re-introduce more 'in person' assessments and interventions. However, since the new, more transmissible variant of the Covid-19 virus has become more prevalent and the third National Lockdown was announced on 4th January 2021, a decision has been made to pause and continue to deliver the blended approach using virtual technology. Due to the on-going concerns around parental stress and impact on infants the service engaged in a partnership approach to share a key public health message to families branded as ICON, delivering the message that all babies cry, and its ok to put baby in a safe place and walk away to avoid the heightened risk of harm to the infant - further information can be found in section 6.2: Support for New Parents.

Also in November, a letter was issued by the Chief Nurse Office calling for the Healthy Child Programme to be protected in the event of any NHS redeployment to support the Covid-19 response. This position is supported locally and by Public Health England.

As the country moves into a third national lockdown, the service once again has had to review how it operates – further information can be found in section 9: Learning so far and future planning.

# 4.0 Universal & Community Offer

4.1 The HCP must be able to provide health advice, information and signposting to services and support. This needs to be easily accessible to parents, young people and other professionals alike. This is done via the Single point of access (made up of the Call Us, Text Us and Chat Health services), alongside the digital offer including the website and social media messaging.

It is important to understand the changing demand on this part of the offer within the broader context of what was happening in communities during this time. The increase in

contacts has direct correlation to the period in which there were significant adverse changes to the wider community support usually available to new parents. Children's centre and community groups had to close their group activities, usual peer support with other new parents was only available online, and support from extended family and other support networks significantly curtailed. Staff have reported that access to the universal community element of the HCP has in part acted as a gateway for parents to express their concerns and anxieties which may have previously been allayed through other support networks.

In early April 2021, as a result of the pandemic, a decision was made to expand access via the 'Call Us' number to include the Emotional Health and Wellbeing service, Children's Paediatric services and Children's Specialist therapy services in order to increase resilience within all these teams through sharing resources.

## 4.2 **Single point of access**

### 4.2.1 'Call Us' telephone number

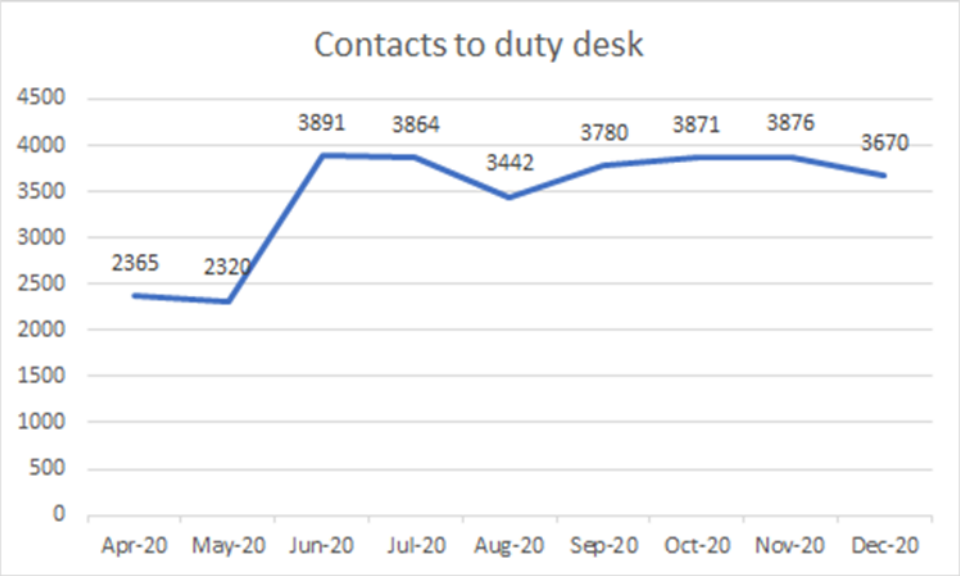



*Figure 1: Contacts to Duty Desk, Apr-Dec 2020*

The volume of calls to the SPA increased significantly from June 2020, in line with the measures outlined above to expand the breadth of services covered by the duty line and has remained steady ever since. When compared against the 2019 position, as outlined in figure X below, there was an initial dip in April and May 2020, when the initial lockdown measures were introduced, however as communities began understanding living with the restrictions the pandemic has caused, contacts to the HCP have increased significantly compared to 2019 and have remained relatively steady from June onwards.

*"I rang the number, got through straight away with no wait and got an appointment."* - **parent**

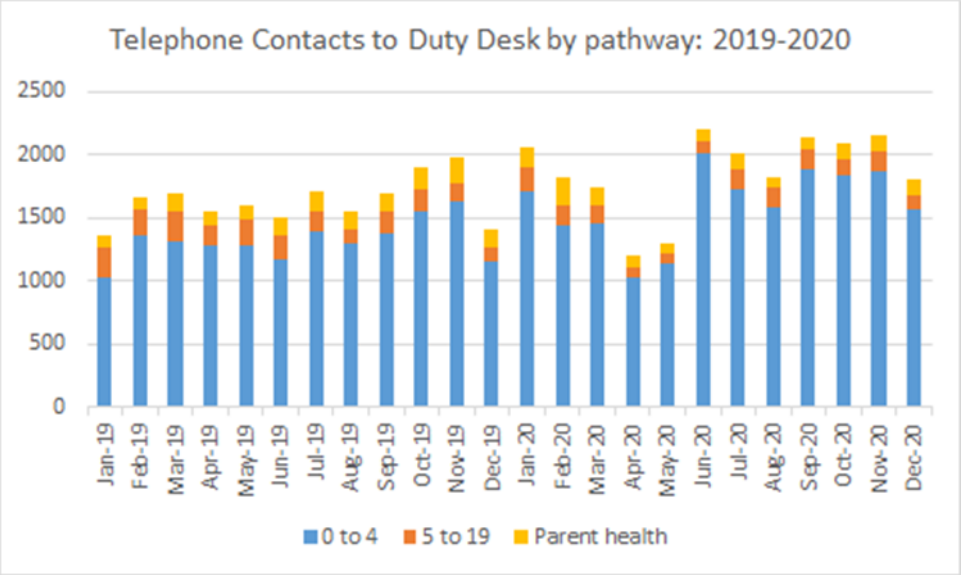



*Figure 1: Contacts to Duty Desk 2019-2020 by pathway*

### 4.2.2 'Text Us' service

The texting offer of the 0-5 Healthy Child Programme has witnessed a significant increase in demand over the Covid-19 period, as shown in table 1 below. This indicates that parents and carers are accessing the service in a more responsive way (rather than waiting for a mandated contact appointment) to address the unmet health needs of their child and that this is a contact method which is proving increasingly popular with families.

**Cambridgeshire and Peterborough Parent Line**

| Month/Year | Messages Received | Messages Sent | Conversations Opened | Conversations Closed |
|---|---|---|---|---|
| Jun-2019 | 1 | 2 | 1 | 1 |
| Aug-2019 | 1 | 2 | 1 | 1 |
| Sep-2019 | 6 | 10 | 3 | 3 |
| Oct-2019 | 185 | 277 | 43 | 43 |
| Nov-2019 | 242 | 378 | 73 | 73 |
| Dec-2019 | 233 | 373 | 88 | 88 |
| Jan-2020 | 436 | 625 | 123 | 121 |
| Feb-2020 | 581 | 811 | 155 | 153 |
| Mar-2020 | 854 | 1266 | 261 | 261 |
| Apr-2020 | 847 | 1256 | 238 | 239 |
| May-2020 | 818 | 1187 | 220 | 219 |
| Jun-2020 | 816 | 1151 | 221 | 223 |
| Jul-2020 | 1331 | 1930 | 415 | 415 |
| Aug-2020 | 1261 | 1843 | 408 | 397 |
| Sep-2020 | 1275 | 1783 | 344 | 355 |
| Oct-2020 | 886 | 1227 | 258 | 234 |
| Nov-2020 | 1140 | 1563 | 272 | 296 |
| Dec-2020 | 927 | 1273 | 234 | 192 |
| **Totals** | **11840** | **16957** | **3358** | **3314** |

*Figure 3- Text Us contact usage*

The Text Us service is managed by a qualified Health Visitor on a rota basis, enabling messages to be risk assessed and triaged appropriately, escalating up or down as required. The line is manned Monday to Friday 8:00-17:00 and has operated as usual throughout the

pandemic. The main issues being inquired about are infant feeding followed by child development.

### 4.2.3 Chat Health Usage

The Chat Health service is managed by a qualified School Nurse on a rota basis, enabling messages to be risk assessed and triaged appropriately – escalating up or down as required. The line is manned Monday to Friday 8:00-17:00 and has operated as usual throughout the pandemic including during school closures and holidays.

