HEALTH COMMITTEE

Thursday, 11 March 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** *Guidance on declaring interests is available at* http://tinyurl.com/ccc-conduct-code	
2	**Health Committee Minutes 12th Feb 2021**	**3 - 10**
3	**Health Committee Minute Action Log from February Committee meeting**	**11 - 14**
4	**Petitions and Public Questions**	

SCRUTINY

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 Kevin Reynolds Councillor Mandy Smith and Councillor Susan van de Ven

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

Clerk Name: Rhiannon Leighton
Clerk Telephone: 01223 728170
Clerk Email: Rhiannon.Leighton@cambridgeshire.gov.uk

HEALTH COMMITTEE: MINUTES

Date: 12 February 2021

Time: 1:30 pm – 2:51 pm

Venue: Virtual Meeting

Present: Councillors Boden, Connor, Dupré, Goldsack, Hay (Vice-Chairperson), Jones, Van de Ven, Ambrose-Smith, Clarke, Wilson, Harvey and Massey

356. Apologies for Absence and Declarations of Interest

Apologies were received from Councillors Hudson, Harford, Reynolds and Smith. Councillors Goldsack, Boden substituting. Councillor Hay acting chairperson.

Following from her passing, Councillor Taverner from the Huntingdonshire District Council was substituted by Councillor Wilson. A minute's silence was held for Councillor Tavener.

Councillor Goldsack declared a non-pecuniary interest under the Code of Conduct in Agenda Item 6, as Chairman of Soham Town Rangers Football Club, currently housing a lateral flow test site.

357. Minutes – 21st December 2020

The minutes of the meeting held on 21st December 2020 were agreed as a correct record and would be signed by the Vice-Chairperson when the Council returned to its offices.

358. Action Log

The Committee noted the action log.

359. Petitions and Public Questions

No petitions or public questions were received.

360. Healthy Child Programme - Service Delivery During the COVID-19 Pandemic

The Committee received a report summary of performance information relating to the 0-19 Healthy Child Programme, an integrated (across Cambridgeshire and Peterborough) Health Visiting and School Nursing service linked with the Best Start in Life programme.

The report examined the impact of Covid-19 on the Healthy Child Programme during 2020 including the impact on families and changing demand into the service; actions taken to respond to these challenges and changes to the delivery model; and service performance during this time with feedback from families.

When invited to speak, the presenting officer highlighted the evolving ways in which the programme had responded to each of the three phases of the pandemic.

Phase 1: Officers reported that during lockdown, the service offered in-person and virtual support for families. The type of support received was determined by clinical need, with more in-person contact for those on Universal Plus and Universal Partnership Plus pathways. Overall, there was an increase in texts to operators which was thought to be because other services were not operating. Fortunately, the Healthy Child Programme was still able to operate at full capacity, with no staff redeployment. Attention was also brought to section 3.1 of the report which stated that during lockdown antenatal and New-birth visits, FNP and safeguarding work were prioritised.

Phase 2: During the 'Recovery and Restoration' phase, the reporting officer stressed that there had been an increase of parental anxiety regarding feeding and toileting, and more reports of domestic abuse. However, she also informed Members that an audit had been conducted on non-accidental injuries in babies which showed that Cambridgeshire and Peterborough levels of incidents were not high in comparison to the national average.

Phase 3: It was reported that a letter from Chief Nursing Officer had been published in Phase 3 of lockdown which provided a clear mandate nationally that there should be no redeployment of staff from Healthy Child Programme.

The service was reported to have expanded the universal offer of a single point of access to aid parents in contacting the Healthy Child Programme. The result has been an increase in families using text and online support services. Attention was brought to 4.3 which underlines the importance of online promotion and social media in advertising the service; and to the introduction of a telephone number - 'Call us' - to improve access to support services.

It was noted that throughout the pandemic, video consultation and telephone consultation increased, while mandated health visitor contact has been maintained with some face to face 'in-person' contact. Face to face contact has been undertaken with the appropriate PPE and prioritised for children on the Universal Plus and Partnership Plus pathways. The aforementioned pathways have expanded as elements of the programme.

The officer report concluded by stressing that the targets set out in the report were local, rather than national, targets and that, in comparison to national performance on mandated checks, Cambridgeshire did well.

In response to Member's questions, officers:

- Acknowledged that the pandemic was ongoing and cyclical in nature, despite the term ‘Recovery and Restoration’ that has been used by the NHS to refer to Phase 2 [and Phase 3] of the pandemic. They were unaware as to whether this terminology would change.

- With regard to section 3.2 of the report, officers clarified that there was no increase in the number of ‘non-accidental’ injuries to babies. They stated that they had worked across systems to ensure support provided to parents was adapted to meet issues arising from the pandemic. As a result, the service offered in-person support, virtual support, and delivered hygiene and activity packs. The ICON system is being promoted to normalise problems such as babies crying and to lessen associated parent distress. The effectiveness of this messaging and support will be reviewed in the next few weeks.

- Informed Members that, after an initial ‘reactive’ learning process, learning about responses in a pandemic was ongoing. Members were directed to section 9.6 of the report which established how this learning was implemented to create a more integrated service. Officers provided examples of what Public Health has educated itself on, including:

    - The importance of providing new parents with physical appointments when needed in addition to online infant feeding appointments. This was implemented after an increase in repeated user calls about feeding to the service.

    - The impact that lockdown has had on parental anxiety as it lessened social support networks. This was noted following an increase in prevalence of parental anxiety as the underlying reason behind calls to the service. Consequently, the service began discussing mental health during calls.

    - The importance of using ‘Teams’ as an informal and formal meeting platform.

    - The diverse response to video, rather than in person, appointments. This includes positive reports from some families regarding the accessibility, and negative reports from some young people and those struggling with body image.

- Confirmed that staff anxiety levels have been often high and keeping staff morale up is a constant challenge. Officers noted ongoing challenge with recruitment and retention. Senior management in the HCP was praised for their response to this problem.

- Expressed hope for a more permanent workforce and stable management. This was following successful recent recruitments to vacancies including filling vacancies in the management structure.

- Confirmed that they had maintained 95% coverage of 1½ and 2 years checks if exception reporting (which included those where an appointment was offered but

declined or not attended by the family) was taken into account. This allowed the 0-5 Health Visiting service to 'remain our eyes and ears on the ground'.

- Noted that zoom and You-tube talks, letters and school communication were used by schools, community hubs and Rapid Response teams to interact with parents. Officers provided examples of information Public Health had distributed advising parents of ways to follow Covid-safe practices in the home over half-term.

- Reported that, with regard to section 6.3 of the report, SEND referrals were ongoing but fewer referrals were occurring. It was suggested this was partially because parents were shielding children at home and not exposing them to external environments where issues were typically picked up. Therefore, the service expected more delayed SEND and mental health diagnoses.

- Explained that they were unable to open the report with a case study, as the report was in the public domain. However, they confirmed that they were aware of case studies, some of which were included in the Quarterly Contract Monitoring meetings.

- Informed members that while vison screening was not being done in school, the vision screening team had been inviting families to community clinics for screening where there were concerns. In addition, the team is working with CUH to pilot the use of a digital screening platform across the county. Digi-viz – a digital platform – was developed by Addenbrookes Hospital to screen children while face to face contact was limited.

Individual Members raised the following issues in relation to the report:

- Thanked the authors for the report. Praised the NHS staff for their role in combatting the Pandemic.

- Noted that, in 2.1 of the report, the lexis 'Communities' should read 'Cambridgeshire Local'.
  ACTION REQUIRED

- Raised the importance of thinking around problems such as internet poverty which impacted users access to the service.

- Expressed concern that the statistics for children and young people contacting ChatTeam services (15 contacts a day) was relatively small.

- Expressed concern about the Liquidlogic system causing barriers to SEND referrals. Officers reassured members that Liquidlogic had not yet been highlighted as a barrier to referrals, but that they could check with this with the providers.
  ACTION REQUIRED

It was resolved to note and comment on performance information and take remedial action as necessary.

361. COVID-19 Issues Report

The committee received a late report detailing Cambridgeshire County Council's Public Health response to the COVID-19 crisis commencing the second wave. The Vice-Chairwoman accepted the report as late on the following grounds:

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

- 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 service for which it is responsible.

The report presentation informed Members that the second wave had seen a higher proportion of hospitalisations and deaths nationally and locally. In Cambridgeshire, coronavirus cases peaked on 4th January 2021 at 500 cases per 100,000. Since lockdown on January 5th, cases lowered nationwide, with Cambridgeshire remaining below national and east England averages. The lowest rates for Cambridgeshire were in Cambridge, while rates of decline in Peterborough and Fenland were slower. It was suspected that the age demographics and quantity of key workers in Peterborough and Fenland populations predetermined these lags. (Officers reported a younger demographic in Peterborough, and an older demographic in Fenland.)

The reporting officer proceeded to give explanations of the different actions taken by the council in response to guidelines from the government and the local initiative.

