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Minutes

HILLINGDON
LONDON

HEALTH AND SOCIAL CARE SELECT COMMITTEE

11 September 2024

Meeting held at Committee Room 6 - Civic Centre, High Street, Uxbridge UB8 1UW

	Committee Members Present: Councillors Nick Denys (Chair), Reeta Chamdal (Vice-Chair), Tony Burles, Philip Corthorne, Kelly Martin, June Nelson and Sital Punja (Opposition Lead) **Also Present**: Michael Breen, Michael Sobell Hospice Charity Trustee, Michael Sobell Hospice Charity Steve Curry, Chief Executive Officer, Harlington Hospice & Harlington Care Keith Spencer, Managing Director, Hillingdon Health and Care Partners (HHCP) Dr Ros Taylor, Medical Director, Michael Sobell House / Harlington Hospice **LBH Officers Present**: Nikki O'Halloran (Democratic, Civic and Ceremonial Manager)
21.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Councillor Corthorne had advised that he would be attending the meeting but that he would be a little late.
22.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in matters coming before this meeting.
23.	**MINUTES OF THE MEETING HELD ON 24 JULY 2024** *(Agenda Item 3)* The Chair noted that the Adult Social Care Market Position Statement report on 24 July's agenda had stated, on page 31, that the capital/income ceiling for receiving financial support from the Council in meeting assessed Adult Social Care needs was £223,250 – this should have been £23,250. On page 54 of the same report, the capacity tracker had stated that 45% had been utilised by self-funders and 26% had been funded by local authorities and the NHS. For clarity, the report should have stated that the remaining 29% related to care home beds utilised by people referred by the Council. **RESOLVED: That the minutes of the meeting held on 24 July 2024 be agreed as a correct record.**
24.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items of business be considered in public.**

25.	**HOSPICE AND END OF LIFE SERVICES IN HILLINGDON** *(Agenda Item 5)* The Chair welcomed those present to the meeting and noted that a number of the Committee Members had attended a site visit at Michael Sobell House on Monday 9 September 2024 where they had had the opportunity to speak to staff, service users and their families about the palliative care services that were available in Hillingdon. An anonymised set of notes from this visit, setting out positive experiences and areas for improvement, would be appended to the minutes. Mr Steve Curry, Chief Executive of Harlington Hospice and Michael Sobell House, recognised that the proposed sale of Lansdowne House had been the cause of public concern. Lansdowne House was located in Harlington; it had always been a day hospice and provided three main services: lymphoedema service; emotional support and complementary therapy. In addition, there were services such as the Friendship café and the Legs 11 club. Although the building was nice, Lansdowne House was being underutilised (around 30% of its capacity was being used). It cost around £100k to run the building which was worth about £3.5m. Mr Curry stated that many hospices were running deficit budget this year so it was important that the charity maximised the use of its assets. Savings had already been made in relation to staffing levels but there had been a commitment to not cut services. The proposed sale of Lansdowne House would free up resources to be able to protect services. Mr Curry advised that he had spoken to Heathrow Airport about buying the hospice but that Heathrow had declined. Members noted that residents had expressed concerns about the sale of Lansdowne House, how the money raised from the sale would be used and the withdrawal of hospice services in the Heathrow Villages. Mr Curry advised that interim options had been included in the report to the Committee which included renting space in community buildings and providing services in residents' own homes. Once the building had been sold, the charity would know what resources it would have to work with. A planning application process had previously been started before Michael Sobell House had temporarily closed. The planners had been approached again 12-18 months ago but they had not ben prepared to support the application. Reasons for refusal were complicated and included the proximity of Lansdowne House to a Grade 1 listed church, protected trees and its location on the edge of the green belt. The increase in the cost of living had meant that the cost of the materials and labour that would be needed for the development had increased significantly. Furthermore, if the third runway were ever to be agreed, the hospice would be within ¼ mile of the runway and under the flightpath which would not be conducive to the environment that a hospice needed. As such, it would need to be relocated. Mr Keith Spencer, Managing Director of Hillingdon Health and Care Partners, advised that Harlington Hospice was the lead organisation for end of life care in Hillingdon. He also noted that the issue of the building needed to be separated from the services that were provided. The services would continue to be provided in the broad locality so these services were not under threat. Although many individuals associated hospices with inpatient beds, it was noted that there were no beds at Harlington Hospice. It was suggested that end of life services in Hillingdon had been a huge success and that more money was going into these services than ever before. However, there were

a number of residents who were unhappy about the sale of Lansdowne House as there was already a lack of services in the south of the Borough and this action appeared to be further reducing those services. Mr Curry and Mr Spencer assured the Committee that services would continue and they both committed to attending future meetings to evidence the continued provision of services in the south of the Borough.

