HEALTH COMMITTEE

Thursday, 06 August 2020

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

1. Apologies for absence and declarations of interest

Guidance on declaring interests is available at http://tinyurl.com/ccc-conduct-code

2. Minutes Health Committee 9th July 2020 **3 - 12**

3. Minute action Log to follow

4. Petitions and Public Questions

5. Covid 19 Update Report to follow

DECISIONS

6.	**Public Health Grant 2020-21**	**13 - 22**
	SCRUTINY	
7.	**Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) Recovery Planning update**	**23 - 28**
8.	**Health Committee Agenda Plan**	**29 - 32**
9.	**Date of Next Meeting**	

The Health Committee comprises the following members:

Councillor Peter Hudson (Chairman) Councillor Anne Hay (Vice-Chairwoman)

Councillor David Connor Councillor Lorna Dupre Councillor Lynda Harford Councillor Linda Jones Councillor Lucy Nethsingha Councillor Kevin Reynolds Councillor Mandy Smith and Councillor Susan van de Ven

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

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HEALTH COMMITTEE: MINUTES

Date: Thursday 9th July 2020

Time: 1.30pm – 3.15 pm

Venue: *Meeting held remotely in accordance with The Local Authorities (Coronavirus) (Flexibility of Local Authority Meetings) (England) Regulations 2020*

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

District Councillors D Ambrose-Smith, S Clark, G Harvey, N Massey, and J Taverner

Apologies: None

311. DECLARATIONS OF INTEREST

Councillor van de Ven declared a non statutory interest under the Code of Conduct in relation to minute 306, Covid-19 Update, as her son worked at Addenbrooke's Hospital.

312. MINUTES – 25th JUNE 2020

That subject to including Cllr Sam Clark as being one of the District Council appointments,

It was resolved

That the minutes of the meeting held on 25th June 2020 were agreed as a correct record.

313. PETITIONS AND PUBLIC QUESTIONS

There were no petitions or public questions.

314. COVID-19 UPDATE

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

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

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

Introducing the report, the Director of Public Health highlighted a major change since the previous report and was so new it was not included in the late circulation report. She indicated that the methodology for reporting positive cases had changed on 2nd July with Local Authorities now having both national and locally identified positive cases reported

against them combining both Pillar 1 and Pillar 2 testing for Covid-19 for in-hospital and out of hospital cases. Previously the data was obtained from local labs and recorded the most serious cases in relation to admissions to hospitals and those that had been identified in local care homes. The national statistics were from people who attended test centres, or who undertook home testing. Pillar 2 national testing was much more about what was going on in a community and was often not the very serious cases requiring admission to hospital.

Due to this change, many cases previously not attributed to any area were now included in local area totals. The Director however wished to assure the Committee that the new statistics did not represent a large jump in the number of people testing positive and that it was as a result of the changeover to this new way of recording local cases. Cambridgeshire as a whole in the national league table was still below the national average.

The most up to date figures for identified infections for July showed that Cambridgeshire's cumulative Covid-19 infection rate was 340 per 100,000 resident population with 2193 recorded new cases, with 318 cases in Cambridge, 191 in East Cambridgeshire, 469 in Fenland, 872 in Huntingdonshire and 343 in South Cambridgeshire. Huntingdonshire was above the national average, while all other districts were currently similar or below. As an oral update the most up to date data showed that there had been between 14-18 new cases, which was a low number. The local trends for new cases continued to be downwards including those in hospitals. However with the lockdown easing, the data would continue to be monitored closely.

In respect of the local systems response, Public Health continued to work closely with a range of system partners as detailed in the report. The Strategic Coordinating Group was focussing on the work to set up test and trace operations, as well as the ongoing multi agency response. The LRF Restoration Group has been co-ordinating plans to gradually reopen services – such as recycling centres and schools – as well as linking city and town centre reopening plans to avoid 'pinch points'. Public transport plans and new schemes for cyclists and pedestrians were also being shared to ensure all agencies were aware and prepared for any impact on their own organisations. The reopening of leisure facilities and recreational spaces and culture venues was for discussion at their next meeting.

In respect of the Cambridgeshire and Peterborough Local Outbreak Control Plan (LOCP) designed to ensure there were good local systems to identify and mitigate outbreaks in a timely manner, and covered seven work streams as detailed in the report. The Plan had been discussed at a special meeting of the Cambridgeshire & Peterborough Health and Wellbeing Board's (HWB) Whole System Joint Sub-Committee on 29th June. The HWB Board members emphasised the contribution that local community groups and volunteers working in district hubs had already made to the Covid-19 response, and the importance of their involvement in delivering the LOCP, together with the input from Councillors and community champions. Following final amendments, it was published on the Cambridgeshire County Council website on 30th June. The focus was now on its implementation. As a result, the Surveillance Group and the Outbreak Management Team were meeting daily to deliver the functions described in the LOCP, with on-call arrangements for week-ends. Activity was being overseen by the multi-agency Covid-19 Health Protection Board which met weekly. A detailed action plan to put further capacity and infrastructure in place would be overseen by the Programme Delivery Group. The first public meeting of the Member- led Local Outbreak Engagement Board was due to take place on 10th July.

Following discussion at the last meeting, an update was provided on the outbreak at the Princes food processing factory in Wisbech highlighting that having been fully managed,

the outbreak had stabilised with monitoring ongoing. Section 4 set out the ongoing work of the Public Health Team.

