NHS
North West London

How are we going to deliver the new model of care for adult (18+) community-based based specialist palliative care services (CSPC) in NW London?

Joint Health and Wellbeing Board of Kensington and Chelsea and Westminster

23 November 2023

Contents

Our vision is

“For North West London residents and their families, carers and those important to them have equal access to high quality community-based specialist palliative care (CSPC) and end-of-life care and support, that is coordinated, and which from diagnosis through to bereavement reflects their individual needs and preferences.

We want to make sure service provision is sustainable and that we can continue to deliver the same level of high quality care in the future.”

Scope

The scope of our review programme work is provision of community-based specialist palliative care for adults (18+years) in North West London.

It does not include universal or generalist palliative care services such as those provided by your GP, District Nurses or Care Home staff for example but recognises the importance of these services all working closely together to support your care needs.

The intended outcomes are

- ✓ Improving patient, carer and family/friends experiences
- ✓ Incorporating cultural sensitivity in care delivery
- ✓ Improving personalised care
- ✓ Greater care co-ordination
- ✓ Improving communication among providers of care and with patients/families
- ✓ Financially sustainable care, value for money and efficient use of resources

Section 1 Revisiting the new model of care, describing the process for making decisions and tasks in the next phase of our work

What stage are we at in this work – and what we want to discuss with you today

Aug 2023	Co-designed new model of care	Published a model of care for community-based specialist palliative care for adults – co-designed by a wide group of stakeholders.
Sep 2023	Engagement on new model of care	Engaged with the public and other key stakeholders on this model of care. It received strong public support. We are in the process of making some revision following feedback from engagement.
	Long list of options for delivery of the model of care	Development of a long list of options by considering the widest possible set of scenarios for how the model of care could be delivered. 54 possible options identified.
Oct 2023	Shortlisting	We applied hurdle criteria to reduce possible potential options to a manageable set of choices that we can examine in more detail. 5/6 shortlisted options identified.
Nov 2023	Engagement	**We want to get local resident and stakeholder feedback on shortlisted options. We want people to suggest options if you think we have missed something.**

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

We are the model of care working group. We comprise of people who have experienced bereavement, health and care professionals and providers of community-based specialist palliative care in NW London. Together we have developed this proposed care model. Community-based specialist palliative care services work together to care for individuals with life-limiting illnesses, and those close to them, outside of a hospital setting.

We have ensured the changes:

1. Respond to feedback & engagement
2. Align with policy and best practice guidance
3. Respond to future need (5-years)
4. Respond to inequalities
5. Address variation in care across NW London
6. Embed greater care co-ordination
7. Make NW London a more attractive place to work
8. Will be tested for affordability

How?

What people wanted to see and how we have incorporated it in the model of care:

- **Improve partnership working and coordination of care** by better sharing of information across people caring for you at the end-of-life, working together to deliver case management and care planning across teams.
- **Improving personalisation** through holistic needs assessments and making sure patients & families are more involved in the planning of their bespoke care package.
- Delivering care in a **culturally sensitive** way through workforce training and development to better understand diverse needs among our communities.
- Improving **communications** with patients and among health and care professionals
- Better use of **technology** over time to minimise unnecessary travel and improve outcomes.

We engaged with the public on this proposed model of care for community-based specialist palliative care services in NW London. While there were some areas for development identified, there was broad consensus for the model of care.

[View the proposed new model of care for adult community-based specialist palliative care]

What changes will you see in how care is provided?

NHS North West London

Care in your own home

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

Care in a community inpatient setting

Service	Key change
Enhanced end-of-life care beds	Increase beds from 8 beds in Hillingdon to 54 beds across all our boroughs
Specialist hospice inpatient unit beds	56 beds are needed to meet future need. Improve access to them by increasing hours in which people can be admitted

Outpatient and wellbeing are

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

How and where decisions are made on process and options

1. Engagement

We have extensively engaged with the public and key stakeholders at each stage, with the model of care being co-designed by a model of care working group made up of public members and wide variety of other stakeholder. Engagement will allow us to:

- Test and shape potential solutions for delivery of the model of care
- Gather input to support decision-making

