North Central London Integrated Care System

NCL Start Well

JHOSC – 30 November 2023

This presentation is an update on the NCL Start Well programme

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This pack contains the following:

- Context and background to the Start Well programme
- Maternity and neonatal services proposals
- A proposal for the birthing suites at the Edgware Birth Centre
- Proposals for surgery for babies and children
- Our proposed consultation activity

The content of these materials has been informed by a number of documents which are being considered by the NCL ICB Board at their meeting on 5th December. **These documents can be viewed here:** https://nclhealthandcare.org.uk/wp-content/uploads/2022/07/NCL-ICB-Board-Meeting-5.12.23.pdf

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Background and context

Purpose of today's briefing

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Today we are giving an update to the JHOSC on the Start Well programme. At the end of the update JHOSC members are asked to:

- **Note** the programme update
- **Support** the consultation plan, subject to the outcome of the ICB Board meeting on 5 December 2023
- **Agree** how JHOSC would like to be consulted with during the formal public consultation phase, including any additional information or meeting requirements for members
- **Agree** to receive a report on the the public consultation responses following its completion

The drivers for this programme and the need for change are rooted in our relentless focus on improving outcomes and reducing inequalities within our population

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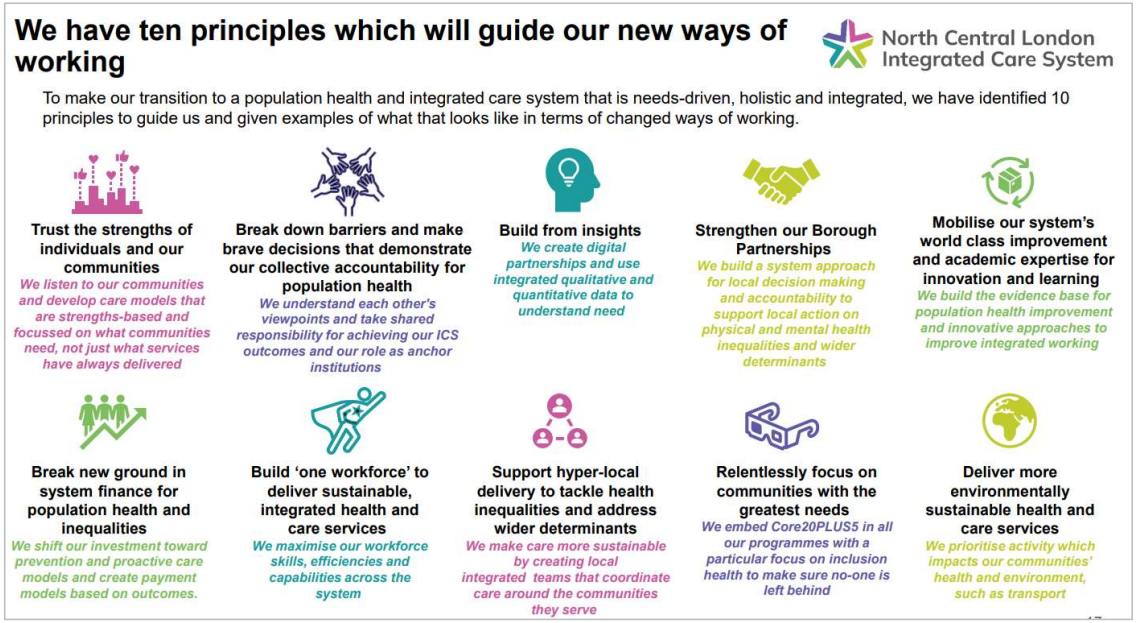
North Central London ICS has an ambition to provide services that support the best start in life, both for our residents and for people from neighbouring boroughs and beyond who choose to use our services.

We know that care received at the beginning of life is a powerful force against health inequalities and a catalyst for improved life chances which is why Start Well is a key priority in our Population Health and Integrated Care Strategy.

Central to the Start Well programme are the needs of pregnant women and people and their babies. We want to ensure our services are in the best position to support families through the life changing journey of pregnancy and birth.



Source: North Central London ICS Population Health and Integrated Care Strategy

https://nclhealthandcare.org.uk/our-working-areas/population-health/

The Start Well programme will support us to tackle inequalities and improve population health outcomes

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The Start Well programme was initiated to ensure services are set up to meet population needs and improve outcomes. The drivers for starting the work demonstrate that the programme is key to delivering against our duties around population health improvement and tackling inequalities

- **Improving care at the start of life has the potential to have far reaching impacts on overall population health and life outcomes**
- **There is longstanding inequity in service provision across maternity, neonatal and paediatric services – with not everyone having access to the same care as others**
- **The quality of services could be improved, and some service users face differential outcomes and experience**
- **Our workforce is constrained and, in some instances, our people are working in environments that are not set up for them to provide the best possible patient care**
- **Ensuring we are in a position to respond to national reviews and best practice guidance such as the Three Year Delivery Plan for Maternity and Neonatal Care**

The ICS also has a number of other programmes which are aiming to achieve population health improvements and integration of care such as a review into community services, mental health services and the implementation of a Long Term Conditions Locally Commissioned Service for Primary Care.

Start Well is a collaborative programme involving a wide range of patients, carers, community representatives, clinical leaders and ICS partners