Officers noted that a letter has been received from the MHCLG and Ministry of Health and Social Care outlining the role of local authorities in vaccinating. The letter highlighted the responsibility of the Council to locate possible vaccination sites, aid accessibility, vaccinate care staff, and communicate with communities. Members and officers acknowledged that this meant the Committee would need to transition from a commissioning directorate to an operational directorate. In response to the letter, officers reported that the rapid national vaccination programme had been rolled out across Cambridgeshire through primary care networks, large scale vaccination centres, hospitals and was being piloted in pharmacies. They reported an expectation that responsibilities for the vaccination programme would become increasingly local, especially for the final 10% of vaccinations.

Members noted that the council had responded to rates of infection occurring in the work setting, by developing rapid lateral flow testing kits which would be available in every district by Monday 15th February 2021. These would be available twice a week for possible asymptomatic workers. Symptomatic individuals remained encouraged to go to drive through test sites.

In preparation for a possible influx of coronavirus cases, officers noted that various actions would, and had, occurred. Response plans had been developed for the possibility of new strains entering into Cambridgeshire. These were influenced by Hertfordshire's approach to the South African variant. Also, contact tracing needed to be made sustainable, and an assessment of the workforce and operational needs would be taking place.

Officers drew attention to the ongoing weekly COVID Gold meetings in which Public Health collaborated with district councils to deliver epidemiology information. This enabled prevention and rapid response.

The officer concluded by emphasising that cases were still high – at 186 cases per 100,000. This was over ten times higher than the numbers seen in summer and early autumn. Therefore, officers reinforced that it how imperative it was individuals followed control measures and lockdown restrictions in order to drive down the rate of infection.

In response to Members' questions officers:

- Commented that outbreaks of coronavirus in schools were being managed by education staff, Public Health staff, headteachers and their staff. Officers reported that these individuals had a strong understanding of pandemic prevention and were prepared for an increase in cases as coronavirus strains developed and schools returned. Members were also asked to note the provision of both local and national support for schools.

- Reassured Members that the Public Health team had attended Cambridge University Gold meetings and was monitoring the university return. At the time of the presentation, they were satisfied that the right measures were being put in place by the university.

In discussion Members:

- Reported on the success of Public Health's involvement in community support groups in South Cambridgeshire.

- Reported that the Soham Town Rangers Football Club lateral flow test site had tested 130 individuals on Friday 12th February 2021 with no COVID-positive results.

- Showed concern that consistently national responsibilities were handed down to Public Health, but that resources given to Public Health was not reflecting this change.

- Informed officers of a case whereby a local resident was unable to go to their nearest vaccination centre. The Member expressed concern that this may be occurring elsewhere. Officers informed Members that they would pass the information on to the CCG, but that community transport should also be available to improve vaccination site accessibility.
  ACTION REQUIRED

- Expressed concern about the ability of NHS diagnostic services to handle non-COVID related health problems under the strain of the pandemic. In response, the Director of Public Health said she was unable to comment but suggested Members could raise it as a topic for scrutiny in future.

It was resolved to note the progress made to date in responding to the impact of the Coronavirus and to note the Public Health service response.

362. Scrutiny Item: NHS Dental Services

Representatives from Cambridgeshire Dental Services were unable to attend the meeting, due to the ongoing Category 5 incident [the COVID-19 pandemic]. Apologies were received.

It was resolved unanimously to postpone the scrutiny item until the next meeting, or until an appropriate time could be found.

363. Health Committee Agenda Plan and Appointments to Outside Bodies and Advisory Groups

The Committee resolved unanimously to note its agenda plan. There were no appointments made to outside bodies and advisory groups.

Chairman

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. 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 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.		
Meeting 15th February 2021				
1.Healthy Child Programme - Service	Raj Lakshman	Check with providers whether Liquidlogic has been a barrier for SEND referrals.		

Delivery During the COVID-19 Pandemic				
2. Public health response to COVID-19	Liz Robin	Inform CCG of a case where a local resident was refused vaccination at their nearest vaccination centre.		

Cambridge Cancer Research Hospital – Project and Engagement Update

To:	Health Scrutiny Committee Meeting
Meeting Date:	11th February 2021
From:	Cambridge Cancer Research Hospital patient engagement team at CUH
Electoral division(s):	All
Key decision:	No
Forward Plan ref:	N/A

Purpose:	The purpose of this report is to formally brief the Committee on the ongoing work to engage and involve patients in the production of Cambridge Cancer Research Hospital. We are also seeking to invite two councillors to join the Cambridge Cancer Research Hospital project as 'liaison councillors'. We hope that, in a similar manner to the Cambridge Children's Hospital, the councillors will work closely with us, and represent the interests of the Health Committee.
Recommendation:	The Health Committee is asked to note the report and confirm that formal consultation is not required in the development of the Cambridge Cancer Research Hospital.

1. Background

As the Committee will remember, in 2018 the Trust Board of Cambridge University Hospitals (CUH) formally submitted a business case for the construction of a Cambridge Cancer Research Hospital (CCRH) alongside one for Cambridge Children's Hospital to NHS England/Improvement. Despite best endeavours, this was not approved at the time.

On the 2nd October 2020 the Prime Minister announced that the NHS Health Infrastructure Plan ('HIP') would include funding for the Cambridge Cancer Research Hospital. Please note that management of the HIP is now under the remit of the NHS New Hospitals Programme ('NHP').

Planning work for this exciting new phase of cancer care on the Cambridge Biomedical Campus did not cease between 2018 and 2020, and the government funding announcement has allowed us to once again submit a business case to capture that planning.

On the 19th February 2021 we submitted the Strategic Outline Case (SOC) to NHSE/I, which they will submit to the Department of Health and Social Care (DHSC) and Her Majesty's Treasury (HMT) for formal approval to meet to the next phase of business case planning.

Meanwhile we continue to work apace towards the next phase of development – submission of an Outline Business Case (OBC) (approx. June 2021) and a Full Business Case (approx. August/September 2022) with a view to this transformative new hospital being completed in November 2025.

2. Main issues

2.1 Cancer patient engagement and involvement at CUH and across the Biomedical Campus

There are many patient representative groups across the Campus, including:

- The Addenbrooke's Cancer Patient Partnership Group (CPPG);
- Breast Cancer Research Unit cancer PPI Group;
- CRUK Cambridge Centre/Cambridge ECMC PPI Group;
- CRUK Cambridge Centre Ovarian Cancer Programme.

The Addenbrooke's CPPG is open to all cancer patients and carers, past and present. The group currently works with hospital staff to improve cancer services by sharing patients' views and raising concerns on their behalf. The other patient representative groups work with researchers in specific areas of cancer; there is at least some, if not considerable, overlap between the groups on the campus.

2.2 Co-production at CUH

The Addenbrooke's CPPG has been very active in recent years, with the appointment of a dedicated Macmillan Co-Production Lead. It currently has around 50 members.

Below are a few of the recent CPPG's projects:

- Co-productive of information aim at people referred for suspected on the two week wait pathway. Aim to increase attendance for screening and to empower people to revert to their GP should they be waiting beyond the two week wait target;
- Co-designed with staff the refurbishment of the CUH Oncology Outpatients Department;
- Led participation of cancer voices in the Trust's Reader Panel to improve patient information leaflets;
- Co-produce with staff Improvement of the plasma screens in Oncology Outpatients, leading to adoption of the same principles Trust-wide;
- Led from experience on the creation of system wide information on patient buddy schemes to share with patients and staff.

The group has demonstrated the value of patient involvement. Co-production is now considered essential by CUH Cancer Services when planning new developments or looking to improve services.

Our co-production video on how patients and staff work together to improve cancer services can be seen here .

2.3 Patient involvement so far in plans for the Cambridge Cancer Research Hospital

Patients have been deeply and intrinsically involved in our plans for the Cambridge Cancer Research Hospital from its inception. Prior to the original submission in 2018, there were stakeholder engagement events where clinical staff and CPPG members shared their combined views to shape what services and spaces they wanted included in the new cancer hospital. This included an away day to collect views and later a series of stakeholder events to review and further evolve the building design.

The outputs of these co-produced discussions were fed into the CCRH design team, and subsequently been incorporated into the design plans. Examples of this co-production approach can be seen in the use of side room design, the suitability of underground tunnels for moving patients between different locations and the flow of patients around the building.

