Health Committee: Minutes

Date: 15th October 2020

Time: 1.30p.m. - 4.22p.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, S Clark, D Ambrose-Smith, G Harvey, and N Massey

335. Apologies for Absence and Declarations of Interest

No declarations of interest were received. Apologies for absence were received from Councillor J Tavener.

336. Minutes – 17th September 2020

The minutes of the meeting held on 17TH September 2020 were agreed as a correct record.

337. Health Committee Action Log

The Action Log was noted and the following points were raised:

Item 1 Minute 310 Health Committee Agenda Plan

The text required to be changed in the first column so that it read 'Arranging meetings between Members of the Committee and the CCS" and not the CCG as currently drafted
Action: Democratic Services

Item 3 Minute 322 - Public Health Grant 2020/21 – Tackling Obesity

A Member suggested that more clarity was required regarding an expected date for the completion of the work and when a report was expected to come back to Committee. The Chairman replied that they had run out of time at the meeting referenced, but understood the intention was that a report would come back to the November Committee.

338. Petitions and Public Questions

There were no public questions.

One petition was received with the Chairman having considered whether it was within the remit of the Committee had used his discretion to allow it to be presented to the Committee. The text to the petition was read out by Democratic Services and has been included as an appendix to the minutes.

Cheryl Godber, Unison regional organiser representing North West Anglia Trust members was invited as the nominated spokesperson to speak to the petition.

She explained that the Trust already had already outsourced a number of soft FM services to private contractors with contract due to come to an end in January 2021 and had made an unrecorded decision to outsource additional services to be undertaken by

a single private provider with a contract value of around £40m. The 70 plus staff affected by the current proposals currently worked in or around Hinchingbrooke Hospital.

Regarding the award winning catering service they provided food cooked fresh from locally sourced suppliers. Staff were concerned not only about their own jobs but of the quality of the service going forward, especially in the middle of the pandemic and believed as the Unions did, that the best course of action was to bring all the services back in-house under Trust direct control. They believed this was better for services, Staff and patients.

As has been reported in the text of the petition it was not only staff that had these concerns but over 1400 local Cambridgeshire residents who had signed the petition. She stated that the Trust had not provided any rationale for their proposal to continue to outsource further services and had no or business case or Community Impact assessment to support the decision with their being no formal record of the decision being made. She further stated that the Trust had only just now started to look at the cost of keeping the services in house and had refused to halt the procurement exercise.

In conclusion she asked that the Committee take any action in its power to hold the Trust to account and allow for proper for public scrutiny of their decision which staff and those Cambridgeshire residents who had signed the petition believed would adversely impact on the services provided to Cambridgeshire residents.

As there was no report on the agenda, the Chairman explained that under the council constitution the normal procedure was that there could be no debate and a written response would be provided to the petition organiser ten working days after the meeting. However the Committee was able to ask the petition spokesperson questions of clarification from the presentation just made and the Chairman had an alternate solution that he would present after all questions had been dealt with.

Questions of clarification raised included;

- What was meant by the reference to an in-house bid being made. In reply it was explained that what should happen was that where an organisation intended to outsource or further outsource other in-house services to an outside private company there should be the option for an in-house bid/ an assessment made of the current cost of the service. With regard to assessing the costs the Trust had only recently commissioned a private company to carry out this assessment on their behalf.
- Clarification of what was meant by the Hospital catering service being an award winning service. In reply it was explained that the Team provided good quality food in-house locally sourced at 46% less cost than a private contractor could produce and for the quality of the food had won awards. There was a link to a report from John Lister produced on behalf of staff that provided more information and included details on the awards they had received. Action: Democratic Services to circulate details outside of the meeting
- What were they asking the Committee to do on their behalf? In reply they were requesting that the Committee write to the Chief Executive asking for full disclosure of the business case, details of any community impact assessment undertaken and background information to allow proper scrutiny of their proposal.
- What the timescale was for the Trust to make the decision. It was explained that the Trust had already invited expressions of interest to tender and three contractors had responded and had been invited to undertake presentations in two weeks' time with the intention to award the contract at the end of December / early January.

- A Request was made for details of the written material relating to the petition to be circulated to the Committee. Action: To be provided by Democratic Services outside of the meeting.

The Chairman in summing up reiterated the normal procedure for responding to a petition where no report was included on the agenda and highlighted that the petition spokesperson had asked that the Committee write to the Trust Chief Executive requesting further clarification details. However as an alternative the Chairman proposed another option which was to raise the issues directly with the Trust Chief Executive at the quarterly meeting to be held with Hinchingbrooke later in the month which Members of the Committee attended. He believed this was more appropriate as Members representing the Committee would be able to ask questions directly, have more time to discuss the issues and obtain the necessary clarification from hearing the Trust's side and would be able to report back to the Committee.

One Member expressed concern at the timescale this would involve as the Trust were already so far advanced with presentations from applicants already arranged, questioning whether the quarterly meeting was the appropriate forum to raise such issues, as they were goodwill informal liaison meetings rather than formal scrutiny meetings.

Cllr Harford who would be one of the two Members along with the Vice Chairman attending the liaison meeting, supported the Chairman's that there was nothing to preclude asking the issues of concern raised at the current meeting and seeking the necessary clarification of the process undertaken by the Trust and would be the necessary scrutiny being requested and would provide a good in depth report would come back to the Chairman and the Committee on the replies they received.

It was resolved:

> That the Vice Chairman would take the petition to the next Trust Liaison meeting and highlight the issues requiring further clarification raised at this Committee meeting with the Trust Chief Executive.

