



Brent

North West London Joint Health Overview and Scrutiny Committee

Thursday 1 May 2025 at 10.00 am

Conference Hall - Brent Civic Centre, Engineers Way,
Wembley, HA9 0FJ

This meeting will be held as an in person physical meeting with all members of the Committee required to attend in person.

The meeting will be open for the press and public to attend with a limited number of seats available. Alternatively, the link to follow the webcast live will be made available [HERE](#).

Membership:

Members

Councillors:

Ketan Sheth
Natalia Perez
Ben Wesson
Nick Denys
Chetna Halai
Lucy Knight
Concia Albert
Samina Nagra
Claire Vollum

Representing

London Borough of Brent
London Borough of Hammersmith & Fulham
London Borough of Ealing
London Borough of Hillingdon
London Borough of Harrow
Royal Borough of Kensington and Chelsea
Westminster City Council
London Borough of Hounslow
London Borough of Richmond - non-voting

For further information contact: Chatan Popat
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Notes for Members - Declarations of Interest:

If a Member is aware they have a Disclosable Pecuniary Interest* in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent and must leave the room without participating in discussion of the item.

If a Member is aware they have a Personal Interest** in an item of business, they must declare its existence and nature at the start of the meeting or when it becomes apparent.

If the Personal Interest is also significant enough to affect your judgement of a public interest and either it affects a financial position or relates to a regulatory matter then after disclosing the interest to the meeting the Member must leave the room without participating in discussion of the item, except that they may first make representations, answer questions or give evidence relating to the matter, provided that the public are allowed to attend the meeting for those purposes.

***Disclosable Pecuniary Interests:**

- (a) **Employment, etc.** - Any employment, office, trade, profession or vocation carried on for profit gain.
- (b) **Sponsorship** - Any payment or other financial benefit in respect of expenses in carrying out duties as a member, or of election; including from a trade union.
- (c) **Contracts** - Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.
- (d) **Land** - Any beneficial interest in land which is within the council's area.
- (e) **Licences** - Any licence to occupy land in the council's area for a month or longer.
- (f) **Corporate tenancies** - Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.
- (g) **Securities** - Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:

- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party or trade union).

(b) The interests of a person from whom you have received gifts or hospitality of at least £50 as a member in the municipal year;

or

A decision in relation to that business might reasonably be regarded as affecting the well-being or financial position of:

- You yourself;

a member of your family or your friend or any person with whom you have a close association or any person or body who is the subject of a registrable personal interest

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item	Page
1 Apologies for absence and clarification of alternate members	
2 Declarations of interests	
Members are invited to declare at this stage of the meeting, the nature and existence of any relevant disclosable pecuniary or personal interests in the items on this agenda and to specify the item(s) to which they relate.	
3 Minutes of the previous meeting	1 - 8
To approve the minutes of the previous meeting, held on 13 March 2025, as an accurate record of the meeting.	
4 Matters arising	
5 Community-based Specialist Palliative Care	9 - 356
To receive an update on the consultation, emerging themes and anticipated next steps for the implementation of a new, consistent model of community-based specialist palliative care (CSPC) across North West London.	
6 Update on the Mount Vernon Cancer Centre	357 - 382
To receive an update on Mount Vernon Cancer Centre (MVCC), including next steps.	
7 Introduction to a New Involvement Strategy	383 - 398
To receive a presentation on the new Involvement Strategy.	
8 Verbal update from the Chief Executive of the North West London Integrated Care System (NWL ICS) on recent developments and announcements	Verbal
To hear from the Chief Executive of the NWL ICS regarding recent developments and announcements.	

**9 North West London Joint Health Overview and Scrutiny Committee 399 - 421
Recommendations Tracker**

To receive the 2023-24 and 2024-25 scrutiny recommendations trackers.

10 Any other business

Notice of items to be raised under this heading must be given in writing to the Deputy Director - Democratic and Corporate Governance or their representative before the meeting in accordance with Standing Order 60.

Agenda Item 3

Minutes of the Meeting of the North West
London Joint Health Overview & Scrutiny
Committee held in Committee Room 1, Town
Hall, Hornton Street, W8 7NX at 10.00 am on
Thursday, 13 March 2025

PRESENT

Committee Members

Cllr Ketan Sheth, London Borough of Brent (Chair)
Cllr Natalia Perez, London Borough of Hammersmith and Fulham (Vice-Chair)
Cllr Concia Albert, Westminster City Council
Cllr Chetna Halai, London Borough of Harrow
Cllr Lucy Knight, Royal Borough of Kensington and Chelsea
Cllr Samina Nagra, London Borough of Hounslow
Cllr Claire Vollum, London Borough of Richmond upon Thames
Cllr Ben Wesson, London Borough of Ealing

Others Present

Rob Hurd, North West London Integrated Care system (NWL ICS) Chief Executive Officer
James Biggin-Lamming NWL ICS Director of Strategy and Transformation
Rory Hegarty, NWL ICS Executive Director of Communications and Involvement
Tina Benson, Hillingdon Hospitals NHS Foundation Trust Chief Executive Officer

Council Officers

David Abbott, Head of Governance – Hammersmith & Fulham
Vid Calovski, Policy Analyst - Hounslow
James Diamond, Scrutiny & Policy Officer - Kensington and Chelsea
Nicholas Garland, Democratic Services Manager - Richmond upon Thames
Tommy Hanmer, Governance Officer - Kensington and Chelsea
Linda Hunting, Policy and Scrutiny Officer - Westminster
Naureen Matlib, Senior Scrutiny Officer - Harrow
Nikki O'Halloran, Democratic Services Manager - Hillingdon
Chatan Popat, Strategy Lead - Performance - Brent
Anna-Marie Rattray, Scrutiny Review Officer - Ealing

1 APOLOGIES

Cllr Denys submitted apologies for absence and Cllr Nagra submitted apologies for lateness.

2 DECLARATIONS OF INTEREST AND CLARIFICATION OF ALTERNATE MEMBERS

Cllr Sheth declared that he was the Lead Governor of North West London NHS Foundation Trust, Cllr Wesson declared that he was employed by the Nursing and Midwifery Council, and Cllr Vollum declared that she was employed by West London NHS Trust.

3 MINUTES OF THE PREVIOUS MEETING HELD ON 05 DECEMBER 2024

Cllr Perez called the Committee's attention to an action at paragraph 5.15 *"that the Committee will receive a breakdown of GP face to face appointments across the NWL eight boroughs"*. Chatan Popat confirmed that an update would be circulated to the Committee after the meeting.

The minutes were confirmed as a correct record and were signed by the Chair.

4 MATTERS ARISING

The Chair noted that the Integrated Care System update from the Chief Executive of the North West London ICS would now be heard as Agenda Item 5, with North West London Planned Care Strategy now being heard as Agenda Item 6. This was due to Rob Hurd having to attend a concurrent NHS meeting.

5 INTEGRATED CARE SYSTEM UPDATE FROM THE CHIEF EXECUTIVE OF THE NORTH WEST LONDON ICS

The Chair invited Rob Hurd, North West London Integrated Care System (NWL ICS) Chief Executive Officer, James Biggin-Lamming NWL ICS Director of Strategy and Transformation, Rory Hegarty, NWL ICS Executive Director of Communications and Involvement, and Tina Benson, Hillingdon Hospitals NHS Foundation Trust Chief Executive Officer, to introduce the report. This was followed by questions to the presenters from the Committee. During the discussion, the Committee:

1. Relayed a question from Dr Kyla Cranmer, Chair of Hammersmith and Fulham Local Medical Committee, which noted that there had been delays in distributing the Enhanced Access to General Practice fund of £6.6 million. Rob Hurd responded that the £6.6 million fund had been allocated to Same Day Access Hubs and the NHS operated rigorous application process for Primary Care Networks (PCNs). Due to this process, £4.7 million was to be allocated by 31 March 2025. Rob Hurd added that the excess funds could not be carried forward into the next financial year but would be reinvested in frontline NHS services.
2. Noted reports that the Government was set to announce the reduction of ICB spending by 50% and queried the impact this would have on ICB operations. Rob Hurd responded that the Government wanted to spend a larger portion of NHS funds on frontline services, to be raised from cuts ICB and NHS England funding. Cuts would greatly affect the ICB's ability to carry out its current duties. He could not comment further until the Government released its full announcement.
3. Asked for an update on the public consultation project on proposals to relocate Mount Vernon Cancer Centre to Watford General Hospital. Rob Hurd responded that the consultation process was still planned and that

the decision-making business case process was underway. Alternative solutions were being sought due to the NHS's difficult financial situation. The Committee requested that these alternative solutions be outlined for the Mount Vernon Cancer Centre Joint Health Overview and Scrutiny Committee's next meeting.

Action for: *Chief Executive Officer of North West London Integrated Care System*

4. Noted that the NHS Ten Year Plan included funding to Healthwatch Brent, Westminster, and Kensington and Chelsea, and asked if this funding would extend to Healthwatch within other boroughs. Rory Hegarty responded that this funding was allocated to allow Healthwatch in those three boroughs to carry out ICB local events across the whole of north west London.
5. Requested that Rob Hurd provide the Committee with an update on the impact of the Government's proposed 50% cuts on ICS and ICB services.

Action for: *Chief Executive Officer of North West London Integrated Care System*

[Cllr Samina Nagra arrived at 10:26 am]

6. Asked for detail regarding preventative work with children, young people and families. Rob Hurd responded that Integrated Neighbourhoods Teams (INTs) and Family Hubs were central to the NHS's preventative young people and family's strategy. INTs would reach across the community and ensure cohesion between primary care service providers.
7. Queried whether the Government's proposed 50% cuts on ICS and ICB services would affect the Additional Roles Reimbursement Scheme (ARRS). This scheme provided funding to support frontline service recruitment. Rob Hurd replied that the proposed cuts would not have an impact on these frontline services and that the ICB's strategy would continue to support further investment to frontline services, especially roles related to prevention.

[Rob Hurd left the meeting at 10:30am]

6 NORTH WEST LONDON PLANNED CARE STRATEGY

The Chair invited James Biggin-Lamming, Rory Hegarty, and Tina Benson to introduce the report. This was followed by questions to the presenters from the Committee. During the discussion, the Committee:

1. Enquired what work was being done to reduce time spent waiting for treatment. James Biggin-Lamming replied that the number of patients waiting for treatment within the NWL ICB had increased, but that providers had been able to reduce the waiting list over the 2024 at a high financial cost. The sustainability of these measures over a five-year period were

being assessed by the ICB to ensure that NHS constitutional standards were being met across the ICB.

2. Queried how the ICB was working to improve communication with patients and residents. James Biggin-Lamming responded that patients on the waiting list for an extended period were now asked if they still needed their appointment to reduce the number that were missed. Tina Benson added that deprived populations had the highest numbers of missed appointments and that the hospitals were working with voluntary organisations to make the phrasing of patient questions more inclusive. This had now been tested successfully and would be rolled out fully over 2025. Hospitals had also introduced a digital portal for those patients who were able to book and reschedule their own appointments online. Tina Benson added that Hillingdon Hospitals were piloting a reduction in patient communication as a response to patient feedback. This was to enable ease of communication and to ensure the correct information was given to patients.
3. Enquired if there were plans to expand the use of Community Diagnostic Centres (CDCs). Tina Benson responded that there were currently plans to secure funding for CDC expansion, but that this would depend on the NHS's financial position. The North West London Acute Provider Collaborative would be working to utilise surgical centres such as the Central Middlesex Hospital Elective Orthopaedic Centre better, considering the NHS's financial position and difficulty in funding new surgical hubs. James Biggin-Lamming added that the bulk of the NHS waiting list involved outpatients rather than those requiring surgeries and that resources had to focus on outpatient care.
4. Asked how the ICB would ensure an equality of service across all boroughs. Tina Benson responded that equality assessments were made for all proposed changes and that all major service changes would be brought before individual borough committees or the Joint Health Overview and Scrutiny Committee. Tina Benson confirmed that there were no major service changes currently planned.
5. Queried whether the NHS was able to check if patients experiencing long waiting lists had visited Accident and Emergency (A&E) whilst waiting. Tina Benson confirmed this and noted that only a low proportion of patients experiencing long waiting lists attended A&E.
6. Enquired why mental health care was not included within the Planned Care Strategy. James Biggin-Lamming explained that the overall strategy would include mental health care and physical acute hospitals. The first phase of this strategy would include primary and community services, with the second phase focusing on mental health care providers.
7. Asked how the ICS was ensuring that the Planned Care Strategy would serve patients who were unable to engage with consultation. James Biggin-Lamming responded that equity of care was important for the strategy and that ensuring that residents with complex needs such as neurodiversity, learning disabilities, or language needs were included in

resident consultation. The ICS had begun collaborating and meeting with local community groups and healthcare professionals to develop an inclusive strategy, but this was still in the listening phase and recommendations had not yet been made.

8. Asked for examples of digital tools and care being used across the ICS. Tina Benson replied that there were several small Artificial Intelligence (AI) projects being developed across the ICS which performed administrative tasks, including the translation of maternity referrals into local systems. There were also some large AI projects being developed. These included using AI to perform preliminary chest x-rays so expert radiologists could focus on abnormal chest x-rays. AI was being used within one organisation to predict if patients were likely to attend their appointments. Great Ormond Street Hospital was trialling AI active listening, which listened to a doctor-patient conversation and would write up the notes, enabling the clinician to focus solely on their patient. Tina Benson added that the ICS worked with regulators to ensure any AI usage was safe for the population.
9. Enquired if the NHS would use AI translation services. James Biggin-Lamming responded that the NHS would continue to use the current live translation services. These were provided via video link and telephone. AI may be used in the future to expand the NHS's translation offer but current services would not be replaced if it would reduce the quality of translation.
10. Queried how the NHS could navigate the risk of implicit biases within AI and ensure that use of AI does not create or intensify inequality. Tina Benson responded that the expansion of the Equity Index and commitment to granular analysis of patient data were important in tracking the effectiveness of any interventions. Tina Benson added that the NHS did not want to use any intervention that would cause inequalities and that all AI tools used by the NHS had a failsafe built into them.

The Committee RECOMMENDED that NHS North West London research the possibility of bias in AI technology being used for Planned care, both regarding the gathering of data and in the assistance of care arrangements and appointment handling.

11. Noted that Black and Minority Ethnic (BME) and economically deprived patients were more likely to experience long waiting lists and asked if there had been analysis on the reason for this. Tina Benson responded that LNWH chief executive Pippa Nightingale was leading a working group dedicated to analysing this data. Further data was being collected through telephone conversations between volunteers and patients, with the pilot scheme being expanded and fully rolled out over the coming year. Tina Benson added that LNWH had developed an equity index which assessed the equity of services across a range of demographic categories. The ICS was exploring how to expand this index to the whole of north west London.

12. Asked if AI could assist in translating appointment letters and other communications to a patient's preferred language. Tina Benson replied that a project was underway in Hillingdon to understand the demand for translated appointment letters better. It had found that many patients would not indicate their preferred language out of fear of discrimination. Other patients preferred English letters as they would have someone to read it for them. This project was ongoing and currently in its first phase. Tina Benson added that any clinical letters must be translated through a licensed service due to patient data concerns.
13. Asked if the Planned Care Strategy had identified any priorities for the boroughs to integrate into their health strategies. James Biggin-Lamming responded that the strategy was still in an early phase. The different specialist healthcare provisions within the boroughs had to be managed to suit the unique healthcare needs of each borough, and this would be a focus of the strategy's later recommendations stage.
14. Enquired how the ICB was engaging with residents that were hard to contact. Rory Hegarty responded that the Communications team worked with the voluntary sector and local authorities to reach out to diverse communities and noted that the ICB's Involvement Strategy was due to be renewed in 2025. Rory Hegarty added that the current strategy involved consistent engagement with diverse communities, building a stronger relationship based on trust and respect. The Committee requested further information regarding the Involvement Strategy.

Action for: *NWL ICS Executive Director of Communications and Involvement*

15. Asked how the ICB was engaging with young people. Rory Hegarty responded that a recent piece of analysis demonstrated that young people were not being effectively engaged with by the ICB. A piece of work was now ongoing to address this.
16. Queried when the issue paper detailing stakeholder feedback to the strategy would be shared with the Committee. James Biggin-Lamming responded that all feedback would be incorporated into the strategy and that this would be shared with the Committee after being signed off by the ICB Planned Care Board in May 2025.
17. Asked what role local authorities and community organisations would have in the implementation of the Planned Care Strategy. James Biggin-Lamming responded that the NHS' Integrated Neighbourhoods Teams (INTs) maintained links with local authorities and community organisations through social care and education services. This connection would be utilised in the implementation of the Planned Care Strategy.
18. Queried how the length of waiting lists varied across the ICB's different boroughs. Tina Benson offered to share this data with the Committee.

Action for: *Hillingdon Hospitals NHS Foundation Trust Chief Executive Officer*

The Committee RECOMMENDED that North West London NHS assess the impact of the new Planned Care Strategy on the elderly population.

7 NORTH WEST LONDON JHOSC RECOMMENDATIONS TRACKER

The Committee noted the Recommendations Tracker.

8 ANY OTHER BUSINESS

There was no other business.

The meeting ended at 11:18am

Chair

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Report Title:

Update on the ‘Compassionate care for all’ public consultation and proposals for the north west London model of care for adult (18+) community specialist palliative care (CSPC) services

Committee Date:

01 May 2025

Report Deadline:

23 April 2025

Appendices:

Appendix 1 – Compassionate Care for All Consultation Document

Appendix 2 – Pre-consultation Business Case

Appendix 3 – Equality Health Impact Assessment

Appendix 4 – London Clinical Senate Report NWL Palliative Care

Appendix 5 – Compassionate Care for All Service Improvements by Borough

Appendix 6 – Frequently Asked Questions

Purpose

To provide an update to the North West London Joint Health Overview and Scrutiny Committee on the consultation, emerging themes and anticipated next steps for the implementation of a new, consistent model of community specialist palliative care (CSPC) across north west London.

Acknowledgment

We would like to thank all the members of the public who have given up their time throughout the review and provided their thoughts and feedback. Their energy, insights, ideas and challenges, along with the good and bad experiences of care their loved ones received, have directly informed the model of care that we wish to introduce.

Introduction

The consultation represented a pivotal moment for palliative and end-of-life care in north west London. [The proposed model of care has been shaped by extensive engagement and co-design with residents, community organisations, clinicians and NHS and charitable providers since December 2021.](#) This has included multiple phases of engagement, targeted outreach to underrepresented communities, the input of specialist working groups and a comprehensive Equalities Health Impact Assessment (EHIA).

[The consultation has been an important opportunity to listen to residents and work together to shape the future of these important healthcare services.](#) We are grateful for the engagement and thoughtful contributions from the community, which have been instrumental in refining the proposed model of care.

Feedback has been central to shaping the direction of the model. This includes, for example, the introduction of **enhanced end-of-life care beds across all boroughs**,

which are designed to bridge a gap in our current healthcare provision that many residents who contributed to the development of the proposed new model of care identified. These beds address the needs of patients who do not meet the criteria or need for a hospice inpatient bed, but can't stay at home, do not wish to stay at home or prefer not to be in a hospital for their care. This is especially true for those living alone without a local support system. They also offer the possibility of short-term respite care.

Partner support

- NHS North West London acknowledges and values the support from all stakeholders, including the NHS and four charitable hospices – Central London Community Healthcare NHS Trust, Central and North West London NHS Foundation Trust, Harlington Hospice, St Luke's Hospice, St John's Hospice, and Royal Trinity Hospice
- All have confirmed their support of the new model of care and have played an active role in the steering group that has guided the programme.
- Their expertise and contributions have been vital in co-designing a model that respects the diverse needs of patients, families, carers and friends.

In a time of significant financial pressure across the NHS and during ongoing organisational change, NHS North West London is taking a proactive, forward-looking approach. This model is about **levelling up services** and ensuring that every adult in north west London, regardless of where they live, can access consistent, culturally competent and high-quality specialist palliative care. It is designed to deliver **real, tangible improvements for patients, families, carers and friends**, providing better support outside of hospital, more timely advice, and a clearer, more coordinated care journey.

The proposed changes also recognise the need for financial sustainability. Whilst both options passed the core affordability test during the shortlisting financial assessment, **Option A**, NHS North West London's preferred implementation approach, delivers all the benefits of the new model **with a smaller additional financial ask and maintains support at the current or a higher level for charitable providers**. In contrast, **Option B**, which would reopen the Pembrooke inpatient unit, would require significant new financial and staffing investment, delaying implementation and would lead to a reduction in funding of our charitable hospices, at a time when they face significant financial challenges.

Background and case for change

Access to community specialist palliative care in north west London has been inconsistent for many years, with significant variation in what services are available depending on where a person lives. This includes differences in access to:

- Hospice at Home
- community specialist palliative care team support

- out-of-hours support
- psychological and bereavement care.

As a result, many residents, especially those from under-served, global majority or marginalised communities—have been unable to access the support they need. This has contributed to increased hospital admissions, variation in place of death, and inequitable care at the end of life.

The **"Compassionate Care for All"** programme, led by NHS North West London, the integrated care board (ICB), has sought to address this inequity by designing a **single, consistent model of care** for all eight boroughs, co-produced with patients, carers, clinicians and providers.

Context and case for change

National context

Palliative and end-of-life care services support people who have a terminal diagnosis or are approaching the last year of life. These services play a crucial role in improving quality of life, reducing unnecessary hospital admissions, and providing care that respects people's choices.

Demand for these services is rising. As people live longer and with more complex conditions, the need for specialist palliative care is expected to increase significantly. National estimates suggest that by 2040, the number of people requiring palliative care in England and Wales could rise by between 25% and 47%.

In response to this, national policy has strengthened the role of integrated care boards (ICBs) in commissioning services that are personalised, high-quality, and meet the needs of local populations. In 2022, ICBs were given statutory responsibility for commissioning palliative and end-of-life care, with a requirement to carry out a gap analysis against the six national ambitions for palliative and end-of-life care.

Figure 1: Ambitions for Palliative and End-of-Life Care

Ambition 1	Ambition 2	Ambition 3	Ambition 4	Ambition 5	Ambition 6
Each person is seen as an individual	Each person gets fair access to care	Maximising comfort and wellbeing	Care is coordinated	All staff are prepared to care	Each community is prepared to help

Local context

In north west London, as of April 2024, approximately 35,600 people (1.52% of the population) are considered to be in the last phase of life. In 2023/24, 4,352 people died with a Universal Care Plan (UCP) in place. Of those who had recorded preferences, 67.9% died in their preferred place. While this is encouraging, it also highlights that a significant number of people do not have care preferences recorded, and work remains to be done to improve access and equity.

The current configuration of CSPC services varies across our eight boroughs, leading to differences in what services people can access depending on where they live. In some boroughs, inpatient hospice services are not available locally. In others, community-based support such as hospice at home is either not available or limited in hours. We also know that demand is not evenly distributed and this has implications for future planning. The map of provision is a complex arrangement of commissioners, including lead commissioner arrangements, and providers. These providers have mixed funding models:

- **NHS-funded providers** - Central London Community Healthcare NHS Trust (CLCH), Central and North West London NHS Foundation Trust (CNWL) and London North West University Healthcare NHS Trust (LNWT).
- **combined NHS and charitable funded providers** - St Luke's Hospice Harrow, Harlington Hospice, Royal Trinity Hospice and St John's Hospice.

Why change is needed

Since 2021, we have been working with local residents, clinicians and providers to explore how services could be improved. This engagement identified eight key issues that make up the case for change. These include:

- variation in access to community specialist palliative care services
- limited access to 24/7 community specialist palliative care advice and support
- inconsistencies in access to psychological and bereavement services
- inequalities in outcomes, particularly for people from minority ethnic backgrounds
- gaps in the provision of hospice at home services
- limited access to specialist palliative care inpatient beds in some boroughs
- fragmentation in how services are delivered and coordinated
- challenges in recruiting and retaining a skilled palliative care workforce.

In addition to these long-standing issues, we also recognised that we had to resolve the future of the Pembridge Palliative Care Centre consultant-led inpatient unit beds, which were suspended in 2018 due to an inability to provide safe and consistent consultant in specialist palliative care.

This programme is about addressing these issues through a new, consistent model of care for adult community specialist palliative care, one that supports people wherever they live in north west London, respects their wishes and helps them stay at home if that is their choice.

Model of care

We are proposing a new model of care for adult community specialist palliative care across north west London. This model is designed to address the inequalities and inconsistencies in the current service offer, and to ensure that every resident, regardless of which borough they live in, has access to the right support, at the right time, in the right place.

Overview of the model

The proposed model is built around the principle of a single, consistent offer of care across north west London.

Care in your own home

Service

Adult community specialist palliative care team
Hospice at home
24/7 specialist phone advice

Key change

7 day service available 12 hours per day in all boroughs
7 day service available in all boroughs
Consultant-led advice, available to anyone in all boroughs

Care in a community inpatient setting

Service

Enhanced end-of-life beds

Specialist hospice inpatient beds

Key change

- Increase beds from 8 beds in Hillingdon to 54 beds across all our boroughs
- Will provide specialist palliative care weekly ward round support in a 24/7 care facility by clinicians and staff with enhanced palliative care skills and knowledge
- Available to patients who do not meet the hospice inpatient bed admission criteria
- 57 beds are needed to meet future need
- Improve access to them by increasing hours in which people can be admitted
- Improving the referral process so it is more clear which patients are eligible for a hospice inpatient beds
- All patients will be able to access any hospice inpatient bed irrespective of where they live in north west London

Outpatient and wellbeing care

Service

Hospice multidisciplinary team (MDT) outpatient clinics

Dedicated bereavement and psychological support

Lymphoedema

Key change

Increasing specialist palliative care consultant and practitioner led clinics in all boroughs
A consistent care pathway in all boroughs offering one-to-one counselling and group sessions
Expansion of service to care for cancer and non-cancer patients in all boroughs

Key principles

The model is based on five key principles that emerged through extensive engagement and co-design. These are listed below.

- **Equity:** Everyone should be able to access the same high-quality care, no matter where they live in north west London
- **Consistency:** Services should be offered in a coordinated way, with clear service standards and a shared approach across providers
- **Personalisation:** Care should be tailored to individual needs and preferences, with a focus on what matters most to the person and their family
- **Integration:** Health and social care services should work together to provide joined-up care, including coordination with GPs, hospitals, and voluntary sector partners
- **24/7 access:** People should be able to access specialist support at any time, particularly during evenings and weekends when the current offer can be limited.

Ensuring equity of access

While the proposed model is designed to provide a consistent standard of care across the region, we recognise the importance of local access to services, particularly for bedded care. Wherever possible, we will ensure that services are delivered close to home and reflect the specific needs of local communities and the overall increase in the amount of beds available will help facilitate this.

This is supported by the [travel mapping analysis](#) which found that, on average, north west London residents travel around 40 minutes by public transport and 19 minutes by car to reach their nearest inpatient hospice unit. The current suspension of the Pembridge specialist palliative care inpatient unit led to a modest increase in travel times for affected residents, bringing them in line with the times all north west London residents have to travel to hospice inpatient provision now.

Comparison of average travel times

		Average peak time travel Public transport	Average peak time travel Driving
Whole NWL population	Travel time to nearest hospice inpatient unit (INCLUDING) Pembridge	40-mins	19-mins
	Travel time to nearest hospice inpatient unit (EXCLUDING) Pembridge	43-mins	21-mins
Pembridge catchment only	Travel time to Pembridge	31-mins	17-mins
	Travel time to next nearest hospice (Pembridge closed)	43-mins	23-mins

Consultation process

A 14-week public consultation ran from **18 November 2024 to 24 February 2025**, following extensive pre-consultation engagement since 2022.

Engagement summary

- **84 engagement sessions** with local communities, borough forums and faith-based groups
- **10 formal consultation events**, including three north west London-wide sessions
- Targeted events for specific communities: learning disabilities, Black African and Caribbean, South Asian, French African, LGBTQ+
- Materials translated and available in easy read and other formats
- Independent analysis of responses commissioned from **3ST**, a VCSE sector alliance.

The consultation was an important opportunity to listen to residents and work together to shape the future of healthcare services in north west London. We are grateful for the engagement and thoughtful contributions from the community, which have been instrumental in refining the proposed model of care.

What was consulted on

The consultation tested support for two implementation options, both of which are built around a shared new model of care.

Key features of the new model (both options)

- **12-hour (8am–8pm), 7-day-a-week specialist palliative care community teams** in all boroughs
- **24/7 telephone advice and support line**, available to professionals, patients and families
- **Hospice at Home services** expanded across all boroughs
- **Specialist palliative care consultant and practitioner led outpatient clinics** delivered locally
- **Bereavement and psychological support** available and consistent
- **Lymphoedema care** for both cancer and non-cancer conditions
- **Culturally competent care**, underpinned by staff training and community outreach
- **46 new enhanced –end of life care- beds**, in addition to the 8 already available in Hillingdon
- **Retain the current 57 specialist palliative care in patient hospice beds.**

Enhanced bed provision

- Introduction of **46 new "enhanced end-of-life care beds"**, based in nursing homes or community settings to support patients who prefer not to be in hospital but cannot or do not wish to remain at home, and they do not require the short, intensive specialist palliative care admission in a specialist palliative care inpatient bed.

- Retention of **57 existing inpatient hospice beds**, considered sufficient for projected population need.

Future inpatient bed base

Borough	Estimated hospice inpatient beds per 100,000 population with current operational beds (57)	Enhanced end-of-life care beds
Hillingdon	3.28	8
Harrow	3.08	7
Brent	2.42	9
Ealing	2.29	9
Hounslow	2.29	7
Westminster	2.97	5
K&C		4
H&F		5
Total no of 24/7 bedded care	2.73 average = 57	54
Total bed base	111	

The introduction of local enhanced end-of-life care beds across north west London, in addition to those already in Hillingdon is a direct response to what residents told us they need, better, more accessible options for those who cannot be cared for at home.

These beds are designed to bridge the gap between hospital and home, offering high-quality palliative care in familiar, local settings. The beds will be provided locally by NHS, charitable or private providers and supported by community specialist palliative care teams and staff with enhanced palliative care knowledge and skills., The addition of enhanced end-of-life care beds respond directly to what residents have told us they need and strengthens our ability to deliver responsive, personalised care closer to home.

Following a long-listing, short-listing, appraisal and assurance process, we consulted on two options:

- **Option A (preferred option):** Fully implement the proposed model, including 46 new enhanced end-of-life care beds, while maintaining the number of existing hospice beds without reopening the Pembridge Palliative Care Inpatient Unit beds. This option would be easier and quicker to implement and benefit more north west London residents as a whole.
- **Option B:** Fully implement the proposed model, including 46 new enhanced end-of-life care beds and reopen Pembridge Palliative Care Inpatient Unit beds inpatient beds. This would require a reduction in hospice beds elsewhere and have a longer implementation timeline due to the need to recruit specialist palliative care consultant cover and 35 additional staff.

Financial considerations

While both options have been assessed as deliverable, it is important to acknowledge the significant financial pressures currently facing the NHS. A detailed financial appraisal was undertaken as part of the development of the Pre-Consultation Business Case (PCBC). This outlined the overall financial impact and cost difference between Option A and Option B.

- **Option A** costs **£27.6 million**
- **Option B** costs **£29.7 million**
- The actual cost difference between the two options is **£2.1 million**.

Option A scored higher in the financial assessment due to it requiring less additional funding than option B and providing the full benefits that are associated with delivery of the new model of care including acute bed days avoided due to people being supported in enhanced end-of-life care beds and avoided hospital attendances and admissions through community services enabling people to die in their place of residence.

However, in a constrained financial environment, Option A presents a more viable way forward because it:

- requires less additional funding in order to fully deliver the model of care
- enables faster and more equitable implementation across all boroughs by building on current financial and work force arrangements.

In contrast, Option B:

- requires £2.1m additional funding
- significant workforce investment, with past history of ongoing challenge for the Pembridge in patient unit
- significant capital costs of re-opening the Pembridge inpatient unit
- would delay the full rollout of the new model, undermining early benefits.

In addition, implementation of Option B would lead to a reduction in funding to charitable hospices due to the reduction of inpatient beds in these locations. This is important because the financial stability of charitable hospices across the UK has reached a critical point according to Hospice UK, which represents more than 200 hospices; with the sector facing unprecedented pressure. This has been echoed by the four local charitable hospices providing care to north west London residents, advising NHS North West London that their financial positions have worsened since the programme began.

In summary, whilst both options are deemed affordable, Option A provides a more financially sustainable solution that ensures timely and equitable benefits for residents, without compromising the viability of essential hospice or community specialist palliative care based services.

Consultation outcome

An independent analysis of consultation responses by 3ST is underway. The ICB has agreed that it will be finalised following the JHOSC meeting and any subsequent JHOSC submissions. However, themes that have emerged include:

1. Equity of access to services

- A consistent concern across all feedback channels, particularly in boroughs with higher levels of deprivation
- Many participants stressed the need for care to be available closer to home, citing difficulties with travel, especially for those with mobility issues or limited financial means
- Some correspondents were concerned that access to hospice inpatient beds would worsen in some boroughs if Pembridge did not reopen.

2. Strengthening community and home care services

- Strong and widespread support for improving home-based palliative care, including 24/7 services and culturally responsive provision.
- Many respondents welcomed investment in this area, regardless of their view on inpatient provision, highlighting a preference for care in familiar environments where possible.

3. Need for local inpatient services

- While views varied on how inpatient care should be configured, many participants emphasised the need for local availability and welcomed the introduction of enhanced end-of-life care beds.
- Many participants expressed the view that Pembridge inpatient unit was an important local resource and should reopen
- Others acknowledged the practical challenges of reopening any facility.

4. Workforce capacity and feasibility

- Some respondents, especially professionals, raised concerns about the feasibility of implementing expanded services without affecting stability in existing hospices
- This was particularly relevant to proposals involving recruitment of additional specialist staff to support any increase in inpatient provision including any potential reopening of Pembridge Palliative Care Inpatient Unit.

5. Cultural competence and inclusive services

- Strong messages from ethnic minority communities stressed the importance of culturally sensitive care—whether in the home, hospital, or inpatient settings.
- Respondents wanted reassurance that care would be respectful of diverse languages, faiths, and beliefs.

6. Continuity and familiarity of care

- For all, familiarity with existing services, including community teams and their local hospice inpatient unit was a key factor in shaping preferences
- Respondents described comfort and reassurance in known facilities and staff, especially where continuity of care could be maintained.

8. Service design clarity: enhanced end-of-life beds

- Some requested more detail on what enhanced end-of-life beds would offer, how they would be staffed, and how the public would access them.
- There were calls for clearer definitions and practical information.

The most significant themes raised in the consultation were:

1. **equity of access**, particularly concerns from deprived and inner-city areas about travel distances and care availability;
2. **desire for stronger community-based and home services**, with high support for expanding care closer to where people live;
3. **the importance of local inpatient care**, including support for introduction of enhanced end-of-life care beds.

There was strong support for the full introduction of the model of care including enhanced end-of-life care across all boroughs in north west London. Support for Option A was strongest in outer boroughs where they were not concerned about the future of the Pembridge inpatient unit and felt that equity of provision was more important. Support for Option B was strongest in inner boroughs where some expressed support for the reopening of the Pembridge inpatient unit.

Other important themes included workforce capacity, transparency in planning, culturally appropriate care, and continuity for families and carers.

Due to delays in agreeing the formal scrutiny process for the consultation options, NHS North West London had extended the deadline for any response from local government to 30 April, 2025. Given that it has now been agreed to discuss the meeting at the JHOSC meeting on 1 May 2025, we are able to offer a final deadline for response of 15 May 2025.

What is happening now

While no final decisions have been made, we have begun working with NHS and charitable hospice partners at borough level to hold initial planning discussions to explore how the new model of care could be implemented. This includes identifying who is best placed to deliver different elements of the model and considering where services could be located. Local planning is split into four areas, each with assigned leads.

- Brent and Harrow is being led by Lindsey Bennister (St Luke's Hospice) and a place based co-lead is to be confirmed. The initial planning workshop is scheduled for 20 May 2025.
- Ealing and Hounslow leads are to be confirmed and the initial planning workshop is in the process of being scheduled.

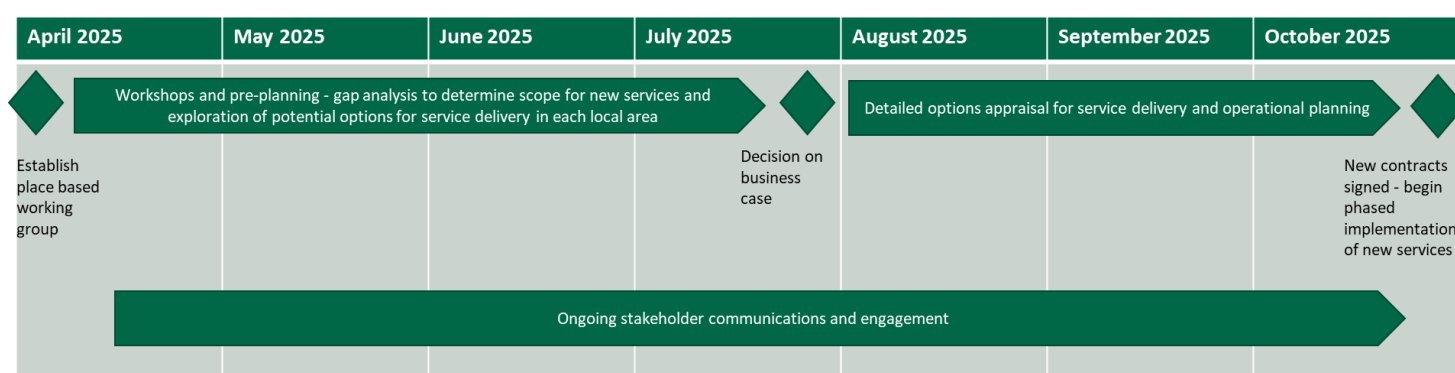
- Hillingdon is being led by Jane Wheeler (Harlington Hospice). This will be absorbed into an existing palliative care transformation programme so a separate planning workshop is not required.
- West London, Central London and Hammersmith & Fulham is being led by Emily Carter (Royal Trinity Hospice) and Navneet Willoughby (CLCH). The initial planning workshop took place on 26 March 2025.

Early planning discussions are focused on identifying local needs, addressing service gaps, and exploring potential delivery options. Once a final decision on the consultation outcome has been made, we will begin a more detailed appraisal of options and support the development of tailored implementation plans for each area.

For instance, Central London Community Healthcare NHS Trust, the current provider at Pembridge, has expressed interest in delivering the proposed enhanced end-of-life care beds for Hammersmith & Fulham, Kensington and Chelsea and Westminster and we will be exploring with them whether these could be provided from existing NHS estate.

The high level timelines for the implementation planning are:

- **March – July 2025** – Initial workshops and pre-planning of services. Determining what needs to be done to bring services in line with the new model of care for each local area and exploring possible delivery options.
- **July 2025** – Confirmation of final consultation outcome and business case decision on funding.
- **August 2025 – October 2025** – Detailed appraisal of options for service delivery and operational planning to develop plan for phased implementation of services over 2 years.
- **October 2025** – New contracts begin and phased implementation of services commences.



We are also progressing work on the five enablers that will underpin delivery of the new model of care. A reducing inequalities working group has been established, and alongside this, a community reference group is in place to guide and support the work on tackling inequalities, bringing in diverse voices and lived experiences.

In terms of digital and data enablers, we are continuing to expand the use of the Universal Care Plan and improving our data collection capabilities. This will allow us to monitor services more effectively and use data to inform continuous improvement.

Work is also underway to bring providers together to deliver the workforce development enabler through a collaborative, pan-north west London approach.

Next steps

A Decision-Making Business Case (DMBC) will be presented to NHS North West London Board, with a final decision expected by summer 2025.

Contract extensions for charitable hospices have been agreed to ensure that current CSPC services continue until the end of September 2025.

It is planned that implementation of the new model will begin in autumn 2025, on a phased basis across boroughs.

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Compassionate care for all

**Improving adult community
specialist palliative care services
in north west London**

An opportunity to give your views on
how we best improve these services
for north west London residents.

Public consultation 18 November 2024 to 24 February 2025
www.nwlondonicb.nhs.uk/cspc

HOW TO FIND OUT MORE AND GET INVOLVED

To find out more about Compassionate care for all and the work that has got us to this stage visit www.nwlondonicb.nhs.uk/cspc.

Our website also features:

- The shorter summary version of this consultation document
- An easy read version of the summary of the consultation document
- The full pre-consultation business case.

To hear more on the proposals, ask us questions and have your say you can:

- Come to the public meetings that we are arranging around the consultation www.nwlondonics.nhs.uk/cspcevents
- Invite us to attend a meeting by contacting the team at nhsnwl.endoflife@nhs.net
- Complete a [questionnaire](#)
- Write to us at nhsnwl.endoflife@nhs.net to ask us questions, share your views or to arrange a call with a member of the team so that you can feedback verbally.

We can also provide support for those who may need some additional help to participate, including translations, different versions of the consultation document (e.g. audio, large print, Braille) and tailored support to participate if you have a learning disability or difficulty in communicating.

Further details on the support available is provided in section 6 on ways to take part in [the consultation section](#).



Proposal developed by NHS North West London.
www.nwlondonicb.nhs.uk/cspc
nhsnwl.endoflife@nhs.net

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1. EXECUTIVE SUMMARY: COMPASSIONATE CARE FOR ALL

This document sets out plans for formal consultation on the north west London adult (18+) community specialist palliative care (CSPC) review.

1

We have called the consultation 'Compassionate care for all'.

Compassionate care for all is doing the best for patients, families and friends when they have a serious or life-limiting illnesses such as cancer and need the care and support to live the best possible life that their condition allows.

Compassionate care for all is making sure we have high quality and compassionate care whilst you are at your most vulnerable during the last few months or weeks of life.

Compassionate care for all is knowing that all adults who live in north west London have equal access to the highly specialist care and support you get from our NHS and charitable hospices at home, in the community or, if you need it, a hospice bed.

"How we care for the dying is an indicator of how we care for all sick and vulnerable people. It is a measure of society as a whole and it is a litmus test for health and social care services."

End-of-Life Strategy,
Department of Health 2008



The document includes an overview of:

- Why we are carrying out the review, looking to improve the services and the support that is available to all north west London patients, families and carers
- What the new co-designed model of care looks like and how engagement has informed its development
- Which service options have been considered to best deliver the new model of care
- Which options we are consulting on and how you can share your views.

We are now at the stage where a decision needs to be made on the best way to implement the new model of care and it is important that we have your input to ensure we are delivering a future model that is fit for purpose and sustainable.

1.1 What is the adult community specialist palliative care review?

Adult (18+) community specialist palliative care services support our residents to live well for as long as possible and have the most comfortable death at the end of their life. These services support people in the community and respond to complex and specialist needs. General palliative care services such as those provided by GP practices, community nurses and acute hospital specialist palliative care services are not included in this review.

To help you fully understand what services we are describing, we have set out clear definitions over the page.

When we talk about **community** services, we mean all services that are not based in a hospital. The proposed services would be in hospices, care homes and people's usual place of residence.

Palliative care describes the treatment and support provided to people who are terminally ill. It focuses on improving quality of life by managing symptoms, relieving pain and addressing any side-effects of a patient's condition. It also provides emotional and practical support for patients, families and carers.

Specialist care refers to the fact that the care is provided by palliative care specialists; 'general palliative care' is care provided by other professionals such as GPs, district nurses or care home staff.

There is a difference between palliative care and end-of-life care. **End-of-life care** is a specific type of care for people nearing the final stages of their life. It aims to ensure comfort, dignity and support, managing symptoms and providing emotional and practical help.

The review of adult community specialist palliative care services began in late 2021 and seeks to respond to identified issues by delivering services that:

- Meet people's needs and wishes
- Are fair and accessible to everyone across north west London
- Deliver better care and improve outcomes for patients and their families.

Since then we have met and worked with patients, families and carers as well as our



colleagues from charitable and NHS care providers to help us create this proposal to improve the care and services available to all residents in north West London.

We know that people care deeply about their local services, whether charitable hospice or NHS, and how they support local residents, families and carers at what is the most difficult of times.

We also know that we need to improve services and make them better for patients and families so that they receive the care and support they need in an environment that supports and helps them at the end-of-life.

People have told us they would prefer to be at home, or in a more therapeutic and calm environment where they will receive the holistic care and support they, their families and their carers need. For many, the thought of dying in a hospital environment is overwhelming and not theirs or their carers' and loved ones' wishes.

We heard through our discussions with local people how choice was so important, that everyone had different needs and that one size

did not fit all. The importance of personalised care was also repeatedly highlighted. All of the invaluable feedback, comments and suggestions fed directly into the [model of care working group](#) that was set up to co-design a fit for purpose and sustainable model of care.

“We are pleased and proud that all of our charitable and NHS partners supported this work and endorse the model of care as the best way forward for north west London residents.”

Over the course of 38 meetings spanning approximately 18 months, the group, chaired by Dr Lyndsey Williams (a local GP and clinical lead for palliative and end-of-life care), twelve resident representatives and an equal number of professionals from the providers of palliative care services, designed and agreed a proposed future model of care. The discussions were, in-depth, complex and complicated and proved invaluable in designing what we believe is a strong and sustainable model of care.

“We are pleased to be recommending that the model of care is implemented across north west London.”

The proposed new model of care was then tested with local residents who were able to provide feedback, which allowed us to strengthen it even further. The feedback confirmed that it was not just about making sure we had the right services in place, but also all of the supporting improvements or enablers that we need to put in place, such as making sure we have culturally competent services, that would allow us to deliver high quality care to all of our diverse communities.

During our work to define the new model, specific concerns were raised about the following three issues, each of which is addressed in this document and the full pre-consultation business case:

- Travel and access to services
- Making sure the new model of care meets the changing needs of the population
- Making sure we have the right number and distribution of our hospice inpatient beds to meet future need.

1.2 Why change is needed

We began this review with the publication of an [issues paper](#)¹ in late 2021. The issues paper set out eight broad reasons we needed to improve these services, including:

- Our ageing (and growing) population
- Reducing health inequalities and social exclusion
- Making services easier to access including for our more diverse communities
- Financial and recruitment challenges.

From late 2021, we repeatedly and consistently sought the views of local residents, clinicians and charitable and NHS palliative care providers on what was important to them about adult community specialist palliative care services. We then published an [engagement outcomes report](#). Key themes which arose throughout included:

¹An issues paper sets out the challenges and need for change facing a service or set of services for the purposes of discussion: it does not make specific recommendations for change.

- Providing the best possible care in the best location for the patient

-
- Providing personalised care reflecting individual needs

-
- Improving service integration and making navigating services easier

-
- Clear information and advice on accessing services and support

-
- The need for staff to be compassionate and culturally sensitive

-
- Better support for patients, carers and families through end-of-life and beyond, including improving access to bereavement support.
-

Also, very importantly, as we examined existing service provision in-depth, we found that there was significant variation in the type and level of care people received across our eight boroughs. It was clear that we needed to propose a new model of care for north west London in which everyone received the same level of high quality care, regardless of their circumstances and where they live.

“Equity is about fairness. It’s about making sure people get access to the same opportunities. Sometimes our differences and history can create barriers to participation, so we must first ensure equity before we can enjoy equality.”

1.3 The new model of care

We have listened to and worked with communities to develop a model of care that responds to identified needs while reflecting best practice and aligning with the broader [strategic objectives](#) for the NHS in north west London. Our new model of care was tested with the public in 2023 and received strong local support².

The model of care recommends the provision of adult community specialist palliative care services in all eight boroughs across north west London including the following.

1. Making sure that all residents have equity of access to the same high standard of care whilst they are at home including adult community specialist palliative care nursing teams, hospice at home and 24/7 specialist telephone advice.
2. Almost doubling the number of community palliative care beds available to local residents through the introduction of enhanced end-of-life care beds and retaining the number of hospice inpatient beds that we have now.
3. We want to improve hospice outpatient’s services so all residents have access to lymphoedema (a long-term condition where a build-up of lymph fluid in your body’s soft tissues causes swelling), psychological and bereavement services, hospice day care and wellbeing services.

You can read more about the potential impact of the new model of care on the care a patient receives in our illustrative [example here](#).

⁴ [Adult community specialist palliative care review How are we going to deliver the new model of care - potential delivery options? Engagement outcome report](#)

In parallel, an issue for some residents in our inner London boroughs, is that Central London Community Healthcare NHS Trust's Pembridge Palliative Care Inpatient Unit at the St Charles Centre for Health and Wellbeing in North Kensington has been closed since 2018, due to challenges staffing the unit³. This review is focused on making sure we have the right services and support across all eight boroughs, but will also need to provide an agreed approach to the future of the Pembridge Palliative Care Inpatient Unit.

1.4 How we propose to deliver the new model of care – we need your views

Having defined the new model of care for adult community specialist palliative care services, the next step is to decide how to deliver this model in a way that both achieves the best outcomes for people across north west London and is affordable.

Following an assessment process, a longlist of 54 possible delivery options was narrowed down to a shortlist of four potential options that included full and partial delivery of the model of care as well as a do nothing option. Engagement with local residents has indicated general support for these options⁴.

Further financial and non-financial appraisal of these options, led by a specially convened steering group, identified the two highest scoring options were those that delivered in full the model of care and a preferred option. A summary of these two options is below, with more detail provided later in this document⁵.

Option A (preferred option): Full implementation of the proposed model of care with Pembridge Palliative Care Inpatient Unit beds not reopening

This option would fully implement the new model of care, including 46 new enhanced end-of-life care beds across north west London, while maintaining the existing 57 hospice beds without reopening the Pembridge Palliative Care Inpatient Unit beds. This option would be easier and quicker to implement and benefit more north west London residents as a whole. We are confident that this model can be delivered within the agreed timescale. This option meets the agreed criteria and offers the most significant benefits for residents across north west London.

Option B: Full implementation of the proposed model of care with Pembridge Palliative Care Inpatient Unit beds reopening

This option would fully implement the new model of care, including 46 new enhanced end-of-life care beds across north west London, and reopen Pembridge Palliative Care Inpatient Unit beds. This would require a reduction in hospice beds elsewhere and have a longer implementation timeline due to the need to recruit specialist palliative care consultants and 35 additional staff.

It is important to us that this consultation is as inclusive as possible and we want to hear from as many voices as we can to inform the final decision making process. This document sets out how you can share your views, with a range of opportunities to get involved.

The consultation will run for 14 weeks, after which all of the feedback received will be independently reviewed, analysed and a report will be produced to inform the final decision making.

² [Adult community specialist palliative care review - the proposed new model of care engagement outcome report](#)

³ [Pembridge Palliative Care Services in-patient unit suspension](#)

⁵ As is made clear on page 42, the two options we are consulting on were referred to as option 3 and option 4 in the pre consultation business case. For simplicity and the purposes of this consultation we are now calling them Option A and Option B

2. ABOUT THIS CONSULTATION

Our review and developing a new model of care.

2

We began to look at the future of adult (18+) community specialist palliative care services across the whole of north west London in late 2021.

Since then we have met and worked with patients, families and carers as well as our colleagues from charitable and NHS care providers to help us create this proposal to improve the care available to all residents in north west London.

We know that people care deeply about their local services, whether charitable hospice or NHS, and how they support local residents, families and carers at what is the most difficult of times.

We also know that we need to improve services and make them better for patients and families so that they receive the care and support they need in an environment that supports and helps them at the end of their life.

Most people we have spoken to have told us they want their care when dying not in a hospital inpatient ward environment but preferably at home, or in a more therapeutic and calm environment where they will receive the holistic care and support they, their families and their carers need.

To do this and improve services for people across the eight boroughs of north west London, we need to make decisions on the future service model.

How was the new model of care developed?

As we set out to determine the future service requirements, we considered what good looked like and how we could deliver the care and support local people told us was needed.

We have previously advised in the executive summary how we have engaged with local residents and how the model of care working group came together to co-design and agree the future model of care.

"Many people have contributed to developing a model of care that will improve the services and support for people here in north west London. We want to acknowledge their commitment and impact."

We would like to thank all the members of the public who have given up their time throughout the review and provided their thoughts and feedback. Their energy, insights, ideas and challenges, along with the good and bad experiences of care their loved ones received, have directly informed the model of care that we wish to introduce.

We also know that we have some wonderful palliative care services in north west London, with incredibly dedicated clinicians and staff. We would like to thank all those from across the charitable hospice and NHS palliative care services in north west London who have come together to work with us on this important programme.

2.1 Implementing the new model of care: consultation on delivery options

Implementing the new model of care requires us to introduce new services, change existing services and make some difficult choices.

We have undertaken an extensive appraisal process to explore the possible ways to deliver these changes.



An initial longlist of possible options for delivery of all elements of the new model of care were assessed against key criteria determined by our [steering group](#). This resulted in a shortlist of four possible options together with a do nothing option. Details of these five options are set out in section 5, where we describe how we would implement the new model of care.

Further financial and non-financial appraisal of these five options has resulted in two highest scoring options. We are formally consulting on these two options as detailed in section 5.

We are pleased that in both of these options, we are proposing to almost double the number of beds available to local residents and fill the gaps in service provision that have meant that some residents in some boroughs have a less good service. We believe this is the fair and right thing to do.

We are also seeking to agree the future of Central London Community Healthcare NHS Trust's Pembridge Palliative Care Inpatient Unit in North Kensington that has been suspended for over six years since before the Covid-19 pandemic, as we have been unable to recruit the necessary specialist palliative care consultant and wider team.

There is a national shortage of these highly specialist staff and despite repeated attempts to recruit, we have been unable to do so. We have also worked with our partners to see if there was any way round this and have been unable to find a solution. We are sorry for this and know how upset some local residents continue to be about the unit's temporary closure.

Whilst one of the two options (Option A) scored higher in the financial and non-financial appraisal to provide us with a preferred option, no decision has been made and we are seeking your views on both options to inform the final decision. This will be made after the consultation has closed and the feedback independently reviewed.

During the consultation, we will aim to obtain a broad range of views from our local communities, services users, clinicians, providers and partners. The feedback gathered during consultation and any further evidence will inform any final decision.

We acknowledge that some people would have liked us to go further and be even more ambitious. Informed by our providers and clinicians, we have tried to strike the right balance between what is realistic and deliverable as well as impactful. We believe these proposals strike that balance.

3. CURRENT SERVICES IN NORTH WEST LONDON AND WHY THESE NEED TO CHANGE

3

We began this review with the publication of an issues paper in late 2021 that set out eight broad reasons we needed to improve these services, including:

- Our ageing (and growing) population
- Reducing health inequalities and social exclusion
- Making services easier to access including for our more diverse communities
- Financial and recruitment challenges.

From late 2021 we repeatedly and consistently sought the views of local residents, clinicians and charitable and NHS palliative care providers on what was important to them about adult community specialist palliative care services. Key themes which arose throughout included:

- Providing the best possible care in the best location for the patient
- Providing personalised care reflecting individual needs
- Improving service integration and making navigating services easier
- Clear information and advice on accessing services and support
- The need for staff to be compassionate and culturally sensitive
- Better support for patients, carers and families through end-of-life and beyond, including improving access to bereavement support.



Also, very importantly, as we started to look at existing service provision in-depth, we found that there was significant variation in the type and level of care people received in different boroughs.

As we moved forward, we were careful to respond to each of these issues and to propose a model of care for north west London in which everyone receives the same level of high quality care regardless of their circumstances and where they live.

The model of care also delivers against the broader strategic priorities for the integrated care system across north west London.

Some facts and figures:

- Nationally, 85% of deaths occur in people over the age of 65 years⁶
- Approximately 55% of deaths occur among the 80+ population. This group is expected to grow by 32% in north west London by 2033

⁶ Monthly figures on deaths registered in England and Wales, ONS, August 2022

- In 2023, we recorded 12,368 deaths in north west London boroughs

- We expect annual deaths to increase to 14,587 by 2033, impacted by an ageing population and overall population growth⁷.

“The majority of people who die do not need highly specialist palliative care support, but we also know there is currently unmet need.”

3.1 Current services across north west London

In north west London, there is a complex and rich tradition of charitable hospice and NHS service provision. They provide a wide range of services and support including:

- Care at home (adult community specialist palliative care nursing teams, hospice at home and 24/7 specialist telephone advice)
- Community specialist inpatient beds (hospice inpatient units, enhanced end-of-life care beds)
- Hospice outpatient services (including lymphoedema, psychological and bereavement services), hospice day care and wellbeing services.

These providers have mixed funding models.

- **NHS funded providers:** Central London Community Healthcare NHS Trust (CLCH), Central and North West London NHS Foundation Trust (CNWL) and London North West University Healthcare NHS Trust (LNWHT)
- **Combined NHS and charitable funded providers:** St Luke’s Hospice, Harlington Hospice, Royal Trinity Hospice and St John’s Hospice.

“In north west London, an average of 51% of hospice costs come from fundraising activity and charitable donations. The fundraisers and volunteers do an amazing job and we have to be truly thankful for all they do.”

The link between service providers to north west London and our eight boroughs is described over the page:



⁷ ONS Deaths Data

Figure 1 – Map showing location of providers

Key to: Providers of community-based specialist care services who provide both inpatient unit and other CSPC services – provider name and physical location of inpatient unit

- 1 Harlington Hospice** providing **Michael Sobell House** inpatient unit located at Mount Vernon Hospital
- 2 London North west University Healthcare Trust (LNWH)** providing **Meadow House Hospice** located at Ealing Hospital site
- 3 St Lukes Hospice**
- 4 Central London Community Healthcare NHS Trust** providing **Pembridge palliative care services** (hospice) located at St Charles Hospital site
- 5 St John's Hospice**
- 6 Royal Trinity Hospice**

Key to: Providers of community specialist care services without inpatient units – name of services and boroughs these services are provided in

- 8 Central and North West London NHS Foundation Trust** providing **Hillingdon community palliative team & Your Life Line (YLL) Service** in Hillingdon
- 9 Marie Curie** providing **End-of-life Rapid Response & unplanned nursing services** in Ealing & Hounslow. The teams are based at Meadow House Hospice
- 10 Central London Community Healthcare NHS Trust (CLCH)** providing **Pembridge palliative care services** providing **Harrow palliative care team** in Harrow.

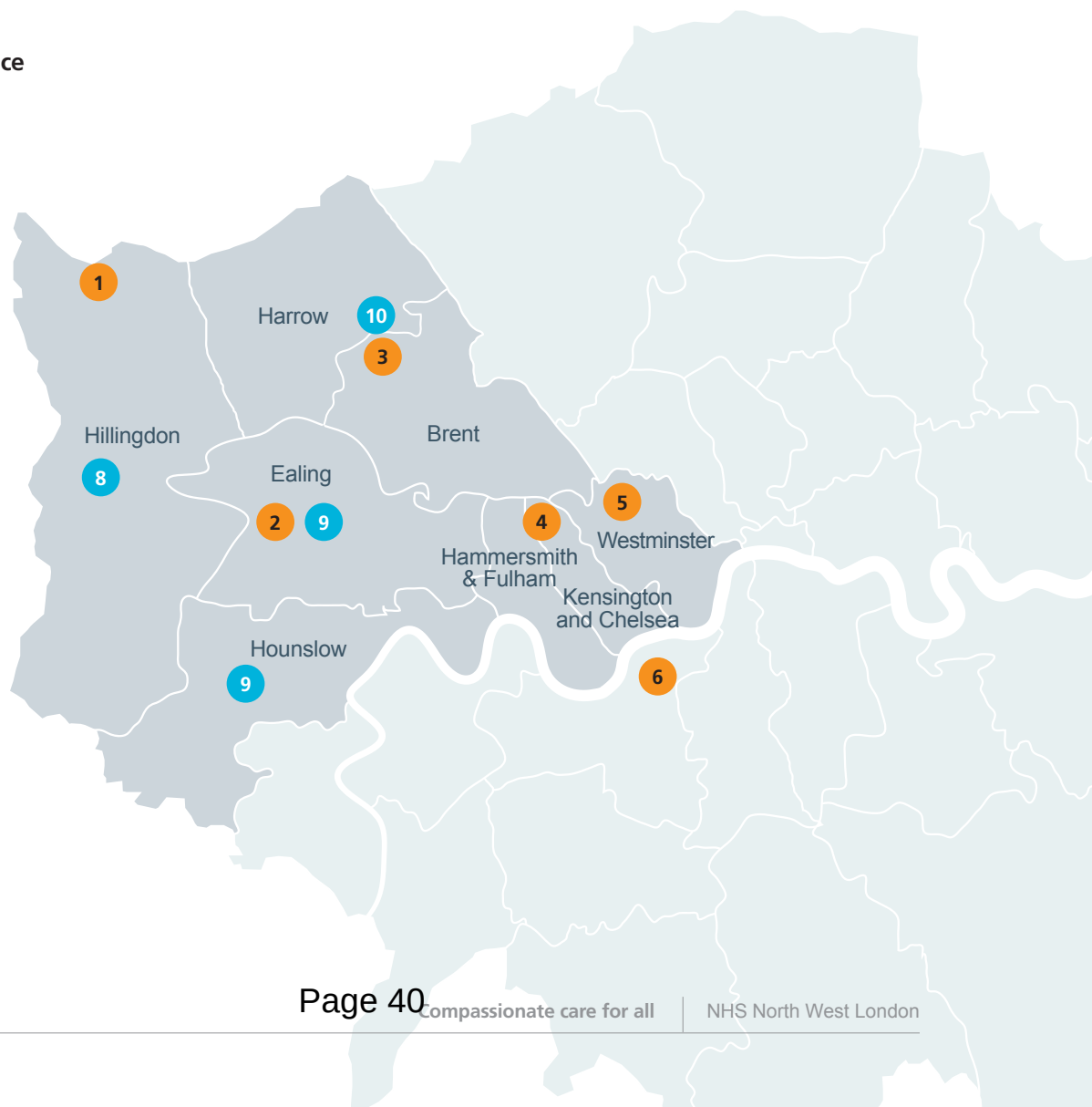


Figure 2 – Service providers by borough

Borough	North west London's commissioned adult community-based specialist palliative care service providers by borough
Brent	● St Luke's Hospice ● Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services ● St John's Hospice
Ealing	● London North West University Healthcare NHS Trust providing Meadow House Hospice
Hammersmith & Fulham	● Royal Trinity Hospice ● Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services ● St John's Hospice
Harrow	● Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services
Hillingdon	● Harlington Hospice (including provision of Michael Sobell House in-patient unit at Mount Vernon Hospital) ● Central and North West London NHS Foundation Trust
Hounslow	● London North West University Healthcare NHS Trust providing Meadow House Hospice
Kensington & Chelsea	● Royal Trinity Hospice ● Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services ● St John's Hospice
Westminster	● Royal Trinity Hospice ● Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services ● St John's Hospice

This review does not cover acute hospital palliative care or universal, generalist palliative care services such as those provided by GPs, district nurses or care home staff (but recognises the importance of these services all working closely together to support patients' care needs). It also does not cover children's services. Transition arrangements for young adults are not changed by this proposed new model of care at this time. It is an ambition for NHS NW London to lead a subsequent piece of work on children's services.



3.2 Why we need to change and improve the services and support available to all our residents

In late 2021, we published an issues paper that set out the eight broad reasons we needed to improve the way we deliver community specialist palliative care services for adults (18+ years). We wanted to achieve all of the following:

1. build on the valuable learning and feedback received from previous reviews of palliative and end-of-life care services carried out in North West London
2. bring services in line with national policy and guidelines
3. meet patients' changing needs arising from changes in (and ageing of) the population
4. reduce health inequalities and social exclusion
5. make sure that everyone receives the same level of care, regardless of where they live
6. make it easier for people to access services, particularly across our more diverse communities
7. cope with the increasing financial challenge, the NHS is facing and the effect this has on adult community specialist palliative care
8. reduce the difficulty we are having in finding, recruiting and keeping suitably qualified staff and the knock-on effect this has on our ability to provide services.

It is also important that the new model of care is aligned to the [broader strategic priorities of the North West London Integrated Care System \(NW London ICS\)](#).

The strategy has six priority areas and our proposed new model of care is supporting five of them, because the model of care is for adults only not children and young people. There has been significant, consistent engagement with local residents to understand their real life experiences.

We have ensured the model of care supports the identified challenges and needs of the north west London population. We recognised the vast variation in services supporting adults and their specialist palliative care needs and have documented how each area of the new model will reduce inequalities and ensure high-quality care across all eight boroughs⁷.

The model of care has a focus on accessibility along with addressing inequalities, by enhancing the hours of care, routes of access and criteria for access. We know our population wish to be cared for at home, what they know as their usual place of residence, where possible and the improved model provides greater opportunity for this through services such as 'hospice at home', 8am to 8pm community specialist palliative care support and 24-hour telephone support.

Throughout the model of care, we reference national documents and best practice because we remain committed to ensuring this new model provides the highest quality of care as efficiently as possible.

3.3 What you said was important to you

Since December 2021, we have talked to local residents, clinicians and the charitable and NHS palliative care providers about what was important to them about adult (18+) community specialist palliative care services. This feedback directly supported the development of the model of care and delivery options.

⁷ [North West London Adults \(18+\) Community specialist palliative care programme Equality health impact assessment](#)

Key themes which arose consistently throughout our engagement include:

- Providing the best possible care: delivered in the optimal place, supported by evidence-based pathways
- Care tailored to individual needs: that is personalised, reflecting individual preferences, conditions and requirements
- Connected care: in which providers work together to provide integration and service navigation and access in easier
- Staying informed: providing clear information for specialist palliative care services across North West London, as well as advice on how to find help and support
- Professional culture and behaviours: that exhibit sensitivity and compassion
- And reflect how faith and culture may lead to differences in the help people need
- Supporting carers and families through end-of-life and beyond: though improving bereavement, respite and emotional support for patients, families, and carers.

3.4 Making sure that care is available equitably across our boroughs

When we started to look at existing service provision we found that there was variation in the type and level of care people were receiving:

- In Hammersmith & Fulham, Ealing and Hounslow there was no hospice at home provision



- Patients in Harrow could not be treated for lymphoedema which was not caused by cancer
- Only patients in Hillingdon were able to get access to enhanced end-of-life care beds
- Patients in Harrow could only access specialist palliative care team services five days a week compared to the seven days per week found in the other boroughs in north west London
- Consultant and nurse-led outpatient clinics are not available in Ealing or Hounslow
- 24/7 telephone advice has varying degrees of consultant supervision and is delivered by nurses of varying specialism.
- Variation existed in the level of trained specialist psychology and bereavement practitioners.

“When looking at the model of care and possible service options we want improving fairness of provision across the whole of north west London to be a core principle when we come to making decisions.”

4. THE NEW MODEL OF CARE

The proposed new model of care will provide more accessible adult community specialist palliative care provision that has a wider reach for our north west London population, with the expectation that this will contribute to a reduction in hospital admissions at the end of life and improve integration of care.



“We need our Model of Care to be like a patchwork coat that fits each individual and wraps around them so they feel supported as it meets their health, social and spiritual needs.”

Kensington and Chelsea resident,
model of care working group



The model of care consists of three key service areas which, will deliver a comprehensive range of services for all north west London residents, comprising:

- **Service area 1:** Care in the home
- **Service area 2:** Community specialist inpatient care
- **Service area 3:** Hospice outpatients, day care and wellbeing

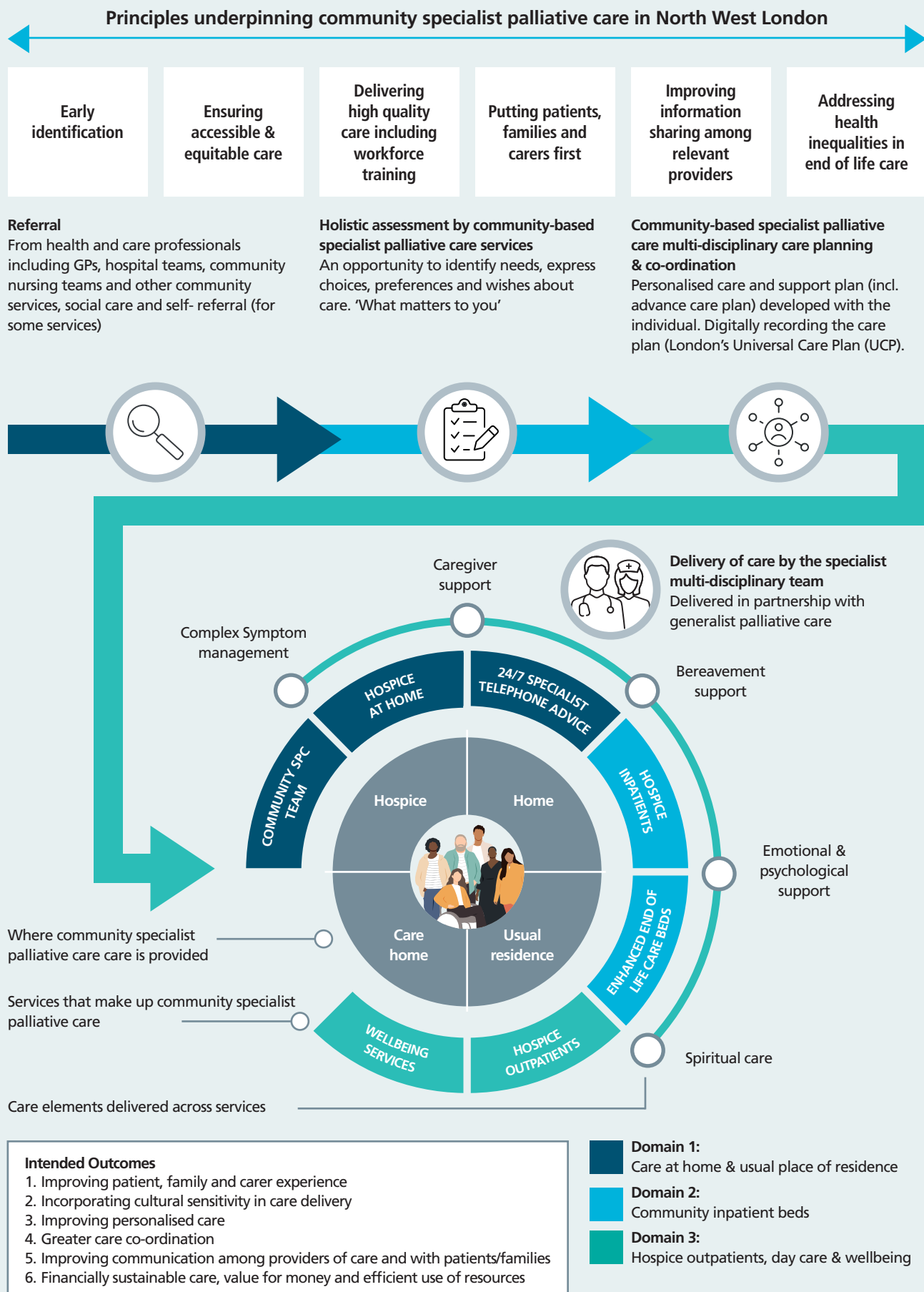


These services will work together around the needs of patients and their families, friends and carers to deliver high quality care and support.

They are described in figure 3 over the page.

“Patient choice is important. And being able to make an informed choice alongside professionals underpins everything. The new model of care aims to make sure people, based on their needs, have a choice, getting the right care, at the right time, by the right team and in the right place, alongside their wishes and preference. Through it, all residents, no matter their circumstances, will be able to access the services they need.”

Figure 3 – Principles underpinning community-based specialist palliative care



What changes will you see in how care is provided?

Figure 4 – The key improvements to services and care all north west London residents will receive as a result of the introduction of the new model of care

 Care in your own home	
Service	Service
Adult community specialist palliative care team	7 day service available 12 hours per day in all boroughs
Hospice at home	Care available in all boroughs, 7 day service
24/7 specialist phone advice	Consultant-led advice, available to anyone

 Care in a community inpatient setting	
Service	Service
Enhanced end-of-life care beds	Increase beds from 8 beds in Hillingdon to 54 beds across all our boroughs
Specialist hospice inpatient unit beds	57 beds are needed to meet future need. Improve access to them by increasing hours in which people can be admitted

 Outpatient and wellbeing care	
Service	Service
Hospice MDT outpatient clinics	Increasing specialist clinics in Ealing and Hounslow to improve consistency
Dedicated bereavement & psychological support	A consistent care pathway in all boroughs offering one-to-one counselling and group sessions
Lymphoedema	Expansion of service to care for cancer and non-cancer patients

“What is important in the model of care is that the whole range of services are available to everyone in north west London meaning people can ‘step up’ and ‘step down’ between services as their needs change.”

4.1 The introduction of enhanced end-of-life care beds to support this approach

An innovative development that directly responds to resident concerns, is the proposed introduction of enhanced end-of-life care beds in all eight boroughs in north west London that will serve patients with a moderate level of need.

Many people do not realise that hospice inpatient services support short, intensive admissions to help stabilise pain or provide respite for families. Many do not die in an in patient hospice setting.

“Enhanced end-of-life care beds will help fill a gap in provision that local residents have identified, where patients need cannot be met at home, but they also do not need or meet the admission criteria for the highly specialist consultant-led inpatient hospice care.”

However, at present, in the majority of boroughs in north-west London, if in-patient hospice admission is not appropriate or necessary, and you do not wish to, or are unable to, spend your final days in your usual place of residence, including a care home, the current alternative is hospitalisation. Enhanced end-of-life care beds would provide an additional option.

Enhanced end-of-life care beds will be paid for by the NHS and supported by their local specialist palliative care team providing extra support and expertise. Benefits include:

- More beds closer to where people live making it easier for family and friends to visit
- Fewer people admitted to hospital at the end-of-life
- Keeping the highly specialist hospice beds for the patients with the most complex needs
- Meeting people’s preferences of preferred place of death
- Improving comfort and wellbeing at the end-of-life.

Figure 5 – Proposed number of enhanced end-of-life care beds per borough

Borough	2023 population	Proposed number of enhanced end-of-life care beds
Brent	353,690	9
Ealing	380,722	9
Hammersmith & Fulham	188,103	5
Harrow	270,741	7
Hillingdon (existing beds)	315,198	8
Hounslow	300,880	7
Kensington & Chelsea	145,328	4
Westminster	211,814	5
North west London total	2,166,475	54

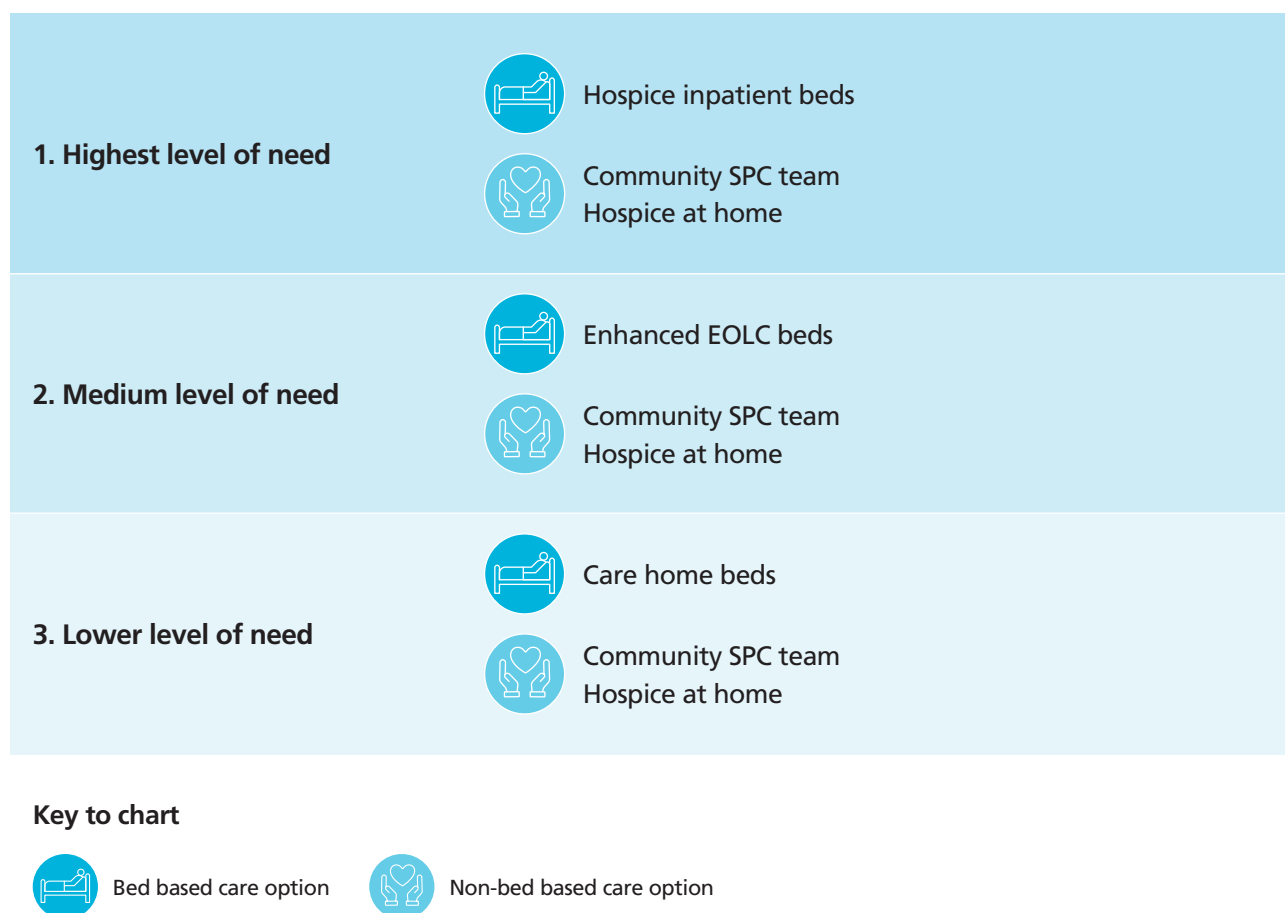
There are currently eight enhanced end-of-life-care beds in Hillingdon. Based on this number and the population of each borough we are proposing the introduction of 46 additional end-of-life care beds meaning 54 in total.

Given the geography of north west London and availability of sites, some shared work across boroughs could be possible to give improved access for residents.

“During our engagement we were told many times that there was nowhere for people to go if they lived on their own and could not care for themselves. The introduction of enhanced end-of-life care beds across all boroughs in north west London responds directly to this.”



Figure 6 – Summary of levels of need for bed-based adult community specialist palliative care



A proportion of patients who have specialist palliative care needs being supported by our community-based specialist palliative care services will also qualify for NHS continuing healthcare⁸. We recognise if needs change the patient may need to use an inpatient or enhanced end-of-life care beds.

Our new model of care proposes that adult community specialist palliative care services and teams work closely with NHS continuing healthcare teams to support eligible patients to access the right care at the right time. This could be in a hospice inpatient bed, enhanced end-of-life care bed or care home bed with support of fast track funding.

How the new model of care will work for north west London residents

About Susan⁹ – A case study

Susan is 78 years old and was diagnosed with dementia five years ago. She has a care plan and remains at home with the help of her husband and carer support three times a day from the council.

She currently receives general palliative care from her GP, community district nurses and the community mental health team.

She is now showing signs of entering the terminal phase of her illness and a review of her care plan by the generalist palliative care teams identifies additional complex needs including pain management and social factors.

She is referred to the adult community specialist palliative care team, part of the community specialist palliative care services in north west London to provide specialist support for Susan, her carers and the generalist palliative care team supporting her at home.

Current model of care

1. The adult community specialist palliative care team accept the referral but are unable to support Susan, her carers and general care teams at this time due to their current limited capacity and a need to prioritise more complex patients.
2. Susan's husband and the community teams providing generalist palliative care are unable to support her complex needs. As per her care plan Susan is taken to hospital when she deteriorates and needs extra care and support.
3. Susan is discharged and her care plan updated for increased social care support. The adult community specialist palliative care team ensure all available community support is now being accessed. The adult community specialist palliative care team visit and provide support for the complex care needs. The care plan includes a care preference for an inpatient hospice bed should her complex needs continue not to be met.
4. Susan, her carers and the community teams continue to struggle, and she is re-admitted to hospital as her deterioration was rapid and out of hours and the hospice was unable to admit her to an inpatient bed as they had to prioritise patients with more complex needs.
5. Sadly, she passes away whilst awaiting a care home.

See an animation that explains how the care Susan receives will improve.
<https://www.nwlondonicb.nhs.uk/get-involved/service-change/compassionate-care-all/about-susan-case-study>

⁸ www.nwlondonicb.nhs.uk/chc

⁹ About Susan is an illustrative example highlighting the impact on the care a patient would receive through the introduction of the model of care

Future model of care

1. Due to their increased hours, the adult community specialist palliative care team are able to support Susan with her increasingly complex needs, her carers and the community teams providing general palliative care. Her care plan includes guidance on complex need management.
2. At night when worried there is a 24/7 telephone advice line that Susan and her family can call so they are supported and provided with symptom management advice.
3. The adult community specialist palliative care services regularly review Susan, her carers and community teams changing needs. A multidisciplinary team (MDT) discussion and review of Susan's care plan is arranged by the community palliative care team with Susan and those involved in her care. All agree Susan would be best cared for and supported in an enhanced end-of-life care bed as she does not need nor meet the criteria for the most complex care and support that is provided in a hospice in patient specialist palliative care bed.
4. Susan, her carers and those involved in her care were involved in the MDT and care plan. Susan is transferred to an enhanced end-of life bed. Where her long-term complex needs can be met.
5. Susan was safe, comfortable and supported and her family were able to be with her in her final days.



4.2 What we expect to be the benefits of delivering the new model of care?

Our residents have engaged with this work because they believe it will improve the experience of our residents, carers and those who are important to them.

Figure 7 – The benefits of delivering the agreed model of care

Benefit	Outcomes which deliver this benefit	Description of how the preferred option best delivers the outcomes and benefits of the agreed model of care
Improved quality of life for people at the end-of-life	Improved patient and carer experience	• equalising the services available at borough level by levelling up is expected to improve patient experience • better information sharing among providers of adult community specialist palliative care services, will improve the delivery of joined up care including the use of the London Universal Care Plan • improving the training of staff to include cultural competency, the services will be more responsive to the needs of our diverse communities such as religious beliefs.
	Care is aligned to individual's needs (improved personalisation)	• By delivering holistic needs assessment as part of personalised care planning, the needs of patients, their carers and families are reflected in the care provision arranged • By delivering the full model of care, services will be equipped to respond to the personalised needs of individuals through extended hours and weekend provision.
	Inequalities of adult community specialist palliative care provision are addressed	• Addressing gaps in provision among our boroughs as well as introducing improvements to the overall care model will address inequalities in provision • The Equality Health Impact Assessment (EHIA) for this option consistently assessed as improving provision for all nine protected characteristic groups and additional groups considered in our analysis.
	More people die in their preferred place of death. Fewer people die in hospital.	• Expansion of bed-based capacity through enhanced end-of-life care beds means patients who do not meet the stringent criteria for hospice inpatient care but are unable to be cared for at home, can receive care at the end-of-life in an alternative environment to hospital, with 24/7 access to care and input from the adult community-based specialist palliative care team • Utilising hospice inpatient capacity for those who have the most complex needs, means these individuals are not unnecessarily admitted to hospital due to lack of capacity • Increasing hours of provision of key services such as hospice at home and adult community specialist palliative care teams minimises the risk that deterioration in health condition leads to hospitalisation.

Benefit	Outcomes which deliver this benefit	Description of how the preferred option best delivers the outcomes and benefits of the agreed model of care
Improved value for money	Care is aligned to individual's needs (improved personalisation)	• By better understanding the care needs and circumstances of individuals needing adult community-based specialist palliative care through holistic assessment, we ensure the patient and their family receive the right care and support, in the right place • Delivery of more care at home and in less acute settings represents better value for money which supports the long term financial sustainability of adult community-based specialist palliative care services.
	Inequalities of adult community-based specialist palliative care provision are addressed	• Actively addressing unmet need and supporting underserved populations will maximise our ability to prevent hospitalisation at the end-of-life and adverse outcomes including preventing deaths in hospital • Fully delivering the model of care addresses current inequalities in access uncovered during this work. Providing equitable access to care improves our ability to prevent unnecessary hospitalisation where possible • Providing enhanced end-of-life care beds in boroughs other than Hillingdon addresses the current inequality in north west London and provides alternatives to hospital care.
	More people die in their preferred place of death. Fewer people die in hospital.	• Providing greater access to non bed-based care such as adult community specialist palliative care nursing and hospice at home services through extended hours of provision means more people are successfully supported to die at home • Providing greater volume of enhanced end-of-life care beds capacity across our boroughs will support more people to die in their preferred place of death. Only a small number of people with the most complex needs require the support by hospice inpatient care and death at home is not always possible or preferred. This in turn is expected to reduce hospitalisation toward the end-of-life.

4.3 Key areas of concern we heard during engagement to date

As part of our work to define the new model, specific concerns were raised about:

- Travel and access to services (including the impact of Pembridge Palliative Care Inpatient Unit's suspension)
- Making sure our model of care meets changing population needs
- Making sure we have the right number and distribution of our hospice inpatient beds to meet future need.

The sections below summarise the approach we have taken to addressing these concerns as well as providing links to all published supporting modelling and planning documents.

Our communities also told us what was important to them when providing views on the draft model of care. We responded to the key themes (as detailed below) in the revised model of care.

4.4 How we will know there is good enough access to services

Access to services must be fair to all and also ensure there are reasonable and equitable travel times

Travel times and accessibility are important when considering any change to services. We used a tool developed by Transport for London to compare the average travel times by car and public transport at peak time travel to the nearest eligible hospice. We found:

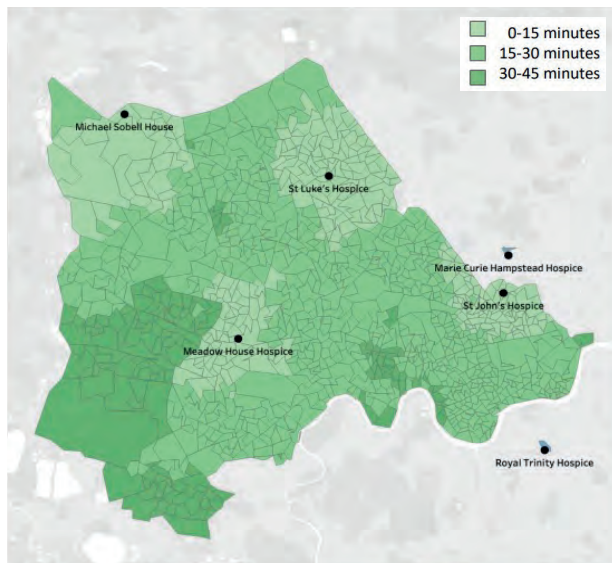


- On average it took all north west London residents 40 minutes by public transport and 19 minutes by car to get to their nearest hospice
- It was found that around a third of people (34%) can access their nearest eligible hospice within 30 minutes and 80% can access it in less than 45 minutes
- For those travelling by car, approximately 30% of people would incur a travel journey of 15 minutes or less and 90% would be travelling for 30 minutes or less.