2. Specialist/expert input

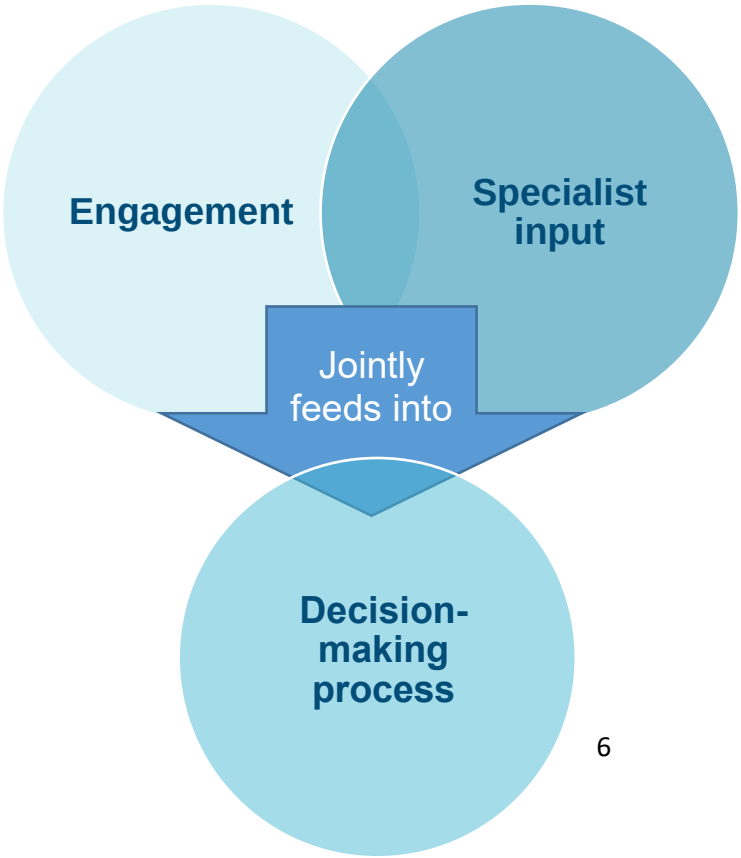
We have worked with clinicians, providers and partner organisations to ensure the model of care represents high quality and evidence based care. Going forward, specialist input includes:

- NW London Joint Health Overview and Scrutiny Committee
- Advice from the London Clinical Senate to inform development of a case for change, options appraisal and proposed clinical model
- Assurance we are following good practice in implementing change programmes from NHS England

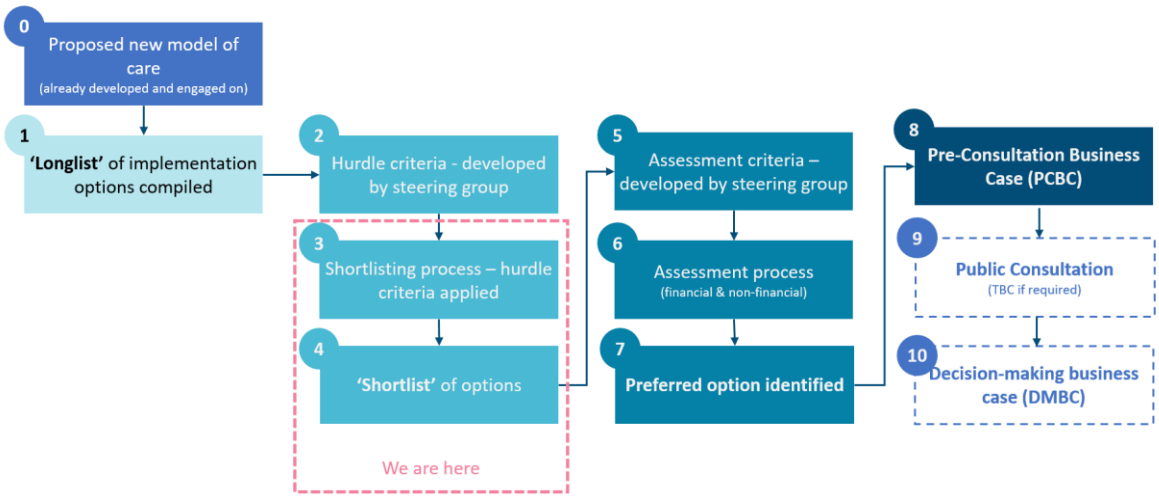
A panel of 'experts' including experts by experience who will assess options for delivery.

3. Decision-making

Final decisions on optimum approach to delivering the service will be jointly through the NHS NW London Integrated Care Board, and the charitable hospices' Board structures.



Where decisions on different ways of delivering an outcome are needed there is a formal NHS process to follow- this ensures transparency and weighing up of different approaches, benefits and risks



The services we need to develop and why people feel they are important

"What matters to me is just as important as what's the matter with me"