Scrutiny

339. NHS England and NHS Improvement East of England Response to Covid-19 and the delivery of NHS Dental Services in Cambridgeshire

Tom Norfolk and Jessica Bendon from NHS England and NHS Improvement – East of England were welcomed by the Chairman and invited to present the report included on the agenda.

It was explained that following the Prime Minister announcement on social distancing to stop the spread of Covid-19 on 25th March all non-urgent face to face dental treatment had been stopped and across every NHS region, local Urgent Dental Care (UDC) systems had been created to provide care for people with urgent dental problems. Seven were in place across Cambridgeshire along with three minor oral surgery urgent care centres. They were continually reviewed to ensure that patients with urgent dental needs were being treated in a timely manner.

In June 2020 the Office of the Chief Dental Officer set out guidance for the resumption of face to face dental services where the necessary Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE) requirements were in place taking account of the urgency of needs, the particular unmet needs of vulnerable groups

And the available capacity to undertake activity. Nationally this has been undertaken with services having been slowly restored between 8th June and 30 September.

It was highlighted that:

- Dental practices were required to undertake 20% of minimum contract activity which took into account the "fallow time" required when using aerosol procedures. This limited the time available to treat patients as it required the treatment room to be left for an hour so that aerated particles settled before a clean of all the surfaces was undertaken which was necessary before being able to see the next patient. As a result on average each dentist was only able to deal with 5-7 patients a day rather than an average of 23-30 patients a day pre covid-19 restrictions. As a result during the period, very few dental practices had the capacity to be able to offer routine appointments.
- There were now in Cambridgeshire 38 NHS Dental Surgeries providing face to face services including aerosol procedures and seven offering advice, analgesics and antibiotics (3As). This was alongside the seven Urgent Dental Care (UDC) centres and three Oral Surgery Urgent Dental Care centres put in place as a response to the initial restrictions to deal with urgent cases.
- All practices had been advised to treat both regular and new attendees requiring urgent dental care and at least one urgent appointment, per dentist, per day was required to be made available to support referrals from the 111 service.
- Three practices in Ely, Littleport and March were part of the Urgent Care and Stabilisation Project set up prior to Covid to treat urgent care dental patients, and where appropriate, provide stabilisation treat to the patients to improve their overall oral health.

It was acknowledged that the suspension of primary care dental services had, had an impact on patient's ability to receive dental care and NHS England and NHS Improvement – East of England had put in place the following measures to support the resumption of dental services:

- Emphasising the need to prioritise treatment in terms of urgency of need
- Requiring dental practices to hold one urgent care slot, per dentist, per day for any patient that presents with urgent needs (not just for usual patients to that practice) above and beyond their normal appointment slots.
- Supporting providers to attend FIT testing training to ensure the correct size and fit of an FFP3 facemask to enable the resumption of face-to-face full range of services. Three face fit testing courses (10 places in each course) had been delivered in Cambridgeshire.
- Amending the Directory of Service to ensure that patients were sign-posted to UDC's and practices with urgent slots as the first responder practices to contact (ensuring patients are sign-posted to practices that are able to clinically diagnose and treat).
- Ensuring that GP and Community Pharmacies and other stakeholders were made aware of how patients could access urgent and emergency dental care.
- Encouraging and working with providers and the wider dental team to prioritise access and clinical needs of patients to reduce inequalities.
- Working with the Health Oversight Scrutiny Committees (HOSC's) and Healthwatch to explain local provision and sign-post patients.
- Working with the Local Dental Committee's to send out communications to their respective members supporting NHS England and NHS Improvement – East of England regarding the resumption of dental services.
- Encouraging practices to work in a Hub and Spoke model to sign post patients with urgent needs between themselves to ensure the patient was seen in accordance with their needs.

Issues raised included;

One member raised four questions of which in reply it was explained that not all the questions could be answered as the data asked for was not collected cumulatively to provide one overall total. The questions raised were:

- What percentage of normal number patients were now being seen. In response it was explained that due to the restrictions already in place the percentage of patients being seen by dental practices was between 20-25% (the minimum required being 20%) but this type of data was not currently kept on individual primary care practices as they were private firms with individual contracts with NHS England . The capacity of the dental practices in terms of dentist being available to treat patients was at about 80% and was governed by such factors as staff sickness and the amount the fallow time required to be undertaken.
- What was now the average wait to receive an appointment and what was now the cumulative backlog? Priority was by necessity limited to urgent need patients and this was generally working well through the network of emergency centres previously referred to.
- What was the expected impact of the backlog on the long term of the general health and dental health of the population. Covid-19 had highlighted current inequalities but moving forward there would be a greater need for preventative measure programmes as the biggest cause of tooth decay was sugar and much of it was self-inflicted from people's lifestyles. The strategy to mitigate this included starting to draft a new Transformation contract which would replace the current contract with the aim of moving to a more flexible service offer from providers with more emphasis on prevention and dental providers working together in clusters rather than being sole entities. The aim would by this would be to provide in the future better and more equitable access to dental services through greater sharing of patient needs information and directing them to the most appropriate area of expertise. Modelling work on the proposals was currently being undertaken with stakeholders.
- That as it was being said no routine checks were being carried out concern was expressed at the serious affect this would have on children's dental health and the question in respect to this was what was being done to increase capacity for routine care and the need to make it a higher priority. If the issue was physical space capacity, what steps were being taken to provide additional capacity. Linked to this point the question was raised that if not all dental work involved aerosol processes, was it not possible to set aside some space in practices to allow for routine check-ups not requiring fallow periods. It was confirmed that not all procedures were aerosol procedures and where there was a reduction in urgent cases requiring such procedures as a result of dealing with the backlog through the measures set out earlier, there was now an increased capacity to provide routine check-ups.
- The Chairman highlighting that different practices were adopting different approaches as the dental practice his wife went to was starting to undertake routine appointments, while the practice he went to was prioritising children and was not currently taking routine adult appointments. This partly answered the question that had previously been asked. Practices needed to prioritise urgent patients in pain then they needed to risk assess a safe flow of patients. There was no homogenised model of a dental practice, some had more urgent cases to deal with than others, and the size of practices varied. As had been said, some children were being seen and screening was undertaken in some practices to determine which children were deemed to be more at risk and should be called in. The point was again made that there was a need to move away from the idea that the only way to look after teeth was by six monthly dentist check-ups and using the wider dental service.
- Was consideration being given to providing check-ups for children in other places such as schools. In answer it was explained that positive consent was required from

