Interim Integrated Impact Assessment (IIA) – Summary Report

Each of the numbered sections below must be completed
Please state if the Integrated Impact Assessment is interim or final.

1. Title of proposal

Front Door Palliative Care Model – Introducing Specialist Palliative Care Consultant Triage at Acute Front Door

2. What will change as a result of this proposal?

The project will introduce a proactive "Front Door" in-reach (consultants, nurse) team within the Emergency Departments of the Royal Infirmary of Edinburgh (RIE) and Western General Hospital (WGH).

Key Change: Patients presenting at the acute hospital front door will have earlier access to specialist palliative care assessment. This aims to:

- improve identification of individuals who may benefit from a palliative approach
- provide alternatives to hospital admission where clinically appropriate
- improve symptom management and holistic assessment
- reduce unnecessary investigations and interventions
- enhance patient flow within acute hospitals
- strengthen early involvement of carers, families and community services
- improve equity of access to specialist palliative care

Objective: To reduce unplanned hospital admissions, improve patient choice regarding place of death, and align with the Edinburgh Integrated Joint Board (EIJB) and the National Palliative Care Strategy

3. Briefly describe public involvement in this proposal to date and planned

Consultation on the Edinburgh Integrated Joint Board (EIJB) Strategic Plan took place in 2024 and 2025. This proposal aims to deliver a key priority within that strategic plan.

An integrated impact assessment workshop was held with clinicians, paramedics, hospice representatives, managers, analysts and community practitioners.

- Stakeholders contributed evidence, potential impacts and mitigations.

- Further public and carer involvement will take place during the service design phase.
- A final IIA will be completed once the model is fully developed.

4. Is the proposal considered strategic under the Fairer Scotland Duty?

No.

5. Date of IIA

24 March 2026

6. Who was present at the IIA? Identify facilitator, lead officer, report writer and any employee representative present and main stakeholder (e.g. Council, NHS)

Name	Job Title	Date of IIA training
Sarah Hayden (Facilitator)	Project Manager	June 2023
Olalekan Somefun (Scribe)	Project Manager	
Colette Reid	Palliative Care Consultant (WGH)	
Lynn Forrest	Reablement Service Manager	
Caroline Todd	Commissioning Programme Manager	
Elaine Veitch	Access and Emergency Social Care Service Manager (Adults)	
Carla Dempster	Team Leader Data Analytics and Reporting Team	
Shek Selina	Senior Information Analyst - Data Analytics and Reporting Team	
Cara Black	SAS (Scottish Ambulance Service) Rep	
Sarah Bryson	Planning and Commissioning Officer	
Rachel Kemp	Palliative Care Consultant Marie Curie Hospice	
Dr Tony Duffy	Palliative Care Consultant St Columba's Hospice	
Mandy Murray	Head of Clinical Services St Columba's Hospice	
Karyn McIlhone	Student Nurse	

7. Evidence available at the time of the IIA

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
Data on populations in need – where available use disaggregated data	Joint Strategic Needs Assessment (JSNA) City of Edinburgh HSCP (2020)	Provides current and projected data on the wider population in the City of Edinburgh - Over 65's account for a smaller proportion of the population in Edinburgh than elsewhere in Scotland but the older population is expected to grow significantly - Each of the older population age groups in Edinburgh and Scotland are expected to grow by at least a fifth by 2030. This growth highlights the need for the future sustainability within the service. *(Population and demographics - Edinburgh Health & Social Care Partnership (EHSCP) (edinburghhsc.scot)*. Provides an understanding of what contributes to poor health and wellbeing and the barriers and challenges to seeking and obtaining support (many being interrelated). Actions highlighted as needed to address these include: • Staff training including cultural sensitivity • Recognition of the role of the Third Sector • Effective community engagement • Developing effective approaches to prevention including overcoming isolation.
	The Edinburgh Partnership – Data and Intelligence	The data within the Joint Strategic Needs Assessment (JSNA) documents are reviewed on a regularly basis and updated where there are significant updates in the datasets. This means that some data point may be older than others depending on the publication cycle for those data points.
	Carers - Edinburgh Health & Social Care Partnership	Edinburgh has a large and diverse unpaid carer population, including young, adult and older carers who provide essential support to people unable to live independently due to illness, disability or age. Caring roles range from short-term to lifelong, high-intensity care, with substantial impacts on carers' health, wellbeing, finances and daily life. Carer feedback and lived

