London Borough of Islington

Health and Care Scrutiny Committee - Monday, 4 March 2024

Minutes of the meeting of the Health and Care Scrutiny Committee held in the Council Chamber, Town Hall, Upper Street, N1 2UD on Monday, 4 March 2024 at 7.30 pm.

Present: **Councillors:** Chowdhury (Chair), Croft (Vice-Chair), Burgess, Clarke, Craig, Gilgunn and Russell

Councillor Jilani Chowdhury in the Chair

37 INTRODUCTIONS (ITEM NO. 1)

The Chair welcomed everyone to the meeting and members and officers introduced themselves. Fire safety, webcasting and microphone procedures were explained.

38 APOLOGIES FOR ABSENCE (ITEM NO. 2)

None. Apologies for lateness received from Councillor Gilgunn

39 DECLARATION OF SUBSTITUTE MEMBERS (ITEM NO. 3)

None.

40 DECLARATIONS OF INTEREST (ITEM NO. 4)

Councillor Finn Craig declared an interest in items on the agenda insofar as they related to Great Ormond Street Hospital and Whittington UCL.

41 MINUTES OF THE PREVIOUS MEETING (ITEM NO. 5)

RESOLVED:

That the minutes of the meeting held on 23 January 2024 be confirmed as an accurate record of proceedings and the Chair be authorised to sign them.

42 CHAIR'S REPORT (ITEM NO. 6)

The Chair thanked Councillors who attended the three evidence gathering sessions for the scrutiny review into access to GP services and Adult Social Care. Members had now heard from a number of residents and were very grateful to the residents who had taken the time to feedback on this topic. Particular themes were definitely emerging, around e-consult and digital access, staff retention and training, and access via phonelines and to familiar members of staff.

The Chair invited Councillors who had attended the sessions to report back to the Committee.

Councillor Burgess said that the sessions were interesting. Two of the attendees had children with special educational needs and a third was a user of the Shared Lives Service, which provided foster care for adults. This latter person had cared for two or three different people in her home, over a period of about forty years, and was content with all that the Council had provided by way of support. Her son, who had supported her, was also going into the same service, which was a positive for continuity. The Chair of the Family Carers' Group and another member of that group

who had a very disabled son, had raised the issue of what would happen when they were no longer able to look after their children. This was a major worry for many people in the same circumstances. Another worry was not being able to hire personal assistants. Recipients were happy with the direct payments from the Council, but there was a shortage of personal assistants. The lack of suitable staff willing to do this type of caring was a major concern at the present time in Social Services generally.

Councillor Clarke had attended an Age UK meeting, which was well attended, by approximately 60 people. The theme of the meeting was access to GP surgeries. There seemed to be a split in the Borough, with some people struggling with digital exclusion and experiencing difficulty with the e-consult forms and others able to walk in to, or telephone, their surgery, to make an appointment. Concern had been expressed about people with mental health or learning difficulties being able to make appointments with GPs, as many of them could not access or navigate the e-consult form. She suggested that this was an issue upon which the Committee needed to make a recommendation. The other matter considered was the question of people not being aware of, or not knowing how to access, the seemingly plentiful Adult Social Care resources in Islington. She anticipated that the establishment of hubs could help in this regard, advising people on getting the help they needed, given this apparent inequality of service. Some users had mentioned that staff had been rude to them on the telephone and of their difficulties in accessing the complaints system and in receiving responses. Attendees had also mentioned the amount of time they had wasted on the telephone, waiting for responses from GPs or Social Services. Some attendees had mentioned the helpfulness of pharmacies. Safeguarding had also been raised as an issue, with an example given of an issue being raised with the Safeguarding Team and no response having been given for four months, which could also be considered as an area for a recommendation.

Councillor Burgess concurred with the point about the digital divide faced by users and said that a carer of a person with severe needs simply would not have the time to engage with IT to access forms. Also a point had been made that it would make an enormous difference to someone with a learning disability to be looked after by the same GP at each visit.

The Chair stated that the minutes from the sessions would be circulated to members. The recommendations of the review had been moved to the April meeting to allow time for consideration of residents' feedback and the presentation from the Access Islington Hubs, which was due to be considered later at this meeting

The Chair asked Committee members and everyone presenting to keep presentations and questions short and to the point.

43 PUBLIC QUESTIONS (ITEM NO. 7)

None.

44 UNIVERSITY COLLEGE LONDON HOSPITALS (UCLH) PERFORMANCE UPDATE (ITEM NO. 8)

The Committee received a presentation from Simon Knight, Director of Planning and Performance, and Liz O'Hara, Director of Workforce, UCLH NHS Foundation Trust, on performance against key targets. The Committee had also requested an update on staff morale, which would also be covered in the presentation.