parents some of whom refused to give such consent. The way-forward for the future required a change to providing a service using far more preventative work and the plans being drawn up would look at the greater use of technology such as zoom technology which could be used to address larger numbers of people through for example undertaking presentations on oral hygiene at schools and in nursing / care homes. One member replied to this that there was already a great deal of preventative information on oral hygiene but for some families the issue was about being able to afford decent toothbrushes and that for some children the only way to detect tooth problems was from face to face appointments.

- One Member understood that fallow time was three hours and asked if this was still the case. It was clarified that fallow time was originally decided on with a duration of 60 minutes which was an arbitrary figure as not that much was known about the virus. New guidance from Scottish experts suggested that this could be reduced to thirty or even fifteen minutes, but currently the national guidance had not changed although some practices were operating shorter time periods.
- In answer to whether with more level 2 or 3 restrictions being introduced there would be an impact again on the provision of dental services it was not expected at level 2 to have much impact as all practices had Personal Protective Equipment measures in place and at Level it would still be possible to carry out urgent services.
- Clarification was requested regarding the Urgent Care and Stabilisation project and the role of the seven Urgent Dental Care (UDC) centres and three Oral Surgery Urgent Dental Care centres. These were for people with an urgent need for treatment to relieve pain whereby an appointment could be made and treatment carried out quickly to stabilise them back to normal health at which time they could revert to being seen by their normal dental practice.
- Clarification was sought on how the flexible contract / transformation strategy would be able to deliver improvements as what was being proposed was to apply it to privately run practices, some of which were more successful than others. It was explained that there had been pilots running for a decade but there had been a reluctance to move away, but Covid-19 had forced the issue and brought recognition that the current system was unsustainable going forward with the increase in populations and subsequent demand for what was a relatively fixed serves and with the changes that had already been made to address the crisis this was to be built on with the intention to create a financial model that would remunerate practices and access for providing more preventative care access rather than counting generic units of dental activity undertaken.
- There was a request that when the Draft Strategy was available it should be made available to the Committee. Tom Norfolk indicated that he would be very happy to share it and come back to a future Committee to discuss it further. Action: Add as a future item to the programme

It was resolved unanimously to:

> note the report and to receive a presentation of the proposed new Strategy at a future meeting

340. Public Health Response to Covid-19

As the Director of Public Health was required to attend another meeting the Chairman agreed that this report updating the Committee on the public health response to COVID-19 should be brought forward from the published agenda order and taken as the next item of business.

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.

The Director of Public Health gave a brief introduction to the report highlighting that nationally there had been recent significant rises in Covid-19 cases and this trend was also reflected in Cambridgeshire and Peterborough, especially since the end of September as set out in the information on page 2 of the report. Some of this was expected to be as a result of students at external universities who had not yet changed their GP and were therefore coded to Cambridgeshire when the outbreak may have originated in another area for example, Manchester or Newcastle. But even without these, the number of cases had doubled since the week ending 27th September and the week ending 4th October.

There had been some rise in hospitalisations, but not a significant number at present. The overall trend showed an increase in the younger age groups who were less likely to become seriously ill contracting the virus. A lot of joint working was being undertaken by Public Health with Universities and schools and the implementation on the containment framework along with work with district councils planning for winter and ongoing campaigns.

Issues raised:

- Clarification was sought on what advice Members' should be giving when asked by residents what the position was in respect of holding public events to celebrate Halloween, Bonfire night and Remembrance Sunday. Public Health (PH) had been working with the Communications team on a campaign to publicise advice for those events and others, while always seeking to ensure that the public was not confused by contradictory advice. Public Health aimed to ensure the guidance was the same as the Government's, for which an announcement was expected shortly. Slots had already been booked on local radio stations and publicity around the events would start on Monday 26th October. In terms of Halloween this would advise that children should not go out and door knock trick or treating but should celebrate the event in their own homes. PH were working closely with the Fire Service regarding advice on Bonfire night so there would be joined up communications. Remembrance Sunday events were more complicated as each event tended to be different and PH were still awaiting for Government advice. The current advice was for organisers to provide details including their risk assessment plans to the local District Safety Advisory Group and if they had concerns about an event they would feedback or pass them on to PH. There was also more general advice on events management during Covid on the Council's website.
- In answer to a further question in advance of Government advice on Halloween on what groups who had already made advanced plans for Halloween events could or could not do to be legal, (examples were provided of events being organised including window displays for children to identify and receive sweets as a reward), the Director thanked the Councillor for providing this additional information and would ensure that in addition to radio slots, there would be a section on the Council website providing additional detail.
- Request for the latest infection rate per 100,000 figure - It was explained that this usually came out on Wednesday or Thursday nationally and would be made

available on the Cambridgeshire Insight website page ACTION: The Director would provide the link to the Committee.

