North West London Integrated Care System

NHS North West London

Adult Community-Based Specialist Palliative Care Services

Pre-consultation business case

18 November 2024

NHS North West London

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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 2022[1]. 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 Partnership[2]:

[1] Palliative and end-of-life care - POST (parliament.uk)
[2] ambitions-for-palliative-and-end-of-life-care-2nd-edition.pdf (england.nhs.uk)

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*

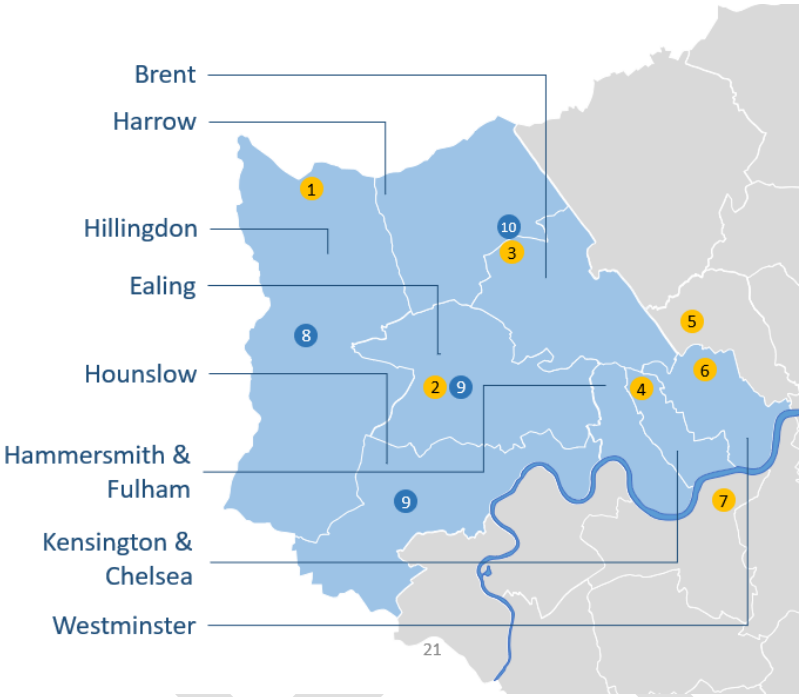
Borough	North west London's commissioned CSPC service providers by borough
Brent	• St Luke's Hospice • Central London Community Healthcare NHS Trust providing Pembridge Palliative Care Services including hospice inpatient care (which is currently suspended). • St John's Hospice
Ealing	• London North 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

Key	Providers of community-based specialist palliative care services who provide both inpatient unit and other CSPC services – provider name, service 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 Luke's Hospice**
4	**Central London Community Healthcare NHS Trust** providing **Pembridge palliative care services** (hospice) located at St Charles Hospital site
5	**Marie Curie Hospice Hampstead (permanently closed)**
6	**St John's Hospice**
7	**Royal Trinity Hospice**

Key	Providers of community-based specialist palliative 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. The team is based at St Luke's Hospice.



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 Pembridge 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 CSPC 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 Pembridge 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 Pembridge 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 years[3]. 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 nationally[4]. 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

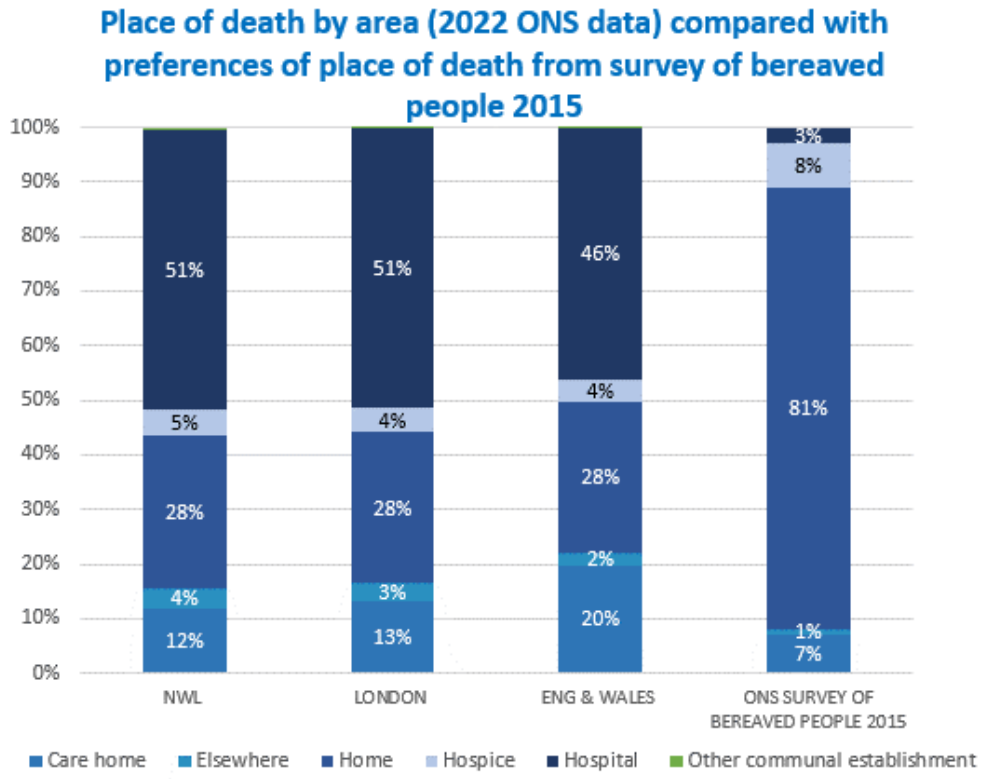


Figure 3: Place of death by area, and preferred place of death (Source, ONS 2022)

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/ siting service available.

2.3 We need to reduce health inequalities.

Ambitions for Palliative and End-of-life Care[6] 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 documented[7]. 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

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

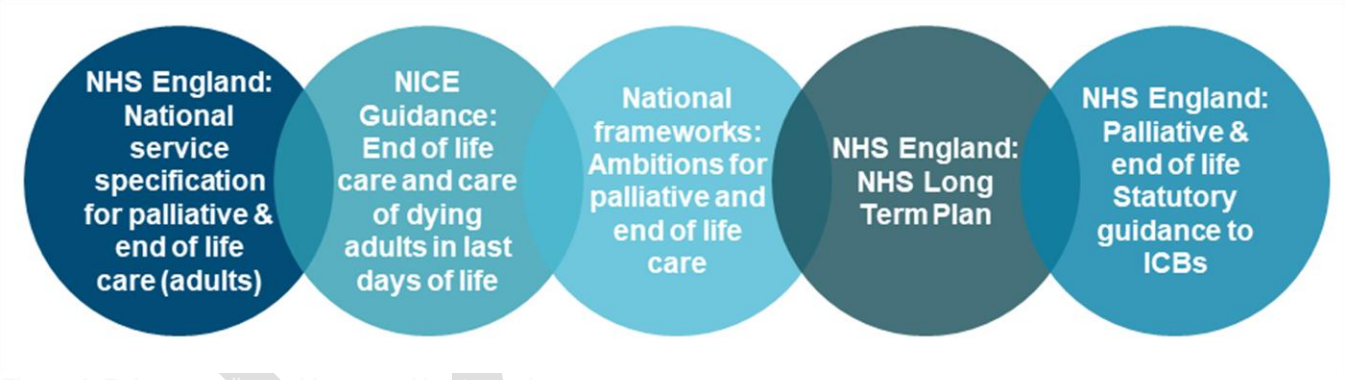


Figure 4: Relevant policy guidance and best practice.

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 positon 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 statistics[8] 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 Standard[9] 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 Pembridge 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.

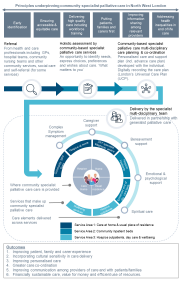
Key driver for case for change

The prime driver for this work is to ensure that our residents, their families, cares 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 Table 6