On the quality of care provided:

- Infections – all hospitals were required to monitor infections carefully. Numbers of MRSA cases had been kept low for the past few years. UCLH had more cases of clostridium difficile than other hospitals and it was thought that this was principally driven by the fact that UCLH looked after a number of cancer patients. However, these numbers remained below the target set for UCLH, which was somewhat reassuring.
- A good indicator of nursing care was the low number of patients with pressure ulcers, with numbers remaining no higher than seven or eight each month. As a result of following best practice, UCLH was proud of the low number of these cases.
- Another good indicator of the quality of care was demonstrated by the comments by patients about services. UCLH compared well to other London Trusts in this respect and appeared top in a table of comparison with peers.
- On the matter of the amount of time patients waited for care, there had been approximately 30,000 patients awaiting treatment in 2010, with the figure rising to 70,000 by 2023. This trend was similar across the country during that timeframe. However, numbers had increased significantly for UCLH in 2019 when a new electronic health system was taken on and which had proved a difficult time for the Hospital, attempting to keep on top of the figures and to work out what was happening in the system. This had also coincided with the Covid pandemic. One of the challenges now was for the Hospital to address the very long waits some patients were experiencing. UCLH was now focusing on patients waiting the longest for treatment
- UCLH was tracked around the longest waits. A couple of years ago, the aim was to ensure that no patient was waiting more than two years, but the focus was now on getting the numbers down to 78 weeks, or a year and a half and 65 weeks, which was 15 months. UCLH had attained the 78 week target by March of last year, although there had been particular spikes in dermatology services, affecting cancer care especially. However, this had now improved.
- On the number of patients waiting for over a year for treatment, current guidance was that no patient should be waiting longer than a year for treatment by the end of March 2025. It was anticipated that this would be a very hard target for UCLH to meet, so time was being spent predicting which specialties were likely to face the most challenge, through mathematical modelling and looking at referral rates and opportunities for maximising outpatient space.
- There had also been a significant reduction in the number of patients seen in time for diagnostic checks, which were meant to happen within six weeks of a referral. The numbers had been affected due to the issues associated with the introduction of the health records system and the Covid19 pandemic, The new standard was that 95% of patients should be seen within six weeks of a referral for a test and UCLH was currently at about 90%. Further improvements were being made to the MRI, which would hopefully assist the Hospital in moving closer to the 95% target in the next couple of months. UCLH performed well on endoscopy.
- Cancer care – UCLH performance had recovered faster, following the pandemic. The target for patients being given a diagnosis from time of referral was 28 days and UCLH had achieved this consistently for the last year and a half, together with the target of patients being treated within 31 days of a decision to treat them. The target of 96% was largely met, apart from a tail off in the past couple of months in the urology service.
- On the 62-day service target for cancer patients, from referral time to treatment for patients, performance had tailed off in the past year. Diagnosis and treatment were performed well at UCLH, but there were challenges with pathways from other Hospitals, where referrals were sometimes late. UCLH

managed to turn around treatment quite swiftly, but not enough to achieve the standard. This was a challenge to the sector as a whole, to try and make those pathways much clearer, along with the accountability for that pathway much clearer. There was room for improvement on this issue.

- A & E – where the main target was for patients to be seen and discharged within four hours, performance had tailed off in the past year or two, which could be attributed to lack of bed capacity. There were also numbers of people attending A&E who could perhaps be seen elsewhere, though UCLH worked well within the sector to ensure that patients went to alternative services.
- On safe care in A&E and the target of ensuring that patients did not wait longer than twelve hours, considered a clinical risk, UCLH had performed well against its London peers until the last quarter.
- Ambulance handover times – the target for which was to make sure that ambulances dropped off patients safely at the Hospital, and then moved on to look after the next patient, UCLH had performed well, close to the 95% target and ambulance handovers at the Hospital taking no longer than half an hour.
- Delayed transfers of care – the position had been improving over the past two or three quarters. UCLH enjoyed good relationships with Council colleagues and those providing services. Due to this, the position felt generally positive and because of the support from partners, UCLH had a relatively low number of patients waiting in Hospital who did not need to be there.
- UCLH's ability to meet all of its targets had been significantly affected by the number of strikes within the Hospital and across the NHS. Patients who needed to stay overnight in Hospital (elective care) were most affected. Fortunately, highest risk patients, including those with cancer, were being managed well, with any cancellations swiftly rebooked. However, the action had had an affect on those patients who had waited longest, as those patients were usually not in as serious a condition and could afford to wait longer for treatment.