- In relation to the University address mix up - with two large universities in Cambridge the question was raised whether there could also be an inverse affect from students not registering with local GP's which could increase the infection figures locally. Local date was being received from NHS England and close work was being undertaken with the local universities to help advise on measures and provide publicity to help reduce the risk of a local outbreak.
- A query was raised on whether the issue of proactive testing in care home had been resolved and whether it was just staff that were being tested or residents as well. It was confirmed that asymptomatic testing had resumed and Public Health would be informed if there were cases identified with care home staff. Regarding regular testing for residents, in line with Government advice this was likely to be carried out less often as it is was more distressing for them to have such invasive procedures undertaken on a regular basis. ACTION The Director would investigate the current position on testing in care homes and residential homes dealing with dementia patients and come back to Committee with an update outside of the meeting.
- One Member referencing PH advice to shops/ commercial premises which had recently had to be withdrawn as a result of changed government advice asked whether revised guidance had been issued. Action: The Director explained that this would have been sent out from the District Environmental Health data base but would check with the District Environmental Health Team and come back to the Committee outside of the meeting.
- Concern was raised that one Member had been informed that local people arriving to the drive in test centres at Milton Park and Ride and the Peterborough show ground were being turned away if they were not motorists with a car or arrived on a bike. This was raised as a concern as many people did not own or drive a car. To clarify it was explained these test centres were for any person not local people but now required to be made by a prior appointment and therefore anyone arriving without an appointment whether in a car or otherwise would be turned away. This was required as like other test centres they had been overwhelmed by people turning up requesting a test whether they had symptoms or not. This could be undertaken on line by ringing the phone line to request a home testing kit. It was also highlighted that a new mobile testing centre would shortly be opening in the Coldhams Lane area. It was suggested that more publicity should be undertaken on the need to pre-book a test to stop people turning up at a test centre without appointments. ACTION: Director of Public Health to liaise with Communications Team.
- One Member raised the issue of inconclusive tests undertaken in care homes and whether this was an issue with the time taken to process the results at testing laboratories. The Director while clarifying the tests were not undertaken by PH had heard that there had been some issues, while also highlighting that it was not always easy to get the requisite number of cells on a swab to provide a conclusive test result.
- Reference was made to paragraph 3.9 and the pressures on the Public Health Team from the additional work generated from amongst other things schools and what the position was regarding the Government's intention to provide support from the Test and Trace Grant. In reply it was explained that the grant was being utilised to deliver local Outbreak planning and increased staffing capacity in Communications and PH with funding also given to the District and City Councils for increased capacity in the Environmental Health workforce.
- With reference back to Halloween celebrations there was a request that at the same time when the advice was being given to restrict activities it should also include advice on what could still be undertaken to avoid it being a completely negative message. ACTION: Director of Public Health / Communications Team

- As it was likely that due to the restrictions a larger than usual number of students at universities would not be able to go home for Christmas at the end of the Autumn term a question was raised on what Universities would be doing differently to help support them. ACTION: The Director of Public Health would contact the Universities and come back to the Committee.

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.

341. Public Health Grant Funding For NHS Commissioned Services

The Committee received a report seeking approval to the proposed investment of the Public Health Grant for 2020/21 of £27,248,493, an increase of £1,688,493 or 6.6% on 2019-20 which included funding for meeting the Agenda for Change cost pressures. After these costs, the increase in funding for investment in Public Health was 4.4% £1,120,144.

It was proposed that the following cost pressures for Public Health commissioned services created by the 'Agenda for Change' salary increases should be met through the increased Public Health grant allocation.

- Cambridgeshire Community Services Healthy Child Programme £447,362

- Cambridgeshire Community Services Integrated Sexual and Reproductive Health Services (iCaSH) £94,660

- Cambridgeshire and Peterborough Community Foundation Trust Falls Prevention Programme £6,661

- Cambridgeshire and Peterborough Community Foundation Trust Children and Young People's Substance Misuse Service £4,666

- Change Grow Live Adult Drug and Alcohol Treatment Services £15,000

TOTAL £568, 349

The Committee was also reminded in October it had approved the use of the Public Health grant funding increase, not required to meet the Agenda for Change pressures, to support interventions to address obesity vis the Healthy Weight Programme.

It was resolved unanimously to:

a) Note the increase in the ring fenced Public Health Grant allocation and

b) Approve the allocation of funding to commissioned services to meet the cost pressures created by increases in 'Agenda for Change' salaries as set out in paragraph 2.2 of the report and as detailed in the body of this minute.

342. Recommissioning of Counselling Service for Children and Young People

This report was introduced by Raj Lakshman Public Health Consultant and Karlene Allen Head of Children and Maternity at the Clinical Commissioning Group (CCG). The contract for the mental health counselling service for children and young people's (CYP) health

was due to expire on 30th June 2021 and therefore needed to be re-commissioned urgently to ensure the best outcomes for CYP in Cambridgeshire. This report sought approval to endorse a Section 76 Agreement with Cambridgeshire & Peterborough Clinical Commissioning Group (C&P CCG) which would transfer £280,000 of Cambridgeshire County Council (CCC) Public Health funds per annum to contribute to the re-commissioning of children and young people's mental health counselling service led by C&P CCG creating a three way pooled budget.