In subsequent discussion the following issues were raised / points made:

- On the 14-18 new cases, was there a breakdown by district, the member who asked it also asking if there were any underlying causes that might be contributing to the high numbers in Huntingdonshire, the district that had been most affected by the Covid-19 outbreak. It was explained that Huntingdonshire and Fenland had historically had more cases than the other districts, however the outbreaks did move around the County. The Princes factory outbreak had contributed to the higher figures for Fenland. Nationally outbreaks involving food processing premise appeared to be a trend and there was also a link to areas of deprivation, multi-generational households, ethnic groups, older age groups and male gender, were deemed at higher risk with all these categories showing a higher incidence of cases,. The biggest risk remained age and then gender. As a result, some areas in Huntingdonshire, Cambridge City and North Fenland where there was greater ethnic ethnicity/ multi occupational overcrowding and involved people in front line jobs, were seen as higher risk areas. Assurance was given that all rises in areas were very closely monitored and there was an officer working cell for socially excluded and high risk groups looking at how they could be supported in terms of prevention.
- It was confirmed that the Service was now receiving postcode date on a weekly basis from Public Health England so hotspots were now easier to track. The Director of Public Health considered that the Test and Trace Programme had greatly improved but the Service was still not getting everything required as it was only receiving postcode data on a weekly basis. The Service was seeking to be involved in a pilot scheme to receive it on a daily basis. While the Service was receiving individual residents' postcode details, this was not able to be linked to a specific outbreak or work setting and so the Service was also additionally seeking to obtain this information. However the data now being received was still a huge improvement on how it had been just three weeks previous.
- As more test results data was now being provided, was the Director confident the Service could deal with another spike and that lessons learnt were being shared? In answer it was highlighted that in many ways the avoidance of a second spike was in the hands of how residents behaved and their willingness to continue to undertake social distancing measures, good personal hygiene, to help prevent a further spread of the virus. The Health Protection Board was meeting that day to discuss key learning points taking into account all feedback received from agencies.
- It was suggested that as the number of teams involved was so complex, to help the public and even Members gain a better understanding, a structure chart should be produced for the website, showing in diagrammatic representation how they interacted. The same Member also indicated that there seemed some confusion of how the Local Resilience Forum and the Local Resilience Recovery group worked together. The Member further suggested a case study would be useful for illustrative purposes e.g. the Princes Factory outbreak. **This was agreed. Action Liz Robin**
- It was highlighted and the Director agreed that obtaining accurate data speedily was essential now that the lockdown was being lifted, as well as also ensuring communication on outbreak hotspots was passed on to the public. Giving precise information on where outbreaks has been identified was essential.
- One Member asked in relation to the outbreak in Huntingdonshire for confirmation of whether it was in the north of Huntingdonshire as it would help people change their behaviour in a local area if they were aware that the outbreak was in their locality. In reply it was explained that details were not available on older previous, positive tests as they had been identified from tests carried out at drive in testing centres. Rapid response work was being undertaken where there was a concentrated outbreak and the Public Health Team were working with district partners on the necessary

communications message.

- Regarding the awareness of the contributions of local community groups and continuing communication with them, reassurance was given that District Council Chief Executives had been very engaged in their intention to help support and maintain the good work these groups were doing. The Director of Public Health had spoken to four of the five Chief Executives regarding their continued support in the last week and was meeting with the particular member's District CE later in the week.
- On seeking reassurance that the methods used to analyse data streams would be able to cope with a ten-fold increase in positive cases this was answered in the affirmative, as there was now sophisticated intelligence in place and also at Regional level with analysis of any disparities and at regional level because of the resourcing available it would not be affected by the numbers involved**.**
- As there were now more positive tests on Pillar 2 than on Pillar 1, a question was raised on whether there were concerns that the Covid figure was higher than was being estimated as the Service was not getting accurate positive results or was it that the outbreaks were becoming less damaging. The Service when looking at the likely levels of Covid cases did not just look at local tests as it was recognised that some people never showed any symptoms of Covid even when they had the virus, so the national survey results were always more reliable than just using local test results. Testing would never pick up all cases and therefore as stated at the previous meeting, National Survey results which tested thousands of people on a regular basis whether they have symptoms or not, were a more reliable measure than just test results of people with symptoms. . Because it was known that there was virus circulating in the County and nationally, people were being encouraged to get tested if they had symptoms and to self-isolate when receiving positive results.
- As had been previously stated the more testing undertaken would lead to more positive results. Peterborough's positive results had jumped as a result of having drive-through centres and the social conditions in certain areas, while Cambridgeshire had not increased to the same level. However, at the time of the current meeting, the rate in Peterborough was reducing and so could not be compared currently to, for instance the type of outbreak that had been experienced in Leicester, where the rates were still rising. There was a concern that when students returned to Cambridge it was possible the rates could rise again.
- In term of gaps in data, one Member drew attention to the Covid mobile phone app which 3 ½ million people were recording data daily on whether they had symptoms and was massive resource which was only just beginning to be utilised. The data on the app kept identifying Fenland as an area that needed to be closely monitored. This was a massive data resource with the Member who had raised it suggesting that it was no less accurate than some other data sources and in fact presented a rather different picture. The Member highlighted that it was from this source that it was discovered that Covid symptoms included in many cases both the loss of the sense of smell and taste. The Member who had raised the above issue urged as many people as possible to use the app as a way of increasing the accuracy of overall data on the spread of the virus and help guide Public Health to target those areas effectively. Another Member for clarity explained that the Covid 19 app was not the same one as the test and trace app that had been unsuccessfully tested on the Isle of Wight
- A question was raised regarding what data sharing was currently taking place. It was explained officers from the Service were working on data sharing agreements with the District Councils and these were nearly in place and were in the process of being signed off.
- One of the Members explained that as a local Member she received concerns regarding the significant delays in receiving testing kits when ordered from the Internet and asked how it fitted into the picture of Local Authority work and what should people do when experiencing such delays as it undermined confidence. Liz

Robin indicated that her team were looking at getting soft intelligence from local level back to the Central Outbreak Management Team and through district level communications. The majority of the time the system was working, but it was good to get feedback where problems were being experienced. In terms of residents obtaining more help, there was a national phone line to be able to book tests. People should look to it if they were having issues.

- On the issue of the longevity of the virus, one Member shared a conversation he had, had with a Chinses doctor back in January / February and the latter's prediction that it was likely to decrease in the summer months and did not like ultra violet light and infection rates would rise again when the temperatures started dropping again in the Autumn. On this he asked whether that prediction was likely to be the case. This was a question for the research colleague and scientists to try to answer, based on the latest academic test results.

It was resolved:

to note the report.

SCRUTINY

315. COVID 19 CCG UPDATE

The Chairman welcomed Jan Thomas from the CCG to the meeting to provide a short update on the current position and the CCG response to the Simon Stevens Annex A letter 29th April 2020 as this was previously expressed to be of particular interest of the Committee. In addition, to help structure the debate the Committee had prepared four questions which had been provided to Jan in advance so she was better able to provide responses to areas where additional information / comments was of interest to the Committee. The Chairman indicated that he would be was limiting the discussion to forty minutes.