- Health, Wellbeing and Morale
  First and foremost, UCLH recognised that good patient care required staff being looked after and health and wellbeing were consequently at the centre as key strategic priorities. The Hospital was fortunate in having a charity which helped to enable some of the issues which mattered most to staff.
- A number of issues had impacted the drive on health, wellbeing and morale within the organisation, including the Covid pandemic. It was recognised that staff needed ongoing support for this.
- Many lower paid staff were affected by the cost of living crisis and much had been done by UCHL as an employer eg providing advice and directing staff to services. Hardship funds had also been set up. On industrial action, UCLH was an open organisation and time and effort had been put into communication with staff. Formal and informal mechanisms of communication with staff had been established. Hospital management enjoyed good relationships with trade unions which had helped with continuing work which needed to take place, with staff feeling valued and respected through these difficult times.
- Health and Wellbeing indicators
  To enable UCLH to measure and have a grip on what was happening with regard to staff morale, one of the biggest indicators was the annual staff survey, which helped to measure staff morale against peers and nationally. UCLH tended to be above the national average in terms of how staff felt about working at UCLH. Particular attention was paid to staff sickness, managing vacancy rates and staff turnover. UCLH had noticed good signals with regard

to vacancy rates and staff turnover. There were also quarterly staff surveys, alongside a range of other informal ways of ensuring that the situation was being monitored. Regular fortnightly briefings with the Chief Executive were held, which staff could attend remotely and pose questions, whilst remaining anonymous, allowing staff to say exactly what they thought. UCLH tried to be aware of what was important to their staff and to ensure that subject experts were available to address any points raised by staff.

Some of the things which UCLH was proud of and had received good feedback directly from staff, all assisted by the Charity, were the launch of a long term programme which the Chief Executive started called “Be Well”. This was a range of ways to support staff, including basic hygiene factors, such as accessing hot food on an evening shift, discounted food and access to advice services, all based on what staff had asked for. There was also a spa, based on volunteer masseuses, all to make the working space better. All received good feedback from staff.

UCLH also recognised that staff needed to be able to let them know when things were not going well. Staff could raise issues through the “Freedom to speak up Guardian Service”, which was external to UCLH, with staff knowing that any concern raised through that Service would be acted upon. Mediation services were also available to help to address any conflict in the work place.

UCLH was particularly proud of its staff briefings and revamped staff network, which all helped to keep UCLH focused on diversity, equality and inclusion issues. In addition, there were a number of local champions who were passionate about Health and Wellbeing and could deliver messages about the services available. A staff psychological service and occupational health service were available to support day to day activity that people might need access to as part of their working lives at the Hospital. There were also reward and discount platforms for all staff, including bank staff, and salary sacrifice schemes. This year, UCLH was working to support working parents and carers at the Hospital, with a Strategy being launched this year. It was considered that one of the biggest things that could be done, and often the least expensive, was how staff in the NHS were thanked. How staff were rewarded was really important, and this was supported through the Charity, by long service awards and recognising the valuable work done by staff over a number of years. Recognition awards were held annually and staff enjoyed attending, with staff feeling valued and respected.

Questions/responses were supplied as follows:

Confirmation was given that the data supplied included children.

On the 31-day cancer wait to first treatment, did the wait include people waiting for radiotherapy and was that considered primary treatment? Was it considered that disproportionately affected the figures as there was often a slightly longer wait for radiotherapy than for chemo? It was not considered that the figures were disproportionately affected and figures has turned around in the past six months.

Regarding the12- hour trolley wait in A&E at UCLH and comparing the experience of a relative in another A&E department at another hospital, the relative was told that they had to be moved to a bed, as the wait approached 12 hours, and a bed was brought down to A&E so that person was no longer

on a trolley. It was confirmed that this was not the practice at UCLH, meaning the patient was actually in a hospital bed, or had gone home.

The work of UCLH with regard to its staff wellbeing was impressive and much of that work could be usefully shared with others. These were incredibly difficult times for the NHS and the days lost through industrial action were tragic. Agency staff had to be employed to cover staff on strike, which was an extra cost, and how could this be managed financially? UCLH were congratulated on their work for staff and, although staff morale was noted to be above average compared to other hospitals, it was still relatively low at 5.9%. A response was given that some central funding was provided for the impact of industrial action. Legislation had changed as to how the funding was used. It was UCLH's own staff who were used in different ways during the strike days, to support their colleagues to undertake their right to strike, while essential care services were still being provided.

One of the councillors commented that she had been offered a massage while in the staff canteen, proving that those services were being offered to staff!

The Chair thanked Simon Knight and Liz O'Hara for attending and for their presentation. The Committee was pleased to hear about all of the good work being carried out at UCLH.

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45 **UPDATE ON NCL START WELL PROGRAMME (ITEM NO. 9)**

Anna Stewart, Programme Director for Start Well, at North Central London Integrated Care Board, gave a presentation to the Committee on proposals that had been developed as part of the Start Well Programme proposals. This Programme of work had been initiated in 2021 to ensure maternity, neonatal, children and young people's services were set up to meet population needs and improve outcomes.