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	Edinburgh HSCP Joint Strategic Needs Assessment: Health and Care Needs of People from Minority Ethnic Communities (April 2018) EHSCP Strategic Plan 2025-28 Census data	experience have directly shaped the Joint Edinburgh Carer Strategy. All JSNA data and intelligence for Edinburgh is now hosted at this link for the Edinburgh partnership – and this includes relevant data from the NHS Lothian Public Health team. Edinburgh Health and Social Care Partnership, Joint Strategic Needs Assessment, Minority Ethnic Communities Report, 2018 Edinburgh Health and Social Care Partnership (EHSCP) Strategic Plan 2025-2028 This plan covers the three financial years running from 1 April 2025 to 31 March 2028. This strategic plan has been produced with extensive input from the people of Edinburgh and organisations/teams that serve our communities. Home | Scotland's Census provides data on Scotland's population and demographics.
Data on service uptake/access		**Insight from NHSL Acute admissions (Aug 2024) – Day of Care Audit (DOCA)** • c28% of patients are in their last year of life. • c10%-20% of people will die during their current stays. • c34.5% of people in their last year of life are >85 years old. **Hospital Mortality Rate (within 30 days)** Royal Infirmary of Edinburgh **(RIE)**: 6%; Western General Hospital (**WGH)**: 3.5%; St. John Hospital **(SJH)**: 5.8% **Patient counts that died in hospital and all >85years old (*Does not include patients from Out of Area)*** **RIE**: 23% of patients in their LYOL died in the hospital, of which 61% were aged over 85yrs.

<table>
<tr><th>Evidence</th><th>Available – detail source</th><th>Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal</th></tr>
<tr><td></td><td></td><td>
WGH: 38% of patients in their LYOL died in the hospital, of which 63% were aged over 85yrs.

SJH: 23% of patients in their LYOL died in the hospital, of which 86% were aged over 85yrs.
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<table>
<tr><th>Site</th><th>Total</th><th>Last Year of Life (LYOL)</th><th>Aged >85</th></tr>
<tr><td>RIE</td><td>998</td><td>230</td><td>140</td></tr>
<tr><td>WGH</td><td>586</td><td>225</td><td>141</td></tr>
<tr><td>SJH</td><td>376</td><td>87</td><td>75</td></tr>
</table>

Patient count by hospital in LYOL and died on final admission (Does not include patients from Out of Area)

RIE: 70% of patients in LYOL who were admitted died on final admission
WGH: 43% of patients in LYOL who were admitted died on final admission
SJH: 68% of patients in LYOL who were admitted died on final admission

<table>
<tr><th>Site</th><th>Last Year of Life (LYOL)</th><th>Died on final admission</th></tr>
<tr><td>RIE</td><td>230</td><td>162 (70%)</td></tr>
<tr><td>WGH</td><td>225</td><td>96 (43%)</td></tr>
<tr><td>SJH</td><td>87</td><td>59 (68%)</td></tr>
</table>

Average Length of Stay in Acute (RIE, WGH, SJH) by week
Mean = 58

Median = 41
</td></tr>
</table>

<table>
<tr><th>Evidence</th><th>Available – detail source</th><th>Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal</th></tr>
<tr><td></td><td></td><td>Speciality Breakdown for Last Year of Life (LYOL)

A high proportion of patients in their last year of life are concentrated in frailty, geriatic, and cancer pathway. This icludes geriatic orthorehabilitation (55%), medical oncology (53%), medicine of the elderly (49%), renal medicine (47%), and acute geriatric assessment (43%).