Early in the pandemic in order to build further resilience and to think about working together across wider community health teams, the service developed its relationship further with the Emotional health & Wellbeing team particularly knowing that schools at the time were closed so both services worked together to co-deliver the Chathealth offer to young people. This was very well received by staff from both services as it enabled the sharing of clinical expertise and joined up working practices to support young people.

| Cambridgeshire and Peterborough School Nursing Team | | |
|---|---|---|
| Month/Year | Messages Received | Messages Sent |
| Jan-2019 | 445 | 487 |
| Feb-2019 | 646 | 809 |
| Mar-2019 | 457 | 573 |
| Apr-2019 | 411 | 471 |
| May-2019 | 349 | 468 |
| Jun-2019 | 465 | 541 |
| Jul-2019 | 493 | 459 |
| Aug-2019 | 80 | 115 |
| Sep-2019 | 320 | 352 |
| Oct-2019 | 341 | 443 |
| Nov-2019 | 581 | 640 |
| Dec-2019 | 683 | 712 |
| Jan-2020 | 610 | 740 |
| Feb-2020 | 597 | 747 |
| Mar-2020 | 596 | 659 |
| Apr-2020 | 371 | 451 |
| May-2020 | 1007 | 1070 |
| Jun-2020 | 337 | 400 |
| Jul-2020 | 88 | 138 |
| Aug-2020 | 479 | 598 |
| Sep-2020 | 444 | 450 |
| Oct-2020 | 338 | 399 |
| Nov-2020 | 498 | 637 |
| Dec-2020 | 417 | 463 |
| **Totals** | **11053** | **12822** |

*Figure 4- Chat Health usage*

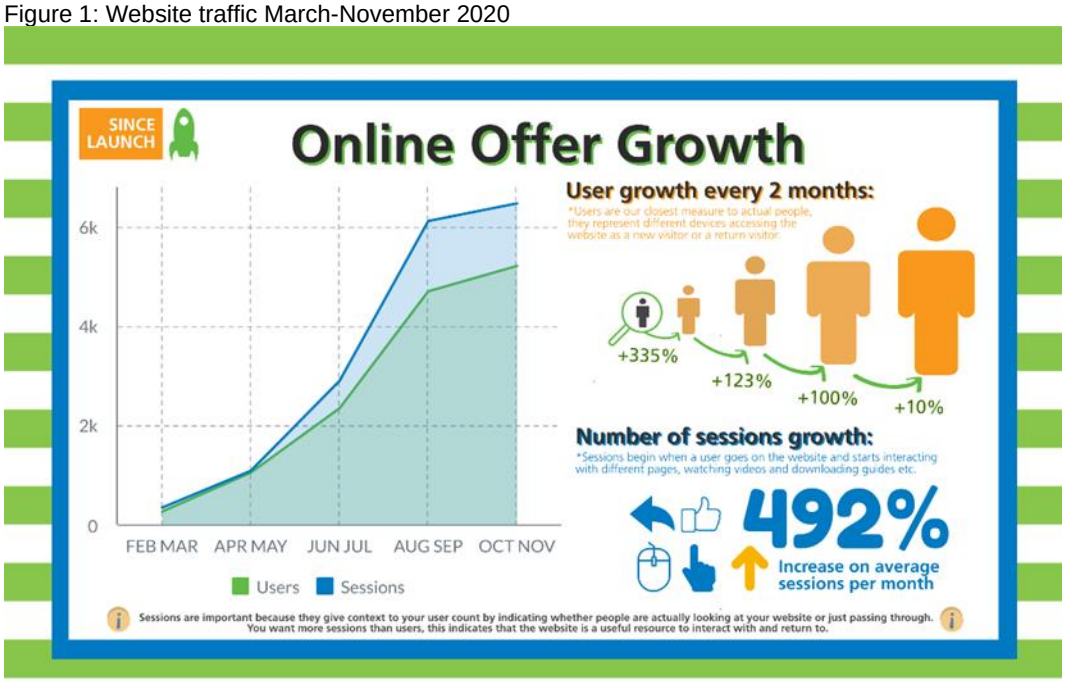
The table above highlights that engagement by young people has fluctuated during this period. Recognising the need to improve engagement and address unmet need, throughout May there was an extensive social media campaign delivered to promote the service amidst growing local and national concern over the adverse impact the pandemic, lockdown measures, school closures, and disruption to exams would have on young people. The impact of this campaign is evident in the significant increase in service access during this month, with the number of texts from young people almost tripling during this month. As much of the previous promotion of the Chat Health service came via schools directly, it was imperative that the HCP needed to think creatively in how to reach this cohort of young people and remains an ongoing piece of work.

4.3 Digital development and self-help

There were plans already in place within the service redesign programme to develop the digital platform of the HCP to improve self-help capabilities and provide easy access to information for families. The impact of Covid-19 on community services accelerated the need to focus on this as an area of priority.

The service has developed its digital offer extensively and the website www.bit.ly/nhscambspboro-hcp includes advice and guidance on areas such as: infant feeding support; childhood development; childhood illness; and safeguarding. Furthermore, a Covid-Specific Webpage for families with children who have complex care needs has been developed. This covers concerns such as feeding, bones and joints, emotional support and behaviour, equipment and epilepsy and information for clinically extremely vulnerable (shielding) children and Covid-19. Since April 2020 when the website pages were developed there have been in excess of 10,000 users. The data in the infographic below (Figure X) demonstrates that families appear to have been extremely receptive of this new offer, with traffic to the site increasing exponentially since the launch in March, both in terms of individual users and the length of sessions/interaction within the website.

Figure 1: Website traffic March-November 2020




The pandemic has also significantly altered the ways in which services communicate with families and the need to have an active presence on social media channels has never been more pressing. This period has bolstered organisations across the system to come together to share one another's social media content to maximise reach, ensure consistent messages are shared to families and continue to promote support available to families during this time. In addition to a formal online digital help offer, throughout the pandemic the HCP has continued to promote services and information for families via Facebook and Instagram social media channels.

## 5.0 Mandated Health Visitor Contacts

The HCP 0-5 service, led by health visitors and their teams, offers every child a schedule of mandated health and development reviews, screening tests, immunisations promotion, health promotion guidance and support for parents tailored to their needs, with additional support when needed and at key times.

The 0-5 HCP service recognises six high impact areas:

- **transition to parenthood** and the early weeks
- maternal (perinatal) **mental health**
- **breastfeeding** (initiation and duration)
- **healthy weight** (including healthy nutrition and physical activity)
- managing minor illness and **reducing hospital attendance** and admission
- health, wellbeing and development of children aged 2 and **school readiness**

As outlined in section 3.0, locally the HCP were able to maintain an offer for all the mandated contacts throughout the period, which is commendable, especially as regionally across the East of England this was not possible for some areas. The competing pressures created by the pandemic meant that performance and ability to meet KPI targets was not always achievable.

Due to Covid-19, some of these contacts were held virtually, either by telephone or video conferencing. The workforce is encouraged to undertake risk assessments and their professional judgement to determine the most appropriate method to deliver the contact. Staff are following infection control recommendations in line with the NHS Trusts infection control protocols and using the appropriate personal protective equipment for all in person contacts.

## 5.1 Antenatal Contact

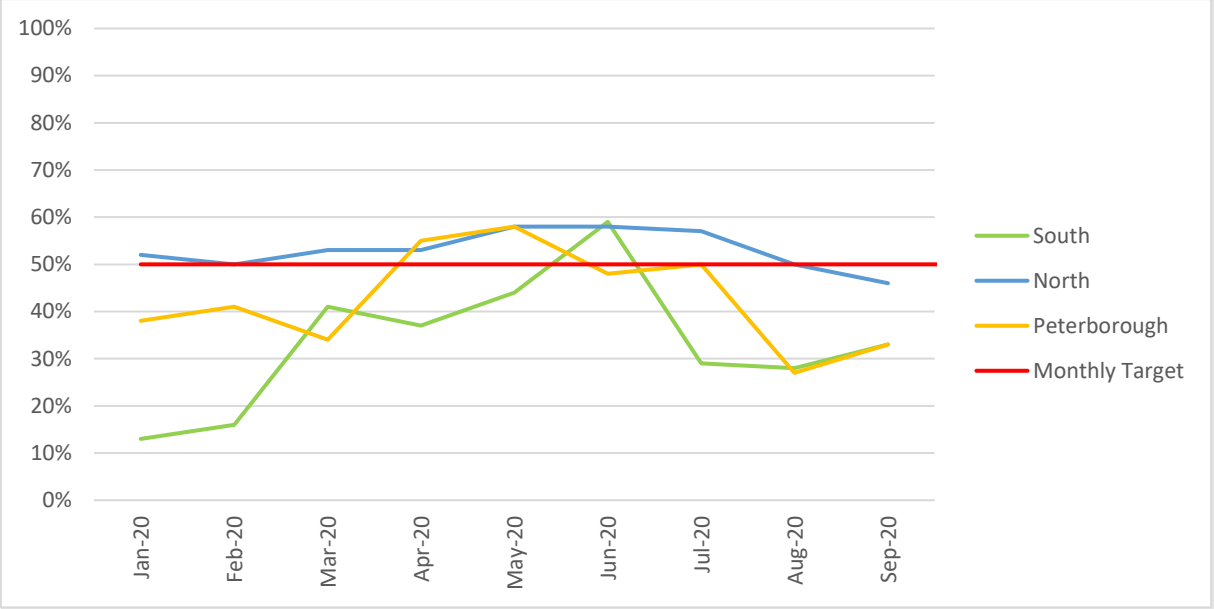



*Figure 2: % families receiving an Antenatal Contact, Jan-Sept 2020*

There is no national target set for this contact, although it continues to be a mandated visit. Across the county a local target has been agreed at 50% with a longer-term goal of achieving 90% of all antenatal contacts. Initially this was set to be achieved by the end of 2020, however Covid-19 has significantly impacted ability to work towards this.

