North West London Integrated Care System

NHS North West London: Adults (18+) Community-based specialist palliative care programme

Equality health impact assessment

24 November 2023

About this document

This Equalities Health Impact Assessment (EHIA) report is the product of exploring the potential impact that NW London's proposed new model of care for adult (18+) community-based specialist palliative care services will have on health inequalities and the well-being of different population groups in NW London.

This report is intended for a broad audience, encompassing healthcare professionals, stakeholders and advocates for palliative care, and the communities and individuals that this new model of care aims to serve. The aim if for the report to become the compass that guides our endeavours to ensure that this proposed new model of care and the its implementation benefits all individuals equitably.

By investigating the EHIA's purpose and its application to adult (18+)community-based specialist palliative care, we hope to empower stakeholders to make informed decisions and adjustments that foster a healthcare landscape marked by inclusivity, compassion, and respect for diversity.

In the following sections of this report we will provider an overview of the NW London health inequalities landscape and explore the EHIA process for the 9 protected characteristics (and other vulnerable groups that we have identified as key during our engagement on this work to show summary of equity impact. Our goal is to make sure that this new model of care and way of providing care is fair and equal for everyone, giving help and support without any bias.

About North West London

- North West London is a richly diverse area, with around 2.4 million people from a wide range of backgrounds. We have a younger than average population and a wealth of cultural heritage
- However, in our least resourced neighbourhoods, people are dying over a decade earlier than their peers. This is a long-standing issue and the inequalities gap in health and life expectancy has widened in recent years. This has been affected by cost of living pressures and Covid-19, and ill-health creates a significant cost
- When our communities don't have the things they need, such as warm homes and healthy food, and are in low-paid or unstable jobs, it can lead to chronic stress, poor physical and mental health and lives being cut short. To create a society where everybody can thrive, we need all of the building blocks in place: stable jobs, good pay, quality housing and good education
- Creating an environment which does not support healthy behaviours and lifestyles will also have a negative impact on health
- People from our different communities also have very different experiences of the health and care services that we provide, including different levels of access, leading to very different health outcomes in different neighbourhoods, and some of our communities experience chronic stress due to the discrimination they face
- By working together across the Integrated Care System, we can empower people in NW London so that we better understand their experiences and we can help to tackle these issues. This will improve equity across services for everyone and particularly those with the least resources or largest barriers, helping people to thrive. The Health Equity Programme focusses on reducing inequalities, improving people's health outcomes and reducing the differences in healthy life expectancy
- It is fundamental to the delivery of the ICS's four key purposes of improving population health, reducing inequalities, improving value for money and building social and economic growth, and inequalities is a golden thread that weaves throughout the work of the system
- The programme delivers that change using a consistent methodology and set of levers, including effective use of data, engagement and co-production with our communities and evaluation of impact. We work with and through other programmes and Borough teams to effect change
- We have already made an impact, for example through blood pressure outreach work, expanding health checks, supporting people from more deprived neighbourhoods into volunteering and better understanding the barriers people face to accessing care
- Our NW London inequalities programme work is arranged around three pillars: identifying and tackling inequalities; population health management building blocks; and partnership working on wider determinants of health

North West London is a richly diverse area, with around 2.4 million people from a wide range of backgrounds. We have a younger than average population and a wealth of cultural heritage

12.3%
of the population are over the age of 65 (national average is 19%)

36.9
is the average age (national average is 39)

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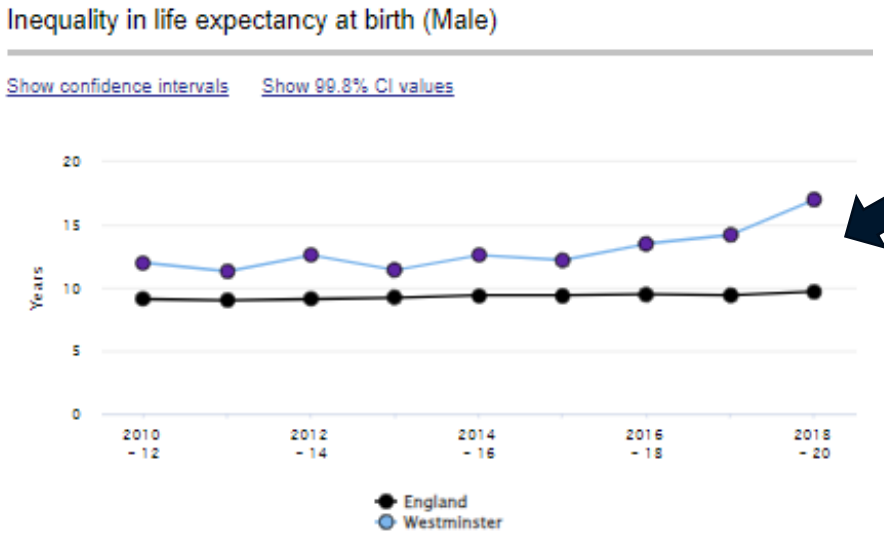
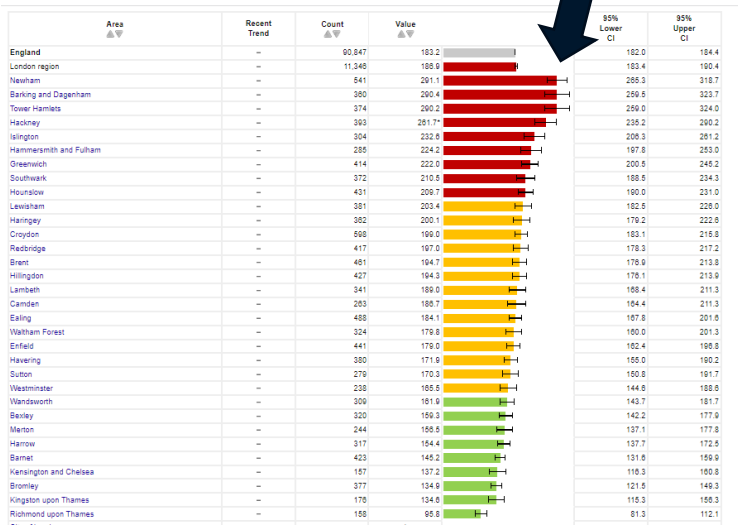
However, in our least resourced neighbourhoods, people are dying over a decade earlier than their peers. This is a long-standing issue and the inequalities gap in health and life expectancy has widened in recent years. This has been affected by cost of living pressures and Covid-19, and ill-health creates a significant cost



Inequality in life expectancy at birth (for men) in Westminster has been widening, now standing at 17 years. Healthy life expectancy at birth varies between 61.4 years in Ealing and 67.4 years in Kensington and Chelsea

Under 75 mortality rate from causes considered preventable varies from 224.2 in Hammersmith and Fulham to 137.2 in Kensington and Chelsea



As well as people dying earlier, socio-economic inequalities cost the NHS **£4.8 billion a year**, with people living in the most deprived fifth of neighbourhoods having **72% more emergency admissions and 20% more planned admissions** than those living in the most affluent fifth of neighbourhoods

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When our communities don't have the things they need, such as warm homes and healthy food, and are in low-paid or unstable jobs, it can lead to chronic stress, poor physical and mental health and lives being cut short. To create a society where everybody can thrive, we need all of the building blocks in place: stable jobs, good pay, quality housing and good education

When people have insecure or irregular work…
...It is harder to afford decent housing…
…Living in cold, damp homes can result in respiratory problems and other health issues…
…Constantly worrying about having enough money to pay the rent can also lead to chronic stress, anxiety and depression.

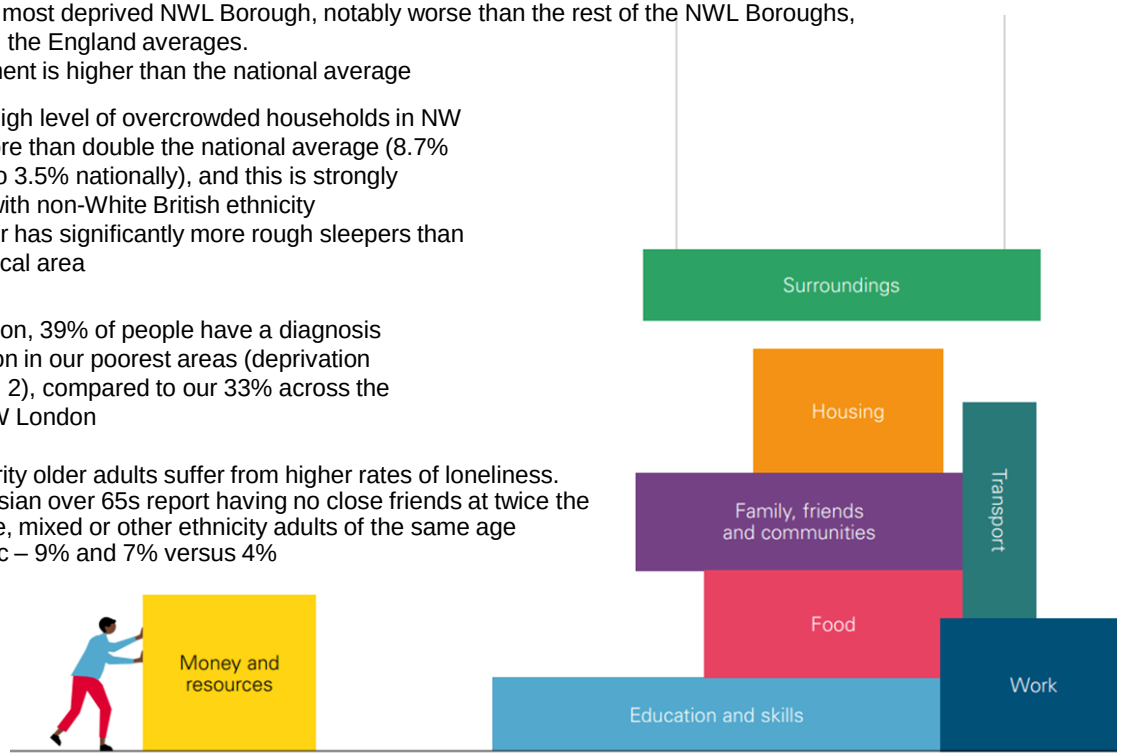
People in the bottom 40% of the income distribution are almost twice as likely to report poor health than those in the top 20%. Poverty is associated with worse health outcomes