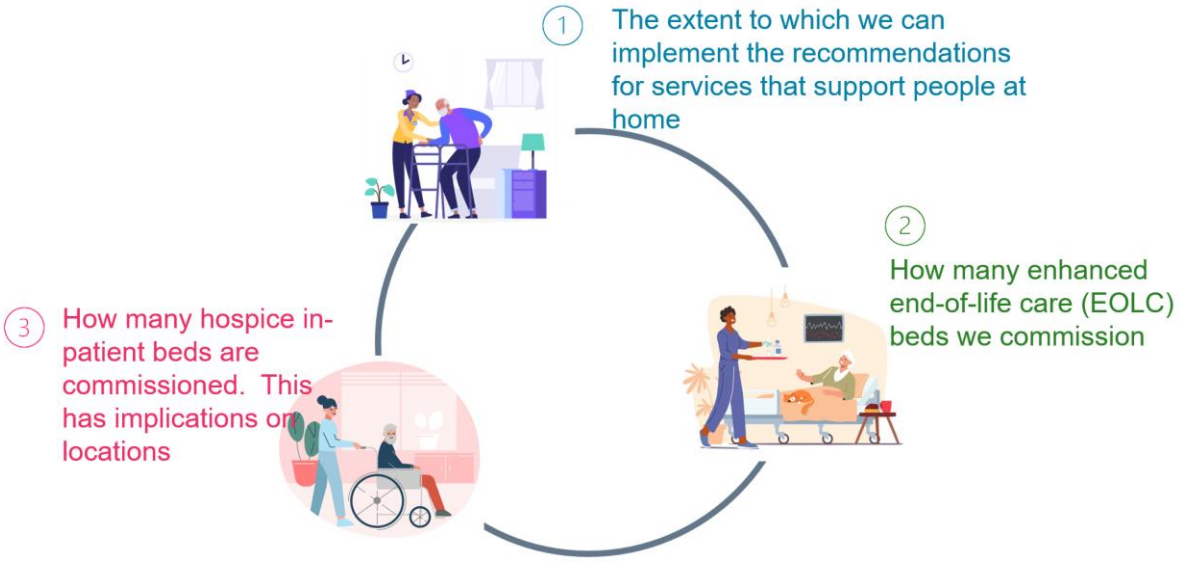
Our ambition is to develop services that are patient-centred and provide choice where it is available. There will be a focus on tailoring services and treatment plans to meet the individual needs and preferences of each patient. It recognises that healthcare should not be a one-size-fits-all approach 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
- Making decisions together
- Tailored accessible information that explains things clearly
- Providing choice where it is available
- Respect for the choices that people wish to make
- Continuity of care
- Looking at the individual as a whole
- Keeping people as well as possible, managing their condition.

The Universal Care Plan is a key enabler on this.

We talk a lot in this document about service capacity and bed numbers, but our model of care document also highlighted that changes to ways of working are needed. Their development and implementation are assumed throughout all options and include important work such as on culturally competent services, use of data and digital, and the ways we join up services.

In developing options, we have focussed on three types of changes described in the community-based specialist palliative care (CSPC) model of care



We assume that the maximum option for delivery is all additional capacity described in the model of care document. **We are not proposing more than we have evidenced is needed.**

We have considered all the ways these three areas can be delivered

1. **The extent to which we can implement the recommendations for services that support people at home**

- We continue to provide care as it is currently
- We implement some of the changes described in the model of care by improving fairness in provision
- We fully deliver model of care.

2. How many enhanced end-of-life care (EOLC) beds we commission?

- We reduce the number of beds we commission to 0
- We continue with the number of beds we have (8)
- We increase beds by making them available across other boroughs (54)

We recognise there are options between 8-54 and propose as we cost service models we explore what this options could mean.

3. How much hospice in-patient bed care is provided and where it is located

- We keep the number beds we currently commission (66.5) ***by*** **re-opening unutilised beds**
- We keep the number beds we currently commission (66.5) **by closing unutilised beds and open additional beds elsewhere**
- We reduce number of beds to 56 outlined in our bed modelling **by re-opening under-utilised or unutilised beds**
- We reduce number of beds to 56 outlined in our bed modelling **by closing beds where there is more opportunity to improve access**
- We reduce number of beds to 56 outlined in our bed modelling **by closing all current beds and open a single site located centrally**
- We reduce number of beds below 56 **by closing unutilised and under-utilised beds.**

We compiled every combination from these three categories to develop 54 possible options. For example…..

Option 1:

- We continue to provide non bed-based care as it is currently
- We reduce enhanced EOLC beds to 0
- Keep 66.5 hospice in-patient beds by re-opening empty suspended beds

1. **The extent to which we can implement the recommendations for services that support people at home**

    - **We continue to provide care as it is currently**
    - We implement some of the changes described in the model of care by improving fairness in provision
    - We fully deliver model of care

2. **How many enhanced end-of-life care beds we provide**

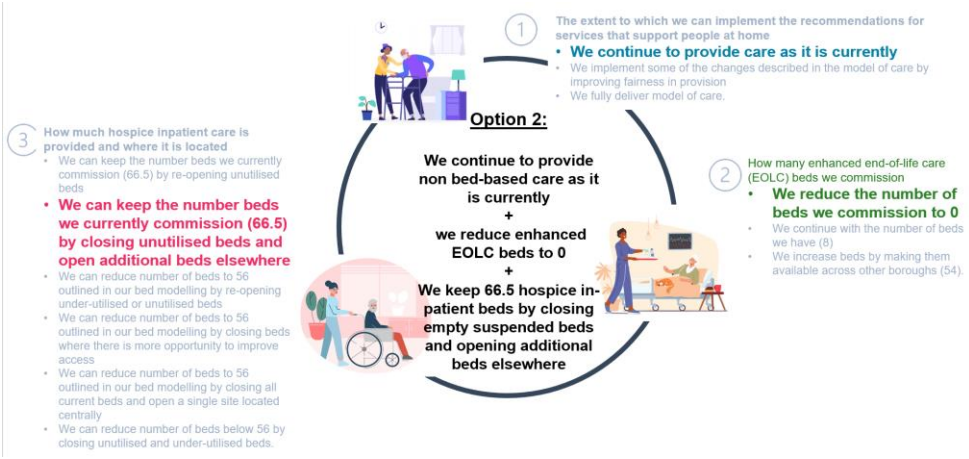
    - **We reduce the number of beds we commission to 0**
    - We continue with the number of beds we have (8)
    - We increase beds by making them available across other boroughs (54)