Performance against this target increased substantially in the early part of the pandemic following a drive from team managers and whilst this is a considerable achievement, the improvement was seen during a period where this contact was preserved as an essential service within national Covid-19 guidance for Community Services. Performance subsequently decreased following this success and is more in line with previous averages. Staffing capacities and increased demand in other areas of the service have been cited as reasons for this decline.

Due to Covid-19, a number of these contacts were delivered virtually, either by telephone or video conferencing. First time pregnancies and vulnerable women continue to be prioritised by the service to receive a face to face in person antenatal contact and as the service moved into phase three of their service restoration plan, all families have started to receive a face-to-face contact in person for at least one of the 3 first mandated contacts, including the antenatal contact.

Feedback from staff has highlighted that a general increase in parental anxiety due to the restrictions imposed by the pandemic caused this contact to take far longer than it did previously as families were expressing more concerns and having more questions. This was adding to capacity pressures, so a creative solution has been implemented to address the issue. From January 2021, all families are being signposted to this video to watch in advance of the antenatal contact, which outlines key information, expectations and

introduces the HCP. This is then followed up by a 30-minute contact which is used to focus on the areas of concern and questions held by the individual family.

**Antenatal Contact: What families are telling us…**

*"Very clear. All information was relayed to me. Made me feel less anxious. Really liked the idea of meeting health visitor before baby arrives"*

*"Daisy was absolutely lovely, really helpful and answered all of my questions. She was very supportive of my decisions and made me feel comfortable whilst giving me information about what would happen after baby is born." "Clear, good connection, useful advice and video of feeding."*

## 5.2 New Birth Visit

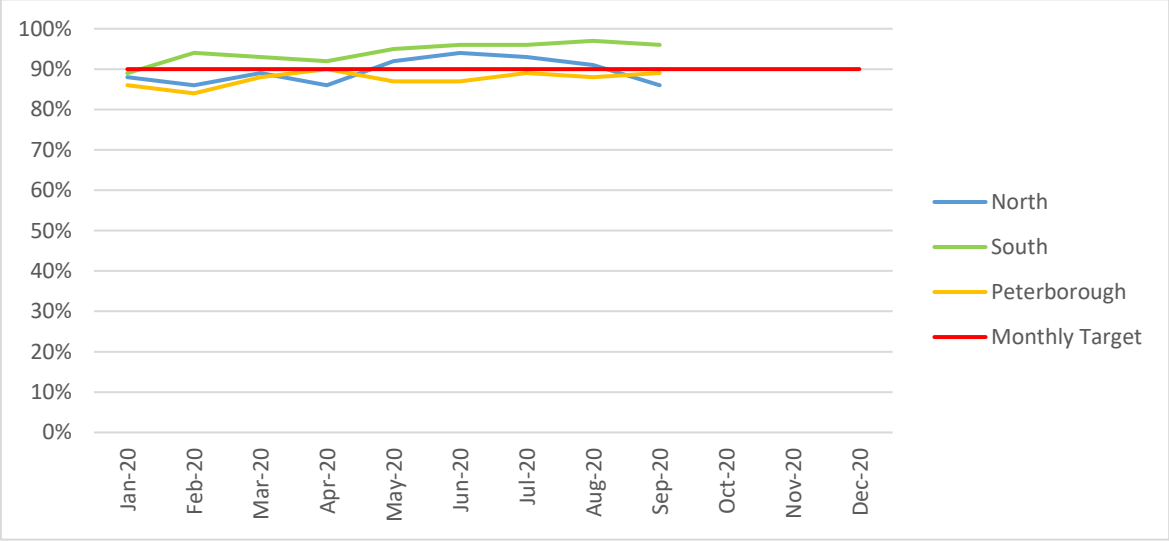



*Figure 3: % infants receiving a New Birth Visit within 14 days of birth, Jan-Sept 2020*

The proportion of New Birth Visits completed within 14 days of birth has stayed within target throughout the pandemic. Processes have been established to ensure that all babies receive a physical examination as part of this contact. If those completed after 14 days are included, this average increases to 96% indicating most families are receiving this contact.

The service reports that, to achieve continuity of care between the antenatal assessment and the new birth review, the new birth review has sometimes needed to take place outside of the 14-day target to a stretched target of 21 days. The thinking behind this revised time frame is to enable the service user to experience the best possible opportunity from the wider care system acknowledging that the midwife care continues until day 10 and therefore by stretching the Health visitor contact by a further 7 days this enables the most use of the universal touchpoints a new family has access to.

In the early stages of the pandemic, there were concerns over an uptick of infant admissions back to maternity wards for issues that would have usually been picked up by a Health Visitor. This prompted the establishment of essential weighing clinics which have

had their capacity extended to also offer some of the new birth physical checks that have been re-introduced. There have been no recent reports from the acute trusts of above average re-admissions.

## 5.3 6-8 Week Contact

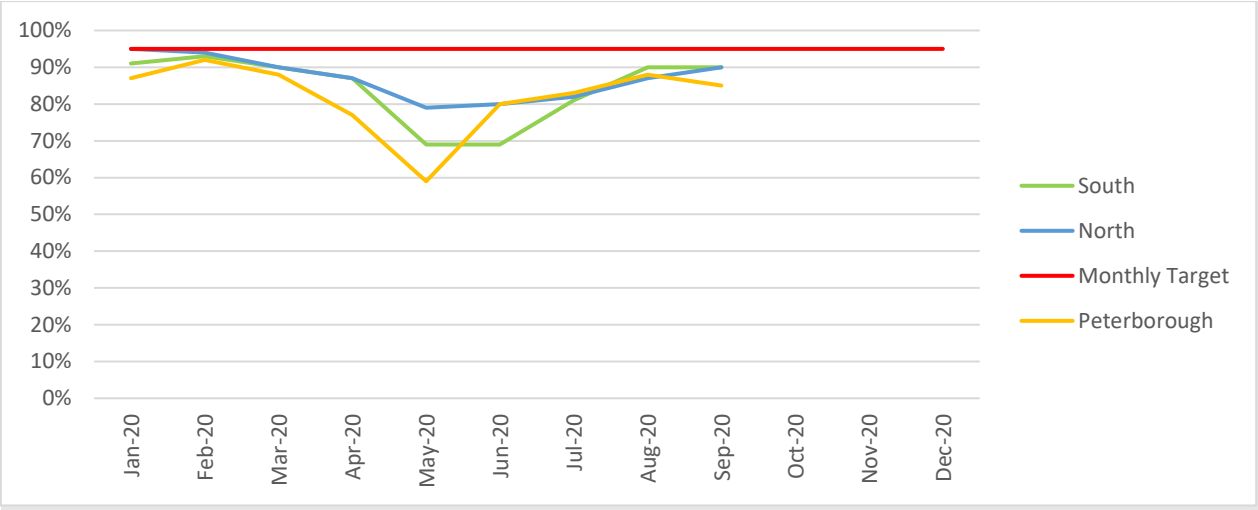



*Figure 4: % of families receiving a 6-8 week contact within 8 weeks of birth, Jan-Sept 2020*

Performance has shown improvement following a significant dip between March and May 2020, where activity dropped substantially due the early Covid-19 response, when national guidance did not prioritise this contact as an essential service.

As with the New Birth visit, it has been agreed between the commissioners and the provider to adjust the timeframe for completing this contact from 8 weeks to 12 weeks.

This has been agreed to ensure that families are receiving support at the most appropriate time and that we are spreading out the touch points families have with professionals during this period of limited social contact. Considering that infants also receive a GP review at 6-8 weeks, extending this contact to 12 weeks allows Health Visitors to schedule this contact with a family at the most appropriate time.