- Kensington and Chelsea has the greatest income inequality in London
- 29% of children in Westminster are from low income families, vs 13.9% in Harrow (16% nationally)
- 15.9% of children in Brent live in low income families, compared to 6.1% in Kensington and Chelsea
- There is a fivefold difference between the Income Deprivation affecting Children Index (a measure of child poverty) between Hammersmith and Fulham's richest and poorest wards
- Brent is the most deprived NWL Borough, notably worse than the rest of the NWL Boroughs, London and the England averages.
- Unemployment is higher than the national average

- There is a high level of overcrowded households in NW London, more than double the national average (8.7% compared to 3.5% nationally), and this is strongly correlated with non-White British ethnicity
- Westminster has significantly more rough sleepers than any other local area

- In NW London, 39% of people have a diagnosis of depression in our poorest areas (deprivation levels 1 and 2), compared to our 33% across the whole of NW London

- Ethnic minority older adults suffer from higher rates of loneliness. Black and Asian over 65s report having no close friends at twice the rate of White, mixed or other ethnicity adults of the same age demographic – 9% and 7% versus 4%



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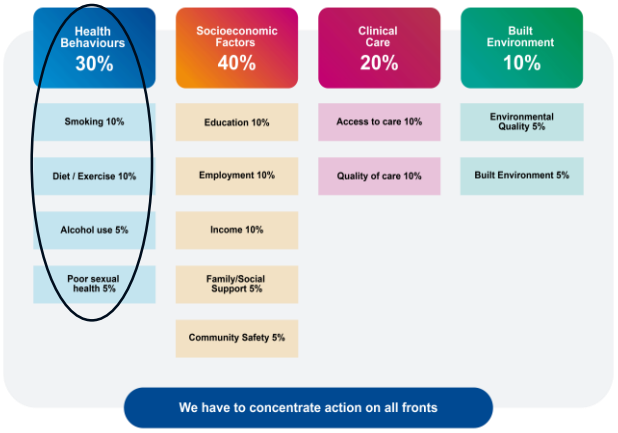
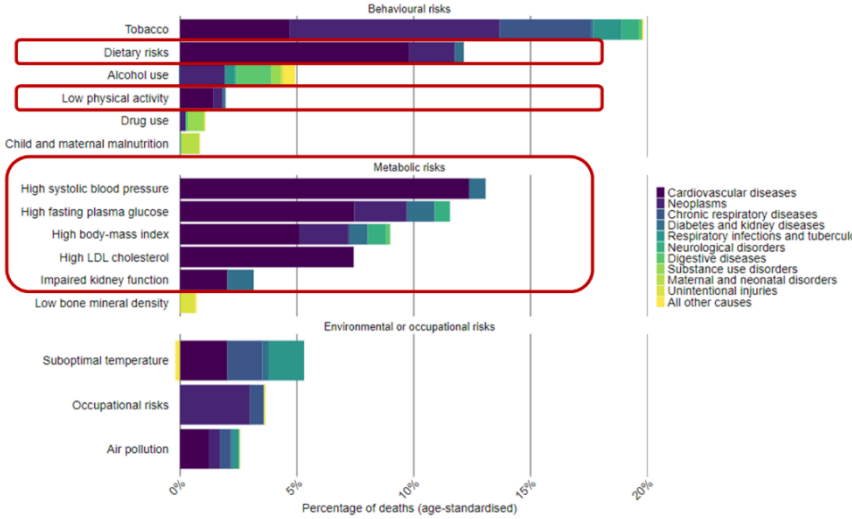
Creating an environment which does not support healthy behaviours and lifestyles will also have a negative impact on health





50% of all adults (over 18) are **overweight** – ranging from **48%** in Westminster to **62.4%** in Hillingdon (63% nationally)
1 in 4 of our **10-11 year-olds are obese** (1 in 5 nationally)

Tobacco remains the highest risk factor for disease in NW London. **17.1%** of people in Hillingdon **smoke**, versus **9.2%** in Ealing (13% across NW London – 14% nationally)

Alcohol admissions in Ealing are above the average in England, with **2,200 admissions a year** per 100,000 people (England 1,815)

Around 55% of our resource goes in to acute hospitals and our **hospital admission rate is one of the highest in the country**, even taking into account the needs if our population – we are not investing in upstream, proactive, preventative care

There is significant variation between boroughs for healthy behaviours such as exercise and substance misuse.
For example, hospital admissions per 100,000 due to substance misuse vary between 16.9 in Hammersmith and Fulham and 64.9 in Brent

Risk factors such as smoking and obesity are linked to each of the main long term conditions people in NWL have: Neoplasms (cancer) and Cardiovascular disease

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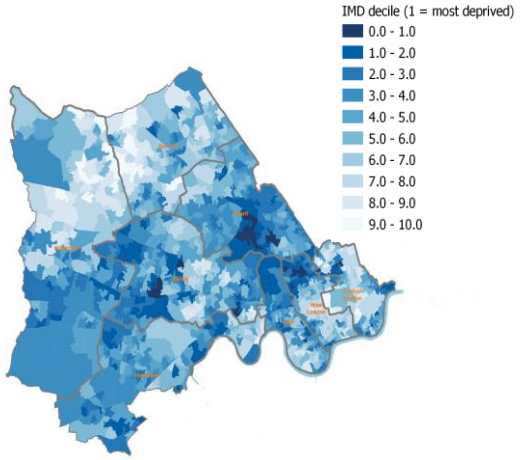
People from our different communities also have very different experiences of the health and care services that we provide, including different levels of access, leading to very different health outcomes in different neighbourhoods, and some of our communities experience chronic stress due to the discrimination they face



Around 900,000 people in NWL have at least one LTC, varying between 24% of the population in Hammersmith and Fulham, and 43% in Hounslow

1 in 5 adults (18+) has two or more **long term conditions** compared to 1 in 4 nationally

1 in 10 people have **diabetes** or non-diabetic hyperglycaemia (NDH) (1 in 16 nationally)

Diabetes disproportionately affects our Asian and Asian British community. 43% of registered diabetes patients are in this group, compared to just 24% of the population as a whole

There is **variation in the quality of care** provided e.g. 28% of people with diabetes in Brent receive appropriate care versus 51% in Kensington and Chelsea (against the 9 key care processes)

Our Asian and Asian British community is also disproportionately affected by heart disease (30% of registered patients, 24% of population)

Black women in NWL are XX more likely to die in childbirth compared to white women

Gender and ethnicity are strong predictors of Hypertension, with the Black population an outlier. **Asian/Asian British and Black/Black British people with cancer are more likely to have a "bad outcome"**

- **38,000+** (11%) children and young people aged between 5 and 18 years have a **mental health** disorder (12% nationally)
- **Mental health problems disproportionately affect our Black and Black British community.** This group represents more than twice the number of registered mental health patients (17%) as population (8%)
- Rates of emergency hospital admissions for **self-harm are twice as high in Hounslow as they are Harrow** (England average 181 per 100,000)

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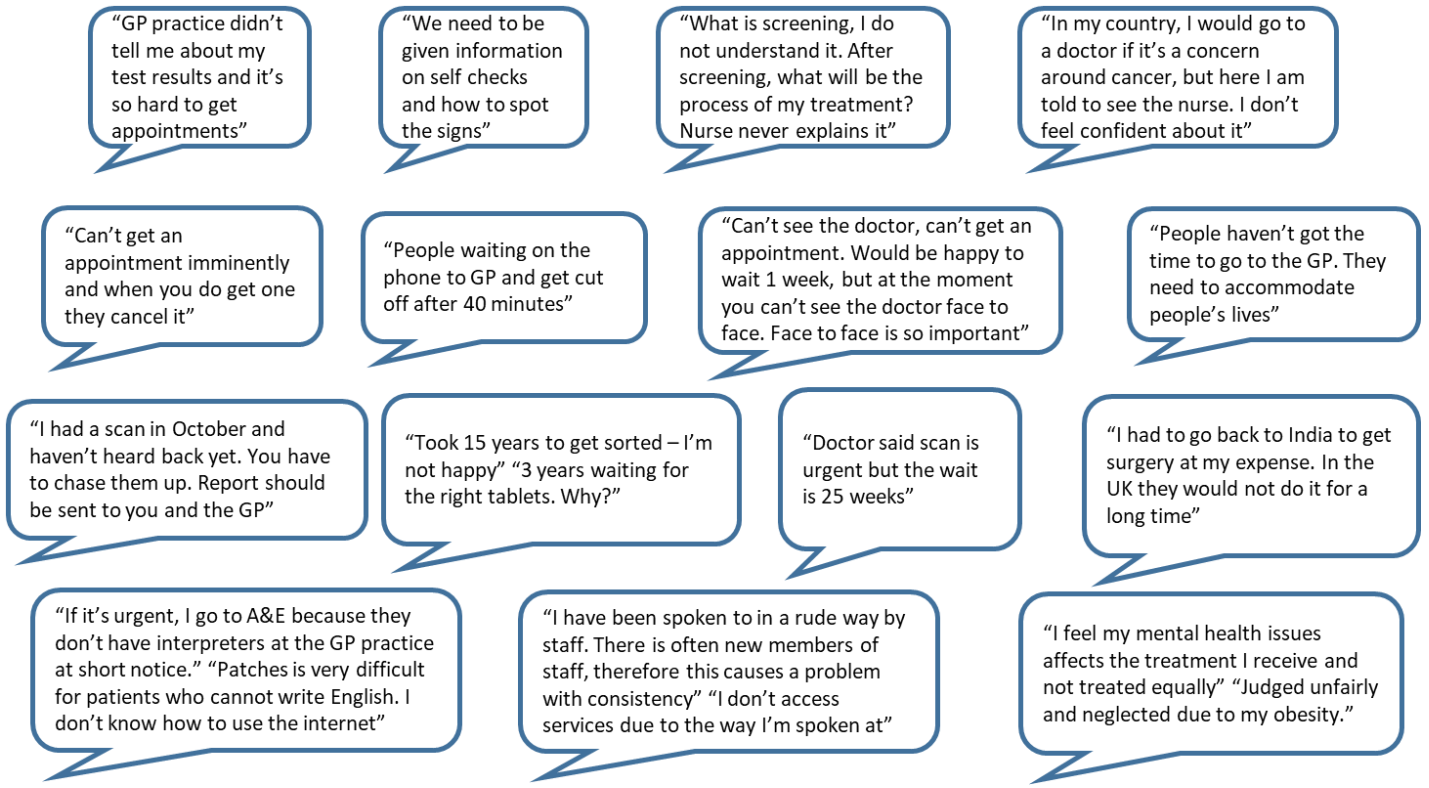
People from our different communities also have very different experiences of health and care services, including different levels of access, leading to very different health outcomes

1. **People are struggling to get the information they need**
2. **People are struggling to access primary care**
3. **Frustration with waits is leading to people losing confidence in services**
4. **There are additional barriers to people accessing services**



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Summary of proposed changes and overall equality impact

Personalised care and choice

With many of the individuals and groups that we spoke and engaged with there was a consistent and clear theme to the feedback they gave. People simply want to be listened to and for health and social care providers to respect their individual preferences and needs. They want to be treated as a unique person, which is even more important at end of life. People want care that is personalised to them and takes into account and embraces their culture, beliefs, preferences and the choices they wish to make in the way care is delivered and where it is delivered.