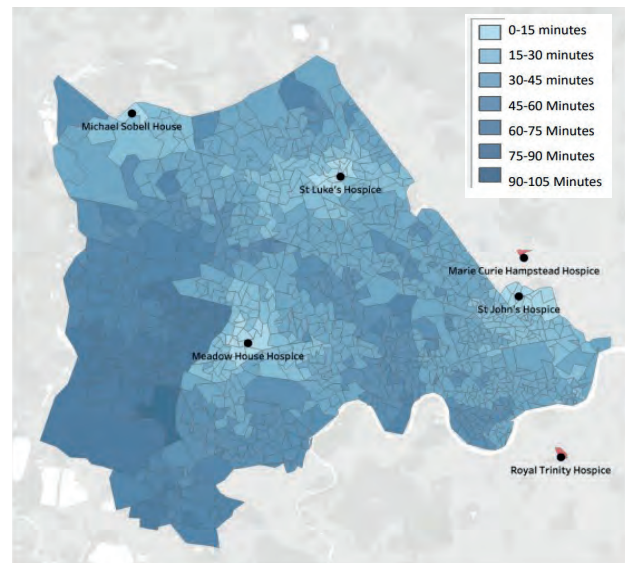
People living in the south of Hillingdon and Hounslow were found to have among the longest travel times to a hospice inpatient bed care unit because of the absence of available alternatives in the area.

Figure 8 – Travel journeys

Driving – Travel Bands (Peak)



Public Transport – Travel Bands (Peak)



Impact of Pembridge Palliative Care Inpatient Unit suspension on travel time

The suspension of Pembridge Palliative Care Inpatient Unit means that patients have to travel a little bit further to get inpatient care in one of our other hospices¹⁰.

We recognise that any permanent changes to the unit will mean longer travel for those who live in the local area. Whilst options include this potential outcome we recognise the strength of local feeling on this impact.

"If the closure were to become permanent it would lead to an increase in travel time for people living near Pembridge but is comparable to the times people are having to travel if they live in other parts of north west London."



¹⁰ NHS NW London travel mapping analysis

Figure 9 –Comparison of average travel times

		Average peak time travel Public transport	Average peak time travel Driving
Whole NWL population	Travel time to nearest hospice Inpatient unit (INCLUDING) Pembridge	40 mins	19 mins
	Travel time to nearest hospice Inpatient unit (EXCLUDING) Pembridge	43 mins	21 mins
Pembridge catchment only	Travel time to Pembridge	31 mins	17 mins
	Travel time to next nearest hospice (Pembridge closed)	31 mins	23 mins

Our analysis also shows that people living in the most deprived areas are not adversely impacted by travel times to their nearest hospice. The exception is Hillingdon where travel times for residents who live in the south of the borough using the Michael Sobell Hospice take at least 60 minutes to get there if they use public transport at peak time.¹¹

Each person's travel time is individual to them and the information in this document is an indication to help inform the consultation.



4.5 Making sure our model of care meets changing population needs

In order to make sure that the services that we were putting in place would meet likely demand over the next ten years we looked at population growth projections as well as how many people are going to die¹².

¹¹ [North west London community specialist palliative care hospice inpatient units travel mapping analysis](#)

¹² [Respond to future need - meeting the palliative care needs of NW London's changing population](#)

Figure 10 – Summary findings of our population modelling

Summary findings	Implications for how we implement the model of care
- While the overall population is set to grow by 5%, the 65+ age group population is set to grow by 30% over a ten-year period. - Greatest percentage growth in north west London can be seen in Brent, Ealing, Hammersmith & Fulham and Hounslow. - Mortality across all ages grows by 5.5% over a ten-year period (based on ONS data).	Our service planning needs to reflect increase in annual mortality in north west London.
9.5% of households in north west London are reported to be one-person households with the resident aged 66+ years. This means that, while most potential patients do not live alone, a significant number do.	- Where choices and decisions about preferred place of care are needed and there is a reliance on carer support, additional help will be needed to support those without household support. - Growth in single person households may place additional requirements on keeping people safely cared for in their homes. Use of technology and remote monitoring are likely to be needed to maintain care at home.

4.6 Making sure we have the right number and distribution of our hospice inpatient beds to meet future need

Hospice inpatient beds serve the small number of people with most complex needs. Those requiring 24/7 care in a dedicated unit, supported by specialist teams. Currently, there are 57 beds being used in north west London. 13 beds at Pembridge Palliative Care Inpatient Unit were suspended in October 2018 and we use three additional beds at other hospices when needed.

A joint clinical audit of hospice inpatient admissions was conducted in 2022, covering all five hospices providing inpatient services to north west London found that 26% of patients could have had their needs met with alternative care such as nursing home care or enhanced end-of-life care beds. It meant that we would have had additional hospice inpatient beds available if these patients care had been supported in alternate care settings. Our analysis shows that the number of beds

currently being used would be sufficient to meet future demand for hospice inpatient care until 2027/28 and the beds at Pembridge Palliative Care Inpatient Unit are not needed to meet this future need.¹³

4.7 Ensuring the proposed model of care responds to what our communities have told us is important

In August 2023, we undertook public engagement to gather views and wider input from stakeholders about the proposed model of care. Overall there was widespread support for the proposed new model of care. We did hear some valuable challenges and constructive suggestions on how we might improve the model of care. These included the following key themes which have been responded to the revised model of care:

¹³ [Refreshed ten-year demand projections for hospice in-patient care](#)

More information about enhanced end-of-life care beds

People wanted more detail and a clearer explanation of how these beds would be used to meet the needs of patients and how they could be accessed.

They wanted assurance that these beds are a suitable and high-quality option for patients, rather than a possible sub-par substitute for traditional hospice inpatient care.

Addressing inequalities

People reported that there was a need to address disparities in access, outcomes and experiences of palliative care services. They wanted to make sure that all individuals, regardless of their background or circumstances, receive the same level of high-quality palliative care.

They wanted more to be done to take into account different communities, which considered geographic, socioeconomic, and cultural factors.

Enhance innovation and continue improvements to specialist palliative care services alongside the implementation of the new model of care

People strongly felt this was a starting point and there needed to be a commitment to improving the model of care by exploring innovative initiatives, drawing on local, regional and national pilots already underway. This meant considering areas where there is not currently robust evidence to support them being included in the current model of care that will be implemented following the consultation. This included:

- A care coordination service, facilitating better communication between various care providers, assist in ordering equipment and connecting patients with the right services
- Simplifying access to palliative and end of life care by developing a single point of access which would create an efficient and centralised system that benefits patients, caregivers, and clinicians
- Specialist palliative care multidisciplinary teams (MDT) providing hospice virtual ward care in the patient's own home
- Enhancing integration and access to community-based specialist palliative care support for clinicians and patients in emergency departments by creating improved referral pathways, ensuring a seamless transition between emergency departments and community specialist palliative care services
- Introducing palliative care rapid response teams that work within the hospital to support admission avoidance for palliative and end of life care patients, thus reducing unnecessary hospital admissions and providing timely and appropriate care.

Improved leadership and governance

Robust leadership and governance structures to guide the proposed changes and for improved accountability and sustainability within the new care model.

Improved navigation of services

Simplifying the complex journey through palliative care services and the wider health and care system for patients, families, carers and clinicians to make the services more accessible.

More seamless transition was also emphasised within community palliative care services (spanning both generalist and specialist care providers) and social care services, particularly at local “place” level.

This would be achieved by better communication and collaboration amongst all health and care professionals. This would support a more localised, patient-centred approach with named care coordinators (or a dedicated care co-ordination service to improve the overall patient experience and bridge gaps between generalist and specialist care).

Care co-ordination and integration of services

Seamless transitions between hospital and community services, through better integration and co-ordination from hospitals with hospital community specialist palliative care services.

Figure 11 – How the introduction of new model of care will improve partnership working across all areas

Sector	Care type	Impact of proposed model of care on this group
 Out of hospital care	Primary & community care teams	• Extend hours of provision will reduce some operational pressure on other community teams • 24/7 telephone advice available to clinicians to support care provision and decision support • Increased capacity to provide care at home (e.g. hospice at home) may result in marginal increase in GP and community nursing input
	Social care inc. care homes	• MDT working with social care input remains a key feature of the care model • Extended hours of provision will reduce some operational pressure on other community teams • Expansion of enhanced EOLC beds in NWL will reduce some homecare demand • Increase CSPC capacity to provide care at home (e.g. hospice at home) may result in marginal increase in homecare support
	VCSE	• Charitable hospice providers are significant partners in the provision of CSPC care across NWL • Charitable hospices have established links with other VCSE providers to support care delivery in their services
	Community pharmacy	• 24/7 access to end of life care/anticipatory medication in all boroughs of NW London
 Acute care	Acute palliative care	• Greater capacity to accommodate care in the community (through care at home and enhanced EOLC beds) is expected to reduce emergency admissions at the end of life, freeing up hospital capacity to manage other NEL activity and those with acute specialist palliative care needs
	LAS	• Fewer conveyances to hospital, although this is a low volume area

5. IMPLEMENTING THE NEW MODEL OF CARE

5

Having defined the new model of care, engaged across north west London and improved plans based on feedback, the next step was to explore the possible ways in which the model could be delivered. In line with good practice for service change proposals of this type, a range of possible implementation options were identified. An initial longlist of options was developed which built on the views of residents and staff that had been captured through our engagement processes.

Each of the 54 longlist options was assessed against hurdle criteria defined by the adult community specialist palliative care steering group. Four of these options passed all 'hurdle' criteria and were added to a baseline 'do nothing' option to create five shortlisted options. A number of engagement events with local residents occurred between mid-November and early December 2023, which are all viewable on our website¹⁴, on the five shortlist options, providing the opportunity to do the following:

- Enrich the options through input and feedback from families, carers, professionals and service providers. Making each of the options as detailed as possible allowed us to make the subsequent process to identify the preferred option as effective as possible.
- Ensure that no critical details have been missed, either in relation to the options themselves or, importantly, to the impact which they might have on specific north west London populations. This included, but was not limited to, those with protected characteristics.
- Enhance our understanding of the relative benefits, advantages and disadvantages of each of the options, and the weight of opinion behind each.



There was general support for the shortlisted options and we received no alternative suggestions for consideration.

Subsequent financial and non-financial appraisal of the shortlist options resulted in the identification of two higher scoring options. The outputs of financial and non-financial assessments are combined to provide an overall appraisal of the options. The non-financial appraisal was carried out by a specially convened panel of people with specialist knowledge of palliative care from within and outside North West London who were able to provide an impartial assessment. With each option there are trade-offs, risks and opportunities, which have been considered through the options appraisal process.

We are now consulting on these two highest scoring options to gather your views and feedback.

¹³ <https://www.nwondonicb.nhs.uk/get-involved/cspc/engagement-events-meetings-attended-and-11-conversations>

5.1 The service options we have considered for delivering the model of care

In order to carry out a more detailed analysis of the five shortlisted options, the adult community-based specialist palliative care steering group identified a set of criteria for each option to be assessed and scored against. These criteria were mapped to the eight key issues in our case for change alongside insights gleaned from engagement.

The final criteria were signed off by the steering group in January 2024 and are summarised below.

Objectives and criteria

1. Aligns to delivery of the agreed model of care
2. Meets the needs of the whole of the population
3. Provides the best access and more equal access to care for all residents in north west London
4. Will deliver a high quality and sustainable level of care
5. Has the greatest chance of being deliverable
6. Are we able to afford the services being described?

Options appraisal

The table below provides a summary of the outcomes from the options appraisal process.

Key

- X: does not meet objectives and criteria
- : partially meets objectives and criteria
Y: fully meets objectives and criteria



Figure 12 – The service options we have considered for delivering the model of care

Option	Actions	1	2	3	4	5	6	Ranking	Summary
0. No change	Continue with current provision of service provision with no levelling up and no overall increase in bed base	X	X	X	X	X	Y	5	Our options appraisal concluded that maintaining current levels of service was not acceptable if we were to deliver our ambition of improving the quality and access to care equally for all residents in north west London. The reopening of the Pembridge Palliative Care Inpatient Unit continues to be a challenge due to the shortage of available specialist palliative care clinical staff and the difficulty in recruiting a consultant.
1. Some change	Minimum workable solution with a focus on improving fairness of provision. Pembridge Palliative Care Inpatient Unit remains closed. This option would include the introduction of 54 enhanced-end-of-life care beds and maintaining the recommended level of highly specialist inpatient hospice beds	X	-	-	X	Y	Y	3	Our options appraisal concluded that this was a more easily deliverable option as it acknowledged the difficulty in reopening the Pembridge Palliative Care Inpatient Unit. However, it was less good as we would not be delivering the entirety of the model – and in particular not comprehensive services in patients own homes.
2. Some change	Minimum workable solution with a focus on improving fairness of provision. This option would include the introduction of 54 enhanced-end-of-life care beds. Pembridge Palliative Care Inpatient Unit reopens. In order to maintain the recommended level of highly specialist inpatient hospice beds we would decrease the number of beds used in other hospices in north west London	X	-	Y	X	X	Y	4	Our options appraisal concluded that this was a less easily deliverable option as it included the reopening the Pembridge Palliative Care Inpatient Unit and the difficulty that entails. We would also need to reduce the number of highly specialist inpatient beds in other hospices and this would result in less good access and increased travel times for the majority of the north west population. Lastly this option also does not deliver the entirety of the model – and in particular not comprehensive services in patients own homes

Figure 12 – The service options we have considered for delivering the model of care (continued)

Option	Actions	1	2	3	4	5	6	Ranking	Summary
3.Full implementation	The model of care would be fully introduced with Pembridge Palliative Care Inpatient Unit closed	Y	Y	Y	Y	Y	Y	1	Our options appraisal concluded that this option best met our set objectives and criteria. This would mean fully all services in the home, wellbeing services and new enhanced end-of-life beds are delivered – with the Pembridge unit remaining closed.
4.Full implementation	The model of care would be fully introduced but with Pembridge Palliative Care Inpatient Unit open	Y	Y	Y	Y	X	Y	2	Our options appraisal concluded that this option closely met our set objectives and criteria. This would mean fully all services in the home, wellbeing services and new enhanced end-of-life beds are delivered – with the Pembridge unit reopening. This options scored lower on deliverability reflecting the need for 35 additional new staff to be recruited.

5.2 Consulting on options

We have included in the table above details of all four shortlisted and the do nothing options to enable respondents to the consultation to understand the different trade-offs considered. We believe these options provide the opportunity for debate and weighing up of the relative benefits of different approaches.

We believe that 'do nothing' (option zero) and the options for partial implementation of the new model of care (options one and two) will not deliver the ambition we have for North West London residents and these are provided for information only rather than as proposed options we are consulting on.

We are consulting on two of the options (options 3 and 4 as outlined in the table above, which for the purposes of this consultation we are calling options A and B).

These options scored the highest in both non-financial and financial assessments, with option A being the highest scoring and, therefore, the preferred option.

Option A (preferred option): Full implementation of the proposed model of care with Pembridge Palliative Care Inpatient Unit beds not reopening

This option would fully implement the new model of care, including 46 new enhanced end-of-life care beds across north west London, while maintaining the existing 57 hospice beds without reopening the Pembridge Palliative Care Inpatient Unit. This option would be easier

and quicker to implement and benefit more north west London residents as a whole. We are confident that this model can be delivered within the agreed timescale. This option meets the agreed criteria and offers the most significant benefits for residents across north west London.

Option B: Full implementation of the proposed model of care with Pembridge Palliative Care Inpatient Unit beds reopening

This option would fully implement the new model of care, including 46 new enhanced end-of-life care beds across north west London, and reopen Pembridge Palliative Care Inpatient Unit beds. This would require a reduction in hospice beds elsewhere and have a longer implementation timeline due to the need to recruit specialist palliative care consultants and 35 additional staff.

The timescale for delivery is unclear, as there is little assurance that the necessary staffing, including specialist palliative care consultants and 35 additional staff members, can be recruited in a timely manner.

It is important to note that through engagement, new evidence may emerge that could influence this view. No decisions have been made, and NHS North West London remains open to considering both options A and B post-consultation.

Figure 13 – Changes you can expect to see

	What changes you can expect to see in the preferred option
Non bed-based services	• Community Specialist Palliative Care (SPC) nursing team available 12 hours per day (8am to 8pm), 7 days per week • 24/7 specialist telephone advice available to anyone • Hospice at home care service provided in all 8 boroughs up to 24-hours per day where needed. • Consultant-led and nurse-led hospice outpatient clinics available in all boroughs • Lymphoedema provision for non-cancer purposes in all boroughs • Improved access to psychological and bereavement services.
Enhanced end-of-life care beds	• Beds to be available in other boroughs and not limited to Hillingdon, where they are currently provided • These beds seek to prevent hospitalisation of people whose needs mean they cannot be cared for at home but do not require the onsite 24/7 care of a specialist team • They will improve comfort and wellbeing for people at the end-of-life.
Hospice inpatient beds	• We will retain 57 specialist hospice inpatient beds as this has been analysed to meet the needs of our population for the next five years • We will achieve this by closing Pembridge Palliative Care Inpatient Unit and retaining consultant-led inpatient hospice beds at all remaining hospices.

6. HOW TO GET INVOLVED AND NEXT STEPS

We want to hear from you – engagement to date has changed and improved our plans. There are many ways to give your views.



At every stage in the development of the model of care and this proposal, we have gathered ideas and views from residents, staff, partner organisations and community groups on how we can improve the depth and breadth of services available to deliver adult community specialist palliative care in north west London.

We are now carrying out a formal public consultation programme to inform a decision on whether either of the two options (options A and B) proposing full implementation of the new model of care for adult community specialist palliative care services should be progressed and how they could be improved.

We want to get the views of as many patients, residents, staff and partners as possible to inform our plans during our public consultation, commencing 18th November 2024.

The consultation is expected to last 14 weeks but we will have the option of extending this should it prove necessary. We will be reviewing the responses and feedback we receive on a weekly basis throughout the consultation period and will adapt our approach as required. To assist in this, we will also conduct an interim headline review in week nine of the consultation to inform any additional activity we may wish to undertake in the final quarter of the consultation period and to review whether any extension may be necessary.

6.1 Ways to take part in the consultation

Your views are important in making sure future services meet people's needs and are fair and accessible.

In order to ensure we hear from as many people as possible, we will be engaging in a range of ways throughout the consultation.

To give us your views and feedback on the two proposed options for delivery of the new model of care you can:

Complete our online questionnaire

Please let us know your comments and views on these proposals by completing the [online questionnaire](#).

This can be completed on a desktop computer or on a mobile device.

Complete a printed questionnaire

Please download and print off and complete the questionnaire and send to us using the Freepost address FREEPOST: HEALTHIER NORTH WEST LONDON.

Alternatively, we can send you a printed copy of the questionnaire if you contact us at nhsnwl.endoflife@nhs.net

Write to us

If you would rather write your feedback down without using our questionnaire, you can write your thoughts down in a letter or email.

If you are feeding back on behalf of an organisation, please state the name of the organisation in your correspondence. It is also helpful if you can let us know which borough you live in or the first part of your postcode, to help us analyse responses fully. Return postal letters to: FREEPOST: HEALTHIER NORTH WEST LONDON or email: nhsnwl.endoflife@nhs.net

Come to a public meeting

We are holding a public meeting in each borough and meetings at a north west London level. These provide an opportunity to meet with the programme team and other interested residents to find out more about our proposals, ask questions and give your views.

These events are discussions that give everyone the opportunity to participate.

To attend, you will need to book in advance, so that we can ensure we have adequate space and staff to hear everyone's views.

We are also holding 'drop-in' sessions in some of our hospices and other local community venues.

You get find event details on our website www.nwlonidonicb.nhs.uk/cspc

Invite us to speak to your group

You can also invite us to speak to your group. The programme team would be happy to come to speak to your group, answer questions and receive your feedback.

To arrange this, please contact the team by emailing nhsnwl.endoflife@nhs.net

Additional help to respond to these proposals

We can also provide support for those who may need some additional help to participate for example:

We offer translations and additional support if English is not your first language. We also offer versions of this consultation document in audio, large print, Easy-Read or Braille format, on request

We can offer support to participate if you have a learning disability or difficulty in communicating.

You can also provide feedback verbally by arranging a call with us.

More information

You can find more information about the public consultation on the NHS North West London website www.nwlonidonicb.nhs.uk/cspc.

Next steps following this consultation

Once the public consultation closes, all feedback and responses received will be collated and analysed by Third Sector Together (3ST), a local alliance of the voluntary and community sector across north west London. This will be incorporated into a post-consultation report which will be published on the NHS North West London website www.nwlonidonicb.nhs.uk/cspc.

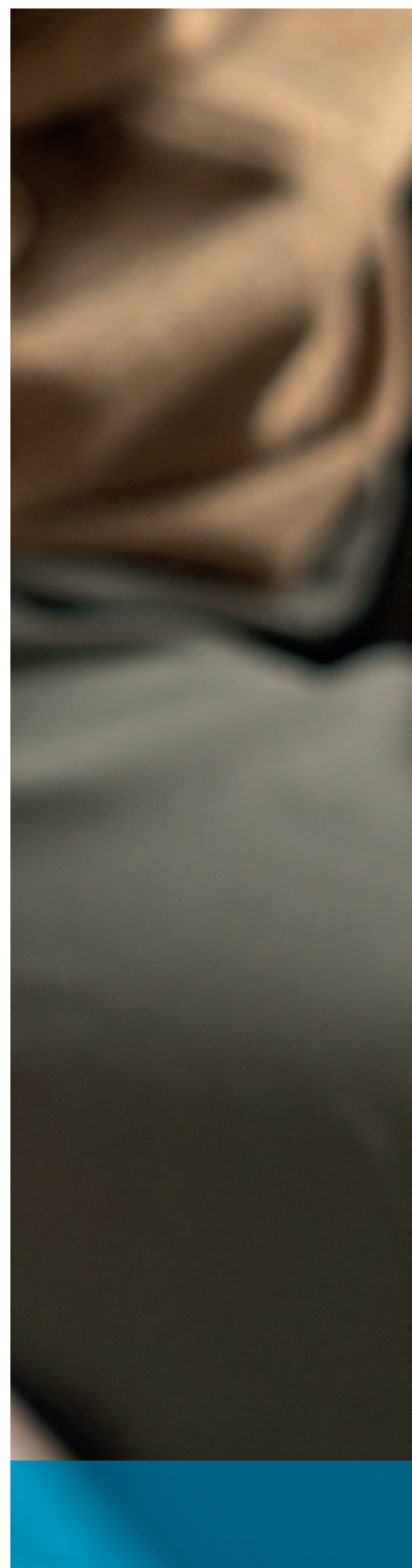
In determining the agreed option for implementation of the new model of care for adult community specialist palliative care, NHS North West London will consider the outputs from the public consultation and use this to inform the final decision.

No decisions about any changes to services will be made until after the full public consultation has taken place and all of the information, including the feedback from the consultation, has been considered.



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Adult Community-Based Specialist Palliative Care Services

Pre-consultation business case

18 November 2024

NHS North West London

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Document control

Document information

Pre-consultation business case	
Owner	Melissa Mellett, Associate Director UEC, NHS North West London
Status	FINAL

Revision history

Version	Date	Review
1.0		

Document sign-off

Approver/governance body	Date
London Clinical Senate	March 2024
NHS NW London Executive Group	March 2024
NHS NW London Planned Care Board	April 2024
NHSE Stage 2 Assurance	May 2024
NHSE Assurance sign off	October 2024

Executive summary

NHS North West London (NHS NW London) is presenting a proposal to improve adult (those aged 18 and over) community specialist palliative care (CSPC) provision across our eight boroughs.

What is community-based specialist palliative care (CSPC)?

Adult CSPC services are part of a larger group of services that support people at the end-of-life. They operate to support people away from hospital and are geared toward people who have complex and specialist needs that cannot be met by general services alone, such as general practice and community nursing. Instead, people with complex needs are cared for by a network of services which are staffed by clinician's and teams who have specialist skills and training in palliative care.

Adult CSPC services do not include generalist palliative care or acute hospital specialist palliative care services. However, both work closely with community-based specialist palliative care provision to provide the best outcomes for patients, families and carers.

Since 2021 we have been working with our population to examine the opportunities to improve CSPC for the benefit of patients, families and carers for adults. Through engagement with our communities, we established eight key issues that needed addressing. This forms our case for change. The proposed new model of care for these services was developed and recommended in 2023 by a model of care working group consisting of patients, clinicians and providers of care. The model of care was endorsed by a steering group and garnered strong support through stakeholder and public engagement. This triggered a series of activities which have led to this proposal. In addition, in late 2023 Marie Curie was forced to close their Hampstead site due to an estates issue and have since given notice to NHS NW London. This business case confirms the ending of commissioning of services for Brent residents from Marie Curie.

Establishing the new model of care for CSPC provision in north west London

We have listened and worked with communities to develop a model of care that works for our needs while reflecting good practice and evidence. Our new model of care was tested with the public in 2023 and received strong local support.

The model of care recommends the common provision of CPSC service in all boroughs:

1. Care at home (adult community specialist palliative care nursing teams, hospice at home and 24/7 specialist telephone advice)
2. Community specialist inpatient beds (hospice inpatient beds, enhanced end-of-life care (EoLC) beds)
3. Hospice outpatients (including lymphoedema, psychological and bereavement services), hospice day care and wellbeing services.

This means introducing new services to boroughs where there are gaps. In others, it involves extending hours of provision so there is a consistent offer for all residents, underpinned by good advance care planning. Additionally, the model of care recommended a set of enablers to support workforce training and development to improve the provision of personalised care. Enabler work intends to improve partnership working and improve integration of services and pathways.

The purpose of this pre-consultation business case (PCBC) document is to:

- Summarise the case for change in north west London
- Provide a synopsis of the model of care and how this was developed
- Describe the anticipated benefits of the model of care and how they address issues identified in the case for change
- Describe how we have engaged our stakeholders until now and how we intend to engage in future.

- Describe how we established the widest possible set of ways in which the model of care could be delivered
- Detail the process, analysis and outputs that allowed us to move from a longlist to a shortlist and to a preferred option
- Analyse affordability and financial impacts associated with the preferred option
- Set out the process for seeking approval
- Describe the next steps for testing the preferred option through engagement or public consultation
- Outline approach to implementing the preferred option following potential consultation.

This document reflects information and analysis known at this time. The content may change based on new information made available.

How we established the widest set of implementation options we could consider

Having articulated 'what good provision looks like' through the agreement of the model of care, we established a framework to elicit the widest set of options for how we could implement the new model of care.

We considered three questions:

1. How much of the non bed-based services described in the model of care can we implement?
2. How many enhanced EoLC beds can we provide?
3. How much hospice inpatient care is provided and where it is located?

We identified 54 options that it was possible to implement.

How we reduced this to a set of feasible implementation options we could assess further

In 2022, the steering group agreed a set of hurdle criteria. These were adapted to be pass-fail criteria and applied to the 54 options. Variables that succeeded in passing the hurdle criteria included:

- Partial and full delivery of the non bed-based services in the new model of care
- The provision of enhanced EoLC beds in other boroughs
- Retaining 57 hospice inpatient beds with or without the inclusion of beds at the Pembridge Palliative Care Centre Inpatient Unit.

This resulted in five implementation options being shortlisted and taken forward for detailed analysis.

How we compared the shortlist to arrive at the most likely implementation option that will maximise benefit for north west London residents

The options were analysed in two parts:

1. A non-financial assessment where we compared options to see how they:
 - Deliver against the model of care and national standards
 - How well they address inequalities
 - How well they represent quality of care and improve access. We also analysed options for how deliverable they are.

The analysis was shared with a specially convened panel consisting of local, regional and national representatives with a variety of expertise including patient perspectives, clinicians and subject matter experts in palliative care. The panel deliberated the evidence and scored the options. Pre-agreed weightings were applied to arrive at a final comparative score for each option.

2. A financial assessment where we considered the costs and benefits associated with each shortlisted option.

The two assessments form some of the sources of evidence the NHS NW London Board will use to support its decision making, alongside the other evidence including feedback from consultation.

The likely most impactful implementation option for the new model of care

This business case includes details of the five shortlisted options that we have progressed through financial and non-financial assessment. We believe these options provide the opportunity for debate and weighing up of the relative benefits of the different approaches.

We are formally proposing that we consult on two of these options. These options scored highest in our assessment, both individually in the non-financial and financial assessments and collectively.

We believe that 'do nothing' and options for partial implementation of the new model of care will not deliver the ambition we have for north west London residents. Accordingly, we have provided information on these options for information to inform feedback rather than as proposed options that we are consulting on.

The preferred option emerging at this stage, based on the input of our stakeholders and engagement activities at every stage, is described below. It is important to note that through consultation new evidence may emerge that changes this view. No decisions have been or will be made on options until consultation has taken place and NHS NW London are receptive to receiving feedback on any feasible options that we can consider.

The option that has been assessed as fulfilling the agreed criteria and delivering widest benefit for residents in north west London is for full delivery of the non bed-based model of care and opening enhanced EoLC beds in all boroughs and the retaining of 57 hospice beds by closing the currently suspended Pembridge Palliative Care Centre Inpatient Unit.

Table 1: Changes you can expect to see in the preferred option

	Changes you can expect to see in the preferred option
Non bed-based services	• Community Specialist Palliative Care (SPC) nursing team available 12 hours per day (8am to 8pm), seven days per week • 24/7 specialist telephone advice available to anyone • Hospice at home care service provided in all eight boroughs up to 24-hours per day where needed • Consultant-led and nurse-led hospice outpatient clinics available in all boroughs • Lymphoedema provision for non-cancer purposes in all boroughs • Improved access to psychological and bereavement services.
Enhanced EoLC beds	• New beds to be available in other boroughs and not limited to Hillingdon, where they are currently provided, increasing from 8 to 54 beds across north west London • These beds seek to prevent hospitalisation of people whose needs mean they cannot be cared for at home but do not need the 24/7 care of a consultant led specialist team in a hospice bed • They will improve comfort and wellbeing for people at the end-of-life.
Hospice inpatient beds	• We will retain 57 specialist hospice inpatient beds as this has been analysed to meet the needs of our population for the next five years. • We will achieve this by closing the currently suspended Pembridge Palliative Care Centre Inpatient Unit and retaining the consultant led inpatient beds at all remaining hospices.

The benefits expected from delivery of this preferred option are:

- Improved quality of care
- Improved outcomes at the end-of-life for patients, families and carers
- Value for money.

Following completion of the public consultation, a final preferred option will be confirmed. We would then expect to develop key performance indicators that would track delivery of the intended benefits.

The next steps for public consultation

Given our ongoing commitment to engage the public, and the strong public interest in this work, we will be going to formal public consultation on the two options, both fully implementing the model of care. Following consultation, we will then prepare a full decision making business case for consideration by NHS NW London before commencing implementation of the new model of care.

1. The current position

Palliative care services are designed to address and meet the health and care needs of people with a terminal diagnosis and/or fewer than 12 months left to live. Adult community-based specialist palliative care (CSPC) services deliver for such patients with specialist needs in hospices and the community (in their usual place of residence including their own home, care home or sheltered housing), and support relatives, carers and people who are important to them.

1.1 National context

The UK Parliament published a research briefing in July 2022¹. It summarised the following position:

“Palliative and end-of-life care are increasingly in demand as people are living longer and with multiple long-term conditions. However, an estimated 100,000 people in the UK that could benefit from palliative care die without receiving it each year. There is substantial evidence that inequalities in access to palliative and end-of-life care relate to various sociodemographic factors. Experts have highlighted that access to palliative and end-of-life care may improve quality of life for patient and family and reduce symptom burden.”

Demand for palliative and end-of-life care is increasing due to people living longer and with increasingly complex needs. The UK's population is ageing, and it is estimated that by 2050, one in four people will be aged 65 years or over. In England and Wales, by 2040, demand for palliative care is expected to increase by 25% to 47%.

The 2019 NHS Long Term Plan committed to improving personalised palliative and end-of-life care for people of all ages and to address health inequity. In 2022, integrated care boards (ICBs) received statutory guidance making them legally responsible for commissioning palliative and end-of-life health services that meet their population needs. As a first step, the guidance requires ICBs to undertake a gap analysis of local care against the six ambitions set out by the National Palliative and End-of-life Partnership²:

¹ [Palliative and end-of-life care - POST \(parliament.uk\)](https://www.parliament.uk/research-briefings/crips-09-2022/)

² [ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf \(england.nhs.uk\)](https://www.england.nhs.uk/longterm/ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf)

Figure 1: Ambitions for palliative and end of life care

Ambition 1	Ambition 2	Ambition 3	Ambition 4	Ambition 5	Ambition 6
Each person is seen as an individual	Each person gets fair access to care	Maximising comfort and wellbeing	Care is coordinated	All staff are prepared to care	Each community is prepared to help

ICBs are then required to specify what needs to be in place to deliver high quality end-of-life care for their population, ensure there is sufficient provision and undertake an equalities health impact assessment and action plan for people at the end-of-life.

1.2 Local context

North West London Strategy

Our strategic priorities align with our commitment to assess and enhance CSPC provision by introducing a new care model, as detailed below. The process by which we developed our model of care is described in more detail in [chapter 3](#).

As of April 2024, 35,593 NW London residents are at their last phase of life which represents 1.52% of the NW London population. From April 2023 – April 2024, 4,352 north west London residents deceased who had a Universal Care Plan (UCP). On average, 67.9% of these patients died in their preferred place of death where their preference was recorded on the UCP.

We are working actively to increase uptake of the UCP which is key to ensuring we capture people's choices, and are able to track whether we meet these stated preferences. The numbers referenced above suggest we have considerable work to do to widen reach for anticipatory care planning in order to better meet the needs of our local population. This new model of care supports both these aims.

Table 2: How the CSPC programme links with strategic priorities of the ICS

North West London Strategic Priority	How CSPC review of adult services responds to strategic priorities of the ICS
Support health and wellbeing for our population	The programme has reviewed provision of services at the end-of-life from the perspective of patients, carers and families. The resulting model of care sets out how we will support all of these groups, in line with local needs and best practice for these services.
Address unwarranted health inequalities	The programme has examined the variation in adult CSPC provision within our boroughs. Our model of care sets out how we will reduce inequality of provision and ensure high-quality services across all boroughs.
Improve access to care	In addition to ensuring equitable access to high-quality services (see line above), we have assessed the accessibility of our inpatient services to ensure that this is not adversely affected by other changes.
Keep people at home wherever possible and ensure far more integrated/joined up services, particularly for our older people	Our model of care includes a comprehensive suite of home-based and community-based palliative care services, including 'hospice at home' provision, alongside hospice inpatient services. It also includes holistic assessment of patient needs, and subsequent co-ordination of care provision, by a specialist palliative care team.
Support babies, children, and young people to lead happy and healthy lives, and	Not applicable. This programme relates only to adults.

become happy and healthy adults	
Ensure our health and care system is as productive and high quality as it can be	As part of the programme, we have assessed both what CSPC services should be provided in north west London to ensure high-quality care, and what level of provision will be needed to meet population needs (ensuring value for money).

Locally commissioned services

The map of provision is a complex arrangement of commissioners, including lead commissioner arrangements, and providers. These providers have mixed funding models:

- **NHS funded providers** - Central London Community Healthcare NHS Trust (CLCH), Central and North West London NHS Foundation Trust (CNWL) and London North West University Healthcare NHS Trust (LNWT).
- **Combined NHS and charitable funded providers** - St Luke's Hospice, Harlington Hospice, Royal Trinity Hospice and St John's Hospice.

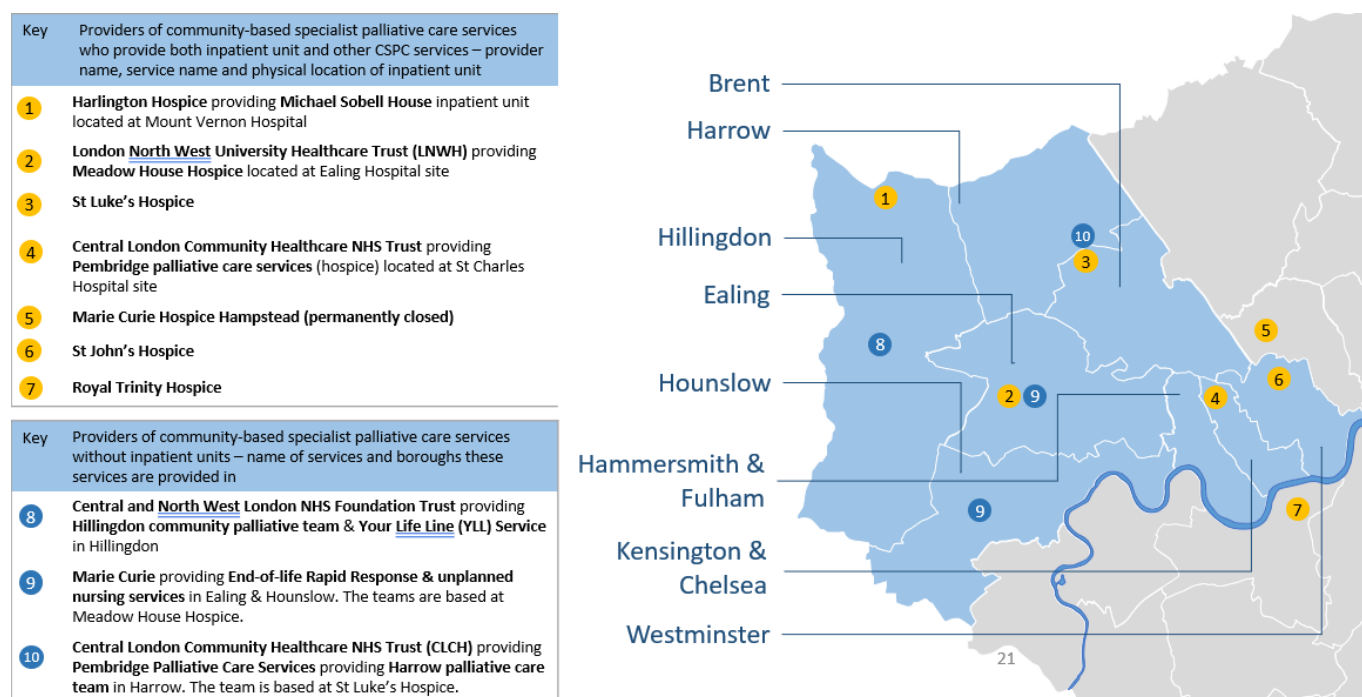
The link between service providers and our eight boroughs is described below:

Table 3: NW London CSPC provision by borough *Table 3NW London CSPC provision by borough*

Borough	North west London's commissioned CSPC service providers by borough
Brent	• St Luke's Hospice • Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services including hospice inpatient care (which is currently suspended). • St John's Hospice
Ealing	• London North West University Healthcare NHS Trust providing Meadow House Hospice
Hammersmith & Fulham	• Royal Trinity Hospice • Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services • St John's Hospice
Harrow	• St Luke's Hospice • Central London Community Healthcare NHS Trust providing Harrow Community Palliative Care Nursing Team services
Hillingdon	• Harlington Hospice (including provision of Michael Sobell House inpatient unit at Mount Vernon Hospital) • Central and North West London NHS Foundation Trust
Hounslow	• London North West University Healthcare NHS Trust providing Meadow House Hospice
Kensington & Chelsea	• Royal Trinity Hospice • Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services • St John's Hospice
Westminster	• Royal Trinity Hospice • Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services • St John's Hospice

Provider landscape

Figure 2: NW London Palliative Care provider landscape



Central London Community Healthcare NHS Trust (CLCH)

CLCH is an NHS funded trust and the largest community healthcare organisation in London, providing community healthcare services across north west London, south west London and services in Hertfordshire. CLCH is split over three hospitals and 100 plus clinics and locations. Until 2018, CLCH provided 13 hospice inpatient unit consultant-led beds located at Pembroke Palliative Care Centre which is on the St Charles Centre for Health and Wellbeing site in North Kensington. These inpatient beds were suspended in October 2018 due to inability to provide safe and consistent consultant care. In response, NHS NW London have arranged for alternative hospice inpatient provision to be provided for patients in this catchment area through other providers such as St John's hospice, St Luke's hospice and Royal Trinity Hospice, through spot-purchase arrangements.

CLCH remains host to other CSPP services including Community Specialist Palliative Care (SPC) Nursing Teams in Harrow and South Brent, Hammersmith & Fulham, Kensington & Chelsea and Westminster, and day hospice services, outpatient's services and a 24/7 specialist palliative care telephone advice line in South Brent, Hammersmith & Fulham, Kensington & Chelsea and Westminster. All these services have continued to operate as usual following the suspension of the inpatient unit (IPU).

The closure of Pembroke Palliative Care Centre Inpatient Unit was of huge concern for local residents. But the timing of the closure which was followed relatively quickly with the Covid pandemic meant the impact was different than could have been predicted. During the initial months of the pandemic across community services we saw many more people supported to remain at home rather than in inpatient settings. This was true for all services but means that the closure did not have the expected impact. We have always been able to offer patients who would otherwise have gone to Pembroke Palliative Care Centre Inpatient Unit care at our other hospice inpatient units. We have done this by spot purchasing care in other units seeking to offer choice wherever possible. We have also increased community team provision in the affected areas.

London North West University Healthcare NHS Trust (LNWH)

LNWH is an NHS funded trust, providing acute hospital and community healthcare services across Brent, Ealing, Harrow and Hillingdon. LNWH is split over four hospitals and a hospice site, as well as four health centres and a clinic location. LNWH's hospice Meadow House, is a 15-bedded consultant-led

IPU, commissioned entirely for north west London patients and provides CSPC services in Ealing and Hounslow. In addition to IPU services, Meadow House also provides a community SPC nursing team, day hospice services, outpatients and 24/7 specialist palliative care telephone advice line.

Central and North West London NHS Foundation Trust (CNWL)

CNWL is an NHS funded trust providing community health and mental health care to an area covering a third of London's population, Milton Keynes and other locations. CNWL is spread across nine hospital and inpatient facilities and in excess of 100 clinics and health centre locations. CNWL provide the adult community-SPC nursing team for Hillingdon residents (Monday to Friday 9am to 5pm). CNWL also provide the Hillingdon Your Life Line 24 (YLL) service which provides weekend and out-of-hours adult community SPC team cover and rapid response visiting (for known patients only) to Hillingdon service users. Provision of the 24/7 specialist telephone advice line service is a crossover arrangement between CNWL's YLL and the Michael Sobell House inpatient unit services.

Harlington Hospice (including Michael Sobell House inpatient unit)

Harlington Hospice is a partially NHS and partially charity funded hospice located in Hillingdon. They provide IPU services from the Michael Sobell House Inpatient Unit (MSH) based at Mount Vernon Hospital in Hillingdon. MSH is a 10-bedded consultant-led hospice inpatient unit commissioned entirely for Hillingdon patients. In addition to IPU services, MSU also provides day hospice services, outpatient services and specialist telephone advice services. Harlington Hospice also provide other non-bed based CSPC services, including hospice at home, well-being and lymphoedema services in Hillingdon, with another site location in Hillingdon called Lansdowne House. Harlington Hospice working closely with CNWL also currently provide eight enhanced end-of-life care home beds located between two nursing homes in Hillingdon (Parkfield Nursing Home and Hayes Cottage Nursing Home).

Royal Trinity Hospice (RTH)

RTH is a partially NHS and partially charity funded hospice located in Clapham Common, providing specialist palliative care services to Hammersmith & Fulham, Kensington & Chelsea and Westminster in north west London, in addition to a number of South West London and South East London boroughs (Lambeth, Richmond upon Thames and Wandsworth). The hospice has a 26-bedded IPU, although only seven of these beds are commissioned by NHS NW London. RTH also provides adult community SPC nursing team, day hospice, outpatients, bereavement support and 24/7 advice line services to service users across the same north west London geography as its IPU. Owing to RTH not providing this service, Kensington & Chelsea and Westminster service users receive hospice at home services from St John's Hospice. Hammersmith & Fulham service users do not receive any hospice at home services at this time as these services have historically not been commissioned for the borough.

St John's Hospice (SJH)

St John's is a partially NHS and partially charity funded hospice located in St John's Wood, providing specialist palliative care services to services users in Brent, Kensington & Chelsea, Hammersmith & Fulham and Westminster in north west London. The hospice also provides care to North Central London. The hospice has a 19-bedded inpatient unit, of which nine are commissioned by NHS NW London. SJH also provides service users with:

- Day hospice and 24/7 specialist telephone advice line services in Hammersmith & Fulham, Kensington & Chelsea and Westminster
- Adult community SPC nursing team, outpatient and hospice at home services in Brent, Kensington & Chelsea, Hammersmith & Fulham and Westminster.

Marie Curie London – Hampstead service permanently closed but commissioned until quarter three 2023/24

Marie Curie Hampstead Hospice was a partially NHS and partially charity funded hospice located in Hampstead, providing specialist palliative care to Brent residents. The Hospice predominantly provided care to people living in North Central London. It had a 28-bedded IPU, of which one bed was commissioned by NHS NW London. It also provided outpatient and well-being services to services users in Brent. Following an issue with RAAC (Reinforced Autoclaved Aerated Concrete) the service was forced to be suspended and Marie Curie have now confirmed this suspension is permanent.

Marie Curie London nursing team continue to provide planned variable overnight nursing and rapid response services in Ealing and Hounslow.

St Luke's Hospice (SLH)

St Luke's Hospice is a partially NHS and partially charity funded hospice located in Harrow, providing CSPC services in Brent and Harrow. The hospice has a 12-bedded specialist hospice inpatient unit, all of which are commissioned by NHS NW London for all Brent and Harrow residents. SLH also provides adult community SPC nursing team services to North Brent residents only.

In addition, they also provide day hospice, outpatients, well-being, hospice at home and 24/7 telephone advice line services (St Luke's Pall24 Service) to residents of Brent and Harrow.

Additional palliative care service providers

In addition to these CSPC service providers, there are other in north west London who provide support including:

- **Acute hospitals:** four acute hospital trust (Chelsea and Westminster Hospital NHS Foundation Trust, The Hillingdon Hospital NHS Foundation Trust (THHT), Imperial College Healthcare NHS Trust (ICHT), London North West University Healthcare NHS Trust (LNWT) provide acute consultant led inpatient palliative care services and can refer directly to the various CSPC services.
- **Residential and nursing care homes:** these two types of care serve as a usual place of residence for patients with both generalist and specialist palliative and end-of-life care needs. Specialist end-of-life patients are supported by CSPC services, as required, directly within care homes but also via training and telephone advice lines. Hayes Cottage Nursing Home and Parkfield Nursing Home in Hillingdon have eight enhanced nursing home beds for patients who need palliative care support provided by Harlington Hospice and CNWL. The nursing home staff have received additional palliative training care to support palliative and end-of-life patients.
- **Primary care:** primary care supports the bulk of end-of-life patients who have general palliative care needs. They also work closely with CPSC providers to support more patients with more complex needs. GPs operate as a key point of interface for palliative care patients in north west London and refer directly into the various CSPC services.
- **Continuing health care (CHC) funded care:** CHC funded care provides NHS funded social care for patients with long-term complex health care, including fast track care and expediting the installation of care services. Both generalist and palliative care patients can access CHC care and receive generalist support for care needs.

1.3 Funding arrangements for hospice services

Nationally, it is estimated that the hospice sector supports in excess of a quarter of a million people. As of 2020, hospice expenditure was £1.6 billion (£1 billion on care), an increase of 4.2% compared to 2019. Growth in expenditure exceeded both the rate of spending on the rest of the health sector and inflation, representing an increase in the expansion of people being cared for. Correlation between palliative care need and deaths, the latter predicted to grow nationally by 7% over the next five years, will inevitably result in a growth in the amount spent on palliative care.

The CSPC economy is mixed with NHS and charity funded services. Providers are either:

- Operating as part of an NHS trust and are entirely NHS funded (approximately one in 10 hospices)
- Charitable and receive mixed income from NHS funding and charity funding.

In 2020, charitable hospices in London received 49% of income from the NHS. This was above the England average of 36%, and 4% higher than 2019, owing to additional emergency funding being given to hospices during the coronavirus pandemic. We also need to consider:

- All NHS NW London contracts for adult CSPC service provision are due to expire in March 2025.
- Funding and contracts are based on historic arrangements rather than a clear assessment of need or a specific tariff
- Statutory NHS funding for three providers in north west London are from more than a single ICS
- Costs for the provision of adult CSPC services vary between providers, not least in the cost for inpatient consultant-led hospice beds
- Charitable funding activities form a core part of income generation and spend for hospices. Due to charitable income generation, charities are co-funders of adult CSPC services alongside NHS NW London.

2. The case for change

In late 2021, NHS NW London set out the reasons we needed to improve and increase the level of CSPC for adults (18+ years) in an [Issues Paper](#) and highlighted that it is the most fragile part of the palliative and end-of-life care services in north west London.

We identified eight key issues that needed to be addressed, to do so:

1. We must respond to growing levels of need and changing population preferences.
2. We need to address inequality of provision between our boroughs - making sure that everyone receives the same level of care, regardless of where they live.
3. We need to reduce health inequalities.
4. We need to make care more joined up and easier to navigate.
5. We must respond to feedback and engagement and build on previous work.
6. We must make sure our services are aligned to nationally recommended standards and evidence.
7. We must ensure that our services are financially sustainable, both now and in future.
8. We must be able to recruit and retain a suitably skilled workforce, both now and in the future.

2.1 We must respond to growing levels of need and changing population preferences.

Numbers of deaths in north west London are expected to rise sharply in future years, driven by changing demographics.

North west London population is expected to grow by 5% over the ten-year period between 2023 and 2033. However:

- Nationally 85% of deaths occur in people over the age of 65 years³. In north west London, the 65+ population is expected to grow by 30% over the same ten-year timeframe. This is a much faster rate than the overall population.
- Approximately 55% of deaths occur among the 80+ population. This group is expected to grow by 32% in north west London.

In 2023, we recorded 12,368 deaths across the eight north west London boroughs (0.48% of the north west London population). We expect annual deaths to increase to 14,587 by 2033. This is impacted by an ageing population and population growth and is based on the pattern of change modelled nationally⁴. Not all deaths would have been individuals who needed CSPC care at the end-of-life.

In February 2023, we had identified 31,000 people as potentially needing some degree of palliative care based on GP data. Given a degree of unmet need, we estimate a further 900 may not be included here. This does not represent CSPC demand, which is a subset of this number.

People's preferences for place of death are often not being met

According to national data (see Figure 3 below), the current statistics for north west London show that approximately half of people (48%) die in hospitals, 5% die in hospices, 12% die in care homes and 28% die at home. These figures are consistent with the data observed in London as a whole.

While preferences on place of death have not been collected locally, the National Survey of Bereaved People (2015)⁵ suggested 81% of people wished to die at home. 8% of people stated a preference for a hospice, 7% for a care home and only 3% for a hospital.

³ Monthly figures on deaths registered in England and Wales, ONS, August 2022

⁴ ONS Deaths Data

⁵ National Survey of Bereaved People (VOICES - Views of Informal Carers - Evaluation of Services), England, 2015

Figure 3: Place of death by area compared with preference

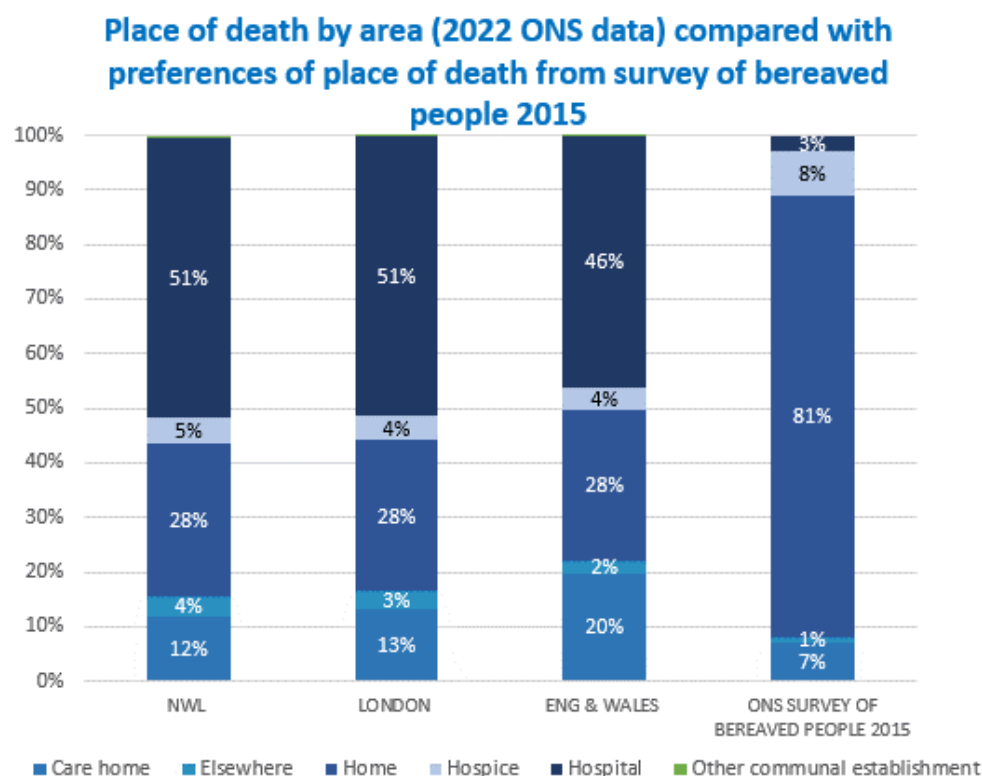


Figure 3: Place of death by area, and preferred place of death (Source, ONS 2022)

During the engagement, we received feedback from north west London specialist clinical teams that some patients using hospice inpatient beds did not need the highest level of consultant led specialist support but were there because there was nowhere else for them to go.

They indicated that these patients could receive more appropriate care in a different bedded care setting (for example a nursing home bed or enhanced end-of-life care bed if these were available across north west London). A joint clinical audit of hospice inpatient admissions was conducted across all five hospices (charitable and NHS Trust) currently providing inpatient bed services to north west London.

Of the 76 sampled admissions (review of consecutive hospice admissions across five inpatient units in mid- January 2023), 26% were determined to have been more appropriate to have their needs met with alternative care such as nursing home care or enhanced end-of-life care beds, if this second type of provision was available in the community.

These findings validate the need to introduce enhanced end-of-life care beds as part of our new model of care. This will not only optimise hospice inpatient bed capacity and usage to support those who need it most, but, more importantly, it will offer a wider and more appropriate range of specialist palliative care bed options in the community, ensuring appropriate care at every stage of our patients' palliative journey. It may also help avoid unnecessary or inappropriate admissions into hospital.

2.2 We need to address inequality of provision between our boroughs - making sure everyone receives the same level of care, regardless of where they live.

Our population currently has access to different CSPC services depending on where they live. Key differences between our boroughs include:

Table 4: Differences in CSPC provision by borough

Borough	Notable differences in adult palliative care provision, compared to other north west London boroughs
Harrow	- The Community Specialist Palliative Care Nursing Team service is available only five days per week. Elsewhere in north west London, it is available seven days per week. - People with lymphoedema needs for non-cancer reasons are not able to access treatment. Elsewhere, lymphoedema treatment is available to people with cancer and non-cancer causes.
Hammersmith & Fulham	Hospice at Home service is not available to Hammersmith and Fulham residents.
Hillingdon	- People have access to enhanced EoLC beds. They are not currently available to people any in other boroughs of north west London. - Hospice at home services for Hillingdon residents are only available overnight but not during the day, whereas in four other boroughs (bar Hammersmith & Fulham, Ealing and Hounslow) these services are available during the day and night time.
Ealing & Hounslow	Hospice at home 24/7 services as per some other providers and boroughs are not available. Only overnight nursing/ sitting service available.

2.3 We need to reduce health inequalities.

Ambitions for Palliative and End-of-life Care⁶ highlighted issues relating to inequalities nationally including:

- People from black and minority ethnic (BAME) communities and deprived areas report poorer quality of end-of-life care.
- There remain unacceptable inequities and inequalities in access to palliative and end-of-life care particularly for those with learning disabilities, dementia and non-malignant long-term conditions
- There are unacceptable variations in aspects of palliative and end-of-life care such as access to pain control, related to different care settings.

We must ensure that our proposed changes make the greatest possible contribution to tackling health inequalities in relation to palliative care services.

2.4 We need to make care more joined up and easier to navigate.

Engagement with local people elicited two recurrent themes in relation to care being 'joined-up':

- Patients and families want to feel that the various health and care professionals coming together to provide aspects of CSPC care are all communicating among themselves to discuss and agree changes to care plans and co-ordinate care delivery
- It is not easy for our population to know what services are available, where they are available and how you access them. There is no central information source that makes navigating services easy for patients and families or health professionals.

We must ensure that our proposed changes address both of these points.

2.5 We must respond to feedback and engagement, and build on previous work.

Ten events and webinars coupled with meetings, interviews and online feedback collectively captured local views on current provision of CSPC in north west London. These included targeted engagement with faith groups, and communities that actively sought out a spectrum of views. This has been fully documented⁷. A thematic analysis of feedback can be summarised as follows.

⁶ [ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf \(england.nhs.uk\)](#)

⁷ [NW London CSPC engagement report summary March 2023.pdf \(nwlondonicb.nhs.uk\)](#)

Table 5: Key themes from engagement events *Table 5*

Engagement themes	Summary feedback
Best possible care	I want high quality care delivered in the optimal place, supported by evidence-based pathways.
Care tailored to my needs	Care should be personalised to me, my preferences and needs. An approach to care planning that factors in my individual requirements, considering my conditions. For example, dementia, my ethnicity or sexual orientation.
Providing connected care	Care providers need to work together so care feels integrated, and services are easy for me and my family to navigate and access.
Staying informed	I need to know where to find information regarding specialist palliative care services across north west London. I want to know who I can speak to, to find help and support.
Creating professional culture and behaviours that exhibit sensitivity and compassion	All staff should exude compassion in their interactions with me, my family and those important to me. They show an understanding of how my faith and culture might lead to differences in the help I need.
Supporting carers and families through end-of-life and beyond	We need to improve bereavement, respite and emotional support for me, my family, and my carers.

2.6 We must make sure our services are aligned to nationally recommended standards and evidence.

We must ensure that our services are consistent with, or exceed, the standard and best practice for CSPC set out nationally.

Figure 4: National best practice

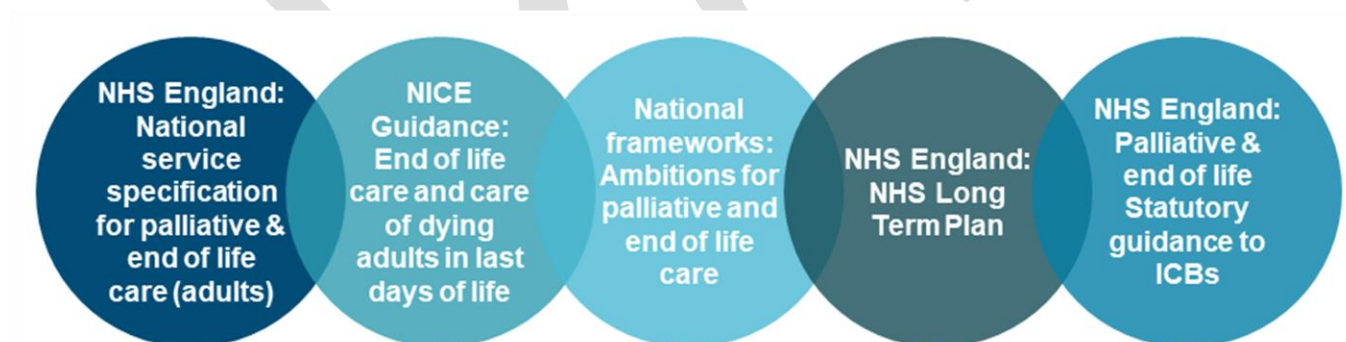


Figure 4: Relevant policy guidance and best practice.

2.7 We must ensure that our services are financially sustainable, both now and in future.

In the financial year 2023/24, NHS NW London expects to spend around £18.6m on CSPC services. In recent years, the increasing complexity of care, inflationary pressures, and staff pay awards have not been fully matched by funding to providers. This means that NHS providers are running at deficits, and the NHS share of charitable hospice funding has been diluted. This is not a sustainable position, and north west London providers need the resources to deliver appropriate care, and the NHS share of funding in the charitable sector needs to be stabilised.

However, as a whole, at the end of 2023/24, NHS NW London has an underlying deficit with a three-year plan to bring the financial position to a sustainable level. This means that whilst investment is needed in

CSPC, there is not 'new money' available. Investment in CSPC must therefore be balanced by savings elsewhere in the health and care system.

NHS NW London has an overall strategy of moving care closer to patients' homes, and supporting timely discharge from hospital. This is aligned with patient choice, offers a better care experience in a less acute hospital setting, and can represent a more efficient use of finite resources. The future model of care should seek to move activity away from hospitals to free up the resources to invest in creating sustainable CSPC services.

2.8 We must be able to recruit and retain a suitably skilled workforce, both now and in the future.

Making north west London an attractive place to work and train is an essential part of building services for the future. Building a robust and resilient workforce strategy across charitable and NHS sector provision to meet the future needs of our population requires two key foundations:

The ability to recruit and retain a skilled workforce in CSPC provision

Palliative care service provision in north west London is set in the context of wider challenges to recruitment and retention across the NHS. Vacancy statistics⁸ for London show a 12% increase in nursing vacancies between Q1 2023/24 and Q1 2021/22. Vacancies for medical roles grew by 19% during the same period. In 2019, a survey by Marie Curie and Nursing Standard⁹ showed 65% of nurses struggle to provide good care to dying patients due to staffing shortages.

In north west London, recruitment and retention challenges led to the suspension of services at Pembroke Palliative Care Centre Inpatient Unit in 2018. The unit remains closed at this time. Responding to workforce challenges will ask providers to:

- Work together and find novel solutions to collective staffing challenges
- Ensure that north west London remains an attractive place to work through education, training and collaborative working practices.

The ability to train and develop a workforce for the future needs of our population

Engagement with staff, partners and our diverse communities has identified a number of workforce development areas including development of 'cultural competency' among our workforce to cater to underserved populations. This includes awareness for cultural and religious beliefs and incorporating these factors into personalised care planning. By supporting staff to better identify and reach underserved populations in this way, we expect to:

- Ensure we have fair access to high quality CSPC across north west London and address inequalities in health
- Create more supportive and inclusive environments where patients and their families can be supported at a sensitive time.

Key driver for case for change

The prime driver for this work is to ensure that our residents, their families, carers and loved ones can be consistently confident that they will receive the empathetic care that they need at the end of their life. We want this to be available regardless of where people live.

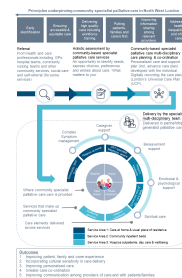
⁸ [NHS Vacancy Statistics England, April 2015 - June 2023, Experimental Statistics - NHS Digital](#)

⁹ [The impact of nursing shortage on end-of-life care - our response | Hospice UK](#)

3. How we developed the proposed model of care

3.1 The development process

The model of care at the heart of these proposed changes ([as set out in chapter 5](#)) has been co-developed with bereaved families, clinical specialists, providers of specialist palliative care with input from wider health and care professionals who interact with specialist palliative care on a day-to-day basis.



Over the course of 38 meetings spanning approximately 18-months, the group, chaired by Dr Lyndsey Williams, a local GP and clinical lead for palliative and end of life care, designed and agreed a future model of care. The key points about its development are set out below:

Table 6: How we developed the proposed model of care

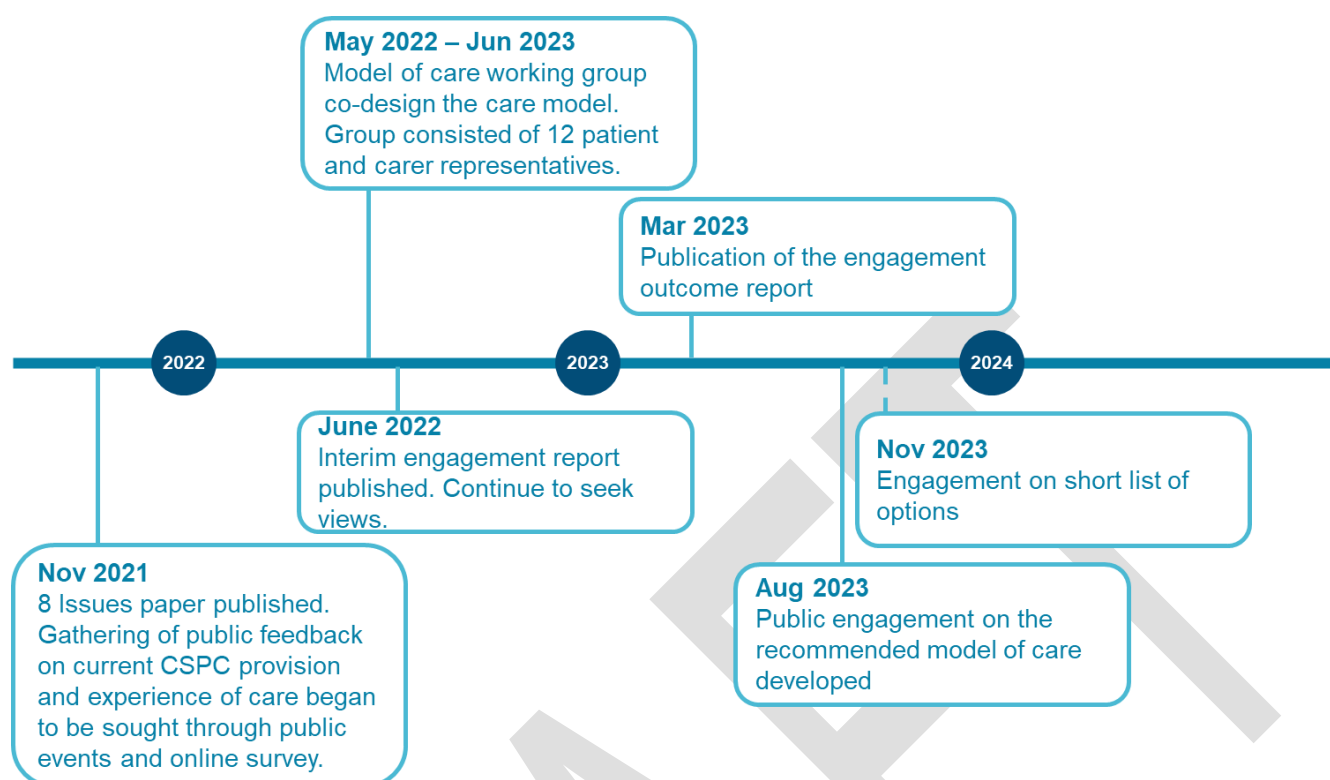
Element	What does this mean?
Co-design	A model of care working group was established in 2022. From the outset there was serious intention to co-design the model of care with our communities and service providers. 50% of membership included people who had experienced bereavement and providing care to people at the end-of-life, with other participants including clinicians and current providers of CSPC in north west London.
Mapping current provision	The group documented and analysed current services provided by the eight providers of CSPC services available within the eight boroughs in north west London.
Reviewing services	The group examined local need through best available data, reviewed public feedback on care provision and compared these with best practice guidance.
Recommendations	Recommendations were made based on local analysis of needs, experiences and feedback for each service that makes up the network of provision in north west London.
Sign off	A separate steering group consisting of patient representatives, provider leads and clinicians subsequently reviewed the outputs and signed off the draft model of care.
Testing	The resulting model of care was tested through public engagement between August and October 2023. Feedback received fed into the final publication of the model of care in November 2023.

Throughout the development process we have been guided by widespread and thorough engagement, as summarised in the next section.

3.2 Widespread engagement

In developing the model of care, we have consistently and thoroughly engaged with a wide and diverse range of communities and interest groups. Engagement activities undertaken to date are summarised below:

Figure 5: Summary of key engagement activities to date



3.3 Engagement with patients, carers, families, staff and residents

Significant engagement has taken place since the commencement of this programme. This ensured patients, carers, families, staff and residents were fully involved throughout. The aims of thorough engagement in this programme were:

- To seek feedback on the case for change from affected groups including people with protected characteristics
- To seek involvement in shaping the model of care
- To be transparent in sharing the feedback and progress
- To seek feedback on how the shortlist of proposed solutions might affect different groups.

Our patient and public participation activity was undertaken with due and proper compliance with both NHS Clinical Commissioning Group statutory patient and public participation duty, and with NHS England guidance.

By consistently and regularly engaging with our communities throughout this programme, we can demonstrate:

- That conscious effort has been successfully made to seek out the views of groups and communities that are less heard
- How feedback and input has shaped and improved the proposed model of care.

Following publication of the [Issues Paper](#) in November 2021, we spent time listening to the views of our communities to understand what was important to them in receiving CSPC. This included:

- 188 responses to online surveys for local residents and health and social care professionals
- Ten events and webinars with members of the public and clinical staff
- One-to-one sessions with voluntary and community organisations including hard to reach groups
- Discussions with health and wellbeing boards, scrutiny committees and health committees

- The development of nine ‘patient stories’ that were shared by people with direct experience of the pathways we were interested in.

These engagement activities culminated in the publication of an engagement outcome report¹⁰ in March 2023, which fed into the development of the model of care.

Extensive engagement with staff has also been undertaken to date including:

- Working in partnership with NHS and charitable providers to provide information to all staff
- Inviting staff to local borough and wider public engagement events
- Briefings to individual borough end-of-life steering group meetings attended by staff and members of the public to gain their feedback
- Briefings and information provided to general practice who were also invited to local borough and wider public engagement events
- Weekly meetings of all charitable and NHS palliative care provider Chief Executives
- The [North West London CSPC Steering Group](#) membership included all north west London NHS community specialist palliative care (SPC) and north west London hospice providers as well as the last phase of life programme GP clinical lead, acute hospital specialist palliative care clinical lead (consultant), acute hospital specialist palliative care nurse lead and community professional lead
- The North West London CSPC [model of care working group](#) included an equal number of clinicians and members of the public who jointly co-designed the model of care.

3.4 Focussed engagement with groups representing people with protected characteristics.

Through a mixture of events, meetings and individual conversations, we have sought out the views and input reflecting diversity in our community. This includes the following focussed engagement:

Table 7: Engagement activities with protected characteristic groups Table 7

Protected characteristic groups we engaged with	Details of engagement undertaken
Age	• Older peoples’ engagement at the Pavilions Shopping Centre in Uxbridge (Hillingdon)
Disability (including MHLDA)	• Kosher Dementia • Carer/spokesperson for people with dementia • Carer interview • Dementia group (Hounslow)
Race	• Sobus (Hammersmith & Fulham) • BME stakeholder event (Kensington & Chelsea, Westminster) • Public engagement events with a focus on ethnic minorities (Hounslow, Ealing, Westminster, Kensington & Chelsea, Hammersmith & Fulham, Brent, Harrow, Hillingdon)
Sexual orientation & Gender reassignment	• Spectra
Other groups: Homelessness	• Westminster workshop on homelessness

3.5 Key messages arising from engagement activities.

Our engagement activities produced a wide range of rich discussions and insights about both our current services and how they could or should change in future. Key themes which have arisen consistently from

¹⁰ [Engagement outcome report :: North West London ICS \(nwlondonicb.nhs.uk\)](#)

engagement with stakeholders, including members of the public, include:

Table 8: Feedback themes from engagement discussions *Table 8*

Engagement theme		Summary feedback
1	Best possible care.	I want high quality care delivered in the optimal place, supported by evidence-based pathways.
2	Care tailored to individual needs.	Care should be personalised to me, my preferences and needs. An approach to care planning that factors in my individual requirements and considers all my factors. For example, dementia, my ethnicity or sexual orientation.
3	Connected care.	Care providers need to work together so care feels integrated, and services are easy for me and my family to navigate and access.
4	Staying informed.	I need to know where to find information regarding specialist palliative care services across north west London. I want to know who I can speak to find help and support.
5	Professional culture and behaviours that exhibit sensitivity and compassion.	All staff should exude compassion in their interactions with me, my family and those important to me. They show an understanding of how my faith and culture might lead to differences in the help I need.
6	Supporting carers and families through end-of-life and beyond.	We need to improve bereavement, respite and emotional support for me, my family, and my carers.

A number of case studies illustrate the good experiences and the challenges that people face when using CSPC services with that forming part of learning from their experiences. Case Studies are published on NHS NW London's website¹¹. See [Appendix E](#) for an example of a case study.

Ongoing engagement

At every stage of development of the model of care, options and development of the pre-consultation business case we have talked with the local residents, staff and partner organisations. That has meant regular attendance at borough forums, updates at north west London patient involvement sessions, frequent written communications and updates.

We are committed to continuing our engagement as we move through the consultation phase to the implementation of the model. We will seek to harness our resident's energies and ideas as we mobilise change. This will include ongoing work on the 'enablers' such as workforce development and how we make our services more culturally competent. We already have a strong resident voice in the work that is happening within individual borough's, and this will be key as we move to implementation and delivery of the new model of care

3.6 Testing the model of care through public engagement

Having published a draft model of care document in August 2023, we undertook public engagement to gather views and wider input from stakeholders. Engagement took place through a series of face to face events and meetings. People also had the opportunity to share comments through online survey and email. This resulted in changes being made and publication of the final model of care in January 2024¹².

¹¹ <https://www.nwlondonicb.nhs.uk/get-involved/cspc/case-studies>

¹² [20240126 NW London ICS CSPC Co-designing a new improved model of care - revised.pdf \(nwlondonicb.nhs.uk\)](#)

Overall there was good support for the proposed new model of care, however we did hear some valuable challenges and constructive suggestions on how we might improve the model, which we committed to reflect in this revised version of the model of care. These included the following key themes:

Table 9: Engagement feedback on the proposed model of care *Table 9*

Engagement theme	Feedback received
1 More information about enhanced EoLC beds	There was an emphasis on more detail and clear explanation of what exactly is being offered in terms of these beds and how they will be made available to ensure that they effectively meet the needs of patients. Assurance was also sought that these beds are a suitable and high-quality option for patients, rather than a possible sub-par substitute for traditional hospice inpatient care.
2 Addressing inequalities	• A need to address disparities in access, outcomes and experiences of palliative care services, ensuring that all individuals, regardless of their background or circumstances, receive the same level of high-quality palliative care • Calls for more tailored strategies for different communities, which considered geographic, socioeconomic, and cultural factors to demonstrate that the model will support addressing these disparities.
3 Enhance innovation and continue improvements to specialist palliative care services alongside the implementation of the new model of care	• Improve the model by exploring innovative initiatives, drawing on local, regional and national pilots already underway • Making sure the current proposed model would remain open to testing the below ideas (which currently do not have robust evidence to support them being included in the current model) as pilots, whilst the model is being implemented: • Emergency department support via in-reach and rapid response, with aims to reduce admissions • Co-ordination service • Single point of access • Virtual hospice (which could include specialist MDT support) • Support for rapid discharge.
4 Improved leadership and governance	Robust leadership and governance structures to guide the proposed changes and for improved accountability and sustainability within the new care model.
5 Improved navigation of services	Simplifying the complex journey through palliative care services and the wider health and care system for patients, families, carers and clinicians to make the services more accessible.
6 Care co-ordination and integration of services	• Seamless transitions between acute and community services, through more integration and co-ordination across acute specialist and community specialist palliative care services • More seamless transition was also emphasised within community palliative care services (spanning both generalist and specialist care providers) and social care services, particularly at local “place” level • Improved communication and collaboration amongst healthcare professionals was also emphasised to support a localised, patient-centred approach with named care coordinators (or a dedicated care co-ordination service/function to improve the overall patient experience and bridge gaps between generalist and specialist care).

Future engagement with key stakeholders, including members of the public, on proposals developed in this pre consultation business case is explored in [section 10](#).

4. Our new model of care

This chapter should be read in conjunction with our detailed model of care proposal document, which has been published separately¹³.

4.1 Our vision for the new service

The vision for our new CSPC service, which forms the overall guide to our new model of care, is:

“To have more accessible community-based specialist palliative care provision that has a wider reach for our north west London population, with the expectation that this will contribute to a reduction in hospital admissions at end-of-life and improve integration of care.”

Our model of care is the culmination of thorough engagement and listening to our communities, staff and providers, combined with best practice in CSPC service design¹⁴. It establishes our ambition for the future of palliative care provision across our eight boroughs. It promotes both quality and consistency across north west London. We believe this represents **what good looks like** in north west London and will benefit patients requiring care, and their carers and families, during their last phase-of-life.

4.2 Our new model of care

The model consists of three key service areas which, taken together, provide a comprehensive range of high-quality services to meet patient needs. The CSPC providers we commission will deliver a comprehensive range of services for all north west London residents, comprising:

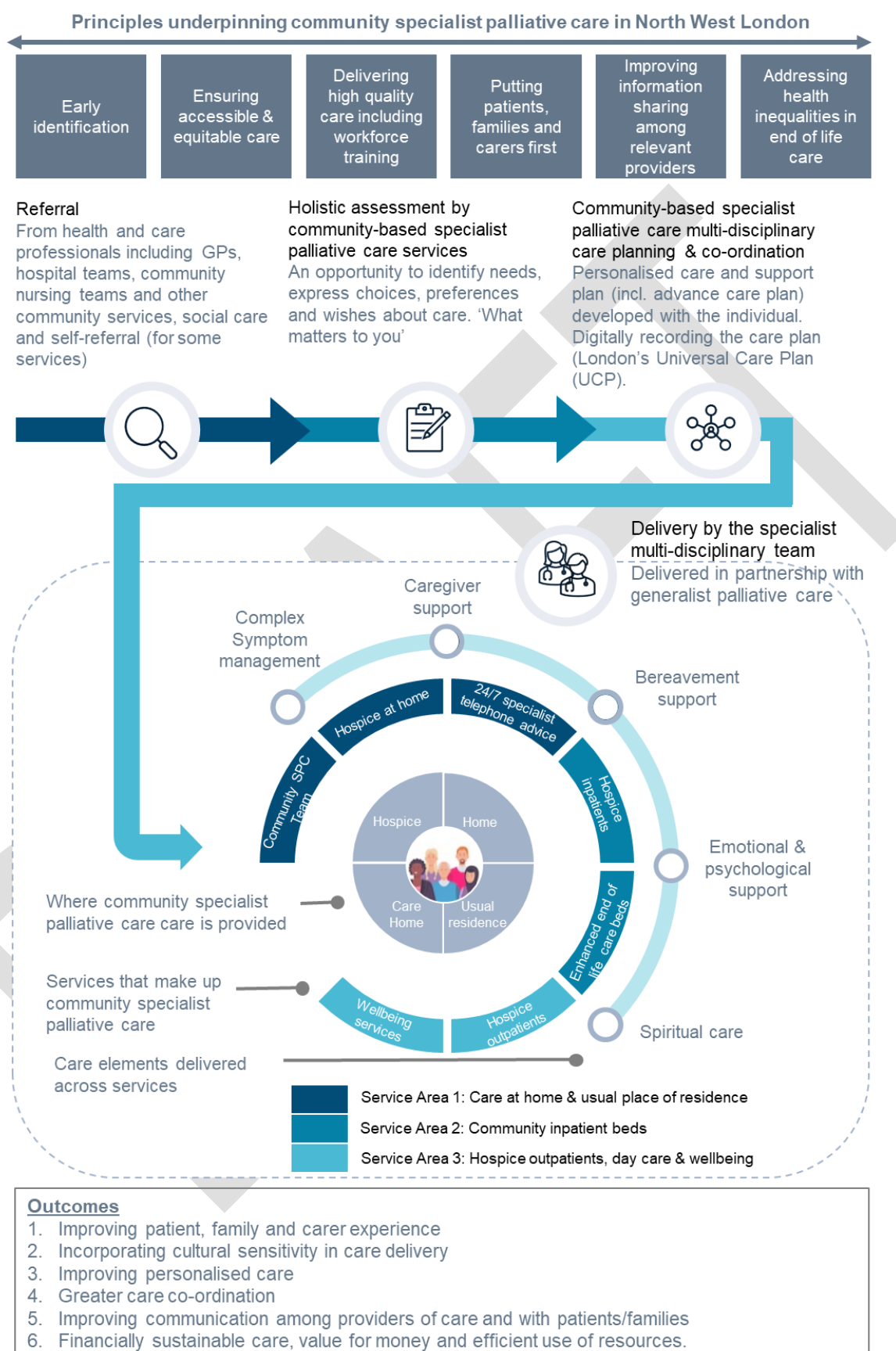
- **Service area 1: Care in the home**
- **Service area 2: Community specialist inpatient care**
- **Service area 3: Hospice outpatients, day care & wellbeing**

The interaction of these services, and how they work together around the needs of the patient and their family and carers, is summarised below:

¹³ [The proposed new model of care for community-based specialist palliative care for adults in NW London :: North West London ICS \(nwlondonicb.nhs.uk\)](#)

¹⁴ A brief summary of our approach to developing the model is provided at [Chapter 3](#) above.

Figure 6: Detailing the interaction of services and how they will work around the needs of patients in the new model of care *Figure 6*



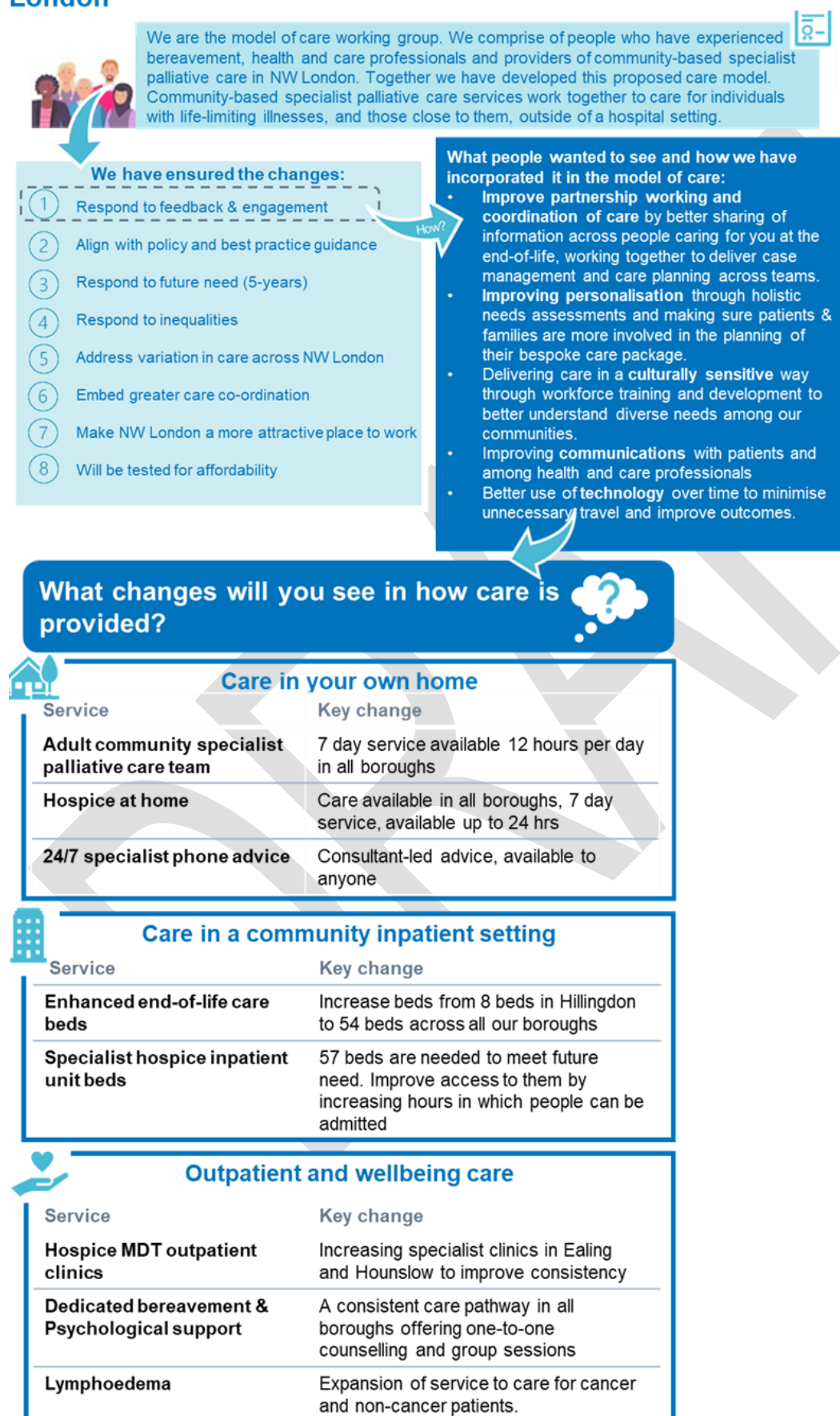
The key changes arising from the proposed model of care can be summarised as follows:

Figure 7: Proposed model of care

Summary model of care for community-based specialist palliative care for North West London



North West London

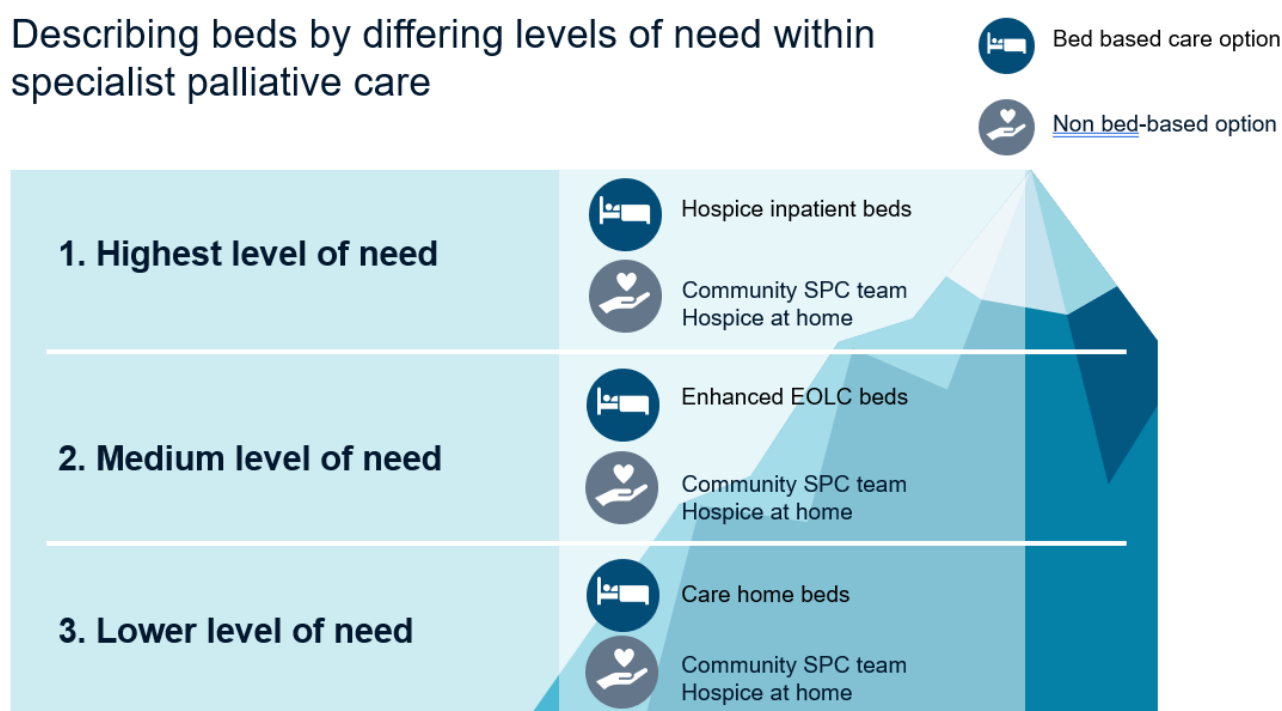


There are three types of bed-based offers included in our model which responds to different levels of need:

1. People who live and reside in a care home can be cared for in this setting with wrap-around support of community teams who will provide in-reach care.
2. Enhanced end-of-life care (EoLC) beds ([explored further in section 4.8](#)) aim to improve comfort and wellbeing and reduce hospitalisation at the end-of-life. They are suitable for people whose needs cannot be met at home or in a care home but are not sufficiently complex to require specialist hospice care. Extending provision of these beds will ensure that people with moderate levels of need have a comfortable death in a non-hospital setting.
3. Hospice inpatient beds aim to support those with the highest and most complex levels of need. They are patients who require 24/7 support from a consultant led specialist team. Hospice inpatient care is a key part of the provision offered in CSPC services. These beds support a very small numbers of people as the majority of patient's journey through their last phase of life without needing this highly complex level of support. We will further analyse the needs and benefits associated with hospice inpatient beds and enhanced EoLC beds in this chapter.