3. **How many hospice in-patient beds are commissioned. This has implications on locations**

    - **We can keep the number beds we currently commission (66.5) by re-opening unutilised beds**
    - We can keep the number beds we currently commission (66.5) by closing unutilised beds and open additional beds elsewhere
    - We can reduce number of beds to 56 outlined in our bed modelling by re-opening under-utilised or unutilised beds
    - We can reduce number of beds to 56 outlined in our bed modelling by closing beds where there is more opportunity to improve access
    - We can reduce number of beds to 56 outlined in our bed modelling by closing all current beds and open a single site located centrally
    - We can reduce number of beds below 56 by closing unutilised and under-utilised beds

<u>Option 2:</u>

- We continue to provide non bed-based care as it is currently
- We reduce enhanced EOLC beds to 0
- We keep 66.5 hospice in-patient beds by closing empty suspended beds and opening additional beds elsewhere



1. **The extent to which we can implement the recommendations for services that support people at home**

    - **We continue to provide care as it is currently**
    - We implement some of the changes described in the model of care by improving fairness in provision
    - We fully deliver model of care.

2. **How many enhanced end-of-life care (EOLC) beds we commission?**

    - **We reduce the number of beds we commission to 0**
    - We continue with the number of beds we have (8)
    - We increase beds by making them available across other boroughs (54).

3. **How much hospice inpatient care is provided and where it is located**

    - We can keep the number beds we currently commission (66.5) by re-opening unutilised beds
    - **We can keep the number beds we currently commission (66.5) by closing unutilised beds and open additional beds elsewhere**
    - We can reduce number of beds to 56 outlined in our bed modelling by re-opening under-utilised or unutilised beds
    - We can reduce number of beds to 56 outlined in our bed modelling by closing beds where there is more opportunity to improve access
    - We can reduce number of beds to 56 outlined in our bed modelling by closing all current beds and open a single site located centrally
    - We can reduce number of beds below 56 by closing unutilised and under-utilised beds.

The potential solutions could be endless. We have applied our methodology to draw out 54 potential options

Option	How much of the non-bed based model of care can be delivered?	How much of the enhanced end-of-life 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	66.5 Beds - re-open unutilised beds
2	Continue with current provision	0 beds - reduce commissioned capacity	66.5 beds - close unutilised beds and open additional beds elsewhere
3	Continue with current provision	0 beds - reduce commissioned capacity	56 beds - close unutilised beds and open additional beds elsewhere
4	Continue with current provision	0 beds - reduce commissioned capacity	56 beds - close beds where there is more opportunity to improve access
5	Continue with current provision	0 beds - reduce commissioned capacity	56 beds - close all current beds and open a single site located centrally
6	Continue with current provision	0 beds - reduce commissioned capacity	< 56 beds - close unutilised and under-utilised beds
7	Continue with current provision	8 beds - Continue existing capacity	66.5 Beds - re-open unutilised beds
8	Continue with current provision	8 beds - Continue existing capacity	66.5 beds - close unutilised beds and open additional beds elsewhere
9	Continue with current provision	8 beds - Continue existing capacity	56 beds - close unutilised beds and open additional beds elsewhere
10	Continue with current provision	8 beds - Continue existing capacity	56 beds - close beds where there is more opportunity to improve access
11	Continue with current provision	8 beds - Continue existing capacity	56 beds - close all current beds and open a single site located centrally
12	Continue with current provision	8 beds - Continue existing capacity	< 56 beds - close unutilised and under-utilised beds
13	Continue with current provision	54 beds – Beds available across all boroughs	66.5 Beds - re-open unutilised beds

14	Continue with current provision	54 beds – Beds available across all boroughs	66.5 beds - close unutilised beds and open additional beds elsewhere
15	Continue with current provision	54 beds – Beds available across all boroughs	56 beds - close unutilised beds and open additional beds elsewhere
16	Continue with current provision	54 beds – Beds available across all boroughs	56 beds - close beds where there is more opportunity to improve access
17	Continue with current provision	54 beds – Beds available across all boroughs	56 beds - close all current beds and open a single site located centrally
18	Continue with current provision	54 beds – Beds available across all boroughs	< 56 beds - close unutilised and under-utilised beds
19	Minimum workable solution	0 beds - reduce commissioned capacity	66.5 Beds - re-open unutilised beds
20	Minimum workable solution	0 beds - reduce commissioned capacity	66.5 beds - close unutilised beds and open additional beds elsewhere
21	Minimum workable solution	0 beds - reduce commissioned capacity	56 beds - close unutilised beds and open additional beds elsewhere
22	Minimum workable solution	0 beds - reduce commissioned capacity	56 beds - close beds where there is more opportunity to improve access
23	Minimum workable solution	0 beds - reduce commissioned capacity	56 beds - close all current beds and open a single site located centrally
24	Minimum workable solution	0 beds - reduce commissioned capacity	< 56 beds - close unutilised and under-utilised beds
15	Minimum workable solution	8 beds - Continue existing capacity	66.5 Beds - re-open unutilised beds
26	Minimum workable solution	8 beds - Continue existing capacity	66.5 beds - close unutilised beds and open additional beds elsewhere
27	Minimum workable solution	8 beds - Continue existing capacity	56 beds - close unutilised beds and open additional beds elsewhere
28	Minimum workable solution	8 beds - Continue existing capacity	56 beds - close beds where there is more opportunity to improve access
29	Minimum workable solution	8 beds - Continue existing capacity	56 beds - close all current beds and open a single site located centrally