The main issues highlighted from the existing service had been the high referral rate. In addition, the service had not always been quick to respond to changes in the delivery model when data and evidence showed it wasn't working. As a result (CYP were being passed around services, causing confusion for families and professionals trying to navigate the complexity of unconnected services. In addition, the 2019 CYP's mental health needs assessment had highlighted further the growing needs and gaps in provision.

One benefit of Covid-19 had been that to avoid duplication, there had been good collaborative working between providers in the CYP mental health system. This had shown commissioners that a local partnership and collaboration model was a realistic option to better meet CYP's mental health going forward. To address the identified challenges it was highlighted that the new service needed to provide:

- A 'single front door' entry to the Cambridgeshire Child and Adolescent Mental Health Services (CAMHS) system so that any CYP referred into the service received the support they needed from the most appropriate service,
- A seamless simplified pathway through a single commissioner across the spectrum of need.
- Systems clinical oversight, quality assurance and a measurable evidence base for the services operating within it.

The report highlighted that a review was being undertaken in respect of the age range the Service should support. Currently the service in Cambridgeshire supported young people from 4-25 years while in Peterborough it was 4-18 years. It was stated that information was being gathered to establish whether the age range in Cambridgeshire should be aligned to that of Peterborough. It was suggested that aligning the age range of the service would alleviate confusion about who could access the service and allow targeted service provision. The report highlighted that the 18-25 year old age group has quite different needs and previous attempts to utilise resource to engage this age group had been unsuccessful and that half of all mental health problems were established by the age of 14 The intention was for the new service to learn and respond to complex issues arising in early adolescent years to reduce problems experienced in later adolescence with the hope that this would be more effective than a broad service covering a larger age range. The officers proposal was that reducing the age bracket would allow more resources to be focused on the under 18s.

In the ensuing discussion, while Members supported the proposal for a single point of entry contact point there was extreme concern expressed regarding moving the age range down to 18 rather than making the proposed unified service adopting the current Cambridgeshire age limit of up to 25, without any supporting evidence that this age range reduction would benefit children with mental health needs as a whole.

Specific Issues raised included:

- That there were a great many children between the ages of 16-18 with mental health problems due to the huge pressures around examinations in that age group and that due to the time often taken to refer them to the appropriate

service, under the new proposal they would now become classed as an adult and referred to adult services that were not appropriate for such young people The Member who raised it expressed the view that there was currently not sufficient support for the 16-18 age group due to the delays in getting them the appropriate support in a timely manner. In response, details were provided of transition care work mental health monies available to the CCG for the 18-25 group whose issues were often more acute and that it was felt were beyond what the service could offer . Therefore this money was being targeted to providing the specialist service they often needed. The Long term plan was for a service for the 0-25 services rather than 0-18 but this was would take time and at the moment with the limited money available, it was considered necessary to prioritise the money for the emotional well -being service needed for the 0-18 age group.

- There was no convincing rationale in the report given for reducing the age range from 18 to 25. The Insight Report link provided in the report when viewed gave even less assurance as on pages 17-19 there was reference to the NHS Plan priority being to provide a comprehensive offer for 0-25 year olds reaching across mental health services and referencing back to page 11 where it stated the prevalence of mental health issues was highest in the age group 20-25 and the 17-19 age group also being very high. She highlighted that in Cambridgeshire three times as many children were diagnosed with mental disorders than in Peterborough and expressed concern regarding a service that did not recognise different need in different areas. There was a clear concern that the contract was being rolled forward without a plan for the 18-25 year olds. While the member making the point understood that there was only a limited amount of money in the budget, the argument could be given that this in fact highlighted more money was required to support rather than cutting the service support to the 18-25 age range. Raj in reply on the Needs assessment study referred to explained that this was based on population estimates applying the national prevalence rates than looking at actual numbers and reflected the size of the population of Cambridgeshire compared to Peterborough. She understood that the report indicated that 18-25 year age group had the largest mental health needs it was more a question of whether the proposed service was the right service for them. It was explained that there was transitions monies CCG Mental Health investment monies available for the 17-25 years olds to help them access the more specialist services needs and online services including ‘Keep your Head’

- It was recognised that the hardest hit group by COVID1-19 was the 18-24 year old age group and yet the report was proposing to take away the service that was more widely used to come in line with Peterborough.

- Reference was made to the County Council’s responsibilities as corporate parents for children in care which covered children up to the age of 25 and these are often the children with the most needs that required protection.

- Highlighted by a number of Councillors was the last sentence in 3.1 that in 2019-20 CHUMS provided interventions for 31 young people who were 18-25 years old with further work underway to understand whether these young adults could be accommodated within another existing service, and whether more broadly there were services with capacity that could cater for this age group. It was suggested that until the answer was known to this, the Committee should not be looking to agree any change to the existing age group for Cambridgeshire

- The point was made the dangers of an arbitrary age cut off point as there were many 19-20 21 year old young people who were mentally immature and for whom adult services would not be appropriate.

- Reference was made to paragraph 3.3 suggesting that the money would be taken from the 18-25 year old group and used for other service support so not only did this suggest it was not known where this group would go to receive a service but that with no details provided that there would be any additional money to provide service provision for this group

- Highlighting paragraph 2.9 with reference to the plethora of suppliers being simplified, a Member sought clarification on whether this meant there would be a reduction in the number of suppliers. It was explained that the lead Commissioner through the one door approach would decide in discussion with the consortium of charitable organisations / providers which of them would be best placed to provide early intervention. The intention was not to reduce the number of providers but to ensure the system worked seamlessly in the allocation of the right service and avoid children being bounced around different organisations.