Mr Curry advised that Hillingdon compared very favourably with other London boroughs with regard to hospice and end of life care services. The charity worked in partnership with the Council and Mr Curry had been appointed as the Senior Responsible Officer for end of life care in Hillingdon. End of life care was all about fitting different types of care together so that individuals were able to "shape your care". Palliative Specialist Community Care services were provided by Central and North West London NHS Foundation Trust (CNWL) which included a 24 hour nursing team that had been in place for about seven years (this was not a service provided elsewhere in North West London (NWL)).

The services run by Harlington Hospice were the right services for carers and relatives (similar to those provided by Marie Curie) but also for patients in their final days of life. For example, they were able to talk frankly in relation to their thoughts and feelings about their situation.

Mr Curry advised that Michael Sobell House had increased its capacity to fourteen beds. Of these, ten were commissioned acute beds and four were long term nurse led beds. In the first four months of 2023/24, 53 patients had been admitted to Michael Sobell House and eight had passed away whilst waiting for a bed. During the same period in 2024/25, 96 patients had been admitted and one had passed away. There had also been an increase in the number of patients that were discharged home after a stay at Michael Sobell House.

In addition to the beds at Michael Sobell House, there were eight enhanced nursing home beds (two at Hayes Cottage Nursing Home and six at Park Field Nursing Home in Uxbridge). This provision had been so successful that it was being replicated across NWL. A 24 hour advice line was also available and a team had been created to provide support to children and young people who were impacted by the loss of someone close to them (the team also worked with neurodiverse children).

Mr Curry noted that the HPAL website had been developed and was available across NWL. This site highlighted the best resources relating to palliative and end of life care in an easily accessible way for clinicians and patients in NWL. An adult bereavement service was also provided. All of these services had been provided using a combination of charitable funds, and funding from the local authority and NHS. Although the NHS had contributed an additional £300k this year (on top of the £2.5m), the charity still needed to raise at least £2.5m through fundraising each year to maintain the services.

It was noted that end of life care had been a top priority in Hillingdon for the last 3-4 years. However, there continued to be issues with regard to the coordination of the different services and further work was needed for the earlier identification of those individuals who would benefit from services. The end of life dashboard had been developed, identifying around 3,700 people in Hillingdon that would benefit from palliative care. Currently, Harlington Hospice had contact with 20% of individuals in the Borough who would benefit from end of life care and provided care to only 17%.

With regard to the 80% of those who would benefit from end of life care but who had no contact with the hospice, Mr Curry advised that the majority of these individuals died in hospital despite them not wanting to die in that setting. Of those who were taken to A&E, 95% would be admitted to hospital and were then unable to get out for some time as they were too ill. Dr Ros Taylor, Medical Director at Michael Sobell House and Harlington Hospice, advised that, if patients were referred to palliative care early, they would have less pain, would experience less depression and would have a better end of life.

In terms of funding, a pilot was being undertaken to look at what action was needed to help move individuals out of hospital faster. The Council had also contributed funding to provide respite for carers.

A clinical model (PICS) had been developed for the delivery of end of life services. PICS coordination provided oversight and assurance that care was managed and would support and respond outside standard working hours. The hospice had been working closely with service providers in the Borough on this model.

Although there had been a focus on providing additional beds, there had also been a focus on improving the experience of patients and their families. It was important to maximise the resources available to deliver the most services possible.

Dr Taylor advised that, many years ago, palliative care only related to cancer and end of life care. Members had seen from their visit to Michael Sobell House on Monday that this was no longer the case as many patients were there for things like pain management. There were also patients with complications that could be better addressed by a hospice than by a hospital. As such, a lot of the work undertaken by the hospice was in relation to the coordination of services to best meet the patient's needs.

Members recognised that the work undertaken at Michael Sobell House benefitted the families as much as it benefitted the patients. There was often a lot of talk about healthcare but the focus tended to be on treatment (heath) rather than care. Patients at Michael Sobell House had described how lonely they had felt when they had been in hospital and how staff there had not had the time to be interested in their care. It was suggested that the provision of end of life and hospice services should be a fundamental part of the NHS and not something that was reliant on charitable fundraising.

Mr Spencer advised that the integration of care across boundaries continued to be a challenge and resulted in patients being kept in hospital for too long. Hospice resources had been used in hospital to help speed up discharge as this would free up resources there which could then be used for palliative care.