30	Minimum workable solution	8 beds - Continue existing capacity	< 56 beds - close unutilised and under-utilised beds
31	Minimum workable solution	54 beds – Beds available across all boroughs	66.5 Beds - re-open unutilised beds
32	Minimum workable solution	54 beds – Beds available across all boroughs	66.5 beds - close unutilised beds and open additional beds elsewhere
33	Minimum workable solution	54 beds – Beds available across all boroughs	56 beds - close unutilised beds and open additional beds elsewhere
34	Minimum workable solution	54 beds – Beds available across all boroughs	56 beds - close beds where there is more opportunity to improve access
35	Minimum workable solution	54 beds – Beds available across all boroughs	56 beds - close all current beds and open a single site located centrally
36	Minimum workable solution	54 beds – Beds available across all boroughs	< 56 beds - close unutilised and under-utilised beds
37	Fully deliver model of care	0 beds - reduce commissioned capacity	66.5 Beds - re-open unutilised beds
38	Fully deliver model of care	0 beds - reduce commissioned capacity	66.5 beds - close unutilised beds and open additional beds elsewhere
39	Fully deliver model of care	0 beds - reduce commissioned capacity	56 beds - close unutilised beds and open additional beds elsewhere
40	Fully deliver model of care	0 beds - reduce commissioned capacity	56 beds - close beds where there is more opportunity to improve access
41	Fully deliver model of care	0 beds - reduce commissioned capacity	56 beds - close all current beds and open a single site located centrally
42	Fully deliver model of care	0 beds - reduce commissioned capacity	< 56 beds - close unutilised and under-utilised beds
43	Fully deliver model of care	8 beds - Continue existing capacity	66.5 Beds - re-open unutilised beds
44	Fully deliver model of care	8 beds - Continue existing capacity	66.5 beds - close unutilised beds and open additional beds elsewhere
45	Fully deliver model of care	8 beds - Continue existing capacity	56 beds - close unutilised beds and open additional beds elsewhere

46	Fully deliver model of care	8 beds - Continue existing capacity	56 beds - close beds where there is more opportunity to improve access
47	Fully deliver model of care	8 beds - Continue existing capacity	56 beds - close all current beds and open a single site located centrally
48	Fully deliver model of care	8 beds - Continue existing capacity	< 56 beds - close unutilised and under-utilised beds
49	Fully deliver model of care	54 beds – Beds available across all boroughs	66.5 Beds - re-open unutilised beds
50	Fully deliver model of care	54 beds – Beds available across all boroughs	66.5 beds - close unutilised beds and open additional beds elsewhere
51	Fully deliver model of care	54 beds – Beds available across all boroughs	56 beds - close unutilised beds and open additional beds elsewhere
52	Fully deliver model of care	54 beds – Beds available across all boroughs	56 beds - close beds where there is more opportunity to improve access
53	Fully deliver model of care	54 beds – Beds available across all boroughs	56 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	< 56 beds - close unutilised and under-utilised beds

Section 2 Introducing the hurdle criteria for reducing the long list to the short list

Reducing the long list to a short list using a transparent set of criteria

- We know that many of the 54 longlisted options will not deliver the level of change we know is needed, and so they would not be acceptable to our residents
- We therefore applied four 'hurdle criteria', developed by the NW London CSPC steering group, to ensure that we systematically eliminated options that would not deliver the outcomes we want
- All of these criteria are based on those agreed by the steering group in 2022, These are used to define a 'pass/fail' assessment in each case (this is essential in ensuring a clear and effective process for eliminating unsuitable options).

Criteria agreed by steering group	Intention	To be asked this assessment (Yes/No questions)
Strategic fit	How well the option advances local, NW London, regional and national priorities	• Does the service offer reduce inequity of provision across NW London? • Does the service proposal meet evidence of need?
Quality of care	How well the option improves the service delivered to residents and outcomes	• Does the service configuration lead to safe, high quality care? • Does the configuration lead to accessible care?
Affordability	How affordable is the option and to what extent does it represent good value for money	• Is the proposal affordable? • Is the proposal good value for money?
Achievability	To what extent can service providers incorporate required changes, including skilled workforce availability, whilst maintaining the same quality of service	Can the proposal be realistically delivered?