Our ambition is to develop community-based specialist palliative care services for adults (18+) that are patient-centred and provide choice where it is available. There will be a focus on tailoring services and treatment plans to meet the individual needs and preferences of each patient. It recognises that healthcare should not be a one-size-fits-all approach and that people have unique health conditions, values, and goals. Here are some key aspects of personalised care and the choices they have that will be introduced as we move forward with the model of care:

Treating people as unique individuals: Personalised care involves customising medical treatments, interventions, and care plans to suit the specific needs of each patient. In addition to taking into account the key protected characteristics such as age, sex, disability etc., this may include considering a person's medical history, genetics, lifestyle, family situation, faith and cultural background.

Making decisions together: Personalised care promotes active involvement of patients in their own healthcare decisions and care planning process and where they are able to express the choices they wish to make for their continuing healthcare journey towards the end of their life. Physicians and healthcare providers work collaboratively with patients and those important to them such as family, carers and friends to develop treatment plans that align with the patient's goals, values and choices.

Tailored accessible information that explains things clearly: Healthcare providers communicate information in a way that is understandable and relevant to the patient. They ensure that the patient is well-informed and empowered to make decisions about their care

Personalised care and choice

Respect for the choices that people wish to make: Personalised care respects the individual choices and values of patients. This includes considering factors like family situation, religious beliefs, faith and cultural practices, and personal values when making healthcare decisions.

Providing choice where it is available: Personalised care will also respect as much as possible the choices people make as to the way care is provided and where that is delivered and provide the flexibility for people to be able to change their mind. Where that choice is not available, care will be taken to explain to the patient, family, carers and friends why that is the case and what the alternatives are so that agreement can be reached as to the way forward.

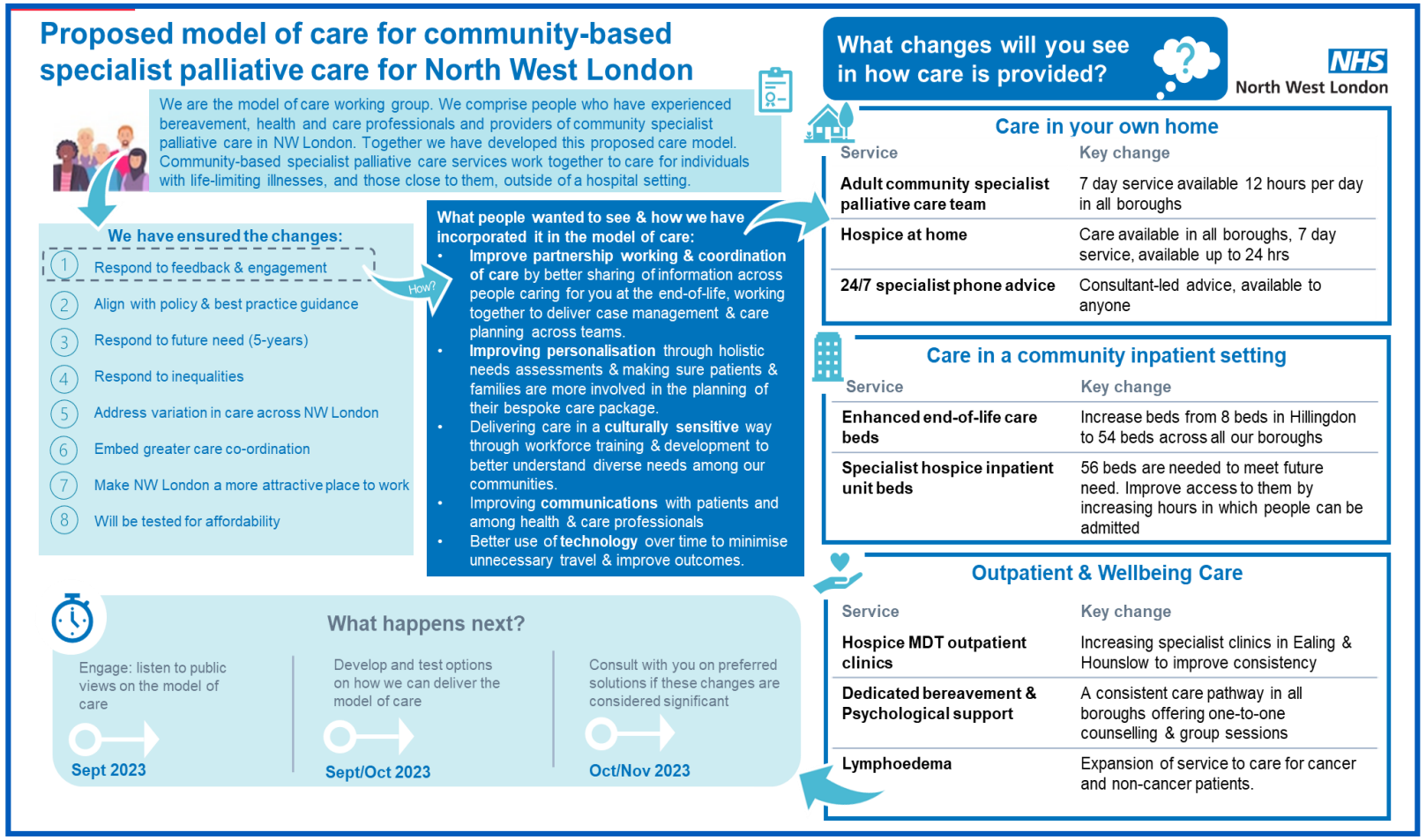
Continuity of care: Personalised care emphasises the importance of maintaining an ongoing and consistent relationship between patients and healthcare providers, ensuring that care is coordinated and comprehensive.

Looking at the individual as a whole: Personalised care takes into account not only the physical health of the patient but also their emotional, psychological, and social well-being. It recognises that these factors can have a significant impact on overall health and well-being.

Keeping people as well as possible and managing their condition: Personalised palliative and end of life care is about helping people to live their best possible life. Personalised care is about proactively managing their health condition to the best that can be achieved and preventing health issues from arising.

Personalised care is seen as a way to improve patient, family, carer, those important to patient satisfaction, healthcare outcomes, and overall quality of care. It recognises that healthcare is not only about treating diseases but also about addressing the unique needs and circumstances of each patient to provide the best possible care.

Summary of proposed changes: A new model of adult (18+) community-based specialist palliative care for North West London



A full description of the proposed new model of care and changes can be found at www.nwlondonicb.nhs.uk/cspc

Adult (18+) patients with specialist palliative care needs and their families/ carers/ those important to them will have greater choice and flexibility of where they are cared for, as well as improved access to a common core offer of services through:

- Expanded service hours of some non-bed based services (eg. adult community specialist palliative care team) and introduction of services in areas where there are currently gaps in service provision (eg. Hospice at home service; 24/7 advice lines for known and unknown patients, outpatient MDT services) supports more care at home, patient choice and reducing gap between who can and can't access services.
- Expansion of enhanced end of life care in-patient bed provision for all NW London boroughs, for patients who might not be suitable for hospice care but can't or don't want to remain at home, provides a safe appropriate alternative care environment, improving patient choice and increasing reach of services.
- Five key enablers (workforce development; , reducing inequalities; data, digital and technology; organisational development and leadership, governance and integration underpinning the delivery of this model

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How our proposed changes will address health inequalities

The model is underpinned by the following principles and strategies to make sure of equitable access to high quality services for all residents of NW London and those important to them who need these services, regardless of their borough of residence, characteristics or circumstances.

1. **Equitable Access:** The model prioritises equitable access to specialist palliative care services in the community for every individual, irrespective of their socio-economic status, ethnicity, culture, or the borough they reside in through establishing community-based palliative care services in areas where these services are currently not provided (eg. Hospice at home, 24/7 telephone advice line for known and unknown patients, enhanced end of life care inpatient beds, outpatient services) to ensure that more people get specialised care reducing the gap between those patients who currently receive these and those that do not.

2. **Culturally Competent Care:** there is recognition of the importance of cultural competency and providing personalised care that respects and accommodates the diverse cultural backgrounds of patients and their families/ carers/ those important to them, through supporting providers to develop a cultural competency framework for NW London CSPC providers to implement which will include appropriate training for staff to deliver culturally competent care to address the unique needs and beliefs of each patient. This will be addressed through enabler work. This ensures that providers will be well-prepared to deliver culturally competent care to NW London's diverse communities.

3. **Care Coordination**: The model recognises the important of developing robust care coordination mechanisms that ensure seamless access to services for individuals with specialist palliative care needs. This entails fostering collaboration and improved partnership working at place between generalist palliative care providers (primary care, social care and other community healthcare teams) and specialist palliative care teams (in community and in hospital), but also within community specialist palliative care teams themselves in the first instance. The model sets out ambitions for boroughs to develop local arrangements for single points of contact/ access for these services and internal care co-ordination approaches for example key workers/ internal co-ordination functions. It also sets out the ambition for more integrated working across Integration neighbour hood teams locally to support increased MDT working.

4. **Outreach and Engagement:** Ongoing engagement by the ICB and providers to actively engage with underserved populations, making an effort to reach those who might not seek palliative care on their own. This could involve outreach programs, partnerships with community organisations, and the provision of home-based care services.