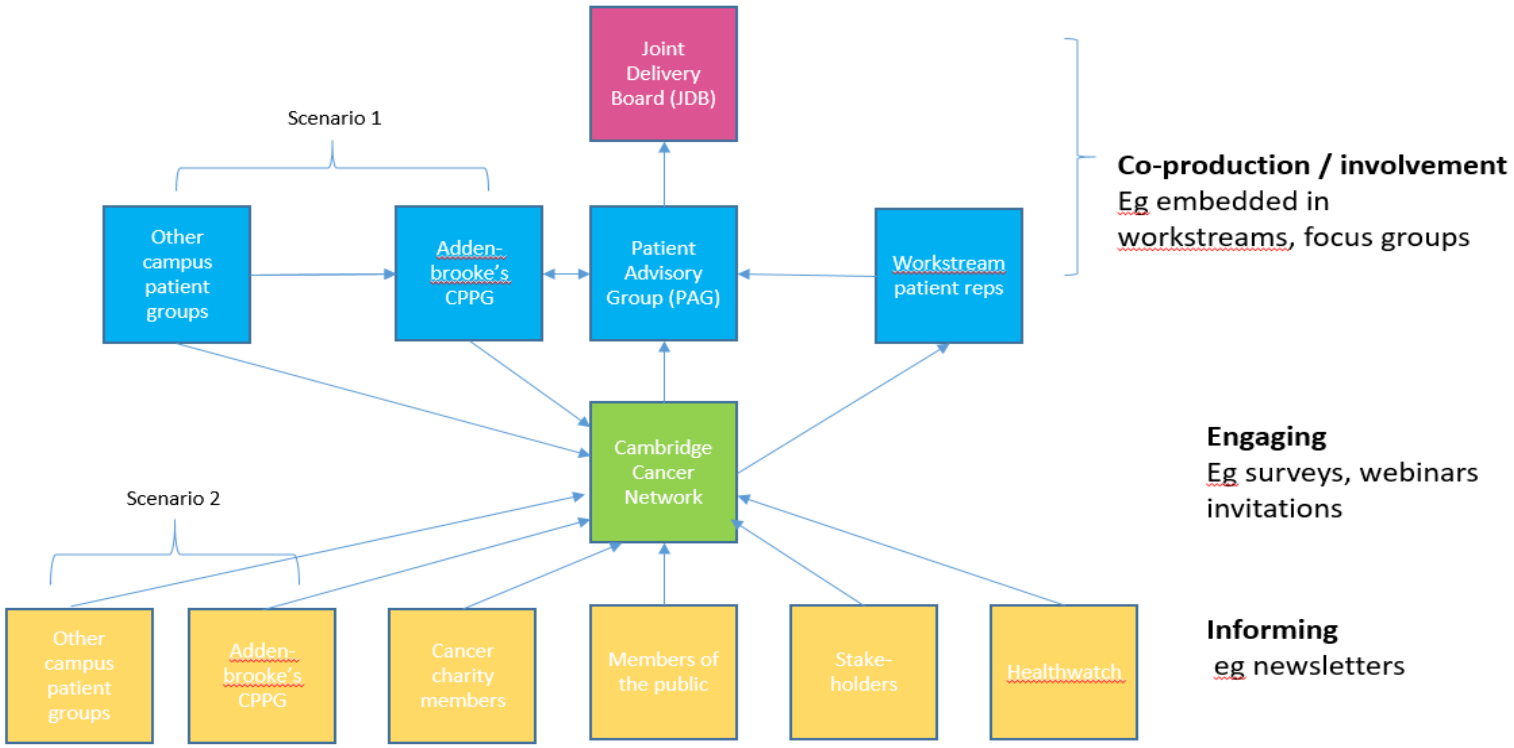
In November and December 2020, we held a series of staff and patient engagement sessions for each specialty with the architects. We are repeating this again in April 2021. These were held remotely and attracted good levels of attendance. The architects ran through the 1:200 scale layouts with staff and patients and invited feedback which has been fed into the next round of drawings for the OBC.

2.4 Where are we now?

2.4.1 Patient engagement strategy

As we move into the OBC phase of the project we are working with patients to fully understand how they would like to be involved, and to set up bespoke PPI groups for Cambridge Cancer.

Provisional patient and public engagement plan for Cambridge Cancer:



This model is being co-produced with members of the CPPG.

We will be setting up a new Cambridge Cancer Network which will be a virtual group of people who have opted to be kept informed and take part in activities (such as surveys or webinars) from time to time. We will recruit to the Network by sending out invitations via partners, existing groups and through the website with an aim to have a Cambridge Cancer Network that reflects our local population.

We will also set up a new Cambridge Cancer Patient Advisory Group (CCPAG) which will be involved at a co-production level. We are currently still seeking further consensus on whether the PAG should be a sub-committee of the Addenbrooke's CPPG (scenario 1) which co-opts members from other campus patient groups and the Network, or a standalone group which draws from the Network (scenario 2).

Discussions are ongoing with the CPPG and the other patient representative groups around the campus to determine which scenario is chosen.

2.4.2 Workstream representatives

As of March 2021, we will formally embed patient representatives into workstream meetings, and via their involvement we will co-produce the role descriptions and responsibilities for the remainder of the project duration.

During March, two patients will join each of the CCRH Joint Delivery Board and the Communications and Engagement workstreams. Learning from this experience, next month we will roll this out to the clinical models of care and design, industrial strategy, and construction workstream meetings. We anticipate the workstream roles to rotate on a six month basis, with the opportunity to extend for a further six months if appropriate. This way the burden is not too significant for any one person, and the opportunity to be involved is open to more patients. Some workstreams, such as clinical models of care, may need more than two patient reps.

We will invite people from the Network and from campus patient groups including the CPPG to put themselves forwards for the workstream roles. Role descriptions and a process for selecting representatives (if the positions are oversubscribed) will be co-produced with patients.

All workstream patient representatives will be part of the CCPAG, which will be an opportunity for the workstream reps to meet and discuss their experiences working with the workstreams. They will provide a report to the CCRH Joint Delivery Board on their observations and experiences.

2.5 Consultation

The involvement of patients and the public in the plans for the new Cambridge Cancer Research Hospital is critical to its success. Given that the plans involve the rebuild of the facilities on the same site, it is the view of NHSE that there will be no substantial change for patients and formal consultation is **not required**. No services are being stopped or halted, and this project is a natural progression to improve care and integrate research closer to clinical expertise. In simplest terms, it's a re-provision of the existing services, albeit in a significantly improved setting of care, approx. 300 metres from the existing services.

As patient engagement and involvement is critical to the delivery of the hospital, the project team is meeting regularly with the NHS Engagement lead to ensure that all opportunities to involve patients are explored and it remains a priority for the project. This report sets out how the project team is working with patients to ensure that co-production is embedded at the heart of each stage.

Agenda Item No: 6

Briefing Paper in Response to Childhood Immunisation Uptake During COVID-19

To:	Health Committee
Meeting Date:	11th March 2021
From:	Director of Public Health
Electoral division(s):	All
Key decision:	No
Purpose:	This report provides an update on: - System response to promoting childhood immunisation uptake during the current Coronavirus pandemic - What the data is telling us about how the Coronavirus pandemic has impacted childhood immunisation uptake, including the winter flu vaccination
Recommendation:	The committee is asked to note and comment on the actions undertaken to date in responding to the impact of the ongoing Coronavirus pandemic on childhood immunisation uptake.

Officer contact:
Name: Raj Lakshman/ Helen Freeman/ Amy Hall
Post: Public Health Consultant/ Team Commissioning Manager
Email: Raj.lakshman@cambridgeshire.gov.uk/ helen.freeman@cambridgeshire.gov.uk
Tel: 07905989337/ 07775406283

Member contacts:
Names: Councillors Peter Hudson/ Anne Hay
Post: Chair/ Vice-Chair
Email: Hudson.Peter@cambridgeshire.gov.uk/ Hay.Anne@cambridgeshire.gov.uk
Tel: 01223 706398

1. Background

1.1. Immunisation is one of the safest and most effective ways of providing protection against disease as, following vaccination, people are far less likely to catch the disease if there are cases in the community. Beyond the individual level, vaccination has numerous benefits for society. If a proper immunisation schedule is implemented in a population, even those who are not vaccinated such as new-born babies, elderly people and those who are too sick to receive vaccination, can benefit from this *herd protection*[1].

1.2. It is widely acknowledged that vaccination programmes have an enormous positive economic impact. Though vaccines require funding, they lead to long-term savings through reduction in health costs and avoidance of loss of productivity from the workforce.

1.3. The ability to reliably measure vaccine coverage plays an essential role in evaluating the success of a vaccination programme, identifying susceptible populations for further interventions, and informing future vaccine policy decisions.

1.4. Children in the UK are vaccinated against a number of infectious diseases through the NHS-funded childhood vaccination programme which protects children from: diphtheria, haemophilus influenza type B (Hib), Human Papilloma Virus (HPV), influenza, measles, meningococcus (ACWY and B), mumps, pertussis (whooping cough), pneumococcus, polio, rotavirus, rubella and tetanus.[2] In addition, children at-risk also receive the BCG vaccination against tuberculosis and hepatitis B vaccine.

1.5. The aim of the universal childhood vaccination programmes is to achieve 95% uptake, although the target uptake in the Public Health Outcomes Framework is 90%.

1.6. The Local Authority does not directly commission childhood vaccination programmes although is responsible for promoting uptake. Infant/early childhood vaccinations are provided through Primary Care, and the school-based immunisations are is provided by community services commissioned by NHS England.

1.7. The Healthy Child Programme (HCP) commissioned by Public Health have the promotion of childhood vaccinations as a core part of their service specification.

2. Context

2.1 Concerns have been raised that the Coronavirus pandemic may have caused significant reduction in childhood vaccinations uptake. It is thought that parental anxiety relating to attending a surgery or clinic setting, along with perceived access and delivery disruptions may be a barrier for parents getting their child vaccinated. There are also concerns that

[1] https://www.abpi.org.uk/new-medicines/vaccines/economic-and-social-impact-of-vaccines/

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/899423/PHE_Complete_Immunisation_Schedule_Jun2020_05.pdf

parents will not know whether a fever in their child following immunisation is due to their immunisation or to COVID-19.