- One member expressed concern if it was the case that the new model was suggesting providers would need to organise themselves. This was not the case, through CHUMMS providers had been working together to deliver services for at least two years and with the advent of Covid-19 this had gone further with regular meetings to help meet the increased system demand. The intention in the model going forward was to build on this collaborative work to create an overarching service through an improved information flow co-ordinated by the one commissioner.

- The point was made about young men in the wider age group being the most vulnerable to committing suicide and therefore this was another reason that unless there was strong evidence provided that they would be appropriately looked after, there should be no change in the Cambridgeshire age range.

In summing up the Chairman made the point that the Committee, while not having an issue with the Section 76 agreement and Cambridgeshire and Peterborough CCG leading on the re-commissioning of a new Children and Young People's Mental Health Counselling Service or the proposal for a single commissioner to help streamline the system, was not minded at the current time to change the Cambridgeshire service offer away from the current 18-25 age group to fit in with Peterborough. The report had not provided sufficient information on the service provision that was being proposed to support them and until this was clarified, including more information on 'Transitions Funding', on-line service funding and the access to psychological services, the Committee was not in a position to agree any changes to the existing age group for Cambridgeshire children. He asked Democratic Services to update the Agenda Forward plan to receive a report back on this detail at the next meeting.

It was resolved unanimously to:

a) Endorse a Section 76 agreement with Cambridgeshire and Peterborough CCG to lead on the re-commissioning of a new Children and Young People 's Mental Health Counselling Service.

b) Not to agree at the current time any proposal to realign the age range for Cambridgeshire from 4 to 25 to that of Peterborough's of 4-18 years and that a report should come back to the next meeting on the proposed service provision and flexibility of the service offer for 18 to 25 year olds.

343. Supporting Children Young People and Families During Covid-19

This report provided an update on:

- identified risks relating to children, young people and families during the Covid period.
- actions taken to support families and mitigate identified risks.
- the continued development of the Best Start in Life programme.

The report was introduced by Raj Lakshman and Helen Freeman the Team Commissioning Manager. As a result of Government guidance during the pandemic, services provided to pregnant women and families with young children had, had to change. The table in paragraph 2.2 of the report detailed the vulnerable groups and risks that had been identified, alongside actions taken to mitigate the risks shown and the support offered. Section 3 of the report. Details of the Best Start in Life Programme was outlined in section 3.1 of the report. Work had now restarted on the full Best Start in Life Programme with the core team meeting with colleagues from across the partnership fortnightly to oversee the workstreams outlined in the report.

Officers were working to join up the Best Start programme with parallel work that had been looking at the early help offer for children aged 5-19 (or up to 25 years for those with Special Educational Needs) and support for vulnerable adolescents bringing in consultancy support, with the ambition to create a single pre-birth to 19 offer for families. The 5-19 service development underway within the Healthy Child programme would link into this wider system approach.

The Best Start programme workstreams had been split into 2 groups: 'Place Based Pilot Areas' and secondly 'Overarching Themes' with the detail as set out in in paragraphs 3.5 to 3.8 of the report.

In discussion issues raised included:

- That the report was statistics free and would have benefitted from more detail rather than just using words like "significant increases" or "large numbers" as currently it was just a report on what was in place with no sense of learning. A question raised was whether there was data on the uptake of need and whether there was identified unmet need. In reply it was explained that a lot of this information would be provided in the follow up quarterly update report on the Healthy Child Programme scheduled for a future meeting. There had been a large rise in Universal Credit and Universal Partnership Plus applicants leading to requests from families now asking for more support from health visitors and schools nurses with a five-fold increase being recorded from the "Phone Us" and texting service. The main areas advice was being sought was in relation to infant feeding and child development. Working with district colleagues, officers were seeking to understand and identify families' needs from those who had not previously approached the service but who were likely to be more vulnerable, to ascertain how best to help them access the services they required.

- Referencing breast feeding on page 30 and the fact that in previous reports the low uptake in Fenland and clear geographical disparity between districts had been identified, a question was raised on whether the Covid pandemic had made things worse, highlighting that the Committee had been promised a report back on breast feeding support. It was explained that breast feeding detail in Fenland was complicated, with many children delivered in the Queen Elizabeth Hospital, but data received provided a mixed picture. However, during the first period of lockdown, there had been

an increase in breast feeding rates particularly in Fenland and Peterborough. It was surmised that this was possibly due to mothers staying at home and having more time to be able to breast feed. There was a new contract with NCT which had been running in Peterborough, and from April also covered the Fenland area with mobilisation now having started, following support worker training. Support included setting up and running peer support groups and liaising with hospitals to identify those mothers who wished to receive home calls. Substantial support was also being undertaken through video conferencing and if there was also a clinical need, providing face to face support.

- In respect of the above, the Chairman understood that a clinic had now opened in Wisbech. It was confirmed that clinics had opened in Wisbech and March as part of Healthy Child Programme but due to Covid restrictions it was not operating as a face to face clinic at the current time for drop in appointments and was only taking pre- booked appointments. It would be re-opening for the wider service when it was safe to do so.