Applying the criteria to the options reduces the potential options to 4, excluding a ‘do nothing’ option

Failure # - see table on next slide

Question	Elements of potential solutions		Pass / Fail	
How much of the non-bed based model of care can be delivered	• Continue with current provision		FAIL: Strategic fit	1
	• Minimum workable solution with a focus on improving fairness of provision			
	• Fully deliver model of care			
How much of the enhanced end-of-life care bed proposal can be delivered	• 0 beds - We reduce commissioned capacity		FAIL: Quality of care	2
	• 8 beds - Continue with existing commissioned capacity		FAIL: Strategic fit	3
	• 54 beds - We increase the number of beds and make them available across all boroughs			
How many hospice inpatient beds do we need to serve the needs of our population for the next five years	Commission 66.5 beds (current commissioned bed base)	• We use empty/suspended beds	FAIL: Achievability	4
		• We can close suspended/empty beds and open additional beds elsewhere	FAIL: Achievability	5
	Commission 56 beds in line with model of care demand projections	• We close empty/suspended and unutilised or under-utilised beds		
		• We use empty/suspended beds & consider remodelling other beds		
		• We close all current beds and open a single site located centrally	FAIL: Achievability	6
	Commission fewer than 56 beds	• We close empty, suspended and unutilised beds and close further beds elsewhere	FAIL: Quality of care	7

Two options remain

X

One option remains

X

Two options remain

+

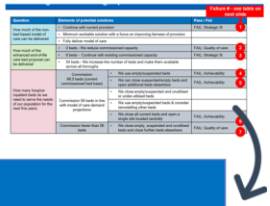
‘Do nothing’ option

=

TOTAL 5 options remain

As noted above there are potential different numbers of end-of life care beds between 8-54
We are committed to exploring any other models which are deliverable within this range.

7 elements are removed by applying hurdle criteria. This removes 50 potential options from the long list of 54



Failure #	Criteria failed	Rationale
1	Strategic Fit	Continuing with current provision would not meet the future needs of our population or help us to reduce inequalities.
	Quality of care	It does not implement the services which are necessary for safe and high-quality care.
2	Quality of care	Reducing capacity of enhanced end-of-life care would mean fewer beds than are needed to provide a high-quality care.
3	Strategic Fit	Would not allow us to tackle inequality of access to these beds (which would remain in Hillingdon only under this option).
4	Achievability	Increasing our commissioned capacity of inpatient beds to 66.5 by re-opening unutilised beds likely to struggle operationally due to insufficient staffing.
	Affordability	Funding more beds than our demand projections suggest are needed 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 66.5 by closing unutilised beds and opening additional beds elsewhere likely to struggle operationally due to insufficient staffing. 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 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	Strategic Fit + Quality of Care + Achievability + Affordability	It would require most people to travel much further to the central hospice site, exacerbating inequalities in access. Would need to source a suitable site and the significant, complex and costly change programme which would be required to implement it.
7	Quality of care	Reducing the number of hospice inpatient beds to fewer than 56 would mean we had fewer beds than are needed to provide a high-quality service.

Section 3 Identifying a short list of options, next steps and programme risks and issues

What do these options mean in Westminster and Kensington and Chelsea?

	Option 0 Do Nothing	Option1	Option 2	Option 3	Option 4	(Variant A)
How much of the non-bed based model of care can be delivered?	**Continue with current provision**	**Some change** Minimum workable solution with a focus on improving fairness of provision	**Some change** Minimum workable solution with a focus on improving fairness of provision	**Full implementation** Fully deliver model of care	**Full implementation** Fully deliver model of care	
How much of the enhanced end-of-life care bed proposal can be delivered?	**8 beds**	**54 beds**	**54 beds**	**54 beds**	**54 beds**	**TBC bed number – between 8-54 beds**
	Continue with existing commissioned capacity	Increase number and make them available across boroughs	Increase number and make them available across boroughs	Increase number and make them available across boroughs	Increase number and make them available across boroughs	With 54 identified as optimum – there a wide range of other 'options'
How many hospice inpatient beds do we need to serve the needs of our population for the next five years?	**66.5 beds**	**56 beds**	**56 beds**	**56 beds**	**56 beds**	
	All commissioned units open including Pembridge inpatient unit	Pembridge inpatient unit does not reopen. All other commissioned units open	Pembridge inpatient unit opens. Consider remodelling remainder of capacity	Pembridge inpatient unit does not reopen. All other commissioned units open	Pembridge inpatient unit open. Consider remodelling remainder of capacity	

Please note variant A equates a different number of enhanced end-of-life care beds

What it means in Kensington and Chelsea

Option 0

- No improvements to current delivery in he home, including no change to 24/7 telephone advice line for unknown residents, no 24/7 hospice at home and no 8am to 8pm CSPC team
- Pembridge reopens = approximately 3 beds
- No 54 enhanced care beds = more people dying in hospital

Option 1

- Minimal improvements to current delivery in the home including no 24/7 Hospice at Home
- Pembridge remains closed – no impact for current hospice IPUs providing services
- 4 enhanced end-of-life care beds.

Option 2

- Minimal improvements to current delivery in the home including no 24/7 Hospice at Home

- Pembridge reopens = approximately 3 beds – may need to remodel other hospice inpatient bed provision in the area
- 4 enhanced end-of-life care beds.