Anna Stewart said that she would take notes during the discussion of this item to feed back into the formal consultation. She also encouraged all present to submit their own feedback if they had not already done so.

She noted that Start Well had been operating in north central London for approximately two years. She described the programme as a "truly integrated piece of work", across the whole of the ICS, involving colleagues from all of the acute trusts across NCL, as well as GOSH as a key partner and local authority colleagues. A case for change had been initiated approximately 18 months previously and then time was spent with a wide range of clinicians developing best practice care pathways, with a view to developing idealised pathways of care needed for maternity, neonatal and children and young people's care. From there, three key areas were identified which would potentially need some organisational changes in order for them to be delivered

and could not be delivered through the normal systems of working together through the integrated care system.

The three main areas of the Programme which were the focus of public consultation were:

- The number of neonatal and maternity units in north central London and the proposal to move from five units to four. The reason for this was changing demographic patterns, the declining birth rate in north central London, the increasing complexity both of women and pregnant people giving birth and the babies they were having who needed additional care. This meant a mismatch between the existing pattern of care available in north central London and the need. There was a lot of pressure on services looking after women with more complex needs and complex babies, meaning pressure on the level three neonatal intensive care unit at UCLH. Conversely, there was a level one neonatal unit in NCL, which cared for the least unwell babies, which was generally half empty, because it was not able to meet the needs of the babies being born.

The proposals around maternity and neonatal services were not to save money, rather they were driven by a belief that having a smaller number of larger units would better deliver best practice care standards, improve the quality of care and improve the resilience of care in services that were historically pressured in terms of recruitment and retention.

Both options would require a considerable investment in the estate in north central London, in terms of the fabric of the buildings. Under both options, £40m capital had been earmarked to invest in those buildings.

Two options were being consulted on:

1. To close maternity and neonatal services on the Royal Free Hospital site and retaining services at UCLH, North Middlesex, Barnet and Whittington Hospitals
2. To close maternity and neonatal services at the Whittington Hospital, whilst retaining services at UCLH, North Middlesex, Barnet and Royal Free Hospitals.

In the interests of transparency, all of the reasons for the preference for option one, closing services at the Royal Free and retaining services at the Whittington Hospital, had been set out by the Board. However, both options were deliverable and affordable and were the subject of consultation.

- Also the subject of consultation was maternity care at the stand-alone midwifery-led unit at the Edgware community hospital site. Out of 20,000 births in north central London per year, only 34 had been born at this site in the last financial year. Only the birthing suite was the subject of closure, the remaining ante-natal and post-natal services would be retained.

- A further part of the consultation related to children's surgery. No changes were proposed to the paediatric emergency departments within north central London. This was about the onward care of very young children after they had been seen and assessed in the emergency department. The first proposal was to set up a paediatric surgical assessment unit at GOSH, to see predominantly under threes who needed a surgical opinion and some surgery. It was anticipated that approximately one thousand children would be assessed there and three hundred would have surgery. These were children who were predominantly seen at GOSH or outside NCL at the moment, so bringing their care into one place. A very small number of under threes would be seen for day surgery at UCLH, where there were a number of paediatric anaesthetists and skills to see children for predominately ENT and dental issues.

Much work had been carried out to involve people in the consultation and to seek their views. An independent partner would evaluate the outcome of the responses to the consultation. Based on that, decisions would have to be made on whether supplementary work was needed and therefore it was not anticipated that a final business case decision would be made until the end of the calendar year. It would then take time for any decisions to be implemented, pending the necessary capital works to buildings. Until that time, all current services remained open.

Questions/responses were as follows:

There was a fear that, with Whittington Hospital as the nearest in Islington, there was competition with the Royal Free. Islington Council did not want to see any closures in maternity wards. If maternity services were closed in the Whittington Hospital, would other services be affected in years to come? The response was that services had been reviewed, including paediatrics, and there were no plans to close emergency departments. There were inter-dependencies for some clinical specialties in both options which would need to be worked through and separated eg obstetrics and gynaecology with joint rotas. The Board had looked at all of the staff groups on all of the sites and the anticipated impact of any changes and this was just one of the reasons why retaining maternity services at the Whittington Hospital was the preferred option, as it would be less disruptive from a staffing point of view.

Islington councillors were in favour of maintaining services at the Whittington Hospital and had been campaigning to retain services there, as they had to retain A&E services at the Hospital some years ago. Noting that the final decision was to be made at the end of the year, it was suggested that this was a long time for people to be "in limbo".