How our proposed changes will address health inequalities

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5. **Research and Data Collection:** Collect data on health disparities within specialist palliative care providers in NW London to identify and address gaps in service provision. Informed by research, targeted interventions and policies can be developed amongst providers to reduce disparities in care delivery and outcomes. NW London ICB is developing an End of life specific dashboard which will include demographic and health inequalities data metrics, alongside developing a standard data set for CSPC providers to report on that includes these key metrics, which will feed the dashboard.

6. **Education and Awareness**: All providers are committed to raising public awareness and providing education about palliative care within clinicians and communities across NW London. By increasing awareness, more individuals can access these services and benefit from them, addressing disparities in care utilisation. Training and education is a key part of the new model of care.

7. **Patient choice and involvement in care: The model aims to e**nhance health literacy among residents through, empowering them with a better understanding of palliative care and their end-of-life options through advance care planning. This will enable patients to make informed decisions about their care and reduce disparities caused by a lack of information or opportunity to have their wishes made known and shared with the system (for example via a Universal Care Plan (UCP)

Summary of impact on groups with particular characteristics (including protected characteristics)

Protected Characteristics	Overall impact	Rationale for inclusion
Age	**Positive**	The impact on populations with these characteristics must be assessed as part of all Equality Health Impact Assessments.
Disability	**Positive**	
Sex	**Neutral**	
Race	**Neutral**	
Religion or belief	**Positive**	
Sexual orientation	**Neutral**	
Gender assignment	**Neutral**	
Pregnancy and maternity	**Neutral**	
Marriage or civil partnership	**Neutral**	
Additional vulnerable groups		
Carers	**Positive**	Populations with these characteristics have been identified through our engagement activities as particularly important for this work. They have therefore been included to ensure that our proposals consider the specific circumstances of people who are most likely to be impacted, and that any negative impacts are either avoided or appropriately mitigated.
Single person households	**Positive**	
Deprived populations	**Neutral**	
People living in sub-standard housing	**Positive**	
Homelessness	**Positive**	
Mental health & dementia		

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Engagement and feedback to support this assessment

Engagement on the issues paper

Following publication of the Issues Paper in November 2021, we spent considerable time listening to the views of our communities to understand what was important to them in receiving community-based specialist palliative care.

We also wanted to build on the valuable learning and feedback received from previous reviews of palliative and end-of-life care services carried out in Brent, Hammersmith and Fulham, Kensington and Chelsea, and Westminster, but the decision taken by the North West London Integrated Care System to expand the review to cover Ealing, Harrow, Hillingdon and Hounslow meant we had to engage again.

We arranged a series of ten events and webinars at which we presented and took questions from members of the public and clinical staff, capturing the key issues raised and ensuring these fed back into the work to develop the model of care. We also attended a number of meetings of borough-based palliative and end of life groups that been set up to look at this important service area at a borough level.

We also were referred to or approached a number of voluntary and community organisations and representatives for further one-to one interviews and discussions aimed at gaining an in-depth understanding of the issues and challenges for specific (often hard-to-reach) groups of people. This included Kosher Dementia UK, BAME Health Forum, SOBUS and SPECTRA and the Dementia Group for Hounslow.

This in turn helped us identify some key groups for whom we lacked information or input and needed to link-in with experts both locally and nationally to better understand what was important to these groups in terms of end-of-life and specialist palliative care. This led to us conducting desk research, reviewing the information published by health providers, charities and journals, and producing three literature reviews covering learning disabilities, people living with homelessness and younger adults (approximately 18-45 years old), which we published and used as evidence in the review.

We attended, and continue to attend, Health and Wellbeing Boards, Scrutiny Committees and Health Committee sessions across the NW London boroughs to brief elected members and stakeholders on our work and answer their questions on the development of the model of care.

In addition to all of these direct meetings and conversations, we developed a number of online surveys through which local residents and health and social care professionals could give their views. Open-ended questions were also included to give respondents the opportunity to express their opinions in their own words. We received feedback from 188 respondents across six surveys, along with two formal written submissions.

Engagement on the issues paper

During this engagement work, we met or spoke to some local residents who were kind enough to share their stories so we could use them as case studies to illustrate both the good experiences and the challenges that people face when using community-based specialist palliative care services. This led to the development of nine patient stories that highlighted problems that need to be addressed and how the model of care will need to support improvements.

The overall feedback was published in the Engagement Outcome Report and we used these valuable insights from members of the public to feed directly into the development of a new model of care.

We have also chosen to focus on characteristics and areas that are not usually included in an EHIA due to the feedback received during our engagement including carers, single person households, deprived populations, deprived populations, people living in sub-standard accommodation, homelessness, mental health and dementia.

We have also taken a number of actions to address issues and make improvements whilst our work on the new model of care is ongoing. These are covered in section 7.2 and within the Engagement Outcome report (pages11-14) and include, for example, increasing access to end-of-life and anticipatory medication in the community and access to 24/7 end-of-care advice.

From the extensive engagement undertaken, we collected a wealth of feedback that described ‘what’ services needed to provide from the perspective of service users and families and also ‘how’ they are cared for. The substantial feedback can be summarised into the following themes.

Engagement and feedback from Issues paper to support this assessment

Engagement Themes		Summary Feedback
1	Best possible care	High quality care delivered in the optimal place, supported by evidence-based pathways
2	Care tailored to my needs	Care personalised to me, my preferences and needs. An approach to care planning that factors in my individual requirements, considering my conditions. For example, dementia, my ethnicity or sexual orientation.
3	Providing connected care	Care providers working together so care feels integrated and services are easy for me and my family to navigate and access.
4	Staying informed	I know where to find information regarding specialist palliative care services across NW London. I know who I can speak to find help and support.
5	Creating professional culture and behaviours that exhibit sensitivity and compassion	All staff exude compassion in their interactions with me, my family and those important to me. They show an understanding of how my faith and culture might lead to differences in the help I need.
6	Supporting carers & families through end-of-life and beyond	Bereavement, respite and emotional support are available for those individuals who are important to the patient (family/ carers/ friends)

The model of care working group

Following the launch of the Issues paper in November 2021 and on the back of our engagement about the issues, the new model of care working group was set up by the NW London ICS to develop a model of care to make sure:

- The themes raised through our engagement were addressed
- All NW London residents are able to access the services, if needed
- That high quality community-based specialist palliative care is delivered equitably and sustainably across NW London.

The model of care does not address how we will configure services. What is describes is the level of care that all residents should expect to receive.

Click here to view the minutes of the model of care working group

Membership of the group, which met thirty-eight times over a year, consisted of local residents, clinicians and other palliative and end-of-life care stakeholders, and more details can be seen in the acknowledgement section of this document.

The objective of the group was to develop a new model of care for community-based specialist palliative care for adults that addressed “what good looks like”, including developing the underpinning design principles and high level cross-cutting enablers to support implementation and delivery of the new model.

This involved using engagement feedback, national guidance and supporting documentation, and key reports to agree a set of key definitions standards and a common core offer of services. This will later be built into a single service specification for NW London once the new model of care has been agreed.

The model of care working group

During meetings the group looked in detail at the different aspects of community-based specialist palliative care drawing on:

- The national service specification for adult palliative and end-of-life care
- The previous NW London palliative care review programme work from 2019/2020
- The qualitative and quantitative feedback from residents and healthcare professionals obtained through our extensive engagement
- Population projections
- Demand modelling
- Travel mapping.

The new model of care working group have collectively agreed and recommended a set of core services with a common core offer for community-based specialist palliative care provision that NW London residents can expect to receive regardless of the borough they live in. Some of these services are already available to all boroughs, while others are new additions for some boroughs and will raise and level-up the standard of care where these services do not exist or vary a lot. They have also agreed five cross cutting enablers to support successful implementation and delivery. The model of care has also been agreed by the NW London community-based specialist palliative care steering group

The proposed new model of care was published in Aug 2023 where local residents were asked to review and respond to the proposed new model of care.

Engagement on the proposed new model of care

We subsequently have continued to engage on it with our residents, boroughs and stakeholders on the new model of care over September and early October 2023. We held a number of engagement events at a North West London and borough events.

Overwhelmingly, there was good support for the proposed new model of care. However, we did hear some valuable challenge and constructive suggestions on how we might improve the model, which we are committed to considering and potentially incorporating as part of the model' of care's improvement process.

Engagement and feedback on proposed new model of care (MOC) to support this assessment

Engagement Themes		Summary Feedback
1	Improved navigation of services	Emphasis on simplifying the complex journey through palliative care services and the wider health and care system for patients, family, carers and clinicians. The aim is to make services more accessible to those in need.
2	Enhanced care coordination and integration of services	• Emphasis on the need for more seamless transitions of patient care between acute and community services. • Fostering collaboration and improved communication among healthcare professionals to support a localised, patient-centred approach with named care coordinators or a dedicated care co-ordination service/function. The aim will be to improve the overall patient experience and bridge gaps between generalist and specialist care.
3	Addressing Inequalities	Emphasis on the need to address disparities in access to palliative care healthcare provision, ensuring that all individuals, regardless of their background or circumstances, receive the same level of high-quality palliative care. Call for more tailored strategies for different communities, considering geographic, socioeconomic, and cultural factors to demonstrate the model of care will help to address these disparities.
4	Enhancing innovation and continuing improvement	Emphasis on improving the model by exploring innovative initiatives, drawing on local, regional and national pilots underway and making sure the current model has openness to testing innovative and new ideas.
5	Improved leadership and governance	Emphasis on robust leadership and governance structure to guide the transformation and for accountability and sustainability of the new care model.
6	More information about enhanced end-of-life care beds	Local residents fed back they wanted a more detailed and clear explanation of what exactly is being offered in terms of these beds and how they will be made available to ensure that they effectively meet the needs of patients.

North West London Integrated Care System

3

Assessment of impact for specific populations

Note: These categories overlap and citizens can span a number of protected characteristics (e.g. older disabled people living alone) and vulnerable groups. As far as possible, the assessment against each characteristic is restricted to that characteristic. For the population noted above, the assessments for age, disability and people living alone would all apply.

Age

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact: Positive	Impact: Neutral	Impact: Negative
Care in your own home	✓		
Care in a community inpatient setting		✓	
Outpatient & Wellbeing Care	✓		
Overall	✓		

Explanation of the main potential positive or adverse impact of the proposal

The aim of this model of care is to improve access to and quality of specialist palliative care in the community at the end of life. It includes all adults, so will have a positive impact across all ages.