*"Melinda put my mind at ease with the few questions I had, and was very thorough with questions etc. Conversation flowed, so didn't feel awkward like some calls can be. It was so nice to hear that as parents we're doing an alright job - I know it's not something anyone will give you an award for but as first time parents it's nice to know that you're on the right track!"*
**- parent**

5.4 12 Month Review

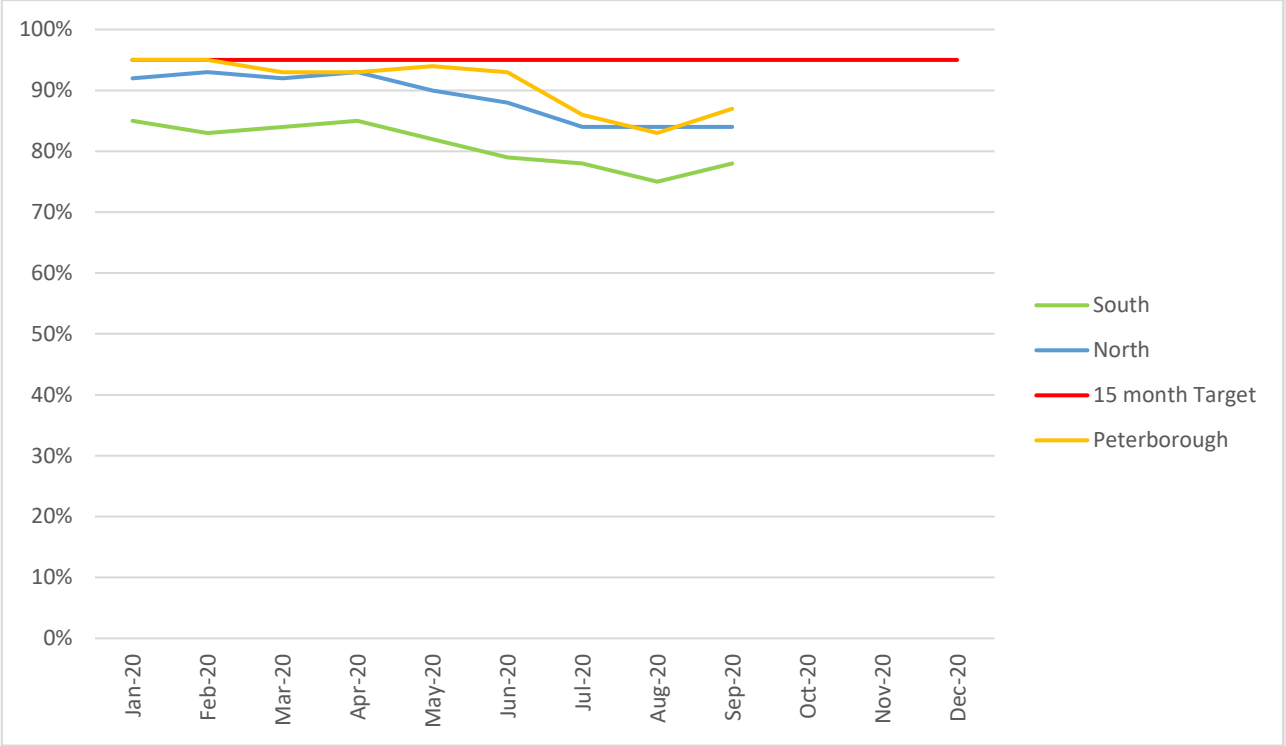



*Figure 5: % of infants receiving a 12 month development review by 15 months, Jan-Sept 2020*

Performance had decreased over the summer but is starting to show signs of improvement. If exception reporting was included, which included those where an appointment was offered but declined or not attended by the family, this would increase the average performance to 98% of families having this review by the time the child turns 15 months. There was an increase in numbers of families opting out of this contact during the summer compared to previous quarters, which is likely to be due to Covid-19 coupled with the Summer Holiday period. Assurances are in place to make sure vulnerable families (those on Universal Plus or Universal Partnership Plus pathways) are receiving this contact and an escalation plan is put in place if these mandatory visits are missed.

## 5.5 2-2.5 Year Review

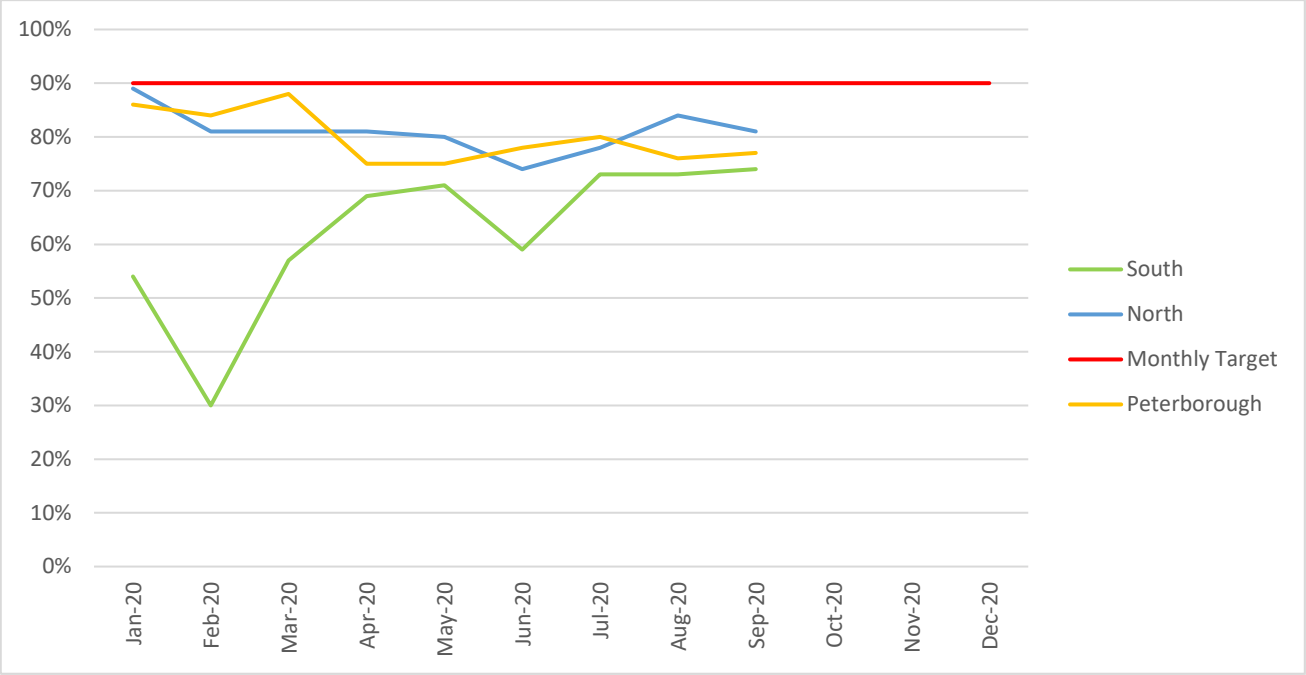



*Figure 6: % infants receiving a 2-2.5 development review, Jan-Sept 2020*

Performance has for the most part remained stable throughout the period. If exception reporting is accounted for, performance would increase to 97%. This means that most families were offered a contact, however on occasions these were not wanted or not attended by the family.

*"We went through all the ASQ paperwork thoroughly and I was given time to consider if there was anything further I wanted to discuss. I was offered, and accepted, a referral to the audiology department. We also covered additional safety and mental health issues, and I was given some very useful recommendations. Five star service!"*
**- parent**

## 5.6 Contact Methods

As outlined in 3.0, the pandemic has meant that community services had to rapidly review service delivery in a context where face to face visits were required to be kept to a minimum. Both NHS trusts worked swiftly to establish 'Attend Anywhere' as a video conferencing platform to enable face-to-face contacts virtually and this started to be rolled out from May 2020.

Throughout the pandemic clinicians have been encouraged to use their professional judgement to aid clinical decision making on the most safe and appropriate way to complete contacts and interventions with families.

Figure 9 below, highlights that overall activity has increased significantly during this period, by and large through the volume of contacts made by telephone. It is important to note that these figures do not include the broader enquiries made via 0300 duty desk number outlined in 4.1.1. This signifies that increasingly families are requiring more follow up calls outside of the core mandated contacts, which creates added pressures of staff capacity and workload.