Mr Spencer noted that Mr Curry and colleagues had been working with the hospital to bring about the cultural change that was needed. Mr Curry had met twice with the hospital this week to try to move end of life care forward but these changes took time (there had been significant progress on elements of this over the last ten years). It was not about spending more money, it was about spending the existing money in the right place and should always deliver the best patient outcomes. Members queried why a cultural change was preferred over a directive to then be able to take the money away and put it where it was actually needed.

It was noted that there was a financial deficit in the NWL system. It would be important to bring clinical hearts and minds along on these changes (which were supported by the hospital leadership team). The challenge was that, on Saturdays and Sunday, clinicians made decisions about discharge and they needed to be encouraged to sort this out quicker.

Mr Michael Breen, Chair of the Board at Michael Sobell House and Harlington Hospice, advised that the charity was in a difficult position and needed to be clever with the money that it had. He noted that the charity had raised some funds by delivering on contracts for the NHS. When the Covid pandemic started in 2020, the charity had had to adjust the way that it handled and raised funds. The cost of living crisis had exacerbated this and had increased overheads such as utilities and salaries. In 2023/24, the charity had had a £500k deficit and roughly the same would be expected at the end of the current financial year. As such, it was important that the charity looked at its assets.

Mr Breen assured Members that the charity would not be reducing the services that it provided. The Board had established that the proposed sale of Lansdowne House would provide a cashflow reprieve and ensure continued services. Once the financial future of the charity had been secured, further investigations could be undertaken to increase the number of beds available - conversations had already started with Brunel University on a way forward but a liquid balance sheet was needed to be able to attract social fundraising to grow services.

Brunel University had land available in Hillingdon and was always on the lookout for placements for its students. Discussions had started in relation to the development of a hospice facility on the Brunel site with acute palliative beds plus longer term beds that would be funded differently (a total of around 60-70 beds). Brunel students would benefit from placements and the hospice would benefit from the students being able to help staff the facility. This initiative could not currently be progressed as funds needed to be raised for the project plans. There were no definite timeframes for deliverables at this stage.

Concern was expressed that some patients did not find out about the palliative care services that were available until far too late in their journey when this was information that should have been available to them right at the start. Mr Spencer advised that Mr Curry had been working with Hillingdon Hospital on the integrated management system and progress was being made, albeit slowly. The new system would help with data recording.

It was agreed that partners (including representatives from Hillingdon Hospital) attend a future meeting to provide Members with an update on the integration of palliative care services in Hillingdon.

Dr Taylor stated that an audit of around 100 hospice patients had been undertaken in the previous year across a number of hospitals. Most of these patients had had a very long wait before being referred to the hospice. Unfortunately, many consultants were not aware of the palliative care services that were available to patients. Dr Taylor had set up a roundtable with geriatricians and other specialist to talk to them about the benefits of early referral.

Members noted that inappropriate hospital admissions and over-treatment could be reduced through systematic advance care planning. These plans should be started

when GPs identified someone with a life limiting illness but they seemed to primarily be completed by palliative care staff. Conversations need to be undertaken with the patient and healthcare professionals needed to be recording the patient's wishes in their universal care plan but it was often too late / after they had been admitted to hospital.

Concern was expressed that NWL Integrated Care Board (NWL ICB) seemed to think that Hillingdon needed fewer hospice beds rather than more. Mr Curry advised that the NWL review had had a narrow remit in relation to specialised palliative care teams in the community. The consultants had looked at how many beds there were across the country and looked at a part of the system in isolation (high cost / small units that were mostly built 20-30 years ago and no longer met patients' needs).

Mr Spencer stated that he led on the work of the Better Care Fund in Hillingdon. The NWL ICB had advised that there should be a common offer across all eight of the NWL boroughs unless specific needs had been identified that needed a different approach. Hillingdon had been using data to illustrate the differences between Hillingdon's needs and those of the other seven NWL boroughs. It was noted that quite a lot of the NWL common model had been copied from what had been developed in Hillingdon.

In terms of representation, it was noted that the Chair sat on the NWL Joint Health Overview and Scrutiny Committee and took the approach that good people ought to be allowed to do good things. It was recognised that the health culture within the Borough was thought to be different to the other seven NWL boroughs and there was concern about having to "level down" in Hillingdon.

Mr Curry advised that H4All was about to start a consultation on end of life and hospice services. Despite the standardisation requirement in NWL, the ICB had agreed that Hillingdon could continue to deliver its current services, acting as a kind of experiment. The Chair advised that the Committee would be responding to this consultation.

Patients in need of palliative care were going to A&E and being admitted to hospital. Members queried how patients were signposted to stop them from going to A&E and how assurance could be made that there would be sufficient capacity in palliative care services to cope with this demand. Mr Spencer would be asked to provide a response to this. Dr Taylor advised that those in need of palliative care would benefit from the availability of a single telephone number to call so that they didn't go to A&E.