On the proposals for surgery, it was noted that GOSH would provide services for children under five, although it was understood that this was something they were currently providing? If, for example, a four year old required an appendectomy, where would that be removed? Were UCLH carrying out much day care surgery at the current time? A response was given that some children who, for example, required an appendectomy, would be treated at GOSH and some were going outside north central London to the Royal London and Chelsea and Westminster Hospitals. Clinical colleagues who had been consulted on this, particularly those involved with paediatric emergency services, had said that there was no completely established pathway for very young children who, although not medically complex, were anaesthetically complex and would require a paediatric anaesthetist for opinion and intubation. It sometimes took hours for clinicians to ring around other hospitals to identify a suitable hospital to take a particular child. Setting up a four-bed paediatric unit at GOSH would assist in caring for those children at that Hospital. Much day care surgery was carried out at UCLH. However, UCLH had a growing service, particularly around radiotherapy, where a large number of children were anaesthetised, and had a large anaesthetic department and were well set up to manage that and to build it into their existing caseload. On dentistry and ENT, much work was carried out at Barnet Hospital and community dental services at the Whittington. GOSH dealt with young children requiring anaesthetics.

Although it would be difficult for staff to have to wait until the end of the year for a final decision on which services were to close/continue, much work had to be carried out between now and then, especially on all the observations to the consultation. It was thought that staff understood this and staff at the Whittington and Royal Free both wanted their points to be considered thoroughly. It was thought best to take time over this.

A comment was made about page 35, which referred to the Royal Free being underused and the Whittington not meeting standards, though no reference had been made to the Whittington being well used. The point was made that maternity services at the Whittington were well used. It was important that people responded to the consultation. However, digital exclusion had been referred to earlier in the meeting and that was an issue here. A person had to be digitally literate to respond to the consultation and it was not that easy. How was the ICB dealing with people who were not able to respond online? The response was made that many staff on multiple sites had been consulted. In terms of the reach of the consultation, the ICB was using a multiplicity of methods to gain feedback. There was an online questionnaire which was fairly intuitive, but it was acknowledged that one required a level of digital knowledge to be able to complete the form. Written questionnaires were also available and it had also been translated into community languages, with all the summary documents translated into eighteen languages, in an attempt to be as inclusive as possible. It was pointed out that the written questionnaire was only one way of responding to the consultation. Many targeted sessions had been arranged with voluntary and community sector groups, identified through the integrated impact assessment, and commissioned highly targeted

engagement through a specialist organisation to work with traditionally hard to reach groups, such as asylum seekers and traveller and gipsy roma communities. All of this feedback would be collated. There was an email address, postal address for a letter and a telephone number. It was pointed out that this was not a vote. Engagement and feedback in the round would help to guide the next steps.

It was good that the ICB was reaching out to community groups. How could Bangladeshi and Somali groups be reached? The response was that many engagement events had been held with the Somali community, working through VCS partners in Haringey. The Elfrida Society had assisted with some specialist work with particular groups too. If there were other groups that might not have been reached, members were asked to contact the ICB to let them know. There were between 3-4 hundred groups on the ICB's mailing list, who had been updated throughout the course of the consultation. It was pointed out that the Bangladeshi community was the largest ethnic community group in Islington and the second largest in Camden and that it would be good to have a system to reach out to them.

A question was asked about the impact of this on home births, noting that there were home birth services at all of the Hospitals and sites under consideration. What were the numbers for home births, which was a good option for some people? Had the impact of the home birth service being sited at Whittington or Royal Free been factored in to the proposals? In response, it was noted that there were not large numbers of home births. However, under both options, ICB wanted to enable the range of choice for birth, in an alongside unit, home birth, or an obstetrics led unit. One of the issues was that there were recruitment and retention challenges and, if there were pressures currently on the service, it was likely that home births and the alongside units were shut temporarily to support the obstetrics led units. The new proposition was that if there were a smaller number of resilient services, women and pregnant people would be better supported in their choices. There was no difference between the Whittington and the Royal Free options in this case. In the event that a decision was taken to move to a four site model, the boundaries of the home birth units would need to equalised, given the sizes of the units.

It was noted that approximately £40m of capital would need to be invested under both options. The funding would be used not only on the buildings, but also in upgrading services, dependent on the option chosen. The proposals were quality driven, rather than financially driven.

If Whittington Hospital lost its maternity unit, would it also lose its neonatal unit? It was confirmed that both would close. Clinicians were clear that there should be no level one neonatal units, as these were rare in London.

On behalf of the Committee, the Chair re-iterated the wish for maternity services to remain at Whittington Hospital. He thanked Anna Stewart for attending and for her presentation.

46 SCRUTINY REVIEW EVIDENCE - ACCESS ISLINGTON HUBS (ITEM NO. 10)

Manny Lewis, Assistant Director of Resident Experience, highlighted some aspects of the presentation from the Access Islington Hub initiative, which were based on the Covid response model "We are Islington", with a specific focus on early intervention and prevention, collaboration and wrap-around support for residents. Although the initiative had started off as a simple model of meeting residents' basic needs, it quickly expanded into a more sophisticated model including vaccine support, support for clinically extremely vulnerable residents and a test and trace service. All of the learning was remodelled into a face-to-face offer, meeting residents' needs at the initial point of contact, or assisting them through the journey to achieve their needs.