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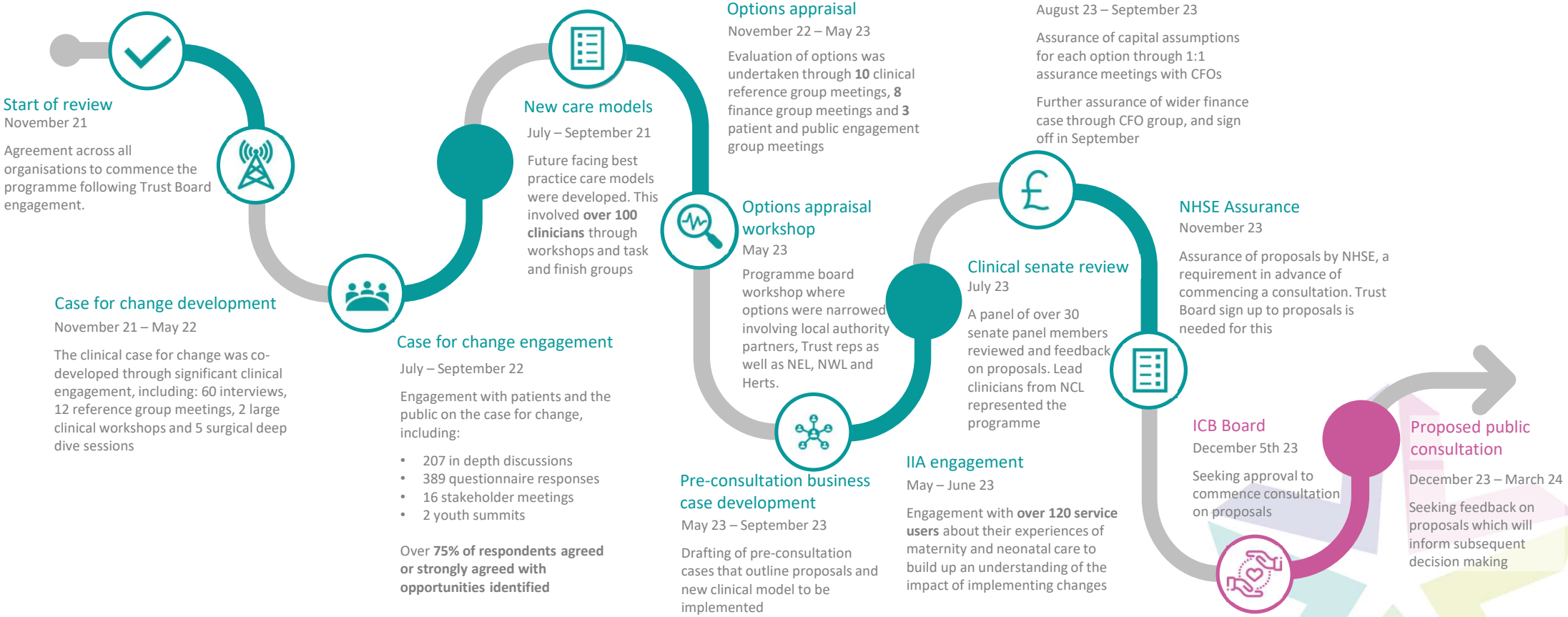

Start of review
November 21

Agreement across all organisations to commence the programme following Trust Board engagement.

Case for change development
November 21 – May 22

The clinical case for change was co-developed through significant clinical engagement, including: 60 interviews, 12 reference group meetings, 2 large clinical workshops and 5 surgical deep dive sessions

Case for change engagement
July – September 22

Engagement with patients and the public on the case for change, including:

- 207 in depth discussions
- 389 questionnaire responses
- 16 stakeholder meetings
- 2 youth summits

Over **75% of respondents agreed or strongly agreed with opportunities identified**

New care models
July – September 21

Future facing best practice care models were developed. This involved **over 100 clinicians** through workshops and task and finish groups

Options appraisal
November 22 – May 23

Evaluation of options was undertaken through **10** clinical reference group meetings, **8** finance group meetings and **3** patient and public engagement group meetings

Options appraisal workshop
May 23

Programme board workshop where options were narrowed involving local authority partners, Trust reps as well as NEL, NWL and Herts.

Pre-consultation business case development
May 23 – September 23

Drafting of pre-consultation cases that outline proposals and new clinical model to be implemented

IIA engagement
May – June 23

Engagement with **over 120 service users** about their experiences of maternity and neonatal care to build up an understanding of the impact of implementing changes

Clinical senate review
July 23

A panel of over 30 senate panel members reviewed and feedback on proposals. Lead clinicians from NCL represented the programme

Finance assurance
August 23 – September 23

Assurance of capital assumptions for each option through 1:1 assurance meetings with CFOs

Further assurance of wider finance case through CFO group, and sign off in September

NHSE Assurance
November 23

Assurance of proposals by NHSE, a requirement in advance of commencing a consultation. Trust Board sign up to proposals is needed for this

ICB Board
December 5th 23

Seeking approval to commence consultation on proposals

Proposed public consultation
December 23 – March 24

Seeking feedback on proposals which will inform subsequent decision making

The programme, which began in November 2021, has benefited from extensive clinical and service user input.

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Maternity and neonatal services proposals

Neonatal care is organised into different unit types – ranging from level 1 to level 3

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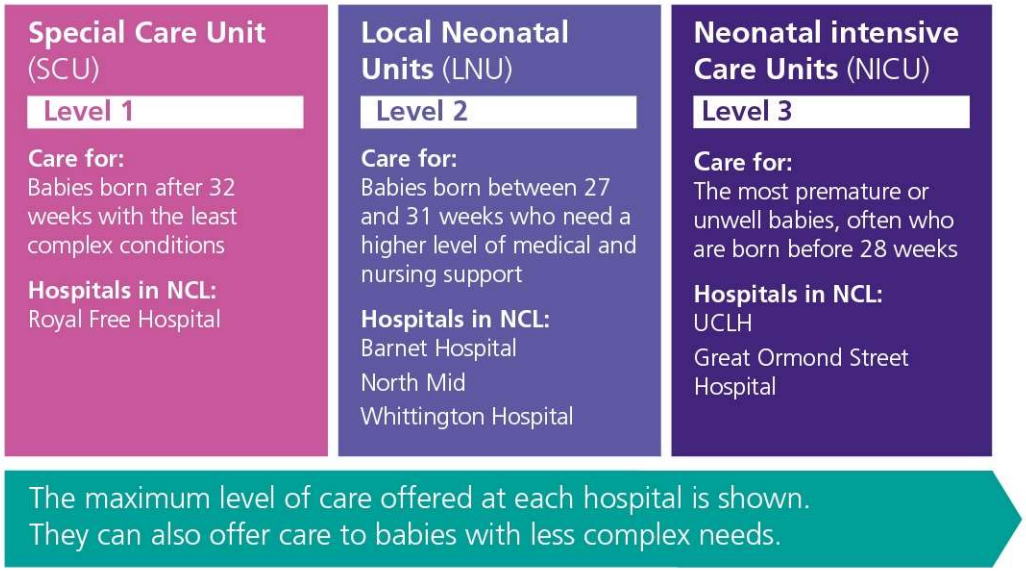
Neonatal care unit types



- Neonatal units differ in their ability to care for the range of needs of babies that are born unwell or premature
- Each unit type is staffed in a different way, with level 3 NICUs units having the most specialist staff and highest staff to baby ratio
- There is evidence that babies looked after in neonatal units that look after a lot of unwell or premature babies have better outcomes
- The British Association of Perinatal Medicine produce guidelines around activity numbers and staffing standards for each type of neonatal unit. This covers things like the number of days that the unit has looked after a baby needing ventilation support, and the on-call cover arrangements for each unit
- There is a network that oversees the neonatal units in London, and they are organised on a regional basis, which ensures that each hospital with either an LNU or SCU has a hospital with a NICU that they are associated with
- Where possible, maternity and neonatal teams work together to ensure that where it is known a baby will need a high level of neonatal care (e.g., they are born very prematurely) they give birth at a hospital site where there is a NICU. This avoids transfers of babies after they have been born and a woman or person who has just given birth being separated from their newborn baby
- when babies have put on sufficient weight and can breathe and feed unaided, or have made improvements if they have been unwell, they are then transferred back to a neonatal unit closer to their home

There are a range of birth settings where pregnant women and people can give birth

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Out of hospital settings

Home birth

Pregnant women and people give birth at home, supported by midwives. They can be transferred to an obstetric-led unit by ambulance if there are complications during or after labour.