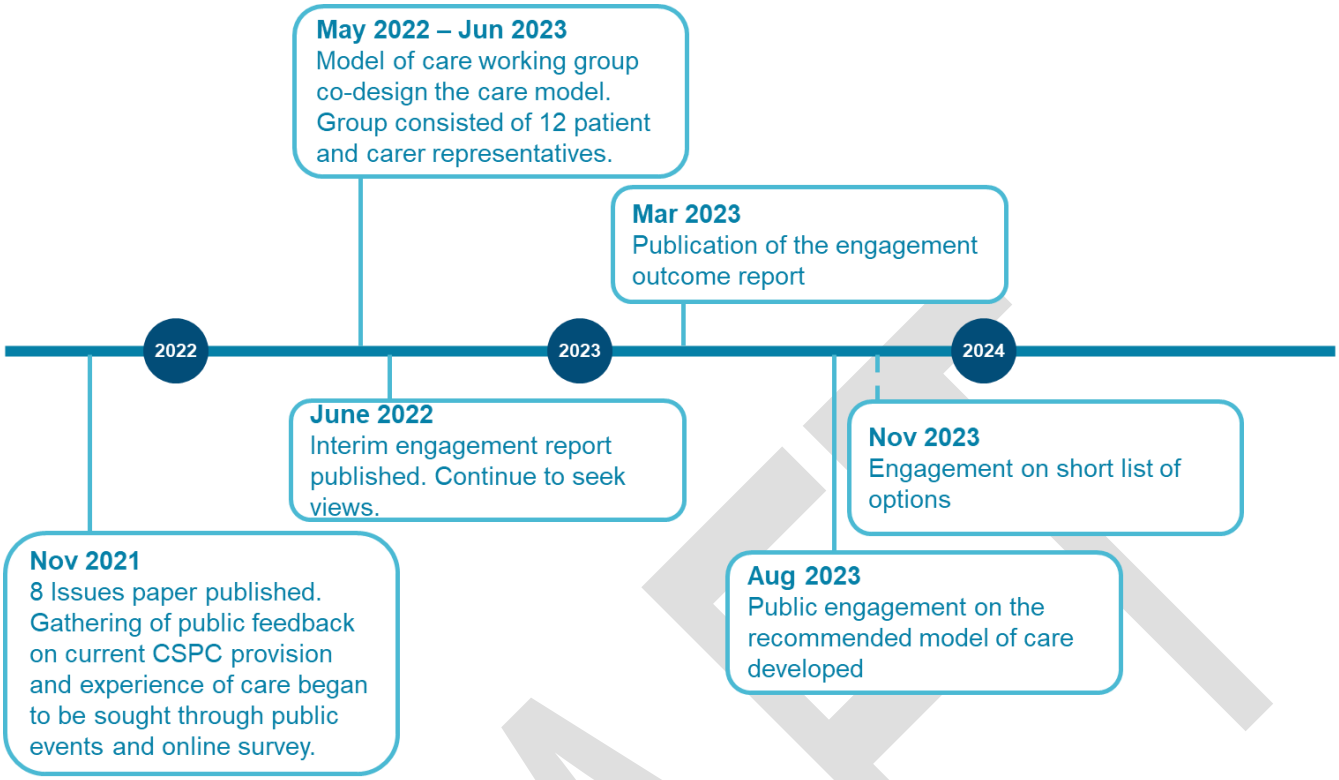
Element	What does this mean?
Co-design	A model of care working group was established in 2022. From the outset there was serious intention to co-design the model of care with our communities and service providers. 50% of membership included people who had experienced bereavement and providing care to 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 report[10] 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 website[11]. See Appendix F 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 2024[12].

[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 rapport 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 separately[13].

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 design[14]. 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:

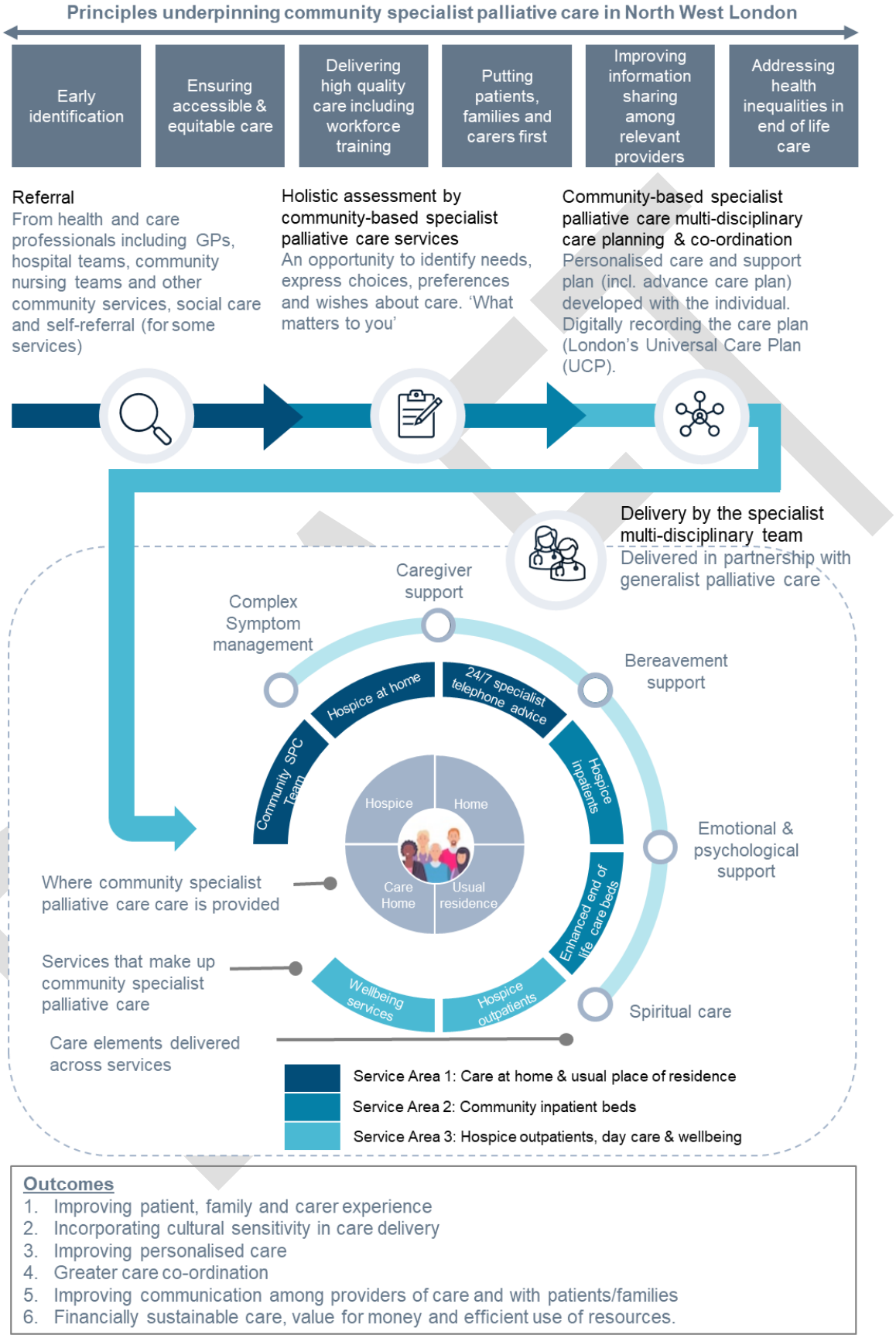
- **Service area 1: Care in the home**
- **Service area 2: Community specialist inpatient care**
- **Service area 3: Hospice outpatients, day care & wellbeing**

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)

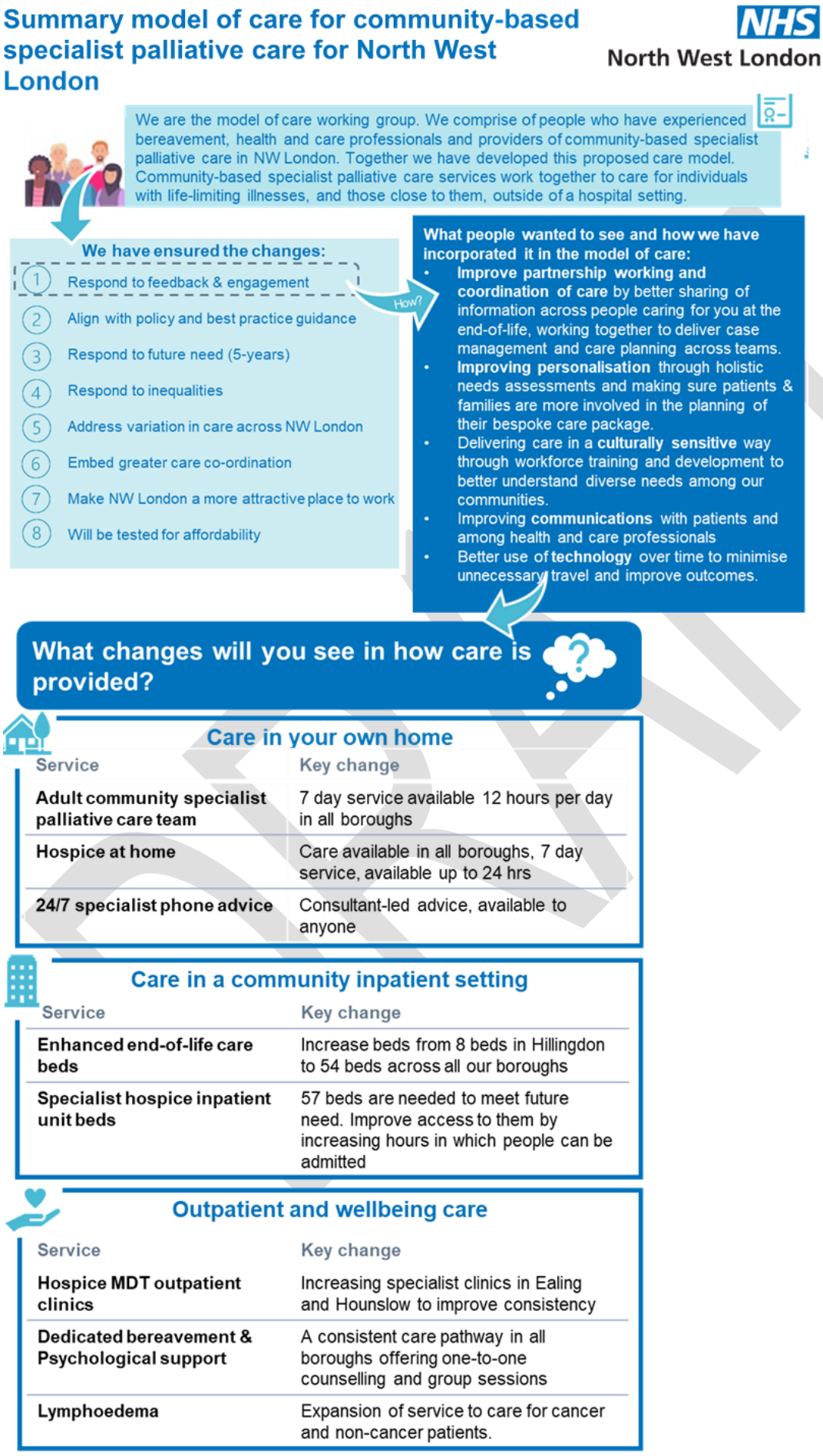
[14] A brief summary of our approach to developing the model is provided at **Chapter 3** above.