There were currently two hubs open: the central hub at 222 Upper Street and the south hub at Finsbury Library, both launched in September 2023. A hub was being developed in the north of the Borough, at the Manor Gardens site, which was due to open in June 2025. The aim of the hubs was to offer comprehensive wraparound support, including money, food, wellbeing, housing, family, community safety and work. Unsurprisingly, the majority of people attending the hubs needed support with money, food, housing and wellbeing, all of which were linked. Staff at the hubs had two roles. Firstly, triage advisers met with residents, talking with them to understand and identify what their needs were. This included assistance with digital technology. Secondly came the connector sessions, which involved more in-depth support to look beyond the preventative needs and attempted to identify the underlying needs. These sessions were not time limited and staff were clear that they had as much time as they needed to get to know the person in front of them, forging a connection to identify their needs and to meet those needs. Staff had undertaken specialised training for these roles, including trauma-informed practice, level three safeguarding and cultural competency. Training was ongoing as the needs of residents became clearer.

In terms of the priorities for the hubs, they were still in development. Continuous engagement, collaboration and partnership working was under way. The links with Bright Lives Coaching were very important as they provided short -term support for those needing it, assisting residents to develop their own resilience and skills to develop in the future, with support from the hub. Talks had taken place with the Single Homeless Project who were now providing sessions at the hubs. Close links with Citizens Advice Bureau, Islington Mind and Bet No More

existed, the latter of whom would be based in the hubs at certain times of the week. The service was already working well with the Council's Access services, adult social care, to see if it might be possible to meet needs at the first point of contact, rather than referring residents to other services, which often fed into dependency. More partnerships were in progress.

Another key element was engagement sessions and working groups. Islington's success was due to the development of good links with the voluntary and community sector, mutual aid groups and tenants associations and the Council was keen to proceed with this work. Discussions were currently being held with Help on Your Doorstep, Age UK and other voluntary and community sector groups about what needed to be done to develop the hub offer. A suggestion had been made to these organisations that Islington would take their lead, as they were often better placed in the community to understand what residents needed. An open day had been arranged with voluntary and community sector groups on 15th March 2024 to pursue further discussions. It was hoped that it might be possible to adapt one of their single assessment processes which seemed to work well. It would be helpful for all to be working in the same way, to be sharing resources and training.

Islington also had excellent links with other teams, such as mental health crisis teams, when housing and poverty and financial difficulties were often linked and being able to identify and report safeguarding issues which might emerge. In terms of next steps, Islington was already liaising with health and public health partners on what work might be done with GPs and other health professionals. The Council was also looking at ways in which they could help health initiatives, for instance by way of encouraging people to take vaccines and boosters.

Questions/responses were made as follows:

It was confirmed that the hubs team could be approached to help residents with assessments for social care.

Staff training was very important. Councillors knew from experience with constituency work that patience and caring were required in dealing with people whose cases could have been ongoing for a very long time. Given that the hubs were new, people may not be aware of their existence. Communication was important in this regard. The NHS staff were also under considerable pressure and needed support to maintain their wellbeing. The importance of staff training was acknowledged and hub staff had been specifically recruited who would be able to have the quality conversations with people to understand what their underlying needs were. Staff who had worked on the "We Are Islington" phoneline had been recruited as they were particularly able to develop the necessary relationships and obtain residents' trust, which often was not easy for people using the service. Managers in the hubs were also being

trained to support the staff who often had to deal with very difficult conversations.

The hubs seemed like a very good idea. Much councillor casework concerned people who had already approached the Council and councillors were merely acting as a conduit between the Council and officers. It was hoped that advice from the hubs would break down barriers and enable residents to obtain the help they needed directly. Were the hubs to be linked to community centres, which were often places where advice was sought anyway? One of the measures of the success of the hub project could be that casework received by councillors was not about issues which had already been raised at 222 Upper Street. The Assistant Director concurred with the idea of community centres and other organisations (working alongside the hubs). He was working on a separate project looking at how community centres and the voluntary and community sector groups could better offer advice and support to residents on their first contact and in one place. He was hopeful that councillors would see a positive impact on their caseloads in the future. On communications, the new website would shortly be launched and officers were looking at how they might advertise the offer of the hubs more widely.