- Page 35 referencing the recovery phase, one Member raised concerns at the use of this word for what she believed was more correctly the restoration of services w3ith the assumptions now being made in reports that the Health Service and Country was in recovery from Covid which was not the case, and suggesting that that the NHS should clarify what they meant by the term 'recovery phase'. While accepting the Members point that the NHS was still more in a reactive, responding phase, the term was being used by the NHS in terms of services restarting, such as immunisation and screening services and to identify some areas where recovery was being seen, such as children returning to school and undertaking the support that was needed. The Member in response suggested that restoration of services might be a better term.

- Taking on board an earlier comment, there was a request for more information about how identified rising and new need would be addressed and a request that there should be a further report back to Committee in due course. On families that were new to the Service, close collaboration work was being undertaken with district councils to establish whether there was already other data available and also whether there were other ways to identify families whose circumstances were changing. Liaison work was undertaken to establish individual needs, including what early help was required and directing them to the services required with a great deal of outreach work being undertaken. It was clarified that it was not necessarily new types of need, but families wishing to access services that were new to the system as a result of changed circumstances.

- Increased 'Domestic Violence' has been significant problem during lockdown and concern was expressed regarding the difficulties experienced by some families that had been under threat finding alternative accommodation, with the Member asking for assurance that people requiring alternative housing would be accommodated. As a result of the awareness of the increase in 'Domestic Violence;' Social care colleagues had an increased focus on keeping eyes on children particularly at recognised stress times such as during pregnancy and the first year of life and undertaking supervision as much as possible through face to face new birth visiting, video conferencing, essential weigh clinic appointments or from the six to eight week check. There had been a look back at all babies born during lockdown and only two babies had not received face to face visits. There with an emphasis on making sure those identified as being potentially vulnerable had received a visit.

- Asking whether the baby weighing programme had reduced during lockdown and what was mean by self-weighing stations. The Healthy Child Programme had continued during Covid with all checks being offered, although face to face appointments had reduced. During initial lockdown it was decided that it would not be possible to have large clinics for social distancing reasons, but these were replaced by essential baby

weighing clinics by appoint but only, or from a referral from maternity or health visitors. These had been extended across the County and all mothers of babies that had not had a home visit were invited by a specified appointment time to go to have their baby weighed and examined. There was calibrated equipment there to allow them to weigh them themselves but help was also on hand if needed.

It was resolved unanimously to:

a) note the progress made to date in responding to the impact of the ongoing Coronavirus pandemic on children, young people and families, and the continued development of Best Start in Life.

b) To receive a further report at a future meeting on how the Healthy Child Programme has adapted to meet the identified increased needs.

344. Homelessness – Safeguarding the Benefits of Additional Services

This paper was provided in response to a request from the Committee for information about the impacts of the COVID-19 pandemic upon the homeless population and how the benefits that had been secured following the requirement to house the homeless and provide medical check-ups during the period would be maintained going forward.

At the start of the pandemic the Government introduced a number of emergency measures aimed at reducing the risks to the homelessness population with the Cambridgeshire Sub-Regional Housing Board overseeing and co-ordinating the local partner response as detailed in the report. All districts were charged with identifying needs and creating a personal housing plan for each resident in emergency accommodation, and where possible other homelessness accommodation, to secure a move-on plan to include any support or other services necessary to help the person settle into a longer term housing solution. The Socially Vulnerable Group Cell had worked closely with housing colleagues to facilitate additional support for those housed in the emergency accommodation from other organisations.

Other areas included:

- The county-wide Trailblazer team producing a new protocol for people with substance misuse, mental health and housing issues in order to create a longer-term guide for staff on those issues which were particularly challenging when together.

- Public Health working with housing and environmental health colleagues from the districts to produce a COVID-19 risk assessment and information for the emergency accommodation and other Houses of Multiple Occupation (HMOs).

- Partners from across health and social care working to increase and improve access to services. Reports from vulnerable individuals housed during this period had been positive with reported improvement in treatment outcomes and their overall health and wellbeing. This marked improvement included having access to decent nutrition while being in emergency accommodation. Going forward there were now many more homeless people registered with GPs and receiving the services that they needed, with one of successes being the increased testing for Hepatitis C and those affected obtaining effective treatment.
- Public Health commissioners of Drug and Alcohol services working to make service user pathways clearer especially into mental health services and promoting registration with a General Practitioner (GP).

- As a result of significant gaps having been identified in access to mental health services, the Cambridgeshire and Peterborough Foundation Trusts (CPFT) and the Clinical Commissioning Group (CCG) agreed that extra resources would be available and the CCG provided funding for training to the District Council Homelessness Teams to help them better manage the identified homeless clients..

- Details were provided and tribute paid to the substantial contributions from voluntary and community organisations which enabled services to be provided throughout the pandemic.

- Details were provide of the Government's "Next Steps" Fund launched in August to provide an immediate response to the crisis but to also create a national asset to try to prevent homelessness growing again when the recovery began. Bids had been submitted for both capital and revenue funding from the district authorities to help secure more permanent housing and private sector rented housing. Table 1 of the report summarised what had been included in the bids.

- The COVID-19 situation had demonstrated the issues that rough sleepers faced in addressing their substance misuse issues. As a result, central government and Public Health England, jointly with the Ministry of Housing, Communities and Local Government (MHCLG) had identified 43 taskforce areas targeted for additional substance misuse funding for rough sleepers. Cambridge and Peterborough being two of the areas. Paragraph 2.13 provided details of bids currently being prepared in these areas, led by Public Health along with other partners along with the gaps that they were designed to plug. Other areas included the need to increase testing and screening for tuberculous. The outcomes of the bids were due to be announced in November.