Jan Thomas as by way of introduction explained that she was the accountable officer being the Chief Executive of the CCG and as the Covid pandemic had been treated as a Level 4 National Emergency, she was also the Co-chairman of the Strategic Co-ordinating Group for Cambridgeshire and Peterborough and under that she was chairing Health Gold command for Cambridgeshire and Peterborough.

She highlighted that she believed that in Cambridgeshire and Peterborough the CCG had done well during lockdown due to the dedication and experience of all health staff across both health and the social care sectors care and this had been a true team effort. She placed on record her thanks for their incredible dedication and for keeping going when they were all now very tired.

To support his view she highlighted that:

- due to stepping up additional, critical care capacity during the pandemic the Service had not been overwhelmed at any point and nor did the service run out of critical beds.
- the discharge programme to empty acute facilities had helped increase critical care capacity by redeploying staff to help improve infection control and keep people stay safe in hospitals.
- There had been unprecedented demand on the 111 Service, but the Service was still maintained.
- Primary care had completely changed its model by using £1m capital investment to secure virtual equipment so all staff had access to the necessary kit.
- Referral Cancer services while they had slowed down did not stop.

- Some services were changed and some services had to be closed to help re-direct resources.
- In respect of Care homes the aim had been to get as many staff into homes to help support the local authority in the early days, and this redeployment of staff had only been possible by changing service delivery in other areas.
- The Service was now ready for any second surge, but it was important to keep promoting the social distancing message and provide infection control guidance.
- The independent sector had been utilised to create additional capacity.
- Recovery plans were now being utilised in respect of Infection Control services and were returning slowly.

In terms of issue going forward:

- There was concern expressed of the impact on Hospices and their commercial viability.
- The Service was very aware of the link between health and inequalities and the crisis had magnified the role inequalities played in health with recovery plans therefore not just concerned with infection control but in building capacity to better address inequalities in conjunction with partners.

Positives had included:

- the close working between the Local authority and Health Services which was unprecedented e.g. outpatient services working on the Local Outbreak Control Plan and the effective way they had co-operated in providing support in local care homes.
- the importance of the close partnership work that had also developed between Health and the district councils.
- Adoption of technology had created opportunities especially in relation to outpatient services and there would be a focus on what elements should be retained going forward in terms of what had proven to add value.

Summing up, she highlighted that the pandemic had been unprecedented and she was proud of the services that had been provided and the dedication shown by the staff and the communication that had been undertaken with the public, stressing how lucky residents were to have world leading hospitals such as in Addenbrooke's and Papworth.

Question 1

From the perspective of the CCG, how effectively have health and social care worked together during the pandemic? What have been key challenges and what have the CCG learned from them?

Most of this had already been responded to in the introduction above. Effective working had been aided by:

- Money / budget issues currently being off the table had helped in a significant way to help the CCG work more freely
- data sharing work between partners having been excellent
- having one single aim meant all partners knew what was require of them to help achieve it all knew what was required

Issues raised:

One Member queried the statement that the work undertaken in care homes had been a success as this would was not the perception of many local people. In reply it was explained that accountability for Care Homes rested with the Local Authority, who undertook the vast amount of the commissioning. Infection control nurses had been working closely with Adult Social care staff. The expertise skills the CCG data team brought were in relation to safety, quality and infection control guidance and that for the first time there had been shared intelligence to help support homes as quickly as possible. She highlighted the excellent work that had been carried out by Carol Anderson and her infection nurses team. The whole system approach had worked very well with no concerns regarding work boundaries and with concerns of financial restraints. This support had been provided at a fairly early stage and especially when compared to other areas of the Country. The challenges had included that many care homes were privately owned. It was highlighted that a paper on Covid including care homes was being taken to the CCG Governing Body that week. What was needed was to continue the excellent collaborative working relationship going forward.

Question 2

What has been the impact on the bottom line? Have past debts formally been 'cancelled' and has the CCG got (or assured of getting) the funding for the extra 400 beds and other costs such as PPE?

It was indicated that CCG had worked very closely with their NHS Regulators and were due to receive compensatory money from the Government. A different working relationship had developed with the financial regulator which was quite unprecedented, being very supportive during the crisis and while no guarantees had been given, they had also been very respectful of the additional resources requested. The aim in budgetary terms was now to break even and with regard to that target they were only hundreds of thousands of pounds short, rather than millions.

Question 3.

How timely and adequate has the information flow been, whether via the Department of Health, Care Quality Commission or Public Health England. What adjustments or improvements in that flow could assist the CCG in future?

Very early on it was realised that it would be necessary to share data and not work in silos and to aid this, an intelligence cell had been developed, enabling the various data services to work together on a predicted model. The Integrated Intelligence Hub had been a fantastic success and in her opinion should be retained.

When speaking to colleagues across the regions it was clear that it would have been useful to have more comparator data from other areas where there had been outbreaks on trigger points / the factors that may have caused local outbreaks e.g. Leicester as learning points.

Questions / issues raised by Members included:

- On speed of testing results coming back nationally, people had been told it would be within 24 hours with the exception of home testing which was 48 hours and while one Member had received the test for the latter in that time scale, her experience was not always the case. She enquired regarding the Service's experience on the speed of responses. In reply it was agreed that early on in the

crisis the delay in receiving test results had been a significant problem, but this had now rapidly improved, with many of the original issues having been resolved. On Pillar 1 and Pillar 2 test results the latter were showing more local positive results and the issue was now to analyse what it meant and how to use it.

- Was there a written response to the Simon Stevens letter that could be shared, and if a general oral response could be provided at the current meeting. In discussion, it was confirmed that there would be a meeting of the Committee in August and that the written response would be included as an agenda item for the next meeting. **Action Jan Thomas undertook to produce a paper on the specifics of the reply.** It was explained that a great many instructions and guidance had been issued from the Department of Health under the level 4 emergency and as the Covid emergency was changing rapidly, any response provided would only be a snap shot on the particular day it was completed.