It was good to see how the good work carried out during the pandemic by the Team had led to the new hubs service. However, councillors needed to be clear about how the hubs would work in connection with their casework. Should constituents be referred to the hubs? The response was that the hubs were looking for referrals from anywhere, be that councillors, neighbours or Council staff, as hub staff had the ability and experience to stand back and look at the system as a whole. It was hoped that, where there was a referral from a councillor, issues could be sorted out swiftly. However, where a matter was complicated, perhaps involving a range of directorates, as was often the case with members' enquiries, there was difficulty. The question then was who was to take the lead? It was probably easier if cases were referred directly to the hubs from councillors.

Under the new hub arrangements, it seemed that people could contact the hubs directly, rather than telephoning the access team to adult social care? The response was that the existing telephone number for access to social services was still operating. The hubs had been introduced to give people an opportunity for face to face contact with someone or who had struggled to gain help elsewhere.

Residents had reported long waits in contacting the access team to adult social care, especially to seek assistance with form filling. How could this be addressed? How would it be possible to monitor the outcomes of contacts with the hubs? The response given was that the hubs team worked very closely with adult social care and had good links. In fact, some of the hub staff had previously worked in the access care team. Those staff would advise and support hub staff and would even join in a

person-to-person conversation with a resident, as necessary. The case would be held until the outcome had been achieved, all as part of the connector session. Resident satisfaction would be sought by the community connector staff to ensure that residents were entirely satisfied with all the support they had received and that they had achieved all they needed to. Information on the number of telephone calls and face-to-face meetings could be supplied if required. However, the most important feedback was from residents, who really valued the service, and staff. Staff often reported that they were enjoying their work and spending time with residents and getting to know them. There were high numbers of enquiries via the Access Islington service and high volumes of numbers had to be dealt with, meaning that calls had to be dealt with as swiftly as possible. That, in turn, put pressure on staff on the amount of time they could spend with residents. There were no time limits on the new hub service which was important. However, it was thought that improved technology would help with monitoring outcomes of cases, perhaps a system similar to one operated pre-Covid, where individuals could be tracked across Council services.

It would be helpful for a cribsheet to be produced for councillors on how casework was to be referred to the hubs.

Manny Lewis was thanked for attending and for his presentation.

47 **EXECUTIVE MEMBER UPDATE (ITEM NO. 11)**

Councillor Nurullah Turan, Executive Member for Health and Social Care, referred to a recent email to councillors about the measles outbreak and MMR.

He was pleased to report that the Council had received about £4m funding for a new GP clinic on Andover Estate. The existing GP clinic on the Estate was due to close as it had been taken over by a private developer, unfortunately sold by its previous owner. The new developers were due to contribute to the new health centre and the Council was working with them. The new clinic

would be on the Newington Barrow Way site and would be a state of the art establishment. All the proposals had been approved in the previous week.

He was also pleased to report that the GP closure he had mentioned at a previous Committee, based in New North Road, would no longer close, as the GP had managed to find a partner, which was apparently unusual. This would mean 1800 patients would not have to move to another GP service or find another pharmacy service as there was one on site.

He also drew the Committee's attention to recent news about the development of two new Alzheimers drugs. These treatments significantly slowed symptom progression of Alzheimers disease and were most effective when given as early as possible. A decision was expected from drug regulators this year as to whether they could be approved for use in the UK. The treatment could mean the end of Alzheimers disease, offering hope that one day it might be considered a long-term condition, with people managing their symptoms and living full lives. However, only a relatively small number of people were likely to be able to access them as the majority of people were diagnosed quite late. However, because services were so well connected in Islington, the Borough was one of the leading places for dementia diagnosis. The Alzheimers Society had unofficially described Islington as a "Dementia Friendly" Borough.

One of the issues discussed at Healthwatch Islington was private care access, where Islington councillors raised the issue of the challenges faced by ethnic minority groups and the changes required. Healthwatch Islington had requested Healthwatch England to reserve a space on the Healthwatch London agenda to ask how others had used the Healthwatch England report to influence delivery and see how good practice might be implemented in Islington. Healthwatch Islington were also developing a strategy to get more men involved in their research.

A meeting had been held with the London Medical Council in the previous week, where he had been informed that fewer older patients were coming through for consultation. He had asked for figures and would take it up with next week's ICB meeting.

He had visited a surgery, the Miller Practice, and one of the issues raised was the estate. A visit had taken place to Pharmacy First in Newington Green, where things were working, although when discussed with LMC, concerns had been raised about the likely overprescription of antibiotics. He had heard a description of an older patient who had been prescribed antibiotics, after complaining of a pain in his throat, which could be a symptom of throat cancer, which was missed. There were obviously risks associated with Pharmacy First and he suggested that the situation be monitored.

He also asked to be kept aware of any pharmacies which were refusing to accept sharps bins for home use as they were meant to accept them. It could be due to lack of funds but, if made aware of it, the ICB would investigate.