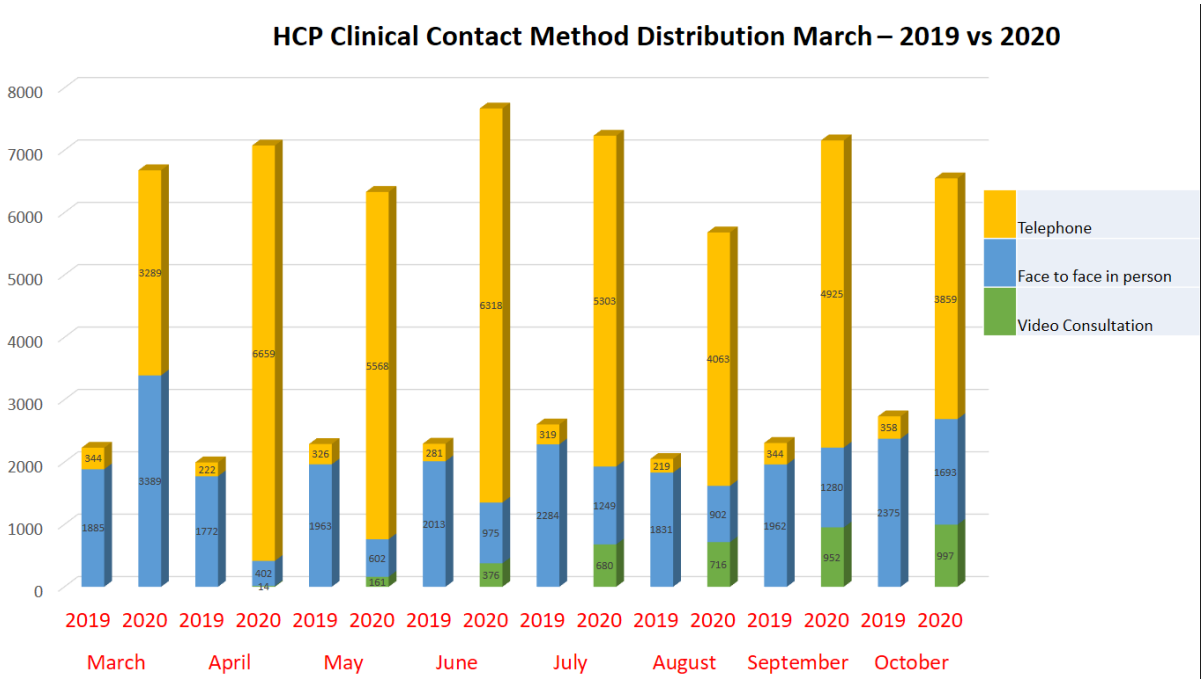



*Figure 7: HCP Contact Methods 2019 vs 2020*

*Figure 9* also illustrates that the HCP have been able to deliver a significant number of face-to-face in person contacts for families who require a more enhanced service offer. The use of Attend Anywhere videoconferencing has been slowly increasing since it was introduced in May. It is recognised however that use of these technologies cannot replace the value of home visiting, especially for vulnerable families where internet access, space and data allowances can be barriers to engagement.

*"As the virus lock down was still existing, we could not do a visiting appointment, so instead of cancelling it, it was scheduled as telephonic appointment, which I very much appreciate. Because, it was very helpful for me."* - **parent**

**Video Consultation & Virtual Contacts: What families are telling us...**

*"She was very good, very thorough, supportive and helpful. Being able to see her on video was great as it's more personal."*

*"Our son is used to video calls so worked well, might be harder if he wasn't"*

*"Very clear, professional, thorough, very nice and approachable. Video calls are good and currently necessary but I wouldn't want them to replace all home visits! They are still needed too."*

*"Worked seamlessly and easier than bringing two children into the centre!!"*

# 6.0 Universal Plus & Universal Partnership Plus Activity

Where there are concerns about a particular aspect of a child's development a family may require additional advice, support and follow up from the HCP. Examples of this include care packages for maternal mental health, parenting support, baby/toddler sleep problems, enuresis, behavioural or mental health in children and young people, domestic violence and safeguarding concerns. When the HCP is the only service providing additional support, then the family is placed on the Universal Plus pathway; when other agencies are involved then the case is allocated to the Universal Partnership Plus pathway.

Throughout the Covid-19 pandemic, the HCP clinicians have been reporting that the universal plus and partnership plus element of the programme has been increasing and the cases they are supporting becoming more complex. It is likely that the loss of wider family and community networks may be a contributing factor to this situation in addition to socio-economic factors such as loss of job security and income.

During this time the service has demonstrated themes in increased activity through the analysis of data to support the emerging feedback for front line clinicians. The data sets show a comparison month by month from 2019 to 2020.

*Figure 10* below acutely demonstrates the increase in families requiring to be on UP and UPP pathways and this increase is reflected in staff perceptions of an increasing workload and holding of risk which comes as a result of having a caseload with increasing complexities and vulnerabilities.

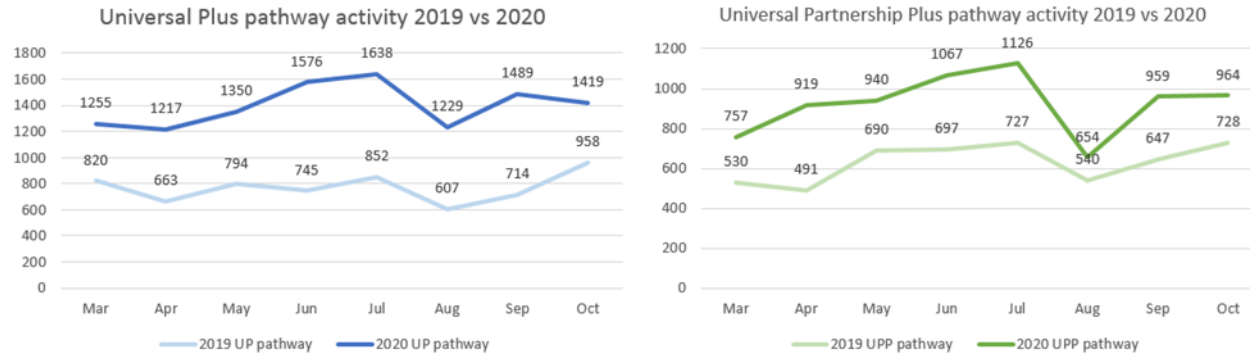



*Figure 8: UP & UPP pathways caseload comparison 2019 vs 2020*

*Figure 11* below shows the contact method for these targeted interventions.

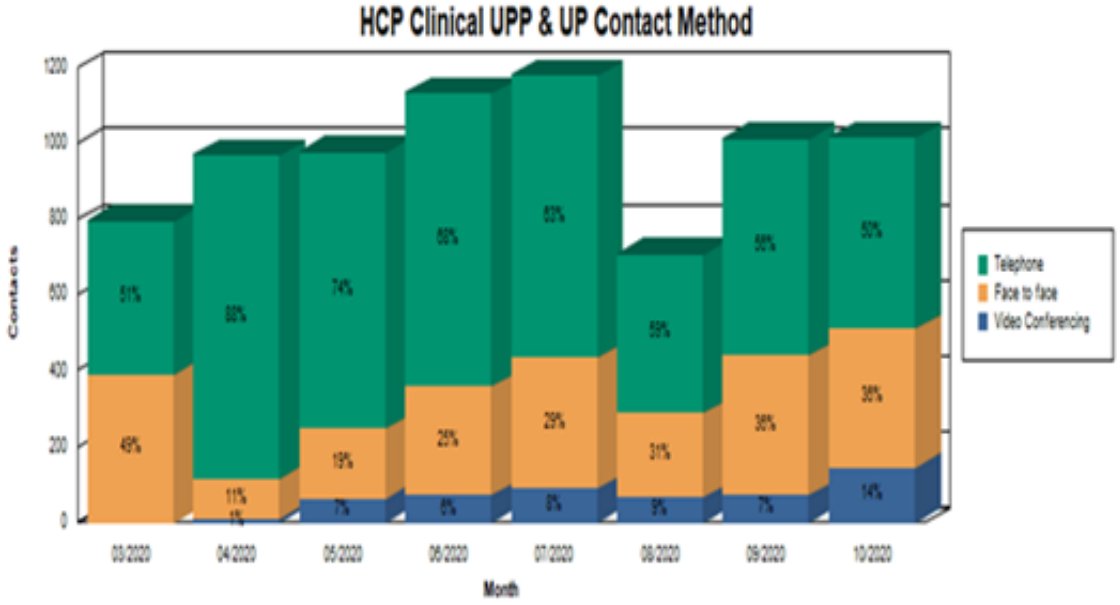



*Figure 9: Contact methods for UP & UPP caseload, Mar-Oct 2020*

## 6.1 Safeguarding & Domestic Violence

6.1.1 Domestic Violence:

Due to the impact of the pandemic on the reported increased pressures within family units, the level of support to families identified with domestic abuse concerns saw an increase in the early part of the pandemic, when lockdown restrictions were at their tightest and therefore it is plausible to assume a potential correlation. There has also been an uptick in November, when the second national lockdown measures were imposed.

The chart below (*figure 12*) demonstrates that the service has been able to safely continue to identify and put in place the appropriate support to families where this is an issue, amid national reporting of concerns the pandemic has had on further hindering the ability to identify domestic violence concerns, which are already a largely hidden issue.