Figure 8: the different levels of need within specialist palliative care

Describing beds by differing levels of need within specialist palliative care



The evidence underpinning this model creates a wider ranging platform on which to build the entirety of the proposed model. It was clear through our co-design work that pulling out strands of evidence and specific interventions was less helpful than seeing the whole model of care. Many of the services within the model of care are relatively small, but they are able to deliver as part of the wider model. For example, whilst increasing hospice at home and community teams will have an impact, the benefit is also that these teams can ensure the 24/7 advice line is aware of patients' needs and can respond in the night time, and that residents can 'step up' into enhanced beds for respite before returning home. It is the joined up and comprehensive service model that both delivers on the evidence but also ensures the quality and safety for our population.

We recognise that there will be a proportion of patients who have specialist palliative care needs and are being supported by our CSPC services that will also qualify for continuing health care fast track funding and bedded care. Our new model of care proposes that CSPC services and teams work closely with Continuing Health Care (CHC) teams to support these patients to access the right care at the right time. This can be a hospice inpatient bed, EoLC bed or care home bed with support of fast track funding.

4.3 Ensuring that our model of care meets changing population needs

In publishing the model of care, we also shared population change analysis¹⁵ and mortality projections¹⁶ for the next ten years. Key findings of this work included:

Table 10: How the model of care responds to changes in population need *Table 11*

Summary findings	Implications for how we implement the model of care
• While the overall population is set to grow by 5%, the 65+ age group population is set to grow by 30% over a ten-year period. • Greatest percentage growth in north west London can be seen in Brent, Ealing, Hammersmith & Fulham and Hounslow • Mortality across all ages grows by 5.5% over a ten-year period (based on ONS data).	• Our service planning needs to reflect the increase in annual mortality in north west London
• 9.5% of households in north west London are reported to be one-person households with the resident aged 66+ years. This means that, while most potential patients do not live alone, a significant number do.	• Where choices and decisions about preferred place of care are needed and there is a reliance on carer support, additional help will be needed to support those without household support • Growth in single person households may place additional requirements on keeping people safely cared for in their homes. Use of technology and remote monitoring are likely to be needed to maintain care at home.

Meeting the changing needs of our population invariably means making sure we have a workforce model that responds to increasing demand. We will work with providers to develop a detailed workforce plan. Principles for how we develop this are that by working together:

- Providers will be better placed to make recruitment decisions that better serve the needs of our communities
- Providers can share details about roles and opportunities to support internal progression, thereby supporting retainment within north west London
- Providers can shape and deliver education and training programmes that make north west London an attractive place for people to work
- Providers can discuss ongoing challenges to recruitment to collectively find solutions.

4.4 Ensuring that the number and distribution of our hospice inpatients beds will meet future demand from those individuals with most complex needs

Hospice inpatient beds serve the small number of people with most complex needs. These are patients requiring 24/7 care in a dedicated unit, supported by consultant led specialist teams. Currently, NHS NW London commissions 67 hospice inpatient beds. 13 beds at Pembridge were suspended in October 2018 with the equivalent of three spot purchase beds currently used. This means we currently have 57 operational providing the care and support our residents need.

¹⁵ [Respond to future need - meeting the palliative care needs of NW London's changing population :: North West London ICS \(nwlondonicb.nhs.uk\)](#)

¹⁶ [10 year demand projections for inpatient hospice care :: North West London ICS \(nwlondonicb.nhs.uk\)](#)

In order to determine whether the current operational position, of 57 beds would be sufficient to meet future demand for hospice inpatient care. We found:

- There is a likely range within which we expect demand to grow
- The range reflects fluctuations in the number of people being admitted for hospice care and how long they stay in hospice beds
- We can expect the number of bed days needed, to grow from approximately 16,000 bed days per year in 2023 to between 17,000 to 19,000 bed days in 2033
- If the number of beds in use remains at 57, we can expect to have capacity for approximately 20,600 bed days each year
- We assume a maximum bed utilisation of 85%¹⁷
- Taken together therefore, this suggests we will have sufficient hospice inpatient beds to meet the needs of the most complex patients in our population until 2027/28 (see below)
- Potentially we have sufficient beds for a longer period of time if the number of people requiring hospice care is slightly lower
- After 2027/28, we expect we would need to make adjustments to either demand or capacity
- Whilst Marie Curie's Hampstead service has closed permanently this does not change our forward plans for demand as these were based on activity.

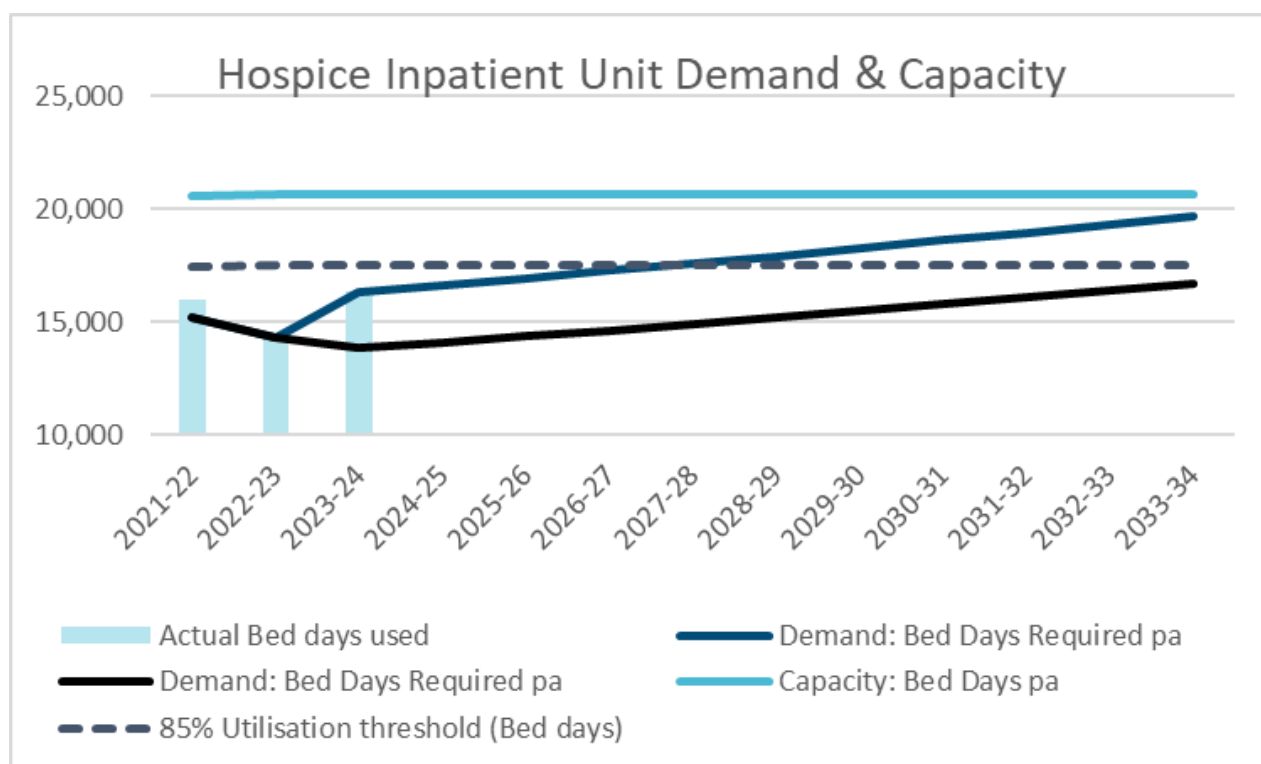
It should be noted that forward projections of need are challenging because we need to factor in unmet need. We also have a different pattern of activity and need during the pandemic to base trends on and because there is a wider shift to more home based care rather than bedded services. This is important to note in the context of Figure 9 below demonstrating that our conservative modelling suggests that the capacity we propose is sufficient for three years, whilst our plan is for a five-year strategy.

Within our modelling we are proposing some 'contingencies' such as a relatively low occupancy rate and expectation at 85% compared to other similar community provision at 92%. We also retain the ability to 'spot purchase' care where needed. At present this is largely utilised for patients who, for reasons of choice, want to be supported in a hospice out-of-area. It should also be noted that our current hospice bed capacity is consistently operating with available beds substantially below the 85% occupancy.

Taken together we believe that the bed numbers modelled can deliver the specialist care needed over the duration of the five-year period of this plan. During which time we will have a more consistent set of data to model accurately into the ten-year period. We will also be able to take into account implementation of the model of care and the impact of investment in others services on demand for hospice inpatient beds.

¹⁷ While there is no national standard for bed occupancy, [NICE](#) recommend acute hospital providers minimise the risk of bed occupancy exceeding 90% as '*high levels of bed occupancy may affect patient care as directing patients to the bed most suitable for their care is less likely to be possible*'. We have applied a lower threshold of 85% for modelling purposes.

Figure 9: CSPC inpatient bed utilisation forecast *Figure 9*



About our analysis of inpatient demand and capacity

Purpose of this analysis

To understand whether we have the hospice inpatient beds needed to serve the inpatient needs of our population, we have undertaken an analysis of future demand and compared this with the capacity we currently have.

Method

- Describe how mortality in north west London changes over the next ten years based on national statistical studies and applying local data
- Apply the annual rate of mortality growth to number of people who may require some palliative care
- Include additional allowance to account for unmet need such as people who are not currently accessing care but need it
- Apply the rate of growth to 2023 actual bed days over ten-year period. For the Pembridge Palliative Care Inpatient Unit this meant using the three spot-purchase bed days currently commissioned
- Compare future bed use with available capacity (bed days) to determine when and if the demand for beds exceeds available capacity.

Assumptions

- Demand for inpatient care grows proportionally to overall palliative care need
- There are no changes to the length of time each bed is used, each time it is used.

What the analysis found

In addition to assessing whether we have sufficient numbers of hospice inpatient beds, we also sought to understand whether they are evenly distributed across the geographical areas covered by the eight boroughs in north west London. By understanding the number of hospice beds available in each hospice and NHS inpatient unit and estimating the proportion of borough population served by each unit, we have estimated the number of hospice beds per 100,000 population at borough level. Although the lack

of national benchmarking makes it difficult to assess whether we have the right number of consultant led specialist inpatient beds for our population, we can use this method to understand whether the distribution of beds is even across our boroughs.

Some hospices serve single boroughs, while others serve multiple boroughs. Allowing for this, the current operational position, with 57 operational hospice inpatient beds, we have 2.73 beds per 100,000 population. We can see similar provision across all boroughs with slightly higher beds per capita serving the Tri-borough area (Hammersmith & Fulham, Kensington & Chelsea and Westminster), Harrow and Hillingdon.

With 67 hospice beds operational, bed provision increases to 3.21 per 100,000 population. Pembridge Palliative Care Centre Inpatient Unit is used by populations of Brent and Tri-borough areas (Hammersmith & Fulham, Kensington & Chelsea and Westminster). Re-opening Pembridge would result in higher-than-average bed provision in these areas.

Table 11: Hospice beds per 100,000 population *Table 12*

	Estimated hospice inpatient beds per 100,000 population with current operational beds (57)	Estimated hospice inpatient beds per 100,000 population with full capacity (67 beds)
Tri-borough	2.97	4.05
Brent	2.42	3.68
Ealing	2.29	2.29
Harrow	3.08	3.08
Hillingdon	3.28	3.28
Hounslow	2.29	2.29
TOTAL	2.73	3.21

This analysis suggests that with 57 hospice beds, we will have sufficient hospice inpatient beds to meet the needs of the most complex patients in our population until 2027/28.

4.5 Ensuring that our hospice inpatient services are accessible to the whole north west London population

As part of the development of the model of care, we undertook an analysis to understand how accessible our hospice inpatient units are by car or public transport. We wanted to:

- Articulate geographical proximity between hospice locations and where people live
- Understand the impact on residents travelling to hospice inpatient locations by car and public transport
- To understand if, and how, accessibility for any of our populations might be affected by the changes we are proposing.

This work has been published as a standalone piece of analysis¹⁸. The key findings are as follows:

Travel time – overall picture

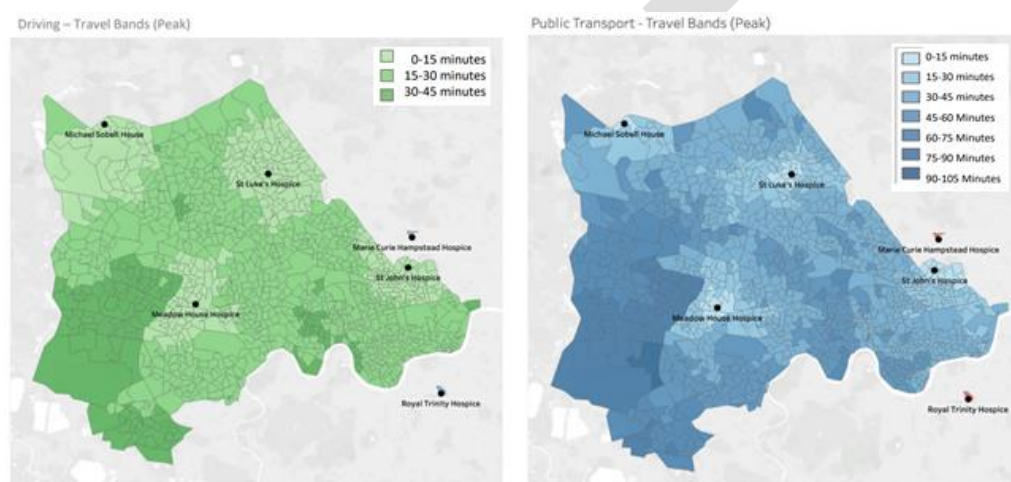
¹⁸ NW London CSPC hospice inpatient units travel mapping analysis. North West London ICS (nwlondonicb.nhs.uk)

Across north west London, average peak time travel to the nearest eligible hospice¹⁹ was 40 minutes by public transport and 19 minutes by car. Around a third of people (34%)²⁰ can access their nearest eligible hospice within 30 minutes and 80% can access it in less than 45 minutes. For those travelling by car, approximately 30% of people would incur a travel journey of 15 minutes or less and 90% would be travelling for 30 minutes or less.

North west London endeavours to offer patients their nearest eligible hospice, and will work closely with hospices and patients to do this, however, in line with all NHS services, we are not able to guarantee this. It is dependent on capacity of the hospices, which can fluctuate throughout the year, and on the clinical needs of the patient. Hospice inpatient beds are modelling on 85% planned bed occupancy over 365 days per year, to allow capacity and be able to accommodate higher demand and fluctuations in demand throughout the year. Non-Emergency patient transport provision is also available in north west London for patient journeys.

People living in the south of Hillingdon and Hounslow have among the longest travel times to a hospice inpatient bed care unit because of the absence of available alternatives in the area.

Figure 10: Map showing indicative travel times



Impact of Pembridge suspension on travel time

The presence of inpatient care at Pembridge Palliative Care Centre offers the catchment population shorter travel times

Figure 11: Average travel times

¹⁹ This is the nearest hospice which someone would currently be able to use. For some people this may not be the closest hospice to where they live, as some services are only accessible to residents of some boroughs. Further information is available in the travel mapping analysis document.

²⁰ This analysis uses lower super output areas (LSOAs) – small geographies of around 1500 people which are used in small area statistics – as the basis for modelling travel time. Standardised populations per LSOA also allows us to infer the proportion of people who will have any particular level of access. Further information is available in the travel mapping analysis document.

Comparison of average travel times

		Average peak time travel Public transport	Average peak time travel Driving
Whole NWL population	Travel time to nearest hospice inpatient unit (INCLUDING) Pembridge	40-mins	19-mins
	Travel time to nearest hospice inpatient unit (EXCLUDING) Pembridge	43-mins	21-mins
Pembridge catchment only	Travel time to Pembridge	31-mins	17-mins
	Travel time to next nearest hospice (Pembridge closed)	43-mins	23-mins

With Pembridge Palliative Care Centre Inpatient Unit services suspended, patients receive inpatient care in one of our other hospices through a spot-purchase arrangement. This arrangement increases travel time for family and carers visiting them, by 12 minutes on public transport and six minutes by car (at peak time). The travel times for this group to the next nearest hospice is 43 minutes by public transport and 23 minutes by driving which is comparable to the experience of the whole north west London population (see figure 11 above for more information). However, comparatively, across the whole of north west London average peak time travel to the nearest eligible hospice (with Pembridge Palliative Care Centre Inpatient Unit services suspended) is 43 minutes by public transport and 19 minutes by driving, which represents the same travel time by public transport, and a 2-minute increase on travel time driving.

Travel time for people living in our most deprived communities

The index of multiple deprivation (IMD) is a measure that allows us to understand differences in deprivation between geographies. In this case, we wanted to understand whether people living in the most deprived areas (known as IMD 1 and 2 deciles) were adversely impacted by travel to a hospice site.

Our findings showed hospice sites are in areas within close proximity of deprived communities. People living in the most deprived areas are not adversely impacted by travel times to their nearest unit except in Hillingdon where travel times are higher to access Michael Sobell House for the seven lower super output areas (LSOA). Within this group nobody can access the site within 60 minutes using public transport at peak time. We are working closely with our local Hospice provider in Hillingdon actively exploring options to address the needs of the south of the borough. Non-Emergency patient transport provision is also available in north west London for patient journeys.

Table 12: Proportion of population able to access closest hospice inpatient site within 30 and 60 minutes

	% of people who can access their closest hospice using public transport at peak time within ...	
	30-mins	60-mins
All populations	34%	96%
IMD 1&2 areas	32%	96%

Key implications regarding accessibility

The use of travel analysis does not fully reflect the user experience of travel. For example, it is not possible to account for the amount of time it takes to walk to the bus stop or tube station or time spent waiting for public transport. It does allow us to compare relative experiences across populations in a consistent way and help understand the impact of changes to provision for our populations. The analysis here shows the following key findings:

Table 13: Conclusions on accessibility *Table 14*

Key finding	Implications for how we implement the model of care
1. At this time, overall travel times in accessing a hospice inpatient unit do not adversely affect deprived communities.	Future considerations for distribution of hospice inpatient provision should not worsen the experience. Non-Emergency patient transport provision is available in north west London for patient journeys to hospice inpatient beds. The new Model of Care seeks to reduce health inequalities. Hospice inpatient beds are one element of the new model of care which aims to improve access to services delivered in non-specialist hospice inpatient settings and support patients to stay within their local community. Due to estate and staffing requirements for hospice inpatient bedded provision, north west London is working within current estate provision.
2. If Pembridge Palliative Care Centre Inpatient Unit does not re-open, the catchment population will continue to travel further to an alternative site. The impact of this would be longer travel time for family and carers than previously experienced in accessing Pembridge. However, the travel time experience becomes similar to that of all families and carers across north west London.	We should continue to test fairness of access when choosing between solutions.

4.6 Ensuring that admissions to hospice inpatient beds are appropriate

A joint clinical audit of hospice inpatient admissions was conducted in 2022, covering all five hospices providing inpatient services to north west London. The objective of this work was to better understand the utilisation of our specialist hospice inpatient beds and to explore the hypothesis that some patients admitted to these beds could have their palliative care needs better met in alternative care settings, such as nursing homes or enhanced EoLC beds.

The clinical audit involved a review of 100 consecutive hospice admissions across the five inpatient units. Of these, 76 had sufficient information to be included in this analysis.

Of the 76 admissions, the analysis determined that 20 (26%) could have had their needs met with alternative care such as nursing home care (14 cases) or enhanced EoLC beds (6 cases). This also meant that 14.7 hospice inpatient beds could have been made available if these patients had been supported in alternate care settings.

4.7 Implications of analysis related to access and capacity

The collective insight of the various analyses above tells us we have rightsized the hospice inpatient unit beds according to our needs. However, more needs to be done to improve the experience of people travelling to these sites by considering changes to catchment areas.

Table 14: Conclusions from analysis regarding access and capacity in bedded care - implications for the model of care

Conclusion from analysis of access and capacity	Implications for the model of care
Our analysis shows a need for 57 hospice inpatient beds to meet our needs for the coming five years.	We must ensure that our implementation approach and plans include sufficient inpatient capacity to match demand for hospice inpatient services.
The catchment restrictions coupled with the geographic arrangement of hospice sites means people in Hillingdon and Hounslow have longest travel times. Alternative provision options combined with changes to catchments would be of benefit to these populations.	- Should Pembridge re-open, then those living near it would (on average) be able to access hospice inpatient care more quickly than the north west London population as a whole. - However, should Pembridge remain closed, then those living near it are not materially disadvantaged when compared to the north west London population as a whole (in respect of travel time). - We should continue to test fairness of access when choosing between solutions.
- The absence of an inpatient care at Pembridge Palliative Care Centre has resulted in longer travel times among people for whom it would be the nearest site (+6 minutes driving, +11 minutes by public transport at peak time). - However, when Pembridge is closed, the travel time to the next nearest hospice is only fractionally greater for those living near Pembridge than for the rest of the north west London population (same time by public transport, +2 minutes by driving).	

4.8 Ensuring we have the right number and distribution of enhanced end of life care beds

Enhanced EoLC beds serve patients with moderate levels of need. This means that their needs cannot be met at home, but they also do not require consultant led specialist inpatient hospice care. The alternative would be hospitalisation, which could be prevented through 24-hour care in an alternative setting such as a care home or nursing home. The table below details the way enhanced EoLC beds differ from hospice inpatient beds.

Table 15: Similarities and differences between hospice inpatient units and enhanced EoLC beds

	Hospice inpatient unit	Enhanced EoLC beds
Location	Hospice site.	Care home, nursing home, community bed site
Workforce	On-site consultant-led team of dedicated specialist palliative care professionals.	- On-site generalist nursing and care teams - Specialist palliative care team input provided by an in-reach offer.
Anticipated length of stay	15-16 days (based on current average length of stay).	30 days (based on 2022/23 mean length of stay at current site).
Patient need	- Highest complexity - Require the full multi-disciplinary team (MDT) with daily consultant input - Final days/weeks of life.	- Lower complexity - Does not require full MDT and daily consultant input.
Intended benefits	- Quality of care for people with the most complex needs - Meeting people's preferences of preferred place of death.	- Fewer people admitted to hospital at the end-of-life - More appropriate use of hospice beds (and therefore greater access for those with the most complex needs)

		- Meeting people's preferences of preferred place of death - Improving comfort and wellbeing at the end-of-life.
How are beds funded	NHS NW London and hospice charitable funds.	NHS NW London including continuing health care fast track.

Local data suggests there are approximately 36,000 people on the end-of-life cohort and that 10,800 people on this cohort were admitted to hospital in the last 12 months²¹ with an equivalent of 210 hospital beds occupied by this group each year.

48% of deaths occurred in hospital and national survey findings tell us this is not the preferred place of death for most. This suggests further opportunity to prevent hospitalisation at the end-of-life in north west London.

Our analysis suggests that the reasons for this includes that patients are admitted to hospital because there is not the right type of bed, in the right place, to meet their needs in a community setting.

Evidence to support this includes:

- The percentage of deaths with three or more admissions in the last 90 days of life for all ages and those aged 75+ years is significantly worse in north west London than England²².
- Deaths in hospital across north west London are significantly higher than England levels, but falling²³.

The case for enhanced EoLC beds also responds to an acute hospital discharge peer review of delayed discharges carried out by senior and operational stakeholders during the summer of 2023 with the aim of identifying shared learning of good practice and challenges across our eight providers. The review showed there was a group of people who had no viable alternative to where they could be discharged from hospital to as hospice inpatient units and the patient's own home were considered inappropriate.

There are currently eight enhanced EoLC beds in Hillingdon. These are reserved for Hillingdon patients and there is no equivalent provision in other boroughs. Introducing these in boroughs other than Hillingdon, would provide alternative access to other areas of the north West London population²⁴.

The lack of other comparative models makes profiling expansion of enhanced EoLC beds difficult. In the absence of a better alternative, we have scaled provision based on the current provision in Hillingdon. This would result in the following number of enhanced EoLC beds per borough, although depending on availability of sites some shared work across boroughs may occur.

Table 16: Proposed number of enhanced EoLC beds per borough *Table 17*

Borough	2023 population	Proposed number of enhanced end-of-life care beds
Brent	353,690	9
Ealing	380,722	9
Hammersmith & Fulham	188,103	5
Harrow	270,741	7
Hillingdon [existing beds]	315,198	8

²¹ Data analysed June 2024

²² [Palliative and End-of-life Care Profiles - Data - OHID \(phe.org.uk\)](https://palliativeandendoflifecareprofiles.org.uk/)

²³ [Palliative and End-of-life Care Profiles - Data - OHID \(phe.org.uk\)](https://palliativeandendoflifecareprofiles.org.uk/)

²⁴ This is based on model of care clinical outputs which suggest an overall need of 2.5 beds per 100,000 population for this service. This analysis was then cross-checked by scaling up Hillingdon's provision of 8 beds for the whole north west London population.

Hounslow	300,880	7
Kensington & Chelsea	145,328	4
Westminster	211,814	5
North west London total	2,166,475	54

Implications of this analysis for the model of care

Table 17: Conclusions from analysis on enhanced EoLC beds

Conclusion from this analysis	Implications for how we implement the model of care
- Enhanced EoLC beds offer additional opportunity to support people whose needs mean they do not need hospice inpatient admission but may be hospitalised if alternative 24-hour care were not available. This may include people living alone without carer support - At present, this service is only available to people living in Hillingdon, where eight beds are available - Providing an equivalent service to the whole of north west London total of 54 beds across all boroughs.	- We must ensure that our implementation approach and plans include: - sufficient capacity to match demand for enhanced EoLC beds - proposals to ensure equitable access to enhanced EoLC beds across our eight boroughs - Sustainability of provision to ensure access to enhanced EoLC beds when required

4.9 Ensuring that care is available equitably across our boroughs

As part of information gathering to review the current provision, the model of care working group examined the distribution of services across our eight boroughs. Differences included:

Table 18: Variation in care provided at borough level

Aspect of care	Current inequity across north west London – key findings	Implications for how we implement the model of care
What care is delivered	- There are three boroughs (Hammersmith & Fulham, Ealing and Hounslow) with no hospice at home provision - In all but one borough (Harrow), lymphoedema for non-cancer causes will be treated - Enhanced EoLC beds are available only in Hillingdon (see above for further information on this).	In developing options, improving fairness of provision across north west London should be a consideration.
When services are available	Specialist palliative care (SPC) team services are largely available seven-days per week except in Harrow where provision is limited to five-days per week	
Which clinicians are available	- Consultant and nurse-led outpatient clinics are not available in Ealing or Hounslow 24/7 telephone advice has varying degrees of consultant supervision and is delivered by nurses of varying specialism - Variation in the level of trained specialist psychology and bereavement practitioners.	

The 24/7 telephone advice approach recognises the need for all residents to have access to a 24/7 advice line across all Boroughs in north west London. We recognise that this will not be a single hub

operating across north west London initially. However, we would seek to develop this approach during future phases of service improvement. We have some boroughs and providers with existing effective models which work with services outside north west London. We do not want to destabilise the wider landscape whilst we deliver 24/7 telephone advice lines for every north west London resident.

4.10 Ensuring that our model of care will contribute to addressing health inequalities

Taken together, the service changes outlined in the model of care will make a significant contribution to reducing health inequalities for people who use CSPC services. A full Equality Health Impact Assessment has been carried out alongside this pre-consultation business case (available via the north west London ICB website²⁵). This highlights contributions to tackling health inequalities including:

Table 19: Responding to inequalities *Table 20*

Characteristic	How the model of care addresses challenges to accessing care identified in this population group
Age	Extending hours of provision of community services, improving opportunities to prevent hospitalisation through the use of enhanced EoLC beds, older people will be better supported in their care needs at the end-of-life.
Disability	The use of holistic needs assessments and extending hours of provision of community services, people are more likely to be cared for at home.
Religion or belief	Improving personalised care provision and improving training for staff to deliver culturally sensitive care, we are building more inclusive care environments for patients and carers.
Carers	Involving carers in holistic needs assessments and improving carer support provision, the experience of carers is improved.
Single person households	Extending hours of provision of key community services, patients living in single person households are better supported to remain at home.
People living in sub-standard housing	Providing care in alternative environments such as enhanced EoLC beds, people will be cared for in better suited environments.
Homelessness	Incorporating a holistic needs assessment into care provision, providers will understand challenges caused by a lack of fixed housing and put in place measures with other agencies to support personalised care provision.

4.11 Ensuring that CSPC services are appropriately integrated across health and care

Successful delivery of this model of care cannot occur in isolation. Teams supporting the care of patients at the end-of-life work in partnership with other providers of CSPC and the wider system.

²⁵

Table 20: Describing how care provision will be more integrated in the new model of care Table 21

Provider type	How joined up care will be delivered
CSPC providers	• A single shared care plan – providers access the single Universal Care Plan (UCP), a digital care plan, accessible to clinical teams caring for the patient • Weekly provider meetings that continue to bring collective discussion and resolution on operational improvements across the care pathway • Multi-disciplinary Teams (MDT) meetings – a forum for people involved in the care of complex cases to come together and discuss care needs and provide collective input. This supports the delivery of integrated care and personalised care.
Primary care, social care and place-based teams	GPs, primary care teams and social care are close partners in the delivery of care and form part of the wider MDT. GPs stay informed on care plans through the UCP and will be able to access the 24/7 advice line for further support.
Secondary care	CSPC nursing team have a responsibility to support timely hospital discharge, and this already requires close interaction with acute specialist palliative care teams. The proposed model of care will enhance this pathway and partnership approach by: • Extending hours of provision for non-bed-based services such as hospice at home. Improved availability of services will lessen the risk of hospitalisation and reduces bed pressures for acute hospitals. • Expanding bed-based options by introducing enhanced EoLC beds maximises the support offer to those who require 24/7 care support and reduces likelihood of hospital admission. This will be further examined in this document.

We are dedicated to collaborating with our acute palliative care consultants, emergency consultants, discharge hubs, generalist and CSPC services and primary care teams to develop these ways of working and improve the ease of access to generalist and CSPC services.

In addition to making acute and community sectors work together better, our goal through this model and ongoing work to foster more collaboration, is to build strong partnerships among our different community services, as well as within CSPC services themselves. By improving how we communicate, and coordinate care, we can offer more seamless care across community services, primary care, social care, and our specialist community palliative care. This is aimed at reducing avoidable hospital admissions and enhancing the overall healthcare journey and experience for patients with serious illnesses and their families.

The overall aim is to create a more streamlined process for accessing and delivering CSPC services. This collaboration is crucial in developing effective ways of working and robust processes to access the right care at the right time.

4.12 Ensuring equitable access to CSPC services

By extending hours of provision of CSPC services such as hospice at home and specialist palliative care team, more people who are at the end-of-life will be able to access the right support for their care needs closer to home. By incorporating a holistic needs assessment and an improved staff training programme, more people will be better supported to remain at home and cared for in a more inclusive environment.

By expanding EOLC beds to all boroughs, people who might not be suitable or eligible for hospice care and are not able to remain at home can access alternative care in a safe environment. In particular, older people living alone are likely to benefit from this provision. Furthermore, the new model of care aims to achieve the following outcomes:

- More people dying in their preferred place of death which will be measured via the UCP dashboard (metric: number of deaths of individuals with a UCP and % that died in their preferred place of death)
- Hospital deaths decreasing and falling in line with national profile measured via Summary Hospital-level Mortality Indicator (SHMI)
- More care being delivered at home which can be monitored via community and hospice at home referral activity
- More people having a completed UCP which can be monitored via the UCP dashboard
- Qualitative: patient, carer and staff feedback via surveys about access, experience and outcomes
- Increase in staff retention and job satisfaction which can be measured via staff turnover rates and surveys.

4.13 Ensuring patient choice and personalised care is considered

Through the new model of care, the person and their family, carers and those important to them go through a comprehensive assessment and care planning process which will identify need and lead to the delivery of a personalised offer of CSPC.

Advanced care planning will also take into account their future care preferences and services will support the patient in as much as possible to have those preferences adhered to. These steps and processes for providing the most appropriate care at the right time are also known as the care pathway. They go beyond palliative and end-of-life care for the patient, and also include emotional, practical and bereavement support for families and caregivers.

The new model of care aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire north west London population. The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural competence training for staff and actively collaborating with local organisations and partners.

The adult community specialist palliative care team through the new model of care will provide personalised care planning involving the patient, their family, carers, those important to them and other health care professionals involved in their care to support personalised care planning, including advance care planning for patients.

Clear information and instructions regarding the patient's care needs and preferences are recorded on and shared via digital personalised care plans which in north west London is the UCP. This digital personalised care plan is used to make sure that the patients' wishes are recorded and shared in real time across the health and care system and that health and social care professionals can access this information whilst providing care.

The UCP is key to supporting patients' wishes and preferences being communicated and facilitated across the health and care system. As part of the new model of care, the use of the UCP will be expanded across north west London's care sectors and settings. Regular reviews and updates of the UCP will support alignment of the care provided with the patients changing needs and preferences. Patient choice is important and being able to make an informed choice alongside professionals underpins delivery of the new model of care and improved quality and outcomes for our residents. This new model of care aims to make sure people have a choice, getting the right care, at the right time, by the right team and in the right place, alongside their wishes and preference. Through it, all residents, no matter their circumstances, will be able to access the services they need.

The new model of care also aims to enhance health literacy among residents by empowering them with a better understanding of palliative care and their end of life options through the promotion of advance care planning. This will enable patients to make informed decisions about their care and reduce disparities caused by a lack of information or opportunity and to have their wishes made known and shared with the health and social care system (for example via the UCP).

When the model of care is agreed and implementation begins, we will work with providers, local stakeholders and our communities to provide clear information to patients, carers, clinicians and the wider public on available services and support.

Simplifying access to CSPC services is a priority for the new model of care. In the meantime, work has already been undertaken to improve available information as part of this new model with the development of a new service directory resource at north west London and local borough level.²⁶

The need for patient choice

Throughout our public engagement, people told us that the model of care needs to be able to provide care that is personal to individual circumstances. Patients, families and carers need to be able to choose how care is delivered to them and at the same time have the flexibility for them to change their mind.

The model of care details a set of standard services and support that will be available to all residents of north west London that will help them to make those personal choices. It means more patients, families and carers will be able to choose to receive care in their own home or in the community, providing an alternative to inpatient acute hospital admission and flexibility to respond to the very specific needs of each individual. Key components of the model that expand choice includes the introduction of:

- Enhanced EoLC care beds in every borough responds directly to community feedback and provides more choice and options for bedded care. It also brings care closer to residents' homes
- The hospice at home service in every borough allows patients to receive hospice care in their homes, further extending the range of options available
- An extension of service hours and a 24/7 telephone service will be available for both known and unknown patients, enhancing access to care
- The plan maintains the current number of hospice inpatient beds across the region. Choosing not to reopen the Pembridge Palliative Care Inpatient Unit may increase travel times for patients in the Pembridge catchment area. However, these times are comparable to those experienced by patients elsewhere in north west London.

The proposal seeks a balance between the number of treatment locations and the quality of treatment provided. The assessments indicate that the proposed options offer a superior range of services and better physical quality of inpatient facilities.

The model of care and service and support options put forward to consultation emphasises enhancing local service provision, offering more choices for patients and their families.

4.14 Ensuring integration

The new model of care will support enhanced care co-ordination and integration of services:

- Feedback emphasised the need for more seamless transitions between acute and community services, through more integration and co-ordination across acute hospital specialist and CSPC services. More seamless transition was also emphasised within CSPC services (spanning both generalist and specialist care providers) and social care services, particularly at local "place" level.
- Improved communication and collaboration amongst healthcare professionals was also emphasised so as to support a localised, patient-centred approach with named care coordinators (or a dedicated care co-ordination service and function designed to improve the overall patient experience and bridge gaps between generalist and specialist palliative care).

²⁶ <https://hpal.medindex.co.uk/p/t/palliative-care/services>

Integration is both a cultural change and a major practical difference in how services work together which will be underpinned by specific requirements in the Service Specifications for the delivery of adult community-based specialist palliative care going forward. It includes:

- Reducing boundaries between organisations by fostering a 'one team' ethos
- Reducing handoffs and the need for people to tell their story repeatedly
- Coordination functions that remove the need for patients and carers to act as coordinators, and also free up our more specialist staff
- MDT's and meetings as a way of working with residents to plan their care needs across CSPC services in the first instance, as well as the wider health and care system
- Integration across north west London and the CSPC and hospice sector through regular sharing forums
- Facilitating improved information sharing between teams, organisation and sectors through use of shared care records where possible, including electronic patient records, the health information exchange (London Care Record) and the UCP
- Fostering collaborative care models such as MDT's within organisations and across organisations, working together to provide comprehensive and holistic care. This may be through encouraging regular team meetings, multidisciplinary ward rounds across CSPC services and wider system partners. The aim is to support shared decision-making, optimising the use of the specialist workforce and enhancing patient outcomes.
- Emphasising effective communication and care coordination among the healthcare providers involved in palliative care. Implementing tools and platforms that facilitate seamless information sharing, care planning, and follow-up
- Creating platforms for staff members to share their experiences, ideas, and best practices with their colleagues and encouraging regular learning forums, case discussions, and peer mentoring to promote collaboration and knowledge exchange.

Through collaborative efforts and the careful consideration and development of strategies within the model of care implementation planning focused on enablers of the new model of care, we can create a robust framework for supporting the successful delivery of the North West London CSPC services new model of care.

By embracing these enablers laid out in model of care for its successful delivery, we aspire to improve patient outcomes, enhance care coordination, address workforce challenges, promote integration, and deliver value for money, all in line with the overarching goals of the new care model.

Through the development of this model of care we have engaged with key stakeholders to understand how to support delivering this. Integrated Neighbourhood Teams (INTs) can provide this joined up way of working. INTs are viewed as a delivery mechanism, aiming to unite the healthcare system to collectively assume responsibility for the population. They are expected to foster a culture of collaboration, problem-solving, and trust-building among primary care, other stakeholders, and communities, ultimately coordinating multi-disciplinary care as patients' needs change.

With this in mind CPSC providers can build on integration within INTs to work together more effectively, leading to better-coordinated and integrated care for patients at the local borough level.

This could include CSPC services leads attending multidisciplinary meetings and being part of case reviews. This is also an opportunity for CSPC services and other professional involved in the patient cases to agree a lead professional approach and ensure that appropriate training is embedded into the process to support this. This way the patient can be supported to have more continuity of care, as well as reducing the need to tell their story repetitively. It can also support to patient to get the right care at the right time through their lead professional.

4.15 Ensuring digital innovation

Embracing data, digital tools, and technology can significantly enhance the sustainability, effectiveness, and efficiency of our CSPC services. Linking into the NHS North West London Health and Care Strategy there is a recognition amongst all providers that we need to make more use of new and innovative technologies to improve and support clinical decision making.

North west London already benefits from the innovative 'whole system integrated' care dashboard. This means information for service improvement can be shared and collated across primary care, secondary care, social care and any providers who are able to submit data. This will include our hospice partners as they implement electronic patient records over the coming year.

Simplifying access to CSPC services is a priority for the new model of care. In the meantime, work has already been undertaken to improve available information as part of this new model with the development of a new service directory resource at north west London and local borough level called HPAL.

Other strategies will include a commitment to greater use of remote monitoring technologies and telehealth services, which can proactively manage patient symptoms, leading to better patient outcomes and reducing the burden on acute care settings. This will include:

- Working together to support coding and counting activity in the same way so we can understand differences in the care services provided by our various providers in more easily comparable ways
- Supporting implementation of shared records and standardisation of clinical systems, as much as possible, so all clinicians supporting the health and care of an individual patient can see their information across multiple care settings. For example, implementing electronic health records and facilitating and embedding use of the health information exchange and London care record can support streamlining the data sharing among healthcare providers and sectors. This will promote care coordination, reduce duplication of efforts and prevent patients having to repeat themselves at each appointment. Use of the UCP to support recording and sharing of patient preferences and care plans will improve this further
- Creating new ways to provide care using advances in technology through, for example, virtual wards and home remote monitoring
- Developing a single dataset of timely, detailed health and care information, that can help clinicians provide the right care and support for patients
- Developing systems to provide a north west London wide overview and management of demand, capacity and patient flows across hospitals and primary care services
- Automating advice and guidance from clinical specialists to support GPs with referrals.

4.16 Ensuring that sustainability and environmental impact have been considered

All of north west London's CSPC providers are committed to help create healthy lives and communities where care is delivered within a sustainable environment.

There are ample examples of excellent work which has already taken place to reduce carbon emissions and embed sustainable practices and principles into every aspect of our operating model. Our NHS providers have launched their Trust Green Plans which sets out the key actions to reduce carbon emissions and how it will meet the NHS England target to reach net zero emissions by 2040.

Good progress has already been made against the objectives in the Green Plans but it is acknowledged that more work is needed to be done. Another example of good practice includes: CLCH having purchased 100% renewable electricity at all their Tier 1 sites and all of their car fleet lease and staff salary sacrifice vehicles are now 100% electric.

Our charitable hospices help to reduce carbon emissions by encouraging buyers to reuse pre-loved items which are sold in their charity shops, generating a circular economy. In 2023, Royal Trinity Hospice saved

360,000 fashion items from landfill by rehoming them within their community, whilst also raising funds for the core work of the hospice.

All of the items in their retail stores are 100% donated. Furthermore, Royal Trinity Hospice launched their Retain Sustainability Report 2022 which sets out their seven step to sustainability plan. A key highlight was purchasing their first 100% electric van which is estimated to save over 2 tonnes of carbon dioxide a year. Other highlights include switching the energy contract for their shops to one that is 100% renewable.

The extensive efforts delivered by Royal Trinity Hospice to become more sustainable resulted in the organisation receiving the Charity Retail Association's inaugural 'Environment and Sustainability Award' last year.

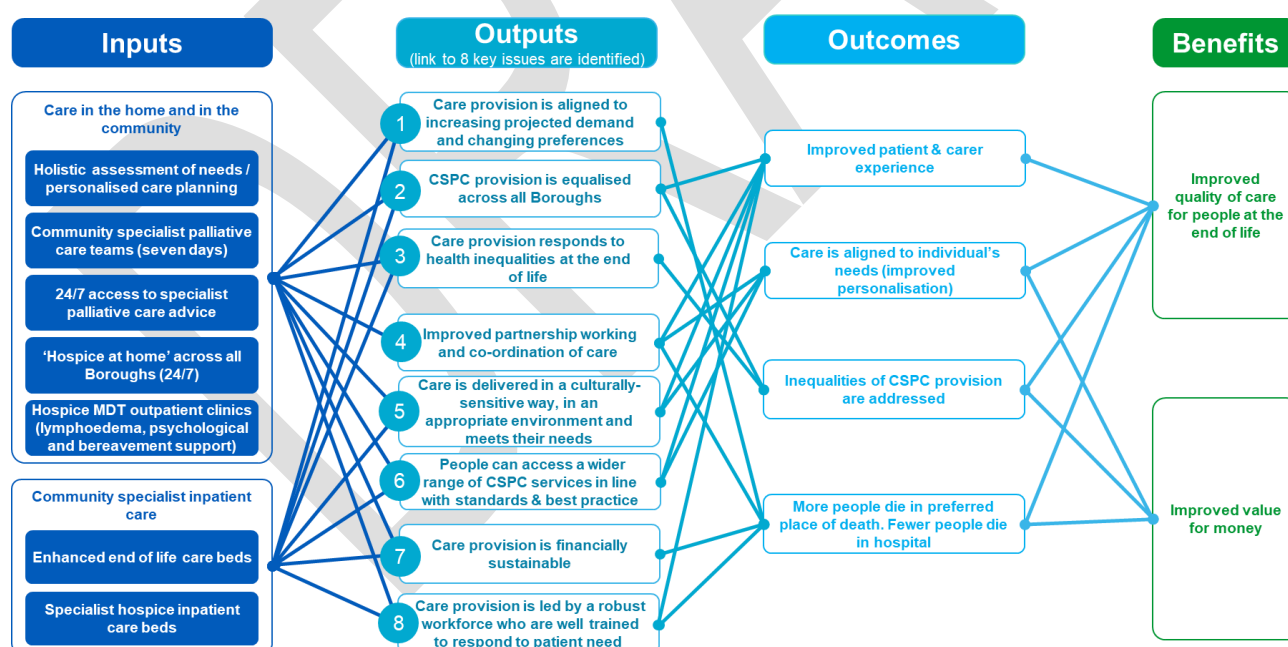
Climate change is one of the biggest public health threats and challenges that we face. Extreme weather conditions, such as flooding and heatwaves are becoming more frequent and severe. This will have impacts on both the health of the local population and the ability of our services to operate effectively.

NHS NW London and all providers are collectively and separately working towards improving climate resilience in terms of preparing for the impacts of climate change and building capacity to recover quickly from those impacts, and adaptation to adjust to the effect of change on our planet. Climate adaptation plans, including heat wave and cold weather, are currently being developed and finalised across our providers which will be reviewed by North West London ICS as stated in the ICS Green Plan²⁷.

4.17 Summary of benefits

The benefits of fully implementing the model of care are improved value for money and improved quality of care for people in north west London at their end-of-life. The summary of the overall benefits detailed in this chapter are summarised in the following diagram, ensuring we are improving the outcomes and addressing the eight key issues identified.

Figure 12: Benefits mapping Figure 13



Further information about the elements of the model of care can be found in [Appendix G](#).

²⁷ www.nhs.uk/sustainability

5. Process for developing and selecting the implementation options

Having defined the model of care and what we wish to change, we then identified a range of potential implementation options for how the change could be made. This approach follows good practice for service change proposals of this type.

Figure 13: Summary approach – developing the implementation options *Figure 14*

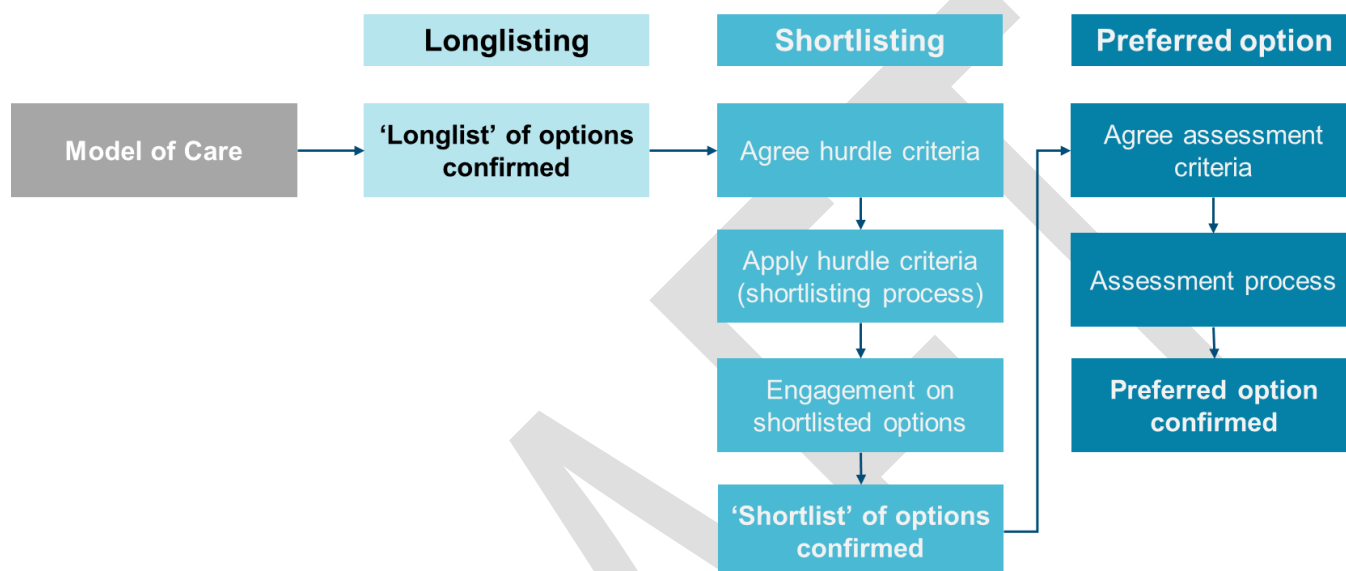


Table 21: Process used to develop and analyse implementation options *Table 22*

#	Element	Description
1	A longlist of implementation options	- To understand how we address the issues identified in our case for change and deliver our model of care, we followed a process to consider a wide range of potential solutions and refine them in a structured and consistent way - We built the views of residents and staff captured in the engagement processes into our longlisting approach - We sought to ensure we considered all potential delivery routes before we start to refine them down - The three categories of care provision recommended in the model of care were used to consider the possible options for delivery. The three categories were: - Changes to care and services provided in community settings and patients' own homes - The introduction of enhanced EoLC beds across north west London - Making sure the number of hospice inpatient beds were sufficient to meet future demand - Combining the options from these categories together, we came up with 54 possible longlist options. - Further information, including on how these 54 options were generated and why others were not considered, can be found in Chapter 6.
2	Developing the hurdle criteria	The CSPC steering group agreed four hurdle criteria in 2022²⁸

²⁸ Importantly, from the perspective of ensuring fair process, these were agreed before the model of care was developed.

	• Applying the hurdle criteria to the longlist • Generation of the shortlist	• These focus on the most important requirements for the new service and are designed as 'pass and fail' criteria • Longlisted options must pass all four of the criteria to be deemed suitable for consideration on the shortlist. • Options which fail any one or more of the criteria are deemed unsuitable, and therefore eliminated. • Further information can be found in Chapter 7.
3	• Developing the shortlist	• Applying the hurdle criteria to the longlist produced a shortlist of four options • To these was added the 'do nothing' or business as usual – current commissioned service model – option, to create a shortlist of five options • The business as usual option represents continuity of current arrangements and is therefore essentially the 'default position' in the absence of any particular change proposal. It is therefore established practice that it should be included on the shortlist. • Having passed the hurdle criteria, we know that the shortlisted options represent a range of feasible solutions for further analysis. Importantly, the shortlist included consideration for re-opening Pembridge Palliative Care Inpatient Unit. • Further information can be found in Chapter 7.
4	• Engaging on and confirming the shortlist	• Having identified a shortlist of options based on a logical assessment and application of the hurdle criteria to the longlist, we undertook a period of focussed engagement on the shortlisted options • Engagement occurred between mid-November and early December 2023. This provided the opportunity to: • Enrich the options through input and feedback from families, carers, professionals and service providers. Making each of the options as rich and detailed as possible allowed us to maximise the effectiveness of the subsequent process to identify the preferred option. • Ensure that no critical details have been missed, either in relation to the options themselves or, importantly, to the impact which they might have on particular north west London populations. This included, but was not limited to, those with protected characteristics. • Enhance our understanding (which will be needed for subsequent analysis) of the relative benefits, advantages and disadvantages of each of the options, and the weight of opinion behind each.
5	• Establishing non-financial assessment criteria	• We developed non-financial assessment criteria using the following approach: • The steering group applied weightings to the four criteria established at the outset of the programme: strategic fit, quality of care, affordability and achievability. • We expanded each criteria by considering how success could be assessed using our case for change (eight key issues – see Chapter 2). This ensures our case for change remains central to our deliberations and options that best address them are reflected in the scoring. • We eliminated any criteria that did not apply to non-financial assessment and established five detailed criteria for the purpose of non-financial options assessment. • Further information can be found in Chapter 8
6	• The non-financial assessment process	• Having tested and established a shortlist of options, we undertook an exercise in January 2024 to carry out a non-financial assessment against the set criteria with the participation and involvement of a specially convened panel. A range of perspectives was needed.

		- Participants were selected for the following reasons, and included two patient representatives: - Their knowledge and responsibilities toward integrated care delivery, quality, public health and clinical care - Their knowledge and experiences in providing or receiving community specialist palliative care - Impartiality - Panel members were provided with a pre-read briefing pack. The panel session involved: - Group deliberations - Individual scoring - Further information can be found in Chapter 8.
7	The financial assessment process	- In parallel with the non-financial assessment, a financial assessment of the shortlisted options was undertaken by NHS North West London in February 2024. The financial assessment sought to answer two key questions: - Which, if any, of the options can north west London afford? - What is the relative cost of each option to the north west London health and care system? - The affordability question means that if the cost of delivering an option is found to exceed the cost of business as usual – current commissioned service model - then additional funding will need to be found within the system to make the option viable - Shortlisted options were subjected to rigorous affordability analysis to validate that they met the affordability hurdle criterion - An economic valuation of non-financial factors, such as delivery risks and health benefits, is possible; however, this was considered to be a ‘double count’ of factors included within the non-financial appraisal - The financial appraisal therefore excludes these economic factors - The relative comparison of options is then combined with the non-financial assessment to give decision makers a rounded view of the financial and non-financial impacts. - Further information can be found in Chapter 8.
8	Preferred option	- The non-financial and financial assessment processes therefore resulted in two independent rankings of the shortlisted options. - These are then combined (using the weighting agreed by the steering group) to identify a preferred option, together with supporting rationale.

6. Developing the longlist of implementation options

6.1 Why we need implementation options

There are two main reasons why we need to develop implementation options, and then to go through the process of identifying an preferred option:

- **There are many ways to implement the model:** Our model of care describes the CSPC services we want to see in place for our population. It does not (for the most part) describe how these services should be put in place or how they should be arranged. We therefore need to consider the various ways in which this could be done and identify a preferred approach.
- **Implementing the whole model of care may not represent best value:** Although all elements of the model of care are important, it may be that it is either not affordable, not practical, or both if we want to implement the whole model straight away. We therefore need to consider the merits, in terms of relative benefits and costs, of implementing only some elements of the model of care.

Developing and accessing implementation options will allow us to be assured that our proposals represent the best possible way of realising the changes which we are seeking.

6.2 Our approach to developing the longlist of options

There are many possible ways in which the model of care could be delivered. To develop a longlist of options which was both manageable and realistic, but which did not close off possibilities unduly, we:

- Applied a set of principles to the longlisting exercise
- For the three key elements of the model (non bed-based care, enhanced EoLC beds and hospice inpatient beds), selected the parameters which most closely match what we know the service needs to achieve.

The principles which we applied to the longlisting exercise are:

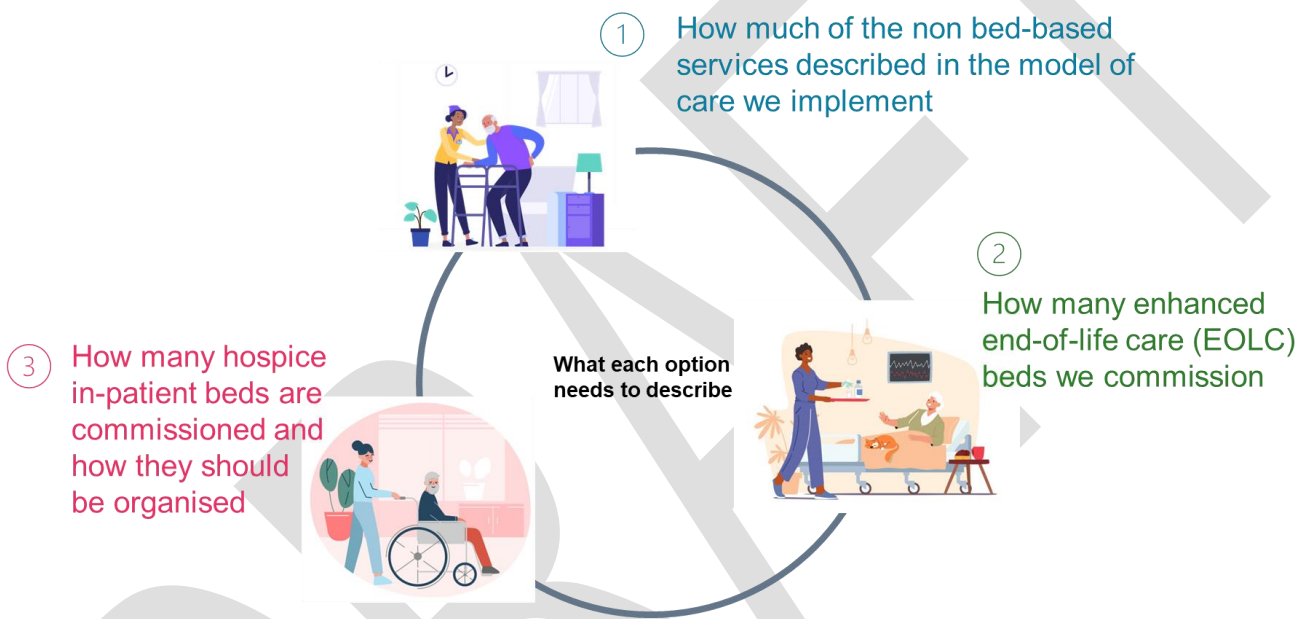
- **We will not include any options which ‘go beyond’ what the model of care proposes:** This includes any option with more hospice beds than would be needed to meet anticipated demand. Any such proposals could not be justified on strategic, operational and financial grounds.
- **We will build the options around what we know we need from the service, as well as around ‘best practice’ in options development.** This means, for example, that we will develop options based around having zero EoLC beds (representing a de-commissioning of the current eight beds), eight EoLC beds (representing the business as usual – current commissioned service model option - current commissioned service model) and 54 EoLC beds (representing the number which our modelling suggests is needed). Each of these numbers of beds reflects an important aspect of either the current service or the service we think we will need in future. Whilst evidence suggests an optimum number of beds for north west London is 54, it would be conceivable to have any number of beds between eight and 54. We are not including those options as we believe the only driver for variation from the optimum is financial.
- **We will consider distribution of hospice inpatient beds only between existing sites:** We recognise the importance of place and local access, but have not been able to identify any new locations for hospice delivery that we do not have now. This means we are working within the constraints of the geographical access we have now. Availability of estates in north west London is extremely constrained and prohibits the introduction of new locations, alongside staff availability. Based on scoping for other community bedded provision settings, new estates are not readily available. Other options for estates, for example NHS estate and care home estate, would not be appropriate for hospice inpatient beds given the therapeutic and clinical requirements for hospice inpatient beds. Therefore, we need to work within existing sites. Based on modelling, we have established that we have enough hospice inpatient beds in north west London and are therefore, not actively looking for any new hospice sites as part of this review.

- **We assume that enhanced EoLC beds will be delivered from appropriate settings in each borough, and so will not consider the particular distribution of these beds:** We believe enhanced EoLC beds are deliverable more easily in local settings, as the requirements for medical cover and co-location with other services are not so onerous, when compared to more intensive service provision.
- **Implementation phasing will be considered separately:** Services will undoubtedly need to be phased in and require an implementation timeline. However, this process is intended to identify what changes should be implemented. The timing of change, and the overall approach to implementation, will be considered later once the preferred option has been identified.

6.3 Generating the longlist of options

Each option on the longlist needs to include all of the elements of the model of care. This means that it needs to describe:

Figure 14: Diagram describing what each option had to describe *Figure 15*



We consider each of these elements in turn before generating the overall longlist.

What are the options relating to the non-bed-based elements of the model of care?

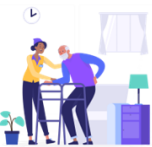
Non-bed-based provision includes the following services:

Table 22: Non bed-based services *Table 23*

Care in your own home	• Adult community specialist palliative care (SPC) team • Hospice at home • 24/7 specialist telephone advice
Outpatient, day-care and wellbeing services	• Hospice outpatient services • Day-care services • Psychological and bereavement support (for patients, families and carers)

In line with the principles listed above, we have considered three possibilities for how the non-bed-based model of care should be delivered:

Figure 15: The three possibilities for delivery of the non-bed based model of care can be delivered *Figure 16*

Question	Possible options	This means
 How could the non bed-based elements of the Model of Care be implemented?	1. Continue with current provision	We do not implement the changes to non bed-based care proposed in the model of care engagement document. We continue with the services and provision we have at this time.
	2. Minimum workable solution with a focus on improving fairness of provision	We implement changes described in the model of care that deliver a fairer spread of services and deliver some improvement, but not all the changes. This means we are closer to meeting national standards.
	3. Fully deliver model of care	We fully implement the changes to non bed-based care including ensuring full delivery against national standards.

A description of what we mean by the 'minimum workable solution' is set out in [Appendix A](#).

What are the options for implementing the enhanced EoLC bed element of the model of care?

There are currently eight enhanced EoLC beds in Hillingdon. These are for the sole use of Hillingdon patients and there is no equivalent provision in other boroughs. Our analysis recommends expanding the number of beds to 54, in order to provide access to this service for the whole of the north west London population who would benefit.

We have therefore considered options including either zero enhanced EoLC beds (de-commissioning the Hillingdon service), eight enhanced EoLC beds (representing the current position), or 54 enhanced EoLC beds (representing anticipated demand). Each of these numbers reflects an important aspect of either the current service or the service we think we will need in future. They are therefore the most logical numbers to build options around.

Figure 16: The possibilities for delivery enhanced EoLC beds *Figure 17*

Question	Possible options	This means
 How many enhanced EoLC beds should be commissioned?	1. 0 beds - We can reduce commissioned capacity	We stop funding enhanced EoLC beds that currently exist in Hillingdon. No enhanced EoLC beds will be available in NWL.
	2. 8 beds - Continue with existing commissioned capacity	We continue with the beds we currently have. This means 8 beds in Hillingdon, accessible to people living in Hillingdon.
	3. 54 beds - We can increase the number of beds and make them available across boroughs	We increase enhanced EoLC beds so they are available in all boroughs. They would be commissioned through existing facilities, for example in nursing homes.

What are the options for hospice inpatient beds and how they are distributed?

Our data modelling suggested we need 57 hospice inpatient beds to meet our needs for the next five years. We currently commission 67 hospice inpatient beds distributed across seven sites. We considered three scenarios:

- We ensure we have more beds than we need
- We commission what we need for the next five years
- We commission less beds than we need.

We then considered the ways in which these beds could be distributed.

Figure 17: The possibilities for delivering inpatient hospice beds

Question	Options – number of beds	Options – how could this number of beds be achieved?	This means
 How many hospice inpatient beds could we have, and how could they be distributed?	Existing commissioned capacity	We can re-open unutilised beds .	We restart hospice inpatient care provision at Pembridge without closing any other hospice inpatient beds. We keep all the beds we currently commission.
		We can close unutilised beds and open additional beds elsewhere.	We replace the beds commissioned at Pembridge by adding beds to other hospice sites. Overall, we keep the same number of hospice inpatient beds that we currently commission.
	Modelled 'required capacity'	We can close unutilised or under-utilised beds.	We close the hospice inpatient beds at Pembridge and retain spot-purchase capacity at alternative sites.
		We can close beds where there is more opportunity to improve access.	We restart hospice inpatient care provision at Pembridge but close beds in other units.
		We can close all current beds and open a single site located centrally.	We have a single site with 57 beds serving our whole population. We stop funding hospice inpatient provision in existing hospices.
	< 57 beds	We can close unutilised and under-utilised beds.	We reduce our bed base below 57 beds by closing Pembridge and beds in operational hospices.

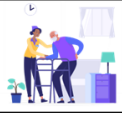
6.4 Putting this thinking together to generate an overall longlist of options

Bringing this thinking together, we have considered in combination:

- Three options for implementing the non bed-based elements of the model
- Six options for the number of enhanced EoLC beds
- Six options for the number and distribution of hospice inpatient beds.

This gives a total longlist of 54 options

Figure 18: Describing the longlist of 54 options *Figure 19*

	Question	Elements of potential solutions	
	How much of the non-bed based model of care can be delivered?	1. Continue with current provision 2. Minimum workable solution with a focus on improving fairness of provision 3. Fully deliver model of care	
	How much of the enhanced EOL care bed proposal can be delivered?	1. 0 beds - We can reduce commissioned capacity 2. 8 beds - Continue with existing commissioned capacity 3. 54 beds - We can increase the number of beds and make them available across boroughs	
	How many hospice inpatient beds do we need to serve the needs of our population for the next five years?	Existing commissioned capacity 67 beds	1. We can re-open unutilised beds 2. We can close unutilised beds and open additional beds elsewhere
		Reduce commissioned capacity 57 beds	3. We can close unutilised or under-utilised beds 4. We can close beds where there is more opportunity to improve access 5. We can close all current beds and open a single site located centrally
		< 57 beds	6. We can close unutilised and under-utilised beds

Three possible options

X

Three possible options

X

Six possible options

=

TOTAL 54 options

The full list of 54 options can be found in [Appendix B](#).

Figure 19: Examples of the longlisted options *Figure 20*

Examples of longlisted options:

Question	Elements of potential solutions						
How much of the non-bed based model of care can be delivered	1. Continue with current provision 2. Minimum workable solution with a focus on improving fairness of provision 3. Fully deliver model of care						
How much of the enhanced EOL care bed proposal can be delivered	1. 0 beds - We can reduce commissioned capacity 2. 8 beds - Continue with existing commissioned capacity 3. 54 beds - We can increase the number of beds and make them available across boroughs						
How many hospice inpatient beds do we need to serve the needs of our population for the next five years	<table border="1"><tr><td>Existing commissioned capacity 66.5 beds</td><td> 1. We can re-open unutilised beds 2. We can close unutilised beds and open additional beds elsewhere </td></tr><tr><td>Reduce commissioned capacity 56 beds</td><td> 3. We can close unutilised or under-utilised beds 4. We can close beds where there is more opportunity to improve access 5. We can close all current beds and open a single site located centrally </td></tr><tr><td>Reduce commissioned capacity - less than 56</td><td> 6. We can close Pembroke and close further beds elsewhere </td></tr></table>	Existing commissioned capacity 66.5 beds	1. We can re-open unutilised beds 2. We can close unutilised beds and open additional beds elsewhere	Reduce commissioned capacity 56 beds	3. We can close unutilised or under-utilised beds 4. We can close beds where there is more opportunity to improve access 5. We can close all current beds and open a single site located centrally	Reduce commissioned capacity - less than 56	6. We can close Pembroke and close further beds elsewhere
Existing commissioned capacity 66.5 beds	1. We can re-open unutilised beds 2. We can close unutilised beds and open additional beds elsewhere						
Reduce commissioned capacity 56 beds	3. We can close unutilised or under-utilised beds 4. We can close beds where there is more opportunity to improve access 5. We can close all current beds and open a single site located centrally						
Reduce commissioned capacity - less than 56	6. We can close Pembroke and close further beds elsewhere						

By way of example, a potential option may arise from the first element of each category where we:

- Continue with current provision for non-bed-based care
- Reduce enhanced end-of-life care bed provision
- Retain 67 hospice inpatient beds we currently have.

This means re-opening unutilised beds.

Question	Elements of potential solutions						
How much of the non-bed based model of care can be delivered	1. Continue with current provision 2. Minimum workable solution with a focus on improving fairness of provision 3. Fully deliver model of care						
How much of the enhanced EOL care bed proposal can be delivered	1. 0 beds - We can reduce commissioned capacity 2. 8 beds - Continue with existing commissioned capacity 3. 54 beds - We can increase the number of beds and make them available across boroughs						
How many hospice inpatient beds do we need to serve the needs of our population for the next five years	<table border="1"><tr><td>Existing commissioned capacity 66.5 beds</td><td> 1. We can re-open unutilised beds 2. We can close unutilised beds and open additional beds elsewhere </td></tr><tr><td>Reduce commissioned capacity 56 beds</td><td> 3. We can close unutilised or under-utilised beds 4. We can close beds where there is more opportunity to improve access 5. We can close all current beds and open a single site located centrally </td></tr><tr><td>Reduce commissioned capacity - less than 56</td><td> 6. We can close Pembroke and close further beds elsewhere </td></tr></table>	Existing commissioned capacity 66.5 beds	1. We can re-open unutilised beds 2. We can close unutilised beds and open additional beds elsewhere	Reduce commissioned capacity 56 beds	3. We can close unutilised or under-utilised beds 4. We can close beds where there is more opportunity to improve access 5. We can close all current beds and open a single site located centrally	Reduce commissioned capacity - less than 56	6. We can close Pembroke and close further beds elsewhere
Existing commissioned capacity 66.5 beds	1. We can re-open unutilised beds 2. We can close unutilised beds and open additional beds elsewhere						
Reduce commissioned capacity 56 beds	3. We can close unutilised or under-utilised beds 4. We can close beds where there is more opportunity to improve access 5. We can close all current beds and open a single site located centrally						
Reduce commissioned capacity - less than 56	6. We can close Pembroke and close further beds elsewhere						

Another example of an option would arise from the last element of each category where we:

- Fully deliver the model of care for non-bed-based services such as hospice at home
- Expand enhanced end-of-life care beds to all boroughs
- Reduce the number of hospice inpatient beds to less than 57 beds.

7. Reducing the longlist to a shortlist of the most promising options

7.1 Defining the 'hurdle' criteria

We know that many of the 54 longlisted options (set out in the previous chapter) will not deliver the level of change needed, and so they would not be acceptable to our residents.

We therefore applied the four 'hurdle' criteria to ensure that we systematically eliminated unacceptable options.

All of these criteria are based on those agreed by the steering group in 2022, with slight adaptation to allow for a 'pass/fail' assessment in each case. This is essential in ensuring a clear and effective process for eliminating unsuitable options.

Table 23: The hurdle criteria *Table 24*

Hurdle criteria agreed by steering group	Intention	Questions to be asked for this this assessment (yes/no questions)
Strategic fit	To ensure that the option advances local, north -west London, regional and national priorities.	- Does the option reduce inequity of provision across north west London? - Does the option meet evidence of need?
Quality of care	To ensure that the option improves the service delivered to residents and the outcomes which they achieve.	- Does the option lead to safe, high-quality care? - Does the option lead to accessible care?
Achievability	To ensure that the option can be effectively implemented by our service provider, including that they have the right skilled workforce available, whilst maintaining quality of service.	Can the option be realistically delivered?
Affordability	To ensure that the option is affordable and represents good value for money.	- Is the option affordable? - Is the option good value for money?

Longlisted options must pass all four of the hurdle criteria to be deemed suitable for consideration on the shortlist. Options which fail any one or more of the criteria are deemed unsuitable, and therefore eliminated.

7.2 Applying the hurdle criteria to the longlist of options

Applying the four hurdle criteria reduces the 54 longlisted options to a shortlist of just five options.

Figure 20: Outcome of applying hurdle criteria *Figure 21*

5	Achievability	Increasing our commissioned capacity of inpatient beds to 67 by closing unutilised beds and opening additional beds elsewhere fails the test of achievability. There will be insufficient staffing available to staff the extra beds, and the combination of closing and opening beds would be more complex than would be necessary to achieve the number of beds we need.
	Affordability	It also fails the test of affordability, in that it would require us to fund more beds than our demand projections suggest are needed, and so does not represent good value for money. It would mean less investment for other CSPC services.
6	Quality + Strategic fit	Closing all current beds and opening a single central site fails the tests of strategic fit and quality of care. It would require most people to travel much further to the central hospice site and would therefore also exacerbate inequalities in access.
	Achievability + Affordability	It also fails the tests of achievability and affordability, given the need to source a suitable site and the significant, complex and costly change programme which would be required to implement it.
7	Quality	Reducing the number of hospice inpatient beds to fewer than 57 fails the test of quality of care, as it would mean we had fewer beds than are needed to provide a high-quality service.

7.3 Shortlisted options

Having applied the hurdle criteria, there are four implementation options which remain. With the addition of a 'do nothing' or business as usual – current commissioned service model – option (option 0), five options will be taken forward to the detailed assessment phase. These options can be summarised as follows:

Figure 21: Description of shortlisted options *Figure 22*

	 How much of the non-bed based model of care can be delivered	 How much of the enhanced EoLC bed proposal can be delivered	 How many hospice inpatient beds do we need to serve the needs of our population for the next five years
Option 0 (business as usual – current commissioned service model – current commissioned service model)	No change	Eight beds Continue with existing commissioned capacity	67 beds All inpatient hospice beds open including Pembridge Palliative Care Centre Inpatient Unit
Option 1	Some change Minimum workable solution with a focus on improving fairness of provision	54 beds Increase number and make them available across boroughs	57 beds - Pembridge Palliative Care Centre Inpatient Unit closed - All other hospice inpatient beds remain open

Option 2	Some change Minimum workable solution with a focus on improving fairness of provision	54 beds Increase number and make them available across boroughs	57 beds - Pembridge Palliative Care Centre Inpatient Unit open - Reconfigure remainder of north west London hospice inpatient bed capacity
Option 3	Full implementation Fully deliver model of care	54 beds Increase number and make them available across boroughs	57 beds - Pembridge Palliative Care Centre Inpatient Unit closed - All other hospice inpatient beds remain open
Option 4	Full implementation Fully deliver model of care	54 beds Increase number and make them available across boroughs	57 beds - Pembridge Palliative Care Centre Inpatient Unit open - Reconfigure remainder of north west London hospice inpatient bed capacity

Although the business as usual –current commissioned service model –option would have been eliminated by application of the hurdle criteria, it is important to include it in the detailed assessment. This is because it:

- Provides a useful baseline to compare the relative benefits and risks associated with the other options
- Will be a 'default' option in the absence of an active decision and subsequent programme of work to implement any of the other options.

Having passed hurdle criteria, all remaining options offer solutions which are feasible. They all differ in what they offer local people in terms of:

- Equity of provision
- Impact on travel
- Deliverability of the solution.

These are examined in the following sections.

Option 0: Business as usual – current commissioned service model – current commissioned service model

Table 25: Advantages and disadvantages of Option 0 *Table 26*

Description	No change to non bed-based services. We continue to have eight enhanced EoLC beds in Hillingdon and retain all 67 hospice inpatient beds currently commissioned.
Advantages	✓ Already represents a good level of overall provision that, at ICS level, delivers fairly well against the national specification ✓ We retain access to hospice inpatient care at Pembridge Palliative Care Centre which means lower travel times, especially to deprived communities in the catchment area.

Disadvantages	✗ Inequity of access to services for people living in some boroughs such as Harrow where no weekend SPC team exists and no lymphoedema treatment exists for people without cancer. ✗ Enhanced EoLC beds remain available to people in Hillingdon only ✗ More hospice inpatient beds than deemed necessary for the next five years. ✗ Ongoing recruitment difficulties have led to Pembridge Palliative Care Centre Inpatient Unit being suspended. Re-opening the unit may not be deliverable. ✗ Lack of specialist provision means that more people die in hospital, often against their wishes to die elsewhere. This represents both poor quality of care and poor value for money.

Option 1: Some changes to non bed-based care, increasing enhanced EoLC beds, 57 hospice inpatient beds (Pembridge Palliative Care Centre Inpatient Unit does not reopen)

Table 26: Advantages and disadvantages of Option 1

Description	Some change to non bed-based services, we increase enhanced EoLC provision to 54 EoLC beds across north west London and reduce hospice inpatient beds to 57 beds by closing hospice inpatient care at the Pembridge Palliative Care Centre
Advantages	✓ Reduced variation in care resulting in more equitable offer within each borough. ✓ Closure of Pembridge instead of other sites results in no workforce impact (as staff were already re-assigned in 2021). It has no knock-on implications for other CSPC providers.
Disadvantages	✗ By not re-opening Pembridge Palliative Care Centre Inpatient Unit, people in IMD Deciles one and two living in this catchment will have increased travel times to alternatives. This increases public transport travel by 12 minutes and drive time by six minutes for these populations. Travel time increases to experiences that are similar to those accessing other hospices in north west London. ✗ Incomplete implementation of the model means that more people die in hospital, often against their wishes to die elsewhere. This represents both poor quality of care and poor value for money.

Option 2: Some changes to non bed-based care, increasing enhanced EoLC beds, 57 hospice inpatient beds (Pembridge Palliative Care Centre Inpatient Unit open)

Table 27: Advantages and disadvantages of Option 2

Description	Some change to non bed-based services, we increase enhanced EoLC provision to 54 beds across north west London and reduce hospice inpatient beds to 57 by re-opening hospice inpatient beds at Pembridge Palliative Care Centre and closing other beds
Advantages	✓ Reduced variation in care resulting in more equitable offer within each borough.
Disadvantages	✗ Ongoing recruitment difficulties have led to Pembridge Palliative Care Centre Inpatient Unit being suspended. Re-opening the unit may not be deliverable. ✗ Opening a unit which is currently not operational (Pembridge) and instead closing beds within operational units would result in workforce disruption to affected sites and loss of income for charitable hospices. ✗ Incomplete implementation of the model means that more people die in hospital, often against their wishes to die elsewhere. This represents both poor quality of care and poor value for money.

Option 3: Full delivery of changes to non bed-based care, increasing enhanced EoLC beds, 57 hospice inpatient beds (Pembridge Palliative Care Centre Inpatient Unit does not reopen)

Table 28: Advantages and disadvantages of Option 3

Description	Fully deliver the model of care for non-bed-based services, we increase enhanced EoLC provision to 54 beds across north west London and reduce hospice inpatient beds to 57 by closing hospice inpatient care at Pembridge Palliative Care Centre
Advantages	✓ Reduced variation in care resulting in more equitable offer within each borough. ✓ Full compliance with the model of care recommendations. ✓ Closure of Pembridge Palliative Care Centre Inpatient Unit instead of other sites results in no workforce impact (as staff were already re-assigned in 2021). It has no knock-on implications for other CSCP hospice and NHS providers.
Disadvantages	✗ By not re-opening Pembridge Palliative Care Centre Inpatient Unit, people in IMD Deciles one and two living in this catchment will have increased travel times to alternatives. This increases public transport travel by 12 minutes and drive time by six minutes for these populations. Travel time increases to experiences that are similar to those accessing other hospices in north west London.

Option 4: Full delivery of changes to non-bed-based care, increasing EoLC beds, 57 hospice inpatient beds (Pembridge Palliative Care Inpatient Unit open)

Table 29: Advantages and disadvantages of Option 4 Table 30

Description	Fully deliver the model of care for non bed-based services, we increase enhanced EoLC provision to 54 beds across north west London and reduce hospice inpatient beds to 57 by re-opening hospice inpatient beds at Pembridge Palliative Care Centre and closing other beds
Advantages	✓ Reduced variation in care resulting in more equitable offer within each borough. ✓ Full compliance with the model of care recommendations.
Disadvantages	✗ Ongoing recruitment difficulties have led to Pembridge Palliative Care Centre Inpatient Unit being suspended. Re-opening the unit may not be possible without critical specialist palliative care consultant staff. ✗ Opening a unit which is currently not operational (Pembridge) and instead closing beds within operational units would result in workforce disruption to affected sites and loss of income for charitable hospices.

7.4 Feedback on the shortlist of options

During November and December 2023, we held 11 engagement events at system level and within boroughs to engage local people on the shortlist of options being proposed for detailed analysis. There was support for the five shortlisted options and we received no alternative suggestions for consideration.

8. Assessment of shortlisted options to identify a preferred solution

8.1 Non-financial appraisal of the shortlisted options

Two activities informed the decision-making process to agree the preferred solution:

- A non-financial score applied to the shortlisted options, based on weighted criteria developed by the CPSC steering group, derived through a specially formed panel
- A financial score developed through analysis of costs and benefits of each shortlisted option.

Establishing the non-financial assessment involved three groups and the following tasks:

Table 30: Overview of tasks in analysing shortlisted options Table 31

Tasks undertaken	Who was involved

January 2022	1. Identification and agreement of four criteria for the purpose of decision making. 2. Agree percentage weightings for each criterion	Steering group
October 2023	1. Describe detailed criteria based on case for change. 2. Provision of objective and impartial analysis to inform panel deliberations based on description indicators.	Project team
January 2024	1. Sign off detailed criteria for use in non-financial assessment.	Steering group
January 2024	2. Scoring shortlisted options against criteria.	Non-financial assessment panel

Defining the non-financial criteria

The CSPC steering group identified four criteria for evaluation in 2022, one of which was 'affordability'. This does not form part of this assessment and will be examined separately as part of the economic assessment.

The three remaining criteria were developed into five detailed criteria which could be assessed and scored against. These were signed off by steering group in January 2024.

These five detailed criteria were mapped to the eight key issues in our case for change alongside insights gleaned from engagement. They are summarised below.

Table 31: Detailed criteria and evidence used in analysis *Table 32*

Criteria	Detailed criteria	Description	Evidence
Strategic fit	Care model alignment	- Aligns to best practice (defined in the NHS England national specification for palliative care and end-of-life care (adults)) - Integrated delivery which is easy to navigate.	1. Model of care 2. EHIA
	Meeting population needs	- Responding to future need and meeting the palliative care needs of north west London's changing population - Reducing health inequalities and social exclusion.	1. Model of care 2. EHIA
Quality of care	Access to care	- Addressing service variation, improving access to care for all and making sure that everyone receives the same level of care, regardless of where they live - The extent to which the option allows patients, staff and visitors to access the site whether using public or private transport, in terms of travel time.	1. Model of care 2. Travel mapping
	Quality	- Responding to feedback and engagement and building on the valuable learning and feedback received from previous reviews of palliative and end-of-life care services and ongoing engagement. - Optimises ability for residents to die in their preferred place of death.	1. Engagement reports/feedback 2. Model of care
Achievability	Deliverability	Foreseeable workforce recruitment and retention risk that will impact implementation.	1. Provider feedback

		- The scale, complexity and risk of the required implementation programme. - The relative impact on others (providers and organisations within north west London and beyond). - Confidence to largely operationalise within two years.	2. Feedback from engagement
Affordability	Not in scope for non-financial assessment. This will be assessed through a separate assessment of costs and benefits.		

Method for examining the non-financial impact of the shortlisted implementation options

Initial weightings were defined and agreed by the CSPC steering group in 2022 for each criterion used in shortlisting. Weighting of detailed criteria was equally split, resulting in the following final weightings. These were signed off by the CSPC steering group in January 2024.

For the purposes of the non-financial assessment, affordability is excluded, meaning that the total weighting for the non-financial assessment is 74%.

Table 32: Weighting of criteria *Table 33*

Criterion	Initial weighting (from steering group)	Detailed criteria	Final weighting
Strategic fit	22%	Care model alignment	11%
		Meeting population needs	11%
Quality of care	32%	Access to care	16%
		Quality and sustainability of care	16%
Achievability	20%	Deliverability	20%
Affordability*	26%		26%*
TOTAL	100%		100%
TOTAL WEIGHTING FOR NON-FINANCIAL ASSESSMENT			74%

* Not for inclusion in non-financial assessment.

To assess how well options responded to the detailed criteria, we used the following scoring methodology. Average (mean) scores are documented for each option. Weightings were then applied to arrive at a weighted score.

Table 33: Scoring methodology *Table 34*

Score	What it means
10	Could hardly be better
9	Excellent
8	Very well
7	Well
6	Quite well
5	Adequately
4	Somewhat adequately
3	Badly
2	Very badly
1	Extremely badly
0	Could hardly be worse

Forming the assessment panel

Having tested and established a shortlist of options, we undertook an exercise in January 2024 to evaluate the qualitative merits of options. A specially convened panel was formed to evaluate each

option against the five detailed criteria set out above. Panel participants were selected for the following reasons:

- Their detailed knowledge of, and responsibility for, integrated care delivery, quality, public health and clinical care
- Their knowledge and experiences in providing or receiving care including community specialist palliative care
- Impartiality to the outcome of the process such as out of area providers and clinicians working in other health and care systems.

The panel is the culmination of a public process of considering criteria and ensuring we are considering the right options. The ten-person panel included:

Table 34: Panel members *Table 35*

Role	Organisation
NW London ICS Programme Director	NHS NW London
Chief Nursing Officer	NHS NW London
North west London CSPC Provider representative	Harlington Hospice
Patient representative	Carers Council/Carers Network
Patient representative	Citizens panel
Director of Programmes	Hospice UK
Acute Palliative Care Consultant	Barts Health NHS Trust
Care Director	St Christopher's Hospice, SE London
Clinical Lead	St Christopher's Hospice, SE London
Public Health	London Borough of Newham

In advance of the session, panel members were provided with pre-read briefing pack and access to:

- The key issues document
- The model of care document
- The engagement report
- Hospice inpatient unit bed modelling
- Travel mapping analysis
- Options engagement
- Equalities and Health Inequalities Impact Assessment (EHIA)
- Deliverability assessment.