2.2 The UK Government's guidance throughout the pandemic is that the childhood vaccination schedule should continue during this time[3]. The World Health Organisation (WHO) have warned that disruption to vaccination programmes during a pandemic can result in an increase in vaccine preventable diseases, stressing the importance of immunising children[4].

3. Infant and Early Childhood Immunisations

3.1 A previous paper to Health Committee on 17th September 2020 summarised the 2020/21 Q1 data (April-June 2020) and this paper provides an update.

3.2 The latest publicly available data is from Q2 2020/21 (July - September 2020)[1]. Please note that this is a provisional data set.

Table 1 - Vaccination coverage at 12 months (July - September 2020, children born Jul to Sept 2019)

Area	DTaP/IPV/Hib 3doses (%)	PCV 2doses (%)	Rotavirus (%)	MenB (%)
Cambridgeshire	95.3%	95.3%	92.5%	94.7%
Peterborough	88%	89.1%	87.6%	88.9%
East of England	93.2%	94%	92%	93.8%
England	92.1%	92.4%	90.4%	92.5%

Table 2 - Vaccination coverage at 24 months (July - September 2020, children born July - Sept 2018)

Area	DTaP/IPV/Hib 3doses (%)	PCV 2doses (%)	Hib/MenC booster (%)	MMR1st dose (%)	MenB booster (%)
Cambridgeshire	96.1%	94.2%	94.2%	94.1%	93.4%
Peterborough	93.1%	88.6%	89.5%	89.3%	88.3%
East of England	94.3%	92.8%	93.1%	92.7%	91.5%
England	93.9%	90.6%	90.8%	90.7%	89.5%

Table 3 - Vaccination coverage at 5 years (July - September 2020, children born July - Sept 2015)

Area	DTaP/IPV/Hib 3doses (%)	MMR 1st dose (%)	MMR 2nd dose (%)	DTaP/IPV booster (%)	Hib/MenC (%)
Cambridgeshire	96.5%	96.2%	91.4%	90.5%	92.9%
Peterborough	94.1%	92.2%	83.6%	82.4%	89.1%
East of England	96.4%	95.7%	90.3%	89.4%	93.2%
England	95.6%	94.4%	86.7%	85.4%	92.7%

Key:
DTaP/IPV/Hib/HepB or hexavalent vaccine - combined diphtheria, tetanus, acellular pertussis, injectable polio, Haemophilus influenzae type b, hepatitis B vaccine
PCV - pneumococcal conjugate vaccine, MenB - Meningococcal B vaccine
MMR- combined measles, mumps and rubella vaccine
[1] Cover of vaccination evaluated rapidly (COVER) programme 2020 to 2021: quarterly data - GOV.UK (www.gov.uk)

[3] https://www.gov.uk/government/publications/vaccine-update-issue-306-march-2020
[4] https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/technical-guidance/2020/guidance-on-routine-immunization-services-during-covid-19-pandemic-in-the-who-european-region,-20-march-2020

3.3 Whilst there are caveats with this data in so far it is has not gone through the quality assurance and validation process and therefore has been published provisionally, early indications into coverage during the first part of the Covid-19 pandemic suggests that uptake has remained stable and comparable to previous quarters, lending itself to the conclusion that this has not impacted by any disruption as a result of the pandemic. The data has in fact suggested that there has been marginal improvements in terms of early childhood vaccination coverage in Cambridgeshire during this period, with coverage rates continuing to exceed the average for both the East of England and England.

3.4 Updated guidance for primary care produced on the 11th January 2021 continues to stress the importance of continuing to deliver the childhood vaccinations, new baby checks and postal checks. These are placed in the Green 'High Priority' category that are services that GP's should 'Aim to continue regardless of the prevalence of COVID-19 for the duration of the pandemic.'[5] The local CCG have also reported that childhood vaccinations have continued to be offered by primary care across the county during this period.

4. School Aged Children

4.1 When the lockdown started in March 2020 all CSAIS (Community and School Aged immunisation service) programmes were paused, and the teams were re-deployed to help pre-school and baby immunisations in primary care, and BCGs for acute trusts. From May half term this work stopped, and the priority turned to catching up on outstanding school immunisations.

4.2 From June 2020 a variety of community clinics were held each day, including during the school holidays, and weekends. In September the service was able to go back into secondary schools and the priority was delivering the outstanding Meningococcal Vaccine (Men ACWY) and teenage booster vaccinations (Td/IPV- Tetanus, Polio, Diprtheria). This continued using all available staff (including bank staff), until the start of the flu programme (advice from NHS England was to prioritise flu vaccination due to the more immediate risks associated with winter flu).

4.3 In January 2021, the service had planned to prioritise outstanding Men ACWY and teenage boosters, before commencing on other programmes. However, due to the current lockdown these school-based sessions were unable to start. Instead, daily community clinics have been held in each area with the priority being on outstanding Men ACWY, teenage boosters, and 1st dose Human Papilloma Virus Vaccine (HPV) from 2020.

4.4 As can be seen in Table 4, priority has been given to the eldest children as the service continues to take every opportunity to catch up on school vaccination clinics that have needed to be cancelled. When more is known about full school re-opening a full catch up plan will be developed.

[5] RCGP_BMA-COVID_workload_prioritisation_5112020.ashx

Table 4 – Cambridgeshire school-aged vaccination update January 2021

HPV dose 1 - Girls				**HPV dose 1- Boys**		
School year	HPV1	Cohort	**%**	HPV1	Cohort	**%**
8	63	3143	**2.0%**	95	3315	**2.9%**
9	2515	2880	**87.3%**	2412	3179	**75.9%**
10	2937	2937	**100.0%**			
Total	5515	8960	**61.6%**	2507	6494	**38.6%**
HPV dose 2– Girls				**HPV dose 2– Boys**		
School year	HPV2	Cohort	**%**	HPV2	Cohort	**%**
9	16	2880	**0.6%**	20	3179	**0.6%**
10	2676	2933	**91.2%**			
Total	2692	5813	**46.3%**			
Men ACWY - boys and girls				**Td/IPV - boys and girls**		
School year	MenACWY	Cohort	**%**	TdIPV	Cohort	**%**
9	44	6059	**0.7%**	107	6059	**1.8%**
10	4289	6095	**70.4%**	4312	6095	**70.7%**
Total	4333	12154	**35.7%**	4419	12154	**36.4%**

Key: HPV: Human Papilloma Virus; MenACWY: Meningococcal vaccine; Td/IPV: Tetanus, Diptheria,Polio vaccine

5. Seasonal Flu Vaccination Programme

5.1 The cohort of children eligible for the seasonal flu vaccination was extended this year to include year 7 children in addition to all primary school children (from reception to year 6). This meant that the number of children across Cambridgeshire eligible for the vaccine grew by over seven thousand, and delivery sessions needed to be put in in the county's secondary schools on top of the usual primary school sessions.

5.2 Despite these challenges, coupled with covid-related disruptions in some year groups, the CSAIS team were able to vaccinate a significantly higher percentage of children than in the previous year (details in table 2 below).

Table 5 – School aged Influenza vaccination take up- 2020/21 and 2019/20

Cambridgeshire	**Full cohort**	**Completed**	**%**
Flu Season 2020/21	61,248	45,183	73.8%
Flu Season 2019/20	53,681	34,608	64.5%

5.3 Flu vaccination for children aged 2 and 3 years of age is delivered via primary care. The below table gives the interim data for this cohort which has currently not gone through the quality assurance and validation process. However, this provisional data does show a rise in vaccination rates for both 2 and 3 year old's during this vaccination year compared to take up rates in 2019/20.

Table 6 – Interim report for 2 and 3 year old flu vaccinations

East of England- Flu Vaccination for 2 and 3 year olds	Aged 2		Aged 3	
2020/21, month Dec-20 extract date (28/01/2021)	**% 20/21**	% 19/20	**% 20/21**	% 19/20
England	**54.1**	37	**56.5**	36.9
East of England	**57.4**	43.8	**60.4**	42.7
NHS CAMBRIDGESHIRE AND PETERBOROUGH CCG	**57.5**	43.1	**59.7**	43.3

6. Evidence Review on Improving Childhood Immunisation Uptake

6.1a Trusted sources of information

- Research suggests only about 1-2% of parents refuse all vaccinations, and parents/carers generally have confidence in national immunisation programmes[2,3]

- Attitudes to vaccines are largely positive; 91% of parents agree that vaccines are important for their children's health[4]

- Regarding anti-vaccine groups/social media – the Royal College of Paediatrics and Child Health (RCPCH) states that there is no compelling evidence to suggest anti-vaccine groups/social media have had a major impact on parent/carer confidence[3]. However, a study published by the Royal Society for Public Health found that two in five parents (41%) report being exposed to negative messages about vaccines on social media. This increased to as many as one in two (50%) among parents with children under five years of age[4]. It is often the case that there are more negative messages around vaccinations on social media compared to positive messages. This is a potential concern as frequent repetition of negative messages can be mistaken as the truth, a phenomenon known as the 'Illusory Truth Effect'[5]. Studies investigating the impact of these negative messages on social media have found that these messages receive more attention, longer viewing time and spread more rapidly compared to positive messages[13,14]

- Whilst there is a concern over the impact of social media; parents **identify scientific experts (94%) and doctors/nurses (92%) as valued sources of information.**[4]

- **Health professionals and the NHS were seen as the most trusted source of advice on immunisation** (90% agreed/strongly agreed with each) in a 2018 study published in the British Journal of General Practice (BJGP)[2]

- Hence, **health professionals are key in communicating information about vaccination, with their trusted advice being key factors in a parent/carer decision to vaccinate.**

- **This high level of trust is important in ensuring high uptake of vaccinations**[4]

6.1b How could we use this evidence to improve uptake?