Neurosurgery recorded the lowest (14%).

<table>
<tr><th>Specialty</th><th>Total</th><th>LYOL</th><th>LYOL (%)</th></tr>
<tr><td>General Medicine</td><td>401</td><td>131</td><td>33</td></tr>
<tr><td>Medicine of the Elderly</td><td>216</td><td>105</td><td>49</td></tr>
<tr><td>Medical Oncology</td><td>60</td><td>32</td><td>53</td></tr>
<tr><td>Geriatic Orthorehabiliation</td><td>51</td><td>28</td><td>55</td></tr>
<tr><td>Respiratory medicine</td><td>72</td><td>23</td><td>32</td></tr>
<tr><td>Orhopaedics</td><td>114</td><td>22</td><td>19</td></tr>
<tr><td>Acute Geriatic Assessment</td><td>51</td><td>22</td><td>43</td></tr>
<tr><td>Stroke Medicine</td><td>64</td><td>21</td><td>33</td></tr>
<tr><td>Clinical Oncology</td><td>51</td><td>21</td><td>41</td></tr>
<tr><td>General Surgery</td><td>89</td><td>19</td><td>21</td></tr>
<tr><td>Gastroenterology</td><td>44</td><td>16</td><td>36</td></tr>
<tr><td>Vascular Surgery</td><td>39</td><td>13</td><td>33</td></tr>
<tr><td>Coloerectal General Surgery</td><td>64</td><td>10</td><td>16</td></tr>
<tr><td>Urology</td><td>51</td><td>10</td><td>20</td></tr>
<tr><td>Intensive Therapy</td><td>40</td><td>10</td><td>25</td></tr>
<tr><td>Neurosurgery</td><td>51</td><td>7</td><td>14</td></tr>
<tr><td>Infectious disease</td><td>26</td><td>7</td><td>27</td></tr>
<tr><td>Haematology</td><td>17</td><td>7</td><td>41</td></tr>
<tr><td>Renal Medicine</td><td>15</td><td>7</td><td>47</td></tr>
</table>
</td></tr>
<tr><td>Data on socio-economic</td><td>dying-in-poverty-scotland-2025</td><td>Over 6,500 people living with terminal illness are dying in end-of-life poverty in</td></tr>
</table>

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
disadvantage e.g. low income, low wealth, material deprivation, area deprivation		Scotland, with 7,700 also dying in fuel poverty in the last year of life, according to the latest research by Loughborough University Centre for Research and Social Policy and Marie Curie.
	Many people in Scotland now benefit from anticipatory care before they die: an after death analysis and interviews with general practitioners	In addition, evidence from Scottish anticipatory care studies in 2014 demonstrates that 60% of patients were identified for a Key Information Summary (KIS), a median of 18 weeks before death. The numbers identified were highest for patients with cancer, with 75% identified compared with 66% of those dying with dementia/frailty and only 41% dying from organ failure had an Anticipatory Care Plan (ACP)/KIS. Organ failure trajectories (Chronic Obstructive Pulmonary Disease (COPD), heart failure). The same study indicated that ACP coverage was affected by societal challenges, and lower awareness and reduced access to palliative discussions among non-cancer patients.
	State of Caring 2025: The cost of caring - the impact of caring across carers' lives | Carers UK	Carers often face additional monthly financial costs, such as specialist food and clothing, transport costs and higher electricity bills. As a result, many carers fall into debt, while others feel stressed and anxious about the future, particularly if they have had to give up paid employment to care or are worried about having to do so in the future.
	Poverty and financial hardship of unpaid carers in the UK | Carers UK	1.2 million unpaid carers are in poverty, and 400,000 are in deep poverty (defined as being more than 50% below the poverty line).
Data on equality outcomes	Palliative Care Strategy –	Where people die is influenced by their age, social circumstances (includes area-based deprivation), and health conditions. Higher

