NHS
North West London

# 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
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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.

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**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:

[1] An 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 support[2].

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 unit[3]. 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 options[4].

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 document[5].

### 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.

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**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.

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

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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 years[6]
- 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 growth[7].

**"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.

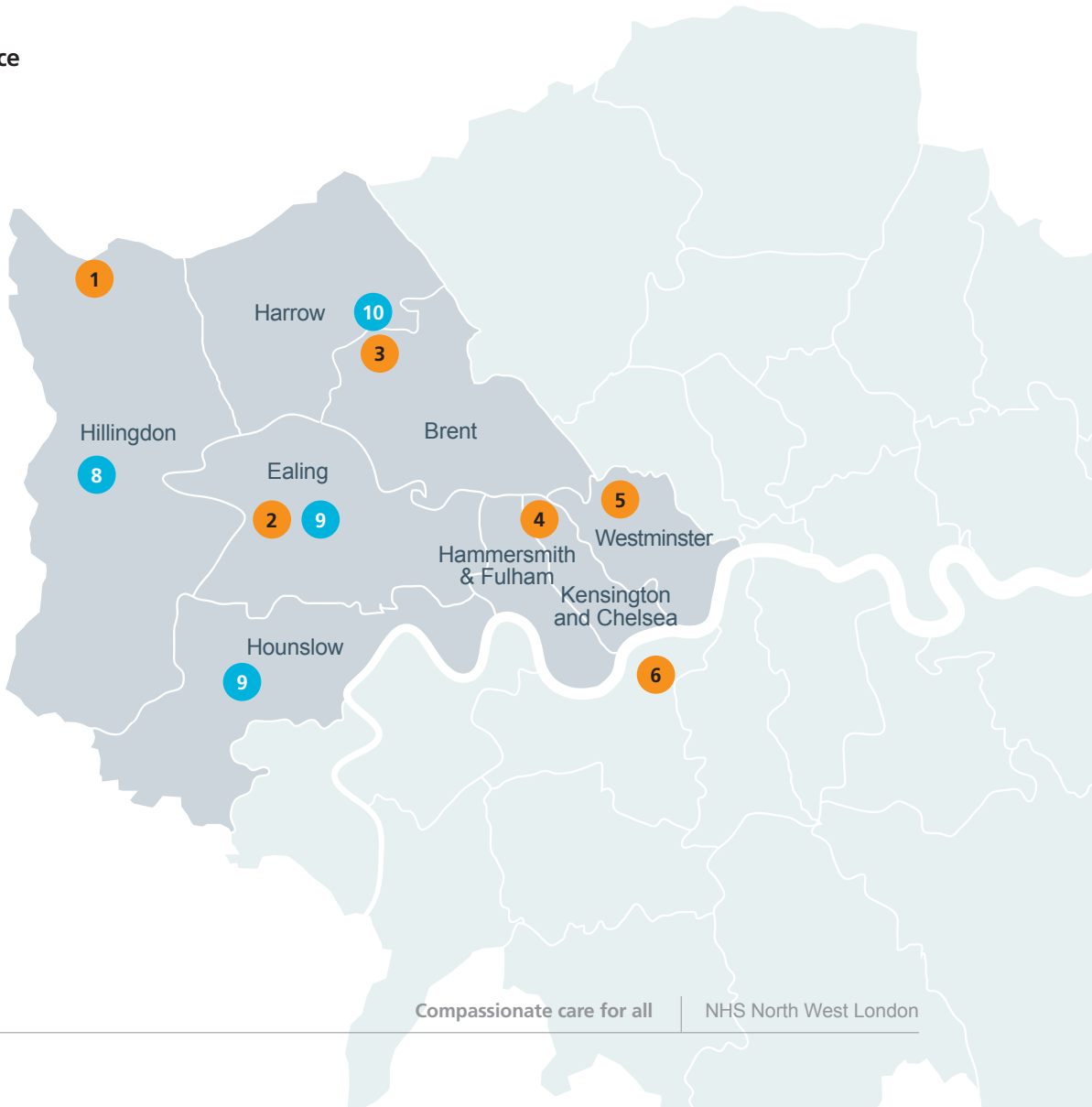

Figure 2 – Service providers by borough

| Borough | North west London's commissioned adult community-based specialist palliative care service providers by borough |
|---|---|
| Brent | • St Luke's Hospice<br>• Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services<br>• St John's Hospice |
| Ealing | • London North West University Healthcare NHS Trust providing Meadow House Hospice |
| Hammersmith & Fulham | • Royal Trinity Hospice<br>• Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services<br>• 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)<br>• 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<br>• Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services<br>• St John's Hospice |
| Westminster | • Royal Trinity Hospice<br>• Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services<br>• 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 boroughs[7].