Standalone midwifery-led unit

A birth unit that is not located with an obstetric-led birth unit or neonatal unit, where care is delivered by a team of midwives. The unit has a more homely, less medicalised feel, often offering the opportunity to use birth pools. Pregnant women and people can be transferred to an obstetric-led unit by ambulance during labour if there are complications during or after labour.

In hospital settings

Alongside midwifery-led unit

A birth unit where care is delivered by a team of midwives. The unit is located in the same hospital as a neonatal unit and an obstetric-led birth unit but has a more homely, less medicalised feel, often offering the opportunity to use birth pools. Pregnant women and people can easily be transferred to the obstetric-led unit during labour if they need additional support with pain relief or delivering their baby.

Obstetric unit (labour ward)

Care is delivered by obstetricians (specialist doctors trained to provide care during pregnancy and labour) and midwives. Anyone can give birth at these units and some pregnant women and people who are higher risk may be advised to give birth in an obstetric-led unit.

Women and people are clinically assessed during pregnancy to determine an appropriate birth setting. Those considered to have more 'high risk' pregnancies will be advised to give birth in a setting that has more medical support available. People may be considered to have high risk pregnancies if:

- They have pre-existing comorbidities such as obesity or diabetes
- If they have developed complications during their pregnancy

Our current configuration of maternity and neonatal care includes five maternity and neonatal units

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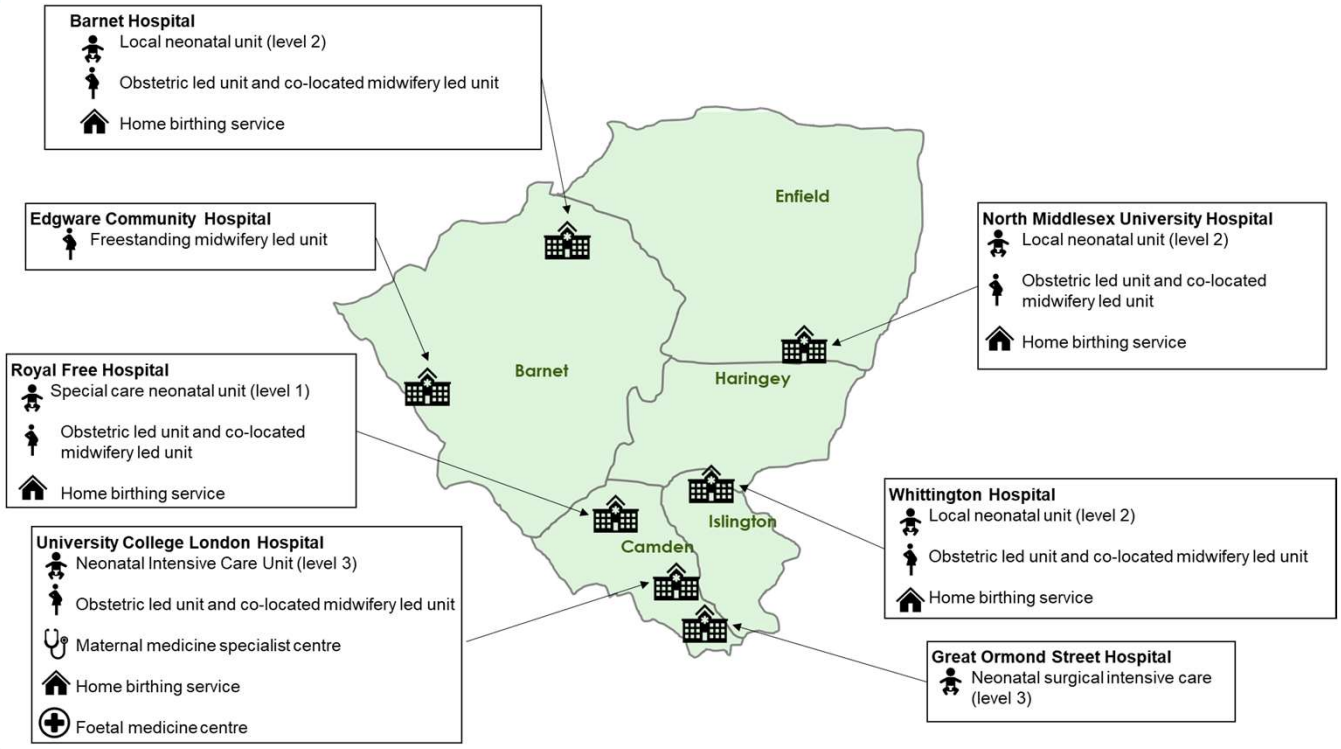

NCL has **five maternity and neonatal units** and a **standalone midwifery led birth centre**:

- Five obstetric units
- Five alongside midwifery-led units
- One standalone midwifery-led unit at Edgware Community Hospital
- One special care neonatal unit (level 1)
- Two local neonatal units (level 2)
- Two NICUs (level 3 – one of which is at GOSH and out of scope of the proposals)

There are important clinical drivers for change in our maternity and neonatal services

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NCL has a declining birth rate, with increasing complexity of service users. There is insufficient activity and staff to sustain five maternity and neonatal units in the long term

Staffing levels do not always meet best practice guidance and there are high vacancy rates which frequently compromise service provision. This often leads to the inability to staff birth centres – meaning the choice of midwifery-led care is often compromised

The level 1 unit at the Royal Free Hospital was only 37% occupied in 2021/22. The number of admissions to the unit have been falling and there are expensive and complex mitigations in place to maintain its safety. This unit does not provide equitable care to service users and it represents a clinical risk, which requires a long-term solution as identified by the London Neonatal operational delivery network and the Trust

The maternity and neonatal estate at the Whittington Hospital does not meet with modern best practice building standards. It has no ensuite bathrooms in its labour ward, its neonatal unit is cramped with risks around infection control which must be mitigated. This was identified by a recent CQC inspection as a cause for concern

The maternity CQC reinspection programme has identified challenges with maternity services in NCL and there are opportunities to improve their quality

Edgware Birth Centre supports an ever-decreasing number of women to give birth – in 22/23 only 34 women gave birth there. Given the declining birth rate and increasing complexity of births it is unlikely this will increase in the future

Our vision for maternity and neonatal care is delivered through our new care model

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The new care model proposes:

- **Bringing together maternity and neonatal care into four units as opposed to our current five**
- **Three level 2 neonatal units as well as the specialist NICU at UCLH**
- **No longer having a level 1 neonatal unit**
- **No longer having a standalone midwifery-led birth centre**