Positive benefit will be felt by patients of all ages wishing greater choice and flexibility of where they are cared for:

- by extending hours of provision of non bed-based services such as hospice at home and specialist palliative care team, we will be better equipped to support care in people's own homes, supporting their preferences regarding place of death.
- By expanding EOLC beds to all boroughs, people who might not be suitable for hospice care but do not wish to remain at home can access alternative care in a safe environment. In particular, older people living alone are likely to benefit from this provision.
- Hospice inpatient facilities are well equipped to accommodate older people and their care needs.
- Outpatient care will remain in current locations. For the majority of providers their outpatient services are delivered out of the same locations as the inpatient services, except for Hillingdon borough where outpatient services are delivered from two locations, but these are both accessible by public transport and for people with physical disabilities.

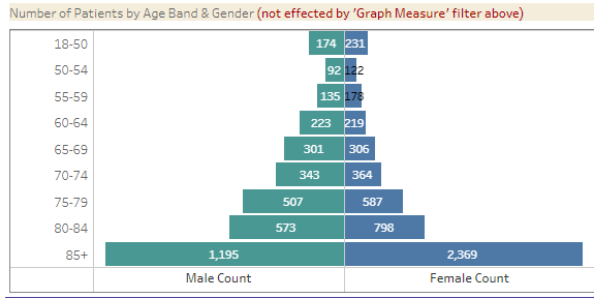
Concerns might include:

- **Suitability of hospices in caring for younger people.** Hospice environments typically have higher volumes of people dying in old age. However, the environment is suited to meet the complex needs of younger adults too. The model of care strengthens the ability to care for people dying in their own home by increasing the hours of provision of key services such as hospice at home and community specialist palliative care team. This ensures people remain with family and informal carers.

Data to support this assessment

Age	% registered deaths (England & Wales, 2023)
0-9	0.5%
10-19	0.2%
20-29	0.5%
30-39	1.2%
40-49	2.4%
50-59	5.9%
60-69	11.3%
70-79	23.0%
80-89	33.6%
90+	21.4%

Data source: Deaths registered weekly in England and Wales, provisional - Office for National Statistics (ons.gov.uk)



Data source: NWL End of Life data dashboard

With almost 80% of deaths occurring in the 70+ age groups *(ONS Household composition data, March 2023)*, catering to the needs of older people within our service design is of importance. Our local data confirms that older people are more likely to be identified as being at end of life.

As the number of older adults increases and people live longer, this will be an increasingly important factor.

Almost 10% of households in NW London are 'single person households aged 66 and over'. Provision of wrap-around support and options for care provision alternatives should be considered (see single person households for more information).

North West London Integrated Care System

Disability

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home	✓			Positive benefit to people with physical disabilities and learning disabilities is offered through: • The inclusion provision of holistic needs assessment and a personalised care plan in the model of care brings the needs of the individual to the forefront of care planning and delivery. This process is inclusive of carers and families, ensuring trust is built and needs of individuals are fully reflected. • Greater provision of care in the comfort of people's own homes by extending hours of provision of key services such as specialist palliative care teams, hospice at home and 24/7 telephone advice. This maximises opportunity for existing support provision (including informal and formal carers) to work seamlessly with community-based specialist palliative care providers and maintaining important social connections with family and friends. • Increasing the options for bed-based provision by introducing EOLC beds in care homes, is more likely to bring options for care provision closer to home. Care providers are required to be CQC registered and a key requirement of premises is "reasonable adjustments must be made when providing equipment to meet the needs of people with disabilities, in line with the requirements of the Equality Act 2010". Neutral benefit to people with physical disability accessing hospice inpatient units is anticipated as: • There is not significant change in driving time to access hospice units • All providers will support carers/ family staying over at inpatient unit to support patients who have disabilities as required . This is considered on a case by case basis. • Some of the CSPC providers have their private transport or can access wider organisational patient transport services that can support patients to access the hospice inpatient services. NW London is currently undertaking a review of Non-emergency patient transport services to support developing a common core offer to be embedded into contracts, so with the new model of care we would aim to make sure that through this work and appropriate contracting mechanisms patients will continue to have access to non emergency patient transport to hospice sites for accessing these services.	A UK disability statistics research briefing published in August 2023 in the House of Commons Library cites Department of Work and Pensions data for 2021/22 showing 24% of the population as having a disability. This has risen by 6% since 2002/03. Key findings include: • Prevalence of disability increases with age with 58% of people aged 80 and over reporting a disability • ONS analysis looked at inequality differences between disabled and non-disabled people and found people with a disability were more likely to be in social rented homes (25%), • People with a disability were more likely to have no qualifications (13%) • People with a disability were more likely to report feeling lonely regularly (13%). • People with a disability were rely predominantly on car travel. Household Census data on disability at borough level
Care in a community inpatient setting	✓				
Outpatient & Wellbeing Care	✓				
Overall	✓				

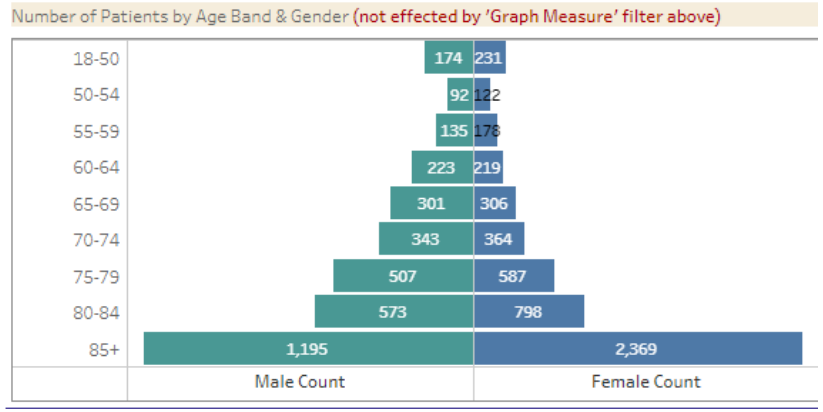
No people disabled in a household (2021 Census)	
Brent	72.9%
Ealing	73.9%
Hammersmith & Fulham	76.9%
Harrow	73.4%
Hillingdon	72.4%
Hounslow	73.3%
Kensington & Chelsea	77.7%
Westminster	76.3%
England	68.0%

A literature review covering people living who live with a learning disability was carried out. Potential improvements to end of life care grouped under four headings – education, communication, collaboration and health and social care delivery. See full literature review.

Data sources: Disability, England and Wales - Office for National Statistics (ons.gov.uk)
UK disability statistics: Prevalence and life experiences - House of Commons Library (parliament.uk)

Sex

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home		✓		1. Concerns would include whether women and men access palliative care equitably. Positive impact will be felt by the whole population as a result of increased capacity in bed-based and non bed-based care, improving access to these services. 2. To address concerns on gender roles in caring, holistic assessment of needs at the outset allow carers and the patient to discuss care needs, identify support required and monitor how well this is working throughout. Where adjustments are needed to suit the patient and carer, this will be discussed and implemented. 3. Women living alone and older women living in poverty will see positive impact from the new model of care in the following ways: • Holistic needs assessment that will factor in their social support and carer support to be cared for at home • Holistic needs assessment that will consider the suitability of their home environment • Strengthened psychological and wellbeing services that would improve the support individuals can access. • Care in a bed-based environment among other people where this is needed.	Local data on people identified to be at the end of life registers more women than men across most age categories. This may link with greater health-seeking behaviour in younger age groups. It may be caused by differences in life expectancy in older age groups. It has not been possible to assess how differences in need translate to equity of provision and this is something that will need to be tracked in future.  Data source: NWL End of Life data dashboard
Care in a community inpatient setting		✓			
Outpatient & Wellbeing Care		✓			
Overall		✓			

North West London Integrated Care System

Race

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact: Positive	Impact: Neutral	Impact: Negative
Care in your own home		✓	
Care in a community inpatient setting		✓	
Outpatient & Wellbeing Care		✓	
Overall		✓	

Explanation of the main potential positive or adverse impact of the proposal

Positive impact will be gained in community specialist palliative care services as a result of introducing this model of care in the following ways:

- Understanding the ethnic diversity of our communities and having heard directly from these communities the importance of understanding cultural factors in the provision of care at the end of life, we are incorporating cultural competence training for staff throughout our provision. This will support people to feel their needs are being met in a way that factors in their cultural identity. It is anticipated this will contribute to closing gaps on unmet need.
- Extending services so they are consistent and high-quality across all Boroughs will improve accessibility to all populations and communities within our boroughs.
- All healthcare providers have access to language and interpretation services in person from 9 AM to 5 PM and over the phone after regular working hours. They are dedicated to using these services to communicate effectively with patients who don't speak English and make sure their medical needs are addressed with respect to their culture and language.
- All providers are dedicated to understanding and meeting their patients' cultural and faith-based dietary needs during their stay.in the inpatient unit or attendance of outpatient appointment. Staff will consult with patients and their families/ carers to support to providing culturally appropriate meals in as much as possible which may include meals being made for them or patients bringing in their own food, as long as it follows food safety rules. The goal is to ensure patients' comfort and dietary preferences are respected throughout their visits to the services.

Data to support this assessment

Ethnicity data suggests a rich mix of people living within our boroughs. Most diverse communities include Brent, Harrow and Hounslow.