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



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

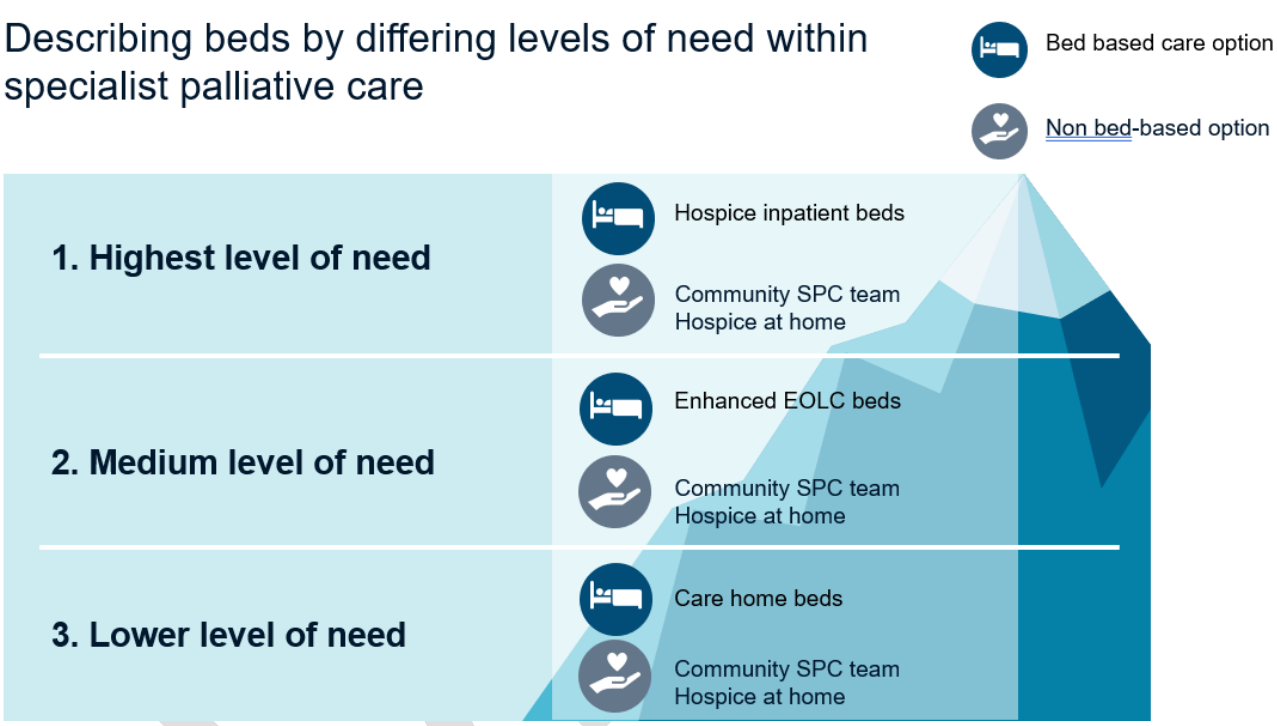
Figure 7: Proposed model of care



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



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 analysis[15] and mortality projections[16] 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.

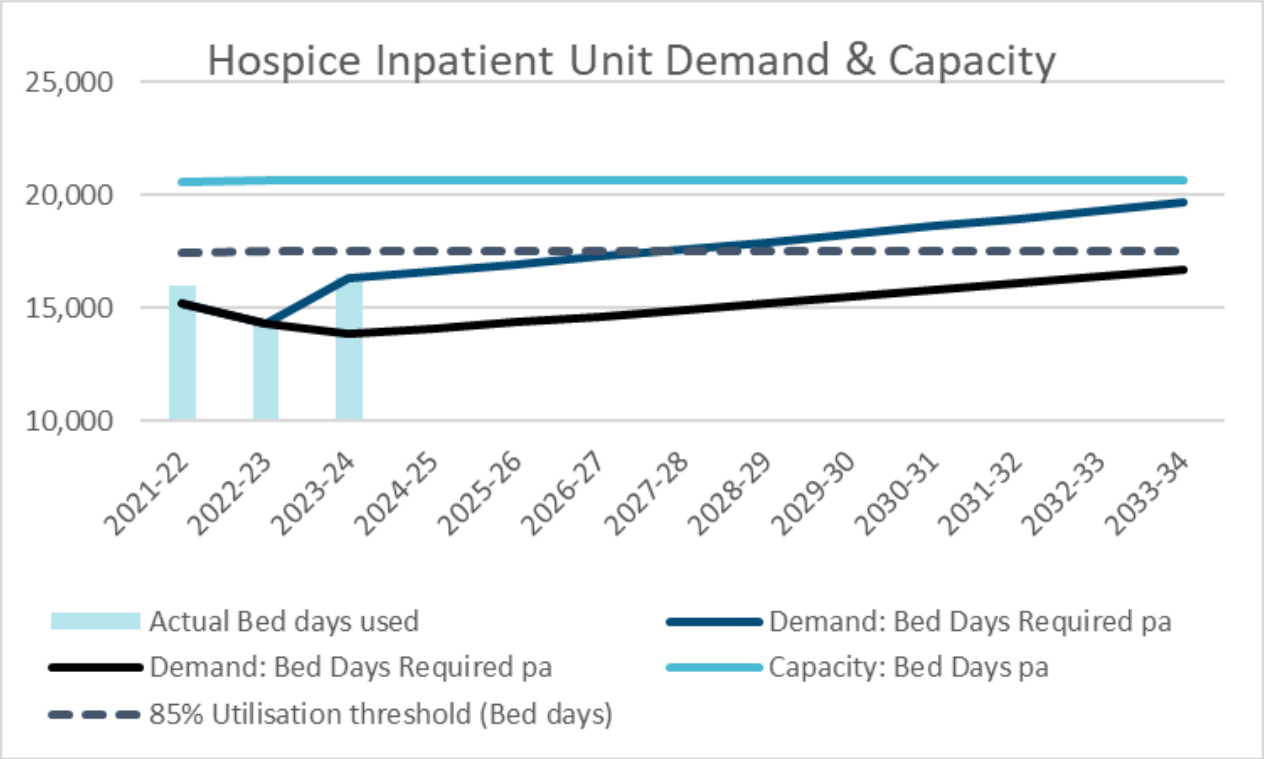
It should be noted that forward projections of need are challenging because we need to factor in unmet need. We also have a different pattern of activity and need during the pandemic to base trends on and because there is a wider shift to more home based care rather than bedded services. This is important 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



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

	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 analysis[18]. The key findings are as follows:

Travel time – overall picture

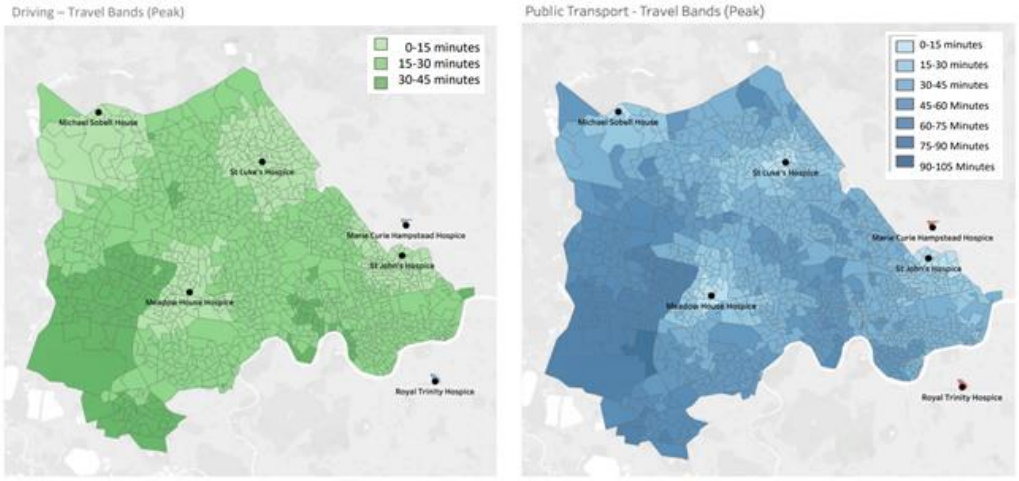
[18] NW London CSPC hospice inpatient units travel mapping analysis. North West London ICS (nwlondonicb.nhs.uk)