Our vision for maternity and neonatal services

Provision of high-quality equitable care: all units being able to provide the same level of neonatal care will address the current inequity of having a level 1 neonatal unit as local provision for those closest to that level 1 unit is less comprehensive than the local provision for those closer to any of the level 2 centres

Units that provide sustainable activity numbers: through consolidation, we will have larger units which are more clinically sustainable in the long term given the declining NCL birth rate and the need to make best use of our scarce workforce

Workforce resilience: units staffed in line with best practice, supporting our teams to deliver high quality care**.** Delivering this over four units as opposed to five means increased workforce resilience and units will be less vulnerable to short term closures – ensuring that choice of birth setting can be facilitated in a more consistent way. This may also help deliver greater continuity of care to parents, which is currently a challenge to deliver as our workforce are spread thinly

The right capacity to meet demand: ensuring that NCL has access to the right level of capacity to meet changing needs of our population – including access to specialist care where it may be needed

Environment that provides a positive patient experience: investing in our estate and making improvements that will address current issues. We will invest in making sure we have optimally sized units, meaning better value for money and wider benefits of adopting the new care model

The options appraisal considered all viable options for the proposed service changes

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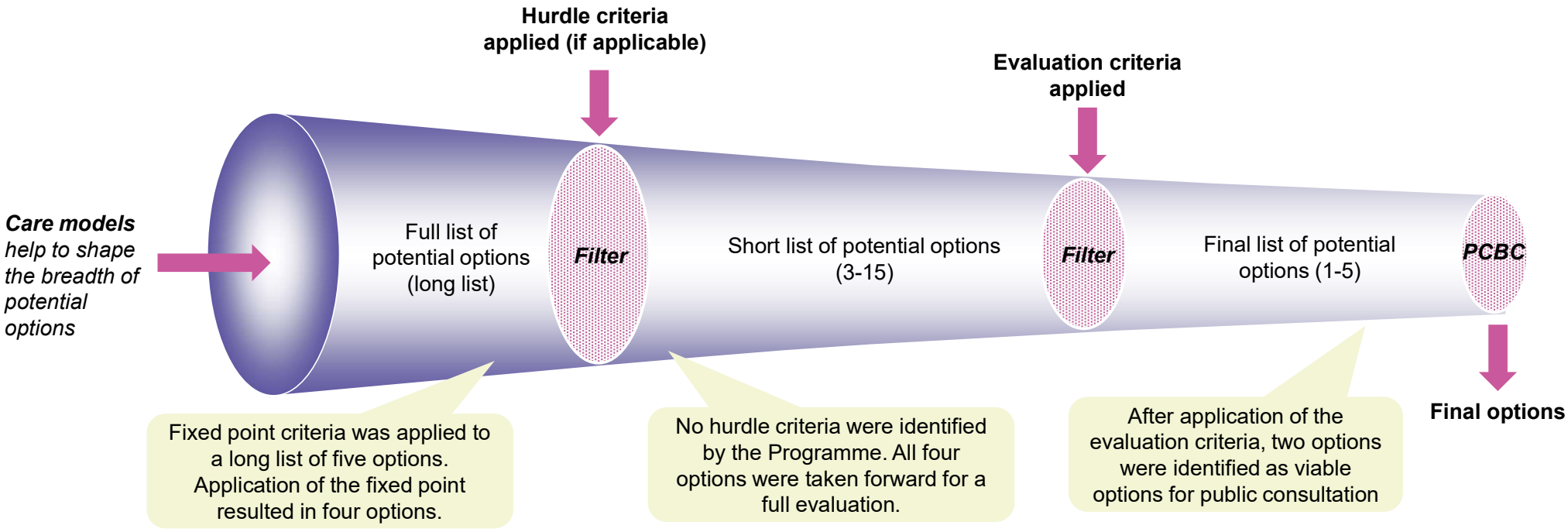
We conducted a thorough options appraisal process for the proposed maternity and neonatal care model to:

- Set out all possible site-specific options for having four obstetric led birthing units co-located with four neonatal units (three of which will be level 2 and one will be level 3), instead of the current five (excluding the specialist level 3 at GOSH)



The options appraisal was supported by a number of different groups including our patient and public engagement group

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Criteria development	Initial evaluation	Final evaluation

Clinical Reference Group: develop **quality and workforce** criteria	• Undertake the initial evaluation for **quality and workforce criteria**.
	• The group have recommended proposed scores against the agreed evaluation measures using a ++, +, /, -, -- evaluation.
		Evaluation event
		The programme board undertook the final evaluation based on the inputs from other groups. The workshop was attended by all members of the programme board including:
		• Executive leads from all impacted Trusts
		• Representatives from neighbouring ICS regions (NEL, NWL, Herts)
		• Local authority reps including:
		  • Haringey DCS
		  • Camden DPH
		  • Enfield Chief Executive

Patient and Public Engagement Group: develop **access** criteria	• Undertaken the initial evaluation for **access criteria** • The group have recommended proposed scores against the agreed evaluation measures using a ++, +, /, -, -- evaluation.	
Finance and Analytics group: develop **affordability and value for money** criteria	• Undertaken the initial evaluation for **affordability and value for money** • The group have recommended proposed scores against the agreed evaluation measures using a ++, +, /, -, -- evaluation.	

Proposed options for consultation – maternity and neonates

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Our preferred option

Option A: *UCLH, North Mid, Barnet, Whittington*	
UCLH	**Consultant-led obstetric unit with co-located NICU (level 3) neonatal intensive care unit, alongside midwife-led unit and a home birth service**
North Mid	**Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service**
Barnet	**Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service**
Whittington Hospital	**Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service**
Royal Free Hospital	**Maternity and neonatal services would cease to be provided**

Option B: *UCLH, North Mid, Barnet, Royal Free*	
UCLH	**Consultant-led obstetric unit with co-located NICU (level 3) neonatal intensive care unit, alongside midwife-led unit and a home birth service**
North Mid	**Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service**
Barnet	**Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service**
Royal Free Hospital	**Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service**
Whittington Hospital	**Maternity and neonatal services would cease to be provided**

Closure of the birthing suites at Edgware Birth Centre

Both options being put forward for consultation are deemed to be implementable

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The status quo is not an option for consultation because:

- The way services are currently set up won't meet the long-term needs of our population and doesn't resolve the challenges identified in our case for change
- Staffing services across five sites as opposed to four would continue to be a challenge and not make best use of our skilled workforce
- The neonatal unit at the Royal Free Hospital would continue to need support to maintain the skills of staff and this does not represent a long term, sustainable solution

Both proposed options being put forward for consultation have been deemed to be implementable and we are consulting on both options.