Improvements for the future and challenges included;

- Seeking to ensure there was sufficient capacity to sustain health care services.
- Reducing waiting list was a real issue, as many of the staff had been redeployed on infection prevention control e.g. Diabetes nurses – and it was known that Covid had a major effect on people with the condition.
- There were concerns regarding public expectations of services going forward. Accident and Emergency departments' waiting rooms were starting to fill up again, 111 calls continued to rise and primary care activity had already reached the level it was before the crisis.
- As discussed earlier in the meeting, she would be happy to ensure the Committee receive the Governing body paper on Covid care which included papers on care homes and public data **Action: Jan Thomas/ Kate Parker**
- One member highlighted the need for a date for reopening the minor injuries unit at Doddington as this was an important service for Fenland residents that needed to re-opened as soon as possible. In reply a date could not currently be given, as previously confirmed, the facility closure was a temporary measure, with staff currently redeployed to other front line duties. If there was a further outbreak the staff might still also be needed for testing and swabbing. She indicated that she was happy to bring back details of a Recovery Plan, but stressed it would not reopen until redeployed staff returned. The Chairman indicated that as this was an area of particular interest to the Committee it would be looking for updates to future meetings. **Action: Kate Parker to liaise with Jan Thomas regarding providing appropriate updates and scheduling them into the work programme.**

Question 4

What has the cumulative impact of focus on Covid on patients with other health conditions and treatments delayed. What is the expected casualty and what plans for dealing with the tailback, bearing in mind the potential eventuality of a second Covid wave?

- The focus of the recovery plan going forward was in terms of reducing harm to the wider community citing areas such as cancer diagnosis having reduced and those people with conditions that were in pain as a result of cancelled operations etc. The way provision would be provided going forward was being reviewed, including referrals, to ensure appropriate, targeted treatment. What was required was a large increase in Diagnostics and more capital funding had been requested to help finance this to create diagnostic hubs. However it was now considered that this additional funding was unlikely to be obtained. Clinicians'

were being given guidance regarding reviewing waiting lists / referrals to establish the best way of treating people and identifying risks going forward.

Questions raised included:

- In respect of information sharing and predictive work, how much of this would be able to carry following the passing of the crisis and how would it link to the STP to make it work, as a key element was information sharing. What had currently been achieved was more of an integrated health system and there were ongoing discussions with regional directors on how this could be retained. In terms of the disproportionate adverse effect of Covid on people who were obese or hand diabetes, there was a need to continue an integrated approach to prevention, with the hope that there would be some help nationally to help retain some of the structures that had been created.
- It was highlighted that in relation to delays in referral pathways and scans not taking place this was building up problems for people's health that would add additional financial pressures further on as people's conditions deteriorated from lack of early diagnosis and treatment. Additional Capital had been requested to support diagnostic with it being acknowledged that the number of patients seen within the six weeks target had reduced

As Jan was required elsewhere in her busy schedule, the Chairman thanked her for attending the Committee to answer questions and asked her to take back the Committee's sincerest thanks and admiration for the excellent job her staff were doing during this very difficult time.

316. HEALTH COMMITTEE AGENDA PLAN

This repot invited the Committee to review its agenda plan. Members made the following comments:

- A request was made on whether it was possible for Tracy Dowling from the CCG to be invited to come to the September Committee meeting to answer questions on the effect of Covid 19 on the normal work and how they had been supporting the work of the pandemic. The Chairman indicated that this request would need to be discussed further at the next Chairman and Lead Member briefing.
- Regarding the request at the June meeting for a council wide review of the Council's performance in response to the Covid 19 emergency, as it was not a Health Committee function to scrutinise the Council as a whole, the Chairman updated the meeting that he had already spoken to Amanda Askham, Director of Business Development and Improvement regarding the issue and was to be discussed at Group Leaders. As it should be a county wide review of all services not just Public Health performance, it would need to be carried out under the auspices of the General Purposes Committee. In reply to a Member asking if the results of the review would come back to the Health Committee, such a report would be on the basis of highlighting any specific health related issues pertaining to the functions of the Committee.

It was resolved to:

to note the agenda plan.

Chairman 6th August

Agenda Item No: 6

PUBLIC HEALTH GRANT 2020/21

To: **Health Committee**

Meeting Date: **6th August 2020**

From: **Director of Public Health**

Electoral division(s): **All**

Forward Plan ref:

Key decision: **No**

Purpose: **The purpose of this paper is to inform the Health Committee of the 2020/21 increase in the ring-fenced Public Health Grant and proposed investment of the increase.**

Recommendation: **The Health Committee is asked to note the increase in ring fenced Public Health Grant allocation and approve the following proposals:**

a) The allocation of funding to commissioned services to meet the cost pressures created by increases in Agenda for Change salaries.

b) To refresh the Cambridgeshire Healthy Weight Strategy and allocate funding in support new actions.

c) To support the allocation of funding for a temporary member of staff to energise and drive the obesity agenda.

	Officer contact:		***Member contacts:***
Name:	**Val Thomas**	Names:	Peter Hudson
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1. BACKGROUND

1.1 The public health grant to local authorities is ring fenced for use on public health functions exclusively for all ages. The Secretary of State has determined, in line with section 31 of the Local Government Act 2003, to pay grants each year to relevant authorities. The core condition of this grant is that it should be used only for the purposes of the public health functions of local authorities.

1.2 There is an expectation that the grant will be spent in-year. If at the end of the financial year there is any underspend local authorities may carry these over, as part of a public health reserve, into the next financial year. However in using those funds the next year, local authorities still need to comply with the ring-fenced grant conditions.

1.3 The grant in 2020/21 includes an adjustment to cover the estimated additional Agenda for Change (NHS) pay costs of eligible staff working in organisations commissioned by local authorities, or by the local authority, to deliver public health services.

1.4 Appendix 1 lists the areas where the grant may be spent. There is a specific grant condition that Local Authorities have regard to the need to reduce inequalities between the people.

2. MAIN ISSUES

2.1 The Cambridgeshire County Council ring-fenced Public Health grant for 2020/21 is £27,248,493, an increase from £25,560,000 in 2019/20. This £1,688,493 or 6.6% increase as indicated above, is intended to include funding for meeting the Agenda for Change cost pressures.

2.2 It is proposed that the following cost pressures for the Public Health commissioned services created by the Agenda for Change salary increases are met through the increased Public Health grant allocation. These increases will be re-occurring.