- **Tackling negative misconceptions**: promote positive social media messages to provide accurate and factual information from trusted sources. Social media platforms should be encouraged to take responsibility with efforts to limit misinformation online.[4]
    - *Example: Egg allergy is NOT a contraindication to MMR vaccination[6]*

- Education on vaccines in schools (PSHE curriculum).[4]

- The high level of trust placed in health professionals should play a vital role in ensuring the uptake of vaccinations.

- Encouraging trusted professionals to **opportunistically advise about vaccination** – Making Every Contact Count (MECC)[7]. Repetition, repetition, repetition!
    - Take every opportunity to enquire about vaccination history, counsel on the importance of vaccination, direct to immunisation services for routine or catch-up immunisations, identifying those children/young people at risk of low vaccine uptake.

- Where possible, offering vaccinations during consultations opportunistically.

- Immunisation eLearning - from eLearning for Healthcare.[8]

- GPs- 'Vaccines in Practice' eLearning (developed by the RCPCH aiming to develop trainees' skills in communicating the benefits of vaccination).[9]

- Early points of contact to start the discussion e.g. midwife contacts *(include childhood immunisation discussion as part of the postnatal discharge conversation)*/health visitor/school nurse.

- National Childbirth Trust (NCT) had 95,662 parents attending in 2018. NCT courses do not mention vaccination, *could this be incorporated?*

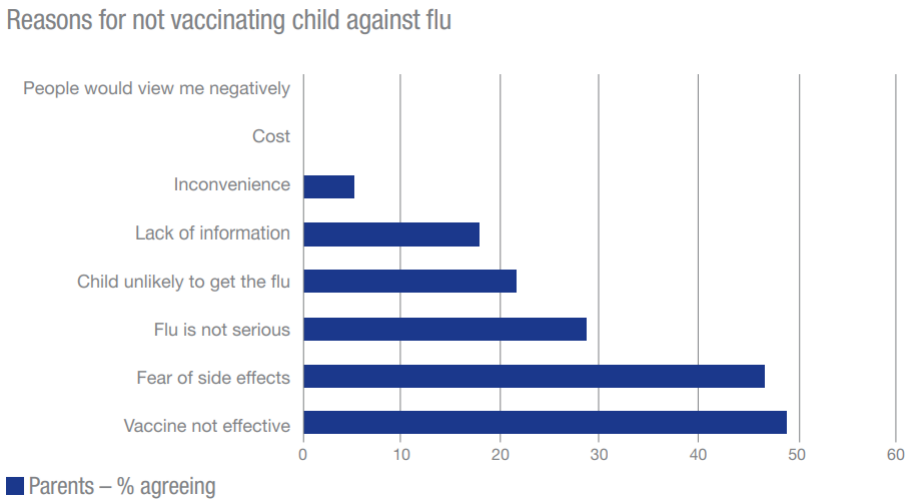
- A targeted approach is required to reach ethnic minorities/areas of social deprivation as we know the vaccination rates are lower within these groups.

6.2a Barriers to childhood vaccinations

- **Fear of side effects of vaccines** is often the primary reason for choosing not to vaccinate (except the nasal flu vaccination – most common reason is doubt over effectiveness).[4]

- Childhood influenza vaccination:
    - Main barriers to uptake are **perceptions of effectiveness and safety.**
    - This is not completely unfounded as effectiveness does vary year on year. In 2017/18, the overall end-of-season vaccine effectiveness for all ages was only 15%. For 2-17 year olds receiving the vaccine in 2017/18, the effectiveness was much higher - estimated at 90.3% against H1N1, and 60.8% against influenza B50
    - Lowest uptakes of flu vaccines in children are in the most deprived areas or areas with larger minority ethnic populations. This could be a target for improving immunisation rates.[12]

Graph 1 – reasons for not vaccinating child against flu[4]



- Difficulty travelling to the clinic (location of clinics) – 19% in survey.[4]
- Difficulty arranging childcare for other children during the vaccination appointment (29% in survey) – *Child's birth order is inversely related to vaccination status.*[11]
- Not receiving reminders about appointments (17% in survey).
- Lack of time (e.g. parents who have returned to work).
- Timing and availability of appointments (access to appointments is especially important when tackling inequalities in uptake e.g. related to socioeconomic status/ethnicity (46-49% in survey[4]).

6.2b How can we use this evidence to improve vaccination uptake?

- Clarity on side effects and what to expect early on in the discussion surrounding vaccinations.
- Social media messages targeting information around side effects (as we know this is often the primary reason why parents decide not to vaccinate).
- Presenting flu data on effectiveness and targeting deprived areas or areas with larger minority ethnic populations.
- Practical steps taken by healthcare providers to facilitate vaccination can influence vaccine uptake:
    - Multiple locations; high street pop-ups; utilising the wider public health workforce[4]; choice of timed appointment vs drop in sessions; weekend appointments.
    - Reminders – telephone call/text message
        - Call-recall systems have been shown to increase uptake of vaccines and form an essential part of immunisation programmes[9]
    - Targeted approach - *identifying locations/populations with low vaccination rates*
        - ? Home visits to vaccinate?
        - Personalised approach – telephone call

7. Ongoing Promotion of Immunisation

7.1 The Healthy Child Programme has continued to promote messages via social media on the importance of immunisations and these are reiterated during mandated contacts. They have amended their caseload database recording system to include a 'quick access' function to enable staff to rapidly view immunisations history prior to a contact - it is anticipated that this will help support MECC (making every contact count) across all contacts.

7.2 Public Health officers worked with colleagues in the CSAIS team and the local authority communications team to promote the importance of giving parental consent for vaccinations. This campaign, alongside other local and national messages, were shared widely across the Best Start in Life partnership.

8. Alignment with Corporate Priorities

8.1 A good quality of life for everyone

The report above sets out the implications for this priority in sections 1 and 2.

8.2 Thriving places for people to live

There are no significant implications for this priority.

8.3 The best start for Cambridgeshire's children

The report above sets out the implications for this priority in sections 1, 2 and 4

8.4 Net zero carbon emissions for Cambridgeshire by 2050

There are no significant implications for this priority.

9. Significant Implications

9.1 Resource Implications

There are no significant implications within this category.

9.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category.

9.3 Statutory, Legal and Risk Implications

There are no significant implications within this category.

9.4 Equality and Diversity Implications

Section 6 sets out details of significant implications identified by officers.

9.5 Engagement and Communications Implications

Section 6 set out details of significant implications identified by officers

9.6 Localism and Local Member Involvement

There are no significant implications within this category.

9.7 Public Health Implications

The report above sets out details of significant implications in sections 1 and 2

10. Source Documents

10.1 Source documents:

UK Government guidance relation to vaccinations during Covid-19 March 2020

Quarter 4 2019/2020 COVER programme data – Health Protection Report

Quarter 4 2019/2020 COVER programme data – Government Vaccination Coverage Statistics

References

1. Quality Watch, “Vaccination coverage for children and mothers,” 2018. [Online]. Available: http://www.qualitywatch.org.uk/indicator/population-vaccination-coverage [Accessed 09 02 2021]

2. Letley, L. & Yarwood, J. 2018. Changing attitudes to childhood immunisations in English parents, British Journal of General Practice.

3. Royal College of Paediatrics and Child Health (2020) *State of Child Health*. London: RCPCH. [Available at: stateofchildhealth.rcpch.ac.uk]

4. Royal Society for Public Health. 2019. Moving the needle: Promoting vaccination uptake across the life course. Royal Society for Public Health.

5. L. Fazio, N. Brashier, B. Payne and E. Marsh, “Knowledge Does Not Protect Against Illusory Truth,” Journal of Experimental Psychology: General, vol. 144, no. 5, pp. 993- 1002, 2015

6. Public Health England. 2019. Measles: the green book, chapter 21. Available from: GOV.UK.

7. NHS, “An Implementation Guide and Toolkit for Making Every Contact Count,” NHS, East Midlands, 2014.

8. Health Education England. E-Learning for Healthcare: Immunisation. Available online: e-LFH.ORG.

9. Royal College of Paediatrics and Child Health. Vaccines in practice – online learning. Available from: RCPCH.

10. Forster, A.S. et al. 2016. A qualitative systematic review of factors influencing parents’ vaccination decision-making in the United Kingdom. SSM – Population Health.

11. Public Health England, “Tailoring immunisation programmes: Charedi community, North London,” PHE publications, London, 2018.

12. Public Health England, “Seasonal influenza vaccine uptake in children of primary school age: Winter season 2017 to 2018,” PHE Publications, London, 2018

13. J. Katsyri, T. Kinnunen, K. Kusumoto, P. Oittinen and N. Ravaja, “Negativity bias in media multitasking: The effects of negative social media messages on attention to television news broadcasts,” PLoS One, vol. 11, no. 5, 2016.