Finally, ear wax removal services were no longer available on the NHS, although 2-3 million people per year used the service. However, NICE guidance was that the service should be provided by GPs through microsuction. However, national services provision were patchy or not available. GP contracts no longer paid for this service.

Councillor Turan undertook to look into an issue raised by Councillor Burgess, relating to the presence of a large van on the Whittington Hospital site advertising "affordable mobile digital imaging".

48 **QUARTER 2 PERFORMANCE REPORT - PUBLIC HEALTH (ITEM NO. 12)**

Jonathan O'Sullivan, Director of Public Health, invited questions on his written report on Public Health performance for quarter 2 in 2023/24.

Questions/responses were as follows:

Could the Committee have a picture of measles in the capital at the moment? The response given was that there had definitely been an increase in measles cases month on month, across London as a whole. There was also a similar pattern in the west Midlands. There was concern about the level of measles, mumps and rubella vaccination uptake, both for the first and second doses. Together with the NHS, the Council was working on a range of activities to improve measles, mumps and rubella vaccination uptake. As was apparent in the report, there was currently no data available through the local health system, so authorities had worked carefully on a triangulation of the other vaccinations given at the same time and the Director of Public Health had said that he was very confident that it was just a data coding issue which was not being picked up in the local system. He noted that in national data, an increase in MMR 2 vaccination was evident, again supporting the sense of a local coding issue. Key messages had been shared with councillors about the importance of the MMR vaccine, including sharing some of the information in community languages. NHS colleagues were doing more in terms of promotion and roll-out to the community to encourage more people to attend for their vaccinations.

The Chair reported that he had met the Bangladeshi Association last year and had met with Islington Public Health staff and offered to attend the mosques with information on vaccinations. He had suggested to the imam that it would be helpful if he could attend a Friday prayers session to talk about the issue. The Director of Public Health said that it would be helpful for councillors, who were trusted in the community, to do anything they could to spread the message about vaccinations.

On substance misuse, it was noted that services were delivered by the organisations "Inroads" and by "Via", the latter including outreach work for various people. Confirmation was requested on whether the carrying of Naloxone was carried by the outreach workers only? There was reference in the report to "services collaborate closely with criminal justice partners to ensure effective pathways into treatment from prison, probation and police, which includes co-locating of services and in reach support" and how exactly this was working in Islington? There was also a reference to "strong service focus for the coming quarter to help increase people with opiate addiction coming into treatment services." and whether there were problems with nitazenes and higher risks of overdose? The Director of Public Health replied that naloxone was carried by outreach workers to promote supplies for people using opiates as it was considered important. Harm reduction was most important. The kits previously were injectables but were now nasally administered. There was an

initiative with community pharmacies who were in contact with people using opiates in order to address that. Naloxone was a treatment which reversed the affect of an overdose and therefore dramatically reduced the risk of mortality. The concern for drug supply around opiates and other drugs in the UK was that it might follow the pattern of drug use in the US and other parts of the world, with synthetic opiates being far more potent and far more dangerous, with a risk of overdose. Part of the reason to proactively reach out to people, was about sharing harm reduction messages and there was a local plan for action if there were reports of overdoses. Over December to January, there had been some deaths due to opiates, which could have been linked to synthetic opiates or metazene, which made it even more important to share the messages about Naloxone and wider harm reduction. On collaboration, Public Health was working hard on relationships with the Criminal Justice System, with a good model in place in Probation and staff working in the custody suite (latter point to be confirmed). The very limiting factor was that the Police had much pressure in terms of vetting procedures as to who could work in those settings. Islington was not the only borough experiencing these difficulties and the matter had been escalated to London level to increase the pace of vetting. Positive work engagement had continued, including with the Prison Service. The Director of Public Health was pleased to note support to black African and black Caribbean men in the criminal justice system. The outreach service was receiving positive feedback from Police colleagues, particularly around the level of knowledge of outreach workers, helping to get people into treatment. Collaborative work was being carried out by the outreach workers, the Police and the Council's Community Safety Team on tackling these issues.

It was noted that there was no reference in the "Smoking" paragraph of the report to the detrimental affects of smoking on pregnant women. The Director of Public Health concurred with the concerns expressed about pregnancy and smoking. He reported that, in the most recent quarter, the quit rate for pregnant women was 84%. This compared to the London average of 56% and the England average of 50%. One of the reasons for maintaining the Start Well programme maternity and neonatal at the Whittington Hospital was because excellent public health services were inputted into that Hospital. Breast feeding initiatives were also high. It was suggested that these points be included in the current consultation on the future of maternity and neonatal services.

49 **WORK PROGRAMME 2023-24 (ITEM NO. 13)**

The Chair suggested that it would be helpful to receive a presentation from the Access Service at a future meeting, particularly to hear about how outcomes were monitored.

MEETING CLOSED AT 9.40 pm

Chair