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."**

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# 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.

4

**"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:

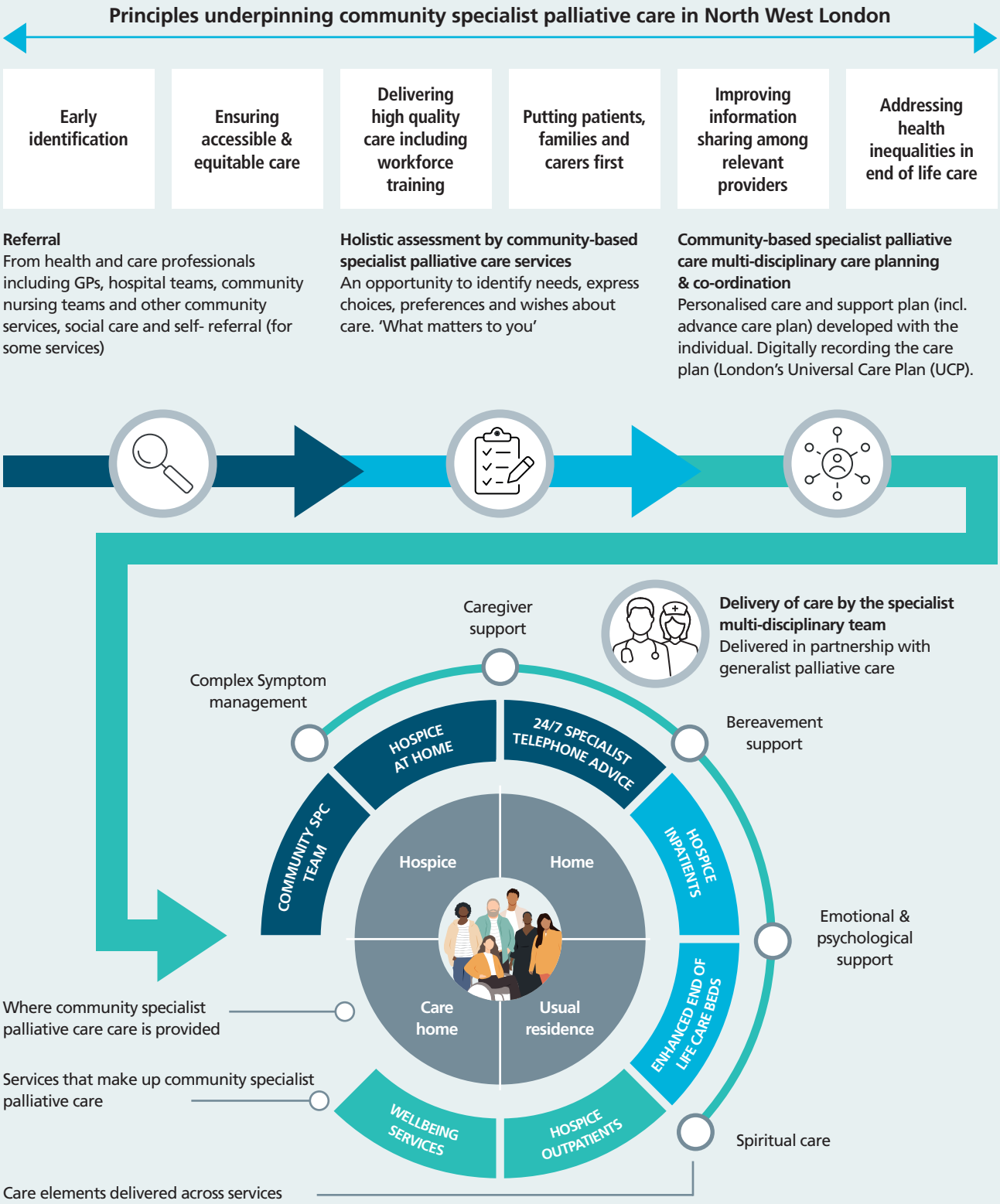
- **Service area 1:** Care in the home
- **Service area 2:** Community specialist inpatient care
- **Service area 3:** Hospice outpatients, day care and wellbeing