14. S. Tsugawa and H. Ohsaki, “Negative messages spread rapidly and widely on social media,” ACM, pp. 151-160, 2015.

Public Health Joint Commissioning Unit COVID-19 Impact Update

To:	Health Committee
Meeting Date:	Thursday 11th March 2021
From:	Liz Robin
Electoral division(s):	All
Key decision:	No
Outcome:	The Health Committee will have additional information and understanding of the impact of COVID-19 upon Public Health commissioned services.
Recommendation:	The Committee is asked to consider and discuss the impact of COVID-19 upon delivery of Public Health commissioned services a) Consider the impact of COVID-19 upon delivery of Public Health commissioned services. b) Note the responses and adaptations to service delivery made by providers in response to the challenges created by the pandemic.

Officer contact:
Name: Val Thomas
Post: Deputy Director of Public Health
Email: val.thomas@cambridgehsire.gov.uk
Tel: 07884 183374

Member contacts:
Names: Cllr. Peter Hudson
Post: Chair
Email: Peter.hudson@cambridgeshire.gov.uk
Tel: 01223 706398

1. Background

1.1 The COVID-19 pandemic has had been impacting upon Public Health commissioned services for nearly a year. This report provides an overview of how services have been affected and the measures that have been taken to mitigate them. How these measures have enabled them to continue to provide services for the local population and contribute to efforts to address the pandemic. It addresses the following aspects of service delivery.

- Impact on service delivery
- Performance headlines
- Adaptation and development of different service delivery models
- Service elements not delivered
- Longer term positive and negative impacts

The objective is to provide the Committee with an understanding of the service changes, how these have affected uptake of services and the potential longer term impact on health and wellbeing.

1.2 The Public Health Joint Commissioning Unit commissions a range of services, this report addresses the following.

- Adult and Young Persons Drugs and Alcohol Treatment Services
- Supportive accommodation
- Community Integrated Contraception and Sexual Health Services
- Lifestyle Services
- Primary Care Services
- Health Schools Support service
- Healthy Workplace Support Service
- Healthy Fenland Fund

2. Main Issues

2.1 Change Grow Live (CGL) Adult Drug and Alcohol Service

The Drug and Alcohol Treatment Service provided by CGL has consistently demonstrated flexibility and innovation in response to the demands created by the pandemic. From the beginning it was clear that the pandemic exacerbated dependency and mental health issues for some of those in treatment. Consequently the Service focused on intensifying support and harm reduction through developing new ways of delivering the Service to clients most at risk.

CGL shifted the majority of provision from face to face to an online/telephone offer whilst still keeping the main service base open for planned and clinically required appointments. Group work/peer support work is now predominately delivered online to minimise the risk of transmission. The service has seen a significant increase in appointment engagement after shifting to online delivery model.
There has been a sizeable shift across the whole sector with regard to the prioritisation of harm reduction and stabilisation of clients. In the initial lockdown period, reductions in

detoxification medication ceased and the focus has been on stabilisation clients and managing risk. Staff responded quickly to support clients, which included delivering prescriptions and even medication to those who needed to isolate. "Burner" telephones were distributed to those with no means of making contact. These cell phones are for short-term use and can come pre-loaded with pre-paid credit. The service has focused on welfare checks with increased frequency of telephone contact and service users are being retained in the service rather than being completed. The observed benefits of the strong harm reduction approach are as follows.

- An increase in provision of safe storage boxes and Naloxone for service users (74% penetration rate for naloxone in the opiate client cohort in Cambridgeshire at October 2020 compared to 40% in March 2020). Naloxone is medication that blocks the effects of opioids and can be very effective in overdose situations.
- An increase in medical reviews and intensive risk management.
- Increased frequency of contacts with services users via phone and virtual methods during lockdown.
- Reduced waiting times to initiate a new script.
- Reduced numbers using street-based drugs on top of prescribed medication, an increase in abstinence rates and a reduction in injecting rates.

Face to face delivery of Blood Bourne Vaccinations (BBV) vaccinations and testing has been affected during the Covid pandemic. Postal dry blood tests are now available and there are some very active outreach clinics. CGL has worked closely with the East of England Operational Delivery Network (ODN – Clinical Networks) to look at innovative ways of continuing to prioritise, test and refer through to Hepatitis C treatment. Cambridgeshire has been identified as a strong partner that helped the eastern region ODN achieve the 'highest achieving' ODN in the country during the summer period.

A new Cambridgeshire Recovery Service which was part of the re-commission of the Service in 2018 has been a particularly valuable and provides critical support for service users. A wide range of both structured and peer led online support has provided both support and contact for individuals in recovery. The expansion to include virtual poetry groups, newsletters, quiz nights, cookery groups etc. has helped develop a strong and stable recovery network helping to reduce social isolation and loneliness. It provides a safe platform for individuals who have successfully completed treatment.

In terms of wider performance measures these have remained strong. Cambridgeshire CGL numbers in treatment have seen an upward trajectory, with an increase in new presentations across all drug types compared to Quarter 2 last year. The largest increases are in the 'opiate', 'alcohol' and 'non-opiate' cohorts. The service has also reported increased levels of complexity in new presentations.

Following the re-commissioning exercise in 2018 there had been a slow improvement in performance after an initial fall lasting for 11 months. During Quarter 1 and Quarter 2 performance has continued to improve and we have seen increases in successful

completion rates across all drug types (however still sitting below national rates). The pace of improvement is slower than expected but now sustained.

There are still significant challenges for the CGL service, there is agreement across the partners that services are seeing an increase in the complexity of new presentations especially alcohol related. Individuals are entering treatment at a later stage in their dependency with poor mental and physical health. This puts an additional strain on the workforce. Ensuring that service users have access to the internet and therefore to the range of online support groups is difficult, a coordinated approach to tackle 'digital inclusion' is being developed.

- The learning and positive aspects are the closer working relationships that have developed between the specialist treatment service and key partners. Most notable were the stronger pathways developed with a range of partners including housing authorities and health in supporting street homeless clients who were housed in "COVID" hotels. There is a very much 'can do' attitude with a range of professionals coming together working collaboratively to support individuals in need.
- The different style of working with clinical interventions delivered in different ways that have brought benefits such as the ability to have more contact time through virtual communication.
- The importance of listening to service users to identify how best to serve and support their individual needs during the pandemic has been key in shaping the response to the challenges that services and their used have and are encountering.

Cambridge City (one of 43 identified task force areas) was invited to bid for Public Health England/ Ministry of Housing, Communities and Local Government monies to support those who are street homeless with substance misuse issues into treatment. The grant bid has been successful and substantial funding will be focused on this cohort over a 15-month period, which includes additional outreach and psychology resource to engage and support individuals who are trapped in the cycle of addiction and homelessness.

2.2 Young Persons Drug and Alcohol Services

The Young People's Drug and Alcohol Service, CASUS, provided by Cambridgeshire and Peterborough Foundation Trust has seen a drop in numbers in treatment, the 2020/21 Quarter 2 figures (104) are lower than the Quarter 2 position in 2019/20 (143). The referral mechanisms for young people have been affected significantly by Covid with school closures, professional 'face to face' contact points reduced and court disruption all having an impact.

CASUS has seen a reduction in planned exit rates during the pandemic period from historically very high rates of 80-85% to 73% in Quarter 1 and falling again to 66% in Quarter 2. The higher complexity of the case load and associated safeguarding concerns has come with challenges especially when trying to build new therapeutic relationships in lockdown situations. CASUS is continuing to work closely and collaboratively with key partners to support these vulnerable young people.

2.3 Supportive accommodation

All the supported housing projects have operated well during the COVID-19 crisis. The controlled drinker's project needed to restrict visitors but continued otherwise as usual with staff on site. In the offenders projects visiting support was restricted to only when necessary but clients received regular welfare checks. The residents have coped well and received ongoing support during the pandemic period.

2.4 Community Integrated Contraceptive and Sexual Health Services (iCaSH)

The Cambridgeshire iCaSH service is provided by Cambridgeshire Community Services. At the start of the pandemic there were national directives related to COVID-19 that necessitated changes in the iCaSH delivery model to minimise infection transmission. The Service moved quickly to identify its essential services and to ensure that all high-risk patients would be seen at a clinic.

The Service experienced pressures that reflected action taken in the rest of system. Waiting times for access to Long Acting Reversible Contraception (LARC) have lengthened which reflected in part additional referrals from primary care, also under pressure. In Quarter 2 the backlog was reduced but this remains a challenging issue. The Service however has focused on ensuring that high risk vulnerable women are treated as quickly as possible. At all times, alternative contraception methods were made available, often using new approaches.

GUM activity reduced during Quarter 1 and was down at 39% at the end of this period. During Quarter 2 attendances improved and performance increased to 66%. Contraceptive attendances for Quarter 1 were at 46% of the planned year to date activity, by Quarter 2 the figure improved to 60%. Quarter 3 figures are pending but are not yet available.

It was agreed between the commissioners and providers that exceptions in the performance reports would not be penalised during this period, as performance is continuing to be impacted upon by the COVID-19 pandemic.