During the session, the panel:

- Received a reminder of summary evidence and analysis contained in the pre-read briefing pack
- Were asked to deliberate as a group by sharing opinion and insight
- Anonymously and individually scored each of the (five) options against each of the (five) detailed criteria. Panel members were not asked to provide a rationale for their scoring.

Care model alignment

In assessing how well options deliver against the detailed requirements of this criterion, we can examine evidence in the model of care document relating to national standards and integrated care and the EHIA.

Table 35: Summary comparison of criteria against care model alignment *Table 36*

Option	Summary of how options compare against criteria requirements
Option 0	While the model of care document suggests a good level of achievement against good practice, it highlighted variation at borough level, meaning lack of consistent and universal achievement against good practice. Addressing variation and gaps in

	provision was a key part of our case for change. This is not possible to achieve in this option. The model of care, including feedback from the engagement exercises, demonstrated a lack of consistency in providing joined up care in all boroughs.
Option 1	By ensuring all services are available in each borough, there is some improvement in alignment with national good practice. However, the resulting offer falls short in meeting national requirements in two areas: • Fair access to care • Maximising comfort and wellbeing By introducing the following services, all change options offer improvement toward joined-up care: • 24/7 access to telephone advice in all boroughs to help clinicians and patients navigate care and access help and advice • Holistic care planning that is shared with the MDT and electronically documented in a way that can be seen by all clinicians involved in the care of the individual • In-reach to communities to improve public awareness of provision.
Option 2	By ensuring all services are available in each borough, there is some improvement in alignment with national good practice. However, the resulting offer falls short in meeting national requirements in two areas: • Fair access to care • Maximising comfort and wellbeing. By introducing the following services, all change options offer improvement toward joined-up care: • 24/7 access to telephone advice in all boroughs to help clinicians and patients navigate care and access help and advice • Holistic care planning that is shared with the MDT and electronically documented in a way that can be seen by all clinicians involved in the care of the individual • In-reach to communities to improve public awareness of provision.
Option 3	Full delivery of the model of care meets all requirements of the national specification. By introducing the following services, all change options offer improvement toward joined-up care: • 24/7 access to telephone advice in all boroughs to help clinicians and patients navigate care and access help and advice • Holistic care planning that is shared with the MDT and electronically documented in a way that can be seen by all clinicians involved in the care of the individual • In-reach to communities to improve public awareness of provision.
Option 4	Full delivery of the model of care meets all requirements of the national specification. By introducing the following services, all change options offer improvement toward joined-up care: • 24/7 access to telephone advice in all boroughs to help clinicians and patients navigate care and access help and advice • Holistic care planning that is shared with the MDT and electronically documented in a way that can be seen by all clinicians involved in the care of the individual • In-reach to communities to improve public awareness of provision.

The mean participant scores against this criterion were (minimum 0, maximum 10):

Table 36: Mean participant scores for care model alignment *Table 37*

Criteria	Option 0 Business as usual – current	Option 1	Option 2 Some change.	Option 3 Full implementation	Option 4 Full implementation

	commissioned service model	Some change. Pembridge closed	Pembridge open	Pembridge closed	Pembridge open
Care model alignment score	1.0	2.7	3.6	7.1	7.4

Meeting population needs

In considering how shortlisted options compare for this criterion, we examined the model of care and the EHIA.

Table 37: Summary comparison of criteria against meeting population needs *Table 38*

Option	Summary of how options compare against criteria requirements
Option 0	- There are currently more hospice inpatient beds than our modelling suggests are needed. - By not improving public knowledge and information about services, we do not improve health literacy, particularly important in improving uptake of help among deprived communities.
Option 1	- By providing access to 57 hospice beds, we are rightsizing bed capacity to the five-year needs of our population. - Some improvement of health literacy and awareness-raising of services combined with improved access to key services improves the offer to deprived populations. - The EHIA shows partial delivery makes “some positive” improvement in reducing health inequalities.
Option 2	- By providing access to 57 hospice beds, we are rightsizing bed capacity to the five-year needs of our population. - Some improvement of health literacy and awareness-raising of services combined with improved access to key services improves the offer to deprived populations. - The EHIA shows partial delivery makes “some positive” improvement in reducing health inequalities.
Option 3	- By providing access to 57 hospice beds, we are rightsizing bed capacity to the five-year needs of our population. - Deprived populations are expected to see additional benefit from better awareness of services and full implementation of the model of care including extended hours of key services. - The EHIA shows full delivery makes better improvement in addressing health inequalities.
Option 4	- By providing access to 57 hospice beds, we are rightsizing bed capacity to the five-year needs of our population. - Deprived populations are expected to see additional benefit from better awareness of services and full implementation of the model of care including extended hours of key services. - The EHIA shows full delivery makes better improvement in addressing health inequalities.

The mean participant scores against this criterion were (minimum 0, maximum 10):

Table 38: Mean participant scores for meeting population need *Table 39*

Criteria	Option 0 Business as usual – current	Option 1 Some change. Pembridge closed	Option 2 Some change. Pembridge open	Option 3 Full implementation	Option 4 Full implementation

	commissioned service model			Pembridge closed	Pembridge open
Meeting population needs scores	1.0	4.2	3.4	7.8	6.9

Access to care

In considering how shortlisted options compare for this criterion, we examined the model of care and the outputs of the travel mapping exercise undertaken in 2022.

Table 39: Summary comparison of criteria against access to care *Table 40*

Option	Summary of how options compare against criteria requirements
Option 0	- Our model of care work uncovered differences at borough level in types of services available and hours of provision. This resulted in variation in care and differences in services available to patients depending on where they live. - This option does little to address variation and does not offer improvement in access to care. An example is the availability of enhanced EoLC beds which will remain accessible to people living in Hillingdon only. - Access to hospice inpatient care at Pembridge Palliative Care Centre results in better travel times for communities within its current catchment area than if it were closed.
Option 1	- Partial delivery of the non bed-based aspects of care addresses gaps in provision. For example, lack of hospice at home provision in three boroughs (Hammersmith & Fulham, Ealing and Hounslow) - Partial delivery of the non bed based aspects of care reduces differences in hours of provision of services available within boroughs. For example, SPC team where seven days per week provision isn't available in Harrow, but is elsewhere. - By providing enhanced EoLC beds to people in boroughs other than Hillingdon addresses variation in care currently experienced. - Closure of hospice inpatient care at Pembridge Palliative Care Centre results in increased travel times to the next nearest alternative for the catchment population of this unit.
Option 2	- Partial delivery of the non bed-based aspects of care addresses gaps in provision. For example, lack of hospice at home provision in three boroughs (Hammersmith & Fulham, Ealing and Hounslow) - Partial delivery of the non bed based aspects of care reduces differences in hours of provision of services available within boroughs. For example, SPC team where seven days per week provision isn't available in Harrow, but is elsewhere. - By providing enhanced EoLC beds to people in boroughs other than Hillingdon addresses variation in care currently experienced. - Access to hospice inpatient care at Pembridge Palliative Care Centre results in better travel times for communities within its current catchment area than if it were closed.
Option 3	- Full delivery of the non bed-based aspects address variation in care discovered during development of the model of care and public engagement. - By providing enhanced EoLC beds to people in boroughs other than Hillingdon addresses variation in care currently experienced. - Closure of hospice inpatient care at Pembridge Palliative Care Centre results in increased travel times to the next nearest alternative for the catchment population of this unit.
Option 4	- Full delivery of the non bed-based aspects address variation in care discovered during development of the model of care and public engagement. - By providing enhanced EoLC beds to people in other boroughs, this option addresses variation in care currently experienced.

	Access to hospice inpatient care at Pembridge Palliative Care Centre results in better travel times for communities within its current catchment area than if it were closed.

The mean participant scores against this criterion were (minimum 0, maximum 10):

Table 40: Mean participant scores for access to care *Table 41*

Criteria	Option 0 Business as usual – current commissioned service model	Option 1 Some change. Pembridge closed	Option 2 Some change. Pembridge open	Option 3 Full implementation Pembridge closed	Option 4 Full implementation Pembridge open
Access to care scores	1.3	3.7	4.7	6.2	7.3

Quality

In assessing this criteria, reference was made to the model of care document and feedback from engagement.

Table 41: Summary comparison of criteria against quality *Table 42*

Option	Summary of how options compare against criteria requirements
Option 0	- Not implementing changes to the model of care does not address the feedback we have received from stakeholders. - Latest information suggests a significant discrepancy between where people actually die, and the public preferences described in national patient surveys. - By not implementing changes described in the model of care, we do not anticipate improvement in the current picture.
Option 1	- Implementing some of the changes to non bed -based care goes part way to addressing feedback received. - In turn this is anticipated to make some improvement to delivering against preferred place of death.
Option 2	- Implementing some of the changes to non bed -based care goes part way to addressing feedback received. - In turn this is anticipated to make some improvement to delivering against preferred place of death.
Option 3	- Implementing the full range of improvements to non bed-based care responds to feedback we have received during public engagement. - Feedback received from some participants suggested a preference to retain hospice inpatient provision at Pembridge Palliative Care Centre. - Delivering the full model of care gives CSPC services the means to improve place of death and reduce deaths in hospital.
Option 4	- Implementing the full range of improvements to non bed-based care and retaining hospice inpatient provision at Pembridge Palliative Care Inpatient Unit would respond to some feedback we have received during public engagement around a preference to retain hospice inpatient provision at Pembridge Palliative Care Centre. There was support during public engagement for all hospice and local provision. - Delivering the full model of care changes gives CSPC services the means to improve place of death and reduce deaths in hospital.

The mean participant scores against this criterion were (minimum 0, maximum 10):

Table 42: Mean participant scores for quality *Table 43*

Criteria	Option 0 Business as usual – current commissioned service model	Option 1 Some change. Pembridge closed	Option 2 Some change. Pembridge open	Option 3 Full implementation Pembridge closed	Option 4 Full implementation Pembridge open
Quality scores	1.0	3.0	3.4	8.0	8.3

Deliverability

In considering how shortlisted options compare for this criterion, we drew on information and analysis from our engagement with providers, a review of local, regional and national evidence and the model of care.

Table 43: Summary comparison of criteria against deliverability *Table 44*

Option	Summary of how options compare against criteria requirements
Option 0	- There are known workforce risks associated with re-opening inpatient provision at Pembridge Palliative Care Centre - CLCH have continued to struggle to recruit to medical roles to clinically oversee provision here, meaning it is not simple or straightforward to fulfil - Current estimates suggest it will take at least two years to recruit and train a fully staffed unit - While no changes occur to other CSPC provision, hospital providers will likely be impacted by emergency presentations for whom community alternatives are not available.
Option 1	- Providers have not flagged recruitment challenges in delivering the partial delivery of the model of care - While there are some complexities in extending hours of provision and introducing services to areas where provision doesn't currently exist, the ability to draw on others within the north west London system means this is less complex - Closing Pembridge Palliative Care Centre Inpatient Unit does not adversely impact other north west London charitable and NHS providers, who have capacity to accommodate demand for the population. As such, delivery of this option is much more easy to achieve within a reasonable timescale.
Option 2	- Providers have not flagged recruitment challenges in delivering the partial delivery of the model of care - CLCH have continued to struggle to recruit to medical roles to clinically oversee provision here, meaning it is not simple or straightforward to fulfil - Current estimates suggest it will take at least two years to recruit and train a fully staffed unit - While there are some complexities in extending hours of provision and introducing services to areas where provision doesn't currently exist, the ability to draw on others within the north west London system means this is less complex - Opening Pembridge Palliative Care Centre Inpatient Unit requires the closing of other beds in line with our bed modelling findings - This means closing beds that are currently operating whilst we attempt to open beds where we have had difficulty recruiting and retaining staff - The impact on other providers is therefore higher and the lead-in time to re-open beds at Pembridge Palliative Care Centre Inpatient Unit means it is unlikely they will be operational within a two year period and this is subject to the successful recruitment of specialist palliative consultant and nursing staff.
Option 3	- Providers have not flagged recruitment challenges in delivering the full model of care - Safe staffing at operational hospice inpatient sites means there are no concerns about ongoing service delivery

	- There are some complexities in delivering the full model of care across north west London, explored in section 8, including the scale and complexity required to implement the new model of care - The relative impact on providers is low as full delivery maximises the system's ability to care for people in non-acute hospital settings, supporting hospital capacity to be utilised for people with acute medical needs - There is a moderate level of confidence of delivery within two years.
Option 4	- Providers have not flagged recruitment challenges in delivering the partial delivery of the model of care however, there are known workforce risks associated with re-opening hospice inpatient provision at Pembridge Palliative Care Centre Inpatient Unit - Complexity and risk are seen to be a high concern given the challenge of implementing the full model of care while also re-opening the Pembridge Palliative Care Centre Inpatient Unit and closing, in its place, beds in otherwise operational hospices - The disruption to currently operational hospice inpatient units mean impact on others is a concern. The difficulties in fully staffing Pembridge Palliative Care Inpatient Unit in addition to recruiting other posts within the full delivery model poses risk that the service will not be operational within a two year period.

The mean participant scores against this criterion were (minimum 0, maximum 10):

Table 44: Mean participant scores for deliverability *Table 45*

Criteria	Option 0 Business as usual – current commissioned service model	Option 1 Some change. Pembridge closed	Option 2 Some change. Pembridge open	Option 3 Full implementation Pembridge closed	Option 4 Full implementation Pembridge open
Deliverability scores	1.9	5.3	2.8	7.1	4.3

Result of non-financial assessment

The scoring workshop resulted in a mean average score for options based on criteria, against which the weightings were applied. Each criterion is scored between 0 and 10. A score of 10 is high. The summary of mean average scores is summarised below.

Table 45: Mean average scores *Table 46*

Criteria	Option 0	Option 1	Option 2	Option 3	Option 4
Care model alignment	1.0	2.7	3.6	7.1	7.4
Meeting population needs	1.0	4.2	3.4	7.8	6.9
Access to care	1.3	3.7	4.7	6.2	7.3
Quality	1.0	3.0	3.4	8.0	8.3
Deliverability	1.9	5.3	2.8	7.1	4.3
TOTAL MEAN AVERAGE SCORE (minimum 0, maximum 50) (UNWEIGHTED)	6.20	18.90	17.90	36.20	34.20

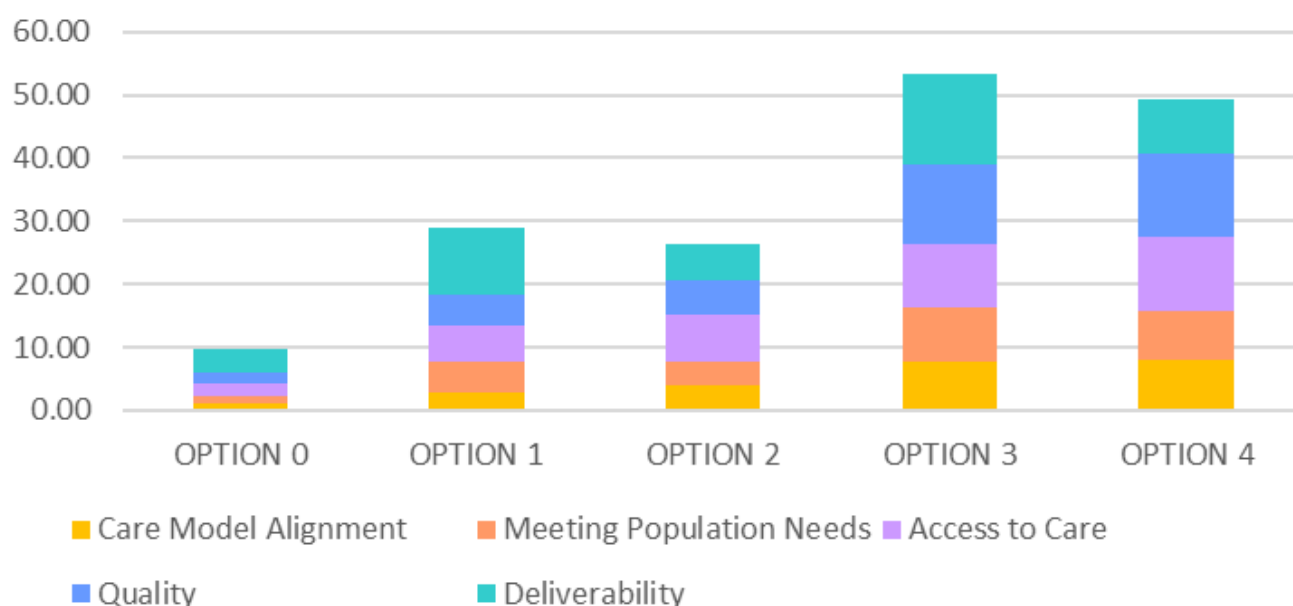
Weightings (described in table 32) were then applied to mean average scores. The table below shows resulting weighted scores for options.

Table 46: Weighted scores *Table 47*

Criteria	Option 0 Business as usual – current commissioned service model	Option 1 Some change. Pembridge Palliative Care Centre Inpatient Unit closed	Option 2 Some change. Pembridge Palliative Care Centre Inpatient Unit open	Option 3 Full implementation Pembridge Palliative Care Centre Inpatient Unit closed	Option 4 Full implementation Pembridge Palliative Care Centre Inpatient Unit open
Care model alignment Weighting applied: 11%	1.10	2.97	3.96	7.81	8.14
Meeting population needs Weighting applied: 11%	1.10	4.62	3.74	8.58	7.59
Access to care Weighting applied: 16%	2.08	5.92	7.52	9.92	11.68
Quality & sustainability of care Weighting applied: 16%	1.60	4.80	5.44	12.80	13.28
Deliverability Weighting applied: 20%	3.80	10.60	5.60	14.20	8.60
TOTAL - WEIGHTED (Min 0%, Max 74%)	9.68%	28.91%	26.26%	53.31%	49.29%

Figure 22: Weighted outputs of scoring *Figure 23*

Total Weighted Scores (out of a max possible score of 74)



The rank of options following this assessment is therefore:

Table 47: Rank of options

Rank	Option
1	Option 3
2	Option 4
3	Option 1
4	Option 2
5	Option 0

The results of this exercise show a clear preference for making changes to the provision of CSPC in north west London over continuing with current service provision. There is also a marked preference for full delivery of the model of care (options three and four) compared with partial delivery options (options one and two). The 4.1 point difference between options three and four shows a preference for full implementation while not re-opening the Pembridge Palliative Care Centre Inpatient Unit.

8.2 Financial appraisal of shortlisted options

Financial appraisal of the shortlisted options was undertaken for two purposes:

- **To confirm the affordability of the shortlisted options:** Affordability was used as a hurdle criterion to identify and remove non-viable options from the long list. As there were a very large number of longlisted options, this necessarily only considered the main costs and benefits of the options to identify if an option was potentially affordable. The financial appraisal validates in greater detail whether the short-listed options are indeed affordable. If an option is found not to be affordable, the hurdle criteria assessment would be revisited, and that option would be removed from the shortlist.
- **To support decision makers in identifying the preferred option in the rounded options appraisal:** The non-financial options appraisal detailed in [section 8.1](#) is supplemented by a financial appraisal to allow decision makers to make a rounded decision on the preferred option. The financial appraisal has been allocated a 26% weighting, and will be considered by decision makers as part of the combined appraisal in determining the preferred option.

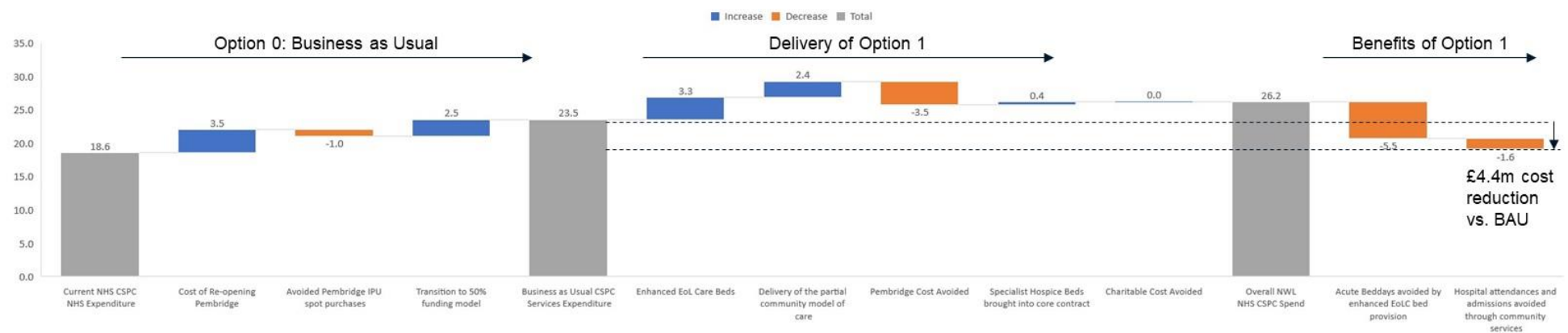
Option 1: Some change with Pembridge Palliative Care Centre Inpatient Unit closed

Under this option:

- 46 new enhanced EoLC beds are commissioned, in addition to the eight existing beds already available in Hillingdon, providing coverage across all boroughs
- The community services model is partly delivered. The full definition of partial and full delivery is set out in Appendix A: Delivery option definitions
- Pembridge Palliative Care Centre Inpatient Unit would be permanently closed and the costs associated with the re-opening of the unit would therefore be avoided and instead would be used to support funding of the new community services and enhanced end-of-life care beds.
- The specialist inpatient hospice beds, which are currently spot purchased, would be commissioned through providers' core contracts leading to an efficiency over the spot purchase model
- As a result of the availability of the enhanced EoLC beds, acute hospitals in north west London would be able to discharge palliative care patients earlier into the enhanced EoLC beds. This would reduce length of stay and occupied bed days in the acute sector, reducing the number of surge beds that require commissioning and result in an overall saving for the NHS in north west London.
- As a result of the improved community services model, palliative care patients would receive improved support and at-home services. This is expected to reduce A&E attendances and resulting admissions. Avoiding these admissions would avoid A&E, treatment and surge bed costs in the acute sector.

This is summarised below:

Figure 24: Financial summary for option 1



Option 1 is shown to be £4.4m favourable to business as usual – current commissioned service model and passes the core affordability test to remain on the shortlist.

Option 2: Some change with Pembridge Palliative Care Centre Inpatient Unit open

Under option 2, as per option 1:

- 46 new enhanced end-of-life care beds are commissioned
- The community services model is partly delivered
- The enhanced EoLC beds provide the same benefit to hospital discharges
- The community care model provides the same benefit of hospital attendance and admission avoidance.

Distinct from option 1:

- Pembridge is re-opened, meaning that the cost associated with this, which is already within the business as usual – current commissioned service - model, remains in the costing of the option
- Specialist beds need not be provided in other providers' core contracts, as they are provided within the re-opened Pembridge.

The financial implication of this is summarised below:

Figure 25: Financial summary for option 2



Option 2 is shown to be £2.4m favourable to business as usual – current commissioned service - model and passes the core affordability test to remain on the shortlist.

Option 3: Full implementation with Pembridge Palliative Care Centre Inpatient Unit closed

Under option 3, as per option 1:

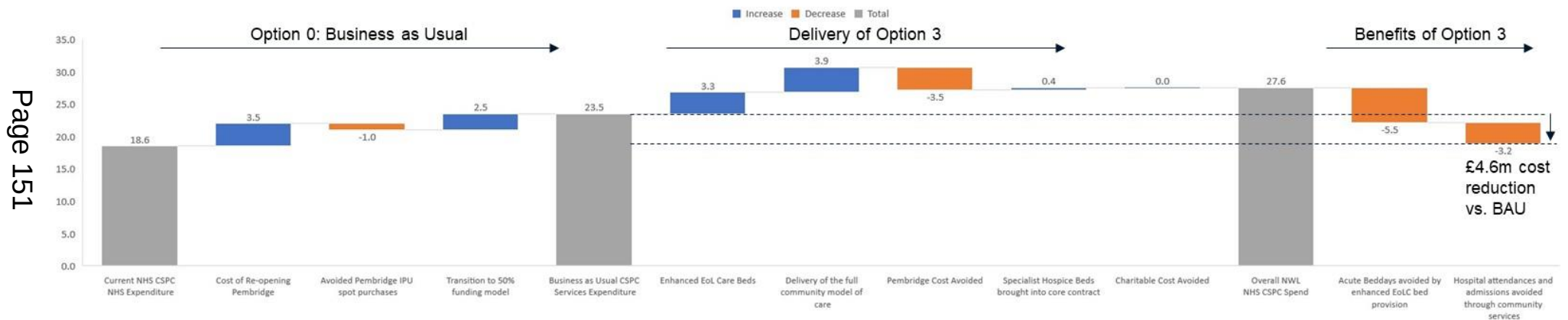
- 46 new enhanced end-of-life care beds are commissioned
- The enhanced EoLC beds provide the same benefit to hospital discharges

Distinct from Option 1:

- The community services model is fully delivered as described in Appendix A: Delivery option definitions.
- The full community care model provides the full benefit of hospital attendance and admission avoidance

This is summarised below:

Figure 26: Financial summary for option 3



Option 3 is shown to be £4.6m favourable to business as usual – current commissioned service - model and passes the core affordability test to remain on the shortlist.

Option 4: Full implementation with Pembridge Palliative Care Centre Inpatient Unit open

In option 4, as per all options 1-4:

- 46 new enhanced end-of-life care beds are commissioned
- The enhanced EoLC beds provide the same benefit to hospital discharges.

As per Option 2:

- Pembridge Palliative Care Inpatient Unit is re-opened, meaning that the cost associated with this, which is already within business as usual – current commissioned service - model remains in the costing of the option
- Specialist beds need not be provided in other providers' core contracts, as they are provided within the re-opened Pembridge Palliative Care Centre Inpatient Unit.

As per Option 3:

- The community services model is fully delivered
- The full community care model provides the full benefit of hospital attendance and admission avoidance.

This is summarised below:

Figure 27: Financial summary for option 4



Option 4 is shown to be £2.5m favourable to business as usual – current commissioned service - model and passes the core affordability test to remain on the shortlist.

We have included details of all five options shortlisted to enable respondents to the consultation to understand the different trade-offs that have been considered. We believe these options provide the opportunity for debate and weighing up of relative benefits of different approaches.

We are formally proposing that we consult on two of these options: option three and option four. These options scored highest in our assessment, individually in non-financial and financial assessments and collectively across both assessments. Of these, option three is the highest scoring and therefore the preferred option.

We believe that 'do nothing' and options for partial implementation of the new model of care (options 0, 1 and 2) will not deliver the ambition for providing the best possible CSpC services and support we have for north west London residents and are providing the information about these to inform feedback rather than as proposed options we are consulting on.

The items which build up the financial appraisal for each option are further defined and sourced in [Appendix H](#), under Key Assumptions and data sources.

Summary of the financial appraisal

All of the options 1-4 are found to improve NHS NW London's financial position against the business as usual – current commissioned service - model, and pass the core test to remain on the shortlist.

The financial impacts compared to the business as usual – current commissioned service - model are then converted into scores for use in the options appraisal. As a 26% weighting has been allocated to the financial appraisal, this score is out of 26. The option most favourable compared to business as usual – current commissioned service - model scores the full 26%, with the remaining options scoring proportionately. This is summarised below:

Table 48: Financial impact of each option. Positive indicates a cost reduction vs. business as usual – current commissioned service model

Option	Financial impact vs. business as usual – current commissioned service model (£m, 23/24 prices)	Affordability check	Appraisal score (out of 26%)
0. Business as usual – current commissioned service - model	n/a – comparator option	n/a – comparator option	0
1. Part implementation, Pembridge Palliative Care Centre Inpatient Unit closed	+4.4	Pass	24.9
2. Part implementation, Pembridge Palliative Care Centre Inpatient Unit open	+2.4	Pass	13.2
3. Full implementation, Pembridge	+4.6	Pass	26.0

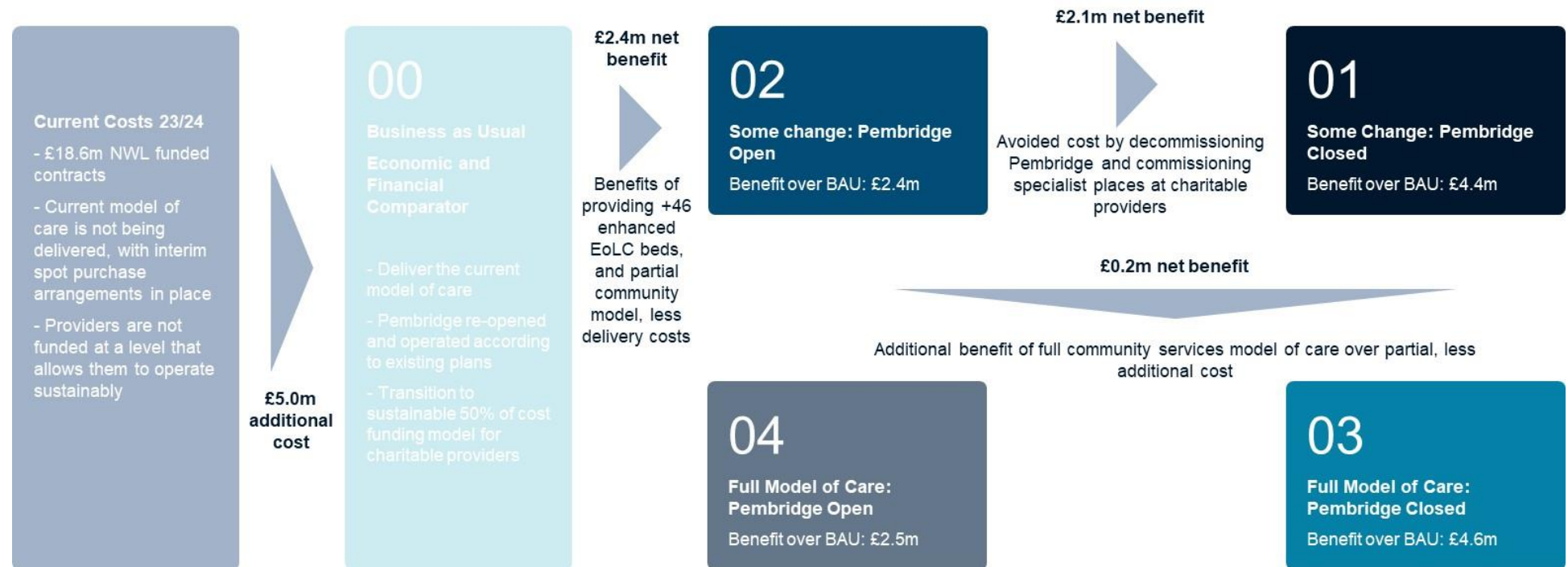
Palliative Care Centre Inpatient Unit closed			
4. Full implementation, Pembrige Palliative Care Centre Inpatient Unit open	+2.5	Pass	14.2

The key factors that affect the financial appraisal are:

- In Options 1 and 3, Pembrige Palliative Care Centre Inpatient Unit is decommissioned. Reopening Pembrige Palliative Care Centre Inpatient Unit would have a greater cost than the option of providing the required capacity through the enhanced EoLC beds and further commissioning of required specialist palliative care inpatient beds in alternative local hospices.
- In Option 3 and 4, the full CPSC model of care is delivered. This has twice the reach in terms of unique patients as Option 1 and 2. There is an economy of scale associated with this, as the benefit is twice, but the cost of the full model of care is not twice that of the partial model of care, due to fixed costs.

The differences between the current business as usual – current commissioned service model, and the five options under consideration is summarised below:

Figure 28 Summary of the financial appraisal *Figure 29*



8.3 Identification of the preferred implementation option

The outputs of financial and non-financial assessments are combined to provide an overall appraisal of the options. This overall appraisal does not mechanistically decide the preferred option, but does provide a clear indication of the preferred option at this stage and should be considered in the decision making process. Decision makers should consider the financial and non-financial factors together and separately in order to form a rounded view of the decision. The financial and non-financial appraisal will be re-visited at the Decision Making Business Case (DMBC) stage, to determine if updates are required based on the latest information and outputs from the consultation process.

The weighted scores are summarised below:

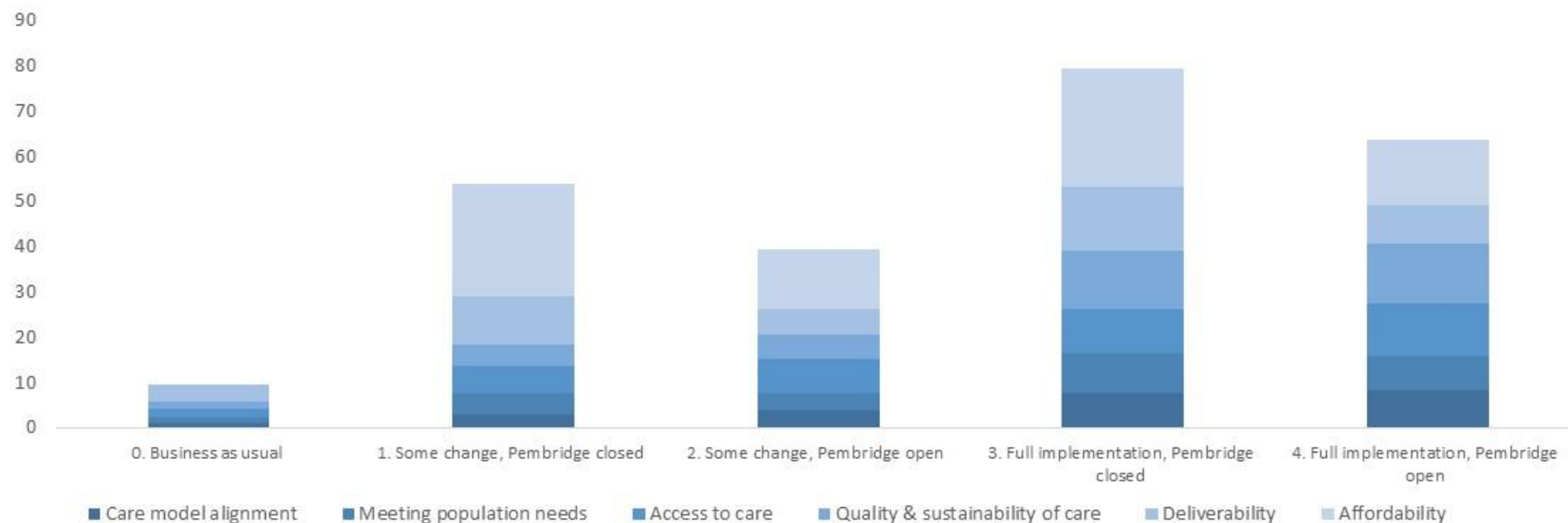
Table 49: Weighted appraisal scores *Table 50*

Criteria	Option 0	Option 1	Option 2	Option 3	Option 4
	Business as usual – current commissioned service model	Some change, Pembridge Palliative Care Centre Inpatient Unit closed	Some change, Pembridge Palliative Care Centre Inpatient Unit open	Full implementation, Pembridge Palliative Care Centre Inpatient Unit closed	Full implementation, Pembridge Palliative Care Centre Inpatient Unit open
Care model alignment	1.10	2.97	3.96	7.81	8.14
Weighting applied: 11%					
Meeting population needs	1.10	4.62	3.74	8.58	7.59
Weighting applied: 11%					
Access to care	2.08	5.92	7.52	9.92	11.68
Weighting applied: 16%					
Quality & sustainability of care	1.60	4.80	5.44	12.80	13.28
Weighting applied: 16%					
Deliverability	3.80	10.60	5.60	14.20	8.60
Weighting applied: 20%					
Affordability	0.00	24.95	13.19	26.00	14.24
Weighting applied: 26%					
TOTAL - WEIGHTED	9.68%	53.86%	39.45%	79.31%	63.53%
(Min 0%, Max 100%)					

These weighted scores are shown graphically below:

Figure 29: Visual summary of weighted appraisal scores *Figure 30*

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The financial and non-financial appraisal both independently and together identify Option 3 as the preferred option. The deliverables from this option can be described as follows:

Figure 30: Describing the preferred option *Figure 31*

NHS

North West London

Preferred Model of Care

Care in your own home

Service

Key change

Adult community specialist palliative care team

7 day service available 12 hours per day in all boroughs

Hospice at home

Care available in all boroughs, 7 day service, available up to 24 hrs

24/7 specialist phone advice

Consultant-led advice, available to anyone

Care in a community inpatient setting

Service

Key change

Enhanced end-of-life care beds

Increase beds from 8 beds in Hillingdon to 54 beds across all our boroughs

Specialist hospice inpatient unit beds

57 beds across existing operational sites. Improve access to them by increasing hours in which people can be admitted. Closure of Pembridge as a hospice inpatient unit.

Outpatient & Wellbeing Care

Service

Key change

Hospice MDT outpatient clinics

Increasing specialist clinics in Ealing & Hounslow to improve consistency

Dedicated bereavement & Psychological support

A consistent care pathway in all boroughs offering one-to-one counselling & group sessions

Lymphoedema

Expansion of service to care for cancer and non-cancer patients.

In [section 4](#), we established the key benefits we would anticipate from delivery of the model of care. This was mapped to outcomes and key outputs. We can now summarise the benefits associated with the preferred option. We would expect to create a set of key performance indicators that allow us to track the delivery of intended benefits. This would allow continuous improvement culture to be embedded within our system.

Table 50: How the preferred option maps to intended benefits *Table 51*

Benefit	Outcomes which deliver this benefit	Description of how the preferred option delivers the outcomes and (therefore) benefits
Improved quality of life for people at the end-of-life	Improved patient and carer experience	- Equalising the services available at borough level by levelling up is expected to improve patient experience - Better information sharing among providers of CSPC services will improve the delivery of joined up care. - Improving the training of staff to include cultural competency, the services will be more responsive to the needs of our diverse communities such as religious beliefs.
	Care is aligned to individual's needs (improved personalisation)	- By delivering holistic needs assessment as part of personalised care planning, the needs of patients, their carers and families are reflected in the care provision arranged - By delivering the full model of care, services will be equipped to respond to the personalised needs of

		individuals through extended hours and weekend provision.
	Inequalities of CSPC provision are addressed	- Addressing gaps in provision among our boroughs as well as introducing improvements to the overall care model are expected to address inequalities in provision - The EHIA for this option consistently assessed as improving provision for all nine protected characteristic groups and additional groups considered in our analysis.
	More people die in their preferred place of death. Fewer people die in hospital.	- Expansion of bed-based capacity through enhanced EoLC beds means patients who do not meet the stringent criteria for hospice inpatient care but are not able to be cared at home, can receive care at the end-of-life in alternative environment to hospital, with 24/7 access to care and input from the CSPC team - Utilising hospice inpatient capacity for those who have complex needs, means these individuals are not unnecessarily admitted to hospital due to lack of capacity - Increasing hours of provision of key services such as hospice at home and community SPC teams minimises the risk that deterioration in health condition leads to hospitalisation.
Improved value for money	Care is aligned to individual's needs (improved personalisation)	- By better understanding the care needs and circumstances of individuals needing CSPC through holistic assessment, we ensure the patient and their family receive the right care and support, in the right place - Delivery of more care at home and in less acute settings represents better value for money which supports the long term financial sustainability of CSPC services.
	Inequalities of CSPC provision are addressed	- Actively addressing unmet need and supporting underserved populations will maximise our ability to prevent hospitalisation at the end-of-life and adverse outcomes including preventing deaths in hospital - Fully the delivery the model of care addresses current inequalities in access uncovered during this work - Providing equitable access to care improves our ability to prevent unnecessary hospitalisation where possible - Providing enhanced EoLC beds in boroughs other than Hillingdon addresses the current inequality in north west London and provides alternatives to hospital care.
	More people die in their preferred place of death. Fewer people die in hospital.	- Providing greater access to non bed-based care such as community SPC nursing and hospice at home services through extended hours of provision means more people are successfully supported to die at home - Providing greater volume of enhanced EoLC capacity across our boroughs is anticipated to support more people to die in their preferred place as only small numbers of people will have the complex needs that need that very specialist consultant led support that hospice inpatient care providers and death at home is not always possible or preferred - This is expected to reduce hospitalisation toward the end-of-life.

8.4 Conclusion

Whilst we have been operating without the Pembridge Palliative Care Centre Inpatient Unit beds for over five years, we reiterate that a decision on the future of the unit has not been made. We have at various points explored approaches to reopen the unit. Our assessment finds option 3 – full delivery of the model of care with increased number of enhanced EoLC beds to 54 beds across north west London, and maintaining 57 specialist hospice inpatient beds, by closing Pembridge Palliative Care Centre Inpatient Unit, to be the highest scoring option at this stage. It is therefore, the preferred implementation option, on the basis it offers:

- Greatest perceived benefits in meeting care model requirements, meeting the needs of the population and greatest confidence on deliverability
- Best value for money
- It is affordable
- Doing nothing is not a viable option.

At this stage, it would be the intention to include all five options as part of the PCBC demonstrating the wider set of considerations the process has taken into account and providing more inputs to a good dialogue with stakeholders. We will be consulting on the two options which have scored highest in both our non-financial and financial assessment. The rationale for keeping these options in our PCBC are:

1. **Retain inpatient provision:** There remains strong public support to retain inpatient provision at Pembridge Palliative Care Centre Inpatient Unit. The inclusion of options that retain this consideration would be publicly important.
2. **Gather meaningful feedback:** A wider range of options would allow us to gather meaningful information or views from stakeholders and allow the emergence of new evidence.

9. Financial benefits and impact of the options

This section examines the financial benefits to the NHS of the options under consideration, further information can be found at [Appendix H](#). The overall benefits of the options are wider than the financial benefits which are examined in this section.

There are five options under consideration which include business as usual – current commissioned service model and four alternative ways forward. All of these four alternatives are shown to be favourable to the NHS compared to the business as usual – current commissioned service - model.

Overall, implementing the new model of care improves value for money through enhancing adult community-based specialist palliative care services to avoid acute hospital admissions and reduce length of stay and reduce A&E attendances and admissions for the supported population. This will also support reduction in the number of people dying in hospital for this population as outlined in figure 31 below.

Figure 31: Place of death: current position vs future expected position

Place of Death: current activity vs future expected activity

In the financial year 2023/24, the approximate number of deaths in each place:

Hospice c.900	Hospital c.8000	Home* c.6000	Other c.600

If the new model of care is implemented, the approximate number of deaths in each place would move to:

Hospice c.900	Hospital c.6000	Home* c.8000	Other c.600

*Home – we use home to describe the patients usual place of residence: What we mean by home or usual place of residence is a place where the person lives most of the time and feels comfortable. It could be an apartment, house, hostel or shelter, dedicated care setting (care home, sheltered housing accommodation and mental health facility) where the person has a consistent living arrangement at this place.

9.1 Introduction

Five options have been shortlisted and are currently under consideration for the future of CSPC services in north west London. These are:

- **Option 0: Business as usual – current commissioned service - model:** The currently commissioned care model is delivered. Current services are maintained, including operating Pembridge Palliative Care Centre Inpatient Unit and the current at home support model.
- **Option 1: Some change, Pembridge Palliative Care Centre Inpatient Unit closed:** Enhanced EoLC beds are commissioned in each borough. Pembridge Palliative Care Centre Inpatient Unit is closed and the 'partial' new community care model is delivered. A number of specialist palliative inpatient beds previously provided at Pembridge Palliative Care Centre Inpatient Unit are commissioned within the core contract of other providers.
- **Option 2: Some change, Pembridge Palliative Care Centre Inpatient Unit open:** Enhanced EoLC beds are commissioned in each borough. Pembridge Palliative Care Centre Inpatient Unit operated as per the current model of care. The 'partial' new community care model is delivered. Beds numbers at charitable providers in north west London are reduced to give the overall number of beds needed to meet patient and the new enhanced EoLC bed services.
- **Option 3: Full implementation, Pembridge Palliative Care Centre Inpatient Unit closed:** Enhanced EoLC beds are commissioned in each borough, Pembridge Palliative Care Centre Inpatient Unit is closed. The 'full' new community care model is delivered. A number of specialist

palliative inpatient beds previously provided at Pembridge Palliative Care Centre Inpatient Unit are commissioned within the core contract of other providers.

- **Option 4: Full implementation, Pembridge Palliative Care Centre Inpatient Unit open:** Enhanced EoLC beds are commissioned in each borough, Pembridge Palliative Care Centre Inpatient Unit operated as per the current model of care. The 'full' new community care model is delivered. Beds numbers at charitable providers in north west London are reduced to give the overall number of beds needed to meet patient need and the new enhanced EoLC bed services.

These options are described in detail in the previous sections, which compare the full range of advantages and disadvantages associated with each option to identify Option 3 as the current preferred option.

The impact of the options on the NHS North West London income and expenditure position is detailed in [Appendix H](#).

9.2 Financial benefits of the options

There are two key benefits of the options, compared to the business as usual – current commissioned service - model:

- **Benefit 1: Enhanced EoLC bed provision:** All of options 1-4 provide a total of 46 additional enhanced end-of-life care beds. These beds create capacity with which patients who would otherwise be in hospital can be cared for at the end of their life. This has a qualitative benefit to patients and means patients can be cared for in a less costly care setting, providing a cost saving against the business as usual – current commissioned service - model.
- **Benefit 2: Community services model avoids hospital attendance and admission:** Option 1 and 2 propose to partially deliver the community care model, and Option 3 and 4 to fully deliver this model. This model will better support patients at home, and is expected to result in fewer A&E attendances and resulting hospital admissions from these supported patients. The cost of delivery of the care model is shown to be less than the cost of hospital admission of these patients, resulting in a cost saving.

These benefits are examined in detail below:

Benefit 1: Enhanced EoLC bed provision

In each of the four options a net 37 additional beds are provided in north west London over the business as usual – current commissioned service - model. This is composed of:

- +46 new enhanced EoLC beds
- A reduction of 13 beds, which are currently spot purchased, but are provided at Pembridge Palliative Care Centre Inpatient Unit under the business as usual – current commissioned service - model
- +4 specialist hospice beds, which are provided at Pembridge Palliative Care Centre Inpatient Unit within the business as usual – current commissioned service - model or Option 2 or Option 4, or would be commissioned within other providers' contracts in option 1 and 3.

These additional 37 places, at a planned occupancy of 85% are expected to provide 11,479 bed days for patients, who would otherwise be in a north west London acute hospital, or be cared for in an alternative setting.

Taking this demand away from the acute sector means that fewer surge beds will be required to be provided to meet this demand or other growth, so fewer surge beds will need to be opened.

These 11,479 bed days, based on NHS NW London's planning assumption of a cost of £475 a day for a surge bed, would result in a gross saving of £5.5m annually (in 23/24 prices).

Benefit 2: CSPC model of care avoids hospital attendance and admission

The CSPC model of care will significantly expand the number of patients supported and extend the hours that care is available. In particular, the available hours of hospice at home services will be expanded to provide up to 24-hour cover, alongside 24-hour telephone support. This extra support has the potential to give patients at the end-of-life alternatives to presenting at A&E, leading to avoidable admission and a typically lengthy hospital stay.

North west London is the integrated care system with the highest rate of patients experiencing three or more emergency admissions in their last year of life³⁰. These admissions also tend to result in long hospital stays, estimated 9.2 day length of stay (LOS)³¹. Whilst this performance is likely in part due to demographic factors, the rate of admission is significantly higher in north west London than other comparable geographies (e.g. other London ICSs).

Improving the support available to patients is expected to reduce A&E attendance and resulting admissions amongst the supported group of patients.

Achieving the London median level of patients experiencing three or more emergency admissions in the last year of life is expected to avoid 743 admissions per year. Based on the £475/day surge bed cost, and the 9.2 day average LOS, this would result in a gross benefit of £3.2m through admission avoidance (in 23/24 prices).

There is good evidence that the hospice at home model reduces A&E attendances and hospital admission for patients at the end of life³². With the Hospice at Home element of the new model of care, this has the potential to avoid a significant number of A&E attendances and resulting admissions.

In options 3 and 4, the full proposed model of care is implemented, so the above benefit applies to options 3 and 4. In options 1 and 2, the additional reach over the business as usual – current commissioned service - model of community services in terms of unique patients is planned to be half that of what delivery of options 3 and 4 would achieve. In options 1 and 2, half of the benefit of hospital avoidance (£1.6m) is expected to be realised by reaching half of the number of additional patients.

9.3 Capital investment for the providers of the service

There is minimal capital investment associated with the options 1 to 4, as all of the options represent a reconfiguration of resource spending, rather than major capital investment. As the enhanced beds that will require some capital spend will be within property owned by providers, this will not impact the ICS's 25/26 capital plan.

The capital spend has been initially estimated at £70,000 per site (i.e. £490,000) should one of options 1-4 be taken forward.

Based on a 20-year useful life, and a 3.5% capital charge, the £490,000 could result in a £41,650 capital charge for the provider. This is not considered material in the context of the benefits or other revenue movements associated with the proposed options.

³⁰ [ICS benchmarking of Last Year of life admissions, University Hospitals Sussex and Midlands and Lancashire CSU](#)

³¹ [LOS of admissions in last year of life, Public Health England, Older people's hospital admissions in the last year of life](#)

³² [Nuffield Trust, The impact of the Marie Curie Nursing Service on place of death and hospital use at the end of life](#)

9.5 Value for money

As the options do not include non-cash releasing benefits, societal benefits or significant capital expenditure, the value for money conclusions mirror the affordability conclusions, and the value for money evaluation did not consider these benefits. The affordability criterion used within the appraisal of the options therefore also represents value for money.

There is the opportunity to quantify, in financial terms, the potential benefits of the improved quality of care and other societal impacts as these are addressed by other appraisal criteria. They were not included within the quantitative appraisal of the options in order to avoid double-counting of these factors.

The financial appraisal is therefore presented as cash expenditures and cash-releasing benefits of the options. These expenditures and benefits are presented as the Net Present Social Value (NPSV) of each option. This has been evaluated over 10 years and is detailed in table 51 below.

All of the options have a positive Net Present Social Value (NPSV), representing that they all represent a reduction in spending by NHS NW London compared to the business as usual – current commissioned service model option.

Table 51: Net Present Social Value (NPSV) of the options

Option	10 year discounted NPSV (£m)
0. Business as usual – current commissioned service - model	Comparator
1. Part Implementation, Pembridge Palliative Care Centre Inpatient Unit Closed	34.8
2. Part Implementation, Pembridge Palliative Care Centre Inpatient Unit Open	18.4
3. Full Implementation, Pembridge Palliative Care Centre Inpatient Unit Closed	36.3
4. Full Implementation, Pembridge Palliative Care Centre Inpatient Unit Open	19.9

9.5 Sensitivity analysis

Sensitivity analysis is a tool used in financial modelling to analyse how the different values of a set of independent variables affect a specific dependent variable.

Sensitivity analysis has been undertaken to identify whether:

- Reasonable changes to the input assumptions could affect the affordability of any of the options
- Reasonable changes to the input assumptions could affect the ordering of the options.

Sensitivities that were tested are:

- Increased cost of enhanced EoLC beds. The base case costing used is based on Harlington Hospice costs, located in Hillingdon. In inner London locations, costs could be higher. Sensitivities of +10% and +25% were tested.
- Avoidance of acute bed days: The discharge benefit to the acute sector assumes that 100% of new community bed days provided, result in a bed day avoided in hospital. It is possible that the length of stay in the enhanced EoLC beds may be longer, or patients may not be discharged as quickly as they would be from hospital. Sensitivities of 75% and 50% were tested.

- Hospital avoidance: The benefit of avoiding hospital attendance and admission through community services is based on an aspiration of achieving the London median level of emergency hospital admissions in the last year of patients' lives. This may not be fully achieved. Sensitivities of half of this benefit, and of the England average, were tested.

These sensitivities are set out below. A 'worst case' is also provided, which is all of the least favourable sensitivities taken together. Figures are shown in red where the sensitivity makes the option costlier than business as usual – current commissioned service model:

Table 52: Financial Sensitivity Analysis *Table 53*

Option	Base case (£m difference to business as usual – current commissioned service - model)	Increased cost of enhanced EoLC beds		Avoidance of acute bed days		Hospital avoidance		Worst case
		+10%	+25%	75%	50%	Half of benefit of London median	England median	
Effect of the sensitivity	Comparator	-0.3	-0.8	-1.4	-2.7	-0.8	1.8	-4.4
1. Part implementation, Pembridge Palliative Care Centre Inpatient Unit closed	4.4	4.1	3.6	3.1	1.7	3.6	6.3	0.1
2. Part implementation, Pembridge Palliative Care Centre Inpatient Unit open	2.4	2.0	1.5	1.0	-0.4	1.5	4.2	-2.0
3. Full implementation, Pembridge Palliative Care Centre Inpatient Unit closed	4.6	4.3	3.8	3.3	1.9	3.8	6.5	0.3
4. Full implementation, Pembridge Palliative Care Centre Inpatient Unit open	2.5	2.2	1.7	1.2	-0.2	1.7	4.4	-1.8

The benefit of being able to discharge patients into the new enhanced EoLC beds is shown to be crucial. The 50% sensitivity (i.e. only 50% of enhanced EoLC bed days avoid acute bed days) as the potential to make options 2 and 4 unaffordable. Options 1 and 3 are affordable in any one of the sensitivities considered.

In the 'worst case' sensitivity considered, options 3 and 1 remain affordable. As option 3 has the most benefit over business as usual – current commissioned service model, it is most resilient to the sensitivities considered.

In addition to the above, an additional sensitivity tested has been carried out by removing finance criteria from the assessment of shortlisted options to identify a preferred solution. By removing the financial

weighting (26%) and re-apportioning it across the non-financial assessment criteria, as per table 53 below, this removes finance from the weighted assessment of the preferred solution.

Table 53: Financial sensitivity analysis 2 – weighted appraisal scores for non-financial assessment *Table 54*

Criteria	Option 0	Option 1	Option 2	Option 3	Option 4
	Business as usual – current commissioned service model	Some change, Pembridge Palliative Care Centre Inpatient Unit closed	Some change, Pembridge Palliative Care Centre Inpatient Unit open	Full implementation, Pembridge Palliative Care Centre Inpatient Unit closed	Full implementation, Pembridge Palliative Care Centre Inpatient Unit open
Care model alignment					
Weighting applied: 14.9%	1.14	3.09	4.11	8.11	8.46
Meeting population needs					
Weighting applied: 14.9%	1.14	4.80	3.89	8.91	7.89
Access to care					
Weighting applied: 21.6%	2.20	6.25	7.94	10.48	12.33
Quality & sustainability of care					
Weighting applied: 21.6%	1.69	5.07	5.74	13.52	14.02
Deliverability					
Weighting applied: 27%	4.07	11.34	5.99	15.19	9.20
TOTAL - WEIGHTED					
(Min 0%, Max 100%)	10.24	30.55	27.68	56.22	51.90

The table above shows that with the removal of the financial affordability weighted assessment, the results of this exercise continue to show a clear preference for making changes to the provision of CSPC in north west London over continuing with current service provision.

There is also a marked preference for full delivery of the model of care (options 3 and 4) compared with partial delivery options (options 1 and 2). The 4.3-point difference between options 3 and 4 continues to show a preference for full implementation while not re-opening the currently suspended Pembridge Palliative Care Centre Inpatient Unit.

In summary, removal of the financial weighted assessment results in the same order of options, with option 3 remaining the highest scoring option based on non-financial assessment alone. The difference in scoring between options 3 and 4 in the main, is due to the deliverability assessment, which is based on:

- the achievability of the model of care
- including workforce recruitment and retention
- implementation
- the relative impact on other providers/organisations
- confidence in operationalising the model of care within two years.

This is a critical area of assessment of the model of care options.

9.7 Risks and conclusion

The largest singular movement within Table 53, is the benefit to the acute sector of making the Enhanced EoLC beds available. Sensitivity analysis ([Section 9.5](#)) has demonstrated that half of the

anticipated benefit is sufficient for the options to remain affordable. Nonetheless, the benefit is needed to mitigate the cost pressures within business as usual – current commissioned service - model. To realise this benefit, the CSPC team will need to work with acute providers to develop a process for the identification and discharge of patients suitable for the enhanced EoLC bed provision. If these patients are not identified in a timely fashion they would remain in hospital, and the enhanced EoLC beds would be under-occupied.

The target of achieving the London median level of emergency hospital admissions for patients in the last year of life is based on benchmarking and an aspiration to improve north west London's performance relative to other ICSs. The validity of this aspiration, and the extent to which community services can support this improvement should be further considered based upon the consultation findings.

Sites for potential provision of enhanced EoLC care beds have not been selected, meaning that implementation costs cannot be robustly verified. Whilst the capital charges associated with these are unlikely to change the ICS's revenue position, it will be necessary to identify capital funding within the ICS's 25/26 capital plan.

Following consultation, NHS North West London will identify the preferred solution which generates maximum benefit for our residents. The Equalities and Health Inequalities Impact Assessment (EHIA) will continually be reviewed throughout the consultation and will be updated following the consultation. Third Sector Together (3ST), a local alliance of the voluntary and community sector across north west London, have been commissioned to provide support and analysis for the consultation and provide the consultation report which will report on findings and outcome from the consultation, and will go through North West London ICBs governance process. This will then inform the decision-making business case which will be prepared and will go through the North West London Board meeting in public for final sign off. Implementation plans will be prepared, including identifying sites and planning transition costs. Any of the option 1-4 are likely to be affordable against the business as usual – current commissioned service - model, and even with demanding sensitivities, options 1 and 3 remain affordable.

10. Engaging with stakeholders on the preferred solution

10.1 Planning for consultation

The next phase of engagement will build on substantial engagement already undertaken prior to development of the model of care, in refining the model of care and during the development of options considered in this document (see [section 3](#) for further information and [Appendix C](#) for a list of stakeholders).

This section considers how we will engage with key stakeholders and the public through public consultation. The options to be considered during the consultation will set out the potential solutions for delivering high quality CSPC services that are sustainable into the future, for the people of north west London. It is our intention to continue to obtain wide ranging and meaningful input on all the options shortlisted and evaluated in this PCBC document.

We aim to obtain a broad range of views from our local communities, services users, clinicians, providers and partners on our proposals. The feedback gathered during consultation and any further evidence will help NHS North West London to make their decision.

No decisions about any changes to services will be made until after the full public consultation has taken place and all of the information, including the feedback from the consultation, has been considered by NHS North West London in line with Gunning principle 4³³.

The consultation will seek to:

³³ [The Gunning Principles – Implications — The Consultation Institute](#)

- Ensure people in the affected areas are aware of and understand the case for change and the proposed options for change, by providing information in clear and simple language in a variety of formats.
- Hear views on the proposed changes to CSPC services in north west London from service users, stakeholders and communities.
- Ensure NHS North West London as decision-makers receive detailed outputs and feedback from the consultation, to ensure they are as well informed as possible for making decisions.
- Hear ideas for alternative solutions via the consultation questionnaire. While we have carried out a robust options development and consideration process, we are still open to other new ideas and suggestions for different ways we could solve the challenges set out in this consultation.

The information collected in a consultation is an important factor in our decision-making. It will help us to make an informed decision on implementing CSPC services changes.

We will analyse all the consultation responses and outputs from all engagement methods. On conclusion of the consultation and subsequent analysis a consultation report will be produced which will be publicly available and shared with the Joint Health and Overview Scrutiny Committee. The report will be used to support deliberation and decision making by NHS North West London and inform the Decision-Making Business Case, on which the NHS North West London final decision will be based.

Delivering consultation

Subject to approval of this pre-consultation business case, we will undertake a full public consultation to test our ideas and any preferred options. Our consultation plan outlines our approach on how we intend to listen to and gather views from our local communities and partners.

Under Section 14Z45 of the NHS Act 2006, the NHS has a duty to ensure that people who use NHS services are involved in the development and consideration of proposals for change in the way services are provided.

We will also be complying with our duty to consult the local authorities under the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the 2013 Regulations") made under section 244 NHS Act 2006.

The consultation is expected to run from 18 November 2024 to 24 February 2024.

We will deliver a best practice consultation, which is founded on the commitment to inform and listen.

We will continue to develop our consultation plan both prior and during the formal consultation by working closely with partners to ensure that all our statutory duties are met. The consultation will also be underpinned by the 4 over-arching tests established by the Secretary of State plus a fifth test in respect of bed closures established by NHS England.

Consultation approach

All elements of the consultation plan will seek to:

- Ensure that the methods and approaches are developed to provide a range of opportunities for stakeholders to respond to the consultation
- Identify the best ways of reaching and engaging key interest groups.
- Provide an easy read version of documents and offer translated versions relevant to the community as required (upon request)
- Make sure there is equality monitoring of participants to ensure the views received reflect the whole of the local population.
- Use different methods or specifically target communities where there is any under-representation.
- Target activity so it covers all the local geographical areas that make up the NHS North West London area.

- Arrange any (in person) events and meetings in accessible venues and offer interpreters, translators and hearing loops where required.
- Purchase or hire resources for delivering consultation activity from the local community whenever it is possible.
- Inform partners of the consultation activity and share the plans for engagement.

Consultation principles

Table 54: Consultation principles *Table 55*

Providing local communities with a range of opportunities to be involved regardless of who they are and where they live. This includes coverage of activity across all north west London geographical areas.	• We will map out all our local communities and map interest groups and stakeholders, so we know who to engage with and how. • We will provide a range of methods of engagement. • We will work closely with a wide variety of local individuals and organisations to make the most of all opportunities to reach out to people. • We will endeavour to go out to where people are, using creative and innovative methods of engagement.
Providing accessible information in clear and simple language and in a variety of formats	• We will stick to plain English standards. • We will provide an easy read version of our consultation document and questionnaire as well as other key documents as required. • We will provide materials in other formats should they be requested. This includes translation of written materials into other formats, including Braille or other languages.
The process will be open and transparent.	• We will publish our evidence, public and stakeholder and interest group feedback, the consultation process and our decision making timeline on our website. • We will be easily accessible for local people to ask questions and raise concerns. • We will update our website with responses to frequently asked questions. • We will work with our local communities to co-design our consultation plan.
Careful management of resources to deliver good value for money.	• We will endeavour to use evidenced based methods of engagement to make sure we deliver good value for money.
Sharing updates on the consultation activity during and after consultation	• We will share updates regarding feedback during consultation. • We will commission an independent analysis of consultation feedback which will be published after the consultation has finished.
Using the feedback received during consultation to inform our decision-making	• We will share our governance structures and timelines so the public and our partners can understand our decision-making process.
Running an evidenced-based, best practice consultation.	• We will work with our partners to design our consultation activities.

Engagement channels

Table 55: channels for engagement *Table 56*

Engagement activity	Description
Listening events	Even distribution across NHS NW London seeking resident and service user views

Focus groups	Actively seeking opportunities to speak to and listen to views of communities with protected characteristics
Engagement with elected representatives	Face to face meetings
Staff and clinical engagement	Using internal communication channels to raise awareness of the consultation. Attending key meetings
Online survey	Publish an online survey and encourage responses throughout our engagement activities

Engagement throughout this period will be continuous and ongoing. A particular focus will be key stakeholders including:

- Patients, families and carers receiving or who have received palliative care
- Staff and clinicians delivering CSPC
- General practice
- MPs
- Local council and councillors
- Health Watch.

Methods and materials

Table 56: methods and materials we will use in engagement

Engagement activity	Description
Consultation document	Full document available on NHS NW London website. Paper copies available on request.
Summary	Available on NHS NW London website. Paper copies available on request.
Easy read	Available on NHS NW London website. Paper copies available on request.
Questionnaire	Aim to gather views and feedback. Available on NHS NW London website. Paper copies available on request.
Videos	Narrated by GP Clinical Lead, covering why change needs to happen and their support for the proposals
Briefings	Actively seek out opportunities to briefed. Arranged and delivered in-person and online.

Risks for stakeholder support

In addition, we have specifically considered risks relating to our key partners and stakeholders' support for these proposals. Risks in relation to particular stakeholder groups, and their mitigation, are shown below.

Table 57: Specific Stakeholder Risks and mitigations

Stakeholder	Risk	Mitigation
Local authority	Local authorities have expressed a range of views when asked with a minority indicating they are likely to oppose the preferred option.	Councillors and officers from local authorities have been involved throughout the process and expressed support for the model of care. We continue to work with local authorities to discuss their concerns and to see how they can be addressed.

		The public consultation on the preferred option has been planned and outlined in Section 10. Consultation will be planned in accordance with Gunning principles. The inclusion of a wide set of options in the consultation allows diverse set of views to be heard.
Patient and carer representatives	Engagement to date has shown very strong positive support for the model of care. However, some groups are likely to oppose any option put forward for consultation that does not include the reopening of the Pembridge Palliative Care Centre Inpatient Unit.	All service development across north west London is done in partnership with service users and carers. Views raised through the pre consultation engagement were used by the model of care working group to influence discussions and decisions and have been incorporated into the model of care and options. This includes the preferred option and the introduction of enhanced end of life care beds and a doubling of bed capacity available to support north west London residents.
NHS and charitable CSPC providers	We believe the risk of this group disagreeing with the preferred option is minimal as they have been members of the steering group and have confirmed their support for implementation of the agreed model of care. However, we recognise that their agreement cannot be taken for granted and there is always a risk.	We have a very good relationship with all our CSCP providers who have been full partners throughout this programme. All providers were members of the model of care working group and jointly co-designed the model of care. All partners were members of the steering group and agreed the hurdle criteria through which the potential services and support options were short-listed to those options moving forward to consultation,
Acute providers of palliative care	The main expected concern from acute providers is likely to centre around the delay in palliative care needs out of A&E and acute wards.	The implementation of the model of care in full, including the doubling of bed capacity with the introduction of enhanced end of life care beds, will offer the prospect of higher flow out of A&E and acute beds. We continue to work with acute providers on the whole palliative care pathway to make sure there is full integration of care.

Consultation Analysis

Once the consultation period concludes, all feedback will be gathered, analysed and captured in a consultation report.

Third Sector Together (3ST), a local alliance of the voluntary and community sector across north west London, have been commissioned to provide support and analysis for the consultation and provide the consultation report.

The report will highlight:

- Implications for the options considered.
- New evidence that requires further consideration
- Impact on specific groups or populations that warrants further analysis.

11. Decision making and approvals

11.1 Decision-making timelines

Decisions by NHS North West London will be informed by:

- The outputs of engagement and consultation
- Seeking external assurances on this PCBC (i.e. regulatory assurance)
- Seeking views of the London Clinical Senate
- Equalities and Health Inequalities Impact Assessment

Table 58: Approval Process

Group	What is their role in the PCBC approval process?
NHS North West London Board	Receive information on the PCBC and supporting documentation Approve plans to proceed to consultation
EHIA Panel	Assure ICB that due consideration of the impact of the preferred model of care on inequalities has been made.
London Clinical Senate	Provide independent clinical review of proposed model of care including recommendations for amendments. To support the ICB make the best decisions for service users.
NHS England Assurance	Assuring ICBs on statutory duties within the Assurance Framework.
Joint Health Overview & Scrutiny Committee	Scrutinise proposals.

We will describe the findings from clinical senate and NHS England below.

11.2 NHS North West London

The Health and Care Act 2022 establishes the triple aim as a statutory duty for ICBs³⁴. This triple aim places responsibility on ICBs to consider the effects of their decisions on:

1. The health and wellbeing of the people of England (including inequalities in that health and wellbeing)
2. The quality of services provided or arranged by both themselves and other relevant bodies, (including inequalities in benefits from those services)
3. The sustainable and efficient use of resources by both themselves and other relevant bodies

The ICB will consider the merits of this business case alongside supporting information, and advice, to form a decision on next steps to proceed with further engagement or consultation. This includes:

Table 59: Supporting Documentation

³⁴ [Health and Care Bill: integration measures - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/bills-2022/health-and-care-bill)

Triple Aim	Supporting documentation that will be used in making decisions
Health & wellbeing	The impact of proposed changes on the communities are described in the Equalities Health Impact Assessment (EHIA).
Quality	- Feedback on the clinical model of care from London Clinical Senate. - The impact of proposed changes on the communities are described in the Equalities Health Impact Assessment (EHIA). - The impact of proposed changes on disparities in the population, experience of care at the end-of-life and access to care are examined in the Integrated Impact Assessment (IIA).
Sustainability	The impact of proposed changes on sustainability are assessed in the IIA.

11.3 London Clinical Senate

We have iteratively engaged the clinical senate to obtain impartial and informed view of the clinical model and change proposal. The NHS NW London team highly valued the constructive approach from the senate which has enabled us to make real and meaningful changes to our plans – and our implementation programme beyond this business case.

Table 60: London Clinical Senate engagement

Date	Subject
October 2023	Model of care review
March 2023	PCBC review

The senate formed a panel and met to review the model of care document and PCBC in March 2024. Draft feedback was received on 15th March. The following themes and changes have been incorporated into the model of care documentation as a result of the feedback received.

Table 61: Recommendations from the London Clinical Senate

Date	Recommendations
Narrative & learning	The Senate requested information on how proposals would improve overall service resilience among providers. They also suggested strengthening descriptions for how learning from innovations (e.g. enhanced EOLC beds in Hillingdon) has informed planning and implementation and improving clarity on how the proposed model differs from current provision.
Demographics	Better emphasis of other conditions supported through this model e.g. heart failure. Consideration for broader accessibility (e.g. learning disabilities) on making informed choices and how resources can be used to support vulnerable populations. Consider the needs of the population whilst recognising CQC registration requirements of providers of care. Reflect the input of different faith and cultural communities, support to carers and information provision to patients.
Model	Additional narrative about service offer and how patients will be supported in the community using pathways or vignettes and describe in greater detail the function of hospice MDTs and clinics.
Outcomes	Describe how outcomes will be used to track and demonstrate improvement in care.
Stakeholders	Demonstrate engagement with key groups such as local medical committee. Consider the role of other voluntary organisations beyond charitable hospices.
Sustainability	Demonstrate links with building stronger place-based model. Provide assurance the plans are deliverable i.e., capacity in care homes exists and workforce development plans are thought through.

Workforce	Strengthen workforce content in the model of care by describing social care workforce support needed, developing leadership and workforce development model including training and describing the workforce model needed to support the proposals.
Digital & innovation	Describe integration touch points with other services and consider demand modelling to staff this appropriately. Describe ambitions for single point of contact over time and consider how further creativity can be fostered among teams during implementation to drive further innovation. Encourage systems integration.
Implementation	Consider how leadership across providers can be aligned to coordinate implementation.

11.4 NHS England assurance

The NHS England Stage 2 Assurance Panel took place on 9th May 2024 to:

- Assess the proposals against the 5 key tests for assuring service change and Best Practice checks
- To assess whether NHSE were assured to provide approval to proceed

NHSE have confirmed that NHS North West London meet the requirements of the NHS England service reconfiguration assurance and have provided sign off to proceed to formal consultation.

11.5 Overview & Scrutiny Committee

The North West London Joint Health Overview and Scrutiny Committee (JHOSC) comprises of representatives across all eight boroughs. JHOSC have reviewed outputs of this programme at a number of points in the design and development of this proposal. Consulting local authorities is essential when considering substantial change to provision of health services. With strong links to communities within boroughs and interest groups such as Healthwatch, the collective view of this committee strengthens engagement processes and forms an important consideration in the decision making process.

The following engagement with JHOSC has occurred to date:

Table 62: Engagement with JHOSC Table 63

Date	Subject
14 September 2022	Palliative care review paper with findings from engagement report
12 September 2023	Updated model of care
22nd October 2024	Communications and engagement strategy for the public consultation

11.6 Regulatory tests

NHS England five tests

NHS England have five tests for significant service change. The proposal set out in this document satisfies the requirement in the following ways.

Table 63: NHS England five tests

Test	How we meet these tests
1. Strong public and patient engagement	We have consistently and iteratively engaged communities at each step in the development of this proposal including:

	- Public feedback on the issues relating to palliative care provision in north west London, culminating in the 8 key issues document that set out the case for change. - Patient and carer involvement in the design of the model of care through the model of care working group. - Public engagement on the model of care recommended by the model of care working group. - Public engagement on the options development process and shortlisted options for further analysis Engagement to date suggests support for the model of care shortlisted options considered as part of this proposal. Further engagement through public consultation is considered as part of this proposal.
2. Consistency with current and prospective need for patient choice	Commissioners have a duty to ensure that where a patient requires physical health elective referral for first outpatient appointment, the patient can choose a clinically appropriate provider. See guidance for full details³⁵. While this does not directly relate to provision of CSPC care, the following considerations are included in this proposal: Personalised care plan: under this proposal, patients will receive holistic needs assessment and a personalised care plan. Patients will be able to express their needs and preferences for care provision and preferred place of death. It will be the responsibility of the integrated CSPC teams to put in place a care plan that seeks to deliver the needs of the patient. This care plan is documented in the Universal Care Plan (UCP) – an electronic way to share this information with other providers. The care plan is revisited/reviewed to ensure it continues to meet the changes needs of the patient and changes in their preferences.
3. A clear clinical evidence base	The model of care proposed in this document was designed and developed on the basis of clear clinical evidence including gap analysis of local provision with national standards and best practice guidance. The London Clinical Senate have endorsed the clinical model.
4. Support for proposals from clinical commissioners	Support will be sought from NHS North West London through the approval process for this PCBC document.
5. Hospital bed numbers	The benefits model is predicated on preventing future increase in hospital beds and in avoiding surge beds that would otherwise need to be commissioning. It does not propose closing existing substantive hospital capacity.

Mayor of London tests

The Mayor of London has confirmed that he does not plan on applying his Six Tests to the new model of care for adult community-based palliative care in north west London. This follows an officer-led review of information within the new model of care and supporting documents.

12. Implementation

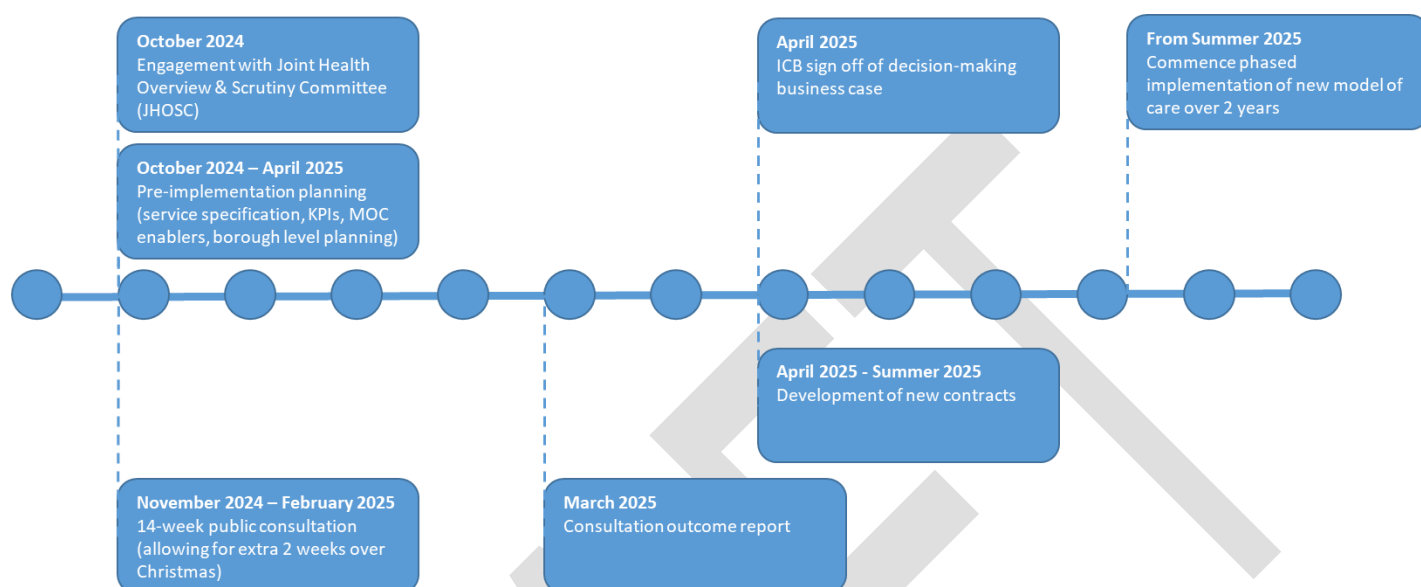
This chapter describes the high-level steps toward decision making and implementation. Once a decision is made on which option will be implemented, a detailed implementation plan will be developed.

12.1 Decision making timeline

³⁵ [NHS England » Patient choice guidance](#)

A summary timeframe for decision making is shown below, with planned NHS NW London sign off of a decision-making business case (DMBC) in April 2025.

Figure 32: Engagement timeline



The timeline is indicative of the activities that we plan to deliver.

12.2 Outline delivery model

Our intention is to work with existing providers of CSPC services in north west London to implement the preferred model of care later this year.

New Provider Selection Regime statutory guidance came into effect in January 2024 following the Health and Social Care Act 2022. The new guidance has been designed to introduce flexibility and proportionality in selecting providers of health care and support greater integration and collaboration among providers. NHS North West London has three choices in awarding contracts:

- Direct award (A, B or C)
- Most suitable provider
- Competitive process

CSPC Service providers will be appointed in accordance with the new Provider Selection Regime (PSR) and we will seek further advice on the way that contracts will be awarded in line with PSR.

Successful implementation beyond January 2024 requires careful planning with our providers in the lead up to the decision making business case (DMBC). Some aspects of the new care model are likely to be delivered at pace while others will require more careful planning and longer lead-in times. We expect full delivery of the model of care within a 2-year period. We intend to work closely with providers to plan delivery, building on the close partnerships forged during the development phase.

Our initial view of implementation from April 2025/26 is summarised below. The draft timeline plan is based on the current preferred option and is subject to change pending engagement and decision-making.

Table 64: Draft implementation timeline

2025/26	Q1	- Commence training programme of workforce to improve patient experience e.g., cultural competency - Extending Lymphoedema provision to all boroughs for non-cancer patients - Commence recruitment of staff for non bed-based services - Begin recruitment and planning for enhanced EoLC beds in boroughs other than Hillingdon
	Q2	- Complete training programme delivery - Complete recruitment of staff for non bed-based services
	Q3	- Go live of new model of care for SPC nursing team, hospice at home and specialist 24/7 telephone advice. - Go live of some enhanced EoLC beds
	Q4	- Go live of new model of care offer for psychological and bereavement care. - Full delivery of enhanced EoLC beds
2026/27	Q1	Commence planning for review and evaluation

Organising for successful delivery

Successful delivery of the next stage of engagement and implementation will require a core team to oversee and deliver tasks. This includes engagement planning, development of service specifications and working with providers to plan and deliver changes to service provision including training and education.

Table 65: Delivery Team and roles

	Project Team	Wider Programme Support
Key roles and groups required in next phase of delivery planning	- Senior responsible officer - Project lead - Clinical lead - Engagement team - Project support team - Contracting/commissioning support Additionally, we are seeking funding for additional support during implementation including a 'strategic transformation lead'. We anticipate this fixed term support to be required for a period of 2 years to support implementation activity.	Steering Group: this network of patients, clinicians and system providers were important in designing the model of care. Their skills and knowledge will be important in testing the next level of detail such as specifications and patient pathways. We will continue to engage this group. Provider network groups: As we move toward designing and implementation, we intend to work with our providers to shape delivery. Place based delivery:

		We will continue to work with end of life programme leads within boroughs to plan and deliver service change.
Known resourcing gaps	A 12-month project lead will be required from March 2024 to support next phase delivery of this programme. NHS North West London will consider how to resource this internally.	

12.3 Strategic risks

The primary risks associated with delivery of the preferred solution are outline below alongside potential mitigations. As changes are implemented, risks will be actively managed as part of the overall programme management approach (and in line with best practice in managing change).

Table 66: Strategic Risks

	Risk	Mitigation
1	There is a risk that stakeholders do not support the indicated recommended proposal	There has been extensive engagement with communities throughout the process including design of the model of care and development of options. The feedback we received garnered strong support for the model of care and no changes to the options we have considered. However, strong public opinion in some boroughs may mean there is opposition to the preferred option. To address this, further public consultation on the preferred option has been planned and outlined in Chapter 10. Consultation will be planned in accordance with Gunning principles. The inclusion of a wide set options in the consultation allows a diverse set of views to be heard.
3	There is a risk staff recruitment hampers service delivery	Staff recruitment and retention is a challenge within CSPC service provision and applies to charitable hospices and NHS providers alike. While hospice providers have experienced challenges in recruitment and retention, they have responded by working differently to adapt and working on their profile in their community to position themselves as good employers. Implementing the preferred option hinges on having a robust workforce. A number of mitigations are planned, including: - Working on our enablers early. Building cultural competency, training and development among our staff would strengthen attractiveness of the services and providers as a place to work. - Building the network of providers toward an alliance to improve joined up working and quality
4	There is a risk external factors put additional pressure on charitable funds, limiting their investment in provision of care	Providers working outside of the NHS do not automatically have access to the same pay deals and the charitable nature of many of our providers exposes their financial risk to uncertainty in charitable income. As cost of living impacts charitable giving, funds available to hospices may alter the funding profile described in this document. The following mitigations might apply:

		• Regular contractual discussions between providers of care and funders of care • Re-evaluation of model of care, phasing of implementation programme or prioritisation of services
5	There is a risk of judicial review and/or referrals to independent reconfiguration panel	The following mitigations apply and are further elaborated in Chapter 11: • We have sought external assurance on service reconfiguration to ensure we are meeting the requirements expected of ICBs. • We have set out clear governance and processes for decision making. • We have taken steps to test the model of care is right by involving clinicians in the design phase and engaging with the London Clinical Senate. • We are demonstrating the preferred option poses the optimal solution for the population through measures such as impact assessment (e.g. travel mapping analysis, EHIA)

12.4 Workforce considerations

Workforce is a key strategic risk of for reconfiguring CSPC services in North West London, as described in Table 66.

Initial analysis has been undertaken to understand the workforce implications of the options. This initial analysis is intended to provide an indication of the number and type of staff which are likely to be needed to deliver each of the options. Once a preferred option has been confirmed, detailed workforce planning will be required for the chosen option to identify and recruit the required workforce which will form part of the implementation of the new Model of Care. It is likely that this detailed planning will refine the results from this initial analysis which has been completed at a high level for all options. It is likely that economies of scale can be found within management structures when a preferred option is confirmed, and a detailed workforce plan developed.

The Model of Care Working Group has discussed workforce at every stage during the development of the Model of Care and recognises it as a key enabler in delivery of the new Model of Care to ensure that it can be delivered by a palliative care workforce (generalist and specialist) that is both sustainable and understands the cultural and faith requirements of our diverse communities.

Our workforce development strategy will need to align with the developing North West London Health and Care Strategy and is seen as a priority that will need to be addressed as a matter of urgency through the implementation phase. There is an opportunity for our non NHS providers to work alongside our wider NHS approach and by doing this, we believe we can address our need for skilled workers to support delivery of the proposed model of care over the next 2-3 years.

A CSPC workforce development strategy will be jointly developed across all charitable and NHS organisations to support workforce development and service delivery. This will ensure that there is a workforce plan in place and the right workforce to support patients with community-based specialist palliative and end of life care needs. And that there are staff across all settings of care who have the requisite skills, from the specialists to the generalists supporting people with palliative and end of life care needs as part of their wider roles such as GPs, community nursing staff and those working in care homes.

In the business as usual – current commissioned service - model, the commissioned care model is operated, and this has the potential to create a workforce challenge, particularly with respect to the

required medical workforce. In options 1-4, there is a significant uplift in CSPC nursing workforce required, along with care home carers, in order to support the enhanced EoLC bed provision.

Medical workforce

In each of options 1-4, either Pembridge Palliative Care Centre Inpatient Unit is decommissioned, or fewer charitable places are commissioned, resulting in a smaller medical workforce being required than in the business as usual – current commissioned service - model. This appears as a negative in Table 67 below.

Nursing workforce

In each of the options 1-4 a significant uplift in CSPC nursing workforce is needed to support the proposed model of care. The uplift in Band 6 and 7 nurses relates primarily to CSPC nursing teams, hospice at home and providing 24/7 telephone support. A significant number of Band 4 carers are also expected to be required to support the enhanced EoLC beds to be commissioned.

Across the options, a growth of between 10 and 34.8 nursing WTEs are required, compared to the business as usual – current commissioned service - model. This is a meaningful proportion of the current c.240 WTE establishment nursing workforce in the North West London CSPC workforce.

Therapies workforce

The enhanced EoLC beds are budgeted for therapies support, and this is reflected as an increase in CSPC workforce requirement in all four options where these places are provided.

Management and administration

Enhanced services, particularly the community services which will support patients at home, come with a management overhead. This has been scaled from today's services to give an indication of required workforce. However, it is likely that economies of scale can be achieved within management structures by delivering larger services, and harmonising service provision across the boroughs.

Workforce summary

The initial workforce outputs are summarised below:

Table 67: Difference in WTE requirement for CSPC services between Business as usual – current commissioned service model and each Shortlisted Option

	Option 1	Option 2	Option 3	Option 4
Medical				
Consultant	-1.0	-0.7	-1.0	-0.7
Specialty Doctors	-3.0	-2.5	-3.0	-2.5
Nursing				
Band 8	2.4	2.4	4.1	4.1
Band 7	7.1	7.6	14.0	14.5
Band 6	-0.5	0.5	3.4	4.5
Band 5	-6.8	-5.4	-6.0	-4.6
Band 4	11.2	12.2	13.6	14.7
Band 3	-3.3	-1.8	0.1	1.6
Therapists				
Band 6	1.4	1.4	1.8	1.8
Management and Admin				

Band 8	0.8	0.8	1.4	1.4
Band 3	2.3	2.3	4.0	4.0
Total	10.4	16.9	32.5	38.9

In options 1 and 2 the partial model of community care is delivered, resulting in a smaller workforce than required in option 3 and 4 where the full model of care is delivered.

In options 1 and 3 Pembroge Palliative Care Centre Inpatient Unit is decommissioned, and this results in a reduction in staffing requirement compared to options 2 and 4 where the north west London bed requirement includes more charitable hospice bed places.

Acute sector workforce

The options are expected to avoid c.14,800 (Options 1 and 2) and c.18,300 (Options 3 and 4) inpatient bed days in the acute sector across north west London, annually. Whilst this would not enable a ward closure on any single site, it is expected to reduce levels of surge bed commissioning across north west London, and avoid the accompanying surge agency staffing.