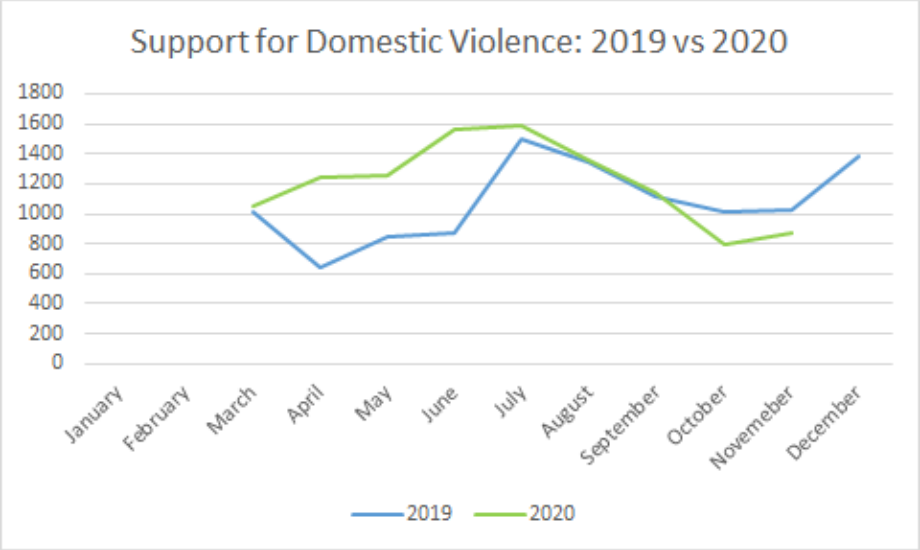



*Figure 10: HCP interventions for Domestic Violence comparison 2019 vs 2020*

### 6.2.1 Attendance at Initial Child Protection Conferences (ICPC's)

Requests for attendance at statutory safeguarding meetings has shown growth within the 0-4 (Health Visiting) cohort compared to 2019, however there has been a considerable decline in 5-19 ICPC activity (see figure 13, below). It can be assumed that this is likely due to school closures adversely impacting this visibility of young people by other professionals, causing a broader reduction in referrals to both Early Help and Children's Social Care for these age groups.

Reassuringly however, the chart below indicates that the HCP remained available to support colleagues in attendance and maintain safeguarding responsibilities throughout the pandemic in line with the demand elsewhere within the system.

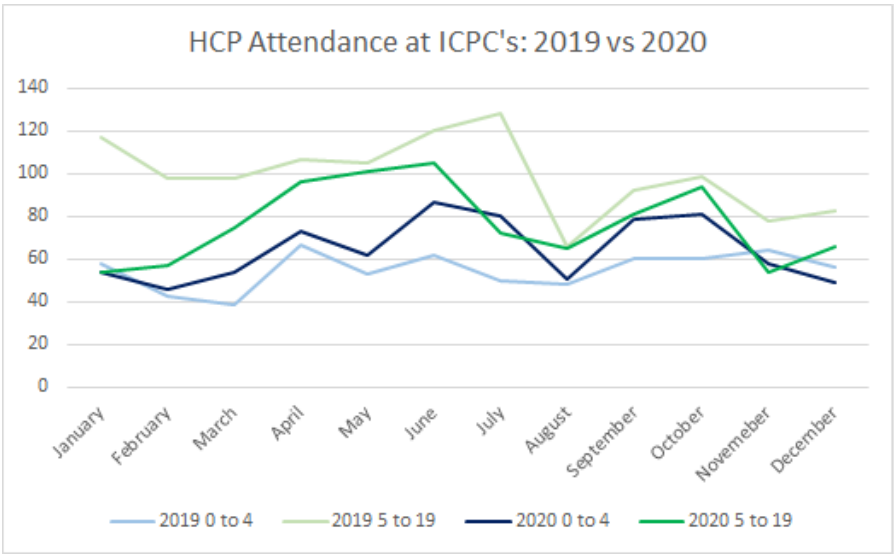



*Figure 11:HCP attendance at ICPC by pathway, 2019 vs 2020*

## 6.2 Support for new parents

### 6.2.1 Infant Feeding and Parental Anxiety

As the pandemic evolved, the service has seen an increase in requests for support for infant feeding advice and guidance. However, in a number of these cases the anxiety that parents are experiencing as new parents is broader than just infant feeding. The restrictions mean many new parents have been cut off from 'in-person' their support network of family and friends, and that lack of informal support can have a negative impact on parental mental health.

*Figure 14* below needs to be considered within the context of pandemic. In an environment whereby in-person community breastfeeding support was delivered virtually and many women, due to the lockdown measures in place, had more time to focus on establishing breastfeeding, it is understandable that the HCP Infant Feeding Team saw an increase in activity, especially during the early part of the pandemic.

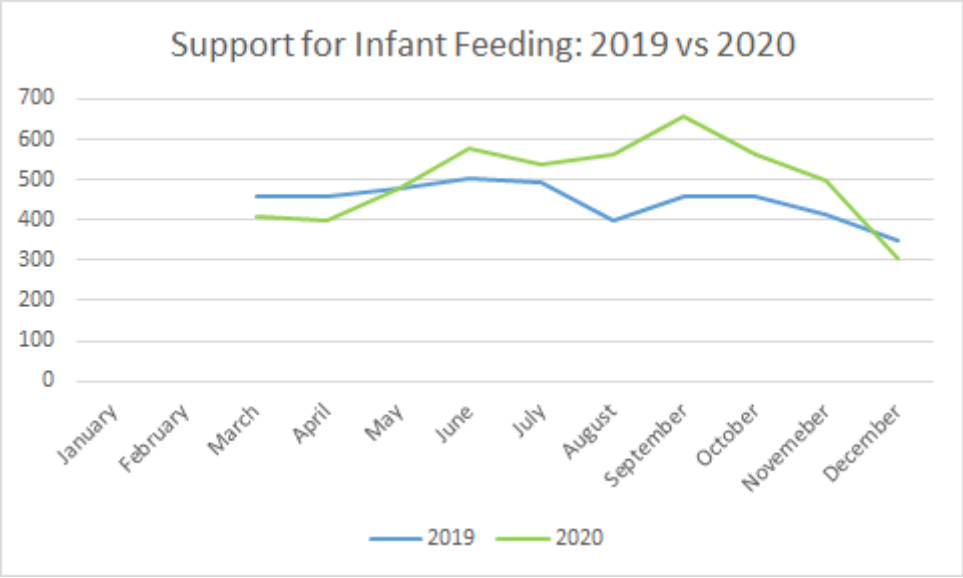



*Figure 12: HCP interventions for infant feeding 2019 vs 2020*

Support for infant feeding requires a visual examination, therefore this service were early adopters of using video consultation methods to provide support to mothers, however the service lead reported that even with these mechanisms in place, more women were seeking follow up contacts and repeated support prior to lockdown measures, which was adding strain on the service. It was because of this the HCP were quick to identify that something wasn't working, therefore this service was prioritised when planning re-establishing clinic-based in-person appointments.

*Chart 14* above demonstrates than during a period when many face-to-face community breastfeeding support services were compromised, the HCP endeavoured to ensure as many women as possible were continuing to get the specialist support needed to continue with the breastfeeding journey.

In addition to ensuring channels remained open to seek breastfeeding support when mothers needed it, data captured by the HCP indicated that during this period, there has been no notable change in breastfeeding prevalence rates at the 6-8 week mark (*figure 15*,

below), which is commendable considering that this is also set against a backdrop when maternity services have anecdotally witnessed a decline in the proportion of women breastfeeding at discharge coupled with an increase in women bringing formula onto the ward to use if breastfeeding cannot be achieved.

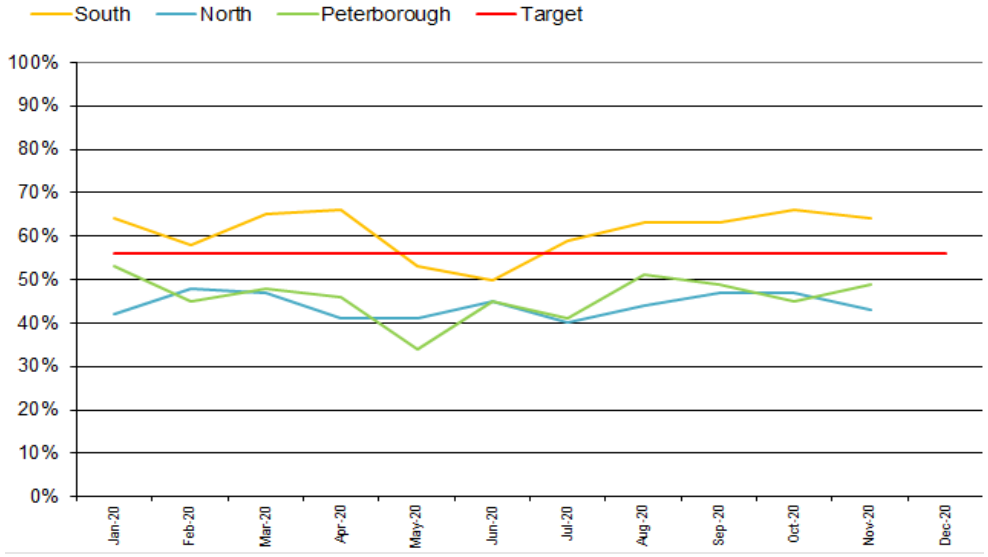



*Figure 13: Breast prevalence by locality at 6-8 weeks post-partum, Jan-Nov 2020*

**Support for Infant Feeding: What families are telling us…**

*"Nina knew all my troubles, the ups and downs. She was there for me all the time for 3 months. She was so supportive. I feel she is my little guardian angel." - Infant Feeding Team*

*"It totally made the difference with tricky breastfeeding. Just being there and just shows what's possible with this way of working. Gen was absolutely amazing. She put a really good plan in place, all her positivity, calling me and being kind. It was really valuable support in the context of having a baby a couple of days before Covid when I couldn't see Mum or sister or anyone else." Infant feeding Team*

*"The breastfeeding ladies were calm and so kind. I felt listened to and my problems/worries were heard. They offered genuinely helpful advice and when it didn't work they had other suggestions to help. I wouldn't have been able to sustain breastfeeding my newborn if it wasn't for their help and guidance. And providing a really safe space to bring concerns."*

### 6.2.2 Non-accidental injury & safety

As the pandemic evolved the service considered the national landscape particularly with some of the data that was emerging nationally regarding the increased concerns regarding non accidental injury particularly in the under 1 year age range (Babies in Lockdown published 5th August 2020 OFSTED). As a result of the findings, that babies crying and increase parental stress during the pandemic for some families can be detrimental, the service adopted the I.C.O.N public health message to support parents to understand that it is 'normal for babies to cry and comforting methods can sometimes help, and it is Ok to walk away and that a baby should never be shaken'. This approach has been adopted across the partnership in Cambridgeshire & Peterborough with sign up from the Safeguarding Partnership Board.