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
	Population Data and Research	emergency admissions and lower community-based support are in deprived populations. Additionally, there are increased barriers related to housing, fuel poverty, and health literacy.
	Does place of death vary by deprivation for... : BMJ Supportive & Palliative Care	A British Medical Journal Specialist Palliative Care study in 2018 from NHSL showed that even after referral to Specialist Palliative Care (SPC), Scottish Index of Multiple Derivation (SIMD)-related inequities persist. Patients from the most deprived areas (SIMD 1-2) were significantly more likely to die in hospital (crisis pathway) and less likely to die in hospice (planned pathway) compared with those from the least deprived areas.
	Scottish House Condition Survey: 2019 Key Findings	The Scottish Housing Condition Survey (2019) shows that 24.6% of Scottish households (over 613,000) homes live in fuel poverty with 12.14% in extreme fuel poverty, alongside widespread disrepair affecting 52% of dwellings, conditions that disproportionately impact deprived communities and exacerbate health deterioration.
	Fuel Poverty Mapping of the City of Edinburgh	In Edinburgh the 2015 fuel poverty maps shows that these risks are concentrated in deprived neighbourhoods listed below where poorer housing quality, colder homes and energy insecurity increase vulnerability for people with advanced illness, accelerating deterioration and triggering avoidable emergency admissions. ♦ Wester Hailes/ The Calders/ Murrayburn/ Clovenstone area; ♦ Stenhouse and Saughton Mains; ♦ Granton South/ Wardieburn/ West Pilton/ Muirhouse area; ♦ South Leith;

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
		♦ Restalrig and Lochend; ♦ Dumbiedykes; ♦ Craigmillar and Niddrie.
Research/literature evidence	Bradford-REACT-Service-Sept-23.pdf An evaluation of marie curie's reactive emergency assessment and community team (REACT) PP-11 Marie Curie responsive emergency assessment and community team (REACT): widening access and knowledge | BMJ Supportive & Palliative Care New REACT service helps patients in the last year of life receive treatment and care at home – Bradford Teaching Hospitals NHS Foundation Trust	The majority of people in the UK want to die at home. Results from a survey commissioned by Marie Curie in 2023 show that 56% of all 10,500 respondents and 42% of people with a terminal illness in their last years of life chose home as their preferred place of death. Being free from pain and other symptoms is a top priority for people in their final year of life. In addition, evidence from Marie Curie/ Bradford REACT (Responsive Emergency Assessment and Community Team) model shows that placing a palliative care team with the Emergency Department (ED) enables significantly earlier identification of patients with palliative care needs, which is associated with better overall outcomes. By December 2024, REACT had supported 1,200 patients, with an average hospital bed days in the last year of life reduced from 38 to 17, demonstrating substantial impact on avoidable admissions. Earlier access to palliative care is evident, with 35% of patients having their first-ever palliative care contact via REACT, and the service reducing inequity of access by reflecting the age, ethnicity, deprivation, and disease profiles of the local population. Patients and family feedback highlights improved comfort, reduced pain, better peace of mind, and appreciation for delivered at home. The programme has also driven positive changes in palliative care practice within Bradford Teaching Hospitals, strengthening integrated, seamless care across General Practitioners (GPs), District Nurses (DNs), hospice services and hospital teams.