12.5 Dependencies on implementation

We will continue to assess and manage dependencies on this proposal including:

Table 68: Key dependencies for implementation

	Context	Dependency
1	National	Changes to policy or strategic framework for palliative and end of life care
2	System	Changes to strategic priorities of the ICS Changes to the financial position of the ICS
3	Programme	Changes to operational circumstances of providers Changes in demand for services or capacity among providers

13. Conclusion and next steps

Within this document, we have:

1. Presented the case for change in improving provision of community specialist palliative care in north west London.
2. Described the process we adopted to develop and co-design the model of care with our stakeholders.
3. Presented our approach to engagement at each stage of development, sharing what we heard along the way and how this shaped our thinking.
4. Articulated the process we used to develop options for delivering the model of care.
5. Set out how we objectively considered options to establish a preferred option to fully deliver the model of care while opening enhanced EoLC beds in other boroughs and retaining 57 hospice inpatient beds by closing Pembroge Palliative Care Centre Inpatient Unit.
6. Demonstrated the affordability of a shortlist of options and their respective financial impacts on NHS NW London.
7. Articulated how relevant regulatory tests apply to this PCBC and the approval process.

The output is a preferred option for implementation of a revised model of care for CSPC in north west London. We will be consulting on the two options which have scored highest in both our non-financial and financial assessment – options 3 and 4.

It is our recommendation that NHS North West London:

1. Consult on the two highest scoring options

Next steps include:

1. Plan and prepare to consult our stakeholders and members of the public on the preferred option.
2. Undertake a consultation process with advice and input of JHOSC and NHS England.
3. Report on findings from consultation.
4. Plan and prepare a decision-making business case. No final decision will be made until after consultation (subject to approval).

Appendix A: Delivery option definitions

In [Chapter 6](#) we looked at possible ways we could deliver non bed-based services. We considered 3 possibilities:

Figure 33: Three possibilities for delivering non bed-based services

Question	Possible options	This means
 How could the non bed-based elements of the Model of Care be implemented?	1. Continue with current provision	We do not implement the changes to non bed-based care proposed in the model of care engagement document. We continue with the services and provision we have at this time.
	2. Minimum workable solution with a focus on improving fairness of provision	We implement changes described in the model of care that deliver a fairer spread of services and deliver some improvement, but not all the changes. This means we are closer to meeting national standards.
	3. Fully deliver model of care	We fully implement the changes to non bed-based care including ensuring full delivery against national standards.

We defined how service provision would differ in these 3 categories:

Table 69: Service provision dependant on delivery options

Model of Care Element	Option 0: Continue with current provision (the business as usual – current commissioned service model option)	Options 1 and 2: Minimum workable solution with a focus on improving fairness of provision	Options 3 and 4: Full delivery
Adult Community specialist palliative care nursing teams	A service is available 7 days a week 9am - 5pm for 7 boroughs but for 1 borough (Harrow) it is only available Monday - Friday 9am - 5pm	Making all services available 7 days a week 9am – 5pm for all 8 boroughs (including Harrow)	Making all services available 7-days a week for all 8 boroughs (including Harrow). Increase service 8am – 8pm
24/7 access to specialist palliative care telephone advice	Variation in staffing, out of hours rota and patient groups that are supported (not all support unknown patients)	All 8 boroughs services will have standardised staffing and out of hours rota, to include consultant supervision and appropriately trained nurse triage (Band 7 Clinical Nurse Specialist preferably or appropriately trained Band 6)	All 8 boroughs service will have standardised staffing and out of hours' rota, to include consultant supervision and appropriately trained nurse triage (Band 7 Clinical Nurse Specialist preferably or appropriately trained Band 6) All 8 boroughs to support known and unknown patients

Hospice at home	Variation in 24 hour support across the 8 boroughs and 3 boroughs without a hospice at home service	Providing access to a Hospice at home service in the 3 boroughs where no such service exists: • Hammersmith & Fulham (currently no day or night service) • Ealing and Hounslow (have overnight nursing from Marie Curie)	Providing access to a home service in the 3 boroughs where no such service exists: • Hammersmith & Fulham (currently no day or night service) • Ealing and Hounslow (have overnight nursing from Marie Curie) Extending hours to support 24 hour care where this is not currently provided for all 8 boroughs
Hospice MDT outpatient clinics: including Lymphoedema psychological and bereavement support	Variation in lymphoedema support. 1 borough (Harrow) without non-cancer related lymphoedema support.	Provide non-cancer related Lymphoedema support for the borough of Harrow	Provide non-cancer related Lymphoedema support for the borough of Harrow
	Variation in hospice MDT outpatient clinics. 2 boroughs (Ealing and Hounslow) have no consultant and nurse led clinics	All 8 boroughs Hospice MDT outpatient clinics should have access to a consultant, nurse, Allied Health Professional (occupational therapist, physiotherapist, dietician), psychologist, counsellor, social worker	All 8 boroughs Hospice MDT outpatient clinics should have access to a consultant, nurse, Allied Health Professional (occupational therapist, physiotherapist, dietician), psychologist, counsellor, social worker. Clinician led group activities (such as Exercise class, Fatigue management, Breathlessness/breath management groups.)
	Variation in the pathway to access psychological and bereavement support. Variation of the level of trained specialist psychology and bereavement practitioners. Variation in support for both adults and children	Robust pathway to access specialist psychological and bereavement support	Robust pathway to access specialist psychological and bereavement support All 8 boroughs to offer 1:1 and group support sessions for pre-bereaved and bereaved adults and children
Wellbeing services:	Variation in well-being services (Carer support, complimentary therapies, group sessions, day care etc.) offer	Hospices to work together to agree common offer	Hospices to work together to agreed common offer.

Appendix B: Full longlist of options

Figure 34: Full longlist of options

Option #	How much of the non-bed based model of care can be delivered? 	How much of the enhanced EOL care bed proposal can be delivered? 	How many hospice inpatient beds do we need to serve the needs of our population for the next five years? 
1	Continue with current provision	0 beds - reduce commissioned capacity	67 Beds - re-open unutilised beds
2	Continue with current provision	0 beds - reduce commissioned capacity	67 beds - close unutilised beds and open additional beds elsewhere
3	Continue with current provision	0 beds - reduce commissioned capacity	57 beds - close unutilised beds and open additional beds elsewhere
4	Continue with current provision	0 beds - reduce commissioned capacity	57 beds - close beds where there is more opportunity to improve access
5	Continue with current provision	0 beds - reduce commissioned capacity	57 beds - close all current beds and open a single site located centrally
6	Continue with current provision	0 beds - reduce commissioned capacity	< 57 beds - close unutilised and under-utilised beds
7	Continue with current provision	8 beds - Continue existing capacity	67 beds - re-open unutilised beds
8	Continue with current provision	8 beds - Continue existing capacity	67 beds - close unutilised beds and open additional beds elsewhere
9	Continue with current provision	8 beds - Continue existing capacity	57 beds - close unutilised beds and open additional beds elsewhere
10	Continue with current provision	8 beds - Continue existing capacity	57 beds - close beds where there is more opportunity to improve access
11	Continue with current provision	8 beds - Continue existing capacity	57 beds - close all current beds and open a single site located centrally
12	Continue with current provision	8 beds - Continue existing capacity	< 57 beds - close unutilised and under-utilised beds
13	Continue with current provision	54 beds - Beds available across all boroughs	67 Beds - re-open unutilised beds
14	Continue with current provision	54 beds - Beds available across all boroughs	67 beds - close unutilised beds and open additional beds elsewhere
15	Continue with current provision	54 beds - Beds available across all boroughs	57 beds - close unutilised beds and open additional beds elsewhere
16	Continue with current provision	54 beds - Beds available across all boroughs	57 beds - close beds where there is more opportunity to improve access
17	Continue with current provision	54 beds - Beds available across all boroughs	57 beds - close all current beds and open a single site located centrally
18	Continue with current provision	54 beds - Beds available across all boroughs	< 57 beds - close unutilised and under-utilised beds
19	Minimum workable solution	0 beds - reduce commissioned capacity	67 Beds - re-open unutilised beds
20	Minimum workable solution	0 beds - reduce commissioned capacity	67 beds - close unutilised beds and open additional beds elsewhere
21	Minimum workable solution	0 beds - reduce commissioned capacity	57 beds - close unutilised beds and open additional beds elsewhere
22	Minimum workable solution	0 beds - reduce commissioned capacity	57 beds - close beds where there is more opportunity to improve access
23	Minimum workable solution	0 beds - reduce commissioned capacity	57 beds - close all current beds and open a single site located centrally
24	Minimum workable solution	0 beds - reduce commissioned capacity	< 57 beds - close unutilised and under-utilised beds
25	Minimum workable solution	8 beds - Continue existing capacity	67 Beds - re-open unutilised beds
26	Minimum workable solution	8 beds - Continue existing capacity	67 beds - close unutilised beds and open additional beds elsewhere
27	Minimum workable solution	8 beds - Continue existing capacity	57 beds - close unutilised beds and open additional beds elsewhere
28	Minimum workable solution	8 beds - Continue existing capacity	57 beds - close beds where there is more opportunity to improve access
29	Minimum workable solution	8 beds - Continue existing capacity	57 beds - close all current beds and open a single site located centrally
30	Minimum workable solution	8 beds - Continue existing capacity	< 57 beds - close unutilised and under-utilised beds
31	Minimum workable solution	54 beds - Beds available across all boroughs	67 Beds - re-open unutilised beds
32	Minimum workable solution	54 beds - Beds available across all boroughs	67 beds - close unutilised beds and open additional beds elsewhere
33	Minimum workable solution	54 beds - Beds available across all boroughs	57 beds - close unutilised beds and open additional beds elsewhere
34	Minimum workable solution	54 beds - Beds available across all boroughs	57 beds - close beds where there is more opportunity to improve access
35	Minimum workable solution	54 beds - Beds available across all boroughs	57 beds - close all current beds and open a single site located centrally
36	Minimum workable solution	54 beds - Beds available across all boroughs	< 57 beds - close unutilised and under-utilised beds
37	Fully deliver model of care	0 beds - reduce commissioned capacity	67 Beds - re-open unutilised beds
38	Fully deliver model of care	0 beds - reduce commissioned capacity	67 beds - close unutilised beds and open additional beds elsewhere
39	Fully deliver model of care	0 beds - reduce commissioned capacity	57 beds - close unutilised beds and open additional beds elsewhere
40	Fully deliver model of care	0 beds - reduce commissioned capacity	57 beds - close beds where there is more opportunity to improve access
41	Fully deliver model of care	0 beds - reduce commissioned capacity	57 beds - close all current beds and open a single site located centrally
42	Fully deliver model of care	0 beds - reduce commissioned capacity	< 57 beds - close unutilised and under-utilised beds
43	Fully deliver model of care	8 beds - Continue existing capacity	67 Beds - re-open unutilised beds
44	Fully deliver model of care	8 beds - Continue existing capacity	67 beds - close unutilised beds and open additional beds elsewhere
45	Fully deliver model of care	8 beds - Continue existing capacity	57 beds - close unutilised beds and open additional beds elsewhere
46	Fully deliver model of care	8 beds - Continue existing capacity	57 beds - close beds where there is more opportunity to improve access
47	Fully deliver model of care	8 beds - Continue existing capacity	57 beds - close all current beds and open a single site located centrally
48	Fully deliver model of care	8 beds - Continue existing capacity	< 57 beds - close unutilised and under-utilised beds
49	Fully deliver model of care	54 beds - Beds available across all boroughs	67 Beds - re-open unutilised beds
50	Fully deliver model of care	54 beds - Beds available across all boroughs	67 beds - close unutilised beds and open additional beds elsewhere
51	Fully deliver model of care	54 beds - Beds available across all boroughs	57 beds - close unutilised beds and open additional beds elsewhere
52	Fully deliver model of care	54 beds - Beds available across all boroughs	57 beds - close beds where there is more opportunity to improve access
53	Fully deliver model of care	54 beds - Beds available across all boroughs	57 beds - close all current beds and open a single site located centrally
54	Fully deliver model of care	54 beds - Beds available across all boroughs	< 57 beds - close unutilised and under-utilised beds

Appendix C: Stakeholders

Throughout the development of the model of care, three core groups have been formed to shape and deliver the outputs of the review of community specialist palliative care in north West London. This includes:

1. A steering group
2. A working group
3. Providers involved in the delivery of care

The membership of these groups is summarised below. Engagement on the model of care has involved a broader set of stakeholders including health and wellbeing boards, voluntary sector organisations and community groups, which can be found in the engagement sections on the NHS NW London website.

Table 70: Steering Group members

Steering Group Members

1	North West London NHS community specialist palliative care and North West London hospice providers (See below)
2	2 patient and carer representatives
3	Clinical leads
4	North West London Last Phase of Life programme and care homes GP clinical lead
5	Acute hospital specialist palliative care clinical lead (consultant)
6	Acute hospital specialist palliative care nurse lead
7	Community services professional lead
8	NHS NW London Local Care Programme Team (4 members)
9	NHS NW London Finance Lead
10	NHS NW London Communications Lead
11	We also invited additional topic or other programme related stakeholders when needed.

Table 71: Members of model of care working group

Members of model of care working group

1	North West London NHS community specialist palliative care and North West London hospice providers (see below)
2	12 patients and carer representatives
3	Primary care representatives including GPs
4	Acute hospital specialist palliative care representatives
5	Acute hospital discharge representatives
6	North West London care homes lead
7	London Ambulance Service
8	Community nursing representatives
9	Continuing Health Care (CHC) representatives
10	We also invited additional topic or other programme related stakeholders when needed.

Table 72: Provider List

Provider list

1	St Luke's Hospice
2	St John's Hospice
3	Harlington Hospice
5	Royal Trinity Hospice
6	Marie Curie Hospice Hampstead
7	Central London Community Health NHS Foundation Trust
8	London North West University Healthcare NHS Trust
9	Central and North West London NHS Foundation Trust

In considering any future public consultation, the stakeholders we would expect to engage in addition to the general public include, but are not limited to, the following:

Table 73: Stakeholders for engagement

1	Providers: CSPC providers, acute hospital providers, community providers, primary care providers including Primary Care Networks and Local Medical Committee, London Ambulance Service
2	Local government: Borough councils, scrutiny committees, joint health overview scrutiny committee, health and wellbeing boards
3	VSCE organisations, community interest groups and carer groups
5	Steering groups: end-of-life steering group,
6	Patient & public involvement groups and Healthwatch

Appendix D: Supporting documentation

The following documents have been referenced in this business case and are available on the NHS NW London website [Adult CSPC \(CSPC\) review :: North West London ICS \(nwlondonicb.nhs.uk\)](https://www.nwlondonicb.nhs.uk/adult-cspc-cspc-review-north-west-london-ics):

Table 74: Local reports

1	Equalities and Health Inequalities Impact Assessment
2	Model of Care
3	Engagement reports
4	Issues Paper
5	Travel analysis
6	Bed Modelling

Table 75: Key National reports

The model of care document contains a full bibliography: [20230821 NW London ICS CSPC Co-designing a new improved model of care.pdf \(nwlondonicb.nhs.uk\)](https://www.nwlondonicb.nhs.uk/20230821-NW-London-ICS-CSPC-Co-designing-a-new-improved-model-of-care.pdf).

1	NHS England: Ambitions for Palliative and End-of-life Care: A national framework for local action 2021-2026
2	NHS England: Service specifications for palliative and end-of-life care: Adults
3	NHS England: Universal Principles for Advance Care Planning (ACP) First published March 2022
4	NHS England: Long Term Plan, 2019
5	Office for National Statistics: National Survey of Bereaved People (VOICES): England, 2015
6	The Kings Fund: Dying Well at Home: Commissioning Quality End-of-life Care, Feb 2023

Appendix E: Glossary of terms

Table 76: Glossary of Terms

Term	Definition
Advance care planning	Advance care planning (ACP) is the term used to describe the conversation between people, their families and carers and those looking after them about their future health and care wishes and priorities. It is a way for a person to think ahead, to describe what's important to them and have this recorded to ensure other people know their wishes to help that person to live well right to the end of their life. Advance Care planning is a key means of improving care for people nearing the end-of-life and of enabling better planning and provision of care, to help them live well and die well in the place and the manner of their choosing.
Bed days	Bed days are the number of days a patient spends in a hospital, hospice, or healthcare facility as an admitted patient staying overnight. For example, if someone is admitted and stays for 3 days, that's counted as 3 inpatient bed days. This is used to see how long patients stay in beds for medical care. The individuals and organisations who commission or oversee these services use bed days as a way to measure and manage healthcare resources. It helps them understand how efficiently hospices and hospitals are working.
Co-design	Co-design is the method of involving users (people), stakeholders (decision makers) and practitioners (front line staff) in the process of service design.
Community-based specialist palliative care (CSPC)	Community-based specialist palliative care refers to providing specialised care for individuals with life-limiting illnesses and those close to them outside of a hospital, typically in their own homes, care homes, or hospices. These services aim to manage symptoms, enhance quality of life, and provide support during the end-of-life process. The goal is to collaborate with patients and their loved ones, tailoring care to meet their specific needs and wishes, and ultimately improving the overall quality of their life and death.
Continuing healthcare (CHC)	NHS continuing healthcare (CHC) is social care funded by the NHS and can be provided in a variety of settings outside hospital, including the patient's own home or a care home. It is sometimes called fully funded care. A person's eligibility for NHS continuing healthcare is based on their assessed needs, and not on any particular diagnosis or condition.
Cultural competency	Cultural competence refers to an organisation's or individual's overall respect for and understanding of different cultures, as defined by nationalities, religions, languages, customs, behaviours and ethnicities and their ability to effectively interact,

	work and develop meaningful relationships with people or groups from different cultural backgrounds.
End-of-life care	End-of-life care is a specific type of care for individuals nearing the final stages of their life. It aims to ensure comfort, dignity, and support, managing symptoms and providing emotional and practical assistance.
Equality and Health Inequalities Assessment (EHIA)	An Equality and Health Inequalities Assessments (EHIA) assess the (potential) impact of a decision on the “protected characteristics” as outlined in the Equality Act 2010.
Home and usual place of residence:	What we mean when we say home or usual place of residence is a place in the community where a patient lives most of the time and feels comfortable. It's where a patient has their own space and belongings and normally live most of the time/ spend the majority of their days and nights. It's the place you call home. It could be an apartment, house, hostel or shelter, dedicated care setting (care home (nursing, residential, learning disability care home), sheltered housing and supported living accommodation and mental health facility) where you have a consistent living arrangement at this place.
Integrated Care Boards (ICBs)	Integrated care boards (ICBs) replaced clinical commissioning groups (CCGs) in the NHS in England from 1 July 2022. An integrated care board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.
Integrated care systems (ICSs)	Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. The North West London ICS consists of all NHS organisations and local authorities in north west London.
In-reach	In-reach health services are medical services that are delivered to patients who are already admitted or residing in a particular healthcare setting, like a hospital, nursing home, or hospice. Instead of patients going out to seek medical care, the care comes to them within the confines of the facility where they are receiving care or residing. This approach aims to enhance patient access to necessary medical attention, convenience, and continuity of care while minimizing the need for external transfers or travel.
Generalist palliative and end-of-life care	Generalist palliative and end-of-life care is the fundamental level of palliative and end-of-life care support provided by healthcare professionals such as a general practitioner (GP), community nurses (including district nurses), care home staff, therapists, domiciliary home care staff (for example care agency staff either arranged by the council, through continuing health care or privately) and hospital ward staff who have a general understanding of and training in palliative care. They provide support to patients with serious illnesses or nearing the end-of-life in their usual place of residence (which may be their home, a care or nursing home or a sheltered housing facility) or a medical facility such as a hospital or hospice. The majority of people with life-limiting and advance illness will only

	need this level of support through their journey of palliative and end-of-life care.
Model of care	A model of care is a framework that explains what care will be provided and how services work together to deliver care that meets the needs of the population and incorporates best practice.
Multidisciplinary teams (MDT)	A Multidisciplinary Team (MDT) is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.
Palliative care	Palliative care is a treatment, care and support approach that focuses on improving quality of life by managing symptoms, relieving pain, and addressing the side effects of a patients' condition. It also provides support for emotional and practical needs, along with those of family, friends and care givers.
Patient outcomes	Patient outcomes are the results from care and treatments patients have received whilst in hospital, other clinical or care settings.
Personalised care planning	Personalised care and support planning is a series of facilitated conversations in which a patient, their family or those close to them can actively participate in exploring the management of the patients' health and well-being within the context of their whole life and family situation.
Specialist palliative and end-of-life care	Specialist palliative and end-of-life care is an advanced and specialist level of palliative and end-of-life care provided by expert health care professionals who have received specialised training in this field. Care is provided by a specialist palliative care multi-disciplinary team (doctor, nurse, therapist) who work with your regular care teams in the community to provide additional support and guidance for complex symptoms and challenges. This type of care is required by individuals with advanced and life-limiting illness that have complex needs (can be medical and social). This care is usually provided in special palliative care units, hospices, or at home/ usual place of residence via the specialist multi-disciplinary team across services. This type of specialist care is not required by everybody with palliative care needs and at the end-of-life.
Triage	Most simply, the general purpose of <i>triage</i> is to sort patients by level of acuity to inform care decisions.
Unknown patients	By 'unknown' patients, we mean patients who have not previously received care from community specialist palliative care services (and are therefore not registered with, or are unknown, to the services).
Universal Care Plan (UCP)	The Universal Care Plan (UCP) is an NHS service that enables people living in London to have their care and support needs and preferences digitally shared with healthcare professionals across the capital. It is the recommended platform for urgent and end-of-life care plans in north west London and London.

Appendix F: Case Study

All Case Studies are published on NHS NW London's website³⁶ [here](#).

One example case study is Rebecca's Story:

Rebecca's mother was diagnosed with pulmonary hypertension and subsequently began using the community palliative care service. She passed away in April 2021 and the family kindly agreed to share a summary of the care and support received so that we can learn from the experience. We thank Rebecca for sharing her story.

The family found the staff of the specialist palliative care service to be friendly and helpful and their helpline to be invaluable, particularly over the weekend. They provided carers who were supportive and respectful, helping the family immensely. The equipment that was ordered arrived promptly and they also found the occupational health and complimentary services to be very good.

The family did encounter some issues with the overall process though.

Rebecca's mother had decided she wished to die at home and was informed by the specialist palliative care nurse and the care planning (My Care My Way) nurse that they would arrange for her required medication to be prescribed. Following a call from the specialist palliative care service team, Rebecca travelled to her mothers' nominated chemist to collect the prescription but one item was out of stock. Rebecca worked out that this was the pain medication that was needed immediately and then had to contact the palliative care service and various chemists to get the missing item. This involved travelling some way and leaving her mother alone at home. Also, when her mother reached the end of her life, there was another item missing that Rebecca was not aware of, as she did not know what was on the prescription.

Rebecca's mother took a turn for the worst at 6pm, which due to service opening times, proved incredibly problematic. The local GP service informed the family it was too late for them to do anything and the 111 service said it was too early for an out of hours GP, so the family had to call an ambulance. When the ambulance arrived the crew asked for the District Nurses folder, which the family didn't have, nor were they aware they should have had one. This was required as the ambulance crew needed a medication chart to administer the drugs. The crew did not have the ability to access the folder online (as they lacked S1 access) and it was too late for them to call the GP or specialist palliative care service (as they don't visit out of hours). Instead they called for an advanced paramedic to attend so the drugs could be administered in the absence of the medication chart. This took a number of hours and was in addition to the missing item of medication, which now could not be prescribed by the GP either. This whole experience was very distressing for both the family and Rebecca's mother.

Next, the District Nurses and other health professionals working with the family, arranged to meet at Rebecca's mothers' property to review her case but no one informed the family this would happen. It meant people arrived and the family did not expect them and didn't know why they were there. One member of staff made a call on his loudspeaker and then had a conversation with the other clinician, suggesting Rebecca's mother was rallying a bit but was basically at the end-of-life and did not have long left. This conversation took place in front of Rebecca and her mother, although fortunately her mother did not hear it. If she had it would have been an awful situation as she was understandably very anxious about what was happening.

Rebecca would like her family's experience to inform improvements to the way in which palliative care is delivered so that other patients and their families receive better outcomes and the best care possible.

³⁶ [Case studies :: North West London ICS](#)

Appendix G: Model of Care – further detail

Community-based specialist palliative and end-of-life care services are also provided by a specialist multidisciplinary care team providing support across a range of services as follows:

Service area 1: Care at home

- Adult community specialist palliative care team
- Hospice at home
- 24/7 Specialist palliative care telephone advice

Service area 2: Community specialist inpatient beds

- Enhanced end-of-life care beds
- Hospice inpatient unit beds

Service area 3: Hospice out-patient services (including psychological support and bereavement support services), hospice day care services and well-being services

- Hospice out-patient clinics (including psychological and bereavement support, and lymphoedema services)
- Hospice day care services
- Well-being services

The services within the new model of care that will support delivery of this are:

- **24/7 specialist palliative care telephone advice** - available for known and unknown patients, families and carers and clinicians via CSPC providers. This supports individuals to have access to expert guidance and signposting without needing to attend a hospital. It supports the reduction of unnecessary hospital admissions, and enhances patient care and family and carer experience particular out of hours.
- **More end-of-life care community specialist inpatient bed capacity**- through the introduction of enhanced end-of-life care beds available to all of north west London residents, more patients will be able to receive appropriate bed care to meet their needs outside of an acute hospital or hospice inpatient unit.
- **Extended operating hours for adult community specialist palliative care teams to provide care at home** - consistent adult community specialist palliative care teams, with longer working hours (7-days, 8am to 8pm) will enable more patients to receive this expert care in the community, particularly out of hours (after 5pm) when we know the access to other community support services and primary care is often challenging.
- **Enhanced and expanded hospice at home care service** – a consistent hospice at home care service, that can provide up to 24-hours of support working closely with other community care teams. The service is available to all boroughs in north west London and is beneficial in further reducing hospital admissions and speeding up discharge for patients who prefer to receive care in the comfort of their own home.

1. Service area 1: Care at Home

1.1 Adult Community Specialist Palliative Care Team

New model of care proposal for the adult community specialist palliative care team services

The recommended new model of care proposal will deliver for all north west London residents regardless of where they live:

- **Service admission criteria:** The service supports adults (18+) with advanced life-limiting illnesses (for example but not limited cancer, end-stage heart or lung disease, neurodegenerative disorders such as

dementia and Parkinson's disease, or advanced organ failure) with complex symptoms requiring expert management and specialised palliative care input for these symptoms and support with advance care planning. Service admission decisions are based on comprehensive assessments of the patients' needs by the team, the patient and their family, and other services.

- **Service hours of operation:** Care will be provided seven days a week, from 8am to 8pm. A 24/7 specialist palliative care advice telephone line will be accessible outside these hours.
- **Referral route and how to access services:** To access the services provided by the adult community specialist palliative care team, individuals can be referred by healthcare professionals such as GPs, hospital teams, hospice teams, and community nursing teams. Residents also have the option to initiate a self-referral, but this will require additional clinical information to be provided from a healthcare professional involved in their care to support the referral process.
- **Where is care provided:** The adult community specialist palliative care team delivers care in residents' own homes or their usual place of residence in the community, which includes care homes (residential, nursing and learning disabilities homes), hostels, shelters, mental health facilities, supported living accommodations and prisons. They strive to create a comfortable and supportive environment wherever the resident prefers to receive their care.

What will be different

The new model of care will boost the quality and accessibility of the adult community specialist palliative care team services through:

- **Consistent seven-day service and equal care across all boroughs:** Services are available 7-days a week, offering needed support during evenings and weekends. All residents, regardless of location, will have access to high-quality care. This is a step up in care from the current situation where coverage varies across boroughs. This will include strengthened weekend workforce arrangements to ensure consistent, uninterrupted care for residents.
- **Extended hours 8am to 8pm:** Unlike the current 9am to 5pm services, the new model extends support hours, offering help in early mornings and evenings (note – this service does not include rapid response).
- **Increased in reach support to care homes and supervision of enhanced end-of-life care beds:** A higher level of standardised support to care homes, including specialist palliative care for patients and improved staff training, and dedicated support for the delivery of the new enhanced end-of-life care beds that will be available to all boroughs.
- **Enhanced palliative care training for wider generalist palliative care workforce:** The wider community palliative care workforce, including care home staff, will benefit from improved education and training.

In summary, the new model of care promises more equitable, comprehensive, and responsive care from the adult community specialist palliative care team service. It addresses existing shortcomings and substantially improves the specialist palliative care landscape for all residents in the community with the increased enhanced end-of-life care nursing home beds.

1.2 Hospice at Home

New model of care proposal for the hospice at home service

The recommended new model of care proposal for the hospice at home service will deliver for all north west London adults nearing end-of-life, regardless of where they live in north west London, personalised, culturally sensitive, expert, and compassionate care in their homes. This care can be available around the clock, for up to 24-hours a day if need. The core service offer includes:

- **Admission criteria and service location:** The service will support adults (18+) with advanced life-limiting illnesses with a terminal prognosis (less than six months to live). This will include those with specialist palliative needs and those with non-specialist palliative and end-of-life care needs. They will uphold the patients comfort, dignity, and preference to stay in their familiar surroundings at home during their final stages of life. Hospice at home is available to patients at their home and usual place of residence including residential care homes, sheltered housing and homeless shelters.
- **Service duration:** The service will typically be offered for a standard duration of 14 days (two weeks), although there will be flexibility to adjust this on a case-by-case basis dependent on individual needs and circumstances.
- **Service support hours:** Hospice at home services will deliver round-the- clock care (up to 24-hours of care) for patients requiring single handed care. If double handed care is required the services will work in close collaboration with other community health services providing support in the home, including continuing health care teams, care home staff and domiciliary care provided through the council, to support 24-hour care.
- **Workforce:** The service will be delivered by a team of healthcare professionals, nurses and health care assistance who possess specialist training in palliative and end-of-life care.

What will be different

The new model of care will boost the quality and accessibility of the hospice at home team services support through:

- **Consistent service and equal care across all boroughs:** Dedicated hospice at home services will be available seven days a week for up to 24- hours of care if assessed as needed.
- **Better integration and collaboration with other community teams involved in patient's care:** To support a more seamless care experience for patient and their families, carers and those important to them.

The new model of care for hospice at home services will be expanded to make sure all north west London boroughs have dedicated hospice at home services available and the variation in these services will be reduced by the implementation of care support up to 24-hours. This will include overnight sitting which will be based on patient, family and carer needs.

The hospice at home services will work more in tandem with other community services (for example adult community specialist palliative care team, community nursing, continuing health care, primary care and rapid response services) to achieve continuous care if required. They will support meeting the medical, psychological and spiritual needs of patients in the home who are nearing their end- of-life The hospice at home services will complement other care services already supporting the patient at home and not replace them.

To support hospital discharge and prevent hospital admission the hospice at home services will also provide 'bridging' care for up to two weeks whilst waiting for other more appropriate care arrangements to be set up for the patient for the longer term.

1.3 24/7 Specialist palliative care telephone advice

The recommended new model of care proposal for 24/7 specialist palliative care telephone advice services will deliver for all north west London residents irrespective of which borough they live in:

- A common core service that will bring personalised and culturally sensitive care, expertise, compassion, and comfort into the homes of adults in north west London with a palliative and end-of-life care need.

- The service will be delivered by a team of healthcare professionals including clinical nurse specialists and other palliative care nurses who possess appropriate specialist training and skills in palliative and end-of-life care.
- The service will support adults (18+) with advanced life-limiting illnesses, both those with specialist palliative needs and those with generalist palliative and end-of-life care needs.

The key elements of the service will include:

- **24/7 specialist palliative care telephone advice:** Offering north west London residents the expert guidance and support they need in relation to their palliative and end-of-life care related queries and needs. The advice line service will also extend beyond mere advice and information sharing. The teams will triage the needs of the callers and provide practical advice on symptom management as well as directing individuals to the most appropriate resources or services, whether that's suggesting other helplines (for example NHS111), local care provider websites, local support groups and other helpful organisations, assisting with referrals to other more appropriate services when necessary, or escalating emergency response through 999.
- **Support for known and unknown patients:** For the first time all north west London residents whether known or unknown to CSPC services will be able to contact the 24/7 telephone advice line provided by individual borough providers (both local hospice and other community specialist palliative care providers). Known callers are individuals who have previously received care or are currently receiving care from community-based specialist palliative care services. Unknown callers are individuals who have not used the service before. Callers will be able to obtain expert advice and support with navigating care services, providing more equitable access for all. The 24/7 specialist palliative care advice lines will also be available to family members, caregivers, and clinicians in the local boroughs.
- **Specialised workforce:** The advice lines will be staffed by professional teams comprising palliative care nurses and clinical nurse specialists, overseen by and with access to palliative care consultants who can provide direct advice when required. All teams will be trained to conduct comprehensive telephone assessments and triage, offering precise information and advice that addresses the specific challenges faced by patients.
- **Known patients and improved co-ordination of care:** For calls from known patients (and with the appropriate consent), advice line teams can use existing health care records and care plans to tailor their advice (with access to available information systems being supported as much as possible). They can assist with complex medical situations, provide symptom management advice in line with patient's care plans, and help coordinate care with other healthcare providers as required.
- **Unknown patients and risk assessment, advice and support:** For calls from patients who are not known to the service currently, the teams may not be able to access complete clinical information for the patient, which may prevent them from providing comprehensive medical advice. They will still be able to provide some medical advice that aligns with safety guidelines, alongside a risk assessment. They will also offer general symptom management guidance, provide information about local resources, and help with navigation of and onward referrals for other community services.
- **Retaining local knowledge and expertise:** We are not recommending the development of a single centralised specialist palliative care telephone advice service or a single point of access for these services in north west London. We have carefully considered the challenges faced in coordinating and navigating palliative and end-of-life care, including generalist and specialist services. The complex infrastructure of our community services providing palliative and end-of-life care, and CSPC services, along with the potential risk of disrupting existing access points, prevent us from implementing this approach at a north west London level.

What will be different

The key changes that the new model of care will bring are around equitable support and consistent expertise:

- Previously, services have not been consistently available to patient's unknown to CSPC services, and the level of expertise of the staff supporting the advice line varied.
- In future, the service will be extended to all who need it, including known patients and those not already known to CSPC services, along with their carers, family and those important to them.
- The teams will be led and supervised by a consultant in palliative care and staff who have been trained in palliative care including clinical nurse specialists and palliative care nurses. They will have appropriate training to support consistent, high-quality triage and provide expert palliative care nursing advice and support. 24/7 access to expert medical advice will be available via the consultant in palliative care.

Summary of the main changes for community-based specialist inpatient bed care as part of the new model of care:

- There will be an overall increase in the number of CSPC inpatient beds following the introduction of 54 dedicated enhanced EoLC beds across all of north west London. These new beds will cater for the needs of patients who do not require an intensive, short stay hospice bed but cannot stay at home due to their specialist needs, do not wish to stay at home, do not want to or do not need to be in a hospital and their needs exceed a usual care home. We will maintain the current number of hospice inpatient unit beds (57) to support our patients with the most complex specialist palliative care needs to receive bed care, but enhance this provision to support 7 days a week admissions for residents regardless of the borough they live in.

2. Service area 2: Community specialist inpatient beds

2.1 Enhanced EoLC beds

The new model of care for enhanced EoLC beds will ensure all north west London residents (irrespective of borough) have:

- An increased number of community specialist inpatient beds for patients who do need short, intensive hospice inpatient unit bed care but are unable to stay at home or their usual place of residence due to their needs and their preference is not to be treated in hospital. These dedicated beds will be in addition to, and not replacing, the current working hospice inpatient unit beds we already have in north west London.
- The new model of care will introduce 54 enhanced EoLC beds for north west London in totality. There is no benchmark for the number of beds required, as this is an innovative addition to provision in north west London and regionally. There is no national or international evidence base for the number of beds needed, however following discussion the model of care working group agreed that a reasonable planning assumption, based on examples from elsewhere in north west London, is 2.5 beds per 100,000 populations. This was further ratified by scaling up Hillingdon's provision of eight beds for the whole north west London population.

What will be different

- The introduction of 54 enhanced EoLC beds across north west London will increase the quality, number and accessibility of community inpatient specialist beds currently available to patients who need more support than what can be delivered in their existing home.
- Patients will also have far greater access to this largely new, enhanced bed option, meaning those already in care homes will have a smoother transition to an enhanced bed, where required. Those living in their own home will receive appropriate non- hospital based support at the end-of-life if they cannot be supported to die at home and they do not need the short term intensive hospice inpatient bed.

2.2 Hospice inpatient unit beds

The new model of care proposal for hospice inpatient unit beds will deliver excellent care for all north west London residents irrespective of which borough they live in.

The recommended future model of care aims to provide highly specialised and comprehensive care, comfort, dignity and comprehensive symptom management for patients with life-limiting illnesses who have complex medical, psychological, emotional, and social needs.

Led by consultants in palliative care medicine and supported by a diverse multidisciplinary team, our hospice inpatient bed units will collaborate to deliver personalised and compassionate care. Where necessary additional multidisciplinary support is sought, much the same as any other inpatient care setting, and may involve any other professional(s) involved in the patients care specific to their conditions.

The key elements of the service will include:

- **Location of services and setting of care:** Patient care is primarily provided within a hospice setting and goes beyond a typical clinical environment that you would find in a hospital. The homely atmosphere creates a serene and tranquil experience, ensuring comfort for all who use these services.
- **Accessing the service:** Patients are admitted to the hospices through referrals from healthcare professionals only, including GPs, adult community specialist palliative care teams, social care professionals, community nurses and other community services teams, as well as hospital teams. Self-referral is not supported. However, patients who make contact with the hospices to discuss hospice inpatient admission will be supported accordingly.
- **Length of stay:** It is important to note that the inpatient bed care unit is not intended to be a long-term care facility. Instead, it serves as a temporary place where patients can receive specialised intensive 24-hour care and support. The typical duration of stay is around two weeks (14 days), although this can vary based on individuals' needs, during which patients receive short-term, intensive support from the hospice specialist multidisciplinary care team. Patients who require these services have a high degree of medical or social complexity, where their needs cannot be met at home with their regular care team. Some patients may pass away in the hospice, while others may stabilise and return to their usual place of care or move to another care setting, such as a nursing home or enhanced EoLC care beds. Once a patient's condition stabilises and if they are not actively dying (meaning someone is in the final stages of life and death is approaching very soon), the hospice team will often work closely with them, and those important to them, to support transfer of their care such as returning home, moving to a care home for the first time or an enhanced EoLC bed, based on their evolving needs,
- **End-of-life care:** For some patients, the hospice unit may provide care until end-of-life, while others may experience symptom stabilisation and transition to a different care setting.
- **Hours of operation:** Services operate seven days a week, providing 24-hour care for patients on the inpatient bedded unit. Routine (planned) and emergency (unplanned) admissions are supported from Monday to Sunday, 9am to 5pm, making sure there is continuous access to care⁸.

What will be different

The new model of care will deliver two notable changes for hospice inpatient bed care services in north west London:

- **Expanded admission acceptance:** By extending admissions for routine and planned care to seven days a week during core hours of 9am to 5pm, we are addressing the national ambition of improving access to care for patients with life-limiting illnesses. This change allows both planned and unplanned admissions to occur on any day. It makes sure that patients can promptly access comprehensive and specialised care. Removing the limitations of admission to specific days of the week eliminates unnecessary delays and enables individuals to receive the care they need when they need it.

- **Revised and standardised hospice inpatient bed admission criteria:** We have updated and standardised the criteria for admitting patients to hospice inpatient bed care units across all hospices in north west London. By implementing consistent clear admission criteria, we make sure that hospice beds across all of our boroughs are allocated to patients with complex care needs that require this consultant-led multidisciplinary team support. These criteria also support the discharge of patients on the continuing healthcare fast track and those who are routinely dying in hospitals. It's important to note that these changes do not compromise the care of complex patients requiring this support, as hospices will robustly triage their referrals and manage any waiting lists. By streamlining the flow within the system and addressing urgent care needs promptly, we optimise resource management and potentially increase our hospice bed capacity, enhancing the overall quality of care we provide.

3. Service area 3: Hospice out-patient services (including psychological support and bereavement support services), hospice day care services and well-being services

3.1 Hospice out-patient clinics (including (including psychological and bereavement support, and lymphoedema services), Hospice day care services and Well-being services

Proposed changes for services within the new model of care

Under the new model of care, existing hospice out-patient services will remain with efforts made to level-up care in areas like Ealing and Hounslow where there is a gap in hospice out-patient services.

The introduction of a common core service for lymphoedema services based on the national lymphoedema specification will allow us to deliver consistent and equitable care across all areas, including Harrow, for both cancer and non-cancer patients.

This minimum common core offer will include:

- Specialist support to care for individuals with chronic upper and lower limb lymphoedema, including support and education to help patients to self- manage their symptoms.
- Eligibility and admission criteria that welcomes all patients with primary and secondary lymphoedema, regardless of the underlying cause.
- Referral system that allows patients to be referred to the service by various healthcare professionals involved in their care. Self-referral will be encouraged, allowing individuals to take an active role in seeking the care they need.
- Qualified service team, consisting of highly qualified therapists who specialise in lymphoedema management. Staff will have a degree-level qualification and be well-versed in holistic management strategies, including rehabilitation, exercise and wound management.
- Operational hours of weekdays from 9am to 5pm. To support continuity of care, there will be mechanisms in place to address urgent needs outside of these hours.
- Triage system where patients are prioritised based on their needs and the nature of their lymphoedema. Patients requiring immediate attention will receive prompt care.
- Wide range of core services covering a variety of comprehensive care approaches. These will include holistic assessments, personalised care planning and treatment, lymphatic drainage, skin care, compression therapy, exercise and weight management interventions, and education for self-management. Staff will also refer and signpost patients to other services as needed.

The new model also proposes introducing a common core offer for psychological support for patients and bereavement support services for their family, carers and those important to the patient within our CSPC provision for all of north west London. The key principles of this will include:

- The acknowledgement that psychological adjustment and grief in the palliative care phase is healthy and normal, as is grieving after death.
- A robust assessment process for more complex needs in both the palliative care phase and after death.
- Personalised assessment and needs led care.
- A range of evidenced-based support and therapeutic support which are based on assessment and need.

- Integrating both psychological and bereavement services to make sure patients, families and those important to them are supported during the different stages of the end of life.
- Palliative psychological family services, bereavement services and social support services will be closely aligned with a clear pathway. This will help make sure people are seen by the best service for them at that time, allowing for stepping up or stepping down levels of support flowing from the clear assessment process.
- Pre-bereavement support such as signposting advice for funeral costs and benefit checks (as raised/ highlighted during our engagement on the model of care).

The support available will include one-to-one counselling and group sessions provided by multidisciplinary psychosocial teams drawn from psychology, psychotherapy, counsellors, social workers, support workers and complementary therapists with appropriate training and knowledge of palliative care and bereavement.

4. What is a continuum of care in the context of specialist palliative care and hospice care services?

A care continuum is a description of how a patient would be moving up and down the levels of specialist support based on their changing needs and preferences.

In the context of specialist palliative care and hospice care services, a continuum of care refers to a seamless and coordinated progression of services that are tailored to meet the evolving needs and preferences of patients facing advanced illnesses. It recognizes that patients' care requirements change over time and ensures that appropriate levels of support are provided at each stage of their journey.

The continuum of care encompasses various levels of specialist support, with includes the following components:

- **Adult CSPC team:** This care is provided in the patient's home or community setting. It involves a team of healthcare professionals, including doctors, nurses, social workers, and counsellors, who specialize in palliative care. They focus on managing symptoms, providing emotional and psychosocial support, and helping patients and their families navigate the challenges of living with a serious illness.
- **Hospice at home service:** When a patient's needs become more complex, they may require additional support that can be provided through a hospice at home service. This involves a dedicated team of healthcare professionals who deliver comprehensive palliative care in the patient's home environment. They ensure symptom management, emotional support, and coordination of care, while respecting the patient's desire to be in familiar surroundings.
- **Hospice inpatient bed care:** In some cases, patients may require a higher level of care that cannot be adequately provided at home. Hospice inpatient care service offers a specialized facility where patients receive 24/7 medical support and symptom management. This level of care may be needed when a patient's symptoms become difficult to manage at home or when complex interventions, such as pain management, require a more controlled environment.
- **Hospice out-patient clinics, day care and well-being services:** Out-patient clinics provide specialized consultations, assessments, and treatments for patients who do not require inpatient care. Patients may visit these clinics for routine check-ups, medication adjustments, counselling sessions, or specialized interventions such as palliative chemotherapy or radiation therapy. Day care and well-being services aim to improve the overall well-being of patients and provide respite for caregivers. Patients attend day care centres or well-being programs where they can engage in therapeutic activities, receive social support, and access complementary therapies to enhance their quality of life.
- **Lymphoedema services:** Lymphoedema services are specialized programs that manage and treat swelling caused by lymphatic system dysfunction. These services include assessment, compression

therapy, exercises, and education to help patients manage and alleviate symptoms related to lymphoedema.

- Bereavement and psychological support services.
- 24/7 specialist palliative care advice line.
- Nursing home enhanced end-of-life care beds and enhanced care for care homes.

The movement of patients up and down the levels of specialist support within the continuum of care is based on their changing needs and preferences. As a patient's condition progresses or becomes more complex, they may require a higher level of care, such as transitioning from CSPC to a hospice at home service or a hospice inpatient care service. This may be due to worsening symptoms, increased care needs, or the need for more intensive medical interventions.

Conversely, as a patient's condition stabilises or improves, they may have the option to transition back to a lower level of care, such as moving from inpatient care to hospice at home or CSPC. This transition allows patients to receive the optimum care and support they need in a less intensive setting that aligns with their preference for being at home or in the community.

The movement within the continuum of care is driven by the goal of providing patient-centred care that matches the individual's needs and preferences at any given time. It ensures that the level of support provided is appropriate to address the physical, emotional, and psychosocial aspects of the patient's condition, while also considering the patient's desire for autonomy, comfort, and quality of life.

Overall, the continuum of care in specialist palliative care and hospice services offers a flexible and adaptive approach to meeting the changing needs and preferences of patients, providing them with the most appropriate level of support throughout their journey with advanced illness.

Appendix H: Finance

Key Assumptions and data sources

The items which build up the financial appraisal for each option are further defined and sourced below.

Table 77: Summary of key assumptions in the financial appraisal *Table 78*

Item	Sources and assumptions
Current CSPC NHS expenditure	Total CSPC contract prices for 23/24 collated across providers by NHS North West London, February 2024.
Cost of re-opening Pembridge Palliative Care Centre inpatient Unit	Cost of restoring Pembridge Palliative Care Centre Inpatient Unit operation provided by CLCH less existing stranded estates cost, as this is already within current expenditure.
Avoided hospice inpatient unit spot purchases	Outturn cost of spot purchases of specialist beds for Pembridge patients in 23/24.
Transition to 50% funding model	- To provide sustainable funding of the NHS and charitable providers, NHS NW London has a target to move to fully funding the cost of NHS provision and a fair and equitable share of the cost incurred by charitable providers (indicatively 50%) - This represents a significant uplift from the current position, which is not sustainable - CSPC providers have provided 23/24 running costs to NHS North West London, and the cost of transitioning from current arrangements to providing 50% funding of charitable provider costs and 100% of funding of NHS provider costs has been calculated.
Enhanced EoLC Beds	- The new 46 enhanced care beds are provided in options 1-4 across the seven boroughs where there is currently no provision - These have been costed based on the funding provided to Harlington Hospice for the current eight beds - The costing assumes that 50% of these beds will be provided by NHS and 50% by charitable providers.
Delivery of the community model of care	- Costing of the full community model of care has been developed by the current providers and collated by NHS North West London - This costing assumes that NHS North West London funds 50% of charitable providers' costs and all of NHS providers' costs - In Option 1 and 2 the model is partly delivered, with a 50% patient reach - Delivery of the partial model of care assumes 50% of the cost, except the 24/7 telephone line which applies in both options
Pembridge Palliative Care Centre Inpatient Unit cost avoided	The cost of re-opening Pembridge Palliative Care Centre Inpatient Unit (above) is avoided in some options.
Specialist hospice beds brought into core contract	- Specialist hospice beds are currently spot purchased from the funding which would otherwise be spent at Pembridge Palliative Care Centre Inpatient Unit - If Pembridge Palliative Care Centre Inpatient Unit is not re-opened (Options 1 and 3), these continue to be required, and will then be brought into providers' core contracts which will be more efficient than the spot purchase model.
Charitable cost avoided	In Options 1 and 3, Pembridge Palliative Care Centre Inpatient Unit remains open and the new enhanced EoLC Beds are provided

	Charitable bed numbers are therefore adjusted at other providers, with 10.5 beds at £96,000/year closed to produce the bed numbers required to meet population need in north west London.
Acute bed days avoided by enhanced EoLC bed provision	- Provision of the new enhanced EoLC beds will provide a discharge route for patients who would otherwise be in hospital. 37 incremental beds will be provided in north west London compared to business as usual – current commissioned service model: 46 new enhanced EoLC beds - Plus, four specialist hospice beds - Less, 13 hospice beds by not re-opening Pembridge Palliative Care Centre Inpatient Unit - This benefit assumes that a bed day provided in the community is a bed day that would otherwise result in a patient remaining in hospital - These avoided hospital bed days are costed based on north west London estimate of a surge bed cost of £475 a day - The operating model for how these patients are identified and referred by the acute sector in order to allow timely discharge will be further developed in the Decision Making Business Case (DMBC). - This benefit is described further in section 9
Hospital attendances and admissions avoided through community services	- North west London has high rates of patients attending and being admitted to hospital in the last year of life³⁷ - These admissions are costly, resulting in invasive interventions and long lengths of stay³⁸ - Full implementation of the CSPC model of care will provide greater support to people at home and is targeting achieving the London median rate of end-of-life admissions in the last year of life (which is based on South West London ICB of 1.11) - The avoided bed days as a result of these avoided admissions is costed at the surge bed cost of £475 a day. - This omits the cost of treatment provided, meaning the benefit may be higher - In options 1 and 2, the community services model is partly delivered, with half the reach in terms of unique patients, so it is assumed that half the benefit would be realised - This benefit is described further in section 9.
Decant costs	There are no associated decant costs.
Stranded costs	- The only stranded costs that will be incurred relate to Pembridge Palliative Care Centre Inpatient Unit. - These have been included within the financial model.

³⁷ [ICS benchmarking of Last Year of life admissions, University Hospitals Sussex and Midlands and Lancashire CSU](#)

³⁸ [LOS of admissions in last year of life, Public Health England, Older people's hospital admissions in the last year of life](#)

Key Sources, assumptions and methodology

Table 78: Key sources, assumptions and methodology

Item	Sources, Assumptions and Methodology
Costing methodology and conclusions for the enhanced EoLC beds currently assessed at £3.3 million	The new 46 enhanced care beds are provided in options 1-4 across the 7 boroughs where there is currently no provision. These have been costed based on the current costing for the provision of the 8 beds provided by Harlington Hospice. These costs incorporate the cost of the bed, management of the referrals and discharges and physio and occupational therapy input. On top of this, costs have been included for the provision of sessions of a Palliative Care Consultant (provided by the Acute Trust), and sessions of a Specialist Palliative Care Nurse (provided by Community Trust). This means a total cost of £71,687 per bed, totalling £3.3m for 46 beds.
Costing methodology and conclusions for the delivery of the new community care model at £3.9 million	Costing of the full community model of care has been developed by the current providers and collated by NHS North West London. Providers (NHS and charitable) submitted their current Business as usual – current commissioned service model costs and their costs of delivering the new model of care. The £3.9m is taken from the difference between those current and new costs. This costing assumes that NHS North West London funds 50% of charitable providers' costs and all of NHS providers' costs. In Option 1 and 2 the model is partly delivered, with a 50% patient reach. Delivery of the partial model of care assumes 50% of the cost, except the 24/7 telephone line which applies in both options.
Rationale and evidence for the bed day savings of 11,479 for the full mobilisation the Model of Care	Calculated based on 37 additional enhanced EoLC beds (over and above business as usual – current commissioned service model), at a planned bed occupancy of 85% over 365 days per year, this is expected to provide an additional 11,479 bed days that would otherwise be in a north west London Acute Hospital.
£475 Bed Day cost	Based on the ICB benchmarked cost for a Non-Elective Bed Day
Calculated of the £3.2 million avoided hospital admissions	A person in north west London has the highest likelihood of having 3 or more emergency admissions in the last year of their life (this is based on the Analysis of HES and death registrations by University Hospitals Sussex and Midlands and Lancashire CSU^[1]) compared to other areas in England. These admissions are particularly costly with an extended length of stay and costly intervention. On average the extended length of stay for these patients is 9.2 days (this is based on Public Health England, Older people's hospital admissions in the last year of life^[2]). The community services model will provide greater support to people at home and has the potential to avoid a significant number of A&E attendances and resulting admissions, and is targeting achieving the London median rate of end-of-life admissions in the last year of life (which is based on south west London ICB of 1.11). Achieving this London median would mean avoiding 743 admissions per year, which equates to 6,818 bed days. The avoided bed days as a result of these avoided admissions is costed at the bed day cost of £475/day, and equates to a gross benefit of £3.2m (based on 23/24 prices). This omits the cost of treatment provided, meaning the benefit may be higher. In Options 3 and 4, the full proposed model of care is implemented, so the above benefit applies to options 3 and 4. In options 1 and 2, the community services model is partly delivered, with half the reach

in terms of unique patients, so it is assumed that half the benefit would be realised (£1.6m).

^[1] [ICS benchmarking of Last Year of life admissions, University Hospitals Sussex and Midlands and Lancashire CSU](#)

^[2] [LOS of admissions in last year of life, Public Health England, Older people's hospital admissions in the last year of life](#)

DRAFT

Impact of the options on the NHS North West London income and expenditure position

Table 79: The financial impact of delivering each option

£m, 23/24 prices	0. Business as usual – current commissioned service model	1. Part implementation, Pembridge Palliative Care Centre Inpatient Unit closed	2. Part implementation, Pembridge Palliative Care Centre Inpatient Unit open	3. Full implementation, Pembridge Palliative Care Centre Inpatient Unit closed	4. Full implementation, Pembridge Palliative Care Centre Inpatient Unit open
Current NHS CSPP expenditure	18.6	18.6	18.6	18.6	18.6
Cost of Re-opening Pembridge Palliative Care Centre Inpatient Unit	3.5	3.5	3.5	3.5	3.5
Avoided Pembridge Palliative Care Centre Inpatient Unit IPU spot purchases	-1.0	-1.0	-1.0	-1.0	-1.0
Transition to 50% funding model	2.5	2.5	2.5	2.5	2.5
Business as usual – current commissioned service model CSPP Services Expenditure	23.5	23.5	23.5	23.5	23.5
Enhanced EoL Care Beds	0.0	3.3	3.3	3.3	3.3
Delivery of the new model of care	0.0	2.4	2.4	3.9	3.9
Pembridge Palliative Care Centre Inpatient Unit cost avoided	0.0	-3.5	0.0	-3.5	0.0
Specialist Hospice Beds brought into core contract	0.0	0.4	0.0	0.4	0.0
Charitable cost avoided	0.0	0.0	-1.0	0.0	-1.0
Overall North West London NHS CSPP spend	23.5	26.2	28.3	27.6	29.7
Acute bed days avoided by enhanced EoLC bed provision	0.0	-5.5	-5.5	-5.5	-5.5
Hospital attendances and admissions avoided through community services	0.0	-1.6	-1.6	-3.2	-3.2
Net Benefit vs. BAU	n/a	4.4	2.4	4.6	2.5

As shown above, all of the Options 1-4 provide a favourable position for NHS North West London, compared to business as usual – current commissioned service model. The net benefits associated with each option therefore work to offset the £4.9m cost pressure associated with the business as usual – current commissioned service - model.

The above full year effect is expected in all years after 2025/26. 2025/26 is expected to be a transitional year, with 50% of the benefit delivered, 50% of the cost base incurred, and therefore 50% of the net benefit of each option accrued.



NHS North West London: Adults (18+) Community-based specialist palliative care programme

Equality health impact assessment

24 November 2023

About this document

This Equalities Health Impact Assessment (EHIA) report is the product of exploring the potential impact that NW London's proposed new model of care for adult (18+) community-based specialist palliative care services will have on health inequalities and the well-being of different population groups in NW London.

This report is intended for a broad audience, encompassing healthcare professionals, stakeholders and advocates for palliative care, and the communities and individuals that this new model of care aims to serve. The aim is for the report to become the compass that guides our endeavours to ensure that this proposed new model of care and its implementation benefits all individuals equitably.

By investigating the EHIA's purpose and its application to adult (18+) community-based specialist palliative care, we hope to empower stakeholders to make informed decisions and adjustments that foster a healthcare landscape marked by inclusivity, compassion, and respect for diversity.

In the following sections of this report we will provide an overview of the NW London health inequalities landscape and explore the EHIA process for the 9 protected characteristics (and other vulnerable groups that we have identified as key during our engagement on this work to show summary of equity impact. Our goal is to make sure that this new model of care and way of providing care is fair and equal for everyone, giving help and support without any bias.

About North West London

- North West London is a richly diverse area, with around 2.4 million people from a wide range of backgrounds. We have a younger than average population and a wealth of cultural heritage
 - However, in our least resourced neighbourhoods, people are dying over a decade earlier than their peers. This is a long-standing issue and the inequalities gap in health and life expectancy has widened in recent years. This has been affected by cost of living pressures and Covid-19, and ill-health creates a significant cost
 - When our communities don't have the things they need, such as warm homes and healthy food, and are in low-paid or unstable jobs, it can lead to chronic stress, poor physical and mental health and lives being cut short. To create a society where everybody can thrive, we need all of the building blocks in place: stable jobs, good pay, quality housing and good education
 - Creating an environment which does not support healthy behaviours and lifestyles will also have a negative impact on health
 - People from our different communities also have very different experiences of the health and care services that we provide, including different levels of access, leading to very different health outcomes in different neighbourhoods, and some of our communities experience chronic stress due to the discrimination they face
- By working together across the Integrated Care System, we can empower people in NW London so that we better understand their experiences and we can help to tackle these issues. This will improve equity across services for everyone and particularly those with the least resources or largest barriers, helping people to thrive. The Health Equity Programme focusses on reducing inequalities, improving people's health outcomes and reducing the differences in healthy life expectancy
- It is fundamental to the delivery of the ICS's four key purposes of improving population health, reducing inequalities, improving value for money and building social and economic growth, and inequalities is a golden thread that weaves throughout the work of the system
 - The programme delivers that change using a consistent methodology and set of levers, including effective use of data, engagement and co-production with our communities and evaluation of impact. We work with and through other programmes and Borough teams to effect change
 - We have already made an impact, for example through blood pressure outreach work, expanding health checks, supporting people from more deprived neighbourhoods into volunteering and better understanding the barriers people face to accessing care
 - Our NW London inequalities programme work is arranged around three pillars: identifying and tackling inequalities; population health management building blocks; and partnership working on wider determinants of health

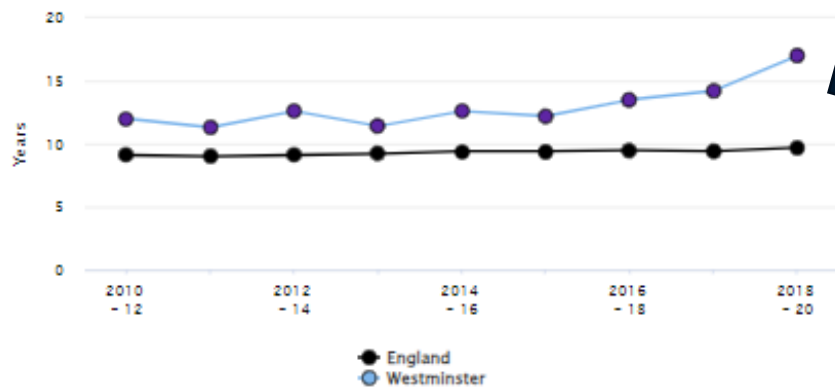
North West London is a richly diverse area, with around 2.4 million people from a wide range of backgrounds. We have a younger than average population and a wealth of cultural heritage



However, in our least resourced neighbourhoods, people are dying over a decade earlier than their peers. This is a long-standing issue and the inequalities gap in health and life expectancy has widened in recent years. This has been affected by cost of living pressures and Covid-19, and ill-health creates a significant cost

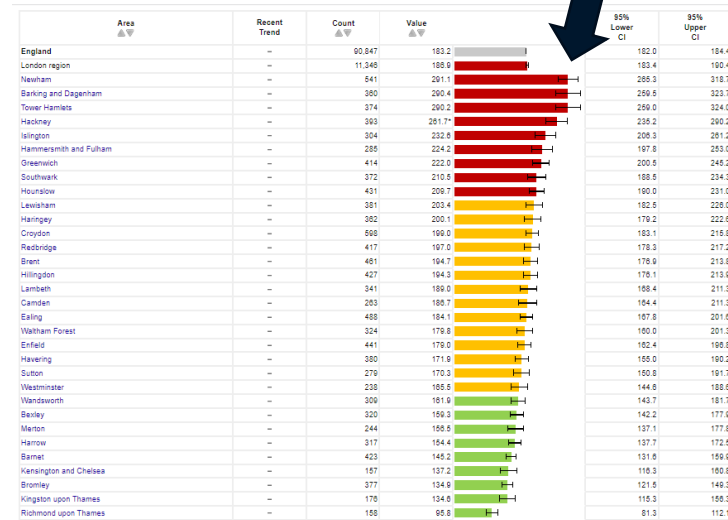
Inequality in life expectancy at birth (Male)

[Show confidence intervals](#) [Show 99.8% CI values](#)



Inequality in life expectancy at birth (for men) in Westminster has been widening, now standing at 17 years. Healthy life expectancy at birth varies between 61.4 years in Ealing and 67.4 years in Kensington and Chelsea

Under 75 mortality rate from causes considered preventable varies from 224.2 in Hammersmith and Fulham to 137.2 in Kensington and Chelsea



As well as people dying earlier, socio-economic inequalities cost the NHS **£4.8 billion a year**, with people living in the most deprived fifth of neighbourhoods having **72% more emergency admissions and 20% more planned admissions** than those living in the most affluent fifth of neighbourhoods

<https://fingertips.phe.org.uk/search/preventable%20mortality#page/6/gid/1/pat/6/par/E12000007/ati/402/are/E09000020/iid/93721/age/163/sex/4/cat/-1/ctpl/-1/yr/1/cid/4/tbm/1/page-options/car-do-0>

<https://fingertips.phe.org.uk/search/life%20expectancy#page/6/gid/1938133217/pat/15/par/E92000001/ati/502/are/E09000033/iid/92901/age/1/sex/1/cat/-1/ctpl/-1/yr/3/cid/4/tbm/1/page-options/car-do-0>

When our communities don't have the things they need, such as warm homes and healthy food, and are in low-paid or unstable jobs, it can lead to chronic stress, poor physical and mental health and lives being cut short. To create a society where everybody can thrive, we need all of the building blocks in place: stable jobs, good pay, quality housing and good education

When people have insecure or irregular work...

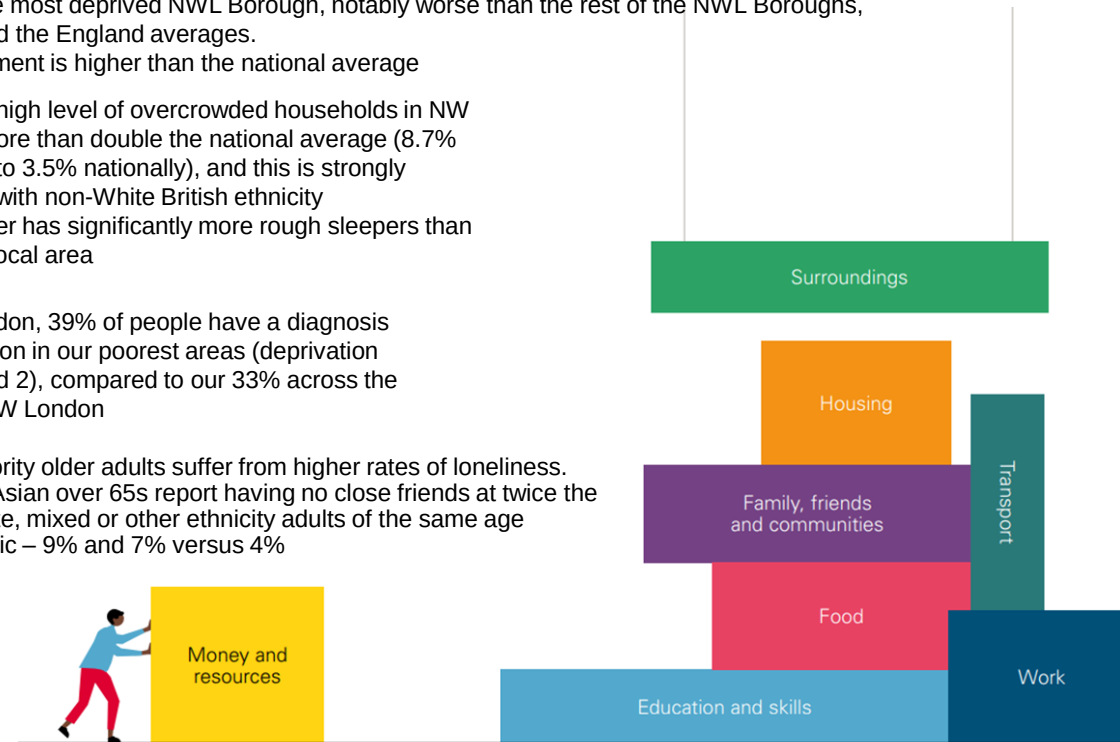
...It is harder to afford decent housing...

...Living in cold, damp homes can result in respiratory problems and other health issues...

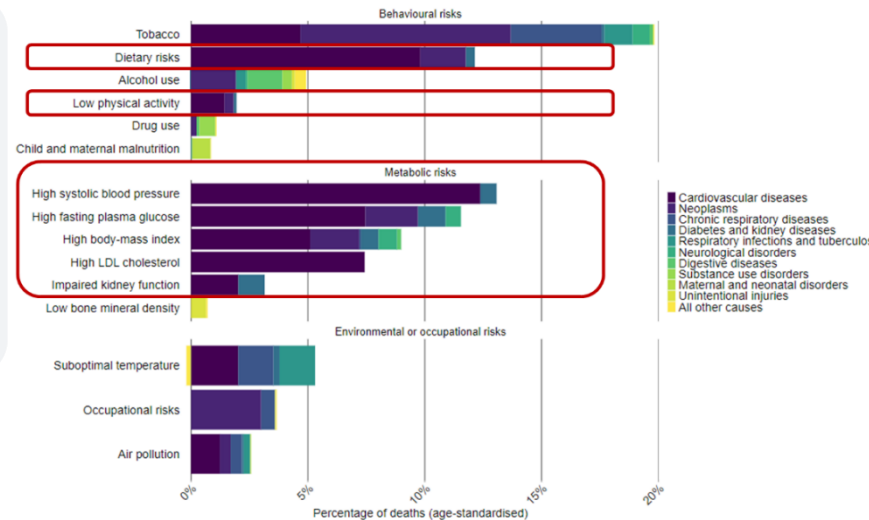
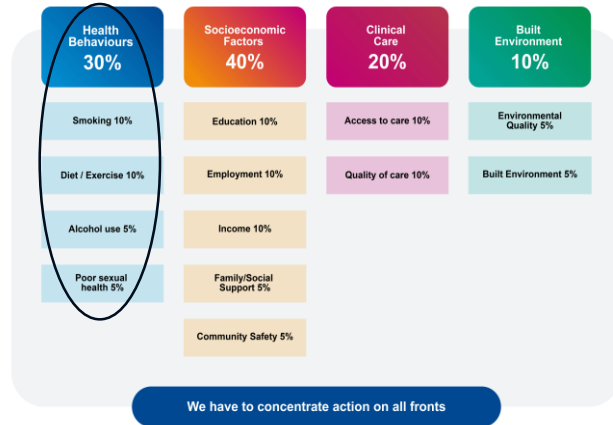
...Constantly worrying about having enough money to pay the rent can also lead to chronic stress, anxiety and depression.

People in the bottom 40% of the income distribution are almost twice as likely to report poor health than those in the top 20%. Poverty is associated with worse health outcomes

- Kensington and Chelsea has the greatest income inequality in London
- 29% of children in Westminster are from low income families, vs 13.9% in Harrow (16% nationally)
- 15.9% of children in Brent live in low income families, compared to 6.1% in Kensington and Chelsea
- There is a fivefold difference between the Income Deprivation affecting Children Index (a measure of child poverty) between Hammersmith and Fulham's richest and poorest wards
- Brent is the most deprived NWL Borough, notably worse than the rest of the NWL Boroughs, London and the England averages.
- Unemployment is higher than the national average
- There is a high level of overcrowded households in NW London, more than double the national average (8.7% compared to 3.5% nationally), and this is strongly correlated with non-White British ethnicity
- Westminster has significantly more rough sleepers than any other local area
- In NW London, 39% of people have a diagnosis of depression in our poorest areas (deprivation levels 1 and 2), compared to our 33% across the whole of NW London
- Ethnic minority older adults suffer from higher rates of loneliness. Black and Asian over 65s report having no close friends at twice the rate of White, mixed or other ethnicity adults of the same age demographic – 9% and 7% versus 4%



Creating an environment which does not support healthy behaviours and lifestyles will also have a negative impact on health



50% of all adults (over 18) are **overweight** – ranging from 48% in Westminster to 62.4% in Hillingdon (63% nationally)
1 in 4 of our **10-11 year-olds** are **obese** (1 in 5 nationally)

Tobacco remains the highest risk factor for disease in NW London. **17.1%** of people in Hillingdon **smoke**, versus **9.2%** in Ealing (13% across NW London – 14% nationally)

Alcohol admissions in Ealing are above the average in England, with **2,200 admissions a year** per 100,000 people (England 1,815)

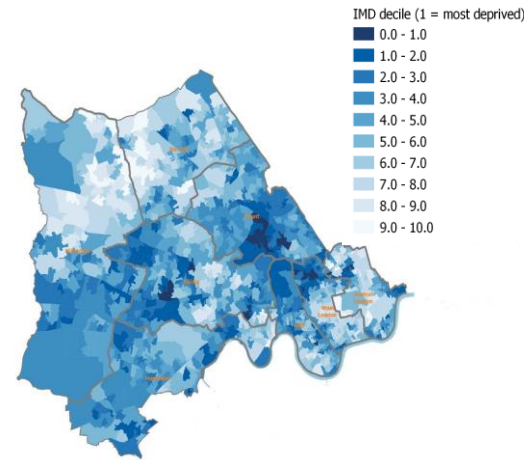
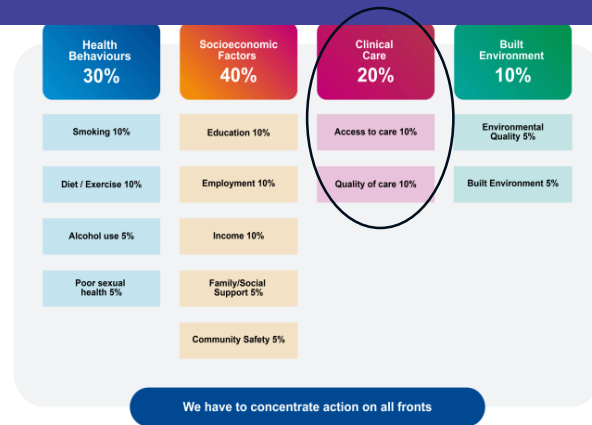
Around 55% of our resource goes in to acute hospitals and our **hospital admission rate is one of the highest in the country**, even taking into account the needs of our population – we are not investing in upstream, proactive, preventative care

There is significant variation between boroughs for healthy behaviours such as exercise and substance misuse.

For example, hospital admissions per 100,000 due to substance misuse vary between 16.9 in Hammersmith and Fulham and 64.9 in Brent

Risk factors such as smoking and obesity are linked to each of the main long term conditions people in NWL have: Neoplasms (cancer) and Cardiovascular disease

People from our different communities also have very different experiences of the health and care services that we provide, including different levels of access, leading to very different health outcomes in different neighbourhoods, and some of our communities experience chronic stress due to the discrimination they face



Around 900,000 people in NWL have at least one LTC, varying between 24% of the population in Hammersmith and Fulham, and 43% in Hounslow

1 in 5 adults (18+) has two or more **long term conditions** compared to 1 in 4 nationally

1 in 10 people have **diabetes** or non-diabetic hyperglycaemia (NDH) (1 in 16 nationally) **Diabetes disproportionately affects our Asian and Asian British community.** 43% of registered diabetes patients are in this group, compared to just 24% of the population as a whole

There is **variation in the quality of care** provided e.g. 28% of people with diabetes in Brent receive appropriate care versus 51% in Kensington and Chelsea (against the 9 key care processes)

Our Asian and Asian British community is also disproportionately affected by heart disease (30% of registered patients, 24% of population)

Black women in NWL are XX more likely to die in childbirth compared to white women

Gender and ethnicity are strong predictors of Hypertension, with the Black population an outlier. **Asian/Asian British and Black/Black British people with cancer are more likely to have a “bad outcome”**

- **38,000+** (11%) children and young people aged between 5 and 18 years have a **mental health** disorder (12% nationally)
- **Mental health problems disproportionately affect our Black and Black British community.** This group represents more than twice the number of registered mental health patients (17%) as population (8%)
- Rates of emergency hospital admissions for **self-harm are twice as high in Hounslow as they are Harrow** (England average 181 per 100,000)

People from our different communities also have very different experiences of health and care services, including different levels of access, leading to very different health outcomes

1. People are struggling to get the information they need

"GP practice didn't tell me about my test results and it's so hard to get appointments"

"We need to be given information on self checks and how to spot the signs"

"What is screening, I do not understand it. After screening, what will be the process of my treatment? Nurse never explains it"

"In my country, I would go to a doctor if it's a concern around cancer, but here I am told to see the nurse. I don't feel confident about it"

2. People are struggling to access primary care

"Can't get an appointment imminently and when you do get one they cancel it"

"People waiting on the phone to GP and get cut off after 40 minutes"

"Can't see the doctor, can't get an appointment. Would be happy to wait 1 week, but at the moment you can't see the doctor face to face. Face to face is so important"

"People haven't got the time to go to the GP. They need to accommodate people's lives"

3. Frustration with waits is leading to people losing confidence in services

"I had a scan in October and haven't heard back yet. You have to chase them up. Report should be sent to you and the GP"

"Took 15 years to get sorted – I'm not happy" "3 years waiting for the right tablets. Why?"

"Doctor said scan is urgent but the wait is 25 weeks"

"I had to go back to India to get surgery at my expense. In the UK they would not do it for a long time"

4. There are additional barriers to people accessing services

"If it's urgent, I go to A&E because they don't have interpreters at the GP practice at short notice." "Patches is very difficult for patients who cannot write English. I don't know how to use the internet"

"I have been spoken to in a rude way by staff. There is often new members of staff, therefore this causes a problem with consistency" "I don't access services due to the way I'm spoken at"

"I feel my mental health issues affects the treatment I receive and not treated equally" "Judged unfairly and neglected due to my obesity."

1

Summary of proposed changes and overall equality impact

Personalised care and choice

With many of the individuals and groups that we spoke and engaged with there was a consistent and clear theme to the feedback they gave. ~~People~~ simply want to be listened to and for health and social care providers to respect their individual preferences and needs. They want to be treated as a unique person, which is even more important at end of life. People want care that is personalised to them and takes into account and embraces their culture, beliefs, preferences and the choices they wish to make in the way care is delivered and where it is delivered.

Our ambition is to develop community-based specialist palliative care services for adults (18+) that are patient-centred and provide choice where it is available. There will be a focus on tailoring services and treatment plans to meet the individual needs and preferences of each patient. It recognises that healthcare should not be a one-size-fits-all approach and that people have unique health conditions, values, and goals. Here are some key aspects of personalised care and the choices they have that will be introduced as we move forward with the model of care:

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Treating people as unique individuals: Personalised care involves customising medical treatments, interventions, and care plans to suit the specific needs of each patient. In addition to taking into account the key protected characteristics such as age, sex, disability etc., this may include considering a person's medical history, genetics, lifestyle, family situation, faith and cultural background.

Making decisions together: Personalised care promotes active involvement of patients in their own healthcare decisions and care planning process and where they are able to express the choices they wish to make for their continuing healthcare journey towards the end of their life. Physicians and healthcare providers work collaboratively with patients and those important to them such as family, carers and friends to develop treatment plans that align with the patient's goals, values and choices.

Tailored accessible information that explains things clearly: Healthcare providers communicate information in a way that is understandable and relevant to the patient. They ensure that the patient is well-informed and empowered to make decisions about their care

Personalised care and choice

Respect for the choices that people wish to make: Personalised care respects the individual choices and values of patients. This includes considering factors like family situation, religious beliefs, faith and cultural practices, and personal values when making healthcare decisions.

Providing choice where it is available: Personalised care will also respect as much as possible the choices people make as to the way care is provided and where that is delivered and provide the flexibility for people to be able to change their mind. Where that choice is not available, care will be taken to explain to the patient, family, carers and friends why that is the case and what the alternatives are so that agreement can be reached as to the way forward.

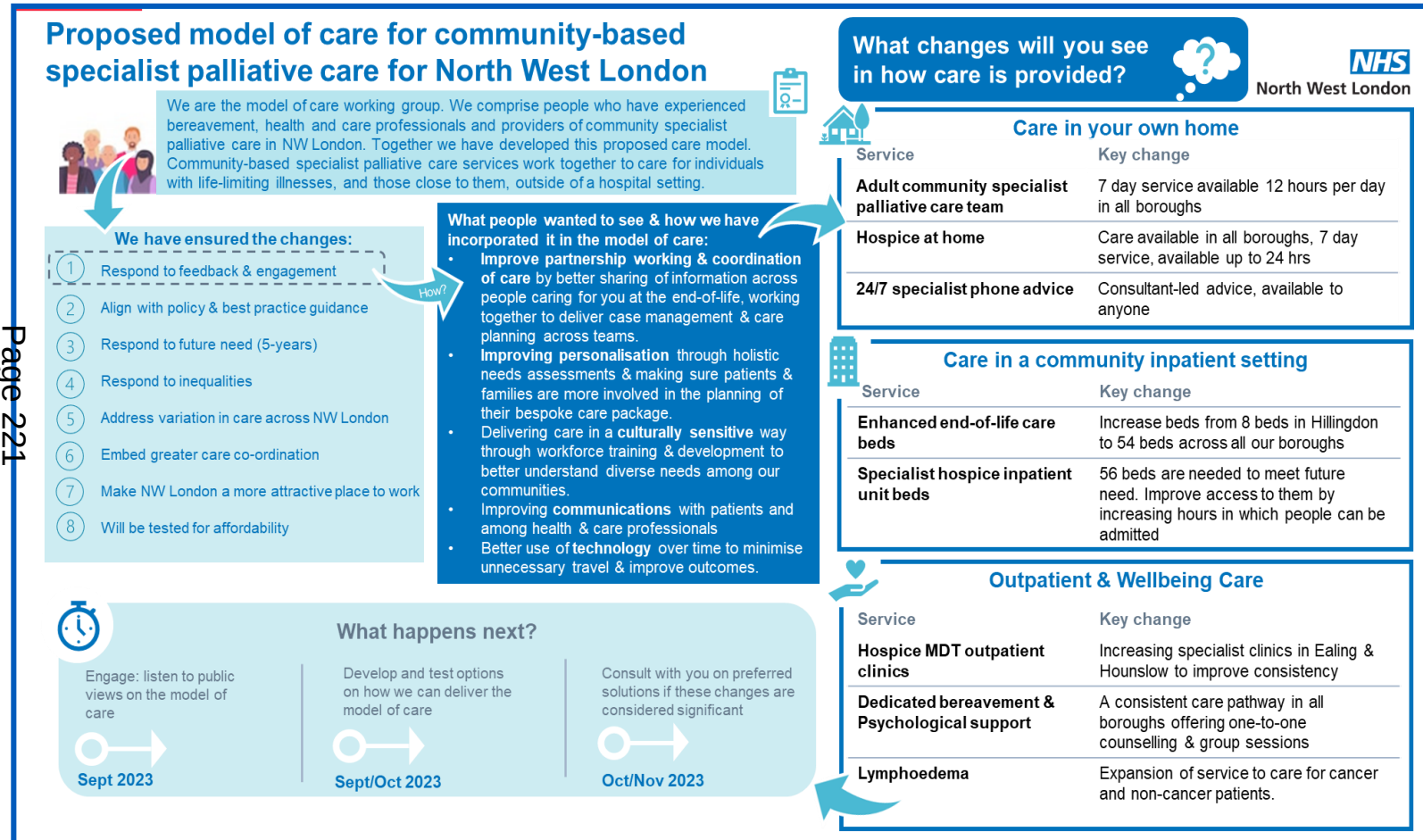
Continuity of care: Personalised care emphasises the importance of maintaining an ongoing and consistent relationship between patients and healthcare providers, ensuring that care is coordinated and comprehensive.

Looking at the individual as a whole: Personalised care takes into account not only the physical health of the patient but also their emotional, psychological, and social well-being. It recognises that these factors can have a significant impact on overall health and well-being.

Keeping people as well as possible and managing their condition: Personalised palliative and end of life care is about helping people to live their best possible life. Personalised care is about proactively managing their health condition to the best that can be achieved and preventing health issues from arising.

Personalised care is seen as a way to improve patient, family, carer, those important to patient satisfaction, healthcare outcomes, and overall quality of care. It recognises that healthcare is not only about treating diseases but also about addressing the unique needs and circumstances of each patient to provide the best possible care.

Summary of proposed changes: A new model of adult (18+) community-based specialist palliative care for North West London



Adult (18+) patients with specialist palliative care needs and their families/ carers/ those important to them will have greater choice and flexibility of where they are cared for, as well as improved access to a common core offer of services through:

- Expanded service hours of some non-bed based services (eg. adult community specialist palliative care team) and introduction of services in areas where there are currently gaps in service provision (eg. Hospice at home service; 24/7 advice lines for known and unknown patients, outpatient MDT services) supports more care at home, patient choice and reducing gap between who can and can't access services.
- Expansion of enhanced end of life care in-patient bed provision for all NW London boroughs, for patients who might not be suitable for hospice care but can't or don't want to remain at home, provides a safe appropriate alternative care environment, improving patient choice and increasing reach of services.
- Five key enablers (workforce development; , reducing inequalities; data, digital and technology; organisational development and leadership, governance and integration underpinning the delivery of this model

A full description of the proposed new model of care and changes can be found at

www.nwlondonicb.nhs.uk/cspc

How our proposed changes will address health inequalities

The model is underpinned by the following principles and strategies to make sure of equitable access to high quality services for all residents of NW London and those important to them who need these services, regardless of their borough of residence, characteristics or circumstances.

- 1. Equitable Access:** The model prioritises equitable access to specialist palliative care services in the community for every individual, irrespective of their socio-economic status, ethnicity, culture, or the borough they reside in through establishing community-based palliative care services in areas where these services are currently not provided (eg. Hospice at home, 24/7 telephone advice line for known and unknown patients, enhanced end of life care inpatient beds, outpatient services) to ensure that more people get specialised care reducing the gap between those patients who currently receive these and those that do not.
- 2. Culturally Competent Care:** there is recognition of the importance of cultural competency and providing personalised care that respects and accommodates the diverse cultural backgrounds of patients and their families/ carers/ those important to them, through supporting providers to develop a cultural competency framework for NW London CSPC providers to implement which will include appropriate training for staff to deliver culturally competent care to address the unique needs and beliefs of each patient. This will be addressed through enabler work. This ensures that providers will be well-prepared to deliver culturally competent care to NW London's diverse communities.

- 3. Care Coordination:** The model recognises the important of developing robust care coordination mechanisms that ensure seamless access to services for individuals with specialist palliative care needs. This entails fostering collaboration and improved partnership working at place between generalist palliative care providers (primary care, social care and other community healthcare teams) and specialist palliative care teams (in community and in hospital), but also within community specialist palliative care teams themselves in the first instance. The model sets out ambitions for boroughs to develop local arrangements for single points of contact/ access for these services and internal care co-ordination approaches for example key workers/ internal co-ordination functions. It also sets out the ambition for more integrated working across Integration neighbourhood teams locally to support increased MDT working.
- 4. Outreach and Engagement:** Ongoing engagement by the ICB and providers to actively engage with underserved populations, making an effort to reach those who might not seek palliative care on their own. This could involve outreach programs, partnerships with community organisations, and the provision of home-based care services.

How our proposed changes will address health inequalities

(...continued from previous page)

5. Research and Data Collection: Collect data on health disparities within specialist palliative care providers in NW London to identify and address gaps in service provision. Informed by research, targeted interventions and policies can be developed amongst providers to reduce disparities in care delivery and outcomes. NW London ICB is developing an End of life specific dashboard which will include demographic and health inequalities data metrics, alongside developing a standard data set for CSPC providers to report on that includes these key metrics, which will feed the dashboard.

6. Education and Awareness: All providers are committed to raising public awareness and providing education about palliative care within clinicians and communities across NW London. By increasing awareness, more individuals can access these services and benefit from them, addressing disparities in care utilisation. Training and education is a key part of the new model of care.

7. Patient choice and involvement in care: The model aims to enhance health literacy among residents through, empowering them with a better understanding of palliative care and their end-of-life options through advance care planning. This will enable patients to make informed decisions about their care and reduce disparities caused by a lack of information or opportunity to have their wishes made known and shared with the system (for example via a Universal Care Plan (UCP))

Summary of impact on groups with particular characteristics (including protected characteristics)

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Protected Characteristics	Overall impact	Rationale for inclusion
Age	Positive	The impact on populations with these characteristics must be assessed as part of all Equality Health Impact Assessments.
Disability	Positive	
Sex	Neutral	
Race	Neutral	
Religion or belief	Positive	
Sexual orientation	Neutral	
Gender assignment	Neutral	
Pregnancy and maternity	Neutral	
Marriage or civil partnership	Neutral	
Additional vulnerable groups		Populations with these characteristics have been identified through our engagement activities as particularly important for this work. They have therefore been included to ensure that our proposals consider the specific circumstances of people who are most likely to be impacted, and that any negative impacts are either avoided or appropriately mitigated.
Carers	Positive	
Single person households	Positive	
Deprived populations	Neutral	
People living in sub-standard housing	Positive	
Homelessness	Positive	
Mental health & dementia		

2

Engagement and feedback to support this assessment

Engagement on the issues paper

Following publication of the [Issues Paper](#) in November 2021, we spent considerable time listening to the views of our communities to understand what was important to them in receiving community-based specialist palliative care.