*Figure 14: ICON promotional advert*

## 6.3 SEND Support

Particular attention has been given to ensuring that we continue to support our children with SEND during this period. If following on from the one- or two-year reviews there is an identified need for further assessment then children and families have been invited into clinic settings for a 'Schedule of Growing Skills' assessment (SOGS), where this can take place in an environment that is safer to manage the Covid-19 risks.

Referrals to Early Support have continued as normal. There are also SEND champions in each area to support staff with decision making and referrals as required. The SEND lead for the service has ensured that the families are aware of how to contact her and the Champions throughout Covid-19. The liaison meetings with partner agencies for SEND have also continued throughout this period.

To support families at home during the Covid-19 crisis the team have promoted access to our web pages and have included links to services who can support. Work is ongoing on a project, together with Community paediatricians, to provide information and guidance for parents of children who struggle with sleep issues to be added to the webpages.

## 6.4 Support for young parents

The FNP programme and Young Parents Service has remained open throughout pandemic, albeit some of interventions have been delivered in a different way. Clinical decision making takes place on whether an FNP nurse is needed to physically see a young person or whether a blended method of delivery of virtual and face to face is more appropriate.

There has been mixed feedback regarding use of virtual tools. Issues with self-esteem and internet poverty been barriers to video conferencing for several clients. Locally the team have reported witnessing an increase in Domestic Violence, drug use (mainly cannabis among partners) and mental health issues (specifically anxiety), which have been exacerbated by the pandemic and lockdown measures. There are early indications to suggest the cohort may be getting younger, but this will become more apparent over the next few months and will need exploring in line with broader changes in the birth rate during this period.

*"The information given by the health Visitor and the young parent partner is very helpful and makes me feel a bit more confident in what I have already done in preparation for arrival for my baby"* - **parent**

### Support for young parents: What families are telling us

*"Some clients have felt that they can be more open and honest as it is less intrusive and they feel more comfortable talking about issues they might find difficult talking face to face."*

*"As many services have offered a much reduced or no contact the consistency of FNP has been positive for many of the clients and has enabled ongoing support and assessment, particularly in relation to safeguarding and mental health"*

*"For some clients telephone/video calls have enabled a greater degree of flexibility for example being able to have contacts at times of day or locations that wouldn't usually have been possible."*

*"Some clients have a number of professionals working with them, who are all offering virtual appointments and clients say this difficult to manage to be present on a virtual call, at the same time as meeting the demands of their baby/toddler"*

## 7.0 Vision screening

7.1 School Entry Vision screening in Reception Class (aged 4/5 years) is a helpful aid in the early identification of vision difficulties, which, if undetected can have a lasting impact on educational attainment. The provider offers an Orthotic-led service to identify all children in the cohort with visual defects, including amblyopia, refractive error and strabismus (squint). For the 2019/20 Academic Year, screening had only taken place in Cambridgeshire - this had been set to be rolled out across Peterborough from April so that by the end of the school year all areas would be covered, however the programme had to be suspended due to the school closures in March. Since the beginning of the 2019/20 academic year in September 2019, 53% of eligible pupils across Cambridgeshire had been screened up until the point of school closures in March 2020.

As set out in **Error! Reference source not found.**, arrangements are in place to deliver a county-wide Orthoptist-Led Vision Screening Service, supported through the NWAFT specialist Orthoptist service. All screeners have successfully completed their competency assessments delivered by a qualified Orthoptist. To pick up 'missed screens' all families were written to asking them to self-assess their child's vision and a community-based clinic service was implemented throughout the Autumn to carry out screening tests on children

where there were identified concerns. The service also wrote to all schools to advise staff they could notify the service if they have any professional concerns regarding a pupil's vision. Planning is now underway to on how to best deliver this service for the 2021 academic year.

**Vision Screening: What families are telling us…**

*"I was surprised that it was an immediate appointment. I thought I would have to wait about 6 weeks."*

*"It was focussed on the child, very child-friendly and good screening."*

## 8.0 Staffing & Capacity

8.1 Throughout the pandemic the Healthy Child Programme has been fortunate that no staff have been required to be redeployed to other areas of the NHS resulting in the workforce being able to sustain and continue to deliver health care to support children, young people, and their families. However, the pandemic itself has caused some pressures around staffing capacity as expected. Whilst there has been some staff absence because of the situation, other pressures have been created due to some staff requiring to shield or self-isolate due to their own health vulnerabilities or indeed members of their household being positive or being exposed to the virus. The service has also experienced some staff resignations due to the altered service delivery model or the wish to work closer to home and there have been fewer external personnel recruited during this time. An additional factor has also been that there has been a 3-month delay in newly qualified Health Visitor and School nurses completing their academic pathway and a delay in the new cohort of student Health Visitors and School Nurses commencing in post.

## 9.0 Learning so far & future planning

9.1 As we are now in another national lockdown, school closures and a mass vaccination programme roll out, it is important that we use the experiences and learning from 2020 to inform practice moving forward.

9.2 <u>Best Start in Life</u>

The strong relationships built across the system as a result of this programme will continue to be invaluable as we work together to support families through this time. Despite significant capacity challenges across organisations, the place-based pilots are still moving ahead with a focus on actions that will support the current situation. The planning phase for these pilots runs until the end of January 2021 with the first round of testing scheduled from February-April 2021.

Details of the pilots are outlined in Appendix 1.

9.3 Staff Capacity

Staffing pressures continue to be a concern and ongoing conversations have been taking place on how best to manage the workload, acknowledging the importance of the universal element of the Healthy Child programme whilst ensuring we can still meet the health needs of the vulnerable families. We will continue to monitor closely the impact of the new stretch targets for the New Birth assessments and the 6–8-week review, as well as the blended approach to the antenatal contact, in order to ensure these are still meeting the needs of families as well as helping to address some of the clinical activity pressures.

Against the backdrop of high infection rates, it is important that we do all we can to keep staff well and reduce the numbers needing to isolate. Infection controls measures and the consistent use of PPE will still be vitally important. The service is also swiftly rolling out its staff vaccination programme with all staff due to receive the vaccine by early February.

9.4 Vision screening

Guided by advice from the Education directorate, there was an agreement to not attempt in-school screening during the autumn term and instead focus on the community clinics. With further school closures imposed in January 2021, exploration is underway with colleagues from the acute trusts to scope out using a digital screening tool in conjunction with the parental screening questionnaires which can be done remotely in a child's home.

9.5 Supporting System wide pressures

2021 also brings with it the hope and challenge of the mass roll out of the Covid-19 vaccination programme. Healthy Child programme services and staff are not expected to be directly redeployed to deliver this, but we are working with CCG commissioners and services to look at how we can understand the pressures this programme has on capacity.

9.6 Learning from "Working for babies- Lockdown lessons from local systems" report
In January 2021 the above report was released that was commissioned by the First 1001 Days Movement (link to report in source documents). It explores the impacts of the coronavirus crisis on babies in their first 1001 days across the UK, bringing together an evolving picture of how babies' lives have been affected, and, crucially, to understand the experiences of systems and services which support them.

The HCP, as part of the broader Best Start in Life group, will use this report to audit our local systems response so far and to identify any actions that could improve our support to families.

## 10. Alignment with corporate priorities

10.1 A good quality of life for everyone

The report above sets out the implications for this priority in paragraphs 2-9

10.2 Thriving places for people to live

There are no significant implications for this priority.

10.3 The best start for Cambridgeshire's children

The report above sets out the implications for this priority in paragraphs 2-9

10.4 Net zero carbon emissions for Cambridgeshire by 2050

There are no significant implications for this priority.

## 11. Significant Implications

11.1 Resource Implications
There are no significant implications within this category.

11.2 Procurement/Contractual/Council Contract Procedure Rules Implications
There are no significant implications within this category.