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	What we learned from the REACT palliative care service - The Pharmaceutical Journal	However, evidence from the pharmaceutical Journal highlights several challenges affecting REACT model. The service depends heavily on timely access to palliative medicines in the community, which was often difficult to achieve and created delays in providing optimal symptom control. REACT also identified system-level issues in medicine supply and coordination, requiring process redesign across multiple services.
Public/patient/client experience information	Empowering unpaid carers during hospital discharge: co-producing change through the IMPACT Network - IMPACT	A national co-produced study (IMPACT Network, 2026) found that unpaid carers commonly experience disjointed communication, unanswered questions, stress, confusion, poor coordination, unrealistic expectations placed on carers and inadequate planning before the patient returns home.
	carers-experiences-of-hospital-discharge-report-2021.pdf	A carers UK report (2021) highlighted that many unpaid carers experienced intolerable stress and declining wellbeing with negative outcomes for people needing care and support. 44% agreed strongly and 38% agreed that being a carer affected their mental health – an overall agreement level of 82%. This is slightly higher than the 79% agreement in 2021 and much higher than the 59% in 2017 who felt that being a carer made their mental health worse. • Agreement with this statement is particularly high for respondents caring for their child (89%), respondents who care for more than one person (89%), respondents caring for someone who is neurodivergent (94%) or using substances (92%), or somebody who has a palliative/terminal condition (92%), or is looking after somebody aged under 25 (92%)
	Improving specialist palliative care	A 2025 qualitative palliative care study found that current specialist palliative care discharge communications risk confusion,

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	discharges from hospitals and hospices to community settings: a qualitative interview study of the communication experiences of patients, carers, and primary care professionals | BMC Palliative Care | Springer Nature Link	distress, and increased workload post-discharge. The study identified numerous suggestions professionals could take to improve this process.
Evidence of inclusive engagement of people who use the service and involvement findings	Palliative Care - Publications	The Scottish Government's Palliative Care Matters for All (2025–2030) strategy was explicitly co-designed with people receiving palliative care, families and carers. The public consultation (Oct 2024–Jan 2025) received 160 responses, with 48% from individuals, many of whom were people living with life-limiting conditions or caring for someone who was. Respondents emphasised the need for flexible, inclusive, person-centred palliative care, better support for carers, and more consistent access across Scotland.
	Palliative Care Strategy: Palliative Care service mapping survey: Additional Paper	The Service Mapping Survey that informed the same national strategy gathered further insights from across all Health Board areas and all 31 HSCPs, including Edinburgh. Although primarily targeted at services, responses incorporated views from families and carers captured by services through local engagement, highlighting unmet needs, variation in access, and gaps in out-of-hours provision.
	Gathering Views Report on Palliative Care-Jul 2024.pdf	Healthcare Improvement Scotland (HIS) carried out a national Gathering Views exercise in early 2024 to inform the new Palliative Care Strategy. HIS directly engaged 42 people across Scotland who had personal experience of palliative care—either as patients, carers (including

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
		bereaved carers), parents, children or young people, and people living in rural and island communities. Engagement was conducted through group discussions and 1:1 interviews, asking participants about their real experiences of health and social care support, community services and hospice care. Participants emphasised the value of palliative care in managing symptoms, providing emotional support, and keeping families informed. They also identified barriers such as delays in accessing support, variability in services across Scotland and gaps in early identification. Their feedback is being used by the Scottish Government to shape the final Palliative Care Strategy and its delivery plan.
Evidence of unmet need	Microsoft Word - Marie Curie Unmet Need Research - Scotland Briefing FINAL Integrating lived experiences of out-of-hours health services for people with palliative and end-of-life care needs with national datasets	The DUECare Project, funded by Marie Curie and involving researchers at King's College London, Hull York Medical School, and the University of Edinburgh, combined two measures, indicating that someone has unmet need for palliative care if they have both unaddressed symptoms and concerns and lack sufficient access to help from GP services, resulting in inability to access or receive person-centred care. Using this new methodology, the population estimates show around 18,500 people (30%) who died in 2022 are considered to have unmet need for palliative care. This represents one in three people in Scotland, and this number is projected to rise by 14% by 2050, compared to 2025. A major Scottish mixed-methods study in 2016 found that 65% of all urgent cares episodes in the last year of life began out-of-hours (OOH), with patients and carers reporting difficulty accessing safe, timely community support, often resulting in avoidable hospital admissions due to unmet OOH palliative need.