Option A has been identified as the preferred option for consultation because:

- It would be significantly easier to implement option A than option B from a workforce perspective because Whittington Hospital already has a **Local Neonatal Unit (level 2)** while the Royal Free Hospital currently has a **Special Care Unit (level 1)** neonatal unit. Therefore, in option A there would be a smoother transition to the new model of care with minimal need for staffing changes
- Option A would result in projected patient flows of **850 deliveries per year to hospitals in North West London** which NWL ICB has confirmed **could be delivered within existing capacity**. In **option B** patient flow to North East London would be **more difficult to manage**

We have built up an understanding of the impact of our proposals through our Interim Integrated Impact Assessment

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Our IIA draws on multiple strands of work which has supported us to build a picture of what the impact of our proposals could be, and who may be impacted:

1. Our case for change took a population health approach and identified service users with characteristics who may be at risk of health inequalities
2. We undertook a supplementary literature Review to identify inequalities in maternal and neonatal outcomes undertaken by public health professionals
3. We engaged with potentially impacted groups to understand their views on the possible impact of proposals
4. We have undertaken extensive analysis on:
   - Accessibility (travel time, cost, parking, public transport access, car ownership)
   - Population demographics
   - Sustainability impact by looking at carbon emissions

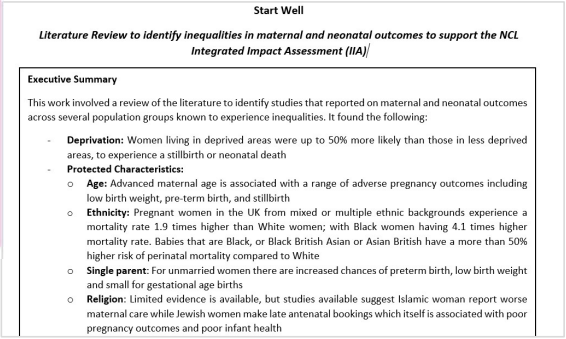
We have identified the following impacts of our proposals:

- **Accessibility**: relatively small average increases in travel time across both options (both by public transport and car)
- **Cost of travel:** additional expenses when travelling by taxi on average of £4, but close to the closing sites up to £11
- **Accessing an unfamiliar hospital site:** changes may mean people having to travel to and navigate around a hospital site which they are unfamiliar with
- **Understanding changes:** service users need to be able to understand their choices of maternity care and what change could mean for them

1 Understand proposed service changes	2 Identify potentially impacted populations	3 Understand the potentially impacted groups	4 Assess impact of proposals on populations	5 Agree mitigations
• Understand current services and where they are delivered • Review the proposed changes to the model of care • Understand where services will be delivered for each potential option	• Assess which local people may be impacted by the proposals	• Understand the demographics and location of the population • Understand populations who might be disproportionally impacted by the proposals or who are vulnerable	• Understand the overall potential impact on moving services on quality, outcomes, patient experience, access, sustainability and geographical areas • Assess this impact for those populations who may be disproportionally impacted or who are vulnerable	• Agree steps to mitigate against any negative impacts and enhance any benefits

IIA engagement reach

- **38** engagement meetings facilitated
- **124** patients, residents and staff have been involved
- **9** sessions with parents who have recent experience of neonatal care
- **5** meetings with specialist midwives supporting women with complex needs



Start Well

Literature Review to identify inequalities in maternal and neonatal outcomes to support the NCL Integrated Impact Assessment (IIA)

Executive Summary

This work involved a review of the literature to identify studies that reported on maternal and neonatal outcomes across several population groups known to experience inequalities. It found the following:

- **Deprivation:** Women living in deprived areas were up to 50% more likely than those in less deprived areas, to experience a stillbirth or neonatal death
- **Protected Characteristics:**
  - **Age:** Advanced maternal age is associated with a range of adverse pregnancy outcomes including low birth weight, pre-term birth, and stillbirth
  - **Ethnicity:** Pregnant women in the UK from mixed or multiple ethnic backgrounds experience a mortality rate 1.9 times higher than White women; with Black women having 4.1 times higher mortality rate. Babies that are Black, or Black British Asian or Asian British have a more than 50% higher risk of perinatal mortality compared to White
  - **Single parent:** For unmarried women there are increased chances of preterm birth, low birth weight and small for gestational age births
  - **Religion:** Limited evidence is available, but studies available suggest Islamic woman report worse maternal care while Jewish women make late antenatal bookings which itself is associated with poor pregnancy outcomes and poor infant health

We looked at people who might be impacted by our proposals when driving (or being driven)

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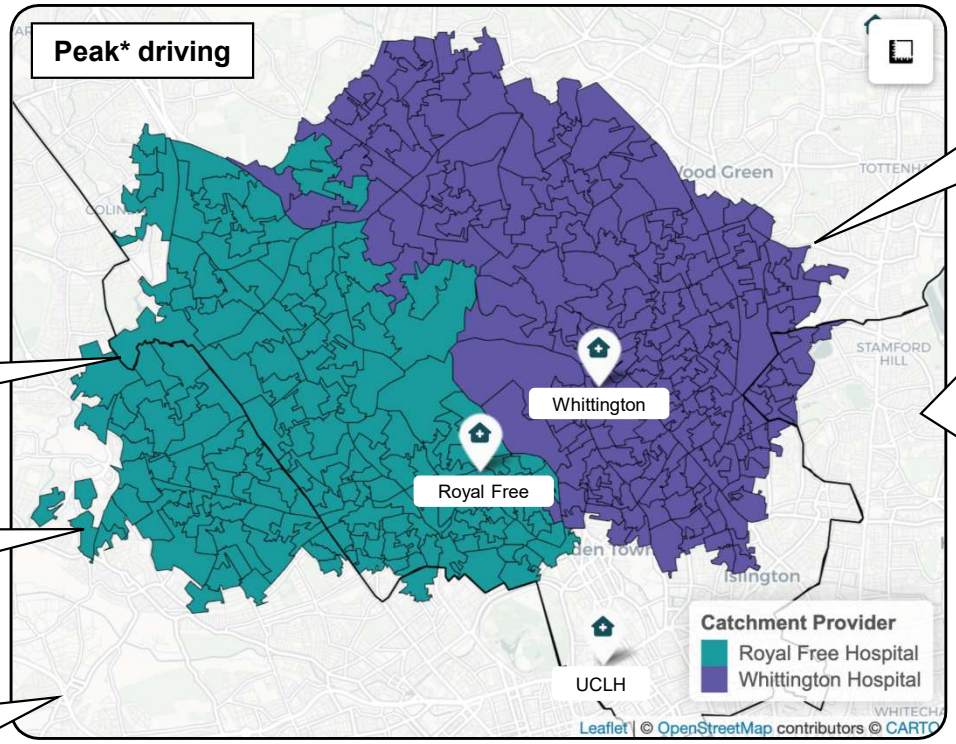
Option A catchment includes:
Population: 373k
Households: 122k
LSOAs:** 188

Option B catchment includes:
Population: 378.5k
Households: 146k
LSOAs:** 204

ICB boundaries

Royal Free Hospital catchment area (people who are closest to the Royal Free Hospital)

The population that would be impacted should option A or option B be implemented includes anyone living within the coloured areas



Whittington Hospital catchment area (people who are closest to Whittington Hospital)

On average, people in the purple area can drive more quickly to Whittington Hospital (B) than other nearby units

On average, people in the blue-coloured area can drive more quickly to Royal Free Hospital (A) than another site.