Across north west London, average peak time travel to the nearest eligible hospice[19] 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 *Figure 10*



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 *Figure 11*

[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
Whole NWL population	Travel time to nearest hospice inpatient unit (EXCLUDING) Pembridge	43-mins	21-mins
Pembridge catchment only	Travel time to Pembridge	31-mins	17-mins
Pembridge catchment only	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 *Table 13*

	% 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

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 Table 15

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 Table 16

	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 months[21] 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 England[22].
- Deaths in hospital across north west London are significantly higher than England levels, but falling[23].

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 population[24].

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)

[23] Palliative and End-of-life Care Profiles - Data - OHID (phe.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 Lond 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 website[25]). This highlights contributions to tackling health inequalities including:

Table 19: Responding to inequalities

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 https://www.nwlondonicb.nhs.uk/application/files/3817/0654/6390/20231124_NW_London_CSPC_equality_health_impact_assessment.pdf

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. Patents, 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.

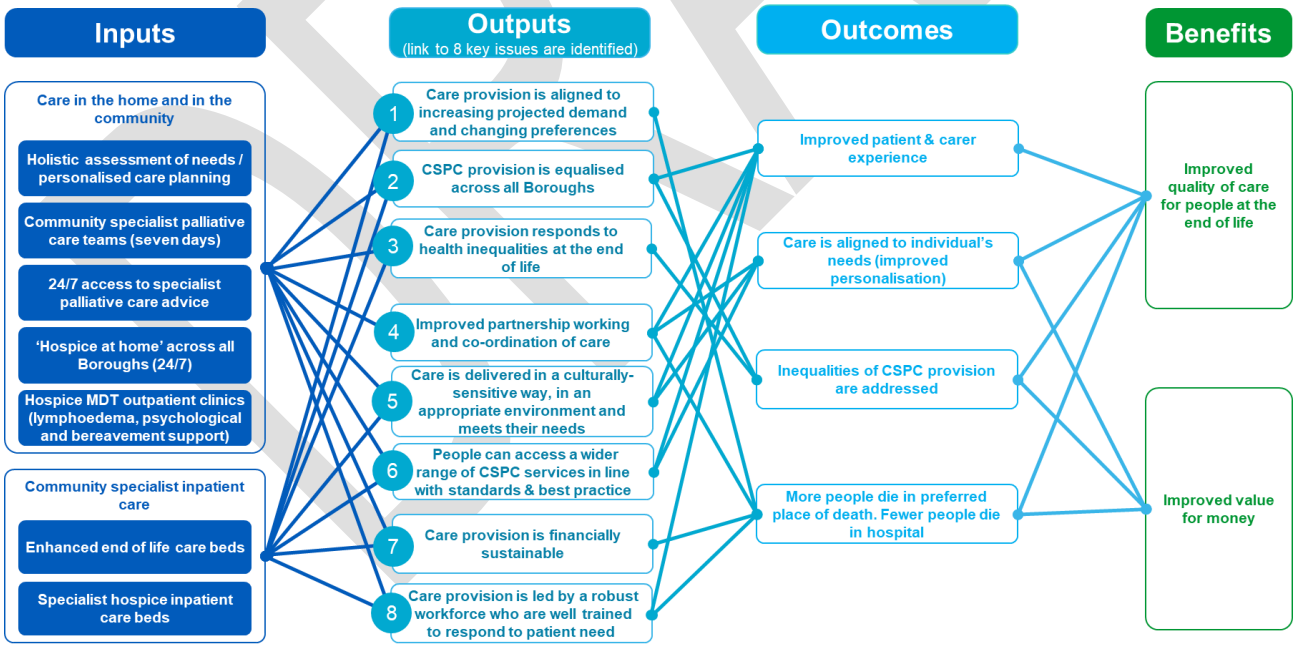
Climate change is one of the biggest public health threats and challenges that we face. Extreme weather conditions, such as flooding and heatwaves are becoming more frequent and severe. This will have impacts on both the health of the local population and the ability of our services to operate effectively.

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 Plan[27].

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

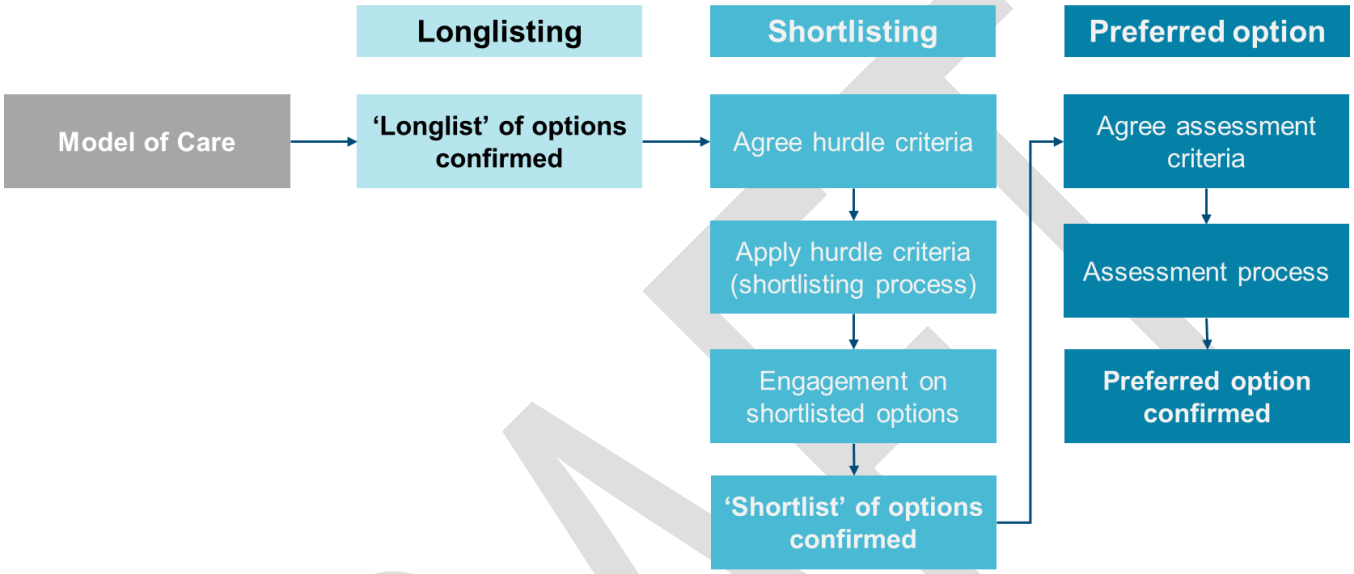


Table 21: Process used to develop and analyse implementation options

#	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: 1. Changes to care and services provided in community settings and patients' own homes 2. The introduction of enhanced EoLC beds across north west London 3. 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 2022[28]

[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:
		  1. Which, if any, of the options can north west London afford?
		  2. 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:

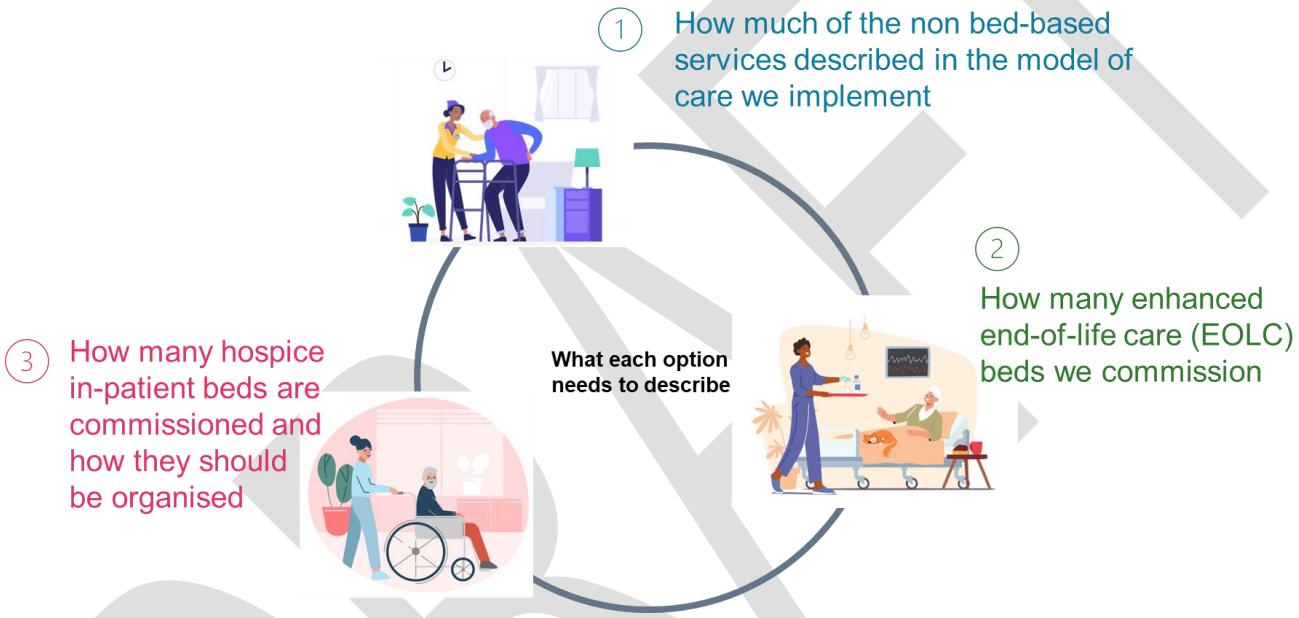
- **We will not include any options which 'go beyond' what the model of care proposes:** This includes any option with more hospice beds than would be needed to meet anticipated demand. Any such proposals could not be justified on strategic, operational and financial grounds.
- **We will build the options 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** **67 beds**	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' **57 beds**	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

	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

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	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 Pembridge 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	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 Pembridge 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*

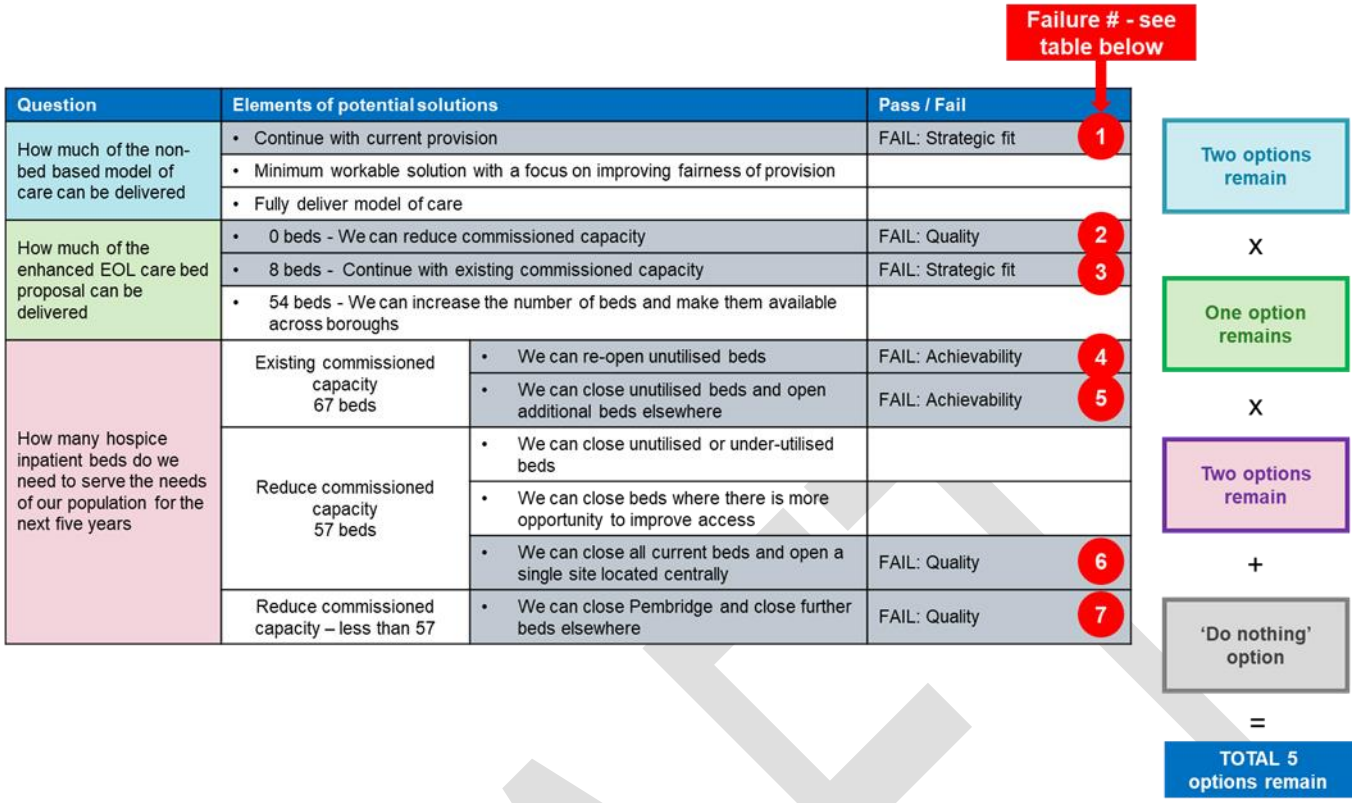
Hurdle criteria agreed by steering group	Intention	Questions to be asked for this this assessment (yes/no questions)
Strategic fit	To ensure that the option advances local, north -west London, regional and national priorities.	• Does the option reduce inequity of provision across north west London? • 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*



The rationale for options failing the hurdle criteria is summarised below.

Table 24: Rationale for options elimination Table 25

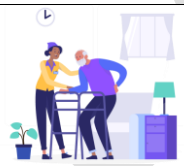
Failure	Criteria failed	Rationale
1	Strategic fit	• Continuing with current provision for non-bed-based care fails the test of **strategic fit.** This is because it would not meet the future needs of our population or help us to reduce inequalities.
	Quality	• It also fails the test of **quality of care**, as it does not implement the services which are necessary for safe and high-quality care.
2	Quality	• Reducing commissioned capacity of enhanced EoLC beds fails the test of **quality of care,** as it would mean we have fewer beds than are needed to provide a high-quality service in this area.
3	Strategic fit	• Maintaining our eight enhanced EoLC beds fails the test of **strategic fit**, as it would not allow us to tackle inequality of access to these beds (which would remain in Hillingdon only under this option).
	Quality	• It could be said to fail the test of **quality of care**, as it would not allow us to provide a service which we know is needed to residents in seven of our eight boroughs.
4	Achievability	• Increasing our commissioned capacity of inpatient beds to 67 by re-opening unutilised beds fails the test of **achievability.** There will be insufficient staffing available to staff the extra beds. Since the Pembridge In-patient Unit suspension, multiple attempts on 4 separate occasions, have been made to recruit staff without success. Ongoing efforts to recruit locum staff have also been unsuccessful.
	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.

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 Table 27

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 Table 28

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 Table 29

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 CSPC 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