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
	for people dying in Scotland in 2016: A mixed methods, multi-stage design	Professionals described difficulty providing effective palliative care during OOH crises when patients had not been identified or care plans were unavailable leading to avoidable admissions.
	Edinburgh-Carer-Survey-2023-Report.pdf	To strengthen support for carers now and for future generations, Voice of Carers Across Lothian (VOCAL) actively seeks carer views and engagement to determine what support might be important to carers in the future: VOCAL Carer Surveys - VOCAL, 2023. Only 24% of carers report a good life balance between caring and other activity, and only 27% felt supported to continue caring. The survey reveals a concerning decline in carers' physical and mental health and wellbeing (compared to 2021 carers survey), highlighting the significant impact of caring as more responsibilities have shifted onto carers to provide care. It is also more likely a carer will be suffering from ill health if they have been caring for longer; if they are a multi-carer; or if they are caring for a child, someone who is neurodivergent, using substances, or who has a palliative and terminal condition. ""Over a previous caring situation, I ended up very ill indeed and was at collapse point as there wasn't enough support for palliative care at home as I was an isolated person with no family support."" 44% agreed strongly and 38% agreed that being a carer affected their mental health – an overall agreement level of 82%. This is slightly higher than the 79% agreement in 2021 and much higher than the 59% in 2017 who felt that being a carer made their mental health worse. • Agreement with this

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
		statement is particularly high for respondents caring for their child (89%), respondents who care for more than one person (89%), respondents caring for someone who is neurodivergent (94%) or using substances (92%), or somebody who has a palliative/terminal condition (92%), or is looking after somebody aged under 25 (92%).
Good practice guidelines	Consultation Document Miles Briggs Right to Palliative Care Palliative Care Matters for All - Palliative Care Startegy 2025-2030 National Health and Wellbeing Outcomes: A framework for improving the planning and delivery of integrated health and social care services	The Scottish Parliament's 2024 proposal for a Right to Palliative Care (Scotland) Bill establishes emerging best practice by defining palliative care as a universal entitlement and calling for consistent, equitable access across all settings for people with terminal illness. The Palliative Care Strategy 2025 –2030 sets out Scotland's commitment to ensuring that everyone regardless of age, diagnosis or location can access timely, high-quality, person centered palliative care. It highlights the early identification, ACP, integrated hospital-community palliative pathways, strengthening the workforce and 24/7 advice lines. It sets national expectation for high quality person centered palliative care. Examples of the kind of improvements that people are trying to make include: • Reducing use of institutional/residential care – increased opportunity for support at home • Making better use of adaptations and technology • Involving people and their families more in decisions • Including wider community supports in care • Professionals working together better across traditional boundaries of health, social care support and other services such as housing • Fair Work principles to improve workers' working conditions; peer

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
	Regulation 9: Person-centred care - Care Quality Commission	support and supervision; and a more consistent approach to providing high quality training for staff **Health and Social Care Integration and Standards-** As part of the integration of health and social care we have a requirement and duty of care to work with our local communities and providers of care to ensure care is responsive to people's needs and that we follow the guidance for the national health and wellbeing outcomes to ensure: People, including those with disabilities or long-term conditions, or who are frail, can live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
Carbon emissions generated/reduced data	Scottish Ambulance Service Annual Climate Emergency & Sustainability Report 202	Reducing avoidable ambulance conveyance lowers healthcare-related carbon emissions, as the Scottish Ambulance Service identifies Travel and Transport as a major source of its carbon footprint, with over 400,000 patient journeys each year. Minimising inter site transfers through earlier palliative assessment therefore directly reduces fleet emissions and supports (Scottish Ambulance Service) SAS's net zero strategy.
Environmental data	Scottish Ambulance Service Annual Climate Emergency & Sustainability Report 2024/25	The Scottish Ambulance Service 2024/ 2025 identifies travel and transport as a major contributed to its carbon emissions, with more than 400,000 patient transport journeys per year, including inter-site transfers. Fleet related emissions form a substantial portion of SAS's annual 23,806 tCO_2e carbon footprint. Reducing avoidable conveyance such as unnecessary ED to hospice or inter-hospital transfers directly supports SAS's net zero strategy and lowers healthcare associated emissions. A front door model that supports patients in the right place earlier helps reduce these transfer journeys and the associated carbon impact.