We also wanted to [build on the valuable learning and feedback received from previous reviews](#) of palliative and end-of-life care services carried out in Brent, Hammersmith and Fulham, Kensington and Chelsea, and Westminster, but the decision taken by the North West London Integrated Care System to expand the review to cover Ealing, Harrow, Hillingdon and Hounslow meant we had to engage again.

We arranged a series of ten [events and webinars](#) at which we presented and took questions from members of the public and clinical staff, capturing the key issues raised and ensuring these fed back into the work to develop the model of care. We also attended a number of meetings of borough-based palliative and end of life groups that been set up to look at this important service area at a borough level.

We also were referred to or approached a number of voluntary and community organisations and representatives for further [one-to one interviews and discussions](#) aimed at gaining an in-depth understanding of the issues and challenges for specific (often hard-to-reach) groups of people. This included Kosher Dementia UK, BAME Health Forum, SOBUS and SPECTRA and the Dementia Group for Hounslow.

This in turn helped us identify some key groups for whom we lacked information or input and needed to link-in with experts both locally and nationally to better understand what was important to these groups in terms of end-of-life and specialist palliative care. This led to us conducting desk research, reviewing the information published by health providers, charities and journals, and producing three [literature reviews](#) covering learning disabilities, people living with homelessness and younger adults (approximately 18-45 years old), which we published and used as evidence in the review.

We attended, and continue to attend, [Health and Wellbeing Boards, Scrutiny Committees and Health Committee sessions](#) across the NW London boroughs to brief elected members and stakeholders on our work and answer their questions on the development of the model of care.

In addition to all of these direct meetings and conversations, we developed a number of [online surveys](#) through which local residents and health and social care professionals could give their views. Open-ended questions were also included to give respondents the opportunity to express their opinions in their own words. We received feedback from 188 respondents across six surveys, along with two formal written submissions.

Engagement on the issues paper

During this engagement work, we met or spoke to some local residents who were kind enough to share their stories so we could use them as case studies to illustrate both the good experiences and the challenges that people face when using community-based specialist palliative care services. This led to the development of nine [patient stories](#) that highlighted problems that need to be addressed and how the model of care will need to support improvements.

The overall feedback was published in the [Engagement Outcome Report](#) and we used these valuable insights from members of the public to feed directly into the development of a new model of care.

We have also chosen to focus on characteristics and areas that are not usually included in an EHIA due to the feedback received during our engagement including carers, single person households, deprived populations, deprived populations, people living in sub-standard accommodation, homelessness, mental health and dementia.

We have also taken a number of actions to address issues and make improvements whilst our work on the new model of care is ongoing. These are covered [in section 7.2](#) and within the [Engagement Outcome report](#) (pages 11-14) and include, for example, increasing access to end-of-life and anticipatory medication in the community and access to 24/7 end-of-care advice.

From the extensive engagement undertaken, we collected a wealth of feedback that described 'what' services needed to provide from the perspective of service users and families and also 'how' they are cared for. The substantial feedback can be summarised into the following themes.

Engagement and feedback from Issues paper to support this assessment

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Engagement Themes		Summary Feedback
1	Best possible care	High quality care delivered in the optimal place, supported by evidence-based pathways
2	Care tailored to my needs	Care personalised to me, my preferences and needs. An approach to care planning that factors in my individual requirements, considering my conditions. For example, dementia, my ethnicity or sexual orientation.
3	Providing connected care	Care providers working together so care feels integrated and services are easy for me and my family to navigate and access.
4	Staying informed	I know where to find information regarding specialist palliative care services across NW London. I know who I can speak to find help and support.
5	Creating professional culture and behaviours that exhibit sensitivity and compassion	All staff exude compassion in their interactions with me, my family and those important to me. They show an understanding of how my faith and culture might lead to differences in the help I need.
6	Supporting carers & families through end-of-life and beyond	Bereavement, respite and emotional support are available for those individuals who are important to the patient (family/ carers/ friends)

The model of care working group

Following the launch of the Issues paper in November 2021 and on the back of our engagement about the issues, the new model of care working group was set up by the NW London ICS to develop a model of care to make sure:

- The themes raised through our engagement were addressed
- All NW London residents are able to access the services, if needed
- That high quality community-based specialist palliative care is delivered equitably and sustainably across NW London.

The model of care does not address how we will configure services. What it describes is the level of care that all residents should expect to receive.

[Click here to view the minutes of the model of care working group](#)

Membership of the group, which met thirty-eight times over a year, consisted of local residents, clinicians and other palliative and end-of-life care stakeholders, and more details can be seen in the [acknowledgement section](#) of this document.

The objective of the group was to develop a new model of care for community-based specialist palliative care for adults that addressed “what good looks like”, including developing the underpinning design principles and high level cross-cutting enablers to support implementation and delivery of the new model.

This involved using engagement feedback, national guidance and supporting documentation, and key reports to agree a set of key definitions standards and a common core offer of services. This will later be built into a single service specification for NW London once the new model of care has been agreed.

The model of care working group

~~During~~ meetings the group looked in detail at the different aspects of community-based specialist palliative care drawing on:

- The national service specification for adult palliative and end-of-life care
- The previous NW London palliative care review programme work from 2019/2020
- The qualitative and quantitative feedback from residents and healthcare professionals obtained through our extensive engagement
- Population projections
- Demand modelling
- Travel mapping.

The new model of care working group have collectively agreed and recommended a set of core services with a common core offer for community-based specialist palliative care provision that NW London residents can expect to receive regardless of the borough they live in. Some of these services are already available to all boroughs, while others are new additions for some boroughs and will raise and level-up the standard of care where these services do not exist or vary a lot. They have also agreed [five cross cutting enablers](#) to support successful implementation and delivery. The model of care has also been agreed by the [NW London community-based specialist palliative care steering group](#)

The [proposed new model of care was published in Aug 2023](#) where local residents were asked to review and respond to the proposed new model of care.

Engagement on the proposed new model of care

We subsequently have continued to engage on it with our residents, boroughs and stakeholders on the new model of care over September and early October 2023. [We held a number of engagement events at a North West London and borough events.](#)

Overwhelmingly, there was good support for the proposed new model of care. However, we did hear some valuable challenge and constructive suggestions on how we might improve the model, which we are committed to considering and potentially incorporating as part of the model's improvement process.

Engagement and feedback on proposed new model of care (MOC) to support this assessment

Engagement Themes		Summary Feedback
1	Improved navigation of services	Emphasis on simplifying the complex journey through palliative care services and the wider health and care system for patients, family, carers and clinicians. The aim is to make services more accessible to those in need.
2	Enhanced care coordination and integration of services	- Emphasis on the need for more seamless transitions of patient care between acute and community services. - Fostering collaboration and improved communication among healthcare professionals to support a localised, patient-centred approach with named care coordinators or a dedicated care co-ordination service/function. The aim will be to improve the overall patient experience and bridge gaps between generalist and specialist care.
3	Addressing Inequalities	Emphasis on the need to address disparities in access to palliative care healthcare provision, ensuring that all individuals, regardless of their background or circumstances, receive the same level of high-quality palliative care. Call for more tailored strategies for different communities, considering geographic, socioeconomic, and cultural factors to demonstrate the model of care will help to address these disparities.
4	Enhancing innovation and continuing improvement	Emphasis on improving the model by exploring innovative initiatives, drawing on local, regional and national pilots underway and making sure the current model has openness to testing innovative and new ideas.
5	Improved leadership and governance	Emphasis on robust leadership and governance structure to guide the transformation and for accountability and sustainability of the new care model.
6	More information about enhanced end-of-life care beds	Local residents fed back they wanted a more detailed and clear explanation of what exactly is being offered in terms of these beds and how they will be made available to ensure that they effectively meet the needs of patients.

3

Assessment of impact for specific populations

Note: These categories overlap and citizens can span a number of protected characteristics (e.g. older disabled people living alone) and vulnerable groups. As far as possible, the assessment against each characteristic is restricted to that characteristic. For the population noted above, the assessments for age, disability and people living alone would all apply.

Age

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment																						
	Positive	Neutral	Negative																								
Care in your own home	✓			The aim of this model of care is to improve access to and quality of specialist palliative care in the community at the end of life. It includes all adults, so will have a positive impact across all ages. Positive benefit will be felt by patients of all ages wishing greater choice and flexibility of where they are cared for: - by extending hours of provision of non bed-based services such as hospice at home and specialist palliative care team, we will be better equipped to support care in people’s own homes, supporting their preferences regarding place of death. - By expanding EOLC beds to all boroughs, people who might not be suitable for hospice care but do not wish to remain at home can access alternative care in a safe environment. In particular, older people living alone are likely to benefit from this provision. - Hospice inpatient facilities are well equipped to accommodate older people and their care needs. - Outpatient care will remain in current locations. For the majority of providers their outpatient services are delivered out of the same locations as the inpatient services, except for Hillingdon borough where outpatient services are delivered from two locations, but these are both accessible by public transport and for people with physical disabilities. Concerns might include: Suitability of hospices in caring for younger people. Hospice environments typically have higher volumes of people dying in old age. However, the environment is suited to meet the complex needs of younger adults too. The model of care strengthens the ability to care for people dying in their own home by increasing the hours of provision of key services such as hospice at home and community specialist palliative care team. This ensures people remain with family and informal carers.	<table><tr><th>Age</th><th>% registered deaths (England & Wales, 2023)</th></tr><tr><td>0-9</td><td>0.5%</td></tr><tr><td>10-19</td><td>0.2%</td></tr><tr><td>20-29</td><td>0.5%</td></tr><tr><td>30-39</td><td>1.2%</td></tr><tr><td>40-49</td><td>2.4%</td></tr><tr><td>50-59</td><td>5.9%</td></tr><tr><td>60-69</td><td>11.3%</td></tr><tr><td>70-79</td><td>23.0%</td></tr><tr><td>80-89</td><td>33.6%</td></tr><tr><td>90+</td><td>21.4%</td></tr></table> Data source: Deaths registered weekly in England and Wales, provisional - Office for National Statistics (ons.gov.uk) With almost 80% of deaths occurring in the 70+ age groups (<i>ONS Household composition data, March 2023</i>), catering to the needs of older people within our service design is of importance. Our local data confirms that older people are more likely to be identified as being at end of life. As the number of older adults increases and people live longer, this will be an increasingly important factor. Almost 10% of households in NW London are ‘single person households aged 66 and over’. Provision of wrap-around support and options for care provision alternatives should be considered (see single person households for more information).	Age	% registered deaths (England & Wales, 2023)	0-9	0.5%	10-19	0.2%	20-29	0.5%	30-39	1.2%	40-49	2.4%	50-59	5.9%	60-69	11.3%	70-79	23.0%	80-89	33.6%	90+	21.4%
Age	% registered deaths (England & Wales, 2023)																										
0-9	0.5%																										
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50-59	5.9%																										
60-69	11.3%																										
70-79	23.0%																										
80-89	33.6%																										
90+	21.4%																										
Care in a community inpatient setting		✓																									
Outpatient & Wellbeing Care	✓																										
Overall	✓																										

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Number of Patients by Age Band & Gender (not effected by 'Graph Measure' filter above)

Age Band	Male Count	Female Count
18-50	174	231
50-54	92	122
55-59	135	173
60-64	223	219
65-69	301	306
70-74	343	364
75-79	507	587
80-84	573	798
85+	1,195	2,369

Data source: NWL End of Life data dashboard

Disability

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment																				
	Positive	Neutral	Negative																						
Care in your own home	✓			Positive benefit to people with physical disabilities and learning disabilities is offered through: - The inclusion provision of holistic needs assessment and a personalised care plan in the model of care brings the needs of the individual to the forefront of care planning and delivery. This process is inclusive of carers and families, ensuring trust is built and needs of individuals are fully reflected. - Greater provision of care in the comfort of people's own homes by extending hours of provision of key services such as specialist palliative care teams, hospice at home and 24/7 telephone advice. This maximises opportunity for existing support provision (including informal and formal carers) to work seamlessly with community-based specialist palliative care providers and maintaining important social connections with family and friends. - Increasing the options for bed-based provision by introducing EOLC beds in care homes, is more likely to bring options for care provision closer to home. Care providers are required to be CQC registered and a key requirement of premises is "reasonable adjustments must be made when providing equipment to meet the needs of people with disabilities, in line with the requirements of the Equality Act 2010". Neutral benefit to people with physical disability accessing hospice inpatient units is anticipated as: - There is not significant change in driving time to access hospice units - All providers will support carers/ family staying over at inpatient unit to support patients who have disabilities as required . This is considered on a case by case basis. - Some of the CSPC providers have their private transport or can access wider organisational patient transport services that can support patients to access the hospice inpatient services. NW London is currently undertaking a review of Non-emergency patient transport services to support developing a common core offer to be embedded into contracts, so with the new model of care we would aim to make sure that through this work and appropriate contracting mechanisms patients will continue to have access to non emergency patient transport to hospice sites for accessing these services.	A UK disability statistics research briefing published in August 2023 in the House of Commons Library cites Department of Work and Pensions data for 2021/22 showing 24% of the population as having a disability. This has risen by 6% since 2002/03. Key findings include: - Prevalence of disability increases with age with 58% of people aged 80 and over reporting a disability - ONS analysis looked at inequality differences between disabled and non-disabled people and found people with a disability were more likely to be in social rented homes (25%), - People with a disability were more likely to have no qualifications (13%) - People with a disability were more likely to report feeling lonely regularly (13%). - People with a disability were rely predominantly on car travel. Household Census data on disability at borough level <table><tr><th colspan="2">No people disabled in a household (2021 Census)</th></tr><tr><td>Brent</td><td>72.9%</td></tr><tr><td>Ealing</td><td>73.9%</td></tr><tr><td>Hammersmith & Fulham</td><td>76.9%</td></tr><tr><td>Harrow</td><td>73.4%</td></tr><tr><td>Hillingdon</td><td>72.4%</td></tr><tr><td>Hounslow</td><td>73.3%</td></tr><tr><td>Kensington & Chelsea</td><td>77.7%</td></tr><tr><td>Westminster</td><td>76.3%</td></tr><tr><td>England</td><td>68.0%</td></tr></table> A literature review covering people living who live with a learning disability was carried out. Potential improvements to end of life care grouped under four headings – education, communication, collaboration and health and social care delivery. See full literature review.	No people disabled in a household (2021 Census)		Brent	72.9%	Ealing	73.9%	Hammersmith & Fulham	76.9%	Harrow	73.4%	Hillingdon	72.4%	Hounslow	73.3%	Kensington & Chelsea	77.7%	Westminster	76.3%	England	68.0%
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England	68.0%																								
Care in a community inpatient setting	✓																								
Outpatient & Wellbeing Care	✓																								
Overall	✓																								

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Data sources: Disability, England and Wales - Office for National Statistics (ons.gov.uk)
UK disability statistics: Prevalence and life experiences - House of Commons Library (parliament.uk)

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

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Overall

Impact				Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment																														
	Positive	Neutral	Negative																																
Care in your own home		✓		1. Concerns would include whether women and men access palliative care equitably. Positive impact will be felt by the whole population as a result of increased capacity in bed-based and non bed-based care, improving access to these services. 2. To address concerns on gender roles in caring, holistic assessment of needs at the outset allow carers and the patient to discuss care needs, identify support required and monitor how well this is working throughout. Where adjustments are needed to suit the patient and carer, this will be discussed and implemented. 3. Women living alone and older women living in poverty will see positive impact from the new model of care in the following ways: - Holistic needs assessment that will factor in their social support and carer support to be cared for at home - Holistic needs assessment that will consider the suitability of their home environment - Strengthened psychological and wellbeing services that would improve the support individuals can access. - Care in a bed-based environment among other people where this is needed.	Local data on people identified to be at the end of life registers more women than men across most age categories. This may link with greater health-seeking behaviour in younger age groups. It may be caused by differences in life expectancy in older age groups. It has not been possible to assess how differences in need translate to equity of provision and this is something that will need to be tracked in future. Number of Patients by Age Band & Gender (not effected by 'Graph Measure' filter above) <table><tr><td>18-50</td><td>174</td><td>231</td></tr><tr><td>50-54</td><td>92</td><td>122</td></tr><tr><td>55-59</td><td>135</td><td>178</td></tr><tr><td>60-64</td><td>223</td><td>219</td></tr><tr><td>65-69</td><td>301</td><td>306</td></tr><tr><td>70-74</td><td>343</td><td>364</td></tr><tr><td>75-79</td><td>507</td><td>587</td></tr><tr><td>80-84</td><td>573</td><td>798</td></tr><tr><td>85+</td><td>1,195</td><td>2,369</td></tr><tr><td></td><td>Male Count</td><td>Female Count</td></tr></table> Data source: NWL End of Life data dashboard	18-50	174	231	50-54	92	122	55-59	135	178	60-64	223	219	65-69	301	306	70-74	343	364	75-79	507	587	80-84	573	798	85+	1,195	2,369		Male Count	Female Count
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Care in a community inpatient setting		✓																																	
Outpatient & Wellbeing Care		✓																																	
Overall		✓																																	

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	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment																																																						
	Positive	Neutral	Negative																																																								
Care in your own home		✓		Positive impact will be gained in community specialist palliative care services as a result of introducing this model of care in the following ways: - Understanding the ethnic diversity of our communities and having heard directly from these communities the importance of understanding cultural factors in the provision of care at the end of life, we are incorporating cultural competence training for staff throughout our provision. This will support people to feel their needs are being met in a way that factors in their cultural identity. It is anticipated this will contribute to closing gaps on unmet need. - Extending services so they are consistent and high-quality across all Boroughs will improve accessibility to all populations and communities within our boroughs. - All healthcare providers have access to language and interpretation services in person from 9 AM to 5 PM and over the phone after regular working hours. They are dedicated to using these services to communicate effectively with patients who don't speak English and make sure their medical needs are addressed with respect to their culture and language. - All providers are dedicated to understanding and meeting their patients' cultural and faith-based dietary needs during their stay.in the inpatient unit or attendance of outpatient appointment. Staff will consult with patients and their families/ carers to support to providing culturally appropriate meals in as much as possible which may include meals being made for them or patients bringing in their own food, as long as it follows food safety rules. The goal is to ensure patients' comfort and dietary preferences are respected throughout their visits to the services.	Ethnicity data suggests a rich mix of people living within our boroughs. Most diverse communities include Brent, Harrow and Hounslow. <table><tr><th>2021 Census population by ethnic group</th><th>1st Largest ethnicity group & %</th><th>2nd largest ethnicity group & %</th><th>3rd largest ethnicity group & %</th></tr><tr><td>Brent</td><td>Asian: Indian 19.5%</td><td>White: Other 15.9%</td><td>White British 15.2%</td></tr><tr><td>Ealing</td><td>White British 24.3%</td><td>White: Other 16.1%</td><td>Asian: Indian 14.9%</td></tr><tr><td>Hammersmith & Fulham</td><td>White British 38.3%</td><td>White: Other 21.4%</td><td>Black African 7.2%</td></tr><tr><td>Harrow</td><td>Asian Indian 28.6%</td><td>White British 20.5%</td><td>White: Other 13.2%</td></tr><tr><td>Hillingdon</td><td>White British 37.1%</td><td>Asian: Indian 18.7%</td><td>White: Other 8.9%</td></tr><tr><td>Hounslow</td><td>White British 28.4%</td><td>Asian: Indian 21.1%</td><td>White: Other 13.9%</td></tr><tr><td>Kensington & Chelsea</td><td>White British 32.7%</td><td>White: Other 28.3%</td><td>Other 5.4%</td></tr><tr><td>Westminster</td><td>White British 28.0%</td><td>White (Other) 24.6%</td><td>Other: Arab 7.6%</td></tr></table> Ethnicity alone does not guide us in planning how we cater for people. Length of residence data using Census 2021 suggests 10.2% of people in Westminster and 8.9% of those in Kensington & Chelsea have lived in the UK less than 2-years. This might mean navigating the health system is less familiar. Diversity in NW London means English spoken as a first language is less common than seen across England (90%). In particular, Brent, Ealing and Harrow flag as areas where people may need additional support to understand and engage with health and care in language they understand. <table><tr><th colspan="2">2021 Census data: Percentage of people who do not speak English as a first language</th></tr><tr><td>Brent</td><td>33.68%</td></tr><tr><td>Ealing</td><td>30.9%</td></tr><tr><td>Hammersmith & Fulham</td><td>21.37%</td></tr><tr><td>Harrow</td><td>30.74%</td></tr><tr><td>Hillingdon</td><td>22.08%</td></tr><tr><td>Hounslow</td><td>28.32%</td></tr><tr><td>Kensington & Chelsea</td><td>23.6%</td></tr><tr><td>Westminster</td><td>26.44%</td></tr></table>	2021 Census population by ethnic group	1 st Largest ethnicity group & %	2 nd largest ethnicity group & %	3 rd largest ethnicity group & %	Brent	Asian: Indian 19.5%	White: Other 15.9%	White British 15.2%	Ealing	White British 24.3%	White: Other 16.1%	Asian: Indian 14.9%	Hammersmith & Fulham	White British 38.3%	White: Other 21.4%	Black African 7.2%	Harrow	Asian Indian 28.6%	White British 20.5%	White: Other 13.2%	Hillingdon	White British 37.1%	Asian: Indian 18.7%	White: Other 8.9%	Hounslow	White British 28.4%	Asian: Indian 21.1%	White: Other 13.9%	Kensington & Chelsea	White British 32.7%	White: Other 28.3%	Other 5.4%	Westminster	White British 28.0%	White (Other) 24.6%	Other: Arab 7.6%	2021 Census data: Percentage of people who do not speak English as a first language		Brent	33.68%	Ealing	30.9%	Hammersmith & Fulham	21.37%	Harrow	30.74%	Hillingdon	22.08%	Hounslow	28.32%	Kensington & Chelsea	23.6%	Westminster	26.44%
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Care in a community inpatient setting		✓																																																									
Outpatient & Wellbeing Care		✓																																																									
Overall		✓																																																									

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Race (Cont)

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

Assessments.																										
	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment																					
	Positive	Neutral	Negative																							
Care in your own home		✓		Ongoing tracking to ensure ethnicity groups are accessing the help and support they need at the end of life will be needed in future. The development of data dashboards will support this.	Ethnicity <table><thead><tr><th>Ethnicity</th><th>% of General Population</th><th>Prevalence or % of Cohort Total</th></tr></thead><tbody><tr><td>White</td><td>53.3%</td><td>53.3%</td></tr><tr><td>Asian or asian british</td><td>27.5%</td><td>27.5%</td></tr><tr><td>Black or black british</td><td>9.8%</td><td>9.8%</td></tr><tr><td>Mixed</td><td>2.4%</td><td>2.4%</td></tr><tr><td>Other ethnic groups</td><td>6.8%</td><td>6.8%</td></tr><tr><td>Not known,Not stated,Unknown</td><td>0.1%</td><td>0.1%</td></tr></tbody></table> Legend: Yellow bar = % of General Population, Teal bar = Prevalence or % of Cohort Total <u>Data source: NWL End of Life data dashboard</u> Our local information suggests proportionally greater representation of White ethnicity group and Black or Black British on the end of life register than is representative in the general population. There appears to be slightly lower representation among Asian or Asian British, mixed ad other ethnic groups.	Ethnicity	% of General Population	Prevalence or % of Cohort Total	White	53.3%	53.3%	Asian or asian british	27.5%	27.5%	Black or black british	9.8%	9.8%	Mixed	2.4%	2.4%	Other ethnic groups	6.8%	6.8%	Not known,Not stated,Unknown	0.1%	0.1%
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Care in a community inpatient setting		✓																								
Outpatient & Wellbeing Care		✓																								
Overall		✓																								

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Overall

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Religion or belief

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment																																																																																										
	Positive	Neutral	Negative																																																																																												
Care in your own home	✓			Positive impact has been identified in the following areas: - The proposed model of care aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire NW London population. The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural competence training for staff and actively collaborating with local organisations and partners. This spans the whole model of care and constituent services. Guidance has been previously published for local use including: Faith at end of life: A resource for professionals, providers and commissioners working in communities (publishing.service.gov.uk) Training programmes that incorporate culture and spiritual needs into end of life care: NHSE elfh Hub (e-lfh.org.uk) Neutral impact has been identified in the following areas: - All our charitable hospices are inclusive environments that are welcoming of people irrespective of their religious beliefs. However, the origins of these providers is largely based on Christian faith. There is a small risk this is perceived by communities to be environments that do not cater for a wide range of beliefs and religious needs at the end of life. Cultural competency training will help staff to feel comfortable with approaching diverse needs and seek out support from faith leaders where required.	Similar to ethnicity profiles, Faith representation vary in our boroughs with while greatest religious denominations including: - Christian - Muslim - Hindu People who report 'no religion' are significant. <table><tr><th>Religion 2021 by local authority ONS Census data</th><th>No religion (percent)</th><th>Christian (percent)</th><th>Buddhist (percent)</th><th>Hindu (percent)</th><th>Jewish (percent)</th><th>Muslim (percent)</th><th>Sikh (percent)</th><th>Other religion (percent)</th><th>Not answered (percent)</th></tr><tr><td>Brent</td><td>13.6</td><td>38.8</td><td>0.9</td><td>15.6</td><td>1.1</td><td>21.4</td><td>0.5</td><td>1.3</td><td>6.9</td></tr><tr><td>Ealing</td><td>19.1</td><td>37.8</td><td>1.1</td><td>7.7</td><td>0.3</td><td>18.8</td><td>7.8</td><td>0.7</td><td>6.7</td></tr><tr><td>Hammersmith and Fulham</td><td>30.6</td><td>45.7</td><td>0.9</td><td>1.2</td><td>0.7</td><td>11.6</td><td>0.2</td><td>0.7</td><td>8.4</td></tr><tr><td>Harrow</td><td>10.6</td><td>33.9</td><td>1.1</td><td>25.8</td><td>2.8</td><td>15.9</td><td>1.1</td><td>2.9</td><td>5.9</td></tr><tr><td>Hillingdon</td><td>19.4</td><td>39.0</td><td>0.9</td><td>10.8</td><td>0.5</td><td>14.4</td><td>8.6</td><td>0.9</td><td>5.6</td></tr><tr><td>Hounslow</td><td>18.6</td><td>38.3</td><td>1.4</td><td>9.5</td><td>0.2</td><td>16.7</td><td>8.6</td><td>0.8</td><td>6.1</td></tr><tr><td>Kensington and Chelsea</td><td>24.8</td><td>48.4</td><td>1.1</td><td>1.1</td><td>1.9</td><td>11.8</td><td>0.2</td><td>0.7</td><td>10.0</td></tr><tr><td>Westminster</td><td>25.9</td><td>37.3</td><td>1.3</td><td>2.2</td><td>2.8</td><td>20.0</td><td>0.3</td><td>0.9</td><td>9.4</td></tr></table>	Religion 2021 by local authority ONS Census data	No religion (percent)	Christian (percent)	Buddhist (percent)	Hindu (percent)	Jewish (percent)	Muslim (percent)	Sikh (percent)	Other religion (percent)	Not answered (percent)	Brent	13.6	38.8	0.9	15.6	1.1	21.4	0.5	1.3	6.9	Ealing	19.1	37.8	1.1	7.7	0.3	18.8	7.8	0.7	6.7	Hammersmith and Fulham	30.6	45.7	0.9	1.2	0.7	11.6	0.2	0.7	8.4	Harrow	10.6	33.9	1.1	25.8	2.8	15.9	1.1	2.9	5.9	Hillingdon	19.4	39.0	0.9	10.8	0.5	14.4	8.6	0.9	5.6	Hounslow	18.6	38.3	1.4	9.5	0.2	16.7	8.6	0.8	6.1	Kensington and Chelsea	24.8	48.4	1.1	1.1	1.9	11.8	0.2	0.7	10.0	Westminster	25.9	37.3	1.3	2.2	2.8	20.0	0.3	0.9	9.4
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Overall	✓																																																																																														

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Sexual orientation

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Posi ve	Neutr al	Nega tive		
Care in your own home		✓		Positive impact will be seen among LGBTQ people accessing community specialist palliative care in the following ways:	In 2021, Wakefield et al considered the access and care requirements for LGBTQ people (Why does palliative care need to consider access and care for LGBTQ people? - Donna Wakefield, Chris EC Kane, Claude Chidiac, Debbie Braybrook, Richard Harding, 2021 (sagepub.com)). Addressing the following issues were cited: 1. Anticipated discrimination even if there is no active discrimination 2. Family estrangement, limited social support with LGBTQ people more likely to be single and childless than heterosexual people. This lack of informal family support may limit their ability to die in their preferred place. 3. Inclusion within hospice environments with faith-based backgrounds. 4. Increased anxiety arising from the factors above In NW London, higher proportions of people who do not identify as being heterosexual can be found in our inner NW London boroughs of Westminster, Kensington and Chelsea and Hammersmith & Fulham..
Care in a community inpatient setting		✓		- Personalised care planning will create better conversations to emerge including the care preferences and needs based on sexual orientation. - The inclusion of people who are important to the patient in the care planning process (as opposed to limiting this to families and spouses) ensures non-heterosexual people are included in accessing help and support.	
Outpatient & Wellbeing Care	✓			- Staff will be better equipped to discuss personalised care needs of LGBTQ people through improved training and education. Supporting material is already available to staff in end of life care including: Marie Curie: Palliative and end of life care for LGBTQ+ people For professionals (mariecurie.org.uk) - Strengthening holistic assessment will highlight social factors and informal care support of the individual, factors that might limit care delivery in their preferred place. By increasing care provision in the community including hours of provision, this group of individuals will benefit from care at home. - Hospices serving NW London population have made strides to be inclusive environments where LGBTQ people feel welcome and comfortable. Expanding bedded care provision in care home environments expand options for people where this is still not a preferred place of care. - Improved psychological and bereavement services will improve access to LGBTQ population seeking support.	
Overall		✓			

Sexual Orientation data by local authority Census 2021	Not Straight or Heterosexual (percent)
Brent	14.90%
Ealing	13.69%
Hammersmith and Fulham	15.10%
Harrow	12.84%
Hillingdon	11.09%
Hounslow	12.83%
Kensington and Chelsea	15.32%
Westminster	16.69%

Gender Assignment

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

Impact				Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment																						
Positive	Neutral	Negative																									
Care in your own home		✓		Likely concerns of this group: - Hospice accommodation options for people who identify their gender as being different to that they were born as - Personal care by same-sex staff - understanding how this is managed Positive impact will be felt in the following areas: - All providers currently can offer individual rooms for hospice inpatient admissions for patients to support privacy for patient and family/ carers/ those important to patient regardless of their gender. - Many of the providers have specific transgender services users policies in place for staff, service users and volunteers and many have these in development or this forms part of their Equity, Diversity and Inclusion Policy. Through implementation of the new model of care we aim to support all providers having relevant policies to support reduce inequalities and raised awareness for this group of individuals accessing the services. - All providers currently consider individual requests from patients regarding preference for the sex of the person providing their care and in the main are able to support these requests, however as part of the new model of care the cultural competency and workforce development enabler work, the aim is to increase the providers' diversity of staff/ organisation to support this. - This group of people may face additional psychological needs arising from compounding factors of palliative care and gender identity. By strengthening the psychological support offer to people cared for in community-based specialist palliative care provision, we expect improved care provision overall. - Improving cultural competency among all clinical staff is expected to result in greater understanding of the needs of this group, careful use of language and building trust in care. The new model of care is proposing collaborative cultural competency development work across providers through the enabler workstream for reducing health inequalities which will look to support development of a NWL cultural competency framework for all CSPC providers to use.	Census 2021 data shows how gender identity varies across England and Wales. Response rates vary, but based on reported identity, the region with highest percentage reporting gender identity that differed from sex at birth was London. Although overall numbers remain relatively small, Brent stands out as an area where greater proportion of people identify as a gender different to that at birth. <table><tr><th>Area name</th><th>Gender identity the same as sex registered at birth (percent)</th></tr><tr><td>Brent</td><td>88.63</td></tr><tr><td>Ealing</td><td>90.19</td></tr><tr><td>Hammersmith and Fulham</td><td>91.50</td></tr><tr><td>Harrow</td><td>90.12</td></tr><tr><td>Hillingdon</td><td>91.70</td></tr><tr><td>Hounslow</td><td>90.57</td></tr><tr><td>Kensington and Chelsea</td><td>90.86</td></tr><tr><td>Westminster</td><td>90.03</td></tr><tr><td>London</td><td>91.21</td></tr><tr><td>England</td><td>93.47</td></tr></table> Data source: Gender identity, England and Wales - Office for National Statistics (ons.gov.uk)	Area name	Gender identity the same as sex registered at birth (percent)	Brent	88.63	Ealing	90.19	Hammersmith and Fulham	91.50	Harrow	90.12	Hillingdon	91.70	Hounslow	90.57	Kensington and Chelsea	90.86	Westminster	90.03	London	91.21	England	93.47
Area name	Gender identity the same as sex registered at birth (percent)																										
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England	93.47																										
Care in a community inpatient setting		✓																									
Outpatient & Wellbeing Care		✓																									
Overall		✓																									

Overall
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Pregnancy and maternity

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home	✓			Core concerns likely to include: • Accessibility of services and sites: Care facilities that provide a calm/peaceful environment • Breastfeeding facilities – what facilities might be available • Access to psychological support and bereavement support	
Care in a community inpatient setting		✓			
Outpatient & Wellbeing Care	✓				
Overall	✓			All providers provide services to patients and their family members/ carers who are pregnant or mothers. This does not preclude these individuals from accessing services. Whilst not all providers have dedicated breast feeding facilities available on site, they are committed to supporting the needs of these individuals and will be able to make arrangements for a quite appropriate room/ environment to support this on request. Positive benefit to women in pregnancy is offered through: • The inclusion of a holistic needs assessment and a personalised care plan for all patients in the new model of care brings the needs of the individual to the forefront of care planning and delivery. This process is inclusive of carers and families, ensuring trust is built and needs of individuals are fully reflected. This includes preferences on place of care and consideration of the ability of pregnant women and mothers to travel to care facilities. • Greater provision of care in the comfort of people's own homes by extending hours of provision of key services such as specialist palliative care teams, hospice at home and 24/7 telephone advice. This maximises opportunity for existing support provision (including informal and formal carers including pregnant women and young families) to work seamlessly with community-based specialist palliative care providers and maintaining important social connections with family and friends. • By strengthening provision of psychological and bereavement support, pregnant women and mothers (patients and family/ carers of patients) will see improved access to support.	

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Marriage and civil partnership

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

Impact				Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment																		
Positive	Neutral	Negative																					
Care in your own home		✓		Likely concerns of this group: The risk presented is people who aren't married may have less input to care planning for their loved ones, may not be able to stay at the hospice to support their loved one and may not be eligible to access help and support for themselves. In response to this, positive impact has been identified in the following areas of the new model of care: - Personalised care planning will include people who are important to the patient in the care planning process (as opposed to limiting this to families and spouses). - The model of care ensures those who are not married do not experience barriers in inputting to care planning or accessing support such as psychological and bereavement support. - Strengthening holistic assessment will highlight social factors and informal care support of the individual, factors that might limit care delivery in their preferred place. By increasing care provision in the community including hours of provision, this group of individuals will benefit from care at home. - All providers will support patients family/ carers/ those important to patients to visit patient as well as stay over at the inpatient unit regardless of their marital status (married or unmarried/ civil partnership). Neutral impact has been identified in the following areas: - Estate planning is widely available within charitable hospices which will support married and unmarried people to arrange their affairs e.g. will	Nationally there are greater proportion of adults under 70 who have never married for formed a civil partnership than in 2011. the number of people getting married is at the lowest rate on record and the median age of those getting married is increasing (ONS Census 2021 data: Marriage and Civil Partnership status in England and Wales). In NW London, lowest levels of marriage and civil partnership are seen among those living in Hammersmith & Fulham, Westminster and Kensington & Chelsea. Data source: Marriage and civil partnership status in England and Wales - Office for National Statistics (ons.gov.uk)																		
Care in a community inpatient setting		✓																					
Outpatient & Wellbeing Care		✓																					
Overall		✓			<table><tr><th></th><th>Married or registered civil partnership (age standardised proportions)</th></tr><tr><td>Brent</td><td>45.6</td></tr><tr><td>Ealing</td><td>46.2</td></tr><tr><td>Hammersmith and Fulham</td><td>35.2</td></tr><tr><td>Harrow</td><td>54.8</td></tr><tr><td>Hillingdon</td><td>50.1</td></tr><tr><td>Hounslow</td><td>47.8</td></tr><tr><td>Kensington and Chelsea</td><td>37.7</td></tr><tr><td>Westminster</td><td>36.3</td></tr></table>		Married or registered civil partnership (age standardised proportions)	Brent	45.6	Ealing	46.2	Hammersmith and Fulham	35.2	Harrow	54.8	Hillingdon	50.1	Hounslow	47.8	Kensington and Chelsea	37.7	Westminster	36.3
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Carers

Why has this characteristic been included?

Carers play an important role in many people's care at the end of life, meaning that it is particularly important to consider potential impacts on them arising from these service changes.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home	✓			Areas where carer support is strengthened in the new model of provision: - Carers are involved in the holistic needs assessment in the new model of care. Development of a personalised care plan that takes account of the needs and preferences of the individual and their circumstances. Tracking improvement in patient, family and carer experience will be tracked and monitored through surveys and seeking feedback. - Caregiver support runs throughout how people are cared for within community-based specialist palliative care provision including access to emotional and psychological support and bereavement support. - More compassionate care and better communication with carers and families through workforce training (including e-learning for health): NHSE elfh Hub (e-elfh.org.uk) Areas of neutral impact: - Travel time access to hospice sites is variable within NW London. The intention to increase bed based options to include EOLC beds within care homes provides greater choice of options, potentially reducing travel time.	National survey of bereaved people (VOICES), England, 2015 revealed the majority (between 74% and 86%) of people responded agree or strongly agree to these questions: "we understood the information given to us" (86%) "we were kept informed of his/her condition and care" (79%) "we had enough time with staff to ask questions and discuss his/her condition and care" (75%) "we had a supportive relationship with the health care professionals" (74%, see Figure 12)
Care in a community inpatient setting		✓			
Outpatient & Wellbeing Care	✓				
Overall	✓				

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Single person households

Why has this characteristic been included?

Parts of NW London have a large number of people living alone, especially older people. Engagement has highlighted that this group might struggle to access community-based specialist palliative care services. It is therefore important to consider their specific circumstances.

Impact				Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment																																																
Positive	Neutral	Negative																																																			
Care in your own home	✓			Area of concern and how this is addressed within the proposal: Single older people living alone might be less able to die in their preferred place because of potentially less informal carer support within the household. The model of care brings holistic needs assessment to personalised care planning. This aims to consider support needs from a range of perspectives. The availability of 24/7 telephone advice would serve as a way for people to access clinical advice at any time of the day or night. By extending the hours of care provided by community services such as hospice at home, the ambition is to support more people dying at home if that is their preference. Equally, where needed or preferable, expansion of options for bed-based care provision means choice options are available. Social isolation experienced by people living alone may compound mental health challenges at the end of life. The use of holistic needs assessment and personalised care planning aims to identify the specific needs of an individual, including psychological and bereavement support. The recommendation in the model of care is that we include improved bereavement and psychological support as a core service element of the well-being offer in the new model of care. This means implementing a core level of service and clearer robust pathway for access to appropriate psychological and bereavement support across all boroughs.	According to Census 2021, almost 10% of households in NW London are ‘single person households aged 66 and over’, slightly higher than the overall London picture, but lower than England and Wales. <table><tr><th>Row Labels</th><th>One-person household: Aged 66 years and over (n)</th><th>Grand Total Households (n)</th><th>% of households that are one-person households aged 66+</th></tr><tr><td>Brent</td><td>9,712</td><td>118,612</td><td>8.2%</td></tr><tr><td>Ealing</td><td>11,837</td><td>133,659</td><td>8.9%</td></tr><tr><td>Hammersmith & Fulham</td><td>7,351</td><td>81,244</td><td>9.0%</td></tr><tr><td>Harrow</td><td>9,050</td><td>89,642</td><td>10.1%</td></tr><tr><td>Hillingdon</td><td>11,143</td><td>109,227</td><td>10.2%</td></tr><tr><td>Hounslow</td><td>9,176</td><td>102,961</td><td>8.9%</td></tr><tr><td>Kensington and Chelsea</td><td>7,750</td><td>66,885</td><td>11.6%</td></tr><tr><td>Westminster</td><td>9,498</td><td>94,817</td><td>10.0%</td></tr><tr><td>NW London</td><td>75,517</td><td>797,047</td><td>9.5%</td></tr><tr><td>LONDON</td><td>313,050</td><td>3,423,899</td><td>9.1%</td></tr><tr><td>ENGLAND & WALES</td><td>3,197,840</td><td>24,783,213</td><td>12.9%</td></tr></table> Data sources: Household composition data, census 2021, ONS Research has linked social isolation and loneliness to higher risks for a variety of other physical and mental conditions including depression, anxiety and cognitive decline (Social isolation, loneliness in older people pose health risks National Institute on Aging (nih.gov)). The Health Foundation published findings in 2018 suggesting older people living alone were 50% more likely to visit A&E than those who lived with others (Older people living alone are 50% more likely to visit A&E than those who live with others (health.org.uk)).	Row Labels	One-person household: Aged 66 years and over (n)	Grand Total Households (n)	% of households that are one-person households aged 66+	Brent	9,712	118,612	8.2%	Ealing	11,837	133,659	8.9%	Hammersmith & Fulham	7,351	81,244	9.0%	Harrow	9,050	89,642	10.1%	Hillingdon	11,143	109,227	10.2%	Hounslow	9,176	102,961	8.9%	Kensington and Chelsea	7,750	66,885	11.6%	Westminster	9,498	94,817	10.0%	NW London	75,517	797,047	9.5%	LONDON	313,050	3,423,899	9.1%	ENGLAND & WALES	3,197,840	24,783,213	12.9%
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Care in a community inpatient setting	✓																																																				
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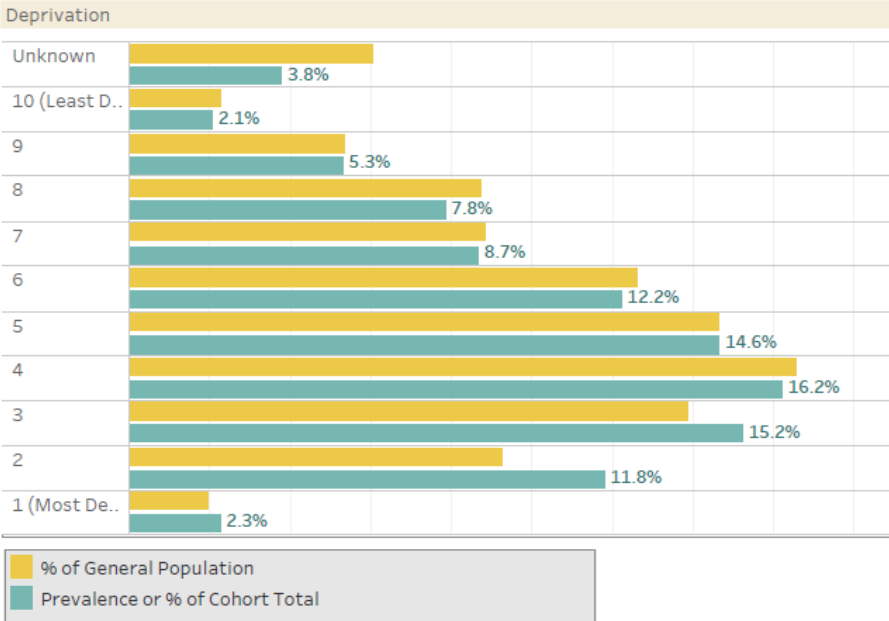
Deprived populations

Why has this characteristic been included?
188 LSOA areas fall among the 20% most deprived in England. Deprivation is linked to lower health literacy, impacts ability to travel and attend health appointments and seek help.

Impact				Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment																																													
	Positive	Neutral	Negative																																															
Care in your own home		✓		Area of concern and model of care response: - People in deprived communities may find it harder to navigate community-based specialist palliative care provision. A key aspect of the new model of care is awareness raising of the services that are available at the end of life, including community specialist palliative care. Staff will be trained to understand the importance of health literacy in achieving good patient outcomes. Training material is already available to support staff delivering NHS services: Health Literacy - elearning for healthcare (e-lflh.org.uk) - People experiencing income deprivation not be able to afford travel to locations where care is provided. Travel to healthcare sites can be supported via non-emergency patient transport schemes and some hospices have their own private ambulances. - People experiencing income deprivation may experience longer travel time to access health sites where care is delivered. Travel mapping was undertaken as part of the development of the model of care. Broadly, our hospice sites are located in areas within close proximity of deprived communities. People living in the most deprived areas (IMDs 1&2) are not adversely impacted by travel times to their nearest unit except in Hillingdon where travel times are higher to access Michael Sobell House for the 7 LSOA areas.	Deprivation in NW London Large income deprivation disparities exist among boroughs and within boroughs in NW London. Overall, Brent sees 15% of the population reported as being income-deprived, ranking at 67 out of 316 local authorities. Ealing and Westminster had the greatest number of LSOA areas categorised as being among the 20% most deprived in England. The disparity within boroughs exists in Kensington & Chelsea and Westminster. <table><thead><tr><th></th><th>%of population that was income-deprived in 2019</th><th>Rank of most income deprived (out of 316 authorities)</th><th>No. of LSOAs</th><th>No. of LSOAs among the 20% most deprived in England</th></tr></thead><tbody><tr><td>Brent</td><td>15%</td><td>67</td><td>173</td><td>33</td></tr><tr><td>Ealing</td><td>14%</td><td>94</td><td>196</td><td>35</td></tr><tr><td>Hammersmith & Fulham</td><td>14.20%</td><td>88</td><td>113</td><td>27</td></tr><tr><td>Harrow</td><td>10.90%</td><td>156</td><td>137</td><td>8</td></tr><tr><td>Hillingdon</td><td>11.40%</td><td>141</td><td>161</td><td>9</td></tr><tr><td>Hounslow</td><td>12.90%</td><td>111</td><td>142</td><td>18</td></tr><tr><td>Kensington & Chelsea</td><td>11.70%</td><td>138</td><td>103</td><td>24</td></tr><tr><td>Westminster</td><td>13.50%</td><td>100</td><td>128</td><td>34</td></tr></tbody></table> In 2021, Age UK published findings that suggest one in five women pensioners are now living in poverty with even higher levels of poverty among black and Asian women. (New Age UK analysis finds one in five UK women pensioners now living in poverty). Data Sources: Exploring local income deprivation (ons.gov.uk) Deprivation & health literacy People with limited financial and social resources are more likely to have limited health literacy. In turn, limited health literacy limits opportunities for vulnerable and disadvantaged groups to be actively involved in decisions about their health and care over the life course. This can undermine people’s ability to take control of their health and the conditions that affect their health. Among the recommendations for improving health literacy and reducing health inequalities by Public Health England in a 2015 report ‘<i>Improving health literacy to reduce health inequalities</i>’ are: - Ensuring clear and accessible information - Community-led approaches, using social networks - Strengthen public-professional communications (e.g. training) Data sources: 4b_Health_Literacy-Briefing.pdf (publishing.service.gov.uk) NHS England » Enabling people to make informed health decisions, Health Information - (library.nhs.uk)		%of population that was income-deprived in 2019	Rank of most income deprived (out of 316 authorities)	No. of LSOAs	No. of LSOAs among the 20% most deprived in England	Brent	15%	67	173	33	Ealing	14%	94	196	35	Hammersmith & Fulham	14.20%	88	113	27	Harrow	10.90%	156	137	8	Hillingdon	11.40%	141	161	9	Hounslow	12.90%	111	142	18	Kensington & Chelsea	11.70%	138	103	24	Westminster	13.50%	100	128	34
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Care in a community inpatient setting		✓																																																
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Deprived populations (Cont)

Why has this characteristic been included?
188 LSOA areas fall among the 20% most deprived in England. Deprivation is linked to lower health literacy, impacts ability to travel and attend health appointments and seek help.

Impact				Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment																																				
Positive	Neutral	Negative																																							
Care in your own home		✓		Tracking of caseload by postcode would give visibility of equity of access across IMD groups.	Deprivation in NW London end of life cohort The profile of people on the end of life cohort using local data suggests higher representation of people living in the most deprived areas than the population at whole. There are a number of inferences from this overview including: 1. This suggests people living in deprived communities with this need are known to health professionals. This isn't the same as being on a CSPC caseload and further analysis would be necessary to assess whether equity of access is present. 2. Premature mortality attributable to socioeconomic deprivation is at play 3. Multimorbidity associated with socioeconomic deprivation and occurring at younger ages is a factor.  Deprivation <table><tr><th>Deprivation Level</th><th>% of General Population</th><th>Prevalence or % of Cohort Total</th></tr><tr><td>Unknown</td><td></td><td>3.8%</td></tr><tr><td>10 (Least De..</td><td>2.1%</td><td></td></tr><tr><td>9</td><td>5.3%</td><td></td></tr><tr><td>8</td><td>7.8%</td><td></td></tr><tr><td>7</td><td>8.7%</td><td></td></tr><tr><td>6</td><td>12.2%</td><td></td></tr><tr><td>5</td><td>14.6%</td><td></td></tr><tr><td>4</td><td>16.2%</td><td></td></tr><tr><td>3</td><td>15.2%</td><td></td></tr><tr><td>2</td><td>11.8%</td><td></td></tr><tr><td>1 (Most De..</td><td>2.3%</td><td></td></tr></table> Legend: % of General Population (Yellow), Prevalence or % of Cohort Total (Teal) Data source: NWL End of Life data dashboard	Deprivation Level	% of General Population	Prevalence or % of Cohort Total	Unknown		3.8%	10 (Least De..	2.1%		9	5.3%		8	7.8%		7	8.7%		6	12.2%		5	14.6%		4	16.2%		3	15.2%		2	11.8%		1 (Most De..	2.3%	
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Outpatient & Wellbeing Care		✓																																							
Overall		✓																																							

Overall
Page 247

Overall
Page 247

People living in sub-standard housing

Why has this characteristic been included?

Poor living conditions will prevent people being cared for at home and is associated with poor health overall. This means alternatives are necessary to support palliative care provision.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment																														
	Positive	Neutral	Negative																																
Care in your own home		✓		Area of concern and model of care response: - People living in sub-standard accommodation may be refused care in their own home if it poses a risk to staff and patient. The new model of care includes options to be cared for in better suited environments including for example the introduction of the enhanced end of life care beds as well as the offer of hospice inpatient care for those patients who are assessed as needing this level of inpatient care. - In the holistic assessment of patient needs undertaken by teams, the social needs of individuals including suitability of the home environment is considered. - Providers also have family support services available which include access to patient and family advice for example benefits assessment and advice/ signposting to access any benefits they may be eligible for and onward referral to social care/ social housing as needed.	In 2021, a household survey by The Department for Levelling Up, Housing and Communities found 14% of private rented sector homes were estimated to be unsafe according to the Housing and Safety Rating System. Dwellings where the household were in receipt of housing support were more likely to contain a hazard than those not receiving support. English Housing Survey 2021 to 2022: private rented sector - GOV.UK (www.gov.uk). Private rented homes were more likely to have damp than all other tenures. 11% are estimated to having damp. In England and Wales, London has the highest proportion of households that rent privately (30%) (Housing, England and Wales - Office for National Statistics (ons.gov.uk)) compared with 20.3% private rental across England and Wales. Among NW London Boroughs, Westminster stands out as having highest proportion of private rental. This might indicate higher proportions of unsafe housing in this area. If we consider 14% of privately rented homes in NW London boroughs are unsafe, approximately 38,000 homes may be affected, or almost one in every twenty households. <table><tr><th>Area name</th><th>Private rented or lives rent free (percent)</th><th>No. of Potentially unsafe privately rented homes</th></tr><tr><td>Brent</td><td>36.2</td><td>6,006</td></tr><tr><td>Ealing</td><td>34.3</td><td>6,412</td></tr><tr><td>Hammersmith and Fulham</td><td>36.6</td><td>4,160</td></tr><tr><td>Harrow</td><td>29.7</td><td>3,731</td></tr><tr><td>Hillingdon</td><td>26.0</td><td>3,978</td></tr><tr><td>Hounslow</td><td>31.2</td><td>4,490</td></tr><tr><td>Kensington and Chelsea</td><td>39.8</td><td>3,722</td></tr><tr><td>Westminster</td><td>43.6</td><td>5,789</td></tr><tr><td>TOTAL</td><td></td><td>38,288</td></tr></table> Data source: Housing, England and Wales - Office for National Statistics (ons.gov.uk)	Area name	Private rented or lives rent free (percent)	No. of Potentially unsafe privately rented homes	Brent	36.2	6,006	Ealing	34.3	6,412	Hammersmith and Fulham	36.6	4,160	Harrow	29.7	3,731	Hillingdon	26.0	3,978	Hounslow	31.2	4,490	Kensington and Chelsea	39.8	3,722	Westminster	43.6	5,789	TOTAL		38,288
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TOTAL		38,288																																	
Care in a community inpatient setting	✓																																		
Outpatient & Wellbeing Care		✓																																	
Overall		✓																																	

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Homelessness

Why has this characteristic been included?

Homelessness creates barriers to accessing health care generally, and care at home more specifically. Homelessness and rough sleeping is particularly prevalent in London.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home		✓		People who experience homelessness may be disadvantaged in a number of ways. Barriers in accessing primary health care may reduce knowledge and awareness of help and may be crisis-led (i.e. greater use of A&E). Fear of being treated badly. Great importance has been placed on equipping staff to better accommodate diverse needs within our population through cultural competency in addition to EDI training. Complications surrounding substance use. Linkages with other teams through the GP including drug and alcohol recovery teams will ensure people can access support for their palliative care needs alongside help for substance use. Lack of planning results in higher use of emergency services. Holistic needs assessment and personalised care planning are central to the delivery of the model of care. This change will support this group to navigate services and seek help early to prevent hospitalisation.	Rough sleeping Estimated snapshot data of rough sleepers show that in London, rough sleeping may have dipped since a peak in 2017. During the Covid-19 pandemic, rough sleeping was at lowest levels since 2014 but might be showing signs of increasing with 2022 increase on previous year. (Rough sleeping snapshot in England: autumn 2022 - GOV.UK (www.gov.uk)) Proportion of households in temporary accommodation Every borough in London, except Hounslow has a higher proportion of households living in temporary accommodation than the average for the rest of England. 15 per 1,000 households live in temporary accommodation across greater London. Westminster (21.43 per 1,000) and Ealing (18.66 per 1,000) have higher proportions than the London average. Data source: London households in temporary accommodation Trust for London People experiencing homelessness are at higher risk of physical health problems that shorten their life expectancy and mental health needs that make planning care important (Homelessness at end of life: Information for professionals (mariecurie.org.uk)) Deaths in homelessness London had the highest number of homeless deaths in 2021 (Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)) and the rate of death has increased since 2013. Drug poisoning, suicide and alcohol-specific causes account for more than half of deaths among homeless people in 2021. Literature review A literature review covering people who are experiencing homelessness was carried out and put forward recommendations including better planning, multiagency working including in-reach to hostels, better training and education and increased provision of services, access and choice. See full literature review.
Care in a community inpatient setting	✓				
Outpatient & Wellbeing Care		✓			
Overall		✓			

Mental health and dementia

Why has this characteristic been included?
Ageing population means services need to accommodate dual needs of end of life and multi-morbidity including mental health and dementia.

Impact				Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home		✓		Area of concern and model of care response: Do people with dual needs of mental health and palliative care receive care fairly? - All providers currently provide services to patients with dual mental health diagnoses and palliative care needs. They are not excluded because of their mental health diagnosis. - Providers have specific pathway in place for the care of patients with mental health issues. They have good working relationships with local mental health NHS trusts and organisations, as well as access to multiple resources and expert advice if required. One of the providers is a joint physical and mental health community NHS trust. - Through the new model of care providers are committed to improving their reach to this cohort of patients through outreach and improved partnership working at local “place”. This work has already commenced through local borough EOL stakeholder forums. Do people with dual needs of dementia and community specialist palliative care need receive care fairly? - All providers currently provide services to patients with dementia diagnosis – they are not excluded from accessing services based on having this diagnosis - All providers currently offer and will continue to offer dementia training/ facilitate access to dementia training for staff. Some providers have dedicated dementia teams with specialist dementia trained staff and other providers have access to dementia experts as part of wider community and frailty services. - All providers are committed to increasing the reach of their services to patients with dementia and their families/ carers and as part of the integration enablers work of the new model of care plans to link universal and specialist teams to support improved partnership working and care continuity will be addressed	How to improve end-of-life care for people with mental illness - NIHR Evidence Dementia NHS England published guidelines on palliative care for those with dementia. palliative-care-guidelines-in-dementia.pdf (england.nhs.uk)
Care in a community inpatient setting		✓			
Outpatient & Wellbeing Care		✓			
Overall		✓			

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Actions arising from this assessment

Actions arising from this assessment

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	EHIA section	Identified need	Actions we will take
1	Tracking equitable access across protected characteristics	Existing data reports from providers do not adequately allow us to assess whether equitable access for protected characteristic groups exists. Adhoc reporting is possible, but more could be done to identify the patterns of use on a regular basis.	1. We need to improve data collection across providers to ensure that populations within NW London are able to access community-based specialist palliative care services in an equitable way. We plan to complete a collaborative exercise across all providers to develop a standardised data set for the services delivered as part of the new model of care, which will include demographic data. We are developing an end of life care dashboard for NW London that includes demographic and deprivation data as part of the metrics to be tracked to support improved population health management and reducing inequalities.
2	Tracking feedback of service users	Although engagement process has been useful in helping us shape the model of care, better collation of comparable user feedback across all boroughs and providers should be gathered to help further service improvement.	1. We will work with NW London providers of community-based specialist palliative care to develop a standard survey(s) to gather comparable information? 2. We will work with Healthwatch, wider community networks and current service providers to undertake site visits each year and speak to users to gather insights that drive improvement. 3. We will systematically collate information on complaints for NW London patients using community-based specialist palliative care services and report themes that drive our improvement plan.
3	Tracking feedback of staff	The solutions described in the EHIA put heavy emphasis on the delivery of cultural competency and improved staff training programmes without understanding their impact of quality of care.	1. We will work with our providers to support undertaking annual staff surveys to test whether the investment in cultural competency and improved staff training is improving their experiences of delivering care. 2. We will systematically collate information on complaints for NW London patients using community-based specialist palliative care services and report themes that drive our improvement plan.
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London Clinical Senate Review

NHS North West London adult (18+) community-based specialist palliative care services improvement programme and proposed new model of care.

London Clinical Senate Council Report

13th May 2024

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1. Contact details of the key personnel coordinating the review process

Review Chair	Heather Richardson
Review Vice Chair	Marianne Leach
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2. Foreword

On behalf of the London Clinical Senate, we are pleased to share the final report which reviews the NHS North West London adult (18+) community-based specialist palliative care services improvement programme and proposed new model of care.

This model and plans for its roll out have been a long time in conception. The London Clinical Senate received an initial proposal in 2019 for the development of palliative care services in this area. At the time, there was agreement by all involved that further work on the plans would be beneficial to enhance services for people dying and those caring for them or grieving their death. Such work has taken place, and the revised plans tell a strong story of wide consultation with the public, engagement with a broad range of providers who work in the area, and tangible attention to equality of provision across a large geographical area and diverse population. We commend this effort and considering this are pleased to support the proposed changes. We see, also, some evidence of innovative thinking and the potential upscale of some exciting developments in provision that reflect the changing demographic and clinical needs of people coming to the end of life. These proposals are exciting, and we encourage all living and working in north west London to continue to invest in novel responses to meet the palliative care needs of local people to ensure an equitable, timely and effective model moving forward.

Members of the London Clinical Senate have been ably supported in their work to review the business case and related materials by a range of experts, drawn in to offer different insights related to current and future needs for community-based specialist palliative care services. We are grateful to them for their time, considered opinions and commitment to this work. Similarly, members of the London Clinical Senate Patient and Public Voice Group have offered valued discernment regarding strengths and gaps in the consultation to date and we encourage the team taking this work forward in north west London to keep talking to local people, engaging them in clear and careful conversations about what is important to them, their choices, what they can expect, and how to access services that are relevant to their needs.

Finally, our thanks to the team based in NHS London who support members of the London Clinical Senate and its work. The timely and comprehensive nature of this report is testimony to their efforts.



Heather Richardson

Heather Richardson, Chair of Review



Leach

Marianne Leach, Vice Chair of Review

3. Executive summary and key recommendations

Following the review of NHS North West London adult (18+) community-based specialist palliative care services improvement programme and proposed new model of care, the London Clinical Senate commend the programme team for the quality and depth of the work undertaken, and the developments from the initial proposals reviewed by the London Clinical Senate in 2019.

The Senate Review Panel are supportive of the changes proposed and thank everyone for the comprehensive materials provided. We hope that the recommendations will enable the programme team to further strengthen and improve the proposals.

The recommendations align to several overarching suggestions, which are focused on achieving greatest positive impact through the proposed changes, namely:

- Continuing to develop the model to reflect contemporary, changing, and future needs.
- Adopting a lens of equity across the diverse populations of north west London to guide the design, roll out and enhancement of the model.
- Being innovative – moving beyond “the basics” of coordinating care to creating connectivity and collaboration across the patch. For example, through digital enablement and by aligning multiprofessional teams including primary care, allied health professionals and a wide range of stakeholders around the need of patients.
- Being confident that the rollout proposed is possible. This will involve due attention to the challenges of implementation; workforce availability and capability; access to care home beds; and a strong working interface with primary care and other services.
- Maintaining and developing public engagement to ensure people are using the right services at the right time.
- Building a range of quality measures and outcomes at population and patient /user reported levels, which are benchmarked, and reviewed across the patch. Using these to help review and continue to develop and improve the model to meet the breadth of the populations needs.

The specific recommendations, which are explained further in the main body of the report are detailed below.

Recommendations

Overview of the model

R1. Explore flexibilities to evolve into a modern palliative care model, emphasising the offer to patients with a range of diseases and conditions eg frailty, heart failure and chronic respiratory disease. The model described is predominantly a traditional community palliative care model, with its foundations in supporting people with cancer.

R2. Include further detail of information provision to patients as part of the service design.

R3. Further emphasise the support that the proposed service design will offer to carers.

Care in the home

R4. Provide greater clarity on the role of the call centre, both who it is designed for (staff, carers, patients) and what it offers (bed management, medication, service navigation). Outline clear principles to reduce potential hand offs.

R5. Consider the demand for the call centre and undertake modelling to help ensure that the service does not become overwhelmed; this may be achieved through a pilot in the first instance, as well as lessons learned from existing call centres/ pilots.

R6. Keep pursuing a single point of access for the call centre to enable greater equity, which may be possible with a tighter clarity on the purpose.

R7. Describe how the 24/7 planned phone service will be supported by out of hours pharmacy provision.

Care in a community inpatient setting

R8. Provide more detail when describing how the learning from innovations underway (Hillingdon Enhanced end of life care beds) will inform the plans and help implementation.

R9. Describe the governance for the Enhanced end of life care beds including model, role and responsibilities for GPs and Primary Care and how clinical issues will be communicated between different clinicians and stakeholders.

R10. Provide assurance that the assumptions made of primary care and associated responsibilities for GPs are realistic and transferrable across the whole of the Integrated Care System (ICS).

R11. Describe the support, training, and resources available to Primary Care to enable them to fulfil their extended role in relation to Enhanced end of life care beds.

R12. Provide further assurance that there is capacity within the care home sector to deliver care via an additional 50 beds as per the current Harlington Hospice model in Hillingdon including consideration of potential unintended consequences eg reduced number of beds available to other frail elders requiring such care.

R13. Describe how the workforce skills and capacity are being developed to make the aspiration of the advice and rehabilitation model of care provided by Harlington Hospice a reality.

Outpatient Care and Wellbeing

R14. Fully consider the need for specialist social care support within the specialist palliative care team following NICE recommendation 1.9 (*NG142- End of life care for adults: service delivery*).

R15. Provide more information on the proposed different services available across the patch provided by the hospices that meets complex/multiple needs including pain intervention clinics, specialist psychosocial and mental health support, breathlessness, and rehabilitation services. Confirm what is available via outpatient clinics/services. Consider patient pathway examples/ vignettes to illustrate this.

Outcomes

R16. Provide additional indicators of clinical quality and other outcomes to establish a baseline of quality of care. Consider measures that indicate improvement in effectiveness of care and identify areas for sustained quality improvement.

R17. Monitor the intended rollout and implementation to redress current inequities across the geographical patch.

Demographics and equity across the diverse populations of north west London

R18. When the Integrated Impact Assessment is complete, explore opportunities to better meet population needs and consider distribution of resources for more vulnerable populations that require support.

R19. Consider broader accessibility and inequalities eg enabling people with learning disability, stroke, and other conditions to make informed choices.

R20. Include input by different cultural and faith communities to strengthen the proposals.

R21. Consider the model of care to ensure the needs of people of all ages are met, whilst recognising the Care Quality Commission registration requirements for different types of provision.

R22. Further describe how opportunities will be maximised to strengthen the concept of compassionate communities, engage community groups, their leaders, and the broader voluntary sector to bring together community action and professional services; this is critical to ensure connection with all communities including those with protected characteristics.

Contemporary, changing, and future needs

R23. Emphasise in the narrative how the proposals may give a better opportunity for future proofing with greater flexibility and increased resilience, including reference to the environment.

R24. Provide further detail on how a stronger place-based component will be promoted to enable a more sustainable service.

Digital, data and innovation

R25. Strongly pursue the availability of the London Care Record as well as EMIS (GP systems) across all services in the pathway to facilitate best decision making and patient care.

R26. During implementation, seeking involvement in potential innovations is strongly encouraged. The transformation provides an opportunity to enhance joined up working and explore further improvement changes in partnership with service users and providers.

Patient, carer, and public engagement

R27. Describe with greater clarity how the model differs from what currently exists, where people would receive their services and how these would connect to the wider system. This may be presented in the form of a patient journey and patient vignettes.

Workforce

R28. Further describe the workforce model that underpins the plans and how the plans address existing workforce challenges.

R29. Consider increasing the workforce ambition and including plans to develop leadership and commissioning opportunities. For example, influencing organisational development; promoting staff training and upskilling; ensure recruitment processes select staff with key competencies required in the new model.

R30. Describe how the proposed introduction of the funded Macmillan post will be built upon to provide a more substantial resource/ fully established team over a longer time to help lead implementation.

R31. Consider staffing in the context of anchor institutions, describing how partners will be encouraged and/or incentivised to recruit staff that reflect the local population.

R32. Consider how identifying time for training can improve workforce skills and retention. This could be a tool for improving retention and as part of the mitigation for the workforce risk (PCBC 10.3 table 54).

R33. Include further detail on the engagement eg Local Medical Committees (LMCs) and other key bodies.

Implementation

R34. Ensure proposed leadership and organisational development are aligned to coordinate implementation and that there is integration with non-specialist systems to provide a safety net for patients.

R35. As the plans are implemented, engage, and co-produce the relevant care models with the multiple communities to increase equity.

R36. Extend engagement of the voluntary sector beyond the local hospices.

4. Background

The North West London community specialist palliative care programme has been designed to develop and implement a future north west London model of care, working closely with residents, partners, and providers. The programme seeks to better join up health and care support for residents. It focuses on the building blocks that underpin service delivery: partnerships, pathways, digital and data, and estates¹.

Adult community-based specialist palliative care (CSPC) services are part of a larger group of services that support people at the end of life. They are designed for people who have complex, and specialist needs that cannot be met by general services such as general practice and community nursing alone. They assist people away from a hospital setting to have comfortable end of life with a network of services staffed by teams with skills and training in specialist palliative care. CSPC services do not include generalist palliative care or acute specialist palliative care services, but both work closely with CSPC provision to support best outcomes for patients².

A key driver to the programme was that Pembridge palliative care services inpatient unit was deemed unsafe due to poor staffing levels. As a result, care provision was suspended October 2018 and inpatient bed capacity was spot purchased from other providers in north west London³.

Subsequently, several key national and local developments have taken place:

- In 2019, the NHS Long Term Plan committed to improving personalised palliative and end of life care for people of all ages and to address health inequity⁴.
- In 2022, Integrated Care Boards (ICBs) received statutory guidance on palliative and end of life care underscoring the Health and Social Care Act 2022 requirement that ICBs have a legal responsibility to commission health services that meet their population needs⁵.

Since 2021, North West London Integrated Care Board has been working with its population to examine the opportunities to improve CSPC for the benefit of patients, families and carers for adults. This resulted in the publication of an Issues Paper *Community -based specialist palliative care improvement programme (2021)* detailing the ambition for everyone in north west London to receive the same high level quality care regardless of their circumstances⁶.

¹ NWL Terms of Reference, page 4, paragraph 1

² PCBC Executive summary, What is CSPC, page 8

³ NWL Terms of Reference, page 6, paragraph 1

⁴ NWL Terms of Reference, The National Context, page 3

⁵ NWL Terms of Reference, The National Context, page 3

⁶ NWL Terms of Reference, page 6&7

5. Approach to the review

The review was undertaken by the London Clinical Senate via Microsoft Teams on 5 March 2024, chaired by Heather Richardson, Director of Academic Learning and Action, St Christopher's Hospice with Marianne Leach, Consultant Paediatrician, St Georges University Hospital as vice-chair.

The Terms of Reference (Appendix G) for the review were agreed by representatives from both the London Clinical Senate and leaders from the North West London adult (18+) community-based specialist palliative care services improvement programme team (North West London Team).

The North West London Team requested specific advice and support from the Clinical Senate on:

1. Is the clinical case for change supported by best evidence and practice guidance?
2. Does the proposed new model of care and potential options for implementation improve the quality and outcomes for the community served?
3. Are the levels of stakeholder engagement and the processes for the engagement conversations held so far sufficient to support formal consultation process?

To ensure a complete and independent panel, representatives for the panel were invited from the London Clinical Senate Council and additional subject matter expertise was secured to complement and extend the panel membership.

All members were asked to sign a confidentiality agreement and to register their interests. Members considered conflicted did not contribute to the review. Whilst most Senate Review Panel members were able to attend on the day, some were unavailable due to unforeseen or unavoidable circumstances. Provision was made for these Senate Review Panel members to contribute electronically (Appendix D).

Upon receipt of the draft pre-consultation business case as well as other supporting documentation from the North West London Team (Appendix C), draft Key Lines of

Enquiry (KLOE) were produced by the London Clinical Senate (Appendix A). These were developed with reference to the *London Clinical Senate principles* and the *NHS 5 key tests for change*.

The KLOEs were discussed in a Senate Review Panel pre meet on 27 February, with subject matter experts commenting and enriching them to ensure a rounded exploration. They were then shared with the North West London Team, which in turn informed the content of their presentation on the day of the Panel.

The review was held on 5 March 2024 (Appendix B). The format was a presentation from the North West London Team (Appendix E) followed by questions from the Senate Review Panel. The review concluded with an opportunity for the Senate Review Panel to meet independently and draw together their conclusions.

To support North West London Team's desired timeline for consultation, an initial and informal discussion of the draft recommendations was provided on 15 March 2024 with an initial draft working document provided on 4 April 2024 for matters of accuracy checks.

6. Findings of the Senate Review Panel

The findings of the Senate Review Panel are aligned with the three key questions asked by North West London Team. An indication of the evidence considered, and the discussion of Panel is provided before the recommendation is made.

6.1 Is the clinical case for change supported by best evidence and practice guidance?

6.1.1 The proposals for Specialist Palliative Care in NWL have emerged from disparity of service provision and workforce challenges:

- 8 providers with mixture of charitable and NHS funding.
- Different historical commissioning arrangements leading to variable services.
- An inpatient unit being suspended for 5+ years due to staffing challenges.
- Some boroughs with multiple providers facing multiple acute sites.
- Some significant workforce challenges- as nationally.
- Different financial models.⁷

6.1.2 Against this backdrop, the North West London Team set out the reasons they were aiming to improve and increase the level of community-based specialist palliative care for adults (18+ years) in an Issues Paper *Community -based specialist palliative care improvement programme* (2021). This highlighted Specialist Palliative Care as the most fragile part of the palliative and end of life care services in NWL.

6.1.3 The case for change was evolved and refined in the pre-consultation business case⁸ shared with the London Clinical Senate. This stated:

“We identified 8 key issues that needed to be addressed:

We must respond to growing levels of need and changing population preferences.

We need to address inequality of provision between our boroughs - making sure that everyone receives the same level of care, regardless of where they live.

We need to reduce health inequalities.

We need to make care more joined up and easier to navigate.

We must respond to feedback and engagement and build on previous work.

⁷ See- London Clinical Senate presentation pack for 5.3.24 Final. Slide 2

⁸ Draft pre-consultation business case 29.1.24 (section2, pages 15-19)

We must make sure our services are aligned to nationally recommended standards and evidence.

We must ensure that our services are financially sustainable, both now and in future.

We must be able to recruit and retain a suitably skilled workforce, both now and in the future.”

6.1.4 The Senate Review Panel agreed that these were important principles which future service provision should meet. They also welcomed the vision: “To have more accessible community-based specialist palliative care provision that has a wider reach for our north west London population, with the expectation that this will contribute to a reduction in hospital admissions at end of life and improve integration of care”⁹.

6.1.5 The model of care emerging from the case for change seeks to combine national recommendations with local need. It was driven by a model of care working group, which was established in 2022 with half of the members being people who had either experienced bereavement or were providing care to people at the end of life. The other participants included clinicians and current providers of community specialist palliative care (CSPC) services in North West London Integrated Care System (ICS). The group drew on a range of key national policy documents, guidelines, specifications, reports, and resources to iteratively co-design the model of care with communities and service providers.

6.1.6 The Panel commended the approach, observing that there had been significant progress in thinking and planning across a broader space following the suspension of Pembridge inpatient unit, which had predominantly affected patient care in three boroughs in the north of the ICS.

6.1.7 The model of care has been built on firm foundations with the following principles or assumptions underpinning its development¹⁰:

- **“Demand modelling** over a 10 year period – we believe this planned model for bedded capacity will deliver over a 5 year period and we will need to plan beyond that whilst implementing
- Model of care is **the ‘what’ and not the ‘how’ deliver** – this important as each borough has different set up of integrated delivery of care with community health, primary care, social care.

⁹ Draft pre -consultation business case.29.1.24. Section 4.1 p26

¹⁰ See- London Clinical Senate presentation pack for 5.3.24 Final. Slide 7

- **Good engagement** with local partners – eg social care – boroughs to work through how to deliver.
- **Care homes**- We have sufficient beds – but not always the ‘right kind’ – and variable in engagement.
- Getting the **basics right** – we have sought to marry up ambition with deliverability. Acute view – would want to see single point of access – but not yet identified an operationalisable [sic] model.
- **Interdependencies** – where there are a) interface issues or b) improvements highlighted for universal services we have drawn these out. There is no widespread change to universal services needed to deliver this model.
- **Spot purchasing** - planned capacity means can meet in sector needs.
 - Retain our current ability to spot purchase outside NWL (assuming not utilising capacity already funded by another ICB). However minimal outside NWL flow. Non-palliative care spot budget available to reflect patient choice.
- **Neighbouring ICBs**
 - Disaggregated commissioning for Royal Trinity Hospice reflecting different approaches and model shared.
 - Good communication flow with NCL – eg re Marie Curie changes
- **Resilience.** Hospices working as a collaborative enables support and cover – several good examples of this.”

6.1.8 These principles for improvement were recognised as providing a strong case for change, although the Panel considered that some of them were met more robustly than others. They therefore recommended furthering the level of ambition in some areas to provide a stronger and more sustainable model.

6.1.9 The resultant proposed changes to CSPC services fall into three categories:

- Care in the home.
- Care in a community inpatient setting.
- Outpatient care and wellbeing.

6.1.10 The proposed community-based model was considered effective in improving the service enabling it to adapt swiftly to meet growing, changing and emerging needs in the local communities.

6.1.11 The Panel judged that the proposed new model was informed by a solid understanding of the evidence base, and that key NICE guidelines *End of life care for adults* (NG142) and *Care of dying adults in the last days of life* (NG31)¹¹ were being addressed within the proposals. There was also a clear intent to make improvements where the current service provision does not meet NICE recommendations equitably across the ICS footprint. The detail of where the proposals could be strengthened to meet the guidelines more comprehensively are included in the relevant sections of this report.

¹¹ See: <https://www.nice.org.uk/guidance/ng31> This guideline covers the clinical care of adults (18 years and over) who are dying during the last 2 to 3 days of life. It aims to improve end of life care for people in their last days of life by communicating respectfully and involving them, and the people important to them, in decisions and by maintaining their comfort and dignity. The guideline covers how to manage common symptoms without causing unacceptable side effects and maintain hydration in the last days of life.

6.2 Does the proposed new model of care and potential options for implementation improve the quality and outcomes for the community served?

6.2.1 Overview of the Model

The three main areas of service and proposed changes in the Model of Care are detailed in the table below¹²:

Service	Key Change
A) Care in the home	
Adult community specialist palliative care team	7-day service available 12 hours per day in all boroughs.
Hospice at home	Care available in all boroughs. 7-day service, available up to 24 hrs.
24/7 specialist phone advice	Consultant-led advice, available to anyone.
B) Care in a community inpatient setting	
Enhanced end of life care beds	Increase beds from 8 beds in Hillingdon to 54 beds across all our boroughs.
Specialist hospice beds	57 beds across existing operational sites. Improve access to them by increasing hours in which people can be admitted. Closure of Pembridge as a hospice inpatient unit.
C) Outpatient & Wellbeing Care	
Hospice MDT outpatient clinics	Increasing specialist clinics in Ealing & Hounslow to improve consistency.
Dedicated bereavement & Psychological support	A consistent care pathway in all boroughs offering one-to-one counselling & group sessions.
Lymphoedema	Expansion of service to care for cancer and non-cancer patients.

6.2.1.1 The proposed model promotes collaboration between universal services and hospices; the North West London Team advised that this ethos of joint working was established during the pandemic. The Panel recognised that the whole system offer and

¹² See- London Clinical Senate presentation pack for 5.3.24 Final. Slide 10

intention to equalise service provision across the ICS had the potential to improve the quality and outcomes for the community served.

6.2.1.2 They also reflected that services should be needs-based and sufficiently flexible to evolve to a modern delivery of palliative care, which recognises the many different trajectories of dying. The proposed model seeks to secure the fundamentals. NWL acknowledge it is not the most innovative model; it will therefore be important to iterate the model according to emerging evidence. There is potential to build on the proposals by drawing out the support for generalist services to improve the overall care provision, enabling non-specialists to develop competence and confidence in other areas of the services.

R1. Explore flexibilities to evolve into a modern palliative care model, emphasising the offer to patients with a range of diseases and conditions eg frailty, heart failure and chronic respiratory disease. The model described is predominantly a traditional community palliative care model, with its foundations in supporting people with cancer.

6.2.1.3 In line with NICE guidance (NG142- *Providing information recommendation 1.4*) there is provision within the proposed model for people to receive different levels of support and intervention during their illness as their needs change. This is critical given that evidence shows that lack of knowledge about end of life care services and poor communication with health and social care practitioners, are barriers to people understanding their treatment options and confidently making decisions about care.

6.2.1.4 There is opportunity to strengthen the model by building in plans to provide information to patients as part of the service design to support shared decision making and enhance experiences of care. This could be informed by the work in Hillingdon led by Harlington Hospice, particularly the use of digital innovation to enhance information and provide guidance to local people about what is available to them and when.

R2. Include further detail of information provision to patients as part of the service design.

6.2.1.5 Further attention may also be given to how the service design supports the needs of carers in line with NG150 *Supporting adult carers* (particularly 1.9.1-1.9.15 supporting carers when the cared for is at end of life and QS13 and QS5): “1.3.1 Local authorities, and social care organisations delegated by local authorities to carry out carers' assessments, should make arrangements for and carry out assessments in cooperation with other relevant health and social care organisations (in accordance with the Care Act 2014 and associated Care and support statutory guidance and the Children and Families Act 2014).”

R3. Further emphasise the support that the proposed service design will offer to carers.

6.2.2 Care in the home

6.2.2.1 The suggested model improves availability of service provision through the availability of an adult community specialist palliative care team in all boroughs 7 days a week 12 hours per day, and hospice at home 7 days a week for up to 24 hours. This was deemed a positive development.

6.2.2.2 It also proposes a 24/7 telephone service. This goes part way to meeting NICE recommendations and related quality standards on planning out-of-hours care (NG142 recommendation, 1.12, and QS13, statement 4), with recommendations for pharmacy provision still requiring attention.

6.2.2.3 The Panel felt that developing a single point of access for the service would be important; this is in line with the feedback the NWL Team received from acute colleagues. Whilst recognising the challenges of achieving this given a range of IT systems and different services providing telephone advice for community teams across the patch, the Panel recommend further work to ensure consistency in the operating models and to reduce the potential of inequity across north west London.

6.2.2.4 The Panel reflected that different stakeholders using the advice line would have varying needs and that clinicians taking calls must have access to appropriate information to be able to support and sign post effectively. Access to GP systems and London Care Record or Universal Care Plan are likely to be important. The model was explored with the North West London Team, and issues such as workforce and complementary work taking place with Non-Emergency Patient Transport Services contract were discussed.

6.2.2.5 The Panel were encouraged by the attempt for consistency, whilst proposing areas to further strengthen the proposal.

R4. Provide greater clarity on the role of the call centre, both who it is designed for (staff, carers, patients) and what it offers (beds management, medication, service navigation). Outline clear principles to reduce potential hand offs.

R5. Consider the demand for the call centre and undertake modelling to help ensure that the service does not become overwhelmed; this may be achieved through a pilot in the first instance as well as lessons learned from existing call centres/ pilots.

R6. Keep pursuing a single point of access for the call centre to enable greater equity, which may be possible with a tighter clarity on the purpose.

R7. Describe how the 24/7 planned phone service will be supported by out of hours pharmacy provision.

6.2.3 Care in a community inpatient setting

6.2.3.1 The two key components of community inpatient care in the proposed model are:

- Enhanced end of life care beds - which increase from 8 beds in Hillingdon to 54 beds across all boroughs.
- Specialist hospice inpatient unit beds- 57 beds intended to meet future need and with access increased by increasing hours in which people can be admitted.

6.2.3.2 The increase in Enhanced end of life care beds is a positive model and builds on the experience of the Harlington Hospice in Hillingdon; there are assumptions that the same model of care, advice and rehabilitation provided by Harlington Hospice will be available for all.

6.2.3.3 The proposals would benefit from describing in further detail the aspects of the Harlington Hospice service that they would like to extend. This includes further information and evaluation on how the Enhanced end of life care beds and other innovations might support actions elsewhere in the ICB eg upskilling GPs and Health Care Assistants. Further consideration or evidencing of the operational detail to ensure that this approach can be scaled across the wider ICB will be important to provide confidence in implementation.

6.2.3.4 The Panel noted that the community Enhanced end of life care beds place the GP as the responsible practitioner for growing numbers of people who can expect end of life care in care homes and for those who wish to remain at home. The NWL Team advised they had received feedback from GPs who felt that this should upskill and empower them, that it should support the relationship between GPs with patients and their families, leading to greater satisfaction as well as a reduced workload. It will be important to ensure that there is the capacity and skill to achieve this; further discussion and engagement will be required.

R8. Provide more detail when describing how the learning from innovations underway (Hillingdon Enhanced care beds) will inform the plans and help implementation.

R9. Describe the governance for the enhanced beds including model, role and responsibilities for GPs and Primary Care and how clinical issues will be communicated between different clinicians and stakeholders. (15- plus feedback from post review meeting)

R10. Provide assurance that the assumptions made of primary care and associated responsibilities for GPs are realistic and transferrable across the whole of the Integrated Care System (ICS).

R11. Describe the support, training, and resources available to Primary Care to enable them to fulfil their extended role in relation to Enhanced end of life care beds.

R12. Provide further assurance that there is capacity within the care home sector to deliver care via an additional 50 beds as per the current Harlington Hospice model in Hillingdon including consideration of potential unintended consequences eg reduced number of beds available to other frail elders requiring such care).

R13. Describe how the workforce skills and capacity are being developed to make the aspiration of the advice and rehabilitation model of care provided by Harlington Hospice a reality.

6.2.3.5 North West London ICB currently commissions 67 hospice beds, of which 57 are operational. Historically, 13 beds at Pembridge inpatient unit in the north of the ICB were suspended in October 2018. The equivalent of 3 spot purchase beds are now used. The demand and capacity calculations which assume an 85% occupancy conclude that this would provide a sufficient bed base for the immediate future but that after 2027/28 they would expect to adjust demand or capacity.

- 57 beds equates to an average of 2.73 estimated hospice inpatient beds per 100,000 population with a range of 2.29 to 3.28.
- 67 beds equates to an average of 3.21 estimated hospice inpatient beds per 100,000 population with a range of 2.29 to 4.05 with a higher than average bed provision in the tri-borough areas where Pembridge inpatient unit is located¹³.

Given the lack of national benchmarking to help determine the recommended number of inpatient beds for the ICS, the Panel felt that the capacity assumptions were reasonable, particularly in consideration of the equity of service provision and value for money. No concerns were raised regarding the balance of the overall total of inpatient beds to Enhanced end of life care beds.

6.2.4 Outpatient care and wellbeing

6.2.4.1 The two key components of outpatient care and wellbeing are described as:

¹³ Draft pre -consultation business case.29.1.24. Section 4.4 p29-30

- Hospice MDT outpatient clinics - Increasing specialist clinics in Ealing and Hounslow to improve consistency.
- Dedicated Bereavement & Psychological support - A consistent care pathway in all boroughs offering one-to-one counselling and group sessions.

6.2.4.2 The drive for increasing equity was welcomed by the Senate Review Panel. They explored the concept of the hospice MDT outpatient clinics with reference to the NICE guidance (especially NG142- *End of life care for adults: service delivery recommendation 1.9*). The description of the service offer in the pre-consultation business case is quite narrow; following discussion it was considered that the breadth and depth of the team may not be fully demonstrated in the written documentation.

6.2.4.3 The Panel considered that there should be a needs-based approach to the suite of services offered by health and social care professionals from the hospice and more widely, which recognises the expertise and high skill level required.

R14. Fully consider the need for specialist social care support within the specialist palliative care team following NICE recommendation 1.9 (NG142- *End of life care for adults: service delivery*).