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 consistentcare 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

| | |
|---|---|
| **1. Highest level of need** | Hospice inpatient beds<br>Community SPC team<br>Hospice at home |
| **2. Medium level of need** | Enhanced EOLC beds<br>Community SPC team<br>Hospice at home |
| **3. Lower level of need** | Care home beds<br>Community SPC team<br>Hospice at home |

**Key to chart**

Bed based care option

Non-bed based care option

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 healthcare[8]. 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 Susan[9] – 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<br>• 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<br>• 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<br>• 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<br>• 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<br>• 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<br>• 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<br>• 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<br>• 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<br>• 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<br>• 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

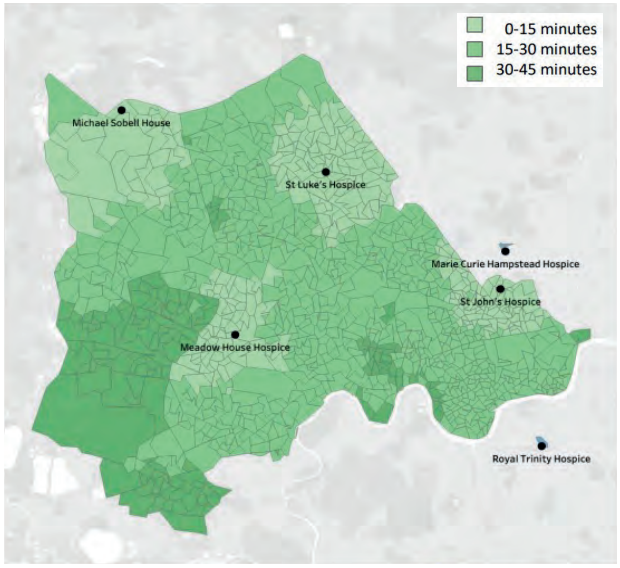
Travel times and accessibility are important when considering any change to services. We used a tool developed by Transport for London to compare the average travel times by car and public transport at peak time travel to the nearest eligible hospice. We found:

- 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.

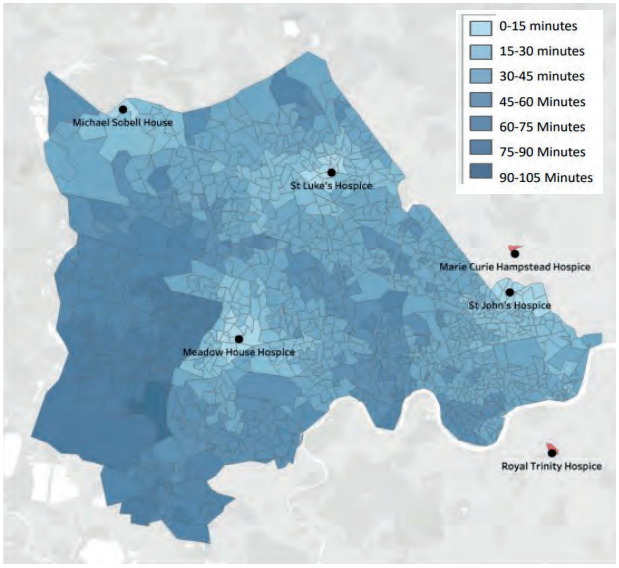
People living in the south of Hillingdon and Hounslow were found to have among the longest travel times to a hospice inpatient bed care unit because of the absence of available alternatives in the area.

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 hospices[10].

We recognise that any permanent changes to the unit will mean longer travel for those who in 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 die[12].

[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.<br>• Greatest percentage growth in north west London can be seen in Brent, Ealing, Hammersmith & Fulham and Hounslow.<br>• 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.<br>• 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 inpatients 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.

### 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.

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).

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<br>• 24/7 telephone advice available to clinicians to support care provision and decision support<br>• 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<br>• Extended hours of provision will reduce some operational pressure on other community teams<br>• Expansion of enhanced EOLC beds in NWL will reduce some homecare demand<br>• 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<br>• 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 website[14], 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.nwlondonicb.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<br>• 24/7 specialist telephone advice available to anyone<br>• Hospice at home care service provided in all 8 boroughs up to 24-hours per day where needed.<br>• Consultant-led and nurse-led hospice outpatient clinics available in all boroughs<br>• Lymphoedema provision for non-cancer purposes in all boroughs<br>• 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<br>• 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<br>• 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<br>• 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.nwlondonicb.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.nwlondonicb.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.nwlondonicb.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.

**Compassionate care for all**
FREEPOST
HEALTHIER NORTH WEST LONDON

Email: nhsnwl.endoflife@nhs.net
Web: www.nwlondonicb.nhs.uk/cspc