**Peak (private car / taxi) is defined as 9:00 AM on a Tuesday*
***LSOAs are lower super output areas and are populations of around 1,000 – 3,000 people that are used to do travel analysis*

We looked at people who might be impacted by our proposals for maternity units when using public transport

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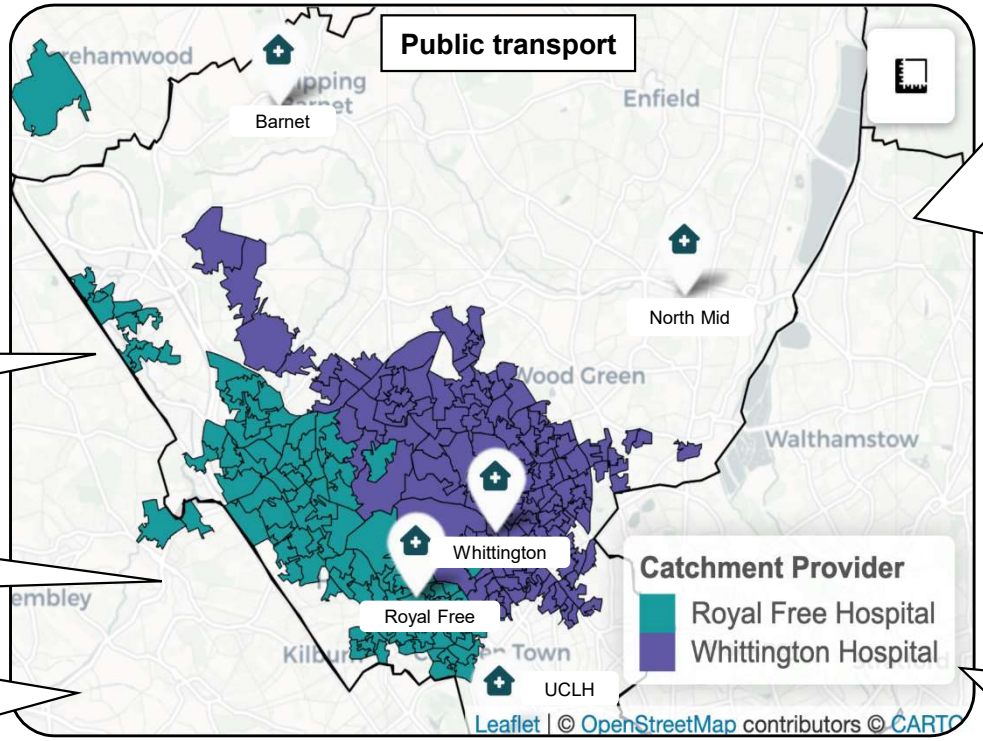
Option A catchment includes

Population: 230K
Households: 74.5k
LSOAs:** 114

Option B catchment includes

Population: 298k
Households: 97.5k
LSOAs:** 164



ICB boundaries

Royal Free Hospital catchment area (people who are closest to the Royal Free Hospital)

The population that is potentially impacted by our proposals includes anyone living within the coloured areas

On average, people in the purple area can arrive more quickly to Whittington Hospital (B) using public transport than other nearby units

People in the Green can arrive more quickly to Royal Free Hospital (A) than another site

Whittington Hospital catchment area (people who are closest to the Whittington Hospital)

**Peak (public transport) is defined as 9:00 AM on a Tuesday*
***LSOAs are lower super output areas and are populations of around 1,000 – 3,000 people that are used to do travel analysis*

There are a range of population groups who may be impacted if we were to implement either option A or B

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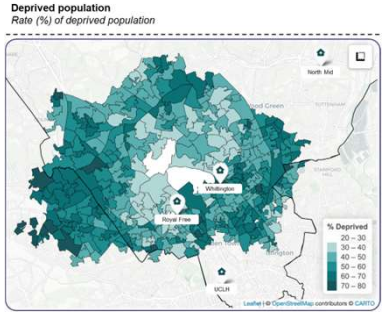
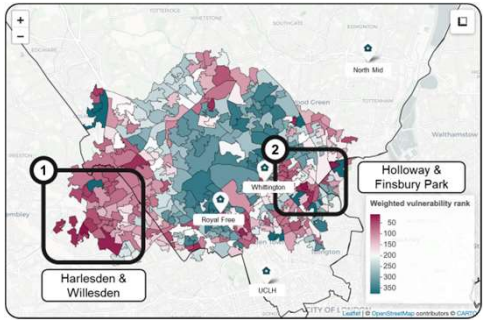
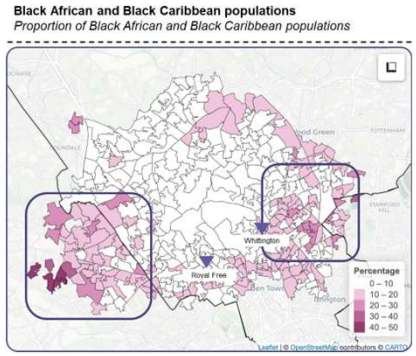
Women and people who live in deprived areas: there is a link between people living in deprivation and adverse outcomes from maternity and neonatal care. People living in these areas may be particularly impacted by increased taxi costs if either option A or B were to be implemented.



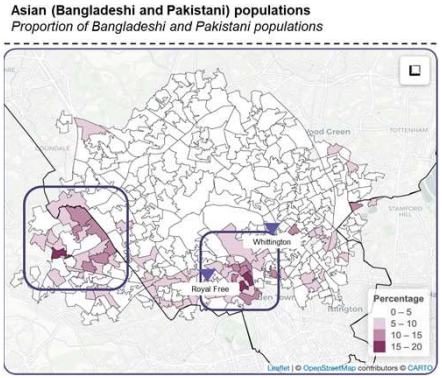
People living in geographic areas who may have vulnerabilities: we identified two neighbouring areas with a higher concentration of people who may be vulnerable to service changes. **Harlesden and Willesden** would be more impacted by option A and **Holloway and Finsbury Park** would be more impacted by option B. The reason that these areas have been identified is due to their higher concentration of people who belong to an ethnic minority, people with poorer English proficiency and areas of higher deprivation. Mitigations for these populations include a focus on continuity of care and ensuring there is integration with other local services



Black African (including Somali) and Black Caribbean women and people of childbearing age: there is evidence that Black African and Black Caribbean women and people may experience poorer maternity outcomes. The impact on Black African and Black Caribbean women of proposed changes may be around navigating to a potentially unfamiliar hospital site, language, additional transport costs and consideration of their wider health needs during pregnancy.