Option 3

- Substantial improvements to current delivery in the home including 24/7 Hospice at Home, 24/7 advice line, 8am to 8pm CSPC team
- Pembridge remains closed – no impact for current hospice IPUs.
- 4 enhanced end-of-life care beds.

Option 4

- Substantial improvements to current delivery in the home including 24/7 Hospice at Home, 24/7 advice line, 8am to 8pm CSPC team
- Pembridge reopens = approximately 3 beds – may need to remodel other hospice inpatient bed provision in the area
- 4 enhanced end-of-life care beds

What it means in Westminster

Option 0

- No improvements to current delivery in he home, including no change to 24/7 telephone advice line for unknown residents, no 24/7 hospice at home and no 8am to 8pm CSPC team.
- Pembridge reopens = approximately 2 beds
- No 54 enhanced care beds = more people dying in hospital

Option 1

- Minimal improvements to current delivery in the home including no 24/7 Hospice at Home
- Pembridge remains closed – no impact for current hospice IPUs providing services
- 5 enhanced end-of-life care beds.

Option 2

- Minimal improvements to current delivery in the home including no 24/7 Hospice at Home
- Pembridge reopens = approximately 2 beds – may need to remodel other hospice inpatient bed provision in the area
- 5 enhanced end-of-life care beds.

Option 3

- Substantial improvements to current delivery in the home including 24/7 Hospice at Home, 24/7 advice line, 8am to 8pm CSPC team

- Pembridge remains closed – no impact for current hospice IPUs.
- 5 enhanced end-of-life care beds.

Option 4

- Substantial improvements to current delivery in the home including 24/7 Hospice at Home, 24/7 advice line, 8am to 8pm CSPC team
- Pembridge reopens = approximately 2 beds – may need to remodel other hospice inpatient bed provision in the area
- 5 enhanced end-of-life care beds

How our proposed changes will address health inequalities?

We believe that implementation of the model of care has the potential to be positive for every individual, irrespective of their socio-economic status, ethnicity, culture, or the borough they reside in through the provision of:

- Equitable access to services by establishing services in areas where these services are currently not provided including almost doubling of bed capacity through the introduction of enhanced end-of-life care beds.
- Providers will be supported to develop a cultural competency framework for NW London CSPC providers which will include appropriate training for staff to deliver culturally competent care
- The important of developing robust care coordination mechanisms that ensure seamless access to services for individuals with specialist palliative care needs.
- ICB and providers will actively engage with underserved populations, making an effort to reach those who might not seek palliative care.
- Our engagement has shown some specific needs – eg people who live on their own, and this model responds to those needs with capacity and different ways of working
- Informed by data collection, research, targeted interventions will be developed to reduce disparities in care delivery and outcomes.
- All partners will raise public awareness and provide education about palliative care with clinicians and communities across NW London.
- We 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 (for example via a Universal Care Plan (UCP)).

See appendix 2 for further details.

Why is this work taking so long, and what are the risks going forward?

Issues:

1. The community-based specialist palliative care sector and this work is complex. There is limited benchmarking and off the shelf examples available regionally or nationally, and limited national definitions for services.
    - This has mean taking longer to develop the proposed new model of care than first anticipated as the working group had to carefully navigate through various definitions and core offers
    - Options development and costing approaches are taking more time to develop.