Throughout quarters 3 and 4 the NHS will be delivering the mass vaccination programme. Some staff at Cambridgeshire Community Service CCS have been redeployed to assist with this work. This is likely to have an impact on services again with LARC in particular being affected. Discussions have been initiated regarding a catch-up programme once the pressures of the mass vaccination programme have started to ease. However, there is an agreement that high risk individuals will be prioritised throughout the period of re-deployment.
The following measures have been introduced to ensure that where possible services have been delivered.

- A new telephone triage service was established in Quarter 1 to offer consultations.
- The LARC service continued to see women who were experiencing problems with devices in situ and high-risk individuals.
- Oral Contraception is provided through a postal delivery following a virtual risk assessment.
- HIV provision has continued where possible to be provided remotely.

- "Express Test" is home testing for asymptomatic infections, this both nationally and locally has moved to include symptomatic infections.
- The Service is working with "ChatHealth" to support young people when the 'normal' mechanisms have not been in place.

National evaluations of these service delivery models have been positive. Locally service user feedback has also been positive. However it too early to identify longer term impact on outcomes such as unplanned pregnancies or increases in sexually transmitted infections.

2.5 Prevention Service of Sexual Ill Health.

During the first six months of the pandemic prevention services were provided by DHIVERSE which shifted many of their services to online delivery and ran additional support for those experiencing isolation and stress during the pandemic, which were well received.

The start newly commissioned Prevention of Sexual Ill Health Service provided by the Terrance Higgins Trust was delayed 6 months until October 1 2020. However, it was clear as the new contract started, that COVID would continue to impact significantly for the first 6 months of the contract. Commissioners agreed revised KPI's which related to the challenges which COVID has presented. Despite these the closure of schools again for an extended period had not been anticipated and this has impacted on the delivery of some school based activity. Other areas that have been impacted include:

- Adult outreach in non-traditional settings;
- Outreach to more deprived wards;
- Screening for Chlamydia and Gonorrhoea.

Some areas of Service delivery have performed strongly despite COVID including:

- Dual screening for adults;
- Support to those living with HIV;
- Outreach to homelessness settings;
- Delivery of campaigns including HIV Testing Week, LGBT History Month.

The service is only in its first quarter of operation and it has been a very challenging time to begin operating with the on-going challenges in respect of COVID and the associated restrictions. Monthly meetings are in place to support the service meet and address the challenges presented.

2.6 Lifestyle Services

At the start of the pandemic the procurement for re-commissioning the Lifestyle Services was nearing completion. The new three tiered service includes Tier 1: community prevention programme Tier 2: health trainer, generic and specialist, Tier 2 weight management services, behaviour change training, NHS Health Checks, National Child Measurement Programme (NCMP); Tier 3: specialist weight management service. The pandemic did cause some delay implementation but the Tier 1 service was launched in July 2020 and Tiers 2 and 3 in October 2020. It is an integrated service with Tier 1 being

provided by a partnership between Living Sport, District Authorities and Peterborough Ltd. The former provider Everyone Health had been awarded the new contract for Tiers 2 and 3.

At the start of the pandemic face to face services stopped because of the transmission concerns but also structural issues. The Service is delivered from community venues and GP practices and these closed their doors to external providers and this situation has continued.

The Tiers 2 and 3 services, where possible, converted to virtual delivery. However it was mandatory for the NCMP and NHS Health Checks to halt delivery. Others stopped locally were the Healthy Schools Service, Behaviour Change Training, community based physical activity and healthy eating sessions, and community based falls prevention talks.
The Tier 3 weight management service provided by Cambridge University Hospitals Foundation Trust was also closed at the beginning of the pandemic, as the hospital was closed to any new referrals. NHS Health Checks were allowed to re-start from August, however as most community venues were still closed setting up clinics was challenging. Similarly there was a national expectation that NCMP would commence from January but the new lockdown made this impossible. Table 1 indicates the impact upon referrals into the Service.

Table1: Referrals to Lifestyle Services

Month	Lifestyle Service	Camquit/Stop Smoking	Total
Jan 2020	692	300	992
Feb	885	259	1144
March	414	268	682
April	23	167	190
May	52	149	201
June	189	181	370
July	270	157	427
August	271	177	448
September	372	168	540

Comparing referrals in April (when the maximum impact of lockdown was felt) to February of 2020 there was a drop of 83% in referrals. The development of virtual offers and the reduction in restrictions led to an improvement in referrals in the summer. However, there was still a sustained impact with a 53% reduction in services for September compared to February.

In October 2020 the new lifestyle service was launched and in the period of October – December 2020 1451 referrals were received. However if overall figures for April-December 2020 are compared to the same period for 2019 there was a 57% reduction in referrals from 8,520 to 3,627. This fall in referrals affected the Service's Key Performance Indicators (KPIs)

- Referrals into stop smoking services remained at a reasonable level and the number of 4 week quits for Q1-3 was above target (650 quits / 550 target). This reflects the request to GP practices to refer their patients wanting to quit smoking to the Lifestyle Service

- 40% of those completed Tier 2 adult weight management in Q1-3 achieved 5% weight loss (self-reported)
- Health checks were vastly reduced in number. In 2020 Quarters 1 – 3 84 were completed compared 413 in the period in 2019, a reduction of 80%.

Given these challenges the Service has introduced new means ways of delivering its services.

- All services where possible converted to virtual or telephone delivery;
- Weight measures were self-reported;
- Carbon Monoxide verification was ceased;
- The Lifestyle Team proactively followed up past service users to offer support and where necessary weekly support calls were set up;
- Staff were encouraged to take part in online training to enhance their skills;
- Staff took part in training to be able to deliver courses such as Making Every Contact Count (MECC) and Mental Health First Aid (MHFA) virtually.

In August training and small group work such as some community physical activity sessions were able to re-start. However, there is an ongoing issue with availability of community venues as they remain closed and GP surgeries will still not allow external providers to use their clinic rooms.

The pandemic has had some positive effects:

- This is a suite of online resources and virtual sessions on offer;
- Some service users like the online offer so where appropriate this will continue to be offered once face to face delivery resumes offering more service user choice;
- Staff are now able to deliver training virtually;
- Lack of access to traditional venues such as GP surgeries led to re-think of facilities required and may broaden access in the future.

It was challenging to start the new Tier 1 in July 2020 as the majority of the services are delivered in community venues, schools and open spaces. The ensuring lockdown changes meant it has been a turbulent time of stopping, restarting, stopping and restarting services. This impacts upon continuity of service and service user engagement

The Quarter 3, October – December report has been delayed through COVID-19 related illness. However the headlines for Quarter 2, July to September are as follows.

- 1,594 participants attending tier 1 programmes
- 39 new structure, non-structured and community programmes have started
- 5 events were delivered this quarter including National Fitness Day (92 people took part) and a Zumba dance festival. All were required to meet COVID-19 safe rules.

There have been a number of Service adaptations and development to meet the pandemic situation.

- A variety of digital offers have been developed;
- Sessions are delivered virtually;
- Online registration platforms developed for non-structured activities such as health walks to ensure COVID-19 safe numbers attend;
- Increased social media presence.

However all face to face activities and promotional events, other than in the summer, have halted.

Across all the lifestyle services user feedback has been positive about virtual services. However there will need to be, given the significant reduction in referral numbers, considerable engagement and communications to ensure they return to pre-COVID-19 levels. All community services will need to be re-started along with re-engagement with many GP services to re-start practice based clinics. However along with efforts to ensure engagement there is also the expectation there will be a backlog of cases and surge in activity when services are able to fully re-open. It will important to monitor if or how the health outcomes that these services contribute to have been affected during the pandemic.

2.7 Primary Care – GP and Community Pharmacies

GP practices provide four public health services, stop smoking, LARCs, NHS Health Checks and chlamydia screening. At the start of the pandemic GP's were closed to all but emergency appointments. Most appointments were held as telephone consultations, only face to face deemed essential, were available, which obviously impacted upon service delivery.

In 2020, Quarter1 NHS Health Checks were suspended nationally. Although they could have re-commenced in Quarter 2, few practices have been actively delivering the Service. This is illustrated in Table 2 where only 10% of the 2019/20 total was completed in the same period 2020/21

Table 2: General Practice NHS Health Checks completed.

Quarter	**Health Checks completed**	
Q1 - Q3 2019/20	10,622	
Q1 – Q3 2020/21	1,041	10% of 19/20 total

The Stop Smoking data always runs two months behind and it has not yet been collated for Quarter 3. Again it clearly shows the impact of the pandemic upon service delivery.

Table 3: General Practice Stop Smoking Services

Quarter	Set Quit Date	4 Week Quitters
Q1 & Q2 2019	1150	546
Q1 & Q2 2020	357 (31% of 2019/20 total)	198 (36% of 2019/20 total)

During 2019/20 there were 5552 LARC fittings. For Quarter 1 to Quarter 3 in 2020/21 there were 1017.

With regards to chlamydia screening there has not been any activity this year compared with 870 screens in 2019/20

Some of the demand has been picked up by other services. The Tier 2 Lifestyle Service has seen an increase in stop smoking referrals. Home testing for chlamydia screening has increased. However the most pressured service is LARCs. Much of the GP activity shifted to the Integrated Contraception and Sexual Health Services. This Service however, as described above, experienced similar challenges as GP practices and its limited support has been targeted at the greatest need and risk. The impact as with other services of COVID-19 is mixed and to some degree as yet unknown.