Asian women and people of childbearing age: there is evidence that Asian (particularly Bangladeshi and Pakistani) women and people may experience worse outcomes from maternity care. The impact for them may be around navigating to a potentially unfamiliar hospital site, language, additional transport costs and consideration of wider health needs given evidence of higher prevalence of conditions such as diabetes.



There are a range of population groups who may be impacted if we were to implement either option A or B

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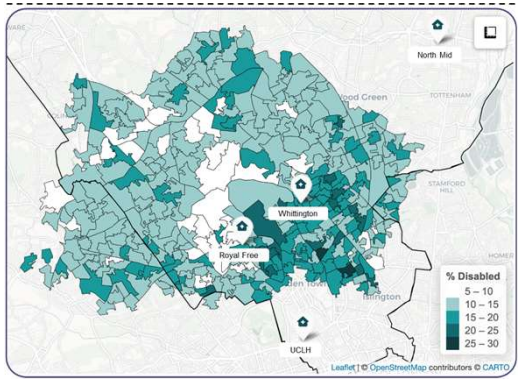
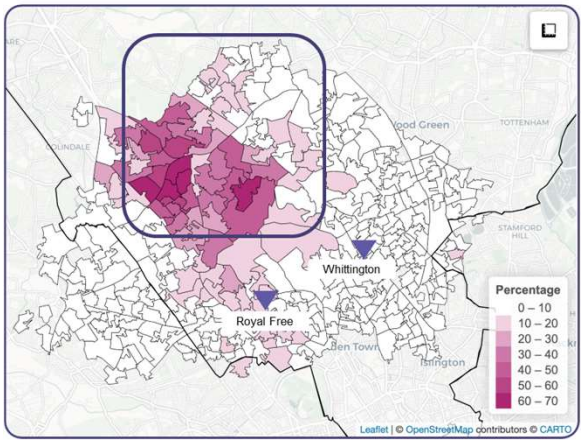
Women and people of childbearing age with disabilities (including learning disabilities): people with disabilities may be more impacted by proposed changes due to challenges navigating to an unfamiliar hospital site, taxi costs due to lower car ownership and the physical accessibility of hospital sites.

People with a disability
Rate (%) of people with a disability



Jewish Population
Proportion of Jewish populations



Women and people from the orthodox Jewish community: Orthodox Jewish people may be impacted by the proposed changes, particularly around Option A. Consideration may need to be given for the specific needs of this group around maternity care. This includes requirements around Kosher food, observance of Shabbat and the impact on travel and ability to access online or digital materials.

Through engagement with service users to date, we have developed mitigations that may need to be put in place to support service users with a range of different needs should a decision be taken to implement proposals. This covers areas such as:

- Communication and information sharing
- Travel and transport
- Ongoing engagement with communities

There are a number of other service users who have characteristics that make them potentially more impacted should we implement option A or B which our IIA identifies. This includes older and younger pregnant women and people, people with poor literacy, women and people in inclusion health groups and

We would seek as a priority to engage with all of these groups during the proposed consultation period.

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The birthing suites at Edgware Birth Centre

We are also proposing closing the birthing suites at Edgware Birth Centre

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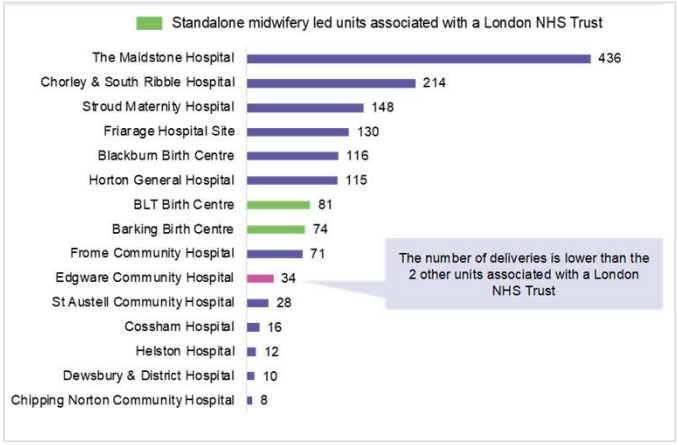
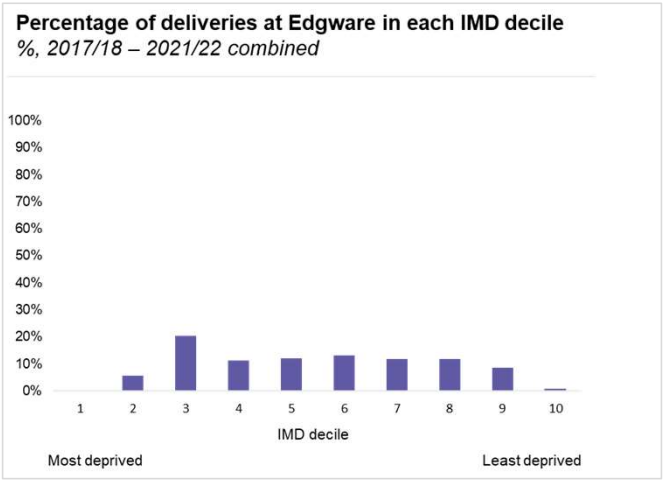
Case for change for Edgware Birth Centre

- Edgware Birth Centre does not provide the right type of capacity for our population, with analysis suggesting only 30% of women across NCL would be clinically appropriate to give birth there and an even smaller number of this 30% would be within close travelling distance of the unit
- Births are becoming more complex and anticipated to decline over the next 10 years, meaning it would be very difficult to increase activity numbers at the unit
- The number of births at the unit has been declining every year since 2017 and it is one of units with the smallest number of births in the country, with only 34 births in the last financial year
- We do not have the workforce to support the unit as well as our other alongside midwifery-led units which leads to short term closures of the service
- There are opportunities to use the space at the site in a more efficient way and provide antenatal and post natal services for our local population there that are more in line with their needs





We propose to consult on this as a separate proposal alongside the maternity and neonatal proposals. They are not dependent on one another.

North Central London Integrated Care System

Surgery for babies and children

There are several important clinical drivers for change in our paediatric surgical services

North Central London Integrated Care System

There is currently a lack of defined emergency surgical pathways for young children meaning that clinicians in emergency departments make multiple enquires to secure the right pathway for individual children.