Evidence	Available – detail source	Comments: what does the evidence tell you with regard to different groups who may be affected and to the environmental impacts of your proposal
Risk from cumulative impacts		• Impact on capacity and demand • Greater burden on community services. Backlog of referrals. • Patient experience could be worse • Increase burden on carers/
Other (please specify)		
Additional evidence required		

8. In summary, what impacts were identified and which groups will they affect?

Equality, Health and Wellbeing and Human Rights and Children's Rights	Affected populations
Positive It provides early recognition of palliative needs and coordinated care for those aged 18+ though majority of service users are older people. More personalised care options; reduced unnecessary ED attendances, improved symptom control, improved communication for people with low literacy; better support for families; increased staff confidence and reduced moral distress. Supports patients with cognitive impairment (dementia) who often find hospital environments distressing; enables care in a familiar home setting. Younger adults (18–25) transitioning from paediatric to adult palliative care will receive greater choice of where their care needs can be met. Patients from Scottish Index of Multiple Derivation (SIMD) 1 & 2 areas (deprived) are less likely to have pre-existing palliative plans; this service identifies them at the front door. Supports Article 8 (Right to Family Life) by facilitating the choice to remain at home with family during last year of life. ED staff feel more confident in supporting people with palliative and end of life care. Improved staff wellbeing and a reduction in moral distress of ED staff through the introduction of palliative care specialists.	Older people; people with frailty/multimorbidity; younger adults transitioning from paediatric care; people with low literacy; refugees and migrants; substance-use population; prisoners; carers; staff. Staff

Equality, Health and Wellbeing and Human Rights and Children's Rights	Affected populations
Negative Younger adults (18–25) transitioning from paediatric to adult palliative care face heightened vulnerability due to complex transitions and increased life responsibilities. Home-based care may place additional strain on families with dependent children, affecting children's wellbeing and rights if support is insufficient. Risk of misunderstanding home-based care as "being turned away" from acute services. Out-of-hours (OOH) inequity; variability in community service availability. Risk unpaid carer burden will increase with the increase of home-based palliative care. For financially vulnerable households, home-based palliative care will increase energy costs powering medical equipment, increased heating needs, and long periods indoors. Inequitable availability of community based palliative care services could result in some parts of the city having a disproportionate benefit to an improved system.	Younger adults, Unpaid Carers, Children, people experiencing poverty; households with poor heating/housing; carers in insecure employment. Females (more unpaid carers are female) All geographical communities

Environment and Sustainability including climate change emissions and impacts	Affected populations
Positive Supporting patients to remain at home through Virtual Ward models reduces carbon-intensive hospital bed days. Hospitals have higher per-capita energy consumption than domestic settings. Early identification of palliative needs at the Front Door may reduce avoidable hospital admissions, unnecessary investigations, lower visitor travel and ambulance conveyance, lowering transport related carbon emission.	Patients, carers, Households receiving palliative care at home, Scottish Ambulance Service, community teams.
Negative Patients in poorly insulated homes may face higher environmental and financial strain as home-based care requires warmer indoor temperatures for comfort and safety, especially in winter. Increase energy use at home contributes to carbon emissions unless households are on renewable tariffs.	Community staff; households receiving oxygen therapy.

Environment and Sustainability including climate change emissions and impacts	Affected populations
Home care may raise household energy consumption, particularly for heating and medical equipment. Increased home clinical waste, Fire risks associated with oxygen therapy in smoking households. Increased community travel emissions from carers visiting homes to provide care.	