Agenda for Change Salary Increase cost pressures for Public Health commissioned services 2020/21 – annual cost		
Cambridgeshire Community Services	Healthy Child Programme	£27,248
Cambridgeshire Community Services	Integrated Sexual and Reproductive Health Services (iCaSH)	£94,660
Cambridgeshire and Peterborough Community Foundation Trust	Falls Prevention Programme	£2,315
Cambridgeshire and Peterborough Community Foundation Trust	Children and Young People's Substance Misuse Service	TBC circa £5,000
Change Grow Live	Adult Drug and Alcohol Treatment Services	TBC circa £15,000
TOTAL		**£144,223**

2.3 It is also proposed that the increase in the Public Health grant allocation be used in support of addressing obesity. The COVID-19 pandemic has focused attention on obesity as it is strongly associated with poorer COVID-19 outcomes. At both local and national levels there is a focus upon addressing the issue.

2.4 Almost two-thirds (63%) of adults in England are overweight or obese.1 in 3 children leave primary school overweight or obese, with obesity-related illnesses costing the NHS £6 billion a year. Living with excess weight puts people at greater risk of serious illness or death from COVID-19, with risk growing substantially as body mass index (BMI) increases. Nearly 8% of critically ill patients with COVID-19 in intensive care units have been morbidly obese, compared with 2.9% of the general population. (Department of Health and Social Care)

2.5 In Cambridgeshire, 62.1% of adults are either overweight or obese, similar to the national figure, but in Fenland it significantly worse at 71.5%. For children in reception class the figure is 17.7% increasing to 27% by year 6, in Fenland the figures are 23.3% and 34.7% respectively. The health behaviours most strongly associated with obesity are diet and physical activity. In Cambridgeshire 68% of adults are physically active which is close to the national figure of 67.2%. However in Fenland the figure is statistically significantly worse than the national figure at 62.8%. In terms of diet 56.5% of the adult population in Cambridgeshire eat “5 a day”, similar to the national figure of 54.6%. In Fenland the figure is statistically significantly worse than the national figure at 47.8%. (All data 2018/19)

2.6 The Government is launching a comprehensive obesity campaign driven in part by the COVID -19 associated risks and by the opportunity to build on some of the lifestyle changes that the pandemic has pre-empted, such as increased cycling activity. It launched its “Tackling obesity: empowering adults and children to live healthier lives” Strategy on the 27th July 2020. This is a call to action and includes the following range of initiatives that provide a new stimulus and opportunity for action at a local level:

- a new campaign “Better Health” which is a call to action for everyone who is overweight to take steps to move towards a healthier weight, with evidence-based tools and apps with advice on how to lose weight and keep it off
- working to expand weight management services available through the NHS, so more people get the support they need to lose weight
- publishing a 4-nation public consultation to gather views and evidence on our current ‘traffic light’ label to help people make healthy food choices
- introducing legislation to require large out-of-home food businesses, including restaurants, cafes and takeaways with more than 250 employees, to add calorie labels to the food they sell
- consulting on our intention to make companies provide calorie labelling on alcohol
- legislating to end the promotion of foods ‘high in fat, sugar or salt’ (HFSS) by restricting volume promotions such as buy one get one free, and the placement of these foods in prominent locations intended to encourage purchasing, both online and in physical stores in England
- banning the advertising of HFSS products being shown on TV and online before 9pm and holding a short consultation as soon as possible on how we introduce a total HFSS advertising restriction online

2.7 Locally the Cambridgeshire and Peterborough Clinical Commissioning Group is concerned about the impact of obesity on diabetes and cardio-vascular disease. It is investing considerable funding in improving services related to prevention and the management of obesity. It has launched its Body Mass Index 'BMI Can Do It' campaign that includes a very comprehensive campaign for residents and organisations across the system to rise to the challenge of losing 1 million kilos.

2.8 There is clear evidence that addressing obesity requires a system wide approach as obesity is complex and requires a multi-faceted approach. This focus and energy to address obesity provides an opportunity to return to the Cambridgeshire Healthy Weight Strategy, to refresh it, reflect the developments and to build a system wide approach. Appendix 2 is the Healthy Weight Strategy on a "page" that captures the different variables for addressing obesity.

2.9 The proposal is to work with members of the Health Committee to explore the evidence, needs and prioritise actions to address the challenges that obesity presents such as changing behaviours that have been formed through complex factors such as affordability and cultural norms. It will require a broad approach that includes consideration of policies that can influence behaviours e.g. cycling routes, access to affordable healthy food, incentives and other innovative ways of influencing behaviours.

2.10 It is essential that this work is taken forward so that we can capture the current energy in the system and work with partners who are already acting to take this work forward. In support of this recommendation it is proposed to recruit an additional temporary staff member to support the energising of this work, to ensure that any opportunities are not missed.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

The report above sets out the implications for this priority in **2.6, 2.7, and 2.8**

3.2 Thriving places for people to live

The report above sets out the implications for this priority in **2.6, 2.7, and 2.8**

3.3 The best start for Cambridgeshire's children

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

- The Cambridgeshire Healthy Weight Strategy and the new National campaign address childhood obesity and call for comprehensive measures to target children

3.4 Net zero carbon emissions for Cambridgeshire by 2050

- Fundamental to any efforts to address obesity is focus upon increasing physical

activity by supporting people to use active travel rather than vehicles

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications in **2.2**

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

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

- This grant (in pursuant of the Local government Act 2003) can be used for both revenue and capital purposes to provide local authorities in England with the funding required to discharge the public health functions,

- 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 action is taken to address obesity.

4.5 Engagement and Communications Implications

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

- Any actions taken to address obesity will include consultation and engagement with communities affected.

4.6 Localism and Local Member Involvement

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

- Addressing obesity will involve working with individuals and communities to identify how they can work together to tackle the many barriers to reducing obesity and improving their health and wellbeing.