R15. Provide more information on the proposed different services available across the patch provided by the hospices that meets complex/multiple needs including pain intervention clinics, specialist psychosocial and mental health support, breathlessness, and rehabilitation services. Confirm what is available via outpatient clinics/services. Consider patient pathway examples/ vignettes to illustrate this.

6.2.5 Outcomes

6.2.5.1 There is a clear driver for improvement expressed in the pre-consultation business case with proposed overarching benefits cited as improved quality of care for people at the end of life and improved value for money. Figure 13 in the PCBC details 4 intended outcomes:

- Improved patient and carer experience.
- Care is aligned to individual needs (improved personalisation).
- Inequalities of CSPC provision are addressed.

- More people die in preferred place of death. Fewer people die in hospital¹⁴.

6.2.5.2 The Panel considered that there are opportunities to better refine outcomes, and to identify specific measures to be captured. They recommend building a range of quality measures and outcomes (at population and patient /user reported levels, benchmarked, and reviewed across the patch) to help develop and improve the model to meet the breadth of needs across the diverse populations of north west London. A baseline assessment of key population and quality indicators across the patch could help elucidate areas of inequity which need prioritisation in the roll out of the model.

6.2.5.3 The Panel reflected on the limitations of preferred place of death as an outcome measure, given that people's views may change the closer they are to death and there may be valid reasons which restricts choice.

6.2.5.4 There was active discussion as to how to capture meaningful outcomes, including proposing reference to symptom burden and other patient/user related outcome measures aligned to focus on increasing quality in all the settings.

6.2.5.5 The Panel suggest that it would be helpful to consider patient related outcomes such as those available in the Outcome Assessment and Complexity Collaborative (OACC) suite of measures, attending to phase of illness, function, and symptom burden. This data can be aggregated a team, organisational, and system levels, and will augment other data regarding impact of palliative care such as admissions in final quarter of life, readmission rates, Emergency Department attendances and carer satisfaction.

6.2.5.6 Enhanced outcome measure could support benchmarking and enable continuous improvement. The Panel felt there are opportunities to take the proposed service model beyond equality of provision to providing equity of care. Further outcome data will be essential in indicating where resources might be appropriately moved to address the needs of more vulnerable populations.

R16. Provide additional indicators of clinical quality and other outcomes to establish a baseline of quality of care. Consider measures that indicate improvement in effectiveness of care and identify areas for sustained quality improvement.

R17. Monitor the intended rollout and implementation to redress current inequities across the geographical patch.

¹⁴ Draft pre -consultation business case.29.1.24. Section 4.12. Figure 13: Benefits mapping p39

6.2.6. Demographics and equity across the diverse populations of north west London

6.2.6.1 The model of care seeks to standardise service provision across the ICB. This improves accessibility compared to the status quo. However, the Panel heard that the concept of personalised care shone through in the feedback from the engagement process and that one size does not fit all. This will therefore require development going forwards.

6.2.6.2 It will be important to gain insights from the completed Integrated Impact Assessment to explore opportunities to better meet population needs, as well as consider distribution of resources for more vulnerable populations that may require support. This should include a full travel analysis including travel times with different modes of transport. In addition, boroughs will need to interpret the model for their local geography and population, supported by the local end of life forum and to guide the design, roll out and enhancement of the model.

6.2.6.3 Consideration will need to include a range of factors such as cultural competency as well as building and developing the range of end of life care pathways for conditions in conjunction with London networks. It will be important that there is a distinction between complexity and co-morbidity recognising that an individual may have complex care requirements with or without co morbidities.

6.2.6.4 There are also areas highlighted in NICE guidance that warrant consideration given the evidence that health inequalities are experienced by people who are homeless and who have learning disabilities.

6.2.6.5 The model provides greater opportunity to address and respond to culture and faith around death. It would be good to see this further enhanced. It will also be important to consider the potential for the proposed support for nursing beds model to fall short of meeting the needs of a numerically small younger cohort who have significant requirements.

R18. When the Integrated Impact Assessment is complete, explore opportunities to better meet population needs and consider distribution of resources for more vulnerable populations that require support.

R19. Consider broader accessibility and inequalities eg enabling people with learning disability, stroke, and other conditions to make informed choices.

R20. Include input by different cultural and faith communities to strengthen the proposals.

R21. Consider the model of care to ensure the needs of people of all ages are met, whilst recognising the Care Quality Commission registration requirements for different types of provision.

R22. Further describe how opportunities will be maximised to strengthen the concept of compassionate communities, engage community groups, their leaders, and the broader voluntary sector to bring together community action and professional services; this is critical to ensure connection with all communities including those with protected characteristics.

6.2.7 Contemporary, changing and future needs

6.2.7.1 The NWL Team outlined their methodology for calculating current and future need, noting that using current activity as the sole predictor of future activity is likely to be flawed, as there may be cohorts of people who feel excluded or who chose not to access services. They recognised that basing future projections on this could risk “baking in” inaccurate assumptions.

6.2.7.2 The challenge of finding a reliable alternative was also outlined by the NWL Team eg they explored obtaining data via the Association of Palliative Medicine but due to variation in bed counting, and interplay with wider services including community services, confidence in a realistic alternative projection was not possible.

6.2.7.3 An outcome of these challenges means that the NWL Team believe they can plan for this proposed model of care providing the right capacity for approximately 5 to 7 years before they will need to iterate. The Panel heard the NWL Team’s belief that the underpinning partnership ethos, relationships and established operational groups would enable them to build upon these solid foundations.

6.2.7.4 Intuitively, the Panel anticipated that a community facing model would demonstrate better environmental sustainability. They encourage the NWL Team to provide assurance that this has been fully explored, as well as considering adaptation to climate change and resilience plans for extreme weather events such as heat and flooding.

R23. Emphasise in the narrative how the proposals may give a better opportunity for future proofing with greater flexibility, and increased resilience including reference to the environment.

R24. Provide further detail on how a stronger place-based component will be promoted to enable a more sustainable service.

6.2.8 Digital, Data and Innovation

6.2.8.1 Digital, data and innovation are fundamental enablers to the service, important for governance, as well as targeting and reducing inequalities. There are many digital opportunities to support the implementation of these changes, examples being the sharing

of records, patient access to their own records and communication through the 24-hour help line. Further detail on digital opportunities to enhance the plans should be explored.

6.2.8.2 The Panel considered how the NWL Team were using technology to support the interface and collaboration between teams. An end of life dashboard is currently work in progress, supported by Whole Systems Integrated Care (WSIC) with plans to roll out Universal Care Plan data into care homes and hospices to enable individual support to patients. There appears an opportunity to build on work by Harlington Hospice in Hillingdon to create a shared patient record; this will be particularly supportive for the team leading the helpline.

6.2.8.3 The Panel felt that a single shared record would be key to the successful implementation. Achieving this may require support and prioritisation from the Integrated Care Board.

R25. Strongly pursue the availability of the London Care Record as well as EMIS (GP systems) across all services in the pathway to facilitate best decision making and patient care.

6.2.8.4 There is also the potential to give further attention to innovation to enhance equity. The suggested model focusses on getting the fundamentals right to achieve equality. Whilst the desire to ensure greater equality of provision across a patch that has historically experienced different service provision according to geography/postcode is welcomed, this approach denies opportunity to ensure greater equity, with particular attention to communities traditionally excluded/ living on the margins.

R26. During implementation involvement in potential innovations is strongly encouraged. The transformation provides an opportunity to enhance joined up working and explore further improvement changes in partnership with service users and providers.

6.3 Are the levels of stakeholder engagement and the processes for the engagement conversations held so far sufficient to support formal consultation process?

6.3.1 Patient, Carer, and Public Engagement

6.3.1.1 Engagement with the public has taken place over several years and has been extensive. This began in 2018 with the temporary closure of Pembridge inpatient unit and has continued to iterate.

6.3.1.2 A model of care group with residents and staff across the system has met weekly a total of 38 times to discuss and refine the proposed models, enabling detailed and completed conversations with a clear feedback loop. They developed a draft model of care which was tested with residents, with feedback prompting a greater focus on personalisation. Twelve patient and carer representatives contributed to the model of care group (approx. 50% of total membership).

6.3.1.3 A stakeholder steering group was also established with representation from two patient and carer representatives, representing a good percentage of the overall membership¹⁵.

6.3.1.4 There has also been a substantial level and range of feedback from the wider public with the engagement activities culminating in the publication of the engagement outcome report in March 2023 which fed into the development of the model of care¹⁶.

6.3.1.5 The NWL Team considered that it would not be possible to gain a representative voice of patients and carers to attend the Senate Panel review day, given their experience of different services and a range of perspectives. Ideally the Panel would have wished to explore the degrees of engagement with patient and carer representatives on the day but recognise and respect the rationale and decision taken.

6.3.1.6 The Panel wish to highlight the need for discussion with communities about their expectation of service provision to help ensure that people use the appropriate services for their needs at the right time.

6.3.1.7 There is potential risk of a gap between the offer (access criteria) and an individual's needs and wishes, which may change over time. There is often a desire from the public to be seen by the specialists in a particular field. Throughout public consultation it will be important to convey that while most patients do not require specialised care, the plans will improve services for all people at the end of life. This recognises that fundamental to the proposals is spreading knowledge and developing clinical competency

¹⁵ Draft pre -consultation business case.29.1.24. Section 15. Appendix C p90

¹⁶ Draft pre -consultation business case.29.1.24. Section 3.3 p22

across the whole system. For some people, effective coordination in primary care will better meet their needs than, for example, specialist inpatient care.

R27. Describe with greater clarity how the model differs from what currently exists, where people would receive their services and how these would connect to the wider system. This may be presented in the form of a patient journey and patient vignettes.

6.3.2 Workforce

6.3.2.1 The pre-consultation business case recognises the need to address workforce¹⁷:

“Meeting the changing needs of our population invariably means making sure we have a workforce model that responds to increasing demand. We will work with providers to develop a detailed workforce plan. Principles for how we develop this are that by working together:

- Providers will be better placed to make recruitment decisions that better serve the needs of our communities.
- Providers can share details about roles and opportunities to support internal progression, thereby supporting retainment within NW London.
- Providers can shape and deliver education and training programmes that make NW London an attractive place for people to work.
- Providers can discuss ongoing challenges to recruitment to collectively find solutions.”

6.3.2.2 The Panel recognised these as laudable principles, whilst also identifying the importance of attending to specific aspects within this.

6.3.2.3 The new model introduces different ways of working and has significant impacts on workforce. The North West London Team recounted that they had candid conversations with providers about feasibility as well as regular weekly meetings with Directors of Adult Social Services and Directors of Public Health and Local Authority Care home leads to ensure close working across universal services.

6.3.2.4 They consider that the model could provide attractive development opportunities to staff with roles with specialisms and enhancements and believe there is workforce availability and capability based on previous recruitment.

¹⁷ Draft pre -consultation business case.29.1.24. Section 4.3 p30

6.3.2.5 A key observation was that primary care are fundamental to the success of the model, particularly around Enhanced end of life care beds. Therefore, support from GPs and their local leadership body is critical to this change.

6.3.2.6 The Senate Review Panel recommended several areas to strengthen the workforce proposals:

R28. Further describe the workforce model that underpins the plans and how the plans address existing workforce challenges.

R29. Consider increasing the workforce ambition and including plans to develop leadership and commissioning opportunities. For example, influencing organisational development; promoting staff training and upskilling; ensure recruitment processes select staff with key competencies required in the new model.

R30. Describe how the proposed introduction of the funded Macmillan post will be built upon to provide a more substantial resource/ fully established team over a longer time to help lead implementation.

R31. Consider staffing in the context of anchor institutions, describing how partners will be encouraged and/or incentivised to recruit staff that reflect the local population.

R32. Consider how identifying time for training can improve workforce skills and retention. This could be a tool for improving retention and as part of the mitigation for the workforce risk (PCBC 10.3 table 54).

R33. Include further detail on the engagement eg Local Medical Committees (LMCs) and other key bodies.

6.3.3 Implementation

6.3.3.1 Implementation is addressed in section 10 of the pre-consultation business case, with the hope that implementation can commence in November 2024. The core team leading on this are described in 10.2.1.

6.3.3.2 Further outlining the governance mechanisms that will help ensure cohesive system improvements across the broad provider landscape would be beneficial. Inclusion and engagement of communities and voluntary groups to support conversations and co-design of the model to reflect marginalised or excluded groups, or currently unaddressed needs would strengthen the quality of care.

R34. Ensure proposed leadership and organisational development are aligned to coordinate implementation and that there is integration with non-specialist systems to provide a safety net for patients.

R35. As the plans are implemented, engage, and co-produce the relevant care models with the multiple communities to increase equity.

R36. Extend engagement of the voluntary sector beyond the local hospices.

Appendix A- Key Lines of Enquiry (KLOE)

The Clinical Senate developed Key Lines of Enquiry with reference to the London Clinical Senate Principles

DRAFT Key Lines of Enquiry (KLOE)

For Pre Review meeting discussion and development

v0.9

NHS North West London adult (18+) community-based specialist palliative care services improvement programme and proposed new model of care

The sponsor is requesting advice and support from the Clinical Senate to provide comment / advice on:

Is the clinical case for change supported by best evidence and practice guidance?

Does the proposed new model of care and potential options for implementation improve the quality and outcomes for the community served?

Are the levels of stakeholder engagement and the processes for the engagement conversations held so far sufficient to support formal consultation process?

Is the clinical case for change supported by best evidence and practice guidance?

You state “by 2040, demand for palliative care is expected to increase by 25% to 47%”. Does the proposed new model of care lend itself to demographic shifts? How will service provision be future proofed?

What would the model demand of support structure and service?

How, within the current proposal, could you enhance the community contribution to care- to reflect the sixth ambition “each community is prepared to help”?

Does the proposed new model of care and potential options for implementation improve the quality and outcomes for the community served?

How would the proposed model impact on younger adults and transition?

How do you see spot purchase arrangements impacted? Is there provision for this?

What working interface do you envisage between hospital services/secondary care and the new community model to:

Facilitate the innovations you propose e.g. rapid discharge.

Support a more integrated approach for patients moving between hospital and home/the community?

How will you monitor a balanced set of quality and outcomes – including cost effectiveness, measures of equality and equity, patient reported outcomes etc.

How are the mental health and wellbeing needs of patients and carers supported?

Are the levels of stakeholder engagement and the processes for the engagement conversations held so far sufficient to support formal consultation process?

What engagement has there been with neighbouring boroughs where there might be shared funding streams?

Are there any significant cross boundary flows to be aware of?

How have you engaged with social care, from an operational perspective?

How will the proposed model be maximised e.g. supported by conversations with the clinical team?

Subject Matter expertise

In addition to the questions posed above, we invited panel members to focus questions on areas of specialism. Initial questions, which panel members may add and refine on the day, is below:

Palliative Care – Voluntary and Community

<i>Heather Richardson (Chair)</i>
How do you envisage assisting patients, families, carers, and others navigate the system and confirm what is available to them?
Palliative Care- Secondary and Hospital interface <i>Polly Edmonds (Consultant in Palliative Medicine)</i> <i>Lucy Pain (Palliative Care Consultant)</i> <i>Maurice Cohen (Consultant geriatrician)</i>
What are the respective admission criteria for care home beds compared to hospice bed? What is nursing home bed availability across the area and how even is the distribution? Are there any plans to support generic nursing home beds (recognising that they are not part of this review)? How confident are you that care homes and particularly nursing homes across the patch are able and have capacity to become an integral part of the model? How will the new community-based model have flexibility in provision to meet: Elders' needs? Other diverse and broad needs within the NW patch including those intersectional in nature? A more equitable service, particularly for those currently excluded, marginalised or underrepresented in the palliative care population served? (geriatrician)
Public Health and Healthcare Inequalities <i>Gladys Xavier</i>

Given there will be different demographic needs across a large geography, to what extent does the spread of beds and community services match the need at place/ borough/ within the ICB (table 9).

How might work with the voluntary and community sector best support patients' diverse needs?

Primary Care

Sumeeta Dhir

Naureen Bhatti

How would the new model interface with primary care and established community nurses and social care support and capacity?

What plans and reassurance do you have that primary care and other community services can provide the input required 24/7 to complement the new model and support it, particularly in the 12 hours a day when specialist support is limited to telephone advice only?

What criteria will be in place to enable access 12-hour care being offered?

Pharmacy

Jas Khambh

How will pharmacy support be integrated to ensure:

Timely access to medicines around the clock

Opportunities to reduce overtreatment at the end of life (pharmacy)

Travel and Transport

Tim Edwards and others

What provision has been made for timely transfer of patients to and from hospital/hospice and home to facilitate rapid discharge where hospital care is no longer required? (LAS)

Have travel calculations considered the particular needs of this population, which may be longer than average travel time?
Allied Health Professionals <i>Adrian Capp</i>
Which elements of the model allow patients living with advancing illness to maintain function and achieve their goals, consistent with a rehabilitative focus? How will you promote this approach in the new model?
Anaesthesia & Pain Medicine <i>Natasha Curran</i>
Where do you envisage provision of interventionalist pain management? What plans are there to evaluate, improve and evolve the service continually after implementation?
Workforce <i>Liz Carty (desktop)</i> <i>Naureen Bhatti</i>
Please can you talk us through your workforce strategy: The model proposes extension from 5 to 7 days a week working in some areas. Is there a workforce plan that supports this? What are your plans around workforce retention? What training do you envisage for the different groups of staff who are vital to the success of this model? e.g. Care home staff. How as an anchor organisation/provider do you plan to support local communities with your workforce proposals? Is there support / protected time in place for training and development?

Health & Care in the Community

Pauline Fahy (desktop)

What are the options around hospice at home availability. What else is being offered? Can community nursing support?

How have you considered the local context – characterised by diverse population, extraordinary mix of providers across variable locations?

Is there any intention to support community response beyond professionals? How will they protect and support families and community partnerships?

Patient and Public Voice

Khushboo Patel

Lucy Brett

What have you learnt about what the community/communities would like to do to support people to die and grieve better in the area that could be complementary to the development of professional services?

How could you maximise these?

PCBC shows positive engagement. To what extent do those providing feedback reflect the demography of the wider population?

(3.6 table 7). How has the feedback received informed the proposals to date and what further needs to be done. Is there a clear plan/ confidence that this will happen?

How do the proposals recognise the potential future aging population with a growing number of conditions who are currently less likely to experience a good enough death and appropriate support in related bereavement or loss?

How have you addressed the cultural variations in attitudes towards death?

Infection Prevention Control/ Healthcare Science

Elaine Cloutman-Green

Whole system pathway/ unintended consequences <i>All panel members</i> How will the proposals facilitate a broad group of providers coming together at ICB level to develop a new approach that “does better things” and with a transformational focus? What leadership will you put in place to assist this? How resilient are your plans to cope with unexpected issues e.g. the potential closure of Marie Curie Hampstead or any other unexpected events in neighbouring Integrated Care Systems.
Evidence Base -Jade Stacey from NICE desktop
Environmental sustainability and moves to carbon neutral
Have you liaised with Greener NHS leads in your ICB to consider the proposals from a carbon and environmental sustainability perspective? How can the model reduce the overall carbon footprint? What consideration has been given to climate adaptation and resilience?
Innovation and Digital enablers What opportunities exist for digital enablement? Are you able to expand on how diagnostic and support services will support this model? What are your plans to share digital records across primary and secondary care? How can you ensure a seamless transition? Have any opportunities to work with virtual wards been explored? How have you considered the use of technology / innovation to provide better outcomes?

How do your plans integrate with other current work programmes like Universal Care Plan?

Appendix 1) London Clinical Senate Council Principles (For reference)

- ✓ Promoting **integrated working across health and across health and social care** and ensure a seamless patient journey
- ✓ Being **patient-centred and co-designed** (this includes patient experience, patient involvement in development and design of services)
- ✓ Reducing **inequalities** (this involves understanding and tackling inequalities in access, health outcomes and service experience, between people who share a protected characteristic and those who do not, and being responsive to the diversity within London's population)
- ✓ Demonstrating **parity of esteem between mental and physical health** for people of all ages
- ✓ Supporting **self-care** and **health and wellbeing** Improving **standards and outcomes** (these include use of evidence and research, application of national guidance, best practice and innovation)
- ✓ Ensuring **value** (achieving the best patient and population outcomes from available resources)
- ✓ Demonstrate how **environmental sustainability and moves to carbon neutral** are included in plans and developments. This includes reference to the National ambition to reach carbon Net zero by 2040 and the London Health Board ambition to ensure that every Londoner breathes safe air.

Appendix B - Panel Day Agenda

London Clinical Senate Review: NHS North West London adult (18+) community-based specialist palliative care services improvement programme and proposed new model of care AGENDA				
Date: Tuesday 5 th March 2024		Time: 09:00-13:00		
	Time	Description	Papers	Lead
1.	09:00	Convene on Teams and pre-meet <i>(Clinical Senate Panel Only)</i>		Heather Richardson , Chair of Review Panel
2.	09:05-09:30	Welcome and introductions - Key task/advice requested - Conflicts of interest declaration and confidentiality agreement - Setting the scene	Terms of Reference Key Lines of Enquiry (KLOE)	Heather Richardson , Chair of Review Panel
		Presenting team join the meeting		
3.	09:30-10:00	Presentation addressing the Key Lines of Enquiry: Summarising the strategic context, Case for Change, purpose of the proposed reconfiguration, clinical model and engagement	Presentation to be given on the day	Jane Wheeler NHS NW London Local Care Programme Director Dr Lyndsey Williams NHS NW London GP clinical lead for palliative end of life care and care homes
4.	10:00-11:45	Panel Questions and Answers in relation to Presentation between the clinical senate Panel and the Presenting team relating to key lines of enquiry and the presentation.	All documentation including PCBC and appendices	Heather Richardson , Chair of Review Panel
5	11:45-11:55	Presenting team leave meeting Panel break – 10 mins		
6.	11:55-13:00	Panel discussion and deliberation: Key findings, evidence base and emerging themes for recommendations	All documentation-including PCBC and appendices	Heather Richardson , Chair of Review Panel

Appendix C- Documentation provided by North West London ICB

Papers provided to Panel

- Review Terms of Reference
- Review Key Lines of Enquiry

Document Pack

Document Reference Number	Document Title
0	Clinical Senate key documentation checklist page with links to docs 31.1.24
1a	NHS NW London adult (18+) community-based specialist palliative care services improvement programme and proposed new model of care - London Clinical Senate - Terms of Reference
1b	NW London Palliative Care proposed timeline v0.3 Clinical Senate 7.12.23
2a	Draft NW London adult community-based specialist palliative care services pre-consultation business case <i>26.2.2024 NWL CSPC draft PCBC final submitted to Clinical Senate.doc (contains financial information)- available to panel on request</i>
3a	NW London community-based specialists palliative care Issues paper November 2021
3b	NW London community-based specialists palliative care summary issues paper November 2022
4a	North West London ICS community-based specialist palliative care for adults (18+): Co-designing a new, improved model of care January 2024

4b	North West London ICS community-based specialist palliative care for adults (18+): Co-designing a new, improved model of care August 2023
4c	North West London ICS community-based specialist palliative care for adults (18+): Co-designing a new, improved model of care summary August 2024
4d	North West London ICS community-based specialist palliative care for adults (18+): Co-designing a new, improved model of care one page infographic August 2025
5a	NW London community based Specialist Palliative Care Review Programme: Refreshed 10-year demand projections for hospice inpatient care 2023 to 2033 published January 2024
6	CQC reports for current providers of adult community-based specialist palliative care services in NW London: As of 26 January 2024
7	Schedule of evidence and best practice that have informed the proposals – No document
8a	NW London Adults (18+) community-based specialist palliative care programme Equality health impact assessment on the proposed model of care 24 November 2024
8b	NHS NW London Equality Health-inequality Impact Assessment Panel outcome for CPSC model of care review
8c	NHS North West London Adults (18+) community-based specialist palliative care programme Draft equality health impact assessment on potential options for the delivery of the model of care 11 December 2023
8d	NHS NW London Equality Health-inequality Impact Assessment Panel outcome for CPSC potential options for delivery of the model of care

9a	NW London ICS Health and Care Strategy 2023
9b	NW London ICS Health and Care Strategy summary 2023
10	Relevant Trust clinical strategies. No document
11a	NW London ICS Adult community-based specialist palliative care review engagement outcome report March 2023
11b	NW London ICS adult community-based specialist palliative care review. The proposed new model of care engagement outcome report January 2024
11c	NW London ICS adult community-based specialist palliative care review - How are we going to deliver the new model of care - potential delivery options? Engagement outcome report January 2024
11d	How are we going to deliver the new model of care for adult (18+) community-based specialist palliative care services (CSPC) in NW London? Next steps presentation
12a	NHS NW London CSPC programme risk log 29 January 2024
13	Assessment regarding sustainable healthcare considerations and carbon footprint. No document
14a	NW London CSPC Model of Care support letter - St Luke's Hospice 29 January 2024
14b	NW London CSPC Model of Care support letter - Royal Trinity Hospice 29 January 2024
14c	NW London CSPC Model of Care for community specialist palliative care – from CNWL [Central and North West London NHS Foundation Trust]

14d	NW London CSPC Model of Care support letter – Harlington Hospice
15	Financial information in PCBC. Second version of PCBC provided. Available on request.
16	Mapping of previous London Clinical Senate report (29 September 2020) recommendations against current NW London CSPC service improvement programme work
17	NW London Adult Community-based Specialist Palliative Care – our co-designed new model of care: London Clinical Senate 05 March 2024 (Slides from panel day)

Appendix D- London Clinical Senate Review Panel membership and declarations of interest

Name	Roles	Interests Declared
Heather Richardson	Chair of Review Director of Academic Learning and Action St Christopher's Hospice	None
Marianne Leach	Vice Chair of Review Consultant Paediatrician St Georges University Hospital	Nothing to declare
Naureen Bhatti	Retired GP – East London	Nothing noted
Lucy Brett	Chair, Patient and Public Voice Group London Clinical Senate	None
Adrian Capp	Head of Therapies, Queen Square Division University College London Hospital	Nothing noted
Liz Carty (contributed electronically)	Interim Local Postgraduate Dean, NHS England (London)	I am an employee of Barts Health I am seconded to NHS England as Interim Local Postgraduate Dean
Elaine Cloutman-Green	Consultant Clinical Scientist (Infection Control Doctor) Deputy Director of Infection Prevention and Control Joint Trust Lead Healthcare Scientist Honorary Professor, Department of Civil, Environmental and Geomatic Engineering, University College London	Nothing noted
Maurice Cohen	Deputy Medical Director and Consultant Geriatrician, North Middlesex University Hospital NHS Trust Clinical Director London Frailty Network NHS England (London)	None
Natasha Curran	Medical Director, Health Innovation Network Lead Implementation and Involvement Team Applied Research Collaboration (ARC) South London Consultant in Anaesthesia & Pain Medicine, University College London Hospitals	None

Sumeeta Dhir	Southwark GP Primary care clinical lead, Palliative and End of Life clinical network, NHS England (London)	None
Polly Edmonds	Consultant in Palliative Medicine Clinical Director Cancer and End of Life Care Chair, Palliative Medicine Specialist Advisory Committee King's College Hospital NHS Foundation Trust	None
Tim Edwards	Consultant Paramedic Clinical Directorate London Ambulance Service NHS Trust	None
Pauline Fahy (Contributed electronically)	Senior Programme Manager, Health & Care in the Community, NHS England (London)	None
Michael Gill	Chair London Clinical Senate. Consultant Physician, Non-Executive Director Homerton Healthcare NHS Foundation Trust	None
Mark Mason	Medical Director, Heart, Lung and Critical Care Clinical Group, Guys & St. Thomas' NHS Foundation Trust	None
Lucy Pain	Palliative Care Consultant, North London Hospice	None
David Parkins	Chair, London Eye Health Network NHS England (London)	None
Khushboo Patel	Patient and Public Voice Group member, London Clinical Senate	None
Jade Stacey (Contributed electronically)	Implementation Consultant- NICE Field Team (London & South East Region) National Institute for Health & Care Excellence	None
Gladys Xavier	Director of Public Health & Commissioning, London Borough of Redbridge	None

Notes

All Panel members completed Confidentiality and Register of Interests forms.
Where information was given, this has been included above.
Where members left their forms blank this has been transcribed as "nothing noted".

Appendix E – North West London Team

Name	Role
David Harman	Communications Manager, NHS North West London
Andrew Pike	NHS North West London Programme Communications Lead
Michelle Scaife	NHS North West London Local Care, Programme delivery manager for Last phase of life
Jane Wheeler	NHS North West London Local Care Programme Director
Dr Lyndsey Williams	NHS North West London GP clinical lead for Palliative End of Life Care and Care homes

Appendix F- Glossary

This glossary includes frequently used definitions and key concepts that are pertinent to the report. It also confirms the terminology used to describe different groups involved in the process.

We have sought to ensure that all words are written in full before an abbreviation is used in the text. If we have included a quoted which has used an abbreviation, we have included the full word/s in square brackets that follow.

The definitions below have been defined from several sources:

- Where the word or phrase is included in the glossary of the Draft PCBC this has been repeated.
- Where there is a helpful definition readily available by a reputable source on the web, this has been linked
- Other definitions have been agreed with the chairs of the review.

Term	Definition
Bed days	Bed days are the number of days a patient spends in a hospital, hospice, or healthcare facility as an admitted patient staying overnight. For example, if someone is admitted and stays for 3 days, that's counted as 3 in-patient bed days. This is used to see how long patients stay in beds for medical care. The individuals and organisations who commission or oversee these services use bed days as a way to measure and manage healthcare resources. It helps them understand how efficiently hospices and hospitals are working. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Co-design	Co-design is the method of involving users (people), stakeholders (decision makers) and practitioners (front line staff) in the process of service design. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Care Quality Commission (CQC)	The Care Quality Commission is the independent regulator of health and social care in England. Care Quality Commission (cqc.org.uk)
Community-based specialist palliative care (CSPC)	Community-based specialist palliative care refers to providing specialised care for individuals with life-limiting illnesses and those close to them outside of a hospital, typically in their own homes, care homes, or hospices. These services aim to manage symptoms, enhance quality of life, and provide support during the end of life process. The

	goal is to collaborate with patients and their loved ones, tailoring care to meet their specific needs and wishes, and ultimately improving the overall quality of their life and death. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
EMIS (originally Egton Medical Information Systems)	Clinical software used by many GP practices
End of Life Care	End of life care is a specific type of care for individuals nearing the final stages of their life. It aims to ensure comfort, dignity, and support, managing symptoms and providing emotional and practical assistance. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Generalist palliative and end of life care	Generalist palliative and end of life care is the fundamental level of palliative and end of life care support provided by healthcare professionals such as a general practitioner (GP), community nurses (including district nurses), care home staff, therapists, domiciliary home care staff (for example care agency staff either arranged by the council, through continuing health care or privately) and hospital ward staff who have a general understanding of and training in palliative care. They provide support to patients with serious illnesses or nearing the end of life in their usual place of residence (which may be their home, a care or nursing home or a sheltered housing facility) or a medical facility such as a hospital or hospice. The majority of people with life-limiting and advance illness will only need this level of support through their journey of palliative and end of life care. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Home and usual place of residence	What we mean when we say home or usual place of residence is a place in the community where a patient live most of the time and feels comfortable. It's where a patient has their own space and belongings and normally live most of the time/ spend the majority of their days and nights. It's the place you call home. It could be an apartment, house, hostel or shelter, dedicated care setting (care home (nursing, residential, learning disability care home), sheltered housing and supported living accommodation and mental health facility) where you have a consistent living arrangement at this place. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)

Integrated Impact Assessment (IAA)	An Integrated Impact Assessment is a process that brings together a variety of impact assessments on health, equalities, travel and access, and sustainability.
Integrated Care Boards (ICBs)	Integrated care boards (ICBs) replaced clinical commissioning groups (CCGs) in the NHS in England from 1 July 2022. An integrated care board (or ICB) is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Integrated care systems (ICSs)	Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. The NW London ICS consists of all NHS organisations and local authorities in NW London. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
In-reach	In-reach health services are medical services that are delivered to patients who are already admitted or residing in a particular healthcare setting, like a hospital, nursing home, or hospice. Instead of patients going out to seek medical care, the care comes to them within the confines of the facility where they are receiving care or residing. This approach aims to enhance patient access to necessary medical attention, convenience, and continuity of care while minimizing the need for external transfers or travel. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Key Line(s) of Enquiry KLOE	In this context the key lines of enquiry are the questions or areas that the Senate Review Panel identified for exploration with the North West London Team. These were shared in advance of the review day and explored further on the review day.
Local Medical Committees (LMCs)	Local Medical Committees are local representative committees of NHS GPs. They interact and work with the General Practices Committee and well as other branch practice committees and local specialist medical committees

	in a variety of ways, including conferences and in providing guidance for practices. Local medical committees (bma.org.uk)
Multidisciplinary teams (MDT)	A Multidisciplinary Team (MDT) is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Model of care	A model of care is a framework that explains what care will be provided and how services work together to deliver care that meets the needs of the population and incorporates best practice. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
NICE	National Institute for Health and Care Excellence NICE are the experts in evidence-based best practice and value for money. Their core purpose is to help practitioners and commissioners get the best care to patients, fast, while ensuring value for the taxpayer. They do this by: • producing useful and usable guidance for health and care practitioners • providing rigorous, independent assessment of complex evidence for new health technologies • developing recommendations that focus on what matters most and drive innovation into the hands of health and care practitioners • encouraging the uptake of best practice to improve outcomes for everyone. Who we are About NICE
North West London Team/ NWL Team	The representatives from north west London community specialist palliative care programme who contributed to the review by providing documentation and on the review day. See appendix E for details of members.
Outcome Assessment and Complexity Collaborative (OACC)	The Outcome Assessment and Complexity Collaborative (OACC) is a validated suite of outcome measures that is aimed to measure, demonstrate, and improve care for patients and families.

Palliative care	Palliative care is a treatment, care and support approach that focuses on improving quality of life by managing symptoms, relieving pain, and addressing the side effects of a patients' condition. It also provides support for emotional and practical needs, along with those of family, friends and care givers. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Patient outcomes	Patient outcomes are the results from care and treatments patients have received whilst in hospital, other clinical or care settings. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Pre-consultation business case (PCBC)	The pre-consultation business case (PCBC) is the legal document on which the commissioner decides to consult. Therefore, it must contain all the information they need to make this decision. The PCBC is also used to inform assessment of proposals against the government's four tests of service change, NHSE's fifth test, and other best practice checks. (Major service change: An interactive handbook. NHS June 23. Available from NHS Futures.)
Personalised care planning	Personalised care and support planning is a series of facilitated conversations in which a patient, their family or those close to them can actively participate in exploring the management of the patients' health and well-being within the context of their whole life and family situation. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Senate Review Panel/ The Panel/ Panel	The group of people who contributed to this review including London Clinical Senate Council member, London Clinical Senate Patient and Public Voice members and subject matter experts in Palliative Care. See appendix D for details of members.
Specialist palliative and end of life care	Specialist palliative and end of life care is an advanced and specialist level of palliative and end of life care provided by expert health care professionals who have received specialised training in this field. Care is provided by a specialist palliative care multi-disciplinary team (doctor, nurse, therapist) who work with your regular care teams in the community to provide additional support and guidance for complex symptoms and challenges.

	This type of care is required by individuals with advanced and life-limiting illness that have complex needs (can be medical and social). This care is usually provided in special palliative care units, hospices, or at home/ usual place of residence via the specialist multi-disciplinary team across services. This type of specialist care is not required by everybody with palliative care needs and at the end of life. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Universal Care Plan (UCP)	The Universal Care Plan (UCP) is an NHS service that enables people living in London to have their care and support needs and preferences digitally shared with healthcare professionals across the capital. It is the recommended platform for urgent and end of life care plans in NW London and London. (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Unknown patients	By 'unknown' patients, we mean patients who have not previously received care from community specialist palliative care services (and are therefore not registered with, or are unknown, to the services). (Draft pre-consultation business case 29.1.24. Section 17, Appendix F)
Whole Systems Integrated Care (WSIC)	The Whole Systems Integrated Care Dashboards are a suite of tools available to clinicians and care professionals who are providing direct care to patients. The WSIC Dashboards provide a linked integrated summary of patient's health and social care which can be used to case find and case manage patients who require more targeted and proactive care. The Dashboards aim to support clinical staff in improving timeliness and quality of care for patients across NWL London. Whole Systems Integrated Care (WSIC) :: North West London ICS (nwlondonicb.nhs.uk)

Appendix G- Terms of Reference¹⁸

NHS NW London adult (18+) community-based specialist palliative care services improvement programme and proposed new model of care

London Clinical Senate

Terms of Reference

Date: 22 December 2023

Email: england.londonclinicalsenate@nhs.net

Web: [www. Londonsenate.nhs.uk](http://www.Londonsenate.nhs.uk)

¹⁸ Terms of Reference wording is consistent with original but for clarity, formatting changes have been made for inclusion in this appendix.

INDEPENDENT CLINICAL REVIEW: TERMS OF REFERENCE

Title	NHS NW London adult (18+) community-based specialist palliative care services improvement programme and proposed new model of care.
Sponsoring Organisation:	NHS North West (NW) London Integrated Care Board
Clinical Senate:	London Clinical Senate
NHS England regional or team:	NHS England – London
Terms of reference agreed on behalf of the London Clinical Senate by:	Dr Mike Gill, Chair, London Clinical Senate Council
Terms of reference agreed on behalf of NHS NWL	Jane Wheeler, Director of Local Care, NHS NW London
Date	22 nd December 23

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1. Background

Background provided by North West London ICB:

Palliative care services are designed to address and meet the health and care needs of people with a terminal diagnosis and/or fewer than 12 months left to live. Adult community-based specialist palliative care (CSPC) services deliver for such patients with specialist needs in hospices and the community, and support relatives, carers and people who are important to patients.

National context

The 2019 NHS Long Term Plan committed to improving personalised palliative and end of life care for people of all ages and to address health inequity. In 2022, ICBs received statutory guidance on palliative and end of life care underscoring the Health and Social Care Act 2022 requirement that ICBs have a legal responsibility to commission health services that meet their population needs. Building on *Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026*, it sets out 6 ambitions from the perspective of a person nearing the end of life:

Ambition 1	Ambition 2	Ambition 3	Ambition 4	Ambition 5	Ambition 6
Each person is seen as an individual	Each person gets fair access to care	Maximising comfort and wellbeing	Care is coordinated	All staff are prepared to care	Each community is prepared to help

Figure 1: Ambitions for palliative and end of life care.

Local context

North West (NW) London ICS Strategy

North West London currently

Our ICS strategic priorities support our intention to review and improve provision of community specialist palliative care (CSPC) in the following ways:

NW London Strategic Priority	How CSPC review responds to strategic priorities of the ICS
Support health and wellbeing for our population	The programme has reviewed provision of services at the end of life from the perspective of patients, carers and families. Our Model of Care sets out how we will support all of these groups, in line with local needs and best practice for these services.
Address unwarranted health inequalities	The programme has examined the variation in CSPC provision within our boroughs. Our Model of Care set out how we will reduce inequality of provision and ensure high-quality services across all Boroughs.
Improve access to care	In addition to ensuring equitable access to high-quality services (see line above), we have assessed the accessibility of our inpatient services to ensure that this is not adversely affected by other changes.
Keep people at home wherever possible and ensure far more integrated/joined up services, particularly for our older people	Our Model of Care includes a comprehensive suite of home-based and community-based palliative care services, including 'hospice at home' provision, alongside hospice inpatient services. It also includes holistic assessment of patient needs, and subsequent co-ordination of care provision, by a specialist palliative care team.
Support babies, children, and young people to lead happy and healthy lives, and become happy and healthy adults	Not applicable. This programme relates only to adults.

Ensure our health and care system is as productive and high quality as it can be	As part of the programme, we have assessed both what CSPC services should be provided in NWL in order to ensure high-quality care, and what level of provision will be needed to meet population needs (ensuring value for money).

The transformation programmes described in the NW London ICS strategy include the ‘Local Care programme’ which is responsible for improvements in palliative care. The programme seeks to better join up health and care support for residents. As such, the programme also focuses on the building blocks that underpin service delivery: partnerships, pathways, digital and data, and estates.

The NW London Community Specialist Palliative Care Programme will develop and implement the future NW London model of care, working closely with our residents, partners and providers.

The current provision of these services in NW London is a complex arrangement of commissioning, including lead commissioner arrangements, and joint funding with non-NHS providers. These providers have mixed funding models:

- **NHS funded providers** - Central London Community Healthcare NHS Trust (CLCH), Central and North West London NHS Foundation Trust (CNWL) and London North West University Healthcare NHS Trust (LNUH).
- **Combined NHS and charitable funded providers** - St Luke’s Hospice, Marie Curie Hospice, Harlington Hospice, Royal Trinity Hospice and St John’s Hospice.

The link between service providers to North West London and our eight boroughs is described below:

Borough	NW London’s commissioned community-based specialist palliative care service providers by borough 1 April 2023- 31 March 2024
Brent	• St Luke’s Hospice • Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services • St John’s Hospice
Ealing	• London North West University Healthcare NHS Trust providing Meadow House Hospice
Hammersmith & Fulham	• Royal Trinity Hospice • Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services • St John’s Hospice

Harrow	Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services
Hillingdon	- Harlington Hospice (including provision of Michael Sobell House in-patient unit at Mount Vernon Hospital) - Central and North West London NHS Foundation Trust
Hounslow	London North West University Healthcare NHS Trust providing Meadow House Hospice
Kensington & Chelsea	- Royal Trinity Hospice - Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services - St John's Hospice
Westminster	- Royal Trinity Hospice - Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services - St John's Hospice

Case for change:

Details regarding the Adult community- based specialist palliative care (CSPC) review were published in November 2021 by [North West London Integrated Care System \(NW London ICS\)](#) published an [Issues Paper](#) that set out eight reasons why community-based specialist palliative care services for adults needed to be improved in North West London, if everyone was to receive the same high level quality care regardless of their circumstances.

These eight reasons were to:

1. Build on the valuable learning and feedback received from previous reviews of palliative care services carried out in Brent, Hammersmith and Fulham, Kensington and Chelsea, Westminster and further engagement activity carried out in Ealing, Harrow, Hillingdon and Hounslow.
2. Align with national policy such as the national Six Ambitions for Palliative and End of life Care and the NHS triple aim of improving access, quality and sustainability.
3. Address the changing demographics and needs of patients. The number of deaths within England and Wales will rise by an additional 130,000 deaths each year by 2040, and more than half of which will be people aged 85 years or older leading to increased need for community-based specialist palliative care.
4. Tackle health inequalities and social exclusion, which act as a barrier to people receiving community-based specialist palliative care.

5. Address variation in the quality and level of community-based specialist care that patients, families and carers receive across NW London which means not all get the support they need and are able to have their wishes supported at the end of their lives.
6. Some of our services are fragmented, not joined-up and do not work well together - not all services having access to clinical information held electronically by other providers. People sometimes find services hard to access, particularly across our more diverse communities, which cannot continue.
7. Take into account the increasing financial challenge the NHS is operating under and what it means for community-based specialist palliative care.
8. Recognise the difficulty we are having finding, recruiting and retaining a suitably qualified workforce and the knock on effect for service delivery. Local data on exact staff shortages among our providers is not available but it is frequently reported in discussions.

An underpinning issue is that provision of hospice inpatient care at Pembrooke palliative care services inpatient unit was deemed unsafe due to poor staffing levels in 2018. As a result, care provision was suspended in October 2018 with patients instead accessing inpatient care through other providers to North West London via spot-purchase of this additional hospice inpatient bed capacity.

The [Issues Paper](#) was designed to facilitate discussions between patients, families and carers, clinicians and stakeholders. We wanted people to tell us of their experiences and we wanted to jointly agree what high quality, safe, equitable care looks like and just as important what excellent patient experience looks like.

Following a widespread engagement exercise we published an [engagement outcome report](#) that contained all of the feedback given following discussions with local residents and those who have first-hand experience of palliative and end of life care received in NW London.

Turning the case for change into action

In 2022 a model of care working group was set up by the NW London ICS to co-produce a model of care with the input of bereaved people, carers, clinicians and providers. The intention was to respond to the issues highlighted above. The group met 38 times, successfully concluding their discussions in June 2023. The output of this group, the proposed new model of care describes the level of care that all residents should expect to receive, not where or how these services will be delivered.

The resulting model of care has also been agreed by the [NW London community- based specialist palliative care steering group](#).

We subsequently published the [proposed new model of care](#) in late August 2023 and have continued to engage on it with our residents, boroughs and stakeholders over September and early October 2023.

By and large there was good support for the proposed new model of care, however we did hear some valuable challenge and constructive suggestions on how we might improve the model, which we are committed to considering and potentially incorporating as part of the model's improvement process.

The following are some of the key themes arising from engagement on the proposed new model of care that will be considered in refining the final model:

- Improved navigation of services
 - Emphasis on simplifying the complex journey through palliative care services and the wider health and care system for patients, family/ carers and clinicians to make the services more accessible to those in need, which could include enhanced information resources for accessibility and navigational assistance for example a single point of access at NWL or local “place” level.
- Enhanced Care Coordination and Integration of services:
 - Emphasis on the need for more seamless transitions between acute and community services, through more integration and co-ordination across acute specialist and community specialist palliative care services, but also within realm of community palliative care services itself (spanning both generalist and specialist care providers) and social care services, particularly at local “place”.
 - Fostering collaboration and improved communication among healthcare professionals to support a localised, patient-centred approach with named care coordinators or a dedicated care co-ordination service/function to improve the overall patient experience and bridge gaps between generalist and specialist care
- Addressing Inequalities:
 - Emphasis on the need to address disparities in access to palliative care service healthcare provision, ensuring that all individuals, regardless of their background or circumstances, receive the same level of high-quality palliative care. Call for more tailored strategies for different communities, considering geographic, socioeconomic, and cultural factors to demonstrate model will support addressing these disparities.
- Enhancing innovation and continuing improvement alongside new MOC implementation:
 - Emphasis on improving the model by exploring innovative initiatives, drawing on local, regional and national pilots underway. Making sure the current model has openness to testing the below ideas (which currently do not have robust evidence to support them being included in the current model) as pilots, whilst the model is

being implemented. To enable evaluation of their effectiveness and support evolving the model over time, making make sure that palliative care services continue to adapt and improve to meet the evolving needs of the NW London communities and any possible future requirements from NHSE:

- Emergency department support via in-reach and rapid response, with aims to reduce admissions
 - co-ordination service
 - single point of access
 - virtual hospice (which could include specialist MDT support)
 - support for rapport discharge
- Improved leadership and governance:
 - Emphasis on robust leadership and governance structure to guide the transformation and for accountability and sustainability of the new care model.
 - More information about enhanced end of life care beds
 - Emphasis on there needing to be more detailed and clear explanation of what exactly is being offered in terms of these beds and how they will be made available to ensure that they effectively meet the needs of patients, to ensure that assurances are given that these beds are a suitable and high-quality option for patients, rather than being seen as a subpar substitute for traditional hospice inpatient care.

The proposal

We believe the proposed new model of care offers the opportunity to improve the level and scope of community-based specialist palliative care in every borough in North West London.

The new model shows “what good care should look like” for adults (18+) across NW London. Some of these services already exist across all boroughs, while others are new additions and will level up the standard of care. This is particularly significant for boroughs where the services currently do not exist or there is significant variation for boroughs.

The model covers a wide range of community-based specialist palliative care services that will help patients to stay in their own home or usual place of residence, whilst allowing them the flexibility to move to a different care setting if needed. It increases the range and number of inpatient bed care options available by introducing enhanced end of life care beds, for people with less complex specialist palliative care needs who still require inpatient care. This is on top of the existing hospice inpatient beds currently in place and projected to be required over the next five to ten years.

The model also includes an extension of a number of existing services to level-up provision and availability across all eight NW London boroughs, including:

- Extended provision of 24/7 telephone advice lines for existing and unknown patients

- Extended days and hours of care provision (7 day services, 8am to 8pm a change from 5 day services 9 to 5pm) by community specialist palliative care teams
- Increased support to care homes from community specialist palliative care teams
- Expansion of Hospice at Home services to all boroughs (currently have 3 of 8 boroughs without this service available at all), with an expansion of current service offer to routinely support up to 24-hour care in patients' homes if needed
- The introduction of new common standards for psychological and bereavement support services
- Expansion of lymphoedema services, to ensure that we have non-cancer and cancer lymphoedema support available for all boroughs.

Specific recommendations

The model of care working group have collectively agreed and recommended a set of core services for community-based specialist palliative care provision that NW London residents can expect to receive regardless of the borough they live in. Some of these services are already available to all boroughs, while others are new additions for some boroughs and will raise the standard of care where these services do not exist or vary a lot.

While hospice inpatient beds remain a vital part of the offer, the model of care working group recommends strengthening other aspects of our services to enable more individuals to be supported at home and have their end of life wishes fulfilled.

The recommended model of care has three key service areas, each providing different services to meet patient needs. These would deliver the following for all NW London adult residents for the first time:

Service area 1: Care at home

- Adult community specialist palliative care team:
 - 7-day service with working hours of 8 am - 8 pm – this is a change from 9am - 5pm working hours and some services (Harrow) only operating 5 days a week at present.
 - Increased support to care homes – common core level of training and support.
- Hospice at home:
 - Supporting up to 24-hour care at a patient's home (including overnight sitting services) in close collaboration with usual community care teams. This is currently not being provided across all existing services.
 - Expansion of services to additional boroughs currently without this service: Hammersmith & Fulham, Ealing, and Hounslow.
- 24/7 specialist telephone advice line:

- A common core service for patients who are already known to community-based specialist palliative care services as well as those who are unknown patients.
- This is a change from current 24/7 specialist palliative care advice line services, which in the main only support known patients and have variation in the level of advice and support offered.

Service area 2: Community specialist in-patient beds

- An increased number of beds in the community, which includes dedicated enhanced end of life care beds available across all of NW London for patients who either do not require a hospice bed but cannot stay at home due to medical and social needs, or who do not wish to stay at home, or who do not want to, or do not meet the need to be in a hospital.
- Maintaining the current number of operational hospice in-patient unit beds to support our patients with the most complex specialist palliative care needs.

Service area 3: Hospice out-patient services, hospice day care services and well-being services (including psychological and bereavement support services for patients and families)

- Whilst all our boroughs currently have access to hospice out-patient clinics, hospice day care services and well-being services via their local providers, variation in the level of support provided was identified. We aim to make sure hospice out-patient multidisciplinary team (MDT) clinics (including but not limited to medical and nursing clinics, rehabilitation via therapists, and dedicated lymphoedema services) deliver the same core level of service. This refers particularly to the boroughs of Ealing and Hounslow where doctor and nurse led clinics are currently not available via Meadow House Hospice, as well as Harrow where there is currently a gap in provision of lymphoedema services for non-cancer patients. We propose to expand lymphoedema service provision for these non-cancer patients in Harrow.
- We aim to make sure well-being services (including hospice day care support groups, family and carer practical support and education, complimentary therapies, and dedicated psychological and bereavement support services deliver a core level of service. Particularly for psychological and bereavement support services for patients, their families, carers and those important to them which includes a more streamlined pathway to access these services, increased personalisation of care for example offering one-to-one and group sessions, face-to-face and virtual support, and increased cultural and spiritual sensitivity to delivery of this care and support. While all boroughs currently have access to some psychological and bereavement services, this varies in level of support.

The key enablers that will help us deliver the new model of care

A key feature in the feedback we received from local people was the need to make sure we put in place effective ways of working and the systems and processes that are needed to support the delivery of high quality palliative and end-of-life care. There was a particular emphasis on the need to reduce health inequalities, have a palliative care workforce (generalist and specialist) that is both sustainable and understands the cultural and faith requirements of our diverse communities.

We have identified five key enablers that we will need to develop and put in place to support the successful implementation and delivery of our recommended new model of care, and achieve the improvements in care we are able to deliver:

- Workforce development
- Reducing inequalities
- Data, digital and technology
- Organisational development
- Leadership, governance and integration

Work is being undertaken to scope and define the various task and finish groups for each of the enablers between September and October 2023.

Engagement and progressing to options for delivery of the proposed new model of care

Since the release of the proposed model of care in late August 2023, we have undertaken engagement seeking input from the public on the proposed new model of care throughout the summer and early October 2023.

However, engagement on the overall model of care will continue beyond this as we progress to business case development, potential public consultation and implementation of any agreed changes.

We have also:

- Developed a long-list of options for delivery of the new model of care with the steering group then conducting the initial shortlisting.
- We know that many of the 54 longlisted options will not deliver the level of change we know is needed, and so they would not be acceptable to our residents
- We therefore applied four 'hurdle criteria', developed by the NW London CSPC steering group, to ensure that we systematically eliminated options that would not deliver the outcomes we want
- We have been engaging on these options with our residents throughout November 2023.

Next steps:

- There have been a number of delays to the programme as we have sought to maintain an open engagement approach. We had hoped to be able to discuss the business case with the senate earlier in the Autumn.
- During winter 23/24 we are intending to publish a revised version of the proposed new model of care incorporating the feedback from this engagement.
- We have been advised by a number of our Local authority overview and scrutiny committees that they would like a full public consultation process around the proposed options for delivery of the proposed new model of care. We are therefore applying to the London Clinical senate for their advice and guidance to support the assurance process which is required to commence a full public consultation later this year, which will be subject to approval from local borough Overview & Scrutiny Committees/ NW London Joint overview and scrutiny committee.

2. Aims of the review and advice requested

The Clinical Senate will review the draft PCBC in advance of submission of the final PCBC to NHSE in accordance with the major service change assurance processes.

This planned approach will enable **NHS NW London** to make best use of Clinical Senate advice and recommendations, integrating them where appropriate into the final version of the PCBC, prior to the assurance process.

In accordance with the agreed timeline, the draft PCBC will be provided to the clinical senate no later than midday 29/01/24.

Specific areas where advice is requested from Clinical Senate:

NHS North West London are requesting advice and support from the Clinical Senate to provide comment / advice on

- a. Is the clinical case for change supported by best evidence and practice guidance?
- b. Does the proposed new model of care and potential options for implementation improve the quality and outcomes for the community served?
- c. Are the levels of stakeholder engagement and the processes for the engagement conversations held so far sufficient to support formal consultation process?

3. Scope of the review

[“Planning, assuring and delivering service change for patients”](#) (NHS England, updated March 2018) requires NHS England to be assured that any proposal for major service change or reconfiguration satisfies four tests set by the Government in 2010:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base

- Support for proposals from commissioners

In 2017 the NHS Chief Executive introduced a 5th new patient care test for hospital bed closures, specifying that alternative provision is in place before any beds are closed.

The clinical senate's advice will be focused on the third test of clinical evidence and the fifth 'beds' test as relevant. It is also cognisant of London Mayor's tests and encourages commissioners to consider their response to these in developing their Consultation Business Case

The London Mayors 6 tests, introduced 6 tests in 2017 were designed to ensure that the changes are in the best interests of Londoners. These are conditions that must be met before the mayor will support any major health and care transformation or service reconfiguration in London.

The 6 areas, which are considered post consultation are:

- Health and healthcare inequalities
- Hospital Beds
- Financial investment and savings
- Social care impact
- Clinical Support
- Patient and Public Engagement

These were refreshed in late 2022, with key changes being:

- Strengthening the health inequalities test and additional supplementary question that highlights the role of the NHS
- Recognising new opportunities afforded through the use of digital healthcare within the Hospital Beds test.

In Scope for this NWL London review are:

- Community-based specialist palliative care services for Adults (18+) – provided by NHS trusts and charitable hospice providers – including services such as hospice inpatient bedded care, hospice at home, community specialist palliative care nursing teams, 24/7 advice lines, outpatient and well-being services.

Out of scope for this NW London review are:

- 'Universal' services that support generalist palliative and end of life care needs – general practice, district nursing, the Universal Care Plan – although recommendations on integration and UCP underpinning advance care planning to be undertaken by community-based specialist palliative care services are made.
- Children and young people
- Views raised by the public as part of engagement on assisted dying/ euthanasia

4. Principles for improving quality and outcomes

The Clinical Senate Council has also agreed a set of principles which it believes are essential to improving quality of care and outcomes. The Council seeks evidence of, and promotes, these principles in the issues it considers and the advice that it provides.

They are:

- Promoting **integrated working across health and across health and social care** and ensure a seamless patient journey
- Being **patient-centred and co-designed** (this includes patient experience, patient involvement in development and design of services)
- Reducing **inequalities** (this involves understanding and tackling inequalities in access, health outcomes and service experience, between people who share a protected characteristic and those who do not, and being responsive to the diversity within London's population)
- Demonstrating **parity of esteem between mental and physical health** for people of all ages
- Supporting **self-care** and **health and wellbeing** Improving **standards and outcomes** (these include use of evidence and research, application of national guidance, best practice and innovation)
- Ensuring **value** (achieving the best patient and population outcomes from available resources)
- Demonstrate how **environmental sustainability and moves to carbon neutral** are included in plans and developments. This includes reference to the National ambition to reach carbon Net zero by 2040 and the London Health Board ambition to ensure that every Londoner breathes safe air.

5. Review Panel

The clinical senate will complete a review via Microsoft TEAMS

Chair

The panel will be chaired by members of the London Clinical Senate Council:

Heather Richardson, Education, Research and End of Life Policy Lead, St Christopher's Hospice

The Deputy Chair will be Marianne Leach, Consultant Paediatrician, St Georges University Hospital

Overseen by Dr Mike Gill, Consultant Physician, Chair London Clinical Senate Council and Non-Executive Director Homerton University Hospital NHS Foundation Trust

Membership

Membership of the review panel will be multi-professional. Its members will have expertise in the services and pathways being considered. Subject to agreement with the Chair, membership will include expertise independent of **NHS NW London** that are unrelated to the changes proposed. Advice on membership will be sought from the London Clinical Senate Council with relevant expertise, and professional bodies as necessary.

The review panel will seek advice from other independent experts on specific issues if indicated. The review panel will not include anyone who has been involved in the development of the proposals being considered or associated with the bodies.

Conflict of Interests

All review panel members will be required to formally declare any interests (which will be noted in the review report) and sign a confidentiality agreement.

6. Method and Approach

In determining the review approach and formulating advice the Clinical Senate Council and Review Panel will draw on the following, which includes guidance on testing an evidence base:

- [Clinical Senate Review Process: Guidance Notes](#), NHS England, August 2014
- NHS England's Service Change Toolkit
- [Planning, assuring and delivering service change for patients](#), NHS England, March 2018

The review is expected to involve the following steps:

- Step 1:** **Establish the review panel**
- Step 2:** **Brief the review panel** and circulate key documentation
- Step 3:** Hold a **review panel meeting** to:
- a. agree the overall methodology applied to formulate the advice
 - b. identify issues that need to be explored, clarified or validated to assist in formulating the advice
 - c. agree any further information/documentation required to inform the review
- Step 4:** Hold an expert **review panel** on the 5th March 2024 via Microsoft to undertake the following:
- a. Meet and discuss the proposals/solutions with stakeholders (commissioners and providers) involved in their development to explore key lines of enquiry
 - b. Provide an opportunity for stakeholders impacted by the proposals to share views with the review panel
 - c. Debate findings within the review panel and finalise conclusions
 - d. Identify any outstanding issues and agree the process for following up (and further review panel discussion as agreed necessary)
- Step 5:** **Prepare a report** setting out overall findings, conclusions, advice and any recommendations. This will be circulated to the review panel and if required, a meeting agreed to discuss matters of accuracy and agree amendments.
- The sponsoring organisations will be provided with a copy of the draft report for a factual accuracy check.
- Step 6:** Once agreed by the review panel, **share the report with the Clinical Senate Council** who will:
- Ensure the terms of reference have been met
 - Comment on any specific issues where identified by the review panel
 - Agree that the report can be issued
- Subject to the schedule of Council meetings the Senate Council Chair may undertake this on the Council's behalf.
- Step 7:** **Issue the report.**

7. Documentation required by the Clinical Review Panel

In formulating advice, the review panel will review documentation that has both informed and been developed by commissioners.

Where possible relevant sections/pages of documents should be highlighted where the whole document does not apply to the proposals or context of a Clinical Senate review.

The documentation that it is anticipated will inform this review is listed below. Further requirements may be confirmed following establishment of the review panel.

- The draft Pre-Consultation Business Case (PCBC)
- The Case for Change (rationale for the proposed change and evidence base)
- Proposed clinical models (description, rationale and evidence base)
- Supporting activity and workforce data and modelling, patient flows and pathways, patient transport, performance against key quality indicators benchmarking data/patient experience data – available information should be provided initially, and any further specific requests will be discussed
- Relevant CQC [Care Quality Commission] inspection and GIRFT [Getting It Right First Time] reports
- Schedule of evidence and best practice that have informed the proposals
- Equality impact assessment
- Alignment to ICB plans
- Relevant Trust Clinical Strategies
- Process used to develop the proposals including staff, service user and public involvement
- Summary of outcomes of patient and public engagement
- Summary of outcomes of stakeholder engagement, including neighbouring trusts and services
- Programme risk log
- Assessment regarding sustainable healthcare considerations and carbon footprint

The review panel will formulate the advice requested based on consideration and triangulation of the documentation provided, discussion with key stakeholders and panel members' knowledge and experience. The advice will be provided as a written report.

8. Timeline

- **Convene a go no go meeting for 8th December. Documentation availability is confirmed.**
- **Clinical senate to convene panel with 8 weeks' notice.**
- **Submit draft PCBC and associated appendices to clinical senate for review no later than 29th January 2024**
- **5 March 2024. Review to be undertaken via Microsoft Teams**

- **1st April 2024 final draft clinical senate report and recommendations issued to NWL for MoA check.**
- **15th April 2024 Final report issued.**

9. Risks

It is essential that the processes through which the Clinical Senate formulates advice are robust and the approach outlined is designed to do this. Recruiting the appropriately experienced review panel members who are available on the key dates set for the review and ensuring adequate time to prepare for key activities are the most critical elements and pose the greatest risk. Every effort will be made to mitigate this risk.

10. Reporting arrangements

The review panel will report to the Clinical Senate Council who will agree the report and be accountable for the advice contained in the final report. The chair of the council may sign off the report pending formal noting at the council meeting.

The Clinical Senate Council will submit the report to the sponsoring organisation and this advice will be considered as part of the NHS England assurance process for service change proposals.

11. Report

A final draft report setting out the advice will be shared with the sponsoring organisation to provide an opportunity for checking factual accuracies prior to completion. Comments/corrections must be received within 5 working days.

Communication and media handling

North West London ICB will be responsible for publication and dissemination of the report. The expectation is that it will be made publicly available as soon as possible following completion. The London Clinical Senate will post the report on their website at a time agreed with the sponsoring organisation.

Communication about the clinical review and all media enquiries will be dealt with by the sponsoring organisation.

If helpful, the Clinical Senate will support the sponsoring organisation in presenting the review's findings and explaining the rationale for the advice provided e.g. at a key stakeholder meeting subject to discussion and availability of review panel members.

Disclosure under the Freedom of Information Act 2000

The London Clinical Senate is hosted by NHS England and operates under its policies, procedures, and legislative framework as a public authority. All the written material held by the Clinical Senate, including any correspondence sent to us, may be considered for release following a request to us under the Freedom of Information Act 2000 unless the information is exempt.

12. Resources for the review

The London Clinical Senate will recruit review panel members and cover members' reasonable expenses. It will also provide management support to the review panel, including coordinating all communication relating to the review, documentation sharing, meeting organisation and report production.

The sponsoring organisation will identify a named contact to coordinate the provision of documentation and any other information requested and to assist in coordinating stakeholders' participation in the review at a local level. The sponsoring organisation will also organise accommodation for meetings and the review panel day.

If during the course of the review the review panel identifies any additional requirements to formulate the advice requested, the review Chair or Clinical Senate Senior Project Manager will, if necessary, discuss these with the sponsoring organisation and may seek resources for this.

13. Accountability and Governance

The review panel is part of the London Clinical Senate's accountability and governance structure.

The Clinical Senate is a non-statutory advisory body and will submit the review report and its advice on the proposals to the sponsoring organisation. The sponsoring organisation remains accountable for decision making. The review report may draw attention to specific issues, including any risks, which the Clinical Senate believes the sponsoring organisation should consider or address.

If the Clinical Senate identifies any significant concerns through its work which indicate risk to patients it will raise these immediately with relevant senior staff in the organisation(s) involved. Please note that depending on the nature of the issues identified the Clinical Senate Council may be obliged to raise these with the relevant regulatory body(ies). Should this situation occur, the Clinical Senate Council Chair will advise the Chief Executives, Clinical Leads and Chief Officers of the provider and commissioning organisations involved.

14. Functions, responsibilities and roles

The sponsoring organisation will:

- Provide the review panel with the proposed PCBC, and associated resources.

- Respond within the agreed timescale to the draft report on matters of factual inaccuracy.
- Undertake not to attempt to unduly influence any members of the review panel during the review.
- Submit the final report to NHS England for inclusion in its formal service change assurance process.

The **London Clinical Senate Council and the sponsoring organisation** will:

- Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

The **London Clinical Senate Council** will:

- Appoint a review panel which may be formed of members of the Senate, external experts, and/or others with relevant expertise.
- Endorse the terms of reference, timetable and methodology for the review.
- Consider the review recommendations and report (and may wish to make further recommendations).
- Provide suitable support to the review panel.
- Submit the final report to the sponsoring organisation.

The **review panel** will:

- Undertake its review in line with the methodology agreed in the terms of reference.
- Submit the draft report to the London Clinical Senate Council for comment, consider any such comments made and incorporate relevant amendments into the report. Review panel members will subsequently submit a final draft of the report to the London Clinical Senate Council.
- Keep accurate notes of meetings.

The **review panel members** will undertake to:

- Commit fully to the review and attend/join all briefings, meetings, interviews, panels etc. that are part of the review (as defined in the methodology).
- Contribute fully to the process and review report.
- Ensure that the report accurately represents the consensus of opinion of the review panel.
- Comply with the confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it.
- Declare to the review panel Chair any conflict of interest prior to the start of the review and/or any that materialise during the review.

15. Contact details of key personnel coordinating the review process

For the London Clinical Senate:

Head of London Clinical Senate

Email address: emilywebster@nhs.net / robin.plata@nhs.net

Please also include the following email address in correspondence
england.londonclinicalsenate@nhs.net

For NHS North West London:**Name: Jane Wheeler**

Title: Director of Local Care, NHS North West London

Email address: jane.wheeler2@nhs.net

Name: Michelle Scaife

Title: Programme delivery manager Last phase of life, NHS North West London

Email Address: michelle.scaife@nhs.net

Name: Andrew Pike

Title: Head of communications, NHS North West London

Email address: a.pike@nhs.net

Name: Dr Lyndsey Williams

Title: NW London GP clinical lead for palliative and end of life care, and care homes.

Email address: lyndseywilliams@nhs.net

Please also include the following email address in all correspondence nhsnwl.endoflife@nhs.net

Compassionate care for all - Improving adult community specialist palliative care services for all residents in north west London

Harrow: summary of service improvement

Harlow community specialist palliative care providers

- St Luke's Hospice
- Central London Community Healthcare NHS Trust providing Harrow Community Palliative Care Nursing Team services

The proposed north west London community specialist palliative care model of care for adults (18+) will deliver the following services for Harrow residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. The service will also be expanded to operate 7-days a week as opposed to the current 5 days a week (Monday to Friday). Harrow residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Community in-patient bed care

- Harrow residents will have access to an increased number of beds in the community, which includes, based on the size of the borough population, the introduction of a proposed seven dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available to all boroughs of NW London. They are currently only available in Hillingdon.
- Harrow residents will continue to have access to specialist hospice in-patient unit bed care.

24/7 specialist palliative care telephone advice

- Harrow residents who are known to community specialist palliative care services already have access to this 24/7 advice via their local hospice.
- This existing service will be expanded to support Harrow residents who are unknown to the community specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Harrow residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of support, as well as expanded to support non-cancer lymphoedema diagnoses which is currently a gap in provision for Harrow. Lymphoedema is a long-term condition where a build-up of lymph fluid in your body's soft tissues causes swelling.
- Harrow residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed service improvement aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire north west London population, including the specific needs of Harrow residents and underserved communities.

It seeks to achieve this by tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.



Public consultation 18 November 2024 to 24 February 2025
www.nwlondonicb.nhs.uk/cspc

Compassionate care for all - Improving adult community specialist palliative care services for all residents in north west London

Hillingdon: summary of service improvement

Hillingdon
community
specialist
palliative care
providers

- Harlington Hospice (including provision of Michael Sobell House inpatient unit at Mount Vernon Hospital)
- Central and North West London NHS Foundation Trust

The proposed north west London community specialist palliative care model of care for adults (18+) will deliver the following services for Hillingdon residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. Hillingdon residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Community in-patient bed care

- Hillingdon residents currently have access to eight dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. This service will be improved through a common core offer that will be available to all boroughs of north west London.
- Hillingdon residents will continue to have access to specialist hospice in-patient unit bed care.

24/7 specialist palliative care telephone advice

- Hillingdon residents who are known to community-based specialist palliative care services already have access to this 24/7 advice via their local hospice and specialist palliative care providers.
- This existing service will be expanded to support Hillingdon residents who are unknown to the community-based specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and Well-being services

- Hillingdon residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core

offer of support. Lymphoedema is a long-term condition where a build-up of lymph fluid in your body's soft tissues causes swelling.

- Hillingdon residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed service improvement aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire north west London population, including the specific needs of Hillingdon residents and underserved communities.

It seeks to achieve this by tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.



Public consultation 18 November 2024 to 24 February 2025
www.nwlondonicb.nhs.uk/cspc

Compassionate care for all - Improving adult community specialist palliative care services for all residents in north west London

Hounslow: summary of service improvement

Hounslow community specialist palliative care providers

- London North West University Healthcare NHS Trust providing Meadow House Hospice

The proposed north west London community specialist palliative care model of care for adults (18+) will deliver the following services for Hounslow residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am to 8pm from current 9am to 5pm. Hounslow residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Hospice at home

- Hounslow residents will have access for the first time a Hospice at Home service. This service currently does not exist.
- This service supports up to 24-hour care at home (including overnight sitting) if needed in close collaboration with usual community care teams.

Community in-patient bed care

- Hounslow residents will have access to an increased number of beds in the community, which includes, based on the size of their borough population, the introduction of a proposed seven dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available to all boroughs of north west London. They are currently only available in Hillingdon.
- Hounslow residents will continue to have access to specialist hospice in-patient unit bed care.

24/7 specialist palliative care telephone advice

- Hounslow residents who are known to community specialist palliative care services already have access to this 24/7 advice via their local hospice.
- This existing service will be expanded to support Hounslow residents who are unknown to the community specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Hounslow residents will have access to consultant and nurse led out-patient clinics for the first time. They will include lymphoedema services that will be improved with a common core offer of lymphoedema support and expanded out-patient clinics to include medical and nurse led clinics. Lymphoedema is a long-term condition where a build-up of lymph fluid in your body's soft tissues causes swelling.
- Hounslow residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed service improvement aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire north west London population, including the specific needs of Hounslow residents and underserved communities.

It seeks to achieve this by tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.



Public consultation 18 November 2024 to 24 February 2025
www.nwlondonicb.nhs.uk/cspc

North West London

Compassionate care for all - Improving adult community specialist palliative care services for all residents in north west London

Kensington and Chelsea: summary of service improvement

Kensington & Chelsea
community specialist
palliative care
providers

- Royal Trinity Hospice
- Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services
- St John's Hospice

The proposed north west London community specialist palliative care model of care for adults (18+) will deliver the following services for Kensington and Chelsea residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. Kensington and Chelsea residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Hospice at home

- This service already exists, but will be improved with a common core offer which includes support up to 24-hour care at home (including overnight sitting) if needed in close collaboration with usual community care teams.

Community in-patient bed care

- Kensington and Chelsea residents will have access to an increased number of beds in the community, which includes, based on the size of the borough population, the introduction of a proposed four dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available to all boroughs of NW London. They are currently only available in Hillingdon.
- Kensington and Chelsea residents will continue to have access to specialist hospice in-patient unit bed care.

24/7 specialist palliative care telephone advice

- Kensington and Chelsea residents who are known to community specialist palliative care services already have access to this 24/7 advice via their local hospice and specialist palliative care providers.

- This existing service will be expanded to support Westminster residents who are unknown to the community specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Kensington and Chelsea residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of support. Lymphoedema is a long-term condition where a build-up of lymph fluid in your body's soft tissues causes swelling.
- Kensington & Chelsea residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed service improvement aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire north west London population, including the specific needs of Kensington and Chelsea residents and underserved communities.

It seeks to achieve this by tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

We can confirm that all other Pembridge Community Palliative Care Services (ie. 24/7 specialist telephone advice line, community specialist palliative care nursing, day hospice services and outpatient services and other services) are unaffected and continue to operate.



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Compassionate care for all - Improving adult community specialist palliative care services for all residents in north west London

Westminster: summary of service improvement

Westminster community specialist palliative care providers	• Royal Trinity Hospice • Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services • St John's Hospice

The proposed north west London community specialist palliative care model of care for adults (18+) will deliver the following services for Westminster residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. Westminster residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Hospice at home

- This service already exists, but will be improved with a common core offer which includes support up to 24-hour care at home (including overnight sitting) if needed in close collaboration with usual community care teams.

Community specialist in-patient bed care

- Westminster residents will have access to an increased number of beds in the community, which includes, based on the size of the borough population, the introduction of a proposed five dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available across all boroughs of north west London. They are currently only available in Hillingdon.
- Westminster residents will continue to have access to specialist hospice in-patient unit bed care.

24/7 specialist palliative care telephone advice

- Westminster residents who are known to community specialist palliative care services already have access to this 24/7 advice via their local hospice and specialist palliative care providers.

- This existing service will be expanded to support Westminster residents who are unknown to the community specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Westminster residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of support.
- Westminster residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed service improvement aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire north west London population, including the specific needs of Westminster residents and underserved communities.

It seeks to achieve this by tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

We can confirm that all other Pembridge Community Palliative Care Services (ie. 24/7 specialist telephone advice line, community specialist palliative care nursing, day hospice services and outpatient services and other services) are unaffected and continue to operate.



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Compassionate care for all - Improving adult community specialist palliative care services for all residents in north west London

Brent: summary of service improvement

Brent community specialist palliative care providers

- St Luke's Hospice
- Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services including hospice inpatient care (which is currently suspended).
- St John's Hospice

The proposed north west London community specialist palliative care model of care for adults (18+) will deliver the following services for Brent residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. Brent residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Hospice at home

- This service already exists, but will be improved with a common core offer which includes support up to 24-hour care at home (including overnight sitting) if needed in close collaboration with usual community care teams.

Community specialist in-patient beds

- Brent residents will have access to an increased number of beds in the community, which includes, based on the size of the borough population, the introduction of a proposed nine dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available for residents in all boroughs of north west London. They are currently only available in Hillingdon.
- Brent residents will continue to have access to specialist hospice in-patient bed care.

24/7 specialist palliative care telephone advice

- Brent residents who are known to community specialist palliative care services already have access to this 24/7 advice via their local hospice.
- This existing service will be expanded to support Brent residents who are unknown to the community specialist palliative care services. They will be able

to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Brent residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of support. Lymphoedema is a long-term condition where a build-up of lymph fluid in your body's soft tissues causes swelling.
- Brent residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed service improvement aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire north west London population, including the specific needs of Brent residents and underserved communities.

It seeks to achieve this by tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

We can confirm that all other Pembridge Community Palliative Care Services (ie. 24/7 specialist telephone advice line, community specialist palliative care nursing, day hospice services and outpatient services and other services) are unaffected and continue to operate.



Public consultation 18 November 2024 to 24 February 2025
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Compassionate care for all - Improving adult community specialist palliative care services for all residents in north west London

Ealing: summary of service improvement

Ealing community specialist palliative care providers

- London North West University Healthcare NHS Trust providing Meadow House Hospice

The proposed north west London community specialist palliative care model of care for adults (18+) will deliver the following services for Ealing residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours of this team will increase to 8am - 8pm from current 9am to 5pm. Ealing residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Hospice at home

- Ealing residents will have access for the first time a Hospice at Home service. This service currently does not exist.
- This service supports up to 24-hour care at home (including overnight sitting) if needed in close collaboration with usual community care teams.

Community in-patient bed care

- Ealing residents will have access to an increased number of beds in the community, which includes, based on the size of their borough population, the introduction of a proposed nine dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available to all boroughs of north west London. They are currently only available in Hillingdon.
- Ealing residents will continue to have access to specialist hospice in-patient bed care.

24/7 specialist palliative care telephone advice

- Ealing residents who are known to community specialist palliative care services already have access to this 24/7 advice via their local hospice.
- This existing service will be expanded to support Ealing residents who are unknown to the community specialist palliative care services. They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Ealing residents will have access for the first time to consultant and nurse led out-patient clinics, including lymphoedema services that will be improved with a common core offer of a common core offer lymphoedema support and expanded out-patient clinics to include medical and nurse led clinics. Lymphoedema is a long-term condition where a build-up of lymph fluid in your body's soft tissues causes swelling.
- Ealing residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed service improvement aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire north west London population, including the specific needs of Ealing residents and underserved communities.

It seeks to achieve this by tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.



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Compassionate care for all - Improving adult community specialist palliative care services for all residents in north west London

Hammersmith and Fulham: summary of service improvement

Hammersmith & Fulham community specialist palliative care providers

- Royal Trinity Hospice
- Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services
- St John's Hospice

The proposed north west London community specialist palliative care model of care for adults (18+) will deliver the following services for Hammersmith and Fulham residents. Some of these services already exist but will have been expanded, whilst some of them will be available for the first time:

Adult community specialist palliative care team

- This service already exists but the opening hours for the team will increase to 8am - 8pm from current 9am to 5pm. Hammersmith & Fulham residents will therefore have access to a 7-day service that operates 12 hours a day to support their care needs.

Hospice at home

- Hammersmith & Fulham residents will have access for the first time a Hospice at Home service. This service currently does not exist.
- This service supports up to 24-hour care at home (including overnight sitting) if needed in close collaboration with usual community care teams.

Community specialist in-patient bed care

- Hammersmith & Fulham residents will have access to an increased number of beds in the community, which includes, based on the size of their borough population, a proposed five dedicated enhanced end-of-life care beds for patients who do not require a hospice in-patient bed but cannot stay at home due to their needs, do not wish to stay at home, and do not want to or need to be in a hospital. These beds will be available to all boroughs of north west London. They are currently only available in Hillingdon.
- Hammersmith & Fulham residents will continue to have access to specialist hospice in-patient bed care.

24/7 specialist palliative care telephone advice

- Hammersmith & Fulham residents who are known to community specialist palliative care services already have access to this 24/7 advice via their local hospices/specialist palliative care providers.
- This existing service will be expanded to support Hammersmith & Fulham residents who are unknown to the community specialist palliative care services.

They will be able to call a local 24/7 specialist palliative care telephone advice line for the first time and receive advice and support.

Hospice out-patient multidisciplinary clinics and well-being services

- Hammersmith & Fulham residents will continue to have access to out-patient clinics, including lymphoedema services that will be improved with a common core offer of support. Lymphoedema is a long-term condition where a build-up of lymph fluid in your body's soft tissues causes swelling.
- Hammersmith & Fulham residents will have improved access to bereavement and psychological support services with a common core offer, including 1:1 and group support, and a clearer pathway to access these services.

The proposed service improvement aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire north west London population, including the specific needs of Hammersmith & Fulham residents and underserved communities.

It seeks to achieve this by tailoring services to individual preferences, cultural competence training for staff, and actively collaborating with local organisations and partners.

We can confirm that all other Pembridge Community Palliative Care Services (ie. 24/7 specialist telephone advice line, community specialist palliative care nursing, day hospice services and outpatient services and other services) are unaffected and continue to operate.



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Compassionate care for all: improving community specialist palliative care for adults in north west London

Frequently asked questions (FAQs)

Service area 1: Care at home

Q: How will the new model improve care at home?

We're improving care at home by expanding services across all boroughs. Here's what will change:

The new model will provide a **7-day specialist palliative care service**, operating 8am-8pm, across all boroughs, expanding from the current 5-day service in some areas, such as Harrow. We're increasing support for care homes, in the form of training and support, to ensure residents get the right care and advice when needed.

Hospice at Home services will now provide 24-hour care in collaboration with your existing community care team. This includes overnight support and personalised care designed to help you stay in your home. This service will also be expanded to areas like Hammersmith & Fulham, Ealing, and Hounslow, which previously didn't have full coverage.

A **24/7 specialist telephone advice line** will be available for anyone, whether you're already known to palliative care services or new to them. This ensures that help is just a phone call away, anytime you need it. This is a change from current 24/7 specialist palliative care advice line services, which in the main only support known patients and have variation in the level of advice and support offered.

Q: Can you tell us more about the hospice at home service?

The Hospice at Home service helps people receive care in the comfort of their own homes. It's focused on providing high-quality, compassionate care, especially for people in the final stages of life who wish to stay at home. The service includes:

- Personal care (e.g., bathing, dressing) and help with daily activities
- Medication management and comfort care
- Overnight support, allowing carers and family members to rest
- Access to a full care team, including healthcare assistants, nurses, and palliative care consultants.

Hospice at Home is designed to ensure that patients feel comfortable and supported, working closely with your usual care team, such as GPs and district nurses.

Service area 2: Community specialist in-patient beds

Q: How will the new model improve access to inpatient beds?

Currently, there are 57 hospice inpatient beds available across north west London for patients with the most complex palliative care needs. These beds provide highly specialised care for people with complex needs in the final stages of life. Under the new model of care:

- We will **keep these 57 hospice inpatient beds open**, so access to specialist hospice care will remain the same
- In addition, we are **introducing 46 new enhanced end-of-life care beds**, which will be available across all boroughs, totalling 54 end-of-life care beds across north west London. These beds are designed for patients who need more support than can be provided at home but do not require the full level of care provided by a hospice
- This means that overall access to specialist palliative care beds will significantly increase, ensuring more people get the right care in the right setting.

These changes mean that more people will have access to the right level of care, whether at home, in a hospice, or in a dedicated care facility.

Q: Can everyone have a hospice bed if they need one?

Hospice beds are for people with the most complex care needs at the end-of-life, and not everyone will need this level of care. But we understand that not everyone can or wants to stay at home. That's why we are adding 46 new end-of-life care beds, which offer extra support for people who don't need hospice care but can't stay at home.

Our goal is to make sure that everyone gets the care that best suits their needs—whether that's at home, in an enhanced end-of-life care bed, or in a hospice. This new model of care offers more options for more people, ensuring that the right level of support is available at every stage.

Service area 3: Hospice out-patient services, hospice day care services and well-being services (including psychological and bereavement support services for patients and families)

Q: How will the new model improve outpatient care and well-being services?

While all boroughs already have access to hospice outpatient services and day care, we've found that some areas, like Ealing, Hounslow, and Harrow, have fewer services available. The new model of care changes this by:

- Making sure every borough has doctor and nurse-led clinics, so residents can access the care they need closer to home
- Expanding lymphoedema services (for patients with non-cancer-related swelling) in areas that currently lack this care
- Improving access to psychological and bereavement services for patients and their families, with options for face-to-face or virtual support, and group or one-on-one sessions.

Our goal is to ensure that everyone receives the same high-quality care, regardless of where they live.

We aim to make sure hospice out-patient multidisciplinary team (MDT) clinics (including but not limited to medical and nursing clinics, rehabilitation via therapists, and dedicated lymphoedema services) deliver the same core level of service. This refers particularly to the boroughs of Ealing and Hounslow where doctor and nurse led clinics are currently not available via Meadow House Hospice, as well as Harrow where there is currently a gap in provision of lymphoedema services for non-cancer patients. We propose to expand lymphoedema service provision for these non-cancer patients in Harrow.

We aim to make sure well-being services including hospice day care, family and carer practical support and education, complimentary therapies, and dedicated psychological and bereavement support services deliver a core level of service.

Particularly for psychological and bereavement support services for patients, their families, carers and those important to them which includes: a more streamlined pathway to access these services; increased personalisation of care for example offering one-to-one and group sessions, face-to-face and virtual support; and increased cultural and spiritual sensitivity to delivery of this care and support. While all boroughs currently have access to some psychological and bereavement services, this varies in level of support

Q: Why are we consulting on these two options?

The financial and non-financial appraisal of the shortlisted options for delivering the model of care, identified the two highest scoring options as being:

- Option A: Full delivery of the proposed model of care with the suspended Pembridge Inpatient beds remaining closed
- Option B: Full delivery of the proposed model of care with the suspended Pembridge Inpatient beds reopening.

Of these two options, Option A scored highest and is therefore identified as the preferred option. In more detail:

Option A (Preferred):

- Fully implement the proposed model, including 46 new enhanced end-of-life care beds, while maintaining the existing hospice beds without reopening the Pembridge Hospice inpatient beds.
- This option would be easier and quicker to implement and benefit more north west London residents as a whole.

Option B:

- Fully implement the proposed model, including 46 new enhanced end-of-life care beds and reopen Pembridge Hospice inpatient beds.

- This would require a reduction in hospice beds elsewhere and have a longer implementation timeline due to the need to recruit specialist palliative care consultants and 35 additional staff.

We are pleased that in both of these options, we are proposing to almost double the number of beds available to local residents and fill the gaps in service provision that have meant that some residents in some boroughs have a less good service. We believe this is the fair and right thing to do.

Whilst one of the two options (Option A) scored higher in the financial and non-financial appraisal to provide us with a preferred option, no decision has been made and we are seeking your views on both options to inform the final decision. This will be made after the consultation has closed and the feedback independently reviewed.

Q: What is the cost difference between Option A and Option B?

A: To develop the pre-consultation business case (PCBC), a detailed financial appraisal was conducted to outline the overall finances and the cost difference between Option A and Option B. Option A costs £27.6 million, while Option B costs £29.7 million. The actual cost difference between the two options is £2.1 million.

Q: Are both options financially favourable compared to the 'business as usual' option?

A: Yes, both options are financially favourable compared to the 'business as usual' option when the benefits are taken into account. Both options passed the core affordability test during the shortlisting financial assessment. Option A is £4.6 million favourable compared to the 'business as usual' option, and Option B is £2.5 million favourable.

Q: How will you take into account if more people say they prefer one option over the other?

A: As with any public body running a consultation, we will take into account all of the feedback received based on the quality of the arguments put forward rather than numerical support for one option or another.

All feedback received will be independently reviewed and analysed by 3ST, an alliance of the voluntary and community sector across North West London who will produce a consultation outcome report.