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

	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

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

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

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

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

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

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

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

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

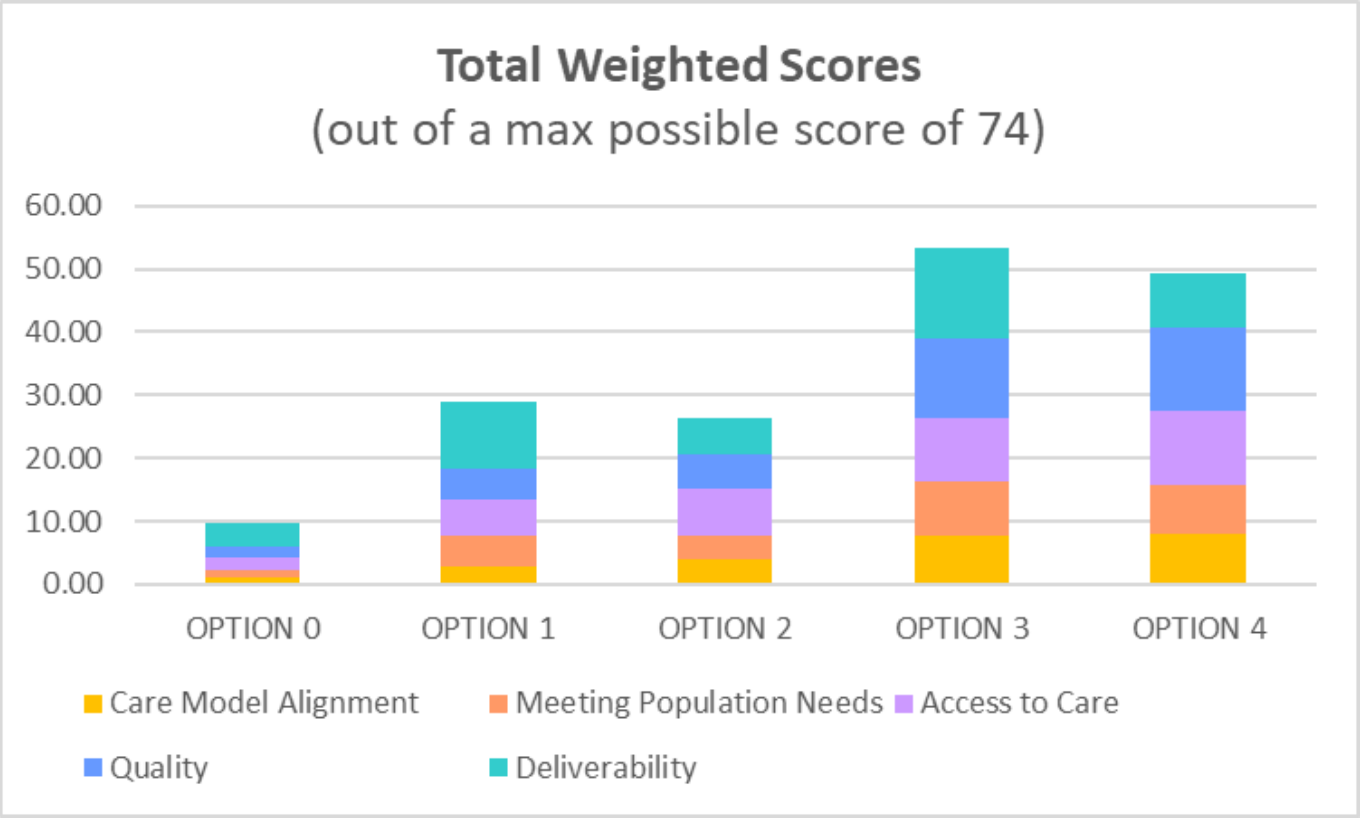
Criteria	Option 0	Option 1	Option 2	Option 3	Option 4
Care model alignment	1.0	2.7	3.6	7.1	7.4
Meeting population needs	1.0	4.2	3.4	7.8	6.9
Access to care	1.3	3.7	4.7	6.2	7.3
Quality	1.0	3.0	3.4	8.0	8.3
Deliverability	1.9	5.3	2.8	7.1	4.3
TOTAL MEAN AVERAGE SCORE (minimum 0, maximum 50) (UNWEIGHTED)	**6.20**	**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

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



The rank of options following this assessment is therefore:

Table 47: Rank of options *Table 48*

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.

All costs and benefits expressed in this appraisal are based on 2023/24 prices. Inflation would apply to all options equally, so inflation has been excluded from all options to simplify comparison. Key assumptions and details which underpin the financial appraisal is provided in Section 9 and Appendix H.

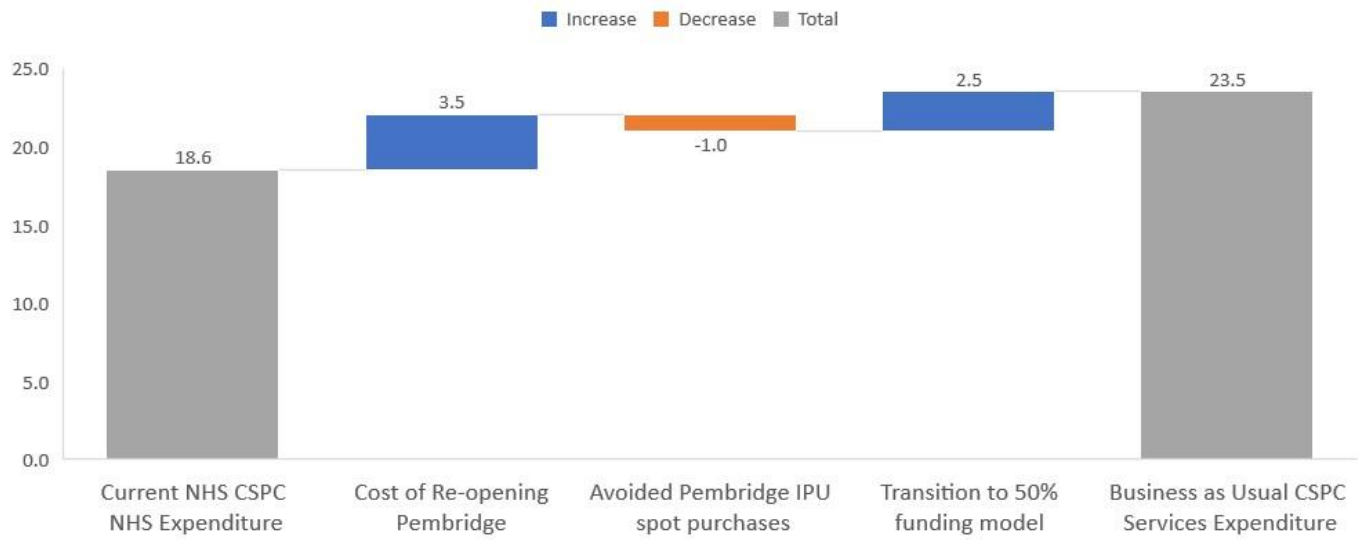
Option 0: Business as usual – current commissioned service model

In business as usual – current commissioned service model, the current model of care is to provide the Pembridge Palliative Care Centre Inpatient Unit, so under Option 0, business as usual – current commissioned service model, this would re-open and operate as per the current design of services. Currently, the Pembridge Palliative Care Centre Inpatient Unit is suspended, and that funding is used for spot purchasing of specialist beds as needed.

Further investment is needed to secure the sustainability of the CSPC sector and to fund the re-opening of Pembridge Palliative Care Inpatient Unit. As described in Section 9, significant recent cost increases have not been fully funded. This is not sustainable for either NHS or charitable providers. Under business as usual – current commissioned service model we will seek to move to a model where NHS North West London funds 50% of the cost of commissioned CSPC services[29] for charitable providers, and 100% of the cost of commissioned CSPC services for NHS providers.

This build-up of business as usual – current commissioned service model - is summarised below:

Figure 23: Business as usual – current commissioned service model costs to NHS North West London of the current CSPC model (23/24 prices)



As seen in Figure 23, under the current delivery model, NHS North West London expects to need to increase funding to CSPC services by c.£4.9m from the 23/24 contract values.

[29] 'Commissioned CSPC services are all the CSPC services these providers offer, excluding complementary 'wellbeing' services, which are expected to be wholly charitably funded by both NHS and non-NHS providers.

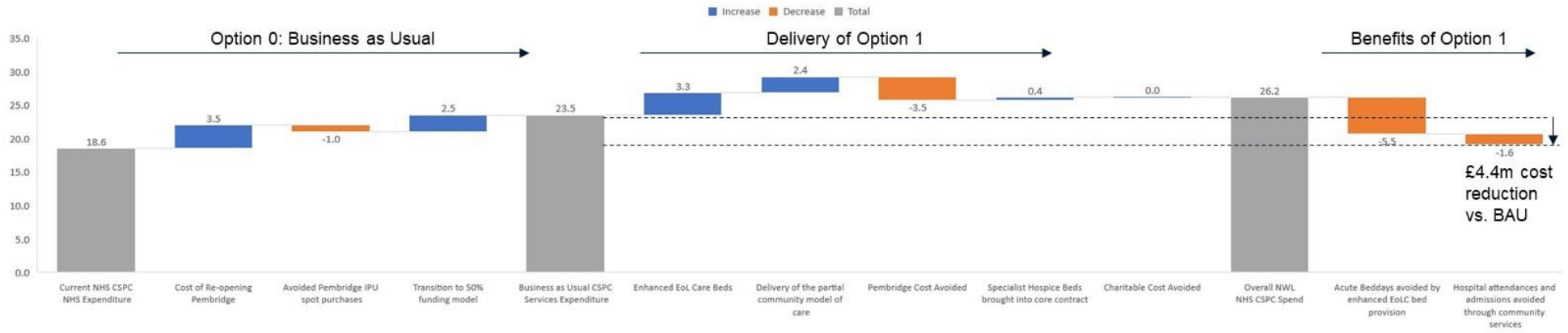
Option 1: Some change with Pembridge Palliative Care Centre Inpatient Unit closed

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 *Figure 25*



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 Figure 26

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 Figure 27

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:

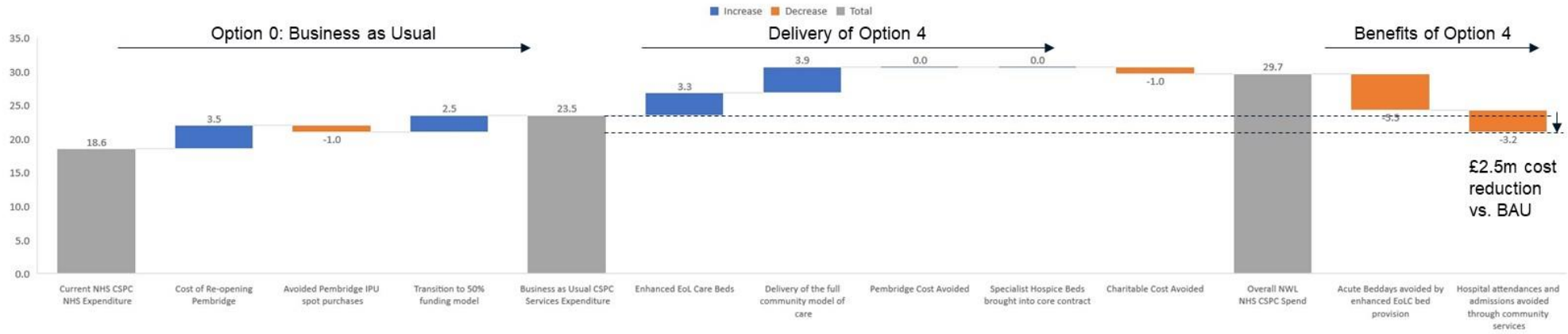
- Pembridge Palliative Care Inpatient Unit is re-opened, meaning that the cost associated with this, which is already within business as usual – current commissioned service - model remains in the costing of the option
- Specialist beds need not be provided in other providers' core contracts, as they 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 *Figure 28*



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 *Table 49*

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

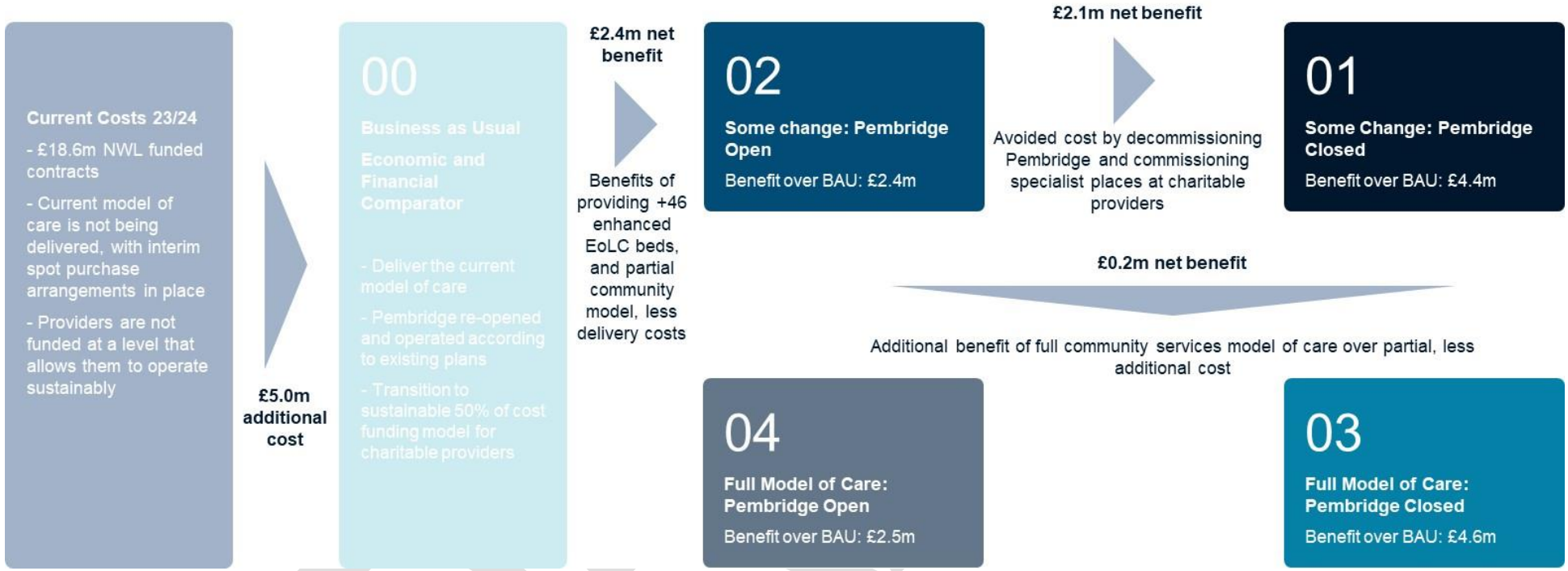
Palliative Care Centre Inpatient Unit closed			
4. Full implementation, Pembridge Palliative Care Centre Inpatient Unit open	+2.5	Pass	14.2

The key factors that affect the financial appraisal are:

- In Options 1 and 3, Pembridge Palliative Care Centre Inpatient Unit is decommissioned. Reopening Pembridge 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.

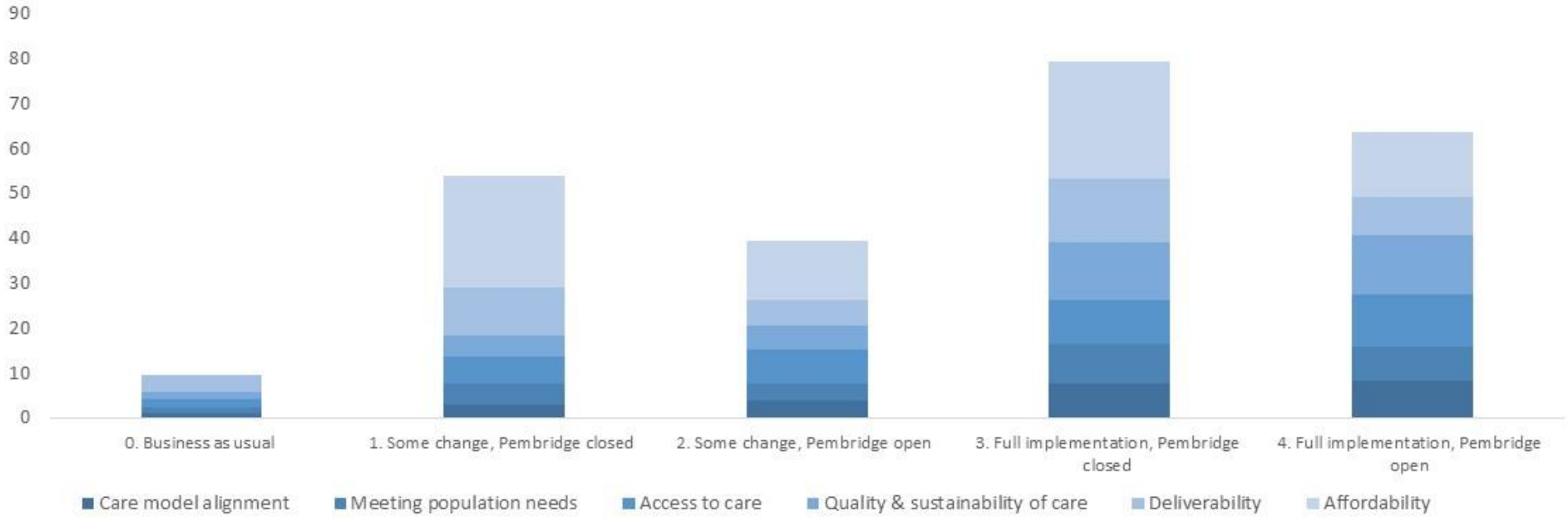
The weighted scores are summarised below:

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%)					

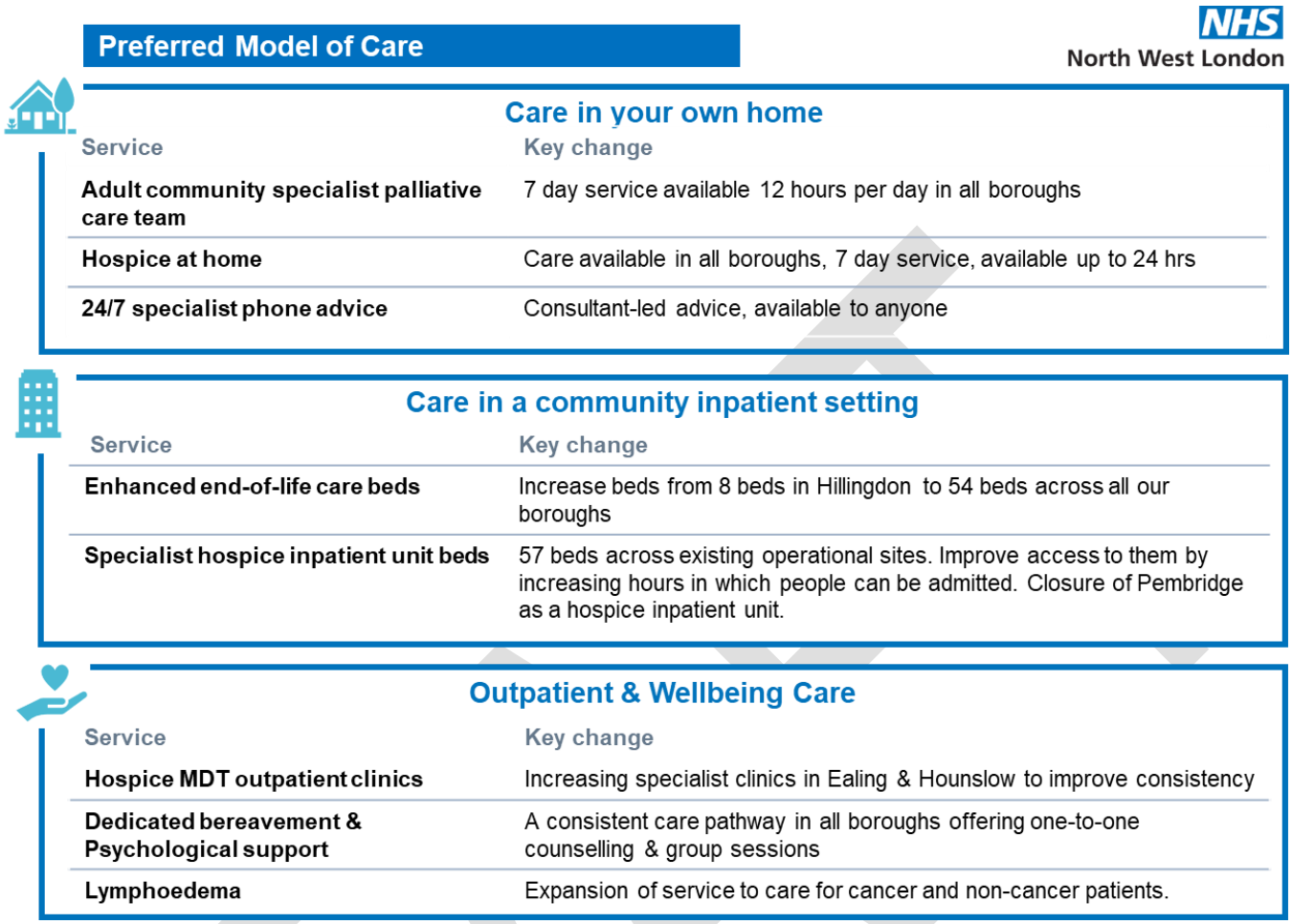
These weighted scores are shown graphically below:

Figure 29: Visual summary of weighted appraisal scores *Figure 30*



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



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

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.

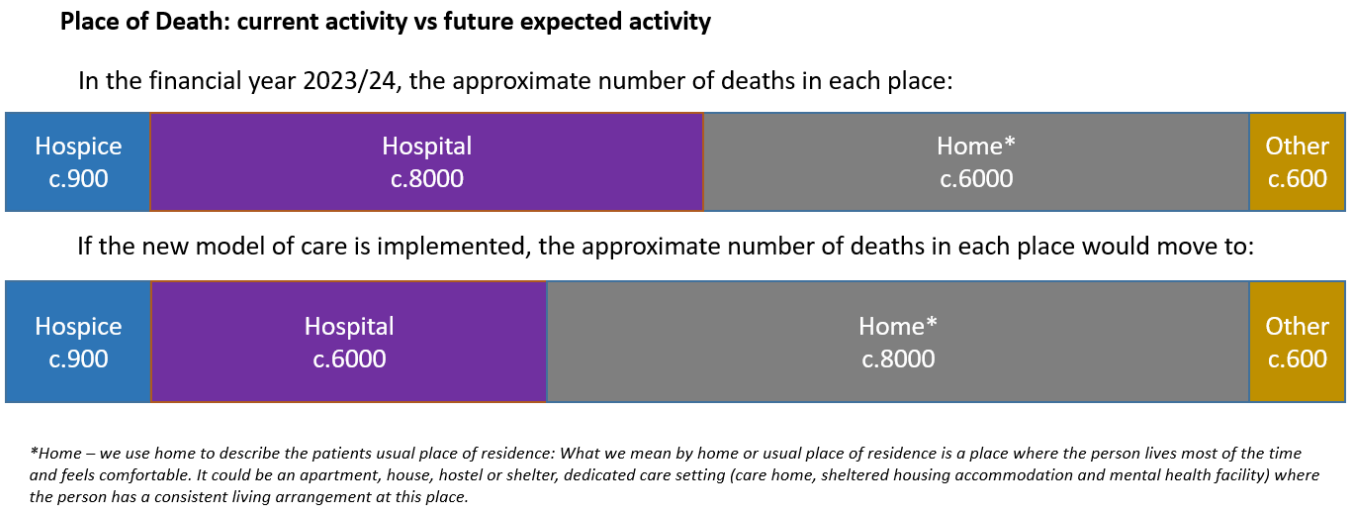
9. Financial benefits and impact of the options

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



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 life[30]. 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 life[32]. 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 *Table 52*

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	1.14	3.09	4.11	8.11	8.46
Weighting applied: 14.9%					
Meeting population needs	1.14	4.80	3.89	8.91	7.89
Weighting applied: 14.9%					
Access to care	2.20	6.25	7.94	10.48	12.33
Weighting applied: 21.6%					
Quality & sustainability of care	1.69	5.07	5.74	13.52	14.02
Weighting applied: 21.6%					
Deliverability	4.07	11.34	5.99	15.19	9.20
Weighting applied: 27%					
TOTAL - WEIGHTED	**10.24**	**30.55**	**27.68**	**56.22**	**51.90**
(Min 0%, Max 100%)					

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 4[33].

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 *Table 57*

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 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 CSPC 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 though 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 ICBs[34]. 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)

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 details[35]. 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

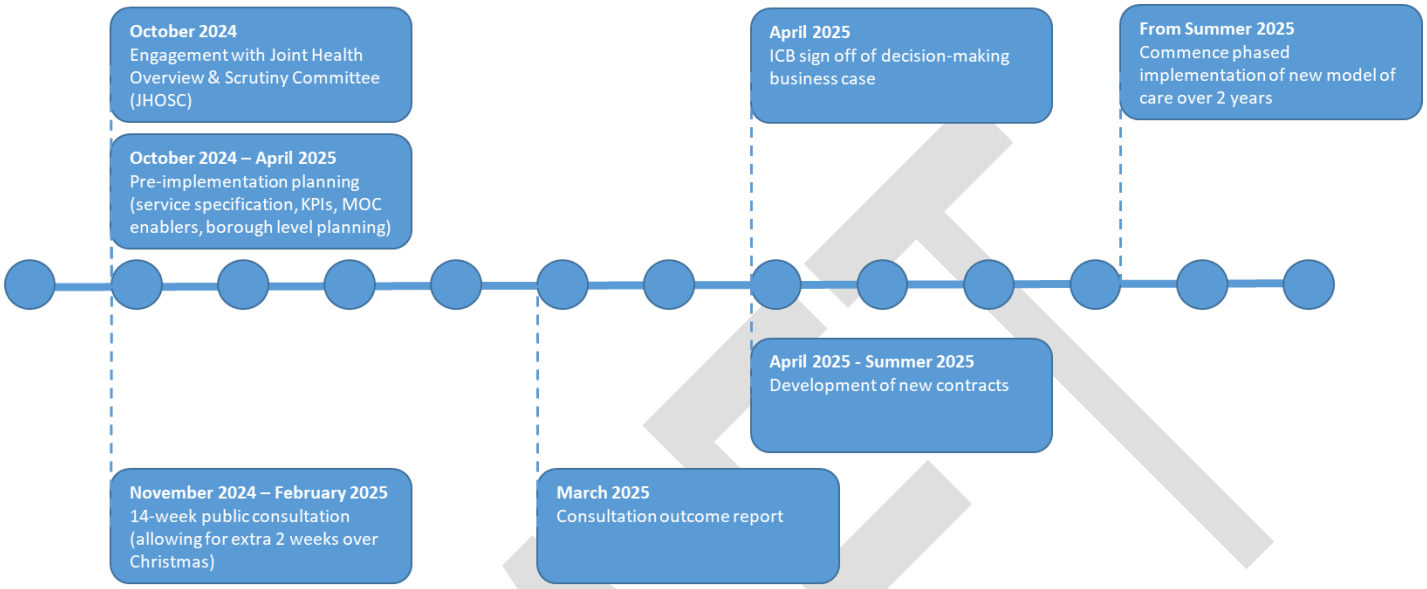
This chapter describes the high-level steps toward decision making and implementation. Once a decision is made on which option will be implemented, a detailed implementation plan will be developed.

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 Table 66

	Project Team	**Wider Programme Support**
Key roles and groups required in next phase of delivery planning	1. Senior responsible officer 2. Project lead 3. Clinical lead 4. Engagement team 5. Project support team 6. 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

of 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 Pembridge 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 Pembridge 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

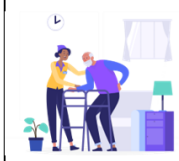
Next steps include:

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 Tabl

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 to 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

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*?
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
15	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

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*?
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 *Table 72*

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 Table 73

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):

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).

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 *triage* 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 website[36] 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 (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 n 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

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 that 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 abed 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 life[37] • These admissions are costly, resulting in invasive interventions and long lengths of stay[38] • 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

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 CSPC 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 CSPC 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 CSPC 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 transitionary year, with 50% of the benefit delivered, 50% of the cost base incurred, and therefore 50% of the net benefit of each option accrued.