4.7 Public Health Implications

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

- Adult and childhood obesity is associated with poorer health outcomes that include increased risks of diabetes, cardio-vascular disease and premature death. It is a public health priority and the overall proposal is to improve these outcomes through a multi-faceted system wide approach

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Stephen Howarth
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Gus da Silver
Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or LGSS Law?	Yes Name of Legal Officer: Gurdeep Sembhi
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Liz Robin

Source Documents	Location
Public Health Outcomes Framework: Public Health England	https://fingertips.phe.org.uk/profile/public-health-outcomes-framework#:~:text=%20The%20framework%20focuses%20on%20the%20two%20high,and%20healthy%20life%20expectancy%20between%20communities%20More%20
Excess Weight and COVID-19 Insights from new evidence Public Health England July 2020	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/903770/PHE_insight_Excess_weight_and_COVID-19.pdf
FORESIGHT Tackling Obesities: Future Choices – Obesity System Atlas Government Office for Science 2007	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/295153/07-1177-obesity-system-atlas.pdf
Public Health England: Guidance Adult obesity: applying All Our Health**:** Updated 17 June 2019	https://www.gov.uk/government/publications/adult-obesity-applying-all-our-health/adult-obesity-applying-all-our-health
Public Health England: Guidance: Health matters: whole systems approach to obesity	https://www.gov.uk/government/publications/health-matters-whole-systems-approach-to-obesity
Tackling obesity: government strategy Department of Health and Social Care July 2020	https://www.gov.uk/government/publications/tackling-obesity-government-strategy/tackling-obesity-empowering-adults-and-children-to-live-healthier-lives

APPENDIX 1

Categories for reporting local authority public health spend in 2020/21

Prescribed functions:
1) Sexual health services - STI testing and treatment
2) Sexual health services – Contraception
3) NHS Health Check programme
4) Local authority role in health protection
5) Public health advice to NHS Commissioners
6) National Child Measurement programme
7) Prescribed Children's 0-5 services

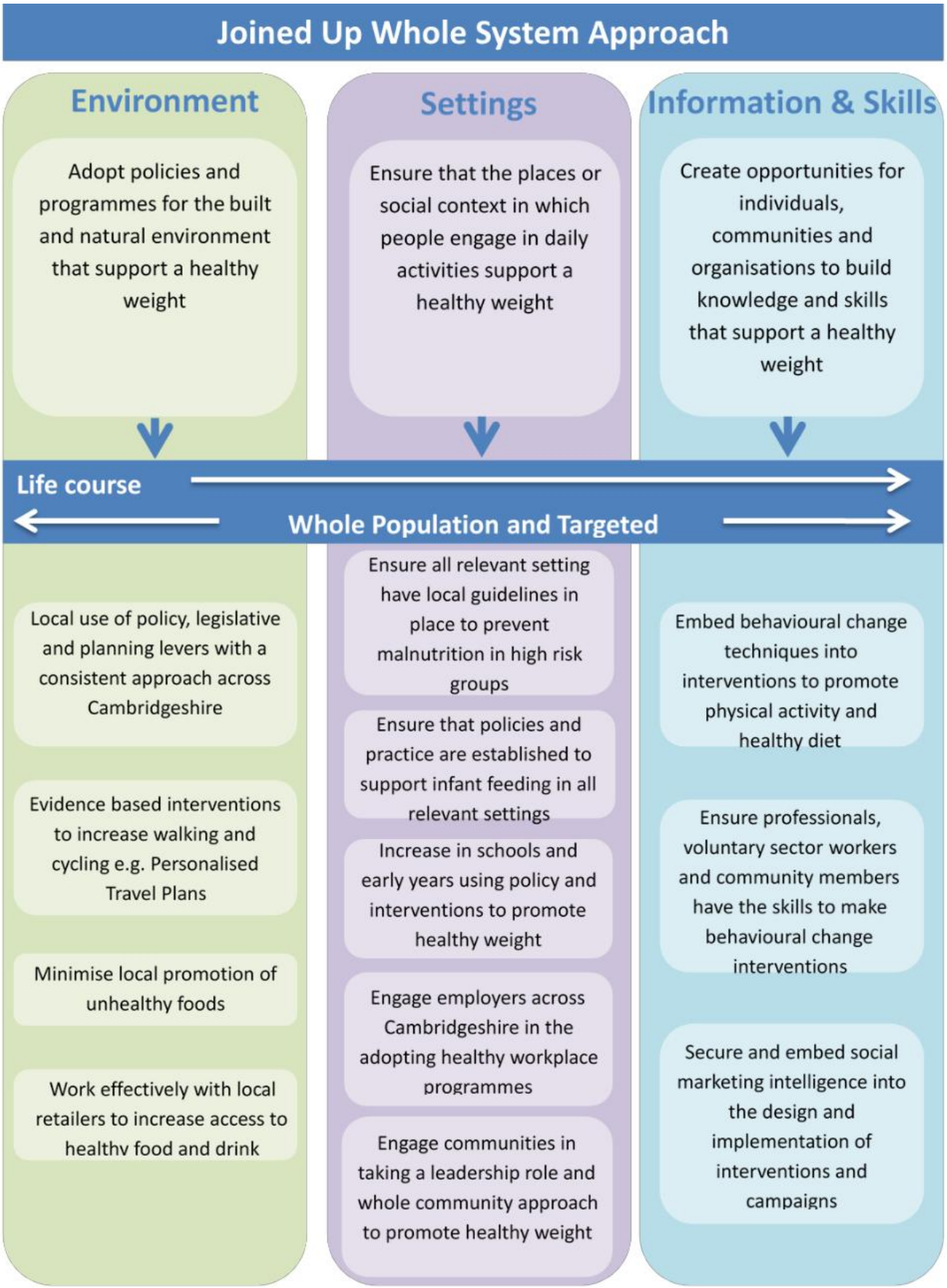
Non-prescribed functions:
8) Sexual health services - Advice, prevention and promotion
9) Obesity – adults
10) Obesity - children
11) Physical activity – adults
12) Physical activity - children
13) Treatment for drug misuse in adults
14) Treatment for alcohol misuse in adults
15) Preventing and reducing harm from drug misuse in adults
16) Preventing and reducing harm from alcohol misuse in adults
17) Specialist drugs and alcohol misuse services for children and young people
18) Stop smoking services and interventions
19) Wider tobacco control

20) Children 5-19 public health programmes
21) Other Children's 0-5 services non-prescribed
22) Health at work
23) Public mental health

24) **Miscellaneous**, can include, but is not exclusive to:

- Nutrition initiatives
- Accidents Prevention
- General prevention
- Community safety, violence prevention & social exclusion
- Dental public health
- Fluoridation
- Infectious disease surveillance and control
- Environmental hazards protection
- Seasonal death reduction initiatives
- Birth defect preventions

APPENDIX 2: Cambridgeshire Healthy Weight Strategy: "On a page"



Cambridgeshire and Peterborough
Sustainability and Transformation Partnership

Briefing for Cambridgeshire Health Committee **Agenda item 7**
27 July 2020

Agenda item:	**7**
Title:	**RECOVERY PLANNING UPDATE**
Lead:	Jan Thomas, Accountable Officer, Cambridgeshire and Peterborough Clinical Commissioning Group
Author:	Catherine Boaden, Head of CCG & System Planning, Cambridgeshire and Peterborough Clinical Commissioning Group

Purpose of the paper
This paper provides an update on the recovery planning work undertaken to date.
Cambridgeshire Health Committee are invited to:
Note the work undertaken to date on recovery planning.