2021 Census population by ethnic group	1st Largest ethnicity group & %	2nd largest ethnicity group & %	3rd largest ethnicity group & %
Brent	Asian: Indian 19.5%	White: Other 15.9%	White British 15.2%
Ealing	White British 24.3%	White: Other 16.1%	Asian: Indian 14.9%
Hammersmith & Fulham	White British 38.3%	White: Other 21.4%	Black African 7.2%
Harrow	Asian Indian 28.6%	White British 20.5%	White: Other 13.2%
Hillingdon	White British 37.1%	Asian: Indian 18.7%	White: Other 8.9%
Hounslow	White British 28.4%	Asian: Indian 21.1%	White: Other 13.9%
Kensington & Chelsea	White British 32.7%	White: Other 28.3%	Other 5.4%
Westminster	White British 28.0%	White (Other) 24.6%	Other: Arab 7.6%

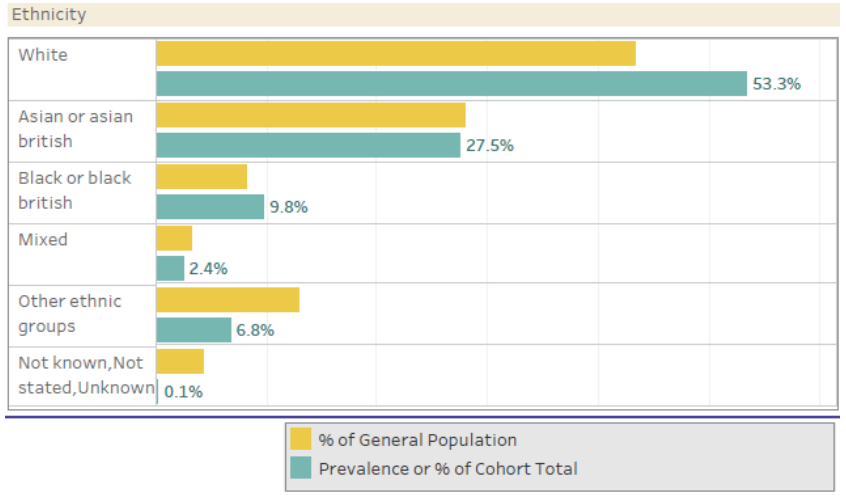
Ethnicity alone does not guide us in planning how we cater for people. Length of residence data using Census 2021 suggests 10.2% of people in Westminster and 8.9% of those in Kensington & Chelsea have lived in the UK less than 2-years. This might mean navigating the health system is less familiar.

Diversity in NW London means English spoken as a first language is less common than seen across England (90%). In particular, Brent, Ealing and Harrow flag as areas where people may need additional support to understand and engage with health and care in language they understand.

2021 Census data: Percentage of people who do not speak English as a first language	
Brent	33.68%
Ealing	30.9%
Hammersmith & Fulham	21.37%
Harrow	30.74%
Hillingdon	22.08%
Hounslow	28.32%
Kensington & Chelsea	23.6%
Westminster	26.44%

Race (Cont)

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home		✓		Ongoing tracking to ensure ethnicity groups are accessing the help and support they need at the end of life will be needed in future. The development of data dashboards will support this.	 Data source: NWL End of Life data dashboard Our local information suggests proportionally greater representation of White ethnicity group and Black or Black British on the end of life register than is representative in the general population. There appears to be slightly lower representation among Asian or Asian British, mixed ad other ethnic groups.
Care in a community inpatient setting		✓			
Outpatient & Wellbeing Care		✓			
Overall		✓			

North West London Integrated Care System

Religion or belief

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		

Care in your own home	✓			Positive impact has been identified in the following areas:
				• The proposed model of care aims to offer more personalised and culturally sensitive care to address the diverse needs of the entire NW London population. The model seeks to achieve this through a number of design principles and enablers which support tailoring services to individual preferences, cultural competence training for staff and actively collaborating with local organisations and partners. This spans the whole model of care and constituent services. Guidance has been previously published for local use including:
				  • Faith at end of life: A resource for professionals, providers and commissioners working in communities (publishing.service.gov.uk)
				  • Training programmes that incorporate culture and spiritual needs into end of life care: NHSE elfh Hub (e-lfh.org.uk)
				
				Neutral impact has been identified in the following areas:
				• All our charitable hospices are inclusive environments that are welcoming of people irrespective of their religious beliefs. However, the origins of these providers is largely based on Christian faith. There is a small risk this is perceived by communities to be environments that do not cater for a wide range of beliefs and religious needs at the end of life. Cultural competency training will help staff to feel comfortable with approaching diverse needs and seek out support from faith leaders where required.
					Similar to ethnicity profiles, Faith representation vary in our boroughs with while greatest religious denominations including:
					1. Christian
					2. Muslim
					3. Hindu
					People who report 'no religion' are significant.

Care in a community inpatient setting	✓				
Outpatient & Wellbeing Care	✓				
Overall	✓				

Religion 2021 by local authority ONS Census data	No religion (percent)	Christian (percent)	Buddhist (percent)	Hindu (percent)	Jewish (percent)	Muslim (percent)	Sikh (percent)	Other religion (percent)	Not answered (percent)
Brent	13.6	38.8	0.9	15.6	1.1	21.4	0.5	1.3	6.9
Ealing	19.1	37.8	1.1	7.7	0.3	18.8	7.8	0.7	6.7
Hammersmith and Fulham	30.6	45.7	0.9	1.2	0.7	11.6	0.2	0.7	8.4
Harrow	10.6	33.9	1.1	25.8	2.8	15.9	1.1	2.9	5.9
Hillingdon	19.4	39.0	0.9	10.8	0.5	14.4	8.6	0.9	5.6
Hounslow	18.6	38.3	1.4	9.5	0.2	16.7	8.6	0.8	6.1
Kensington and Chelsea	24.8	48.4	1.1	1.1	1.9	11.8	0.2	0.7	10.0
Westminster	25.9	37.3	1.3	2.2	2.8	20.0	0.3	0.9	9.4

North West London Integrated Care System

Sexual orientation

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact: Positive	Impact: Neutral	Impact: Negative	Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
Care in your own home		✓		Positive impact will be seen among LGBTQ people accessing community specialist palliative care in the following ways: • Personalised care planning will create better conversations to emerge including the care preferences and needs based on sexual orientation. • The inclusion of people who are important to the patient in the care planning process (as opposed to limiting this to families and spouses) ensures non-heterosexual people are included in accessing help and support. • Staff will be better equipped to discuss personalised care needs of LGBTQ people through improved training and education. Supporting material is already available to staff in end of life care including: • Marie Curie: Palliative and end of life care for LGBTQ+ people | For professionals (mariecurie.org.uk) • Strengthening holistic assessment will highlight social factors and informal care support of the individual, factors that might limit care delivery in their preferred place. By increasing care provision in the community including hours of provision, this group of individuals will benefit from care at home. • Hospices serving NW London population have made strides to be inclusive environments where LGBTQ people feel welcome and comfortable. Expanding bedded care provision in care home environments expand options for people where this is still not a preferred place of care. • Improved psychological and bereavement services will improve access to LGBTQ population seeking support.	In 2021, Wakefield et al considered the access and care requirements for LGBTQ people (Why does palliative care need to consider access and care for LGBTQ people? - Donna Wakefield, Chris EC Kane, Claude Chidiac, Debbie Braybrook, Richard Harding, 2021 (sagepub.com)). Addressing the following issues were cited: 1. Anticipated discrimination even if there is no active discrimination 2. Family estrangement, limited social support with LGBTQ people more likely to be single and childless than heterosexual people. This lack of informal family support may limit their ability to die in their preferred place. 3. Inclusion within hospice environments with faith-based backgrounds. 4. Increased anxiety arising from the factors above In NW London, higher proportions of people who do not identify as being heterosexual can be found in our inner NW London boroughs of Westminster, Kensington and Chelsea and Hammersmith & Fulham..
Care in a community inpatient setting		✓			
Outpatient & Wellbeing Care	✓				
Overall		✓			

Sexual Orientation data by local authority Census 2021	Not Straight or Heterosexual (percent)
Brent	14.90%
Ealing	13.69%
Hammersmith and Fulham	15.10%
Harrow	12.84%
Hillingdon	11.09%
Hounslow	12.83%
Kensington and Chelsea	15.32%
Westminster	16.69%

Gender Assignment

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home		✓		Likely concerns of this group: • Hospice accommodation options for people who identify their gender as being different to that they were born as • Personal care by same-sex staff - understanding how this is managed Positive impact will be felt in the following areas: • All providers currently can offer individual rooms for hospice inpatient admissions for patients to support privacy for patient and family/ carers/ those important to patient regardless of their gender. • Many of the providers have specific transgender services users policies in place for staff, service users and volunteers and many have these in development or this forms part of their Equity, Diversity and Inclusion Policy. Through implementation of the new model of care we aim to support all providers having relevant policies to support reduce inequalities and raised awareness for this group of individuals accessing the services. • All providers currently consider individual requests from patients regarding preference for the sex of the person providing their care and in the main are able to support these requests, however as part of the new model of care the cultural competency and workforce development enabler work, the aim is to increase the providers' diversity of staff/ organisation to support this. • This group of people may face additional psychological needs arising from compounding factors of palliative care and gender identity. By strengthening the psychological support offer to people cared for in community-based specialist palliative care provision, we expect improved care provision overall. • Improving cultural competency among all clinical staff is expected to result in greater understanding of the needs of this group, careful use of language and building trust in care. The new model of care is proposing collaborative cultural competency development work across providers through the enabler workstream for reducing health inequalities which will look to support development of a NWL cultural competency framework for all CSPC providers to use.	Census 2021 data shows how gender identity varies across England and Wales. Response rates vary, but based on reported identity, the region with highest percentage reporting gender identity that differed from sex at birth was London. Although overall numbers remain relatively small, Brent stands out as an area where greater proportion of people identify as a gender different to that at birth. Data source: Gender identity, England and Wales - Office for National Statistics (ons.gov.uk)
Care in a community inpatient setting		✓			
Outpatient & Wellbeing Care		✓			
Overall		✓			

Area name	Gender identity the same as sex registered at birth (percent)
Brent	88.63
Ealing	90.19
Hammersmith and Fulham	91.50
Harrow	90.12
Hillingdon	91.70
Hounslow	90.57
Kensington and Chelsea	90.86
Westminster	90.03
London	91.21
England	93.47

Pregnancy and maternity

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home	✓			Core concerns likely to include: • Accessibility of services and sites: Care facilities that provide a calm/peaceful environment • Breastfeeding facilities – what facilities might be available • Access to psychological support and bereavement support All providers provide services to patients and their family members/ carers who are pregnant or mothers. This does not preclude these individuals from accessing services. Whilst not all providers have dedicated breast feeding facilities available on site, they are committed to supporting the needs of these individuals and will be able to make arrangements for a quite appropriate room/ environment to support this on request. Positive benefit to women in pregnancy is offered through: • The inclusion of a holistic needs assessment and a personalised care plan for all patients in the new model of care brings the needs of the individual to the forefront of care planning and delivery. This process is inclusive of carers and families, ensuring trust is built and needs of individuals are fully reflected. This includes preferences on place of care and consideration of the ability of pregnant women and mothers to travel to care facilities. • Greater provision of care in the comfort of people's own homes by extending hours of provision of key services such as specialist palliative care teams, hospice at home and 24/7 telephone advice. This maximises opportunity for existing support provision (including informal and formal carers including pregnant women and young families) to work seamlessly with community-based specialist palliative care providers and maintaining important social connections with family and friends. • By strengthening provision of psychological and bereavement support, pregnant women and mothers (patients and family/ carers of patients) will see improved access to support.	
Care in a community inpatient setting		✓			
Outpatient & Wellbeing Care	✓				
Overall	✓				