Following receipt of the report, a decision-making business case (DMBC) will be developed that will show how views captured by consultation have informed the final proposal. The DMBC will demonstrate how the proposed change is sustainable in service, economic and financial terms and can be delivered. The DMBC will go then go through the ICB governance processes for final approval.

Q: How will be people be able to gain access to the planned enhanced end-of-life care beds”?

A: The admission and discharge criteria for enhanced end-of-life care beds are set out in the new model of care:

- Patients should be registered with a local GP. Cases will be considered individually to ensure support is made available to those who need it, including for people experiencing homelessness
- Patients should have a life-limiting illness with a prognosis of a few months, possibly nearing the end-of-life stage
- They require enhanced palliative and 24-hour bed end-of-life care that their regular care team, like district nurses, GPs, hospice at home, social care package, or continuing health care, cannot provide
- Patients who can't or don't want to receive care at home due to medical needs, social circumstances, or lack of necessary equipment but don't meet the specific and complex specialist palliative care needs for hospice in-patient unit bed admission
- The anticipated length of stay is up to three months, but this may be less depending on the patient's needs
- Referrals for admission to these beds may come from the patient's GP, the adult community specialist palliative care team, hospice at home, nursing home, community district nursing, hospice in-patient unit, or hospital team
- Patients can be stepped up to these enhanced beds from a regular nursing or residential care home bed through referral by care home staff and the adult community specialist palliative care team
- Patients can also be stepped up to a hospice in-patient unit bed from these enhanced end-of-life care beds through referral from the community specialist palliative care team, GP, and community nursing
- The hospital or hospice in-patient unit can refer and discharge patients (step down) to these enhanced end-of-life care beds.

[Find out more about enhanced end-of-life care beds.](#)

Q: What is the proposed number of enhanced end-of-life care beds per borough?

A: There are currently eight enhanced end-of-life-care beds in Hillingdon. Based on this number and the population of each borough we are proposing the introduction of 46 additional end-of-life care beds meaning 54 in total.

Given the geography of north west London and availability of sites, some shared work across boroughs could be possible to give improved access for residents.

Brent	353,690	9
Ealing	380,722	9
Hammersmith & Fulham	188,103	5
Harrow	270,741	7
Hillingdon (existing beds)	315,198	8
Hounslow	300,880	7
Kensington & Chelsea	145,328	4

Westminster 211,814 5
North west London total 2,166,475 54

Q. Why is option A the preferred option?

When we started looking at all the potential implementation options we originally identified 54. Following a robust assessment process this was narrowed down to two options that scored the highest against the agreed criteria.

Option A is the preferred option as we will be able to make the improvements and implement the new model of care quicker and will provide improved equity of access to the north west London population as a whole. The in-patient specialist hospice beds would remain as they are in option A, versus option B where the Pembridge Palliative Care Inpatient Unit beds would reopen. There are two aspects to this:

- Our analysis shows that the current 57 inpatient hospice beds that we have open are sufficient for the immediate and future needs. We would therefore need to reduce the number of beds in the other hospices in north west London, and would result in a loss of income for charitable hospices. Whilst re-opening Pembridge Palliative Care Inpatient Unit beds would improve access to residents in the immediate surrounding area, on balance it would reduce access to a broader range of the north west London population. Our travel analysis also shows that residents in the immediate area around the Pembridge Palliative Care Unit will still have better access to inpatient hospice beds than pockets of the north west London population elsewhere.
- In order to reopen the Pembridge Palliative Care Inpatient Unit beds, we need to recruit specialist palliative care consultant cover and 35 additional specialist staff. In current circumstances, where there is a national shortage of these really specialist staff and we have failed to recruit in the past, we believe it will be more difficult to implement option B and it is difficult to put a timescale to this.

Q. Why is the Pembridge Palliative Care Inpatient unit not open?

The Pembridge Palliative Care Services in-patient unit has been suspended for use since the end of 2018 as a result of the inability to recruit and retain specialist palliative care consultant cover required to safely run the unit.

All other Pembridge Palliative Care Services (ie. 24/7 specialist telephone advice line, community specialist palliative care nursing day hospice services and outpatient services and other services) are unaffected and continue to operate.

NHS North West London has not made a decision to permanently close the Pembridge inpatient unit site and, together with the Central London Healthcare Trust (CLCH) who provide the service, have remained open to recruiting the specialist palliative care consultant to support the safe reopening of the in-patient unit.

We have heard from local residents there is still a strong desire for the Pembridge in-patient unit to be reopened and that options from the public for how we could reopen the unit could be more widely considered than they have been to date.

We had two meetings in late 2023 with patient representatives, CLCH and Imperial College Healthcare NHS Trust (ICHT) to discuss options for re-opening the in-patient unit. It was agreed that ICHT and CLCH would meet to discuss whether and how the two services could work together in a more integrated manner to support re-opening the inpatient unit in future with a more robust and resilient staffing model and whether joint recruitment to posts at Pembridge may be possible.

These discussions have now taken place. However, it proved very difficult to find a suitable solution and the impact of trying to do this would be significant on both providers and would risk destabilising Imperial's workforce significantly. NHS North West London is satisfied that the relevant conversations between ICHT and CLCH have taken place and no alternative solution has been deemed feasible, and that therefore the discussions have come to a close.

Q: Please can you describe the steps that were taken to try to reopen the Pembridge Palliative Care Inpatient Unit beds?

A: Over recent years, extensive efforts have been made to recruit a Consultant in Specialist Palliative Care (SPC) to enable the reopening of the Pembridge Palliative Care Inpatient Unit. Despite these efforts, significant and ongoing barriers to recruitment, including national challenges in the specialist palliative care workforce, mean that a viable solution has not been found. Below is a timeline of key actions and their outcomes:

September 2018 – Present: Ongoing attempts to recruit a locum Consultant in SPC to cover Pembridge inpatient beds have been unsuccessful due to:

- A nationwide shortage of SPC Consultants interested in hospice-based roles.
- A lack of locums available to provide sufficient cover for safe operation.
- Difficulty securing locums willing to commit to contracts longer than three months.
- Persistent uncertainty regarding the unit's future.

2019: A strategic review of palliative care across the Tri-Borough CCGs (West London, Central London, and Hammersmith & Fulham) was conducted by Penny Hansford, former Director of Nursing at St Christopher's Hospice, South East London; as an independent reviewer. This launched a broader palliative care review programme, including Brent CCG.

2019–2020: Comprehensive public and staff engagement took place as part of the palliative care review programme. This work was paused in March 2020 due to the COVID-19 pandemic.

March–May 2021: Discussions were held with Imperial College Healthcare NHS Trust and St John's Hospice to explore cross-site SPC Consultant roles. Unfortunately, this proposal was not supported by acute colleagues who felt the

change may adversely impact their palliative consultant team by asking them to cover additional services.

May–July 2022: Internal initiatives sought to enhance the appeal of the Consultant role at Pembridge, including increasing leadership opportunities.

June–November 2023: The Consultant job description was updated to an expanded role to include community and bedded work in order to increase appeal. One application was received and subsequently appointed; however the domiciliary specialist palliative case lost their long term agency consultant in October therefore the new appointee was required to cover that role.

April 2024: Further discussions explored joint roles with Imperial College Healthcare NHS Trust. However, concerns about destabilising existing palliative care services prevented progress.

Despite exploring all feasible options, the recruitment challenges remain insurmountable in the current context. We acknowledge the impact this has on the community and understand the importance of accessible and high-quality palliative care.

Q: What has the saving from closure of Pembridge Palliative Care Inpatient Unit been used for?

A: The funding for the Pembridge Palliative Care inpatient unit has been ring-fenced and reinvested back into community-based specialist palliative care provision, other than a small element of fixed costs for the actual Pembridge inpatient unit estate costs.

Q: What arrangements were put in place for patients who would have gone to Pembridge Palliative Care Inpatient Unit if it had been open?

A: An arrangement is in place for patients who would have gone to the Pembridge inpatient unit to access a hospice inpatient bed in one of three other hospices providing services in north west London (St Luke's Hospice, St John's Hospice and Royal Trinity Hospice) and increased capacity for the community specialist palliative care team to support patients at home.

Q. Are charitable hospices considered part of the private sector?

A. No, charitable hospices are not part of the private sector. They are non-profit organisations that provide essential healthcare services. While they operate independently, their services are funded by a combination of NHS and charitable funding, ensuring that patients receive care without direct costs.

Q. What is the difference between NHS-run and NHS-funded services?

A: NHS-run services are directly managed and operated by the NHS. Examples include:

- CNWL Hillingdon Community Specialist Palliative Care Team and Your Life Line
- CLCH Harrow Community Specialist Palliative Care Team
- CLCH Pembridge Palliative Care Services
- LNWH Meadow House Hospice (inpatient, community, and outpatient services)

NHS-funded services are services that receive some or all of their funding from the NHS. Charitable hospices receive part of their funding from the NHS and part from their own charitable fund raising with this differing by hospice.

Combined NHS and charitable funded organisations include:

- St Luke's Hospice Harrow
- Harlington Hospice
- Royal Trinity Hospice London
- St John's Hospice Hampstead

Q: Why are some services run by charitable hospices instead of the NHS?

A: Charitable hospices often have deep roots in their communities and bring specialised expertise in palliative and end-of-life care. By co-funding these hospices, the NHS can ensure high-quality care while benefiting from the additional resources, fundraising efforts, and community support that these charities offer.

Q: Will patients only be able to access a hospice bed within their borough or via whoever provides a hospice service for residents of their borough?

A: The new model of care proposal for hospice in-patient unit beds will deliver excellent care for all NW London residents. Irrespective of which borough they live in, should they need a specialist palliative care hospice in-patient bed they will have access to all 57 hospice in-patient beds available to north west London residents.

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Mount Vernon Cancer Centre Public Consultation 2025

Appendices:

Appendix 1 - Mount Vernon Cancer Centre Review: Engagement with London population

Appendix 2 - MVCC London Data Unique Patients

1. Introduction

Mount Vernon Cancer Centre (MVCC) provides non-surgical specialised cancer care (for example, radiotherapy and chemotherapy) to a population of Hertfordshire, Bedfordshire, North West London, North Central London, and parts of Buckinghamshire and Berkshire.

It is at risk of being unable to continue providing specialist treatment without significant changes, including moving services to an acute hospital site.

Following an independent clinical review which recommended a series of urgent changes, including to the location of the cancer centre, work has taken place with patients, staff and stakeholders to identify a proposed solution that will ensure sustainable cancer services for the cancer centre's 2 million population.

A public consultation is now being planned to seek feedback on proposed changes which aim to secure the long-term provision of specialised cancer care to the population, improve outcomes, enhance research opportunities and make access to treatment easier.

2. The Challenges

MVCC, located in Northwood, lacks essential medical support services such as A&E and intensive care, which are critical for modern cancer treatment. This has already led to some cancer services, including haematology (blood cancers) no longer being provided by the cancer centre. The main reasons we need to make these changes are:

- **Lack of acute medical support** – The site lacks the acute medical support that is necessary for modern cancer care, especially for newer drugs and complex therapies. This limits the services that can be offered, disrupts care and delays treatment.
- **Improving outcomes** – Cancer outcomes are variable and below average in some areas. Reducing health inequalities and improving access leads to better outcomes. Patients face long travel times and inconsistent access to care, particularly in rural and deprived areas.
- **Research opportunities** – The current site limits our ability to offer cutting-edge treatments and take part in trials. We need to increase opportunities for cancer research and treatment.

In addition, there are a range of building constraints. The existing facilities are outdated, difficult to maintain, and unsuitable for modern treatment. However, fixing these without moving to an acute site will not resolve the long-term challenges the services face.

3. The Proposed Solution

The proposal involves relocating MVCC to a purpose-built cancer centre at Watford General Hospital, with additional services offered in local hospitals to minimise patient travel. Watford General Hospital is the closest acute hospital to the current services and whilst some areas will see a small increase in journey times, the proposals reduce average journey times for patients overall, including for those with the longest journeys. The key elements of the plan include:

A. Main Cancer Centre Relocation

- A modern, well-equipped cancer centre next to Watford General Hospital, providing access to essential acute medical services.
- Enhanced research opportunities.
- A new haematology unit to allow specialist inpatient and outpatient haematology care.
- This cancer centre would be run by UCLH (subject to the conclusion of due diligence – a process which enables UCLH to fully understand and agree to the services and risk they would be taking on).

B. Expanded Local Services

- Increased availability of chemotherapy at home for eligible patients, including in North West London.
- More diagnostic services and blood tests at local hospitals.
- A new chemotherapy unit at Hillingdon Hospital and expanded chemotherapy services at Northwick Park Hospital.
- An additional radiotherapy unit at either Lister Hospital (Stevenage) or Luton & Dunstable Hospital to reduce travel times for patients in the north.
- Increased radiotherapy capacity at Hammersmith Hospital.

C. Enhanced Patient Support

- New transport options to ensure no patient misses treatment due to travel difficulties.
- Improved digital and shared care records to allow easier prescription collection and remote consultations.

4. Benefits of the Changes

The proposed changes aim to:

- **Ensure continued access to specialist cancer care** for patients across Hertfordshire, North London, Bedfordshire, Buckinghamshire, and East Berkshire.
- **Improve cancer outcomes** by providing better facilities and immediate medical support.
- **Increase research and innovation** opportunities, enabling access to the latest treatments and clinical trials.
- **Reduce healthcare inequalities** by making care more accessible to underserved communities.
- **Expand local and home-based treatment options**, minimising unnecessary hospital visits.
- **Modernise cancer care facilities** to support current and future medical advancements.

5. Patient and Public Involvement and Joint Scrutiny

Since 2019, extensive engagement with patients, carers, Healthwatch representatives and healthcare professionals has helped shape the proposals. A summary of our London MVCC engagement activity is included as appendix one.

While many patients value the existing staff and care at MVCC, they recognise the need for access to a wider range of clinical services and for modern facilities. Public concerns primarily focus on:

- Ensuring high standards of care are maintained.
- Keeping the existing staff team together.
- Reducing travel burdens for treatment.

We anticipate a public consultation will take place later in the summer of 2025. You can find out more at www.mvccreview.nhs.uk.

As part of our public consultation, we want to hear the views of cancer patients, their families and carers, people living in the area Mount Vernon Cancer Centre serves, staff and other stakeholders.

We are particularly keen to know:

- How the proposed changes affect travel and accessibility for different communities.
- What challenges patient and carers might face in accessing specialist cancer care at a new location.
- What types of cancer care people think should be available closer to home, and how important is the option of an additional radiotherapy unit in Luton or Stevenage.
- Whether there are particular groups that might be disproportionately affected by the proposals and what we could do to reduce inequalities in cancer care.
- Whether there are any improvements that could be made to the proposals.

The proposals have been discussed as they have been developed with a number of Health Scrutiny Committees, or with their chairs and officers. Following a round of meetings in 2024, and an opportunity for chairs and vice chairs to tour the Mount Vernon Cancer Centre and speak to clinicians, a Joint Health Overview and Scrutiny Committee has been established by ten Local Authorities to scrutinise the public consultation. The Committee's Chair is from Hertfordshire (which has the largest proportion of patients) and the Vice Chair is from Hillingdon. The other local authorities represented are: Harrow, Brent, Ealing, Luton, Central Bedfordshire, Bedford Borough, Slough and Buckinghamshire.

You can find the terms of reference here: [Scrutiny Recommendations Update](#).

A draft consultation plan (high-level) and draft consultation document were discussed at the March meeting of the MVCC Joint Health Overview and Scrutiny Committee. Both draft documents can be reviewed as part of the agenda pack for that meeting: [Agenda for Joint Health Overview & Scrutiny Committee on Monday, 24 March 2025, 10.00 am | Hertfordshire County Council](#).

A summary version of the consultation document, easy read document and a video will also be produced to support the consultation.

The Joint Health Overview and Scrutiny Committee has indicated that a ten-week consultation would be acceptable, although it is currently being planned across a 12-week period. Pre-consultation engagement continues.

Discussions are also underway with the London Mayor's Office to ensure that the proposals meet the requirements of the Mayor's tests and any recommendations from the Mayor's office are factored into the Decision Making Business Case once the consultation has been completed and analysed.

6. Impact on London

Mount Vernon Cancer Centre London Activity Data (PDF attached), shows that 4,317 London patients attended Mount Vernon Cancer Centre in 2023/24 out of the total cancer centre patient number of 12,972.

These London patients were from:

- North West London ICB: 4,148
- North Central London ICB: 140
- North East London ICB: 16
- South West London ICB: 12
- South East London ICB: 7

Patient, public and stakeholder engagement has concentrated on the north west London population and on Barnet where the majority of north central London patients attend MVCC from.

Currently Mount Vernon Cancer Centre is in north Hillingdon and provides chemotherapy and radiotherapy services for people living in the London boroughs of Brent, Hillingdon and Harrow, alongside London North West University Healthcare NHS Trust (LNW). Imperial Cancer Centre also serves this population, and provides specialist cancer surgery for north west London patients on behalf of Mount Vernon Cancer Centre (MVCC).

The proposed move of MVCC to Watford will mean longer journey times to the main cancer centre for some of the London population. To ensure that patients are not disadvantaged, additional chemotherapy chairs will be provided at Hillingdon Hospital and Northwick Park Hospital, and additional radiotherapy capacity at Imperial Cancer Centre. Work to integrate digital systems to ensure patients requiring a blood test prior to treatment can have their blood test locally rather than in the main cancer centre.

It is anticipated that the five new chemotherapy chairs provided at Hillingdon Hospital will be supported by doctors from the relocated Mount Vernon Cancer Centre.

The three new chairs at Northwick Park will be an enhancement to their existing chemotherapy unit. It is anticipated that with these changes, Northwick Park and the London North West trust that runs it, will build strong relationships with the Imperial Cancer Centre.

Just over 30% of Mount Vernon Cancer Centre patients live within the London region. It is anticipated that with the additional facilities at Northwick Park, Hillingdon and Imperial Cancer Centre, when MVCC moves to Watford, those living in the south of the catchment will be more likely to attend the Imperial Cancer Centre which also has facilities at Charing Cross and Hammersmith Hospitals.

The estimates have been adjusted through patient and public engagement and better understanding travel flows and take account of population growth predictions for the population.

UCLH currently treats all of Hertfordshire and much of Bedfordshire's haematology patients because the service can no longer be provided at Mount Vernon Cancer Centre as the service specifications for modern treatment require access to acute services not available on the site until after the relocation has taken place. Our proposals mean that in future, most of these patients can be treated at the new cancer centre in Watford which will free up space in UCLH for London patients.

There is a very strong commitment from North West London Integrated Care Board to continue to work closely with colleagues from the East of England Region to further develop the proposals following consultation to ensure we can deliver excellent cancer care to all those who live in the Brent, Ealing, Hillingdon and Harrow boroughs.

An Equality Health Impact Assessment was carried out with the help of public health consultants early in the review and subsequently updated. The proposed changes have taken into account the findings of this assessment, cancer alliance outcomes data and patient and public feedback. The proposal for chemotherapy at Hillingdon Hospital and expanded chemotherapy at home are examples of the result of that work.

Area	% of total patients	The proposals mean	What we are proposing to reduce the journeys to the cancer centre
Hillingdon	14%	Average journey times increase from 16 to 27 minutes	These would still be some of the shortest travelling times but to reduce the number of patients impacted: • We are proposing a chemotherapy unit at Hillingdon Hospital • Blood tests for specialist cancer treatment at local hospitals • Access to chemotherapy at home services • Patients in South Hillingdon would have their radiotherapy at Hammersmith Hospital • A very small number of patients in South Hillingdon would attend Imperial College hospital for complex chemotherapy and chemoradiotherapy (treatment with chemotherapy and radiotherapy together)
Harrow	8%	Average journey times would increase from 20 to 23 minutes.	This increase is minimal, and these are still some of the shortest travelling times. However, to reduce the impact we are proposing: • Expanded chemotherapy services at Northwick Park • Blood tests for specialist cancer treatment at local hospitals • Access to chemotherapy at home services

Brent	5%	Average journey times decrease from 32 to 29 minutes.	In addition, we are proposing: • Patients would be able to access radiotherapy services at Hammersmith Hospital • Chemotherapy at Northwick Park Hospital • Patients could attend Imperial Hospital for complex chemotherapy and chemoradiotherapy (treatment with chemotherapy and radiotherapy together)
Ealing	4%	Average journey times increase from 27 to 37 minutes.	We are proposing patients from Ealing: • Would access radiotherapy services at Hammersmith Hospital • Patients would attend Imperial Hospital for complex chemotherapy and chemoradiotherapy (treatment with chemotherapy and radiotherapy together) • For patients for whom the new Mount Vernon Cancer Centre would be closer, there would also be the option of radiotherapy at the site in Watford and chemotherapy at Northwick Park Hospital

The proposals increase inpatient beds to account for the repatriation of Hertfordshire and Bedfordshire haematology patients from London, freeing up capacity in UCLH to better serve London patients, and to account for growth. The numbers change from 22 beds to 50 beds under the proposals.

The Programme Board has committed to work to further improve access as part of the proposals and a transport and access group has been established.

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APPENDIX ONE:

Mount Vernon Cancer Centre Review: Engagement with London population

1. Introduction

Patient, public and stakeholder engagement to identify the issues and develop solutions to the challenges at Mount Vernon Cancer Centre began at the start of the review in 2019 and has continued throughout.

This paper outlines a summary of the public facing engagement that has taken place in London boroughs during that time.

2. Patient and public engagement:

During the first phase of the programme, an independent company ran a survey and several face to face engagement events.

- 50% of the face to face workshops took place in North West London
- At least 27% of those completing the survey were from NWL based on their selection of closest A&E to where they live

The full report can be found here: <https://mvccreview.nhs.uk/6506/widgets/19100/documents/7948>

Following a pause of the review programme to enable clinical and operational teams to focus on responding to COVID-19, the programme entered Phase 2 – the development of options. October 2020 – April 2021.

This included a range of online focus groups and workshops covering topics including clinical model and estates, radiotherapy and cancer specific pathways. In addition, there were a number of discussions with individuals and attendance at established groups, as well as meetings with Health Scrutiny Chairs and Healthwatch organisations. These have included discussions with the Chair of Northwood Resident's Association and a meeting with a Harrow Somali Women's Group.

Of 73 attendances at focus groups to help develop proposals, approximately 42% of participants declared they were from NWL, with Harrow having the largest proportion.

- The areas of Harrow and Hillingdon are relatively well represented, but there has been little engagement from Brent and Ealing.

Following this, locality events were held (online due to Covid concerns) to understand the impact of the proposals on people living in different areas. Eight of these were specific to the North London population.

Once a preferred proposal had been identified and tested, feedback from patients and the public was used to identify themes for the next series of workshops. These included transport and access, care closer to home, learning disabilities, disabled access and experience, and also some geographical ones, including one for residents of North Central London who had been less likely to attend events than those from North West London. In addition to established communication methods and publication through organisations and groups, a targeted social media campaign was used to communicate information about the locality events, particularly targeting residents of North Central London.

More than 100 face to face and online focus groups were held in total.

- The majority of these were either general events or themed and not specifically targeted at one population rather than another. However, 13 events have been held exclusively for London patients and residents over the course of the review.

Regular information, including updates following Programme Board meetings, and information about how to get involved, is distributed to a network of almost 1,000 stakeholders. This includes communications teams in ICBs, providers, Healthwatch, and Local Authorities within the Mount Vernon Cancer Centre catchment, who use their own networks to further disseminate the information. It also includes all MPs within the catchment (originally 48, now 44 following boundary changes).

A dedicated, interactive MVCC review website was launched in January 2021. The website has received 28,389 visits and has 239 people have registered with the site, 38% of whom have registered with a London postcode. The interactive style of the site enables people to post ideas, stories and questions, amongst other activity.

A number of meetings have been held with the Chair of the Northwood Residents' Association who have a track record for campaigning. Updates on the proposals for Mount Vernon Cancer Centre have been included in each of the Northwood Residents' Association newsletters for the past few years, and the chair recently reported that they felt well engaged with and ready for the change.

3. Patient Reference Group

A Patient Reference Group has been meeting regularly since early in the review to review the case for change, help set criteria and develop proposals. Membership is proportionate to the volume of patients treated at Mount Vernon Cancer Centre from each area and members are nominated via Healthwatch. Hillingdon and Harrow have very active members and one of the Hillingdon members accompanied the Health Overview and Scrutiny Chairs on their visit to the cancer centre in November 2024.

4. Healthwatch

Healthwatch Hillingdon:

- Healthwatch Hillingdon was a member of the communications and engagement group throughout the development of proposals and early engagement. This group was set up at the start of the programme to advise on and assist with the communications and engagement planning and activity linked to the programme.
- Healthwatch Hillingdon has had a place on the programme board since the beginning of the programme and accompanied the Independent Clinical Review team for their visit. Members were also part of the panel appointing UCLH as preferred provider.
- Nominated three representatives to the Patient Reference Group

Healthwatch Harrow:

- Has become engaged since 2020 and participated in a Healthwatch workshop (8th October 2020) to help develop proposals. Representatives have also attended some of the focus groups.
- Nominated two patient representatives to the Patient Reference Group
- Has helped with access to some local communities to undertake some bespoke work, for example with the Somalian community.

Healthwatch Brent and Healthwatch Ealing were invited to the 2020 workshop to develop proposals. They have been regularly provided with information about public facing events with a request to distribute to appropriate patient groups. They were asked to nominate a patient representative to the Patient Reference Group but were unable to provide a representative.

Healthwatch Central West London (Kensington and Chelsea) participated in the Healthwatch workshop and has had patient representation at some events.

Healthwatch Hammersmith and Fulham, Healthwatch Haringey, and Healthwatch Hounslow are among other Healthwatch organisations invited to the workshop and provided with information about the events with a request to distribute to appropriate patient groups.

All NW London Healthwatch organisations receive regular updates about the programme.

5. Health Scrutiny

Joint Health Overview and Scrutiny

The Mount Vernon Cancer Centre Joint Health Overview and Scrutiny Committee (MVCC JHOSC) comprises representatives from the following councils: Bedford, Brent, Buckinghamshire, Central Bedfordshire, Ealing, Harrow, Hertfordshire, Hillingdon, Luton and Slough. It is tasked with reviewing and scrutinising the consultation proposals and consultation with regard to services currently delivered at MVCC.

Ten Local Authorities are fully represented, including the London Boroughs of Hillingdon, Harrow, Brent and Ealing.

Seven out of 17 voting members are from North West London Boroughs (around 40% compared to a 33% share of the cancer centre's patient population). A non-voting member from Barnet attends (approximately 2% share of the patient population).

Membership can be found here: [Committee details - Joint Health Overview & Scrutiny Committee | Hertfordshire County Council](#)

Date of meeting	Link to papers
16/12/2024	Agenda for Joint Health Overview & Scrutiny Committee on Monday, 16 December 2024, 10.00 am Hertfordshire County Council
09/10/2019	Agenda for Joint Health Overview & Scrutiny Committee on Monday, 24 March 2025, 10.00 am Hertfordshire County Council

Hillingdon and Hertfordshire HOSC Chairs and Vice-Chairs visited the Mount Vernon site early in the programme to consider establishing a Joint HOSC. In November 2024, Chairs and officers of

Hillingdon, Harrow, Brent, Ealing, Barnet Health Scrutiny Committees visited the site again in November 2024, along with members from the East of England and South East. They talked to members of the programme team and clinicians and toured the site. The few who couldn't come in person were able to dial in via Teams.

Prior to the establishment of the JHOSC, engagement had taken place with individual HOSCs:

Hillingdon Health and Social Care Select Committee:

Hillingdon Health and Social Care Select Committee (formerly Hillingdon External Services Select Committee) has been briefed on the MVCC review since it was established. Informal meetings took place initially with the Chair prior to attendance at each full committee:

Date of meeting	Link to papers
12/06/2019	https://modgov.hillingdon.gov.uk/ieListDocuments.aspx?CId=118&MId=3452&Ver=4
09/10/2019	https://modgov.hillingdon.gov.uk/ieListDocuments.aspx?CId=118&MId=3455&Ver=4
23/03/2020	Cancelled due to COVID
08/10/2020	https://modgov.hillingdon.gov.uk/ieListDocuments.aspx?CId=118&MId=3793&Ver=4
07/10/2021	London Borough of Hillingdon - Agenda for External Services Select Committee on Thursday, 7th October, 2021, 6.30 pm
26/01/2023	London Borough of Hillingdon - Agenda for Health and Social Care Select Committee on Thursday, 26th January, 2023, 6.30 pm
24/07/2024	London Borough of Hillingdon - Agenda for Health and Social Care Select Committee on Wednesday, 24th July, 2024, 6.30 pm
12/11/2024	London Borough of Hillingdon - Agenda for Health and Social Care Select Committee on Tuesday, 12th November, 2024, 6.30 pm

- All meetings were streamed live and were covered by a local journalist.
- A site visit took place on 4th February 2020 for the Chair, Vice Chair and officer who met with members of the MVCC team and project team and participated in a roundtable discussion that also involved Hertfordshire Health Scrutiny Committee Chair.
- In August 2020, monthly informal meetings were scheduled with the Chair of Hillingdon Scrutiny Committee and the scrutiny officer.
- The Committee receives regular stakeholder updates from the Programme

Harrow Health Scrutiny Committee:

Date of meeting	Link to papers
19/11/20	(Public Pack)Agenda Document for Health and Social Care Scrutiny Sub-Committee, 19/11/2020 18:30
23/02/21	Agenda for Health and Social Care Scrutiny Sub-Committee on Tuesday 23 February 2021, 6.30 pm – London Borough of Harrow
22/06/21	Agenda for Health and Social Care Scrutiny Sub-Committee on Tuesday 22 June 2021, 6.30 pm – London Borough of Harrow
5/11/24	Meeting:
10/12/24	Agenda for Health and Social Care Scrutiny Sub-Committee on Tuesday 10 December 2024, 6.30 pm – London Borough of Harrow

- Informal meetings have been held with Harrow scrutiny chair, vice chair and officers prior to scrutiny meetings and as required since 2020.

- The Committee receives regular stakeholder updates from the Programme

Barnet Health Scrutiny Committee: 05/09/2024

Date of meeting	Link to papers
05/09/24	Agenda for Adults and Health Overview and Scrutiny Sub-Committee on Thursday 5th September, 2024, 7.00 pm

NW London JHOSC

Informal discussions have taken place with Brent Health Scrutiny Committee Chair, Ketan Sheth when the review began and as proposals were developed. Cllr Sheth also chairs the NWL JHOSC and undertook to keep members verbally updated of progress. Each London committee is on the distribution list for stakeholder updates from the Programme.

6. MP and Parliamentary Interest

In 2021 the Clinical Advisory Group (the senior clinicians at Mount Vernon Cancer Centre) wrote to MPs to explain the challenges the cancer centre was facing and offered the opportunity for MPs to visit the site and meet with clinicians. A number of MPs took up that offer.

Date of visit	MP
19/11/21	Dean Russell
24/09/21	Greg Smith
17/09/21	Sarah Owen
09/09/21	Richard Fuller
18/08/21	Gagan Mohindra
23/08/21	David Simmonds and member of PM's parliamentary office
27/27/22	Baroness Thornhill
10/12/24	Paul Burstow

Meetings in Westminster or the MP's constituency have also taken place with Gareth Thomas – February 2020 and August 2023 and David Simmonds (who also attended one of the public focus groups) – May 2024.

There have been various briefings of ministers ahead of potential Prime Minister's Questions, or key meetings, and when MPs have been granted the opportunity to ask an oral question in the House of Commons. These have not all come to fruition.

Most London MP communication has been with Gareth Thomas MP (Harrow West) and David Simmonds MP (Northwood). There was also some communication and a site visit from the constituency office of Boris Johnson (Uxbridge).

Gareth Thomas was granted a Westminster Hall Adjournment Debate for 4th March 2020, at which the House was asked to consider the future of Mount Vernon Cancer Centre.

<https://hansard.parliament.uk/commons/2020-03-04/debates/61190A37-15FF-4F2E-B28F-B90A748913B0/MountVernonCancerCentre>

Hansard record of Mount Vernon Cancer Centre references in the House of Commons:

Date	MP	Item
14/10/19	Gareth Thomas	Debate on the Address
13/02/20	Gareth Thomas	February Adjournment
13/02/20	Stuart Andrew	February Adjournment
04/03/20	Gareth Thomas	Mount Vernon Cancer Centre
04/03/20	Edward Argar	Mount Vernon Cancer Centre
12/01/22	Mohammad Yasin	Access to Radiotherapy
09/03/23	Liz Kendall	Brain Tumour Research Funding
7/11/23	Garnet Thomas	Debate on the Address
04/02/25	Daisy Cooper	Accessibility of Radiotherapy

Written Questions, Answers and Statements:

02/06/23	Gareth Thomas	To ask the Secretary of State for Health and Social Care, what avenues for capital funding are available for the Mount Vernon Cancer Centre, and if he will make a statement.
02/09/23	Bim Afolami	To ask the Secretary of State for Health and Social Care, if he will make an assessment of the future sustainability of Mount Vernon Cancer Centre
29/09/20	Gareth Thomas	To ask the Secretary of State for Health and Social Care, what recent progress has been made in upgrading the cancer facilities at Mount Vernon Hospital, and if he will make a statement
01/12/20	Sir Oliver Heald	To ask the Secretary of State for Health and Social Care, what proportion of cancer patients receiving treatment at Mount Vernon Hospital live in Hertfordshire
10/03/20	Gareth Thomas	To ask the Secretary of State for Health and Social Care when he plans to make a decision on the future of Mount Vernon Cancer Centre
12/02/20	Gareth Thomas	To ask the Secretary of State for Health and Social Care, pursuant to the Answer of 10 February 2020 to Question 12197 on Mount Vernon Hospital Northwood and Northwick Park Hospital: Radiotherapy, what the cost to the public purse will be of replacing each linear accelerator
03/02/20	Gareth Thomas	To ask the Secretary of State for Health and Social Care what estimate he has made of the cost of making safe asbestos on the Mount Vernon Hospital site, and if he will make a statement
06/02/20	Gareth Thomas	To ask the Secretary of State for Health and Social Care what assessment he made of the effectiveness of (1) digital and (b) paper care records at Mount Vernon Hospital and if he will make a statement
03/02/20	Gareth Thomas	To ask the Secretary of State for Health and Social Care what the estimated cost to the public purse is of (a) replacing and (b) relocating the Linear Accelerators on the Mount Vernon site to another location, and if he will make a statement
04/02/20	Gareth Thomas	To ask the Secretary of State for Health and Social Care how many (a) nurses and (b) doctors are employed to provide cancer care at Mount Vernon Cancer Centre and if he will make a statement
04/02/20	Gareth Thomas	To ask the Secretary of State for Health and Social Care whether Mount Vernon Cancer Centre is permitted to provide advanced

		radiotherapy as recommended by NICEEW for the treatment of lung cancer and if he will make a statement.
04/02/20	Gareth Thomas	To ask the Secretary of State for Health and Social Care what the (a) age an estimated remaining working life is of radiotherapy machinery at (i) Mount Vernon Cancer Centre and (ii) Northwick Park Hospital and if he will make a statement
03/02/20	Gareth Thomas	To ask the Secretary of State for Health and Social Care what plans he has to sell off NHS land on the Mount Vernon Hospital site and if he will make a statement
19/12/19	Gareth Thomas	To ask the Secretary of State for Health and Social Care what his department's policy is on the future of Mount Vernon Cancer Centre and if he will make a statement
29/10/19	Stephen McPartland	Whether he plans to increase access to radiotherapy in Hertfordshire by introducing a satellite radiotherapy service in Stevenage
16/10/19	Gareth Thomas	To ask the Secretary of State for Health and Social Care what steps he has taken since the July 2019 publication of the Clinical Advisory Panel's review of cancer services at Mount Vernon and if he will make a statement

Prime Minister's Questions:

16/06/21	David Simmonds	...Will my right honourable friend commit to working with me and other local Members of Parliament, and potential future MPs, to secure the future of services at Mount Vernon Hospital in my constituency, which provides specialist medical treatments to a very wide catchment area?
16/06/21	Boris Johnson	...I look forward to working with him to ensure that the future of services at <i>Mount Vernon</i> is also protected. I know that a full consultation is due to start in September.

7. Media Coverage:

Examples of London media coverage during the period of this review:

Publication	Date	Link
The Guardian	03/10/19	Neglected NHS cancer hospital is unfit for purpose, says report Hospitals The Guardian
Watford Observer and Harrow Times	31/01/20	Mount Vernon Cancer Centre could stay open under new management Watford Observer
HSJ	03/02/20	Major London provider to take over 'dilapidated' cancer centre News Health Service Journal
Northwood News	February 2020	Northwood & Ruislip February 20 Low Res
MyLondon	12/10/20	Some services at Mount Vernon Cancer Centre could be moved to a hospital site to modernise treatments - MyLondon
Brent&Kilburn Times	19/12/20	Brent's cancer services must be moved to a main hospital site Brent & Kilburn Times
Harrow Online	08/09/24	https://harrowonline.org/2024/09/08/residents-invited-to-comment-on-mount-vernon-centre-move-from-northwood-to-watford/

Harrow Online	17/11/24	Councillors slam 'appalling' 5-year delay in Mount Vernon Cancer Centre relocation plans - Harrow Online
Harrow Online	8/12/24	https://harrowonline.org/2024/12/18/mount-vernon-relocation-plans-linked-to-funding-for-watford-general-hospital-redevelopment/

There have also been a number of mentions and discussions on social media:



MVCC London Activity data 2023/24

This document includes the total number of unique patients by former CCG area, District / Unitary Authority and by ward. There may be some duplication where patients have moved during the year, and where NHS and Local Authority boundaries are not aligned. Codes and descriptions are those used by NHS commissioning systems.

ICB	19/20 CCG NAME	District Unitary Authority Na	Electoral Ward Name	PATIENT COUNT
NHS SOUTH EAST LONDON ICB	NHS BEXLEY CCG	E09000004: Bexley	E05011226:Falconwood & Welling	1
	Bexley CCG Total:			1
	NHS GREENWICH CCG	E09000011: Greenwich	E05014075: Charlton Village & Riverside	1
			E05014089: Shooters Hill	1
	Greenwich CCG Total:			2
	NHS LEWISHAM CCG	E09000023: Lewisham	E05013718: Crofton Park	1
			E05013721: Evelyn	1
			E05013725: Ladywell	1
	Lewisham CCG Total:			3
	NHS SOUTHWARK CCG:	E09000028: Southwark	E05011105:Newington	1
	Southwark CCG Total			1
South East London ICB Total:				7
NHS NORTH EAST LONDON ICB	NHS CITY AND HACKNEY CCG	E09000012: Hackney	E05009384: Stamford Hill West	1
	City and Hackney CCG Total:			1
	NHS HAVERING CCG	E09000016: Havering	E05013968: Cranham	1
			E05013973: Harold Wood	1
			E05013977: Marshalls & Rise Park	1
			E05013979: Rainham & Wennington	1
			E05013984: South Hornchurch	1
	Havering CCG Total:			5

	NHS NEWHAM CCG	E09000025: Newham	E05013905: Boleyn	2
			E05013909: East Ham	1
			E05013916: Manor Park	1
			E05013924: Stratford	1
	Newham CCG Total:			5
	NHS NORTH EAST LONDON SUB-ICB	UNKNOWN	UNKNOWN	1
	North East London Sub-ICB Total:			1
	NHS REDBRIDGE CCG	E09000026: Redbridge	E05011239: Clayhall	1
			E05011252: South Woodford	1
			E05011255: Wanstead Village	2
Redbridge CCG Total:			4	
North East London ICB Total:				16
NHS NORTH CENTRAL LONDON ICB	NHS BARNET CCG	E09000003: Barnet	E05013628: Barnet Vale	3
			E05013630: Burnt Oak	21
			E05013631: Childs Hill	1
			E05013632: Colindale North	3
			E05013633: Colindale South	1
			E05013635: East Barnet	6
			E05013637: Edgware	28
			E05013638: Edgwarebury	2
			E05013639: Finchley Church End	1
			E05013640: Friern Barnet	6
			E05013641: Garden Suburb	2
			E05013642: Golders Green	1
			E05013643: Hendon	4
			E05013644: High Barnet	4
			E05013645: Mill Hill	7
			E05013647: Underhill	3
		E05013648: West Finchley	4	

		E05013649: West Hendon	1
		E05013651: Woodhouse	3
		<i>E09000003: Barnet Total</i>	<i>100</i>
	E09000005: Brent	E05013499: Cricklewood & Mapesbury	1
		E05013504: Kingsbury	5
		<i>E09000005: Brent Total</i>	<i>6</i>
	Barnet CCG Total		106
	E09000007: Camden	E05013659: Hampstead Town	1
		E05013663: Kentish Town North	1
		E05013665: Kilburn	1
		E05013670: South Hampstead	1
	Camden CCG Total:		4
	E09000010: Enfield	E05013679: Edmonton Green	3
		E05013681: Grange Park	1
		E05013684: Jubilee	1
		E05013687: Oakwood	2
		E05013689: Ponders End	1
		E05013696: Winchmore Hill	6
	Enfield CCG Total:		14
	E09000014: Haringey	E05013586: Bounds Green	1
		E05013587: Bruce Castle	2
		E05013588: Crouch End	3
		E05013597: St Ann's	1
		E05013599: South Tottenham	2
		E05013601: Tottenham Central	1
		E05013603: West Green	1
		E05013605: Woodside	1
	Haringey CCG Total:		12
	E09000019: Islington	E05013706: Holloway	1

	NHS ISLINGTON CCG		E05013708: Laycock	1		
			E05013712: Tollington	1		
	Islington CCG Total:			3		
	NHS NORTH CENTRAL LONDON SUB-ICB UNKNOWN		UNKNOWN	1		
	North Central London Sub-ICB Total:			1		
North Central London ICB Total:				140		
NHS NORTH WEST LONDON ICB	NHS BRENT CCG	E09000005: Brent	E05013496: Alperton	29		
			E05013497: Barnhill	65		
			E05013498: Brondesbury Park	4		
			E05013499: Cricklewood & Mapesbury	7		
			E05013500: Dollis Hill	31		
			E05013501: Harlesden & Kensal Green	31		
			E05013502: Kenton	40		
			E05013504: Kingsbury	132		
			E05013506: Preston	23		
			E05013507: Queens Park	2		
			E05013508: Queensbury	49		
			E05013509: Roundwood	25		
			E05013510: Stonebridge	34		
			E05013511: Sudbury	21		
			E05013512: Tokyngton	21		
			E05013513: Welsh Harp	5		
			E05013514: Wembley Central	63		
			E05013516: Wembley Park	30		
			E05013517: Willesden Green	13		
		E09000005: Brent Total			622	
			E09000015: Harrow	E05013547: Harrow on the Hill	26	
		E09000015: Harrow Total			26	
		Brent CCG Total				648

NHS CENTRAL LONDON (WESTMINSTER)	E09000007: Camden	E05013662: Holborn & Covent Garden	1
	<i>E09000007: Camden Total</i>		<i>1</i>
	E09000033: Westminster	E05013792: Abbey Road	2
		E05013793: Bayswater	1
		E05013797: Knightsbridge & Belgravia	2
		E05013801: Marylebone	1
		E05013802: Pimlico North	1
		E05013806: St James's	1
		E05013808: West End	2
	<i>E09000033: Westminster Total</i>		<i>10</i>
	Central London (Westminster) CCG Total:		11
NHS EALING CCG	E09000009: Ealing	E05013518: Central Greenford	48
		E05013519: Dormers Wells	28
		E05013520: Ealing Broadway	16
		E05013522: East Acton	1
		E05013523: Greenford Broadway	59
		E05013524: Hanger Hill	7
		E05013525: Hanwell Broadway	7
		E05013526: Lady Margaret	67
		E05013527: North Acton	4
		E05013528: North Greenford	26
		E05013529: North Hanwell	20
		E05013530: Northfield	9
		E05013531: Northolt Mandeville	71
		E05013532: Northolt West End	38
		E05013533: Norwood Green	7
		E05013534: Perivale	23
		E05013535: Pitshanger	4
		E05013536: South Acton	6

		E05013537: Southall Broadway	16
		E05013538: Southall Green	10
		E05013539: Southall West	31
		E05013540: Southfield	1
		E05013541: Walpole	11
		<i>E09000009: Ealing Total</i>	<i>507</i>
		E09000018: Hounslow E05013620: Hounslow Central	2
		<i>E09000018: Hounslow Total</i>	<i>2</i>
		Ealing CCG Total:	509
	NHS HAMMERSMITH AND FULHAM CCG	E09000013: Hammersmith & E05013735: Brook Green	1
		E05013736: College Park & Old Oak	2
		E05013740: Grove	1
		E05013742: Lillie	3
		E05013743: Munster	1
		E05013746: Ravenscourt	1
		E05013749: Walham Green	1
		E05013752: White City	8
		Hammersmith and Fulham CCG Total:	18
	NHS HARROW CCG	E09000003: Barnet E05013630: Burnt Oak	2
		<i>E09000003: Barnet Total</i>	<i>2</i>
		E09000005: Brent E05013502: Kenton	56
		<i>E09000005: Brent Total</i>	<i>56</i>
		E09000015: Harrow E05013542: Belmont	96
		E05013544: Centenary	104
		E05013545: Edgware	40
		E05013546: Greenhill	37
		E05013548: Harrow Weald	92
		E05013549: Hatch End	103
		E05013550: Headstone	31

		E05013551: Kenton East	42
		E05013553: Marlborough	25
		E05013554: North Harrow	97
		E05013555: Pinner	123
		E05013557: Rayners Lane	49
		E05013558: Roxbourne	26
		E05013559: Roxeth	62
		E05013563: West Harrow	105
		<i>E09000015: Harrow Total</i>	<i>1,031</i>
	Harrow CCG Total:		1,089
NHS HILLINGDON CCG	E09000017: Hillingdon	E05013564: Belmore	53
		E05013565: Charville	52
		E05013566: Colham & Cowley	89
		E05013567: Eastcote	191
		E05013568: Harefield Village	101
		E05013569: Hayes Town	56
		E05013570: Heathrow Villages	55
		E05013571: Hillingdon East	151
		E05013573: Ickenham & South Harefield	25
		E05013574: Northwood	158
		E05013575: Northwood Hills	71
		E05013576: Pinkwell	58
		E05013577: Ruislip	275
		E05013579: South Ruislip	80
		E05013580: Uxbridge	178
		E05013581: West Drayton	58
		E05013582: Wood End	47
		E05013583: Yeading	48
		E05013584: Yiewsley	129

	Hillingdon CCG Total			1,866
	NHS HOUNSLOW CCG	E09000018: Hounslow	E05013606: Bedfont	2
		E05013610: Chiswick Homefields		3
		E05013612: Cranford		3
		E05013613: Feltham North		3
		E05013614: Feltham West		1
		E05013616: Hanworth Village		2
		E05013619: Heston West		3
		E05013620: Hounslow Central		3
		E05013623: Hounslow South		1
		E05013624: Hounslow West		8
		E05013626: Osterley & Spring Grove		2
		E05013627: Syon & Brentford Lock		1
		Hounslow CCG Total:		
	NHS NORTH WEST LONDON SUB-ICB	UNKNOWN	UNKNOWN	2
	North West London Sub-ICB Total:			2
	NHS WEST LONDON CCG	E09000020: Kensington & Ch	E05009392: Colville	1
			E05009394: Dalgarno	1
			E05009396: Golborne	1
			E05009401: Queen's Gate	1
			E05009404: St. Helen's	1
		E09000020: Kensington & Chelsea Total		5
		E09000033: Westminster	E05013795: Harrow Road	1
			E05013804: Queen's Park	1
			E05013809: Westbourne	1
		E09000033: Westminster Total		3
	NHS WEST LONDON CCG Total			8
North West London ICB Total:			4,148	
NHS SOUTH WEST LONDON ICB	NHS CROYDON CCG	E09000008: Croydon	E05011467:Crystal Palace & Upper Norwood	1

		E05011488: West Thornton	1
	Croydon CCG Total:		2
		E09000027: Richmond upon E05013775: East Sheen	1
		E05013781: Heathfield	1
	NHS RICHMOND CCG	E05013782: Kew	1
		E05013786: South Richmond	1
		E05013787: South Twickenham	1
		E05013789: Twickenham Riverside	1
	Richmond CCG Total:		6
		E09000032: Wandsworth E05014017: Roehampton	1
		E05014018: St Mary's	1
	NHS WANDSWORTH CCG	E05014026: Wandle	1
		E05014030: West Putney	1
	Wandsworth CCG Total:		4
	South West London ICB Total:		12
	Grand Total		4,317
	Out of MVCC Total:		12,972

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Working with people and communities: our involvement strategy

JHOSC, May 2025

When do we get to have our say?

***“You come and talk to us when you want to shut something.
You come and talk to us when you want us to get vaccinated.
When do we get to say what we want?”***

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North west London resident, 2021



NHS North West London's involvement charter

You can be involved in key decisions that affect you

You will know how your views have shaped and influenced the decisions

We will co-design services with local people, working with all the communities we serve

We will provide you with information that is in plain language, timely, balanced , objective and in different formats when needed

We will be transparent in everything that we do

Resident insights help us identify priorities for improvement

In-reach programme with inequalities focus, asking communities what matters to them

Resident insights help us identify priorities for improvement (as do clinical advice, evidence and performance)

Continued clinical leadership, monitoring of performance, emerging evidence from elsewhere supports continuous improvement

Ongoing feedback and amends

Develop proposals through public involvement/co-design

Decision-making

Formal consultation/involvement where appropriate



Who do we have to reach?

NW London has 2.1m residents, over 100 languages, 200 ethnicities.

1 in 5 adults has 2 or more long term conditions.

This list is not exhaustive: all groups and sub-groups have specific health needs.

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The 'protected characteristics' are:

Age, disability, sex, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation, marriage or civil partnership.

It is also common to take account of:

Carers, people experiencing social or financial deprivation and other groups depending on issue

Groups we have heard from include:

- Gypsy, Roma and traveller communities
- Ex-offenders
- Asylum seekers and refugees
- Rough sleepers/homeless people
- Children and young people
- Mental health service users
- People with physical disabilities
- People with learning disabilities
- People with sensory impairments
- Wide range of community groups

How we reach them

- Extensive **community in-reach programme** reaches hundreds of residents every month – targeted through an inequalities lens, working with local authorities and the voluntary and community sector to identify and speak to groups ‘where they are’
- **Co-Design Advisory Body**, drawn from people working with communities that have been poorly reached in the past, has transformed our understanding of a whole range of communities, including travelling communities, refugees and asylum seekers, homeless people, people with physical disabilities, people with learning disabilities and autism and many more. Attendees have described the group as transformational, as learning from attendees has impacted how we communicate with communities.
- Quarterly **Residents’ Forum** open to all, which has discussed issues as diverse as planned care, primary care access, palliative care and our involvement strategy. Quarterly ‘collaborative spaces’ open to all in each borough are in place or being developed. We also support an independent Patient Participation Group (PPG) Forum.
- Resident voices on ICS programmes via our **lay partners** - 120 currently registered with the ICB.
- A **Citizens’ Panel** of 3,800 people, recruited to reflect local demographics – used for survey and ongoing dialogue.
- **Commissioning local VCS organisations** to get key messages to communities during winter.
- **Partnership work** with local authorities, Healthwatch and voluntary and community sector organisations.
- **Social media**, especially via Next Door, Facebook and less frequently X.

How we work with people

Our involvement programme is strategically focused through:

- alignment of borough and ICB priorities
- use of local data analysis to identify target communities and geographical areas
- building trusted relationships with community leaders and local groups, aligned to the ICB's priority areas
- asking people what matters to them, rather than just focusing on NHS priorities and changes.

Some examples of targeted involvement delivery include:

- an ICB-funded initiative in Harefield, engaging women from the traveller community through floristry workshops combined with health promotion and feedback sessions
- collaborative workshops alongside the British Indian Association in Brent, focused on cervical cancer awareness among South Asian women. Delivered in partnership with Royal Marsden Partners and Brent Public Health, the evaluation showed increased confidence in accessing screening and a reduction in hesitancy
- a continued focus on Chinese-speaking women aged 25–49 in south Westminster, identified through data analysis as having particularly low cervical and breast screening uptake.

What the last quarter looked like

In the last quarter of 2024/25, key outputs included:

- 90+ events delivered to support the Compassionate Care For All public consultation (November–February)
- A breast cancer screening engagement session delivered in partnership with public health, community champions, and VCS partners, including Q&A on hesitancy and barriers
- Over 2,500 resident contacts across 119 involvement events (December–February)
- Presentations and outreach to promote priority areas such as childhood immunisations, including tailored sessions with learning disability and autism groups, women and Family Hubs, and the French-speaking African heritage community
- Two faith-centre events in Hounslow, hosted at a local Hindu temple and gurdwara. These events focused on breast and cervical cancer, hypertension, diabetes, and frailty. Delivered in partnership with Imperial Health Care Partners, Chelsea and Westminster Hospital, and Hounslow Public Health, the events provided health checks and screening referrals. Over 300 community members attended.
- A member-led review of the Co-Design Advisory Body, with attendees describing the group as transformational.
- A Residents' Forum on planned care, which was also a key topic for in-reach work.

How the team is structured

Our **Involvement Team** is structured to support the ICB through a borough cluster-based model, with staff working in three groups.

- Involvement team for Brent, Harrow, Hillingdon and Ealing (each borough has an involvement manager)
- Involvement team for Westminster, Kensington & Chelsea, Hounslow and Hammersmith & Fulham (each borough has an involvement manager)

Our Insights Unit (two staff) works across north west London – producing insight reports and coordinating system-wide activity (lay partners, Co-Design Advisory Body, Citizens' Panel).

The team operates as a single, integrated function within the ICB's Communications and Involvement Directorate, ensuring a clear and consistent connection between resident engagement and the ICB's core programme priorities.

Case studies

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Tackling hypertension

- Harrow has London's highest prevalence of coronary heart disease (2.7% compared to London's 1.9%). It is estimated that there are over 19,000 people in the borough with undetected high blood pressure, accounting for 6.7% of the whole registered adult population in May 2023.
 - Using an innovative machine learning model, the project team identified 19,030 residents in Harrow at high risk (over 60% chance) of having undetected hypertension. The combination of data-driven geographical targeting with community insights as to particular communal 'hot spots', supported the team in achieving a high rate of detection (one in five) where residents being screened were found to have a blood pressure reading outside of the normal range.
- Over 680 participants were screened and results were fed back to GP practices in Harrow for further action. Learnings from this project were a key contributor to the creation of an [NHS North West London toolkit](#), for supporting professional colleagues across the system in leading community outreach campaigns focusing on undiagnosed hypertension.
- The creation of the toolkit was led by NHS North West London's involvement team, co-designed with partners across each of our eight boroughs. The toolkit has been launched and wallet-sized blood pressure reading cards will be distributed to borough teams, to support in ensuring readings are easily shared back to practice.

Hindu women's health event

- In Hounslow, the involvement team have established a set of pilot sessions, bringing together local and system health & care partners to deliver health focused sessions to the congregations of three faith centres in the borough. The first of these took place on 25 March 2025, at the Lakshmi Narayan Hindu temple.
- The team worked with the management committee of the temple to identify core the core theme for steering the engagement session. It was agreed that the initial focus would centre on women's health, in particular breast cancer screening. The team were able to invite a number of partners to provide a positive range of direct interventions and health promotion offers for those residents attending.

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A colleague from Imperial College Health Partners attended and was able to directly book women attending onto screening appointments within the following two weeks, an offer that 4 women took up on the day. The Hounslow public health commissioned Health Outreach Team attended to offer balance checks and blood pressure readings. Over 100 such checks and readings were provided on the day, with 5 women being directly referred onto frailty pathways following balance checks. NHS North West London's local childhood immunisations coordinator attended to collate resident insight relating to vaccines hesitancy, and provide information. The local primary care network were represented by one of their GPs and a practice nurse. Chelsea and Westminster were represented by a colleague offering counselling sessions for those living with, and/or recovering from breast cancer.

- There were 150 attendees throughout the day and the team have already booked in to provide follow-up sessions every two months for the duration of 2025. With the next session to take place on 17 June 2025. Due to the strong relationships, the temple's management committee offered the venue and local promotion for free. Due to the position of the team as strategic coordinators of public involvement, such a positive range of colleagues and partners were able to provide their offers to a key target demographic (South Asian women aged over 40) within a local community safe space. The model hinges upon such trusted relationships, which the involvement team remain uniquely placed to deliver. The pilot continued at a Hounslow gurdwara on 1 April 2025, and a Hounslow mosque on 25 April 2025.

Women's screening event

- RBKC public health team organised an event at Westbourne Park Baptist Church, focused on sharing cancer screening information, specifically breast, bowel and cervical cancer screening. This event was promoted among the church's congregation, local learning disability groups and carers.
- Partner colleagues working on breast and bowel cancer promotion at Imperial College Healthcare NHS Trust presented on these topics.
- The NHS North West London involvement team were asked to support with a talk on cervical cancer screening. The team delivered a talk on the importance of screening and early detection, the eligibility criteria, the screening itself and how to book appointments. The team supported with a Q&A after, where questions on eligibility and the HPV vaccine were answered.
- This event was attended by 28 women, from mostly black heritage community backgrounds.
- This event is a great example of how different parts of the system – local authorities, NHS provider Trusts and the ICB – work together to support our residents and communities.

Legal duties on involvement

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NHS duty to involve

Under the Health and Social Care Act 2022, ICBs must make sure that service users, carers and their representatives are involved in:

- the planning of the ICB's commissioning arrangements
- the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point the service is received by them) or the range of health services available to them
- decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

This could be delivered through public consultation, public engagement or information for the public, depending on what is proposed.

Statutory guidance requires each ICB to produce an **involvement strategy** and ICBs are assessed annually against the implementation of this strategy. NW London has been assessed very positively and been referred to as an exemplar.

[You can read our involvement strategy here.](#)

The 'Triple Aim'

The 'Triple Aim' obliges bodies that plan and commission services – ICBs and NHSE – to consider the effects of their decisions on:

- the health and wellbeing of the people of England (including inequalities)
- the quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services)
- the sustainable and efficient use of resources by both themselves and other relevant bodies.

Working directly with people and communities is essential to achieving this legal requirement. [NHS England »](#)
[Working in partnership with people and communities: Statutory guidance](#)

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Report to the North West London Joint Health Overview Scrutiny Committee – 01 May 2025	
North West London Joint Health Overview Scrutiny Committee Recommendations Tracker	

No. of Appendices:	2 Appendix 1: 2023/24 North West London JHOSC Recommendations and Information Requests Tracker Appendix 2: 2024/25 North West London JHOSC Recommendations and Information Requests Tracker
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Chatan Popat, Strategy Lead - Scrutiny Democratic and Corporate Governance Finance and Resources Brent Council chatan.popat@brent.gov.uk

1.0 Purpose of the Report

- 1.1 To present the latest 2023/24 and 2024/25 scrutiny recommendations trackers to the North West London Joint Health Overview Scrutiny Committee (NWL JHOSC).

2.0 Recommendation(s)

- 2.1 That:

The committee note the latest scrutiny recommendations tracker for the 2023/24 municipal year in Appendix 1 and the 2024/25 municipal year in Appendix 2.

3.0 Detail

- 3.1 The North West London JHOSC, according to its Terms of Reference can make recommendations to the North West London Integrated Care System and its Integrated Care Board, NHS England, or any other appropriate outside body in relation to the plans for meeting the health needs of the population.
- 3.2 The North West London JHOSC may not make executive decisions. Recommendations made by the committee therefore require consideration

from the relevant NHS body. When the North West London JHOSC makes recommendations to NHS bodies, the relevant decision maker shall be notified in writing, providing them with a copy of the committee's recommendations and a request for response.

- 3.3 The 2023/24 and 2024/25 North West London JHOSC Recommendations and Information Requests Trackers (attached in Appendices 1 and 2) provide a summary of scrutiny recommendations made during the previous and current municipal year. These tracks decisions made by NHS colleagues and gives the committee oversight over implementation progress. It also includes information requests, as captured in the minutes of its committee meetings.
- 3.4 Updates to the tracker from the previous meeting are highlighted within the table.

Appendix 1: 2023/24/25 North West London JHOSC Recommendations and Information Requests Tracker

Meeting Date	Item	Recommendation / Information Request	Detail	Response	Status
18 July 2023	Acute beds	Information Request	For the JHOSC to receive ongoing updates regarding extra capital funding for acute beds in relation to winter pressures	Slides around this have been shared with wider council colleagues, as suggested by the JHOSC in July. We should have some more clarity on next steps later in September.	
		Information Request	For the JHOSC to receive updates on the work undertaken by Acute Trust and the ICS to progress the work at delayed hospitals in the New Hospitals Programme.	Imperial College Healthcare Redevelopment update - August 2023 Following the concerns we raised about the delays announced for our schemes (at St Mary's, Charing Cross and Hammersmith hospitals), we hosted a visit at St Mary's in July from Lord Markham, Parliamentary Under Secretary of State at the Department of Health and Social Care. We were able to show the minister the very damaging impact of our failing estate on patients and staff and set out the many benefits of our redevelopment plans, including for the local and national economy. We had a good discussion about the work we have underway to explore the feasibility of potential partnership opportunities that could accelerate the St Mary's redevelopment, leveraging the value of the land that will be surplus to requirements once we have a new hospital on a less sprawling footprint. We are due to meet Lord Markham again in early autumn to update him on the outcome of this work. We have also had significant engagement with the New Hospital Programme team and we are currently working through a process with them to test our capacity and cost modelling for all three of our schemes. We are still hoping to complete a first stage business case for Charing Cross and Hammersmith this autumn and, depending on the outcome of the St Mary's partnership feasibility work, to secure first stage business case approval for St Mary's by the end of the year. While there is still much to be clarified in terms of further	

				process and decision making, progressing our business cases has to be a priority whatever route we take. Meanwhile, our estates team is working hard to delay any further major buildings failures for as long as possible. You may have seen the extensive scaffolding in place at Charing Cross and, more recently, St Mary's. Works include an extensive weather-proofing programme for our oldest buildings at St Mary's, roof repairs at Charing Cross and essential inpatient ward refurbishments across our sites to ensure we are able to maintain infection prevention and control standards. We are keen to continue to share our thinking and plans as they evolve. We also want to engage more broadly with our patients and local communities as soon as we have a little more clarity on next steps.	
	Ophthalmology	Information Request	For the JHOSC to receive more details on the ongoing engagement work related to the standardisation of ophthalmology services.	Engagement so far has been through a series of online and face to face sessions, supported by surveys. As part of the new community service the selected provider will be expected to work with the Integrated Care Board in undertaking focussed patient engagement, looking at experiences of using the service and opportunities to improve the service to better meet the needs of all of our communities. As we further develop the standardisation, the intention is to work with patient representatives to co-design pathways in partnership with primary and secondary care clinical stakeholders. These co-design workshops will be supported by targeted community engagement activities where co-designed pathways will be introduced and feedback from our communities gathered to support further improvements.	

				These activities will commence later this year and continue for the duration of this contract (i.e., 3 years).	
		Information Request	For the JHOSC to receive more information on how the standardisation of ophthalmology services will address health inequalities in North West London.	Standardisation of our ophthalmology service will support the drive to address health inequalities in NW London by: - Ensuring that there is a standard service offering available to all NW London residents – in particular this includes ensuring that all NW London residents have access to a community ophthalmology service - Ensuring that residents are able to access primary eye care through the large number of optical practices available across NW London, which will make it more convenient for patients to access care The ICS will work in partnership with all of the key stakeholders in our communities, bringing them together with colleagues from primary and secondary care and public health to understand how we can better support communities in accessing eye care.	
		Information Request	For the JHOSC to receive baseline data on performance in ophthalmology services in order to measure performance in North West London against national and London standards. With a breakdown by paediatric and adult ophthalmology service performance.	We are developing a data pack for ophthalmology across the ICB footprint, in partnership with clinical colleagues through our Clinical Reference Group. This will be shared with JHOSC later in the summer when completed with validated and evidenced data.	
	Musculoskeletal (MSK)	Recommendation	To ensure that diagnostic capacity across North West London is properly linked to musculoskeletal services to best benefit residents across North West London.	Diagnostic delays were identified as a specific issue in Harrow due to historic local arrangements. These have now been addressed and brought in line with other parts of the ICB.	
		Information Request	For the JHOSC to receive baseline access wait times for musculoskeletal services and details on how the new	We are completing a review of the waiting times data for the new service in partnership with the provider, as part of our regular contract review and management process. When this	

			service standards will improve waiting times for treatment.	data has been formally reviewed, we will share with all partners and ensure that patients are kept informed of likely waiting times.	
		Information Request	To provide information on where the gaps in resource with palliative and end of life care are, how they will be addressed and how this will be monitored.	Separate paper supplied on 27/11/23 to Chatan	
		Recommendation	Provide a report around mental health provision for children and young people to come to a future JHOSC meeting.	We are currently working through the Children and Young People Mental Health Steering Group to refresh our Children and Young People Mental Health transformation plan and also intend to focus the strategy work on Children and Young People in 2024. Suggest that this is timetabled for later on in the year, following agreeing the scope of the CYPMH part of the strategy.	
		Information Request	To receive the details of the alternative provision to accident and emergency located across the boroughs.	An interactive map can be found here	
			To receive further details around on the engagement plans when available.	Everything is on the website, including the engagement report: https://www.nwlondonicb.nhs.uk/get-involved/your-views-mental-health-services-nw-london	
		Information Request	To receive more information around plans or existing activity to support people and communities in deprived areas or intersectional needs.	As we further develop the mental health strategy, this will include a strengthened focus on inequalities. The strategy is being presented at the October 22 nd , 2024, JHOSC.	
	Proposals on the future of The Gordon Hospital	Information Request	To provide the following: - The commentary and output of the pre-consultation workshops. - Completed and upcoming events with service users and carers.	This information is published on the ICB website. <u>Acute mental health consultation: North West London ICS (nwlondonicb.nhs.uk)</u>	

			• Service users' experience of Gordon Hospital. • A more detailed consultation plan. • Historical reports of Gordon Hospital service users over the last 5 years. • Historical demographic data of Gordon Hospital service users.		
05 December 2023	ICS Workforce Strategy and Programme Update	Recommendation	Provide an update to the Committee once NHS have assessed the Government's new position on immigration and how this might affect recruitment and workforce within North West London.	The main impact will be on social care rather than health care professionals. From March 2024, care workers and senior care workers will not be able to bring dependents and only CQC-registered providers in England will be able to sponsor Health and Care Visa applicants. Ahead of this, 53 Senior Carers completed pre-employment compliance through NW London International Recruitment Team. The first Cohort of Senior Carers landed in UK; induction completed with employers supported by NWL Health & Social Care Skills Academy.	
		Recommendation	Provide an update of progress by the Race Equality Steering Group.	The Race Equality Steering Group is Co-Chaired by Rob Hurd and Linda Jackson. The Steering Group commissioned an Independent Report into Barriers to Leadership. The Report and strategic recommendations will be published as a Call for Action.	
		Information Request	Provide regular updates on progress of the seven priority workstreams.	Progress is reported monthly to the Strategic Chief People Officers Meeting and bi-monthly to the ICS People Board. There has been good progress on the pipeline for acute roles following two International Recruitment events, offers made to; 67 Registered Nurses, 40 Registered Midwives, 2 Sonographers, 2 ODP, 26 Radiographers, 5 physiotherapists, 2 ODPs	

				There has also been a strong response to the launch of the ICS Graduate Scheme for future leaders. An undergraduate scheme is also in development. A Spring EDI Summit is being planned to agree sustained medium-term interventions that will embed equality, equity, social and racial justice Work also continues to deliver new ways of working to support new models of care.	
	NWL Elective Orthopaedic Centre	Recommendation	Report to the Committee on the success against metrics and targets identified for the Orthopaedic Centre and also get feedback from staff and patients. It would be interesting to get some reports from staff and patients after March on - how they feel things have been going and what could be improved and what the NHS system can learn going forward.	In January 2024 the EOC operated on 140 patients. Of these 64 were admitted to the EOC ward, with an average length of stay of 2.8 days. Unfortunately, 14 lists (35 patients) were cancelled in January due to the Junior Doctors' industrial action. The Friends and Family Test has reported 100% satisfaction with the service. A selection of patients were contacted for further feedback. Generally, the feedback was positive with all patients highly satisfied with their experience and very likely to recommend the EOC to others. Areas of suggested improvement were around the early morning theatre admission process and clearer signage about where to wait. The EOC's current operating capacity of three theatres will increase to five theatres (full capacity) in March 2024 at which point reporting against metrics and targets can be better undertaken.	
		Recommendation	Report to the Committee on the operation of the dedicated transport provision.	In January 2024 there were 12 EOC patients that used the free patient transport service. Three journeys were from the patients' homes to the hospital, and nine journeys were from the hospital to patients' homes. The earliest arrival at the hospital was 7.30am and the latest departure was 6pm. Eleven	

				journeys were by ambulance and one was by car ambulance. Except for two occasions where the patient wasn't ready, journeys were able to commence on time or earlier than scheduled. Journeys were made to/from Brent, Ealing, Hounslow, Harrow and Hammersmith & Fulham.	
	ICS Updates: ICS Running Costs Reduction	Recommendation	To bring a report to the Committee once there are more detailed plans available on the redesign and consultation.	There is no impact on services, so our focus will be on how we work with partners and our organisational effectiveness.	
14 March 2024	Primary Care Access And Same Day Access Model	Recommendation	That NWL NHS undertake an Equality Impact Assessment and Human Rights Impact Assessment prior to implementing any changes in the way patients access primary care.	Same day access proposals are not currently being implemented. Any significant change at a practice or PCN level would be subject an EHIA at that level.	
		Recommendation	That the Committee should seek meaningful consultation with patients, communities and GPs. Any engagement undertaken should be representative of the whole patient voice.	PCNs are leading a process of engagement and co-design at local level.	
		Information Request	For the NWL JHOSC to be provided with feedback and analysis of the impact of the early adopter PCNs, including case studies that have been learned from.	An update has now been given to the NWL JHOSC at the meeting on 22 October 2024.	
		Information Request	For the NWL JHOSC to receive full details of how patient safety and effectiveness would be measured against the proposals.	The proposals previously discussed are not currently being pursued.	
		Information Request	For the NWL JHOSC to receive information on the outcomes of the work	An update has now been given to the NWL JHOSC at the meeting on 22 October 2024.	

			done by KPMG in a way that was easy to understand and that related to patient outcomes.		

Appendix 2: 2024/25 North West London JHOSC Recommendations and Information Requests Tracker

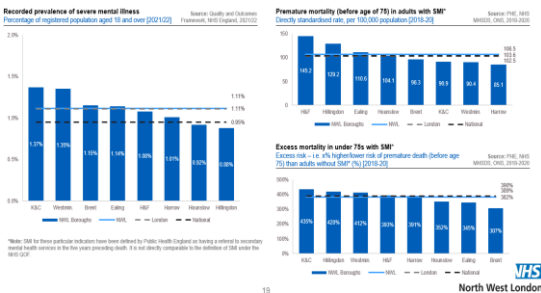
Meeting Date	Item	Recommendation / Information Request	Detail	Response	Status
22 October 2024	NWL Adult Community-based Specialist Palliative Care (CSPC) Review	Recommendation	That NWL NHS consider lessons learnt from previous consultations such as the Gordon Hospital to ensure that the complexity in working with multiple and hard to reach communities and stakeholders is considered throughout the consultation and engagement processes to ensure meaningful insights are acquired resulting in effective decision making.	This has been considered and has been factored in with the design and implementation of the consultation.	
		Recommendation	That NWL NHS take proactive actions with hospitals and clinicians to ensure patients and families have all the information they require in advance regarding their options for end-of-life care planning and support available for families.	The Urgent Care Plan (UCP) is an NHS service that enables every Londoner to have their care and support wishes digitally shared with healthcare professionals across the capital. NHS North West London has identified the further roll-out of the UCP to north west London residents and clinicians as a priority and is in the process of putting together a plan to do so.	
		Recommendation	That members of the committee provide a list of locations in their borough to Chatan highlighting suitable places for drop-in sessions and consultation activities to take place as this could result in enhanced engagement with residents. Chatan to then collate a list and pass on to the NWL NHS Engagement Team.	A list of locations from some boroughs has been received and subsequently forwarded to NWL NHS to consider.	
	NWL Mental Health Strategy	Recommendation	For the JHOSC to be presented with a further, more detailed report on the NWL Mental Health Strategy detailing what the strategy actually entails, it's priorities and	The Mental Health Strategy has been signed off and published. The ICB board made a final decision on acute	

mental health inpatient services in April. This is also published on the ICB website

Data on prevalence of severe mental illness and CMH caseload across boroughs can be found below. This has also been included in the report presented to the committee (pages 19 and 49).

To provide a borough-by-borough breakdown of those with Severe Mental Illness (SMI) across NW London.

The information should include a more detailed breakdown of what has already been provided to the committee including conditions per borough and actual numbers on prevalence rather than percentages.



CMHT Treatment Met & Unmet Need								
Latest 12-Months (01/07/2022 - 30/06/2023)								
Service	Avg. Caseload	Avg. In-Treatment Caseload	Avg. Waiting List (Caseload Waiting for First Contact)	SUs With At Least 2 Contacts in the 12-Month Period	2023/24 Access Goal	Difference	18+ Pop.	Discharged as a % of 18+ Pop.
CMHT - Brent	2,503	1,770	476	3,506	4,235	-729	236,907	1.48%
CMHT - Harr	2,182	1,342	460	2,635	2,842	-207	181,646	1.45%
CMHT - Hill	2,562	1,349	519	2,469	3,581	-1,112	221,491	1.11%
CMHT - K&C	1,700	1,217	252	2,388	2,767	-379	120,664	1.98%
CMHT - Westminster	2,621	1,736	403	3,390	2,370	1,020	210,025	1.61%
MINT - Ealing	4,313	1,710	933	3,419	4,751	-1,332	243,031	1.41%
MINT - H&F	3,178	1,053	739	2,034	2,525	-491	139,004	1.46%
MINT - Hounslow	3,668	1,185	787	2,766	3,361	-595	194,848	1.42%
Total	22,565	11,346	4,569	22,607	26,433	-3,826	1,547,616	1.46%

Further information in regard to the number of adults rather than percentages and a further drilled down layer of data per borough has been shared with the committee.

	NWL Primary Care Access	Recommendation	That future communication plans and survey questionnaires, not only for this item, but also for future planned work and consultations are shared with the committee in advance for comments to ensure effective questioning and constructive discussions can take place at JHOSC meetings.	This has been agreed by the engagement team, and such information will be shared to JHOSC in advance as part of the consultation process whenever possible.	
05 December 2024	North West London Winter Campaign and London Ambulance Performance Update	Information Request	That the Committee receive information about critical care bed capacity, delays and discharges from hospitals and vaccination data.	As data becomes available, it is being circulated to members electronically via Chatan.	
		Information Request	That the Committee receive a breakdown of GP face to face appointments across the NWL NHS eight boroughs.	NW London has consistently had the highest level of face-to-face appointments across London. The published data is per ICB (NW London wide). • November 24: 68.0% • December 24: 66.6% • January 25: 66.4% • Feb 25: 66.6% • March 25: 66.9%	
		Information Request	That the Committee receive information about how the Ambulance Service anticipates managing the changes for domestic abuse coming into effect in early 2025 under Raneem's Law.	This request has been accepted at the meeting. The London Ambulance Service will contact all relevant parties and authorities (individually or through the NWL JHOSC) once an approach has been confirmed.	
		Recommendation	That NWL NHS work more closely with the local authorities to deliver messaging to specific communities and groups about accessing the Ambulance Service.	NHS North West London is picking up as part of joint work with LAS and local authority communication teams. More information to be provided.	
	North West London Health Equity Programme	Information Request	That the Committee receive the information about how the Health Equity Fund of £8 million is divided between the boroughs annually.	This information has now been circulated electronically to all members. Below is a breakdown of the allocation of funds by borough.	

				considered more appropriate and should not be routinely prescribed in primary care because: • there is limited evidence of clinical effectiveness for the item • the item would be prescribed for a condition that is self-limiting and will clear up on its own without the need for treatment • the item would be prescribed for a condition that is appropriate for self-care. Importantly, note being exempt from NHS prescription charges does not automatically override this guidance. However, the policy does recognise the impact of health inequalities. It allows for clinical discretion in exceptional cases, including where a patient may be unable to self-care due to significant medical, mental health, or social vulnerabilities. In such situations, treatment may be prescribed if deemed clinically appropriate by the prescriber. Prescribers are advised to consider safeguarding concerns and use their professional judgement where reliance on self-care could adversely affect a patient's health or wellbeing.	
	Integrated Care System Update	Information Request	That the Committee receive an outline of the new ICB structure and key contacts for each borough.	Rory has provided key contacts to Chetan for circulation. ICB structure chart to follow as still being updated. Note that these are likely to change again due to national changes to ICBs.	
		Information Request	That the Committee receive the communication plan and venues for the palliative care consultation.	The communications plan, venues for the consultation and details of all online sessions have been shared with the NWL JHOSC electronically.	

				Additionally, members have now also been sent links to all online consultation video recordings for their reference.	
		Information Request	That the Committee receive the details about the Work Well scheme which launched in October and that supports residents with health conditions back into employment.	The details of the Work Well scheme have been circulated to all members. Attached below is a detailed document providing further information on the scheme.  WorkWell latest information.docx	
		Information Request	That the Committee receive information about the London Refugee Employment Programme.	The Partnerships, Population Health and Reducing Inequalities team connect into this as a programme, but don't take a strong leadership role within. Interested parties can contact Anthony Sembatya at Anthony.Sembatya@westlondon.nhs.uk for more detailed information.	
	13 March 2025	Information Request	NWL ICB to update the committee on the Mount Vernon Cancer Centre relocation providing information on alternatives to relocation to Watford and any further updates arising.	Paper submitted / agenda item for the May JHOSC meeting.	
		Information Request	NWL ICB to update the NWL JHOSC on the impact of the Government's proposed 50% cuts on ICS and ICB services.	Rob will keep the committee updated as things develop	
		Recommendation	For NWL NHS to conduct investigation / research into the possibility of bias in AI technology being used for Planned Care both in relation to gathering data and assisting with care arrangements and appointment handling.	- Artificial Intelligence technology has numerous possible benefits in healthcare delivery supporting patients, administration and clinical decision making. For example, this includes: - Summarising live audio recordings of appointments to generate first drafts of clinic notes, letters and follow-up actions saving clinicians time and allowing them to focus more on the patient discussion	

				○ Searching and synthesising a patient's record to help clinicians prepare for an appointment and understand their previous, relevant interactions with the healthcare system ○ Support patients access information, provide information and schedule appointments, including through using voice calls with natural language models available in multiple languages to address potential risks to digital isolation if patients are not comfortable using smartphones ○ Population health analyses across multiple data sources to identify unmet needs, prevention opportunities and quality improvement opportunities • While there are demonstration products that support these tasks, none have been adopted at more than a pilot scale for example in individual GP practices using AI-products such as Heidi or Tortus which summarise live audio recordings. • Governance frameworks to support AI-integration into clinical workflows and systems have been designed at the acute hospitals in North West London. These will support further pilots and research of further AI tools. The risks of clinical adoption are well recognised. For example, the positive first impressions these tools often create on their capability create a human factor risk of being too trusting in the future outputs of these tools, which could mean they are not adequately reviewed or edited into a final record. • AI-Tools will need to be an important component of any future planned care and healthcare strategy because of the benefits they offer, including improved patient experience, clinical experience and productivity. NWL institutions will continue its work with academic and industry partners, such as	

				Imperial College London and Imperial College Academic Healthcare Science Network, to evaluate AI-tool pilots, their impact on patients and clinicians, and their risks including bias and hallucination (when AI-models make up something that is not real). This research and support will complement broader national and international efforts and understanding in this rapidly emerging field of technology.	
		Recommendation	For NWL NHS to further assess the impact of the new strategy on the elderly population.	• A significant proportion of planned care activity relates to chronic health conditions such as heart failure, hypertension, rheumatology, diabetes, COPD and chronic kidney disease. The likelihood of developing one, and then more than one, chronic condition increases with age. This means that older people are high users of planned care and may need planned care support from multiple different specialties simultaneously. • During the development of the strategy patients and local communities were invited to offer their ideas and experiences to support its development. Older people formed a significant element of this feedback, including in forums such as the local resident's groups. Clinical stakeholder feedback has also highlighted the importance of older people and how their needs and ability to access care can be different to others. • The strategy is organised around these pillars, all of which will directly and positively impact older people and their experience of planned care. They are: ○ Redesigning primary and secondary care pathways - this includes integration of greater planned care specialist support into neighbourhood health teams. These are closer to where people live, will support more integrated work with primary care and other	

				community healthcare providers, and enable greater focus on coordinating care for individuals whose needs cross multiple specialties. This could have benefits for example in balancing medication needs and reducing the risk of polypharmacy. ○ Improving patient activation and communication - this will support older people through targeted focus on communication and scheduling processes, so that everyone knows how long they should need to wait to their appointment, allow multiple ways to schedule and reschedule appointments, improve the quality of administrative information they receive, and expand how patient initiated follow-ups when suitable are used so that patients do not need to wait for a pre-determined period if they need specialist help more quickly. This will help join visits together, ensure better information is available and make it easier to get follow-up advice. ○ Improving productivity - this will increase the overall level of planned care activity through current available resources. Greater activity will reduce waiting lists more quickly, benefitting the whole population including older people. • The strategy development has held equity central to its development. While there will be an expansion of digital tools and ways of working to support patient experience and productivity, it is recognised that this is not suitable for the whole population. However, using these tools frees up capacity for equitable support to mitigate risks of digital exclusion. • When subsequently implementing major changes identified in the strategy, such as new pathways, tools or projects, Quality and Equality Impact Assessments will be conducted. This is a step in all significant changes made to understand the impacts on different quality issues and population groups including older people, agree how to mitigate their	

				risks and impacts, and sometimes stop initiatives altogether when the risks or impacts are felt to outweigh potential benefits. This means that even as the strategy implementation progresses in future years, impacts on all population groups including older people will remain an important consideration.	
		Information Request	NWL ICB Communications and Involvement Team to provide further information in regard to communications with residents and patients linked to the NWL Planned Care Strategy.	Engagement and involvement activity on planned care strategy Engagement with the residents of across North West London in relation to the planned care strategy took place through a mix of online digital engagement and face to face discussions at events in all eight boroughs. There were a total of 303 responses to the online survey. Insight received from the public focused not only on waiting times, but on communication, preparation, access, and system responsiveness. The feedback gathered a mix of quantitative and qualitative data and identified recurring themes such as the emotional toll of uncertainty, the importance of feeling informed and remembered, and the desire for more proactive, practical engagement while waiting for care. As part of the wider engagement on planned care, <i>The Advocacy Project</i> facilitated Easy Read engagement sessions with people with learning disabilities in Brent and Westminster. This approach ensured that those with communication and cognitive access needs had the opportunity to share their views in a meaningful and supported way. A total of 32 individuals from learning disability communities attended sessions which used Easy Read formats, visuals, and supported discussion. These sessions were delivered in familiar community settings with facilitators trained in accessible communication. Communications and engagement activity included:	

				• a new webpage on the NHS North West London website outlining what planned care is and the work underway • issues paper and briefing document on the ICB website • issues papers and survey shared directly with key stakeholders, patient/public and community groups and in NHS North West London e-bulletins • news article copy for acute provider intranets and NHS North West London websites • borough involvement team cascade to VCS and borough-based stakeholders • newsletter text shared with local authorities for resident and staff email newsletters • newsletter text sent to providers for patient and staff bulletins, provider intranets and NHS North West London websites • social media posts shared on NHS North West London channels • information and survey link shared with North West London Citizen's Panel • information and survey link shared on Next Door social network • update to PPG forum • presentation with question-and-answer session at NHS North West London Residents Forum • email sent to resident forum participants with information and survey link • issues paper and survey sent to Healthwatch representatives • meeting held with NHS North West London Healthwatch representatives • information provided to Local Authority partner communications teams on ICB led sector call including survey link • in person discussions with residents across all eight boroughs with feedback gathered at an average of	

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				five in-person events in each borough during February and March																																													
		Information Request	To provide the Committee with comparative data surrounding wait times across the ICB's different boroughs.	This is data on the length of time patients have been on waiting lists at a borough level – <table><thead><tr><th></th><th>0-17wks</th><th>18-51wks</th><th>>52wks</th></tr></thead><tbody><tr><td>Brent</td><td>51%</td><td>45%</td><td>3.8%</td></tr><tr><td>Central London</td><td>58%</td><td>39%</td><td>2.4%</td></tr><tr><td>Ealing</td><td>53%</td><td>44%</td><td>2.9%</td></tr><tr><td>Harrow</td><td>48%</td><td>48%</td><td>3.8%</td></tr><tr><td>Hillingdon</td><td>48%</td><td>50%</td><td>1.7%</td></tr><tr><td>Hounslow</td><td>58%</td><td>40%</td><td>1.7%</td></tr><tr><td>H&F</td><td>59%</td><td>39%</td><td>2.6%</td></tr><tr><td>West London</td><td>58%</td><td>39%</td><td>2.3%</td></tr><tr><td>Non-NWL</td><td>58%</td><td>40%</td><td>2.1%</td></tr><tr><td>4 Provider Total</td><td>54%</td><td>43%</td><td>2.7%</td></tr></tbody></table> There is variation between boroughs, reflecting historic referral practices and individual NHS provider performance, hence why patients in Brent, Ealing, Harrow and Hillingdon are waiting relatively longer given the tendency of these patients to be referred to THH and LNW. It should be noted that this data is based upon unvalidated datasets and could change (slightly) in proportions as a result of individual pathway validation. However, the basic trend of variation seen across the boroughs reflects the overall performance of the 4 main NHS providers in the sector. The national objective to improve Referral to Treatment Time, including the target to achieve 65% by March 2026, will help improve this situation and local provider and place-based		0-17wks	18-51wks	>52wks	Brent	51%	45%	3.8%	Central London	58%	39%	2.4%	Ealing	53%	44%	2.9%	Harrow	48%	48%	3.8%	Hillingdon	48%	50%	1.7%	Hounslow	58%	40%	1.7%	H&F	59%	39%	2.6%	West London	58%	39%	2.3%	Non-NWL	58%	40%	2.1%	4 Provider Total	54%	43%	2.7%	
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				variation will be monitored and used to help target appropriate interventions.	

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