1. EXECUTIVE SUMMARY

1. This paper provides an update on the recovery planning work undertaken to date. It describes:

   - Our approach to the recovery planning process
   - Requirements from NHS England/ Improvement (NHSE/I)
   - Next steps

2. BODY OF REPORT

Background

2. Since the Covid outbreak began, our response within the Cambridgeshire and Peterborough health and care system has been to ensure we have the capacity to support and treat patients, to maximise survivorship and to keep staff safe.

3. In April we began planning our approach to restarting work that had been paused due to Covid. This work was undertaken in the context that we would have to live with the disease until a vaccine or treatment becomes available. It was also undertaken with the knowledge that a potential second wave was possible and therefore we needed to retain the ability to quickly 'step up' capacity to deal with Covid cases should this be required. We have continued to monitor the data around case numbers since April and use this information to inform our plans.

4. System Partners have worked with a number of system groups to deliver our Covid response.

   - Health Gold, which brings together leaders from across the system, have led on the restart of services, testing, availability of Personal Protective Equipment (PPE), workforce, occupancy and public confidence.
   - Our Joint Clinical Group (JCG) have considered the clinical approach and advised on prioritisation and safety. GP clinical leads have also advised on prioritisation.
   - A number of key cross system groups have advised on finance, workforce, digital infrastructure and the public health response.
   - Our North and South alliances have considered how to support system partners to work together to make the changes required.

5. In addition, we have actively worked at a multi-agency level through the Local Resilience Forum (LRF) to ensure that health and the economy are considered equally as recovery planning takes place across the county. This LRF is co-chaired by the Chief Officer of the CCG and the Chief Executive of Cambridgeshire County Council and Peterborough City Council. It has been an invaluable part of the process, providing command, control and co-ordination across Cambridgeshire and Peterborough.

6. Our initial plans assumed a period of 12-18+ months of managing Covid disease alongside a sustainable model for non-Covid healthcare. Our goal, as a system, was to implement a sustainable clinical and operating model for this period, allowing for future increases and decreases in case numbers, and with the primary aim of maximising the survivorship of patients and protecting our staff.
7. We have had an opportunity to use the recovery period to think about how our services should run and to make our recovery plan and the system's transformation plan one and the same thing.

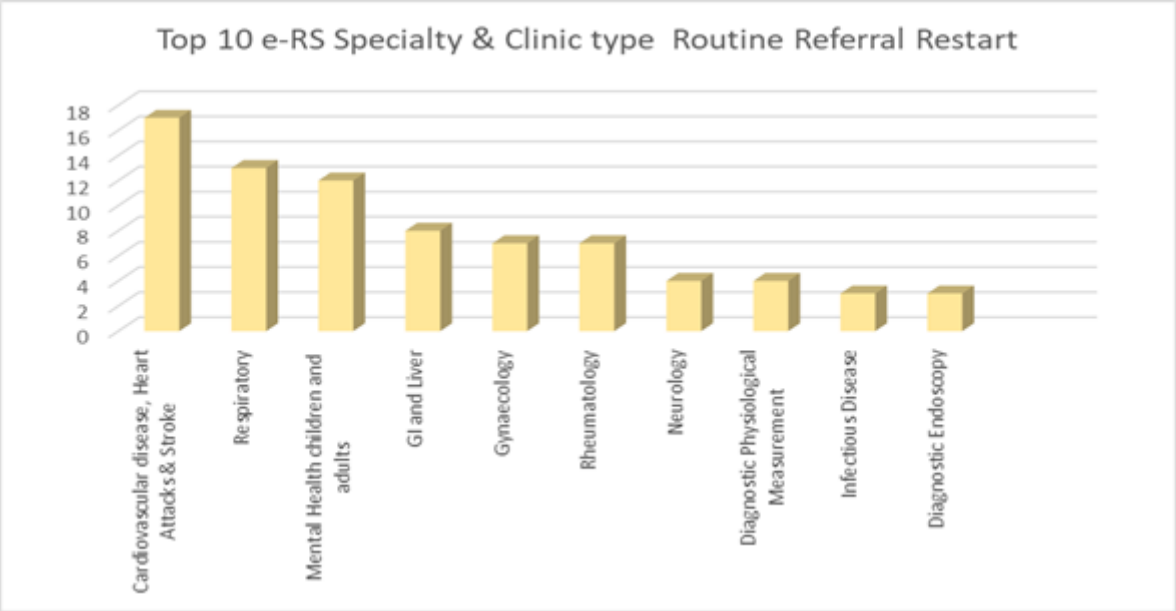
8. A further aim of the recovery planning process was to ensure that as we began to restart services, we captured and sought to incorporate the benefits of the new ways of working introduced during

the peak of Covid, with the aim of embedding them in future ways of working. We have undertaken work to review the positive changes introduced during Covid so that we can decide whether to retain them or to go further and make more radical changes.

9. We have also sought to act on the clinical view of prioritisation, including ongoing clinical prioritisation of the waiting list across all procedures so that those at most risk of harm are treated most quickly. In addition, we have sought to provide the public with the confidence to seek care where appropriate and necessary.

10. This has included ongoing clinical prioritisation of the waiting list across all procedures so that those at most risk of harm are treated most quickly.

11. To support our approach the CCG asked GP clinical leads, on 27 April, to respond to a question about the priority service areas which should be restarted in the Recovery Phase of Covid-19 crisis. The responses, summarised in the graph below, have supported the development of the recovery plan.



12. NHS England/ Improvement (NHSE/I) have developed a phased approach to recovery, and we have used the same approach as we have progressed our own plans.

Phase 1	Apr 20	Immediate Covid response – in healthcare settings, care homes and the community.
Phase 2	May – Jul 20	Continued response to Covid whilst beginning to reintroduce some essential services.
Phase 3	Aug 20 – Mar 21	Continued response to Covid whilst reintroducing more services.
Phase 4	Apr 21 onwards	A new 'normal' where the system has the ability to treat and care for those with Covid whilst providing all other necessary services. (At this point we hope to have a better understanding of the disease.)