11.3 Statutory, Legal and Risk Implications
There are no significant implications within this category.

11.4 Equality and Diversity Implications
The report above sets out details of significant implications in paragraphs 2-9

11.5 Engagement and Communications Implications
There are no significant implications within this category.

11.6 Localism and Local Member Involvement
There are no significant implications within this category.

11.7 Public Health Implications
The report above sets out details of significant implications in paragraphs 2-9

## 12. Source documents

| | |
|---|---|
| "Working for babies- Lockdown lessons from local systems" – Commissioned by the First 1001 days movement and written by Jodie Reed and the iSOS partnership. | https://parentinfantfoundation.org.uk/wp-content/uploads/2021/01/210115-F1001D-Working-for-Babies-Report-FINAL-v1.0-compressed.pdf |

**APPENDIX 1 - BEST START IN LIFE PROGRAMME: PLACE-BASED PILOTS**. One page status report

**Rachel Dunford /25th January 2021**

| AREA | Pilot strand | Stage (research/ plan / test / implement) | Key activities in next 3 months | RAG rating | Risks/issues | Proposed mitigation |
|---|---|---|---|---|---|---|
| **Wisbech** | Using consistent language/messages with families about the 0-5 offer in Wisbech. | Research / early planning | **January**: Identify biggest barrier to communication with families at the moment. Establish priority messages to share with families. Identify priority groups to communicate with: those we struggle to reach now.<br>**February**: Find "quick wins" to respond to the above research: low cost, minimal resource input from practitioners/operational staff. Put these into action.<br>**March**: Plans for the longer-term: what is the issue we want to resolve using BSIL principles? Capture learning from pilot. | **G** | Availability of operational staff at regular meetings may be patchy as workloads increase elsewhere. | Do as much work offline as possible.<br>Find ways to engage staff without requiring meeting attendance<br>A close eye will be kept on resourcing: the project is on track at the moment. |
| **Wisbech** | Reducing smoking in pregnant women | Research/ early planning | **January**: Map out how services currently provide support to pregnant women/families to reduce smoking in pregnancy.<br>**February**: Find "quick wins" to bring this support together. Build the key messages that all teams need to use to have an impact quickly. Put these into action.<br>**March**: Plan for the longer-term: what issue will we resolve using BSIL principles? What are the characteristics of the community that mean smoking in pregnancy is so high? How can we tailor support to make a difference? Capture learning from pilot. | **G** | Workloads are increased due to the implications of Covid-19, and the latest lockdown. Resources may be more stretched than originally anticipated when this strand was first planned. | Instead of focussing on large-scale change straight way, the pilot will look for smaller actions /quick wins to introduce to enable us to make a difference in the short term while things are busier.<br>A close eye will be kept on resourcing: the project is on track at the moment. |
| **Wisbech** | Pathway to parenting | Planning | **January**: Test new blended delivery model before it is opened up to families. Revise protocols to respond to latest Tier 5 COVID restrictions. Book families onto sessions. Send out first set of activities/resources to families booked in for Feb<br>**February**: Deliver the revised course. First families are booked on for sessions starting 3rd February.<br>**March**: Review delivery of early sessions. | **A** | The latest lockdown has required changes to the plans for course delivery in February (e.g. co-location of course leaders during sessions). Not yet known if this will delay delivery. | Amendments are being made to the plans to accommodate the revised rules. |
| **Honeyhill** | Improving the delivery of speech & language and communications development support to families | Planning | **January**: Conduct audit of S&L support/ tools and messages currently used by services. Consider uses, purposes, audiences, training: aim to get consistency of use and share best practice.<br>**February**: Survey staff and families about current awareness of available support<br>**Jan-March:** Map data-sharing needs in order to improve information sharing between professionals, especially for children who drop out of early years provision.<br>**March**: Introduce SLT surgeries to support professionals access advice. | **A** | Covid-19 may affect resource levels within Speech & Language teams which might delay getting face-to-face surgeries running as soon as planned (originally planned for Jan-Mar). | Resource levels are being assessed and plans will be revised accordingly. All pre-schools have been given a named contact in S&L team to approach if they need advice in the short-term. |
| **Cambridge City** | Increasing joint working between professionals supporting the same families in Cambridge City | Research / early planning | **January**: Map current service delivery activities (EHP, HV, Children & Family Centres, Early Years, Midwifery). Map geographies covered by each service. Identify gaps, overlaps and pinch-points.<br>**February/March:** Find opportunities to test BSIL principles to resolve these gaps/overlaps/pinch-points. Plan how to begin to deliver these. Capture learning from pilot. | **G** | Potential resource constraints due to Covid-19 might impede on progress. | Work is being facilitated by RD and so far, remains on track. A close eye will be kept on resource levels as we progress. |
| **Cambridge City** | Using consistent language to increase staff awareness of BSIL | Not yet begun | **Jan – March** Identify members for working group. Set up regular working meetings. Agree priorities. Research issue to be addressed and how to respond to it.<br>Priority will be to develop and agree a shared understanding of what "safeguarding" means to all professionals to ensure consistent communication with families. | **A** | Lack of identified resource will delay progress. | RD to follow this up with pilot leads asap. |
| **Central & Thistlemoor** | Improving immunisation rates | Research | **January**: set up task and finish groups for three strands of activity: 1) Developing a "core script" and a consistent approach to messages promoting the importance of immunisations 2) Getting the process for | **A** | Resource levels have already been flagged as being a | RD to liaise with BSIL programme team about the implications of this. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | recruiting families to immunisations right, using BSIL principles 3) Appointing community champions to support specific families with accessing immunisations. Schedule first meetings and begin to scope out work required.<br>**February/March**: Consider data sharing requirements, feed up to programme level. Agree new ways of working and put into practice to test effectiveness. Capture learning. | | potential problem, within the pilot and at<br>BSIL programme-level which may delay things, e.g. the data-sharing work. | |

# Health Policy and Service Committee Agenda Plan

Agenda Item No: 8

Published on 1st February 2021

Notes

The definition of a key decision is set out in the Council's Constitution in Part 2, Article 12.
* indicates items expected to be recommended for determination by full Council.
+ indicates items expected to be confidential, which would exclude the press and public.

The following are standing agenda items which are considered at every Committee meeting:

- Minutes of previous meeting and Action Log
- Finance Report – The Council's Virtual Meeting Protocol has been amended so monitoring reports (including the Finance report) can be included at the discretion of the Committee.
- Agenda Plan, Training Plan and Appointments to Outside Bodies and Internal Advisory Groups and Panels

| Committee date | Agenda item | Lead officer | Reference if key decision | Deadline for draft reports | Agenda despatch date |
|---|---|---|---|---|---|
| 11/03/21 | Performance Report | Liz Robin | Not applicable | 01/03/21 | 3/03/21 |
| | Public Health Commissioned services & Partnerships– adapting to Covid-19 service delivery changes and recovery plans | Val Thomas | Not applicable | | |
| | Trend Analysis of the Impact of the first COVID-19 wave on childhood vaccinations | Raj Lakshman | Not applicable | | |
| | Covid-19 Issues Report | Liz Robin | Not applicable | | |
| | Cambridge Cancer Research Hospital | Annalise Lister | Scrutiny Item | | |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |

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| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |
| [08/04/21] Provisional Meeting | | | | | |
| 03/06/21 | Notification of Chairman/woman and Notification of Vice-Chairman/woman | Democratic Services Officer | Not applicable | 24/05/21 | 26/05/21 |
| | Co-option of District Members | Democratic Services Officer | Not applicable | | |
| | Finance Monitoring Report | Stephen Howarth | Not applicable | | |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |
| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |
| 24/06/21 | | | | 14/06/21 | 16/06/21 |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |
| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |
| 08/07/21 | | | | 24/06/21 | 29/06/21 |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |
| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |
| 05/08/21 | | | | 26/07/21 | 28/07/21 |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |
| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |
| 16/09/21 | | | | 06/09/21 | 08/09/21 |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |

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| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |
| 21/10/21 | | | | 11/10/21 | 13/10/21 |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |
| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |
| 18/11/21 | | | | 08/11/21 | 10/11/21 |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |
| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |
| 16/12/21 | | | | 06/12/21 | 08/12/21 |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |
| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |
| 20/01/22 | | | | 10/01/22 | 12/02/22 |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |
| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |
| 17/02/22 | | | | 07/02/22 | 09/02/22 |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |
| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |
| 10/03/22 | | | | 02/03/22 | 28/02/22 |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |
| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |

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| 14/04/22 | | | | 04/04/22 | 06/04/22 |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |
| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |
| 19/05/22 | | | | 09/045/22 | 11/05/22 |
| | Health Committee Training Plan | Kate Parker | Not applicable | | |
| | Agenda Plan and Appointments to Outside Bodies and advisory panels | Democratic Services Officer | Not applicable | | |

Reports to be scheduled; –

- Royal Papworth Hospital – Response to Covid-19
- Care Quality Commission on the East of England Ambulance Service

Please contact Democratic Services democraticservices@cambridgeshire.gov.uk if you require this information in a more accessible format