- Currently it is not possible to identify the impact of low levels of LARC activity on unplanned pregnancies.
- As with Lifestyle Services there is likely to be backlog and surge in demand as practices become more accessible.
- Prior to the current lockdown discussion had started that saw some practices allocating some of their NHS Health Checks to Lifestyle Services. This has been paused due to lockdown and the ongoing demands placed on GP practices.
- The pandemic has increased collaboration and the Clinical Commissioning Groups has agreed to extract NHS Health Check data centrally on a quarterly basis which will ease the burden on Primary Care and upon the Joint Commissioning Unit. It is hoped the same approach will be adopted for LARC and Stop Smoking services

2.8 Community Pharmacy

Community pharmacies deliver stop smoking, emergency hormonal contraception and provide chlamydia screening kits. Activity has been low over the period of the pandemic, in part due to capacity of the pharmacists. Also service users are not being able to access the pharmacy for services and pharmacies have been unable to offer virtual support. The performance data clearly reflects the pressures upon community pharmacies. Considerable efforts will be necessary to re-engage pharmacists in delivering public health services.

Table 4: Community Pharmacy Stop Smoking Services

Quarter	Set Quit Date	4 Week Quit
Q1 & Q2 2019	83	18

Q1 & Q2 2020	11	2

In 2019/20 there 3948 Emergency Hormonal Contraception dispensed and 3038 in the comparable time period in20/21. A reduction of 23%

In Quarters 1 -3 in 2019/20 85 chlamydia testing kits were provided compared to 24 in the same period in 20/21.

2.9 Healthy Schools Support Service

The Healthy Schools Support Service is provided by Everyone Health. It supports school with information, training and evidence to develop school practices and policies to ensure that the school environment promotes the health and being of its students, teachers and wider community.

The service has experienced significant challenges in terms of school engagement and delivery of interventions as a direct result of COVID-19. The disruption to delivery has been largely due to school closures and schools prioritising the adherence to Covid-19 secure measures.

The KPI's are very much tailored to the deliverables of the service, meaning that by in large targets are not being met as schools do not have the capacity and resource to engage with the service offer at present.

However the Provider has used this period to make significant improvements to the universal element of the service,

- Adopting a new website host to redesign the Healthy Schools website to improve functionality and navigability.
- A resource hub for parents has been added and all signposting links have been reviewed and refreshed to ensure the most current and up to date content is featured.
- The development digitalising interventions and redesigning materials to enable staff self-delivery, including the development of home-learning based resources where possible - this includes FoodSmart modules and the KickAsh smoking prevention programme.

School based consultation has been available via virtual methods throughout this period, however due to the challenges schools are facing in their own response to the pandemic, uptake of this offer has been limited.

Adaptations to service delivery, as outlined above, has meant that no aspect of the service offer has fully ceased, however due to competing priorities, engagement with schools has made performance against this delivery offer challenging.

However more positively this period has provided ample opportunity to strengthen and develop working relationships with the broader system and the Healthy Schools partner network. As school engagement has been an issue for a number of services, this time has

enabled the system to collectively come together and work towards developing a clear and cohesive offer of support to schools, spanning all elements of the health education agenda, including Relationship Education, Relationship and Sex Education and Health Education, Mental Health and Emotional Wellbeing, Safety along with physical activity and nutrition.

The provider has been a key agent in facilitating linkages across the system and identifying opportunities for collaboration during this period, with a longer term aim of being in a position to communicate a clear multiagency offer to schools in the future.

Although the impact of the pandemic has had on school aged children is not fully understood and therefore what future support will be required to address any effects this period has had on children and young people. However when schools have the capacity and it is safe for them to engage it is envisioned that the support that the Service could offer would help them address some of these COVID-19 impacts upon children and young people.

2.10 Healthy Workplace Support Service

The Health Workplace Support Service is provided by Everyone Health. During the pandemic employers have concentrated on developing and maintaining a safe environment for their workforce or mobilising people to work from home. Face to face delivery in the workplaces stopped. Consequently despite substantial efforts it has been difficult to engage workplaces in the Services.
Quarterly newsletters were produced, campaigns promoted and there were virtual quarterly network meetings but no delivery in workplaces. However there some positives that have emerged during the pandemic period.

- Mental health issues are an acute concern for employers and staff are being trained to deliver virtual mental health packages including Mental Health First Aid.
- Virtual network meetings have proved popular and gained good feedback so will continue with these
- Workplaces are in the main very engaged with infection control and public health measures, which may help to broaden commitment to health outcomes for employees in the future. For instance, some workplaces have opened up COVID testing facilities on site and there may be potential to adapt this model to facilitate health promotional activities/health checks.
- Through the pandemic Public Health as part of outbreak control activities have made contact with some workplaces that have proved difficult to reach previously.

2.11 Healthy Fenland Fund

The introduction of lockdown brought the group activity to a halt. The focus of the HFF moved to responding to the needs of the community and supporting groups and people remotely. It has helped to develop virtual groups and has responded to the need to COVID-19 safe.

- Each quarter the HFF Team has around 200 supportive virtual meetings with Healthy Fenland groups, offering support and advice on how to stay connected with their attendees, and how-to best plan for the easing of restrictions.
- Through the Team's contacts and conversations with groups and people in the community, the Small Grant Fund Application process was adapted to respond to existing groups coming out of lockdown who were struggling with the extra cost for Covid-19 safe venues, PPE and insurance.
- A new Group application form was produced that ensured that applicants could demonstrate that social distancing maintained along with information and support to ensure activities are carried out safely going forward.

2.12 Conclusions

The pandemic has been challenging for the Public Health services included in this report. This has required substantial and sustained efforts to mitigate the impact of COVID-19 and to seize any opportunities to continue to provide services, albeit often changing the service delivery model. Central to the response of providers is a shift of services delivered face to face to alternative means of delivery. Overall these changes have generally been well received by those using the services.

However it must be acknowledged that there are many people who have not accessed services during this period and this could potentially negatively compromise their health outcomes. As yet we do not have information on the impact on longer term health outcomes but we are monitoring on an ongoing basis.

It is anticipated that considerable efforts will be required to re-engage some providers and service users but feedback from many service users is that they want to engage as soon as it is possible.

There are wider positive developments that have arisen from the responses to the pandemic. It is likely going forward that many of these will be incorporated into ongoing delivery models. These include the increased use of virtual services, postal treatment and new behaviour change tools.

We are keen to maintain and further develop the increased partnership working indicated in the report. This has been productive both in terms of providing a more integrated approach to addressing the complex needs of many of our service users along with inter-organisational relationships that provide a platform for ongoing collaborative work. For example there is now a very close relationship with the Housing Board where we take a range of issues affecting vulnerable members of our community.

The services and their staff have worked extremely hard throughout the pandemic to deliver services that are both safe and accessible. More recently fourteen of the Lifestyle Service staff have been seconded into efforts to control the pandemic. Due to acute capacity issues they are working in the Contact Tracing and Lateral Flow Testing Programmes, playing a key role in boosting the ability to deliver these important areas of work. Their work in the Lifestyle Services has been taken on by their colleagues.

3. Alignment with corporate priorities

3.1 A good quality of life for everyone

The following bullet points set out details of implications identified by officers: 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 2.10, 2.11,

3.2 Thriving places for people to live

- The Public Health Services aim to support people to be healthy and enable them to contribute to supporting their local communities.

3.3 The best start for Cambridgeshire's children

The following bullet points set out details of implications identified by officers: 2.2, 2.4, 2.5, 2.6, 2.9,

3.4 Net zero carbon emissions for Cambridgeshire by 2050

Commissioned Public Health services are required to identify how they will contribute to net zero emissions for Cambridgeshire.

4. Significant Implications

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

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The following bullet points set out details of significant implications identified by officers:

- Any implications for procurement/contractual/Council contract procedure rules will be considered with the appropriate officers from these Departments and where necessary presented to the Health Committee before proceeding.

4.3 Statutory, Legal and Risk Implications

- Any legal or risk implications will be considered with the appropriate officers from these Departments and where necessary presented to the Health Committee before proceeding

4.4 Equality and Diversity Implications

The following bullet points set out details of significant implications identified by officers:

- Any equality and diversity implications will be identified before any service developments are implemented

4.5 Engagement and Communications Implications

The following bullet points set out details of significant implications identified by officers:

- Any service changes and developments in response to COVID-19 involve clear and comprehensive communications with individuals and communities to identify how they can work together to tackle the negative impacts created by the pandemic.

4.6 Localism and Local Member Involvement

The following bullet points set out details of significant implications identified by officers:

- Services will require the ongoing support of local communities and members to address the health and wellbeing impacts of the pandemic.

4.7 Public Health Implications

5. Source documents

5.1 Source documents N/A

Health Policy and Service Committee Agenda Plan

Published on 1st March 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
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		
	Scrutiny: Further report on Dental Services	NSHE/I Contact Jess Bendon (Senior Dental Contract Manager) jessica.bendon@nhs.net	Scrutiny Item		
	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		
	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		
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