North West London Integrated Care System

Marriage and civil partnership

Why has this characteristic been included?
This characteristic must be assessed as part of all Equality Health Impact Assessments.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home		✓		Likely concerns of this group: The risk presented is people who aren't married may have less input to care planning for their loved ones, may not be able to stay at the hospice to support their loved one and may not be eligible to access help and support for themselves. In response to this, positive impact has been identified in the following areas of the new model of care: • Personalised care planning will include people who are important to the patient in the care planning process (as opposed to limiting this to families and spouses). • The model of care ensures those who are not married do not experience barriers in inputting to care planning or accessing support such as psychological and bereavement support. • Strengthening holistic assessment will highlight social factors and informal care support of the individual, factors that might limit care delivery in their preferred place. By increasing care provision in the community including hours of provision, this group of individuals will benefit from care at home. • All providers will support patients family/ carers/ those important to patients to visit patient as well as stay over at the inpatient unit regardless of their marital status (married or unmarried/ civil partnership). Neutral impact has been identified in the following areas: • Estate planning is widely available within charitable hospices which will support married and unmarried people to arrange their affairs e.g. will	Nationally there are greater proportion of adults under 70 who have never married for formed a civil partnership than in 2011. the number of people getting married is at the lowest rate on record and the median age of those getting married is increasing (ONS Census 2021 data: Marriage and Civil Partnership status in England and Wales). In NW London, lowest levels of marriage and civil partnership are seen among those living in Hammersmith & Fulham, Westminster and Kensington & Chelsea. Data source: Marriage and civil partnership status in England and Wales - Office for National Statistics (ons.gov.uk)
Care in a community inpatient setting		✓			
Outpatient & Wellbeing Care		✓			
Overall		✓			

	Married or registered civil partnership (age standardised proportions)
Brent	45.6
Ealing	46.2
Hammersmith and Fulham	35.2
Harrow	54.8
Hillingdon	50.1
Hounslow	47.8
Kensington and Chelsea	37.7
Westminster	36.3

Carers

Why has this characteristic been included?
Carers play an important role in many people's care at the end of life, meaning that it is particularly important to consider potential impacts on them arising from these service changes.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home	✓			**Areas where carer support is strengthened in the new model of provision:** 1. Carers are involved in the holistic needs assessment in the new model of care. Development of a personalised care plan that takes account of the needs and preferences of the individual and their circumstances. Tracking improvement in patient, family and carer experience will be tracked and monitored through surveys and seeking feedback. 2. Caregiver support runs throughout how people are cared for within community-based specialist palliative care provision including access to emotional and psychological support and bereavement support. 3. More compassionate care and better communication with carers and families through workforce training (including e-learning for health): NHSE elfh Hub (e-lfh.org.uk)) **Areas of neutral impact:** 1. Travel time access to hospice sites is variable within NW London. The intention to increase bed based options to include EOLC beds within care homes provides greater choice of options, potentially reducing travel time.	National survey of bereaved people (VOICES), England, 2015 revealed the majority (between 74% and 86%) of people responded agree or strongly agree to these questions: • "we understood the information given to us" (86%) • "we were kept informed of his/her condition and care" (79%) • "we had enough time with staff to ask questions and discuss his/her condition and care" (75%) • "we had a supportive relationship with the health care professionals" (74%, see Figure 12)
Care in a community inpatient setting		✓			
Outpatient & Wellbeing Care	✓				
Overall	✓				

Single person households

Why has this characteristic been included?
Parts of NW London have a large number of people living alone, especially older people. Engagement has highlighted that this group might struggle to access community-based specialist palliative care services. It is therefore important to consider their specific circumstances.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home	✓			Area of concern and how this is addressed within the proposal: • **Single older people living alone might be less able to die in their preferred place because of potentially less informal carer support within the household**. The model of care brings holistic needs assessment to personalised care planning. This aims to consider support needs from a range of perspectives. The availability of 24/7 telephone advice would serve as a way for people to access clinical advice at any time of the day or night. By extending the hours of care provided by community services such as hospice at home, the ambition is to support more people dying at home if that is their preference. Equally, where needed or preferable, expansion of options for bed-based care provision means choice options are available. • **Social isolation experienced by people living alone may compound mental health challenges at the end of life**. The use of holistic needs assessment and personalised care planning aims to identify the specific needs of an individual, including psychological and bereavement support. The recommendation in the model of care is that we include improved bereavement and psychological support as a core service element of the well-being offer in the new model of care. This means implementing a core level of service and clearer robust pathway for access to appropriate psychological and bereavement support across all boroughs.	According to Census 2021, almost 10% of households in NW London are 'single person households aged 66 and over', slightly higher than the overall London picture, but lower than England and Wales. **Data sources:** Household composition data, census 2021, ONS Research has linked social isolation and loneliness to higher risks for a variety of other physical and mental conditions including depression, anxiety and cognitive decline (Social isolation, loneliness in older people pose health risks | National Institute on Aging (nih.gov)). The Health Foundation published findings in 2018 suggesting older people living alone were 50% more likely to visit A&E than those who lived with others (Older people living alone are 50% more likely to visit A&E than those who live with others (health.org.uk)).
Care in a community inpatient setting	✓				
Outpatient & Wellbeing Care	✓				
Overall	✓				

Row Labels	One-person household: Aged 66 years and over (n)	Grand Total Households (n)	% of households that are one-person households aged 66+
Brent	9,712	118,612	8.2%
Ealing	11,837	133,659	8.9%
Hammersmith & Fulham	7,351	81,244	9.0%
Harrow	9,050	89,642	10.1%
Hillingdon	11,143	109,227	10.2%
Hounslow	9,176	102,961	8.9%
Kensington and Chelsea	7,750	66,885	11.6%
Westminster	9,498	94,817	10.0%
NW London	75,517	797,047	9.5%
LONDON	313,050	3,423,899	9.1%
ENGLAND & WALES	3,197,840	24,783,213	12.9%

Deprived populations

Why has this characteristic been included?
188 LSOA areas fall among the 20% most deprived in England. Deprivation is linked to lower health literacy, impacts ability to travel and attend health appointments and seek help.

	Impact			Explanation of the main potential positive or adverse impact of the proposal
	Positive	Neutral	Negative	
Care in your own home		✓		Area of concern and model of care response: • People in deprived communities may find it harder to navigate community-based specialist palliative care provision. A key aspect of the new model of care is awareness raising of the services that are available at the end of life, including community specialist palliative care. Staff will be trained to understand the importance of health literacy in achieving good patient outcomes. Training material is already available to support staff delivering NHS services: Health Literacy - elearning for healthcare (e-lfh.org.uk) • People experiencing income deprivation not be able to afford travel to locations where care is provided. Travel to healthcare sites can be supported via non-emergency patient transport schemes and some hospices have their own private ambulances. • People experiencing income deprivation may experience longer travel time to access health sites where care is delivered. Travel mapping was undertaken as part of the development of the model of care. Broadly, our hospice sites are located in areas within close proximity of deprived communities. People living in the most deprived areas (IMDs 1&2) are not adversely impacted by travel times to their nearest unit except in Hillingdon where travel times are higher to access Michael Sobell House for the 7 LSOA areas.
Care in a community inpatient setting		✓		
Outpatient & Wellbeing Care		✓		
Overall		✓		

Data to support this assessment

Deprivation in NW London
Large income deprivation disparities exist among boroughs and within boroughs in NW London. Overall, Brent sees 15% of the population reported as being income-deprived, ranking at 67 out of 316 local authorities. Ealing and Westminster had the greatest number of LSOA areas categorised as being among the 20% most deprived in England. The disparity within boroughs exists in Kensington & Chelsea and Westminster.

	%of population that was income-deprived in 2019	Rank of most income deprived (out of 316 authorities)	No. of LSOAs	No. of LSOAs among the 20% most deprived in England
Brent	15%	67	173	33
Ealing	14%	94	196	35
Hammersmith & Fulham	14.20%	88	113	27
Harrow	10.90%	156	137	8
Hillingdon	11.40%	141	161	9
Hounslow	12.90%	111	142	18
Kensington & Chelsea	11.70%	138	103	24
Westminster	13.50%	100	128	34

In 2021, Age UK published findings that suggest one in five women pensioners are now living in poverty with even higher levels of poverty among black and Asian women. **(**New Age UK analysis finds one in five UK women pensioners now living in poverty).