Core principles

13. We agreed a set of core principles to guide planning

a) Maximise health benefit in the context of limited resources
b) Stay close to the clinical evidence base
c) Reduce health inequality
d) Focus on clinically designed whole pathway interventions

Planning to date

14. We have worked closely with NHSE/I to develop our recovery plans. On 29 April 2020 we received a letter from Simon Stevens, NHS Chief Executive and Amanda Pritchard, NHS Chief Operating Officer setting out some initial guidance around recovery planning.

15. We responded to this guidance by developing an initial draft recovery plan which we submitted to NHSE/I on 7 May setting out our proposed approach to Phase 2 (May to July 2020). This plan gave a detailed overview of our position and plans, setting out the position of each of our organisations against the areas identified in the national letter:

    - Urgent and routine surgery and care
    - Cancer
    - Cardiovascular Disease, Heart Attacks and Stroke
    - Maternity
    - Primary Care
    - Community Services
    - Mental Health and Learning Disability/ Autism services
    - Screening and Immunisations
    - Reduce the risk of cross-infection and support the safe switch-on of services by scaling up the use of technology-enabled care

16. We also described workforce, digital infrastructure and our estate.

17. A follow-up plan covering Phase 3 (August 2020 to March 2021) was submitted on 14 May.

18. We expect to receive further national guidance from Simon Stevens and Amanda Pritchard, in late July/ early August. It is expected that this guidance to ask us to describe progress to date against our plans submitted so far and for further detail about capacity, demand, constraints and solutions. We expect to be asked to submit follow-up plans over the summer and for these plans to cover the remainder of 2020/21 including the winter period.

19. We are anticipating the focus of this guidance to be as follows:

    - A system approach to planning
    - An emphasis on reducing health inequalities
    - An approach which enables us to minimise harm
    - A renewed emphasis on integrated out of hospital care

20. We expect to have to submit plans that are flexible with scope to step services up and down as necessary. This plan will double as our operational plan for the remainder of 2020/21.

21. We think it is likely that we will be asked to submit the next version of our recovery plan to NHSE/I in September.

22. To support our ongoing approach to recovery planning we have set up a Recovery Oversight Group. This group brings together Chief Operating Officers and Directors of Strategy from across the

system, from the local authority and the NHS, to lead the recovery process. The group is leading four domains to focus on specific aspects of recovery:

Domain 1: Out of hospital care
- Primary Care and Medicines Optimisation
- UEC Collaborative
- Community Care
- Care Homes/CHC
- Mental Health Services
- Discharge to assess

Domain 2: Clinical Interface
- Advice & Guidance
- Medicines Optimisation
- Direct Access Diagnostics
- Prioritisation of Service Start

Domain 3: Hospital Care
- OP
- Diagnostics
- Electives Care
- Cancer
- Critical Care
- Urgent Care & Flow

Domain 4: Maternity & Children's Services
- Maternity
- Children's Services

3. RECOMMENDATIONS

23. Cambridgeshire Health Committee members are invited to note the work undertaken to date on recovery planning.

27 July 2020

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Update 22nd July 2020	**AGENDA ITEM: 8**

Notes

Committee dates shown in bold are confirmed.
Committee dates shown in brackets and italics are reserve dates.

In line with the agreed Virtual Protocol during the current lock down necessitating virtual meetings, that with the exception of scrutiny updates, monitoring reports without decisions, including the Finance Monitoring Report, will, be circulated to the Committee separately.

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.

Draft reports are due with the Democratic Services Officer by 10.00 a.m. eight clear working days before the meeting.
The agenda dispatch date is six clear working days before the meeting

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
06/08/20	Covid-19 Issues Report	Liz Robin	Not applicable		29/07/20
	NHS Response to Simon Stevens Annex A letter 29th April	Jan Thomas			
	Forward Agenda Plan	Rob Sanderson	Not applicable		
	Public Health Ring-fenced Grant	Val Thomas			
17/09/20	Finance Monitoring Report (*Only if no longer lockdown and Committee meeting normally)*	Stephen Howarth	Not applicable	07/09/20	09/09/20
	CCG Finance Update	Jan Thomas			
	Covid-19 Issues Report	Liz Robin	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Agenda Plan	Rob Sanderson	Not applicable		
	Mitigation measures to protect Children's Health	Raj Lakshman			
	PH Performance Report Q1 2020-21	Val Thomas/ Raj Lakshman			
	SCRUTINY				
	CPFT response to Covid-19	Tracy Dowling (TBC)			
	Liaison meetings report	Kate Parker			
15/10/2020	Voluntary Organisations and contractors (additional work during Covid-19) and links to recovery	Val Thomas			
	Homelessness – safeguarding the benefits of additional services provided – linking with Housing Board and Suzanne Hemingway	Val Thomas			
	SCRUTINY				
	NHS E review of Dental Services	??			
19/11/2020	Impacts of Covid-19 Needs assessment to confirm with Chair / Vice chair details of this item.	Tom Barden			
03/12/20	Performance Report	Liz Robin	Not applicable	23/11/20	25/11/20
	Covid-19 Issues Report	Liz Robin	Not applicable		
	Health Committee Risk Register	Liz Robin	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Finance Monitoring Report	Stephen Howarth	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and Appointments to Outside Bodies	Rob Sanderson	Not applicable		
21/01/21	Finance Monitoring Report	Stephen Howarth	Not applicable	11/01/21	13/01/21
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and Appointments to Outside Bodies	Daniel Snowdon	Not applicable		
[11/02/21] *Provisional Meeting*					
11/03/21	Performance Report	Liz Robin	Not applicable	01/03/21	3/03/21
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and Appointments to Outside Bodies	Daniel Snowdon	Not applicable		
[08/04/21] *Provisional Meeting*					
10/06/21	Notification of Chairman/woman and Notification of Vice-Chairman/woman	Daniel Snowdon	Not applicable	31/05/21	02/06/21
	Co-option of District Members	Daniel Snowdon	Not applicable		
	Finance Monitoring Report	Stephen Howarth	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and Appointments to Outside Bodies.	Daniel Snowdon	Not applicable.		