Economic	Affected populations
Positive Earlier specialist involvement helps identify financial pressures sooner and enables timely referrals for welfare advice. Better symptom control and fewer crisis admissions can help patients maintain part-time or home-based work for longer. Carers may also experience fewer unplanned disruptions to work, supporting household- income stability. Local job creation through growth in supply chains (pharmacies, equipment providers, home care agencies). Pressure on acute care budgets can be reduced by avoidable hospital admissions. Virtual Ward and early community support may help patients avoid financial shocks with emergency care episodes (travel, missed work, childcare). Preventing crises can reduce reliance on ambulance conveyance and high-cost interventions, contributing to cost savings for NHS Lothian.	Carers; people receiving care at home; local care providers, pharmacies and NHS Lothian.
Negative Carers may experience lost earnings, reduce working hours, or need to take unpaid leave to support palliative care at home. Increased energy and food costs for care at home.	Unpaid carers, low-income households, carers in employment, and community services. Mostly female carers.

Economic	Affected populations
More patients being managed at home increases system reliance on community services whose financial sustainability is already threatened, potentially reducing equitable access to care in the long term.	

9. Is any part of this policy/ service to be carried out wholly or partly by contractors and if so how will equality, human rights including children's rights, environmental and sustainability issues be addressed?

Not at this stage. If contracted services are introduced later (e.g., hospice partnerships, community care), equality, human rights and sustainability requirements will be built into contracts.

10. Consider how you will communicate information about this policy/ service change to children and young people and those affected by sensory impairment, speech impairment, low level literacy or numeracy, learning difficulties or English as a second language? Please provide a summary of the communications plan.

Communications plan is in development and will be produced at the next IIA which will take place at the design stage.

11. Is the plan, programme, strategy or policy likely to result in significant environmental effects, either positive or negative? If yes, it is likely that a Strategic Environmental Assessment (SEA) will be required and the impacts identified in the IIA should be included in this. See section 2.10 in the Guidance for further information.

Not at concept stage. If significant system shifts occur, a Strategic Environmental Assessment (SEA) screening will be undertaken.

12. Additional Information and Evidence Required

If further evidence is required, please note how it will be gathered. If appropriate, mark this report as interim and submit updated final report once further evidence has been gathered.

Realistic Medicine survey and EPC statement to be provided by Palliative Medicine Consultant.

13. Specific to this IIA only, what recommended actions have been, or will be, undertaken and by when? (these should be drawn from 7 – 11 above) Please complete:

Specific actions (as a result of the IIA which may include financial implications, mitigating actions and risks of cumulative impacts)	**Who will take them forward (name and job title**	**Deadline for progressing**	**Review date**
Engage General Practitioners (GPs) Subcommittee including the Community pharmacy network and the existing Palliative Care Network pharmacy lead	Programme Manager – Palliative Care		
Model community capacity	EHSCP Commissioning Team		
Home oxygen safety assessment to care pathway	Clinical leads	Design Phase	
Submit additional evidence (Realistic Medicine, EPC statement)	Palliative Care Consultant Lead (RIE)	1 April 2026	
Consider additional carer support needs, resources and costs as proposal develops	Sarah Bryson		

14. Are there any negative impacts in section 8 for which there are no identified mitigating actions?

Weekend/evening specialist cover.

15. How will you monitor how this proposal affects different groups, including people with protected characteristics?

A robust measurement framework has been developed to monitor how all proposal that deliver Edinburgh Integrated Joint Board (EIJB) Strategic objectives will impact on current performance, including monitoring for unintended consequences such as increased hospital readmissions.

In addition to this, complaints will be monitored for increased activity in this area.

16. Sign off by Head of Service

Name Andy Hall, Service Director – Strategic Planning

Date 13/04/26

17. Publication

Completed and signed IIAs should be sent to: integratedimpactassessments@edinburgh.gov.uk to be published on the Council website www.edinburgh.gov.uk/impactassessments

Edinburgh Integration Joint Board/Health and Social Care
sarah.bryson@edinburgh.gov.uk to be published at www.edinburghhsc.scot/the-ijb/integrated-impact-assessments/