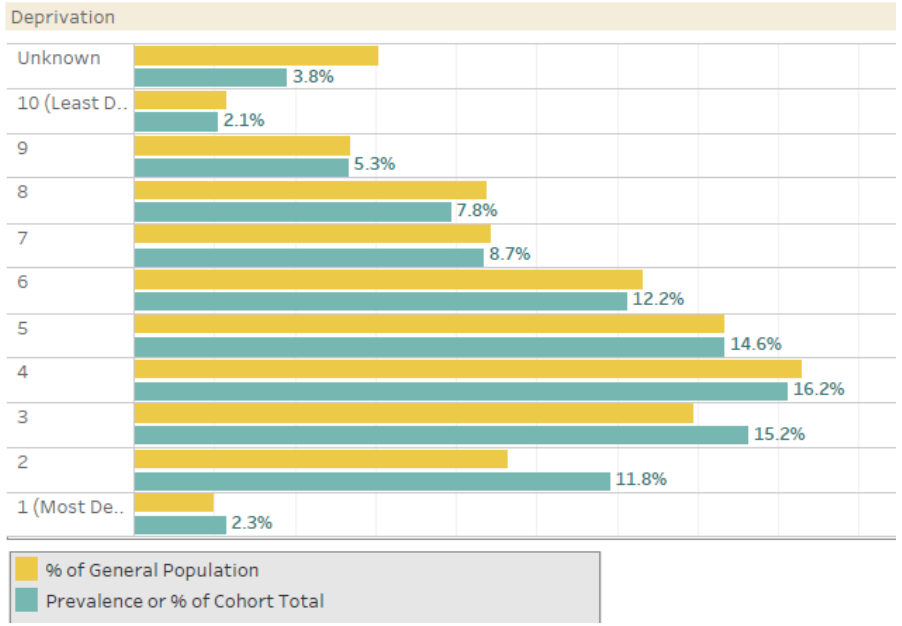
Data Sources: Exploring local income deprivation (ons.gov.uk)

Deprivation & health literacy
People with limited financial and social resources are more likely to have limited health literacy. In turn, limited health literacy limits opportunities for vulnerable and disadvantaged groups to be actively involved in decisions about their health and care over the life course. This can undermine people's ability to take control of their health and the conditions that affect their health. Among the recommendations for improving health literacy and reducing health inequalities by Public Health England in a 2015 report '*Improving health literacy to reduce health inequalities*' are:
- Ensuring clear and accessible information
- Community-led approaches, using social networks
- Strengthen public-professional communications (e.g. training)

Data sources: 4b_Health_Literacy-Briefing.pdf (publishing.service.gov.uk) NHS England » Enabling people to make informed health decisions, Health Information - (library.nhs.uk)

Deprived populations (Cont)

Why has this characteristic been included?
188 LSOA areas fall among the 20% most deprived in England. Deprivation is linked to lower health literacy, impacts ability to travel and attend health appointments and seek help.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home		✓		Tracking of caseload by postcode would give visibility of equity of access across IMD groups.	**Deprivation in NW London end of life cohort** The profile of people on the end of life cohort using local data suggests higher representation of people living in the most deprived areas than the population at whole. There are a number of inferences from this overview including: 1. This suggests people living in deprived communities with this need are known to health professionals. This isn't the same as being on a CSPC caseload and further analysis would be necessary to assess whether equity of access is present. 2. Premature mortality attributable to socioeconomic deprivation is at play 3. Multimorbidity associated with socioeconomic deprivation and occurring at younger ages is a factor.  Data source: NWL End of Life data dashboard
Care in a community inpatient setting		✓			
Outpatient & Wellbeing Care		✓			
Overall		✓			

North West London Integrated Care System

People living in sub-standard housing

Why has this characteristic been included?
Poor living conditions will prevent people being cared for at home and is associated with poor health overall. This means alternatives are necessary to support palliative care provision.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home		✓		Area of concern and model of care response: • People living in sub-standard accommodation may be refused care in their own home if it poses a risk to staff and patient. The new model of care includes options to be cared for in better suited environments including for example the introduction of the enhanced end of life care beds as well as the offer of hospice inpatient care for those patients who are assessed as needing this level of inpatient care. • In the holistic assessment of patient needs undertaken by teams, the social needs of individuals including suitability of the home environment is considered. • Providers also have family support services available which include access to patient and family advice for example benefits assessment and advice/ signposting to access any benefits they may be eligible for and onward referral to social care/ social housing as needed.	In 2021, a household survey by The Department for Levelling Up, Housing and Communities found 14% of private rented sector homes were estimated to be unsafe according to the Housing and Safety Rating System. Dwellings where the household were in receipt of housing support were more likely to contain a hazard than those not receiving support. English Housing Survey 2021 to 2022: private rented sector - GOV.UK (www.gov.uk). Private rented homes were more likely to have damp than all other tenures. 11% are estimated to having damp. In England and Wales, London has the highest proportion of households that rent privately (30%) (Housing, England and Wales - Office for National Statistics (ons.gov.uk)) compared with 20.3% private rental across England and Wales. Among NW London Boroughs, Westminster stands out as having highest proportion of private rental. This might indicate higher proportions of unsafe housing in this area. If we consider 14% of privately rented homes in NW London boroughs are unsafe, approximately 38,000 homes may be affected, or almost one in every twenty households.
Care in a community inpatient setting	✓				
Outpatient & Wellbeing Care		✓			
Overall		✓			

Area name	Private rented or lives rent free (percent)	No. of Potentially unsafe privately rented homes
Brent	36.2	6,006
Ealing	34.3	6,412
Hammersmith and Fulham	36.6	4,160
Harrow	29.7	3,731
Hillingdon	26.0	3,978
Hounslow	31.2	4,490
Kensington and Chelsea	39.8	3,722
Westminster	43.6	5,789
TOTAL		**38,288**

Data source: Housing, England and Wales - Office for National Statistics (ons.gov.uk)

North West London Integrated Care System

Homelessness

Why has this characteristic been included?
Homelessness creates barriers to accessing health care generally, and care at home more specifically. Homelessness and rough sleeping is particularly prevalent in London.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home		✓		People who experience homelessness may be disadvantaged in a number of ways. • **Barriers in accessing primary health care may reduce knowledge and awareness of help and may be crisis-led (i.e. greater use of A&E).** • **Fear of being treated badly.** Great importance has been placed on equipping staff to better accommodate diverse needs within our population through cultural competency in addition to EDI training. • **Complications surrounding substance use.** Linkages with other teams through the GP including drug and alcohol recovery teams will ensure people can access support for their palliative care needs alongside help for substance use. • **Lack of planning results in higher use of emergency services**. Holistic needs assessment and personalised care planning are central to the delivery of the model of care. This change will support this group to navigate services and seek help early to prevent hospitalisation.	**Rough sleeping** Estimated snapshot data of rough sleepers show that in London, rough sleeping may have dipped since a peak in 2017. During the Covid-19 pandemic, rough sleeping was at lowest levels since 2014 but might be showing signs of increasing with 2022 increase on previous year. (Rough sleeping snapshot in England: autumn 2022 - GOV.UK (www.gov.uk)) **Proportion of households in temporary accommodation** Every borough in London, except Hounslow has a higher proportion of households living in temporary accommodation than the average for the rest of England. 15 per 1,000 households live in temporary accommodation across greater London. Westminster (21.43 per 1,000) and Ealing (18.66 per 1,000) have higher proportions than the London average. Data source: London households in temporary accommodation | Trust for London People experiencing homelessness are at higher risk of physical health problems that shorten their life expectancy and mental health needs that make planning care important (Homelessness at end of life: Information for professionals (mariecurie.org.uk)) **Deaths in homelessness** London had the highest number of homeless deaths in 2021 **(**Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)) and the rate of death has increased since 2013. Drug poisoning, suicide and alcohol-specific causes account for more than half of deaths among homeless people in 2021. **Literature review** A literature review covering people who are experiencing homelessness was carried out and put forward recommendations including better planning, multiagency working including in-reach to hostels, better training and education and increased provision of services, access and choice. See full literature review.
Care in a community inpatient setting	✓				
Outpatient & Wellbeing Care		✓			
Overall		✓			

North West London Integrated Care System

Mental health and dementia

Why has this characteristic been included?
Ageing population means services need to accommodate dual needs of end of life and multi-morbidity including mental health and dementia.

	Impact			Explanation of the main potential positive or adverse impact of the proposal	Data to support this assessment
	Positive	Neutral	Negative		
Care in your own home		✓		Area of concern and model of care response: **Do people with dual needs of mental health and palliative care receive care fairly?** • All providers currently provide services to patients with dual mental health diagnoses and palliative care needs. They are not excluded because of their mental health diagnosis. • Providers have specific pathway in place for the care of patients with mental health issues. The have good working relationships with local mental health NHS trusts and organisations, as well as access to multiple resources and expert advice if required. One of the providers is a joint physical and mental health community NHS trust. • Through the new model of care providers are committed to improving their reach to this cohort of patients through outreach and improved partnership working at local "place". This work has already commenced through local borough EOL stakeholder forums. **Do people with dual needs of dementia and community specialist palliative care need receive care fairly?** • All providers currently provide services to patients with dementia diagnosis – they are not excluded from accessing serviced based on having this diagnosis • All providers currently offer and will continue to offer dementia training/ facilitate access to dementia training for staff. Some providers have dedicated dementia teams with specialist dementia trained staff and other providers have access to dementia experts as part of wider community and frailty services. • All providers are committed to increasing the reach of their services to patients with dementia and their families/ cares and as part of the integration enablers work of the new model of care plans to link universal and specialist teams to support improved partnership working and care continuity will be addressed	How to improve end-of-life care for people with mental illness - NIHR Evidence Dementia NHS England published guidelines on palliative care for those with dementia. palliative-care-guidelines-in-dementia.pdf (england.nhs.uk)
Care in a community inpatient setting		✓			
Outpatient & Wellbeing Care		✓			
Overall		✓			

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Actions arising from this assessment

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	EHIA section	Identified need	Actions we will take
1	Tracking equitable access across protected characteristics	Existing data reports from providers do not adequately allow us to assess whether equitable access for protected characteristic groups exists. Adhoc reporting is possible, but more could be done to identify the patterns of use on a regular basis.	1. We need to improve data collection across providers to ensure that populations within NW London are able to access community-based specialist palliative care services in an equitable way. We plan to complete a collaborative exercise across all providers to develop a standardised data set for the services delivered as part of the new model of care, which will include demographic data. We are developing an end of life care dashboard for NW London that includes demographic and deprivation data as part of the metrics to be tracked to support improved population health management and reducing inequalities.
2	Tracking feedback of service users	Although engagement process has been useful in helping us shape the model of care, better collation of comparable user feedback across all boroughs and providers should be gathered to help further service improvement.	1. We will work with NW London providers of community-based specialist palliative care to develop a standard survey(s) to gather comparable information? 2. We will work with Healthwatch, wider community networks and current service providers to undertake site visits each year and speak to users to gather insights that drive improvement. 3. We will systematically collate information on complaints for NW London patients using community-based specialist palliative care services and report themes that drive our improvement plan.
3	Tracking feedback of staff	The solutions described in the EHIA put heavy emphasis on the delivery of cultural competency and improved staff training programmes without understanding their impact of quality of care.	1. We will work with our providers to support undertaking annual staff surveys to test whether the investment in cultural competency and improved staff training is improving their experiences of delivering care. 2. We will systematically collate information on complaints for NW London patients using community-based specialist palliative care services and report themes that drive our improvement plan.
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