Mr Curry offered an open invitation for any Councillor to arrange a site visit to Michael Sobell House.

RESOLVED: That:

1. **partners (including representatives from Hillingdon Hospital) be invited to attend a future meeting to provide Members with an update on the integration of palliative care services in Hillingdon;**
2. **Mr Spencer provide Members with information about how patients were signposted to stop them from going to A&E and assurance that there would be sufficient capacity in palliative care services to cope with demand; and**
3. **the discussion be noted.**

26.	**2025/26 BUDGET PLANNING REPORT FOR SERVICES WITHIN THE REMIT OF THE HEALTH AND SOCIAL CARE SELECT COMMITTEE** *(Agenda Item 6)* The Chair advised that budgets were being reviewed by the newly appointed Corporate Director of Finance, who would also consider how future financial performance was reported to Members. As such, there would be no budget report this month.
27.	**CABINET FORWARD PLAN MONTHLY MONITORING** *(Agenda Item 7)* Consideration was given to the Cabinet Forward Plan. **RESOLVED: That the Cabinet Forward Plan be noted.**
28.	**WORK PROGRAMME** *(Agenda Item 8)* Consideration was given to the Committee's Work Programme. It was noted that Cabinet would now be considering the Annual Older People's Plan at its meeting on 12 December 2024. As such, the Health and Social Care Select Committee would be able to consider and comment on the report at its meeting on 12 November 2024. Councillor Corthorne suggested that adult social care be scrutinsed in line with the CQC framework. It was agreed that the Cabinet Member for Health and Social Care and the Corporate Director of Adult Social Care and Health be invited to a future meeting (possibly 9 October 2024 or 12 November 2024) once the CQC inspection report had been published. **RESOLVED: That:** **1. the Annual Older People's Plan be considered at the meeting on 12 November 2024;** **2. the Cabinet Member for Health and Social Care and the Corporate Director of Adult Social Care and Health be invited to a future meeting (possibly 9 October 2024 or 12 November 2024) once the CQC inspection report had been published; and** **3. the Work Programme, as amended, be agreed.**
	MICHAEL SOBELL HOUSE SITE VISIT NOTES - 9 SEPTEMBER 2024
	The meeting, which commenced at 7.00 pm, closed at 8.28 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on nohalloran@hillingdon.gov.uk. Circulation of these minutes is to Councillors, officers, the press and members of the public.

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MICHAEL SOBELL HOUSE SITE VISIT
2pm Monday 9 September 2024

ATTENDEES: Councillors Nick Denys, Philip Corthorne, June Nelson and Sital Punja, and Nikki O'Halloran

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- Harlington Hospice - provides clinics and daycare
- Michael Sobell House (MSH) – provides inpatient care

POSITIVE EXPERIENCES OF HOSPICE

- Patients and their families have been able to build up relationships with the staff and their consultant and have been able to text/WhatsApp the consultant with their concerns as they arise.
- MSH has given patients an extra lease of life before they pass away.
- Palliative staff offer a human factor that answers the patient's questions.
- The night nurses / sitters are the most valuable part of the service.
- It's not just about physical support, it's also about the emotional support that is provided.
- Pain relief / management is better understood in a hospice (than in a hospital).
- Staff in the hospice make time (where they can) to sit with patients to talk to them.
- Patients value the opportunity to speak to other patients who are have the same / similar experiences.
- Quieter and calmer at MSH than the hospital so able to get some much needed rest. Families are also able to stay over with patients.
- Communication with patients and families has been really good – they are not treated as numbers.
- There are no restrictions on visiting times.
- It's like a family.
- Palliative care team at the hospital liaised with the patient.

AREAS FOR IMPROVEMENT

- Food – although the head chef is always trying to accommodate everyone's preferences and tastes.
- Need to be given a point of contact for referral to hospice services if the offer is initially refused. And the different points of contact through a patient's journey should continually offer hospice services as an option. It was like staff in the hospital were reading from a manual but never really offered anything. It felt disconnected and there was no collaboration between the difference medical professionals (e.g., GP and consultant).
- MSH is rundown in comparison to places like the Marie Curie facility.
- More family space is needed at MSH.
- Palliative care nurse only started after the paperwork had come over from Charing Cross – this should have been earlier.
- Need more funding for MSH – they should not have to rely on fundraising to provide the services that they do.
- It would be good to have some continuity in hospital.
- When in hospital, it feels like you are on your own – it's very lonely.

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