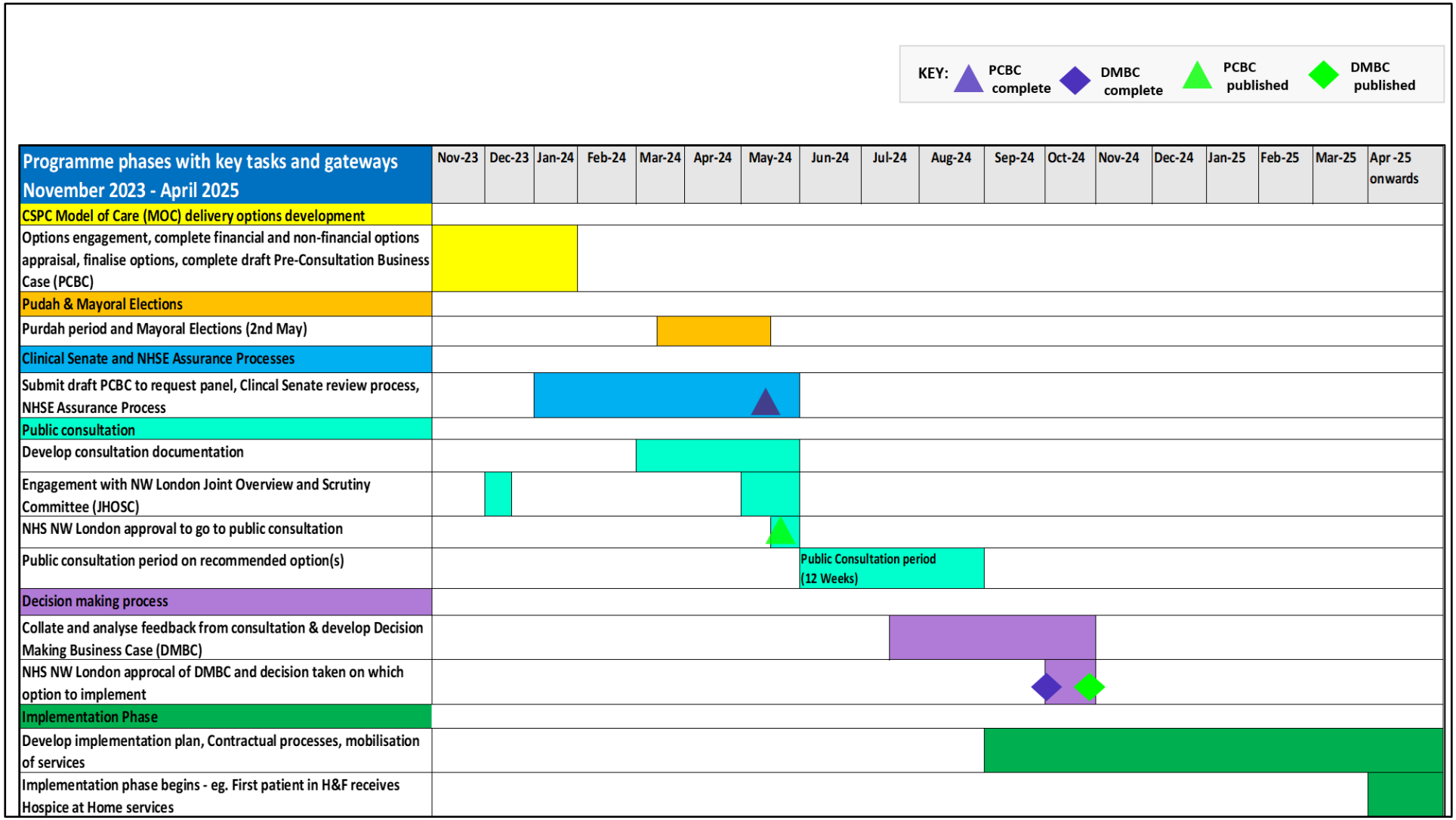
2. Engagement phases have taken more time than expected as this is an emotive topic, but we see it as essential as we are committed to meaningful engagement to make the end product truly meets residents' needs.

3. Unfortunately factors such as Winter pressures, reduced team capacity, and election-related constraints (purdah) have and continue to cause delays in our timeline.

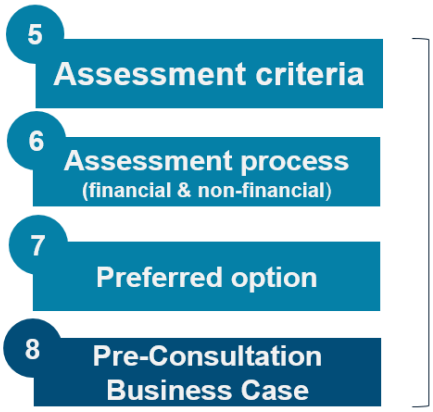
Risks:

- These delays pose a risk to the consistent care and experience for NW London residents who need these services and would benefit from the new model.
- Financial constraints, sustainability concerns for hospices, and workforce shortages are also risks for the implementation of the new care model. However, we are actively collaborating with current providers to address these challenges and have a comprehensive plan in place to mitigate risks.

When does this mean change will happen



Based on what heard you have heard what are we missing?



Your input will help us get the right focused options to do more work on. Once we have consensus on the shortlisted options, we will begin to analyse these in more detail by looking at:

- The comparative benefits they offer to patient care and outcomes
- The comparative costs associated with each option and establish value for money assessment.

This will allow us to identify a preferred solution and proceed with business case development and onward to implementation.

Appendix 1 - 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:

1. **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.
2. **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.
3. **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.
4. **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.
5. **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.
6. **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.
7. **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.

8. **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.
9. 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.

Appendix 2 - How our proposed changes will address health inequalities

We believe that implementation of the model of care would have a positive response including:

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 and 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.

   The almost doubling of bed capacity through the introduction of enhanced end-of-life care beds is likely to bring a range of new beds to more people and closer to their home.
1. **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.
2. **Care coordination:** The model recognises the important of developing robust care coordination mechanisms that ensure seamless access to services for individuals with specialist palliative care needs. This entails fostering collaboration and improved partnership working at place between generalist palliative care providers (primary care, social care and other community healthcare teams) and specialist palliative care teams (in community and in hospital), but also within community specialist palliative care teams themselves in the first instance. The model sets out ambitions for boroughs to develop local arrangements for single points of contact/ access for these services and internal care co-ordination approaches for example key workers/ internal co-ordination functions. It also sets out the ambition for more integrated working across Integration neighbourhood teams locally to support increased MDT working.
3. **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.
4. **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.

5. **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.
6. **Patient choice and involvement in care:** The model aims to enhance health literacy among residents through, empowering them with a better understanding of palliative care and their end-of-life options through advance care planning. This will enable patients to make informed decisions about their care and reduce disparities caused by a lack of information or opportunity to have their wishes made known and shared with the system (for example via a Universal Care Plan (UCP).