- A recent review of homelessness services led by the County Council included several recommendations to improve homelessness services locally and build cross-issue partnerships. Paragraph 2.17 set out the benefits proposed.

- Highlighted were the following ongoing issues which could still lead to increased homelessness:

    a. Evictions had been stopped at the start of the pandemic but they would be re-starting.
    b. The economic downturn with job losses leading to the threat of eviction and homelessness.
    c. Access to services although improved was not equal across services and would require partners to continue to develop pathways in to and for the homeless. Mental health services was an area that was still an ongoing issue and also primary care and further work was currently being undertaken in this area by the CCG.

There was a discussion on whether moving forward councils would have the resources to continue the initiative programme, with one member citing the figures in table 1 in the report to express her disappointment at the combined investment undertaken by Huntingdonshire, East Cambridgeshire and South Cambridgeshire district councils when compared to the efforts that had been made by Cambridge City Council. This was even when accepting that the City had greater needs than the more rural areas due to the size of its population. In reply it was explained that there were initiatives from each district to reduce the use of emergency accommodation such as hotels and bed and breakfast accommodation, and each district had a plan, including a personalised plan for each person to take them out of such accommodation and provide alternative accommodation where possible. Coming to winter each person had to continue to meet with their allocated liaison officer. On securing additional accommodation, Peterborough, Cambridge and Wisbech had submitted significant bids. All revenue bids submitted by the district councils had so far been successful, and the districts referred to earlier by the member as having a disappointing level of spend, had in fact been advised by MHCLG officials to initially limit themselves to revenue bids as it was not believed that they would be able to spend capital grant monies in the tight timescales required. There was however three more years of 'Next Step' funding so there would still be opportunities for them to make further bids.

It was unanimously resolved to:

note the information provided in the report

345. Quarterly Liaison Meetings

Due to the Covid-19 pandemic liaison meetings were cancelled for Quarter 4 (2019-2) and Quarter 1 (2020-21). This report updates the Committee on the liaison meetings undertaken with the following health provider covering Quarter 2 (2020-21):

- Cambridgeshire and Peterborough Foundation NHS Trust (CPFT)
- North West Anglia Foundation NHS Trust (NWAFT)
- Cambridgeshire University Hospital NHS Trust (CUH)

- An Issue of clarification was raised regarding page 50 in respect of the CUH liaison report on the policy regarding testing for covid before elective surgery and whether this would be undertaken by the hospital or was the responsibility of the individual. From those who had attended the meeting it was clarified that although other hospitals might follow different rules for Addenbrooke's Hospital anyone who was due for surgery there was required to self-isolate for a period before the day of the operation and then when they came to the hospital they were tested to ensure they were covid infection free

It was resolved unanimously

To note the report.

346. Committee Agenda Plan

There was a request to officers that in order to allow Committee Members the time to adequately undertake their role they should receive the Covid update report earlier than the day before the meeting and even more so, the papers for the Chairman and lead member meeting. While the Covid update report was produced late to be able to provide Members and the public with the most up to date information, officers would aim to meet the request where at all practicable.

Having discussed additions to the plan raised earlier in the meeting,

It was resolved unanimously:

To note the agenda plan with the following additions and also other issues traised that required to be discussed further:

a) a further report on the Counselling Service on the detail of the mental health services to be made available to those in the 19-25 age group.

b) A further report on the actions being taken to support children young people and families during covid-19.

c) A further report to be scheduled for either the January or February Committee meeting on Dental services.

d) A report on the Obesity and Healthy Weight Programme for either the November or the December meeting if any decisions of the Committee were required.

e) The Care Quality Commission Report on the East of England Ambulance Trust to be discussed at the next Chairman and Lead Member meeting on the best way forward.

Chairman

November 2020

Appendix 1

PETITION RECEIVED WITH OVER 1400 SIGNATURES FROM ADDRESSES WITHIN THE CAMBRIDGESHIRE COUNTY COUNCIL AREA TITLED ‘REVERSE THE OUTSOURCING AT NORTH WEST ANGLIA HOSPITALS’

The text of the petition read:

A few weeks ago NHS staff were praised as heroes, but now North West Anglia Foundation Trust (NWAFT for short) want to sell us off to a new private employer.

In cleaning, catering, linen, patient services, porters, post room and security, we’ve been giving our all during the pandemic – and long before – but as thanks, we face being thrown out of the NHS family.

Indeed, the Trust, which runs Hinchingbrooke, Peterborough City and Stamford & Rutland hospitals, chose to tell us we could be sold off in the middle of the pandemic.

The Trust wants to outsource more than 70 of us, joining over 100 workers currently employed by three different private firms into one single contract.

Outsourcing is bad for staff – workers are paid less than their directly employed NHS colleagues, conditions are worse, standards are worse and morale will plummet.

And it’s bad for patients as well – private providers are responsible to their shareholders, not the public. Outsourcers are driven by getting a profit out of the contract, not providing patients with the best possible care and support.

There is plenty of academic research to show that hospitals with outsourced cleaning departments have lower standards of cleanliness than in-house services. This is particularly concerning given the ongoing threat from coronavirus and real possibility of future spikes.

We are calling on the Trust to stop this outsourcing immediately and keep us in the NHS.

Supported by our unions, UNISON and Unite, we are also calling on the Trust to reverse the existing privatisation of services across the three hospitals and bring everyone back under a single employer: the NHS.