Some children are transferred up to three times before receiving emergency surgical treatment in the right setting. From April 2020 to March 2021, 144 children and young people were transferred from an NCL provider to other hospitals for an emergency surgical procedure

Access to surgical and anaesthetic workforce to deliver care for young children is limited at local sites and scarce nationally, with the ability to undertake an operation often dependent on the skills of the individual staff on duty that day

There are some operations being undertaken in very low volumes at local sites which raises questions about the ability of staff to maintain their skills

There is lack of clarity on the role of Great Ormond Street Hospital in caring for local NCL children and young people requiring surgery, alongside its tertiary and quaternary work

Children are not always looked after in age-appropriate environments, or on child-only lists which does not represent a high-quality patient experience

There are long waits for planned operations, particularly in ENT and Dentistry, and there are opportunities to consider how these high-volume specialties better manage demand and capacity

There were broader opportunities to improve identified through the case for change which are being addressed through other programmes of work.

Our proposals will improve quality outcomes and patient experience for paediatric surgical care

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Paediatric surgery care model benefits

Access

Paediatric surgical care will be delivered in the appropriate setting to ensure that all patients receive the care they require as quickly as possible

Workforce

Make best use of paediatric surgeons and consultant paediatric anaesthetists to deliver planned and emergency surgical care to children at a fewer number of sites

Sustainable services

Consolidating low volume specialties and ensuring staff maintain competencies will ensure that surgical services remain sustainable

Environment

Ensure all children receive care in a child friendly environment where possible, on dedicated children's surgical lists

Surgical pathways

Providing clarity on surgical pathways reduces time taken to find a bed at local units or transfer children

Proposed option for consultation – paediatric surgery

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- We developed and appraised options for the location of planned and emergency surgical services for children and young people in NCL
- Following our options appraisal, there is one option for consultation for the location of the 'Centre of expertise: day case' and 'Centre of expertise: emergency and planned inpatient'

Option for consultation

Centre of Expertise: emergency & planned inpatient		Centre of Expertise: day case	
GOSH	Would deliver majority of surgical care for children under 3 years and under 5 years (general surgery and urology). Would provide planned inpatient surgery for children age 1 years and over for low volume specialties.	UCLH	Would delivers all day case surgery for children age 1 and 2 years. Would provide day case activity for all children age 3 years and over for low volume specialties.

The proposed care model would move less than 10% of paediatric surgical care in NCL

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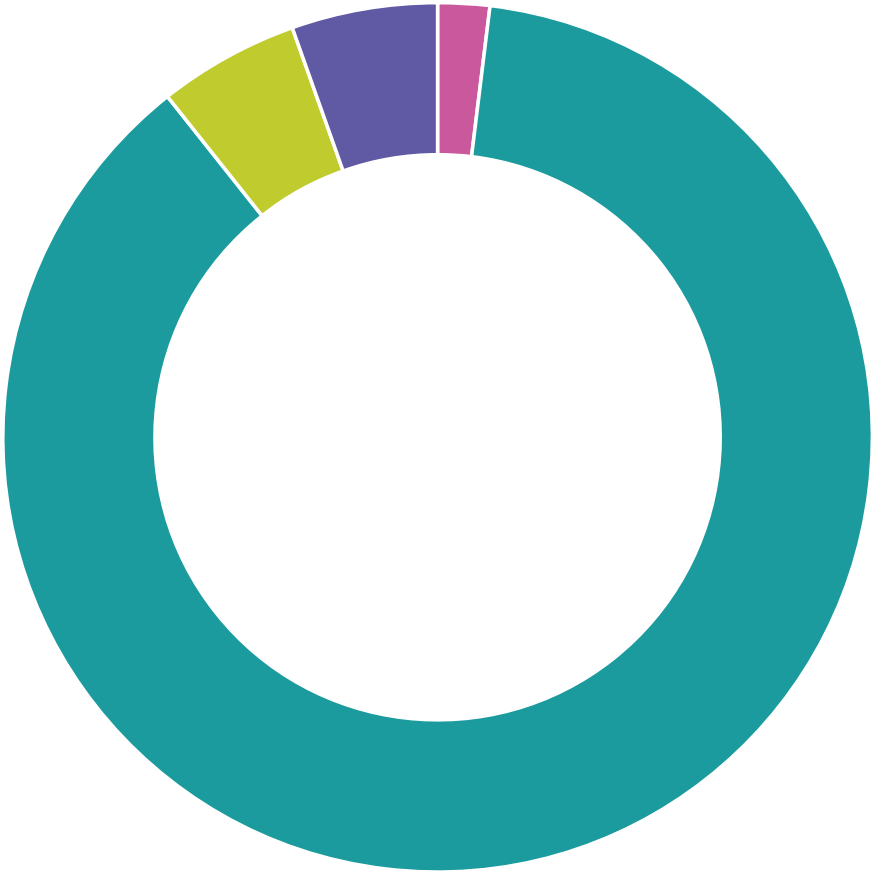
Centre of Expertise: Daycase – c.300 children
Bringing together planned daycase activity

Centre of Expertise: Emergency & planned inpatient – c. 300 children for surgical care and c.1,000 children for surgical assessment
Bringing together emergency for very young children and planned inpatient care



Out of area
Emergency paediatric surgical activity that would continue to be delivered outside NCL (e.g., major trauma)

Local and specialist units
Most of the emergency and planned activity would remain at local units or at specialist units. This means that children and young people are seen at the place best suited to their needs.

We think that our proposals will improve quality and safety of paediatric surgical care, but there could be an impact on travel times

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- Our engagement to date has highlighted that for planned care, parents are willing to travel to receive care from the right specialists, and our proposals formalise arrangements that to some extent are already in place which will lead to improve quality and safety of paediatric surgical care
- The main impact of the proposals are the travel times and cost to both UCLH and GOSH, especially for those who may live furthest away from these sites.

Potential impacts

- **Two geographical areas** were identified as being vulnerable geographies that face barriers to accessing services
- As a result of the proposals at GOSH and UCLH, people in **Tottenham and Edmonton (1)** and **Cricklewood and Dollis Hill (2)** may need additional support to:
  - **Access the hospital site** if the children and young people or the families and carers are disabled/in poor health or are not proficient in English
  - **Travel to hospital by taxi**, if required, as it will cost on average an additional £20 for population living in Tottenham and Edmonton
  - **Access services online** as the families and carers of young children and people may have low digital proficiency
  - **Care for other family members** as they may be a lone parent

Mitigations for any disbenefits have been developed involving clinicians and service users

- Further engagement with service users to understand the impact of changes on them
- Communicating around implementation should changes be agreed and clear information about how to access care that is needed
- Mitigations for those who may need extra support to access an unfamiliar hospital
- Information about how to travel to a hospital site
- Providing as much care locally as possible
- Support with the costs of travel to hospital
- Support for particularly vulnerable populations
- Mitigations around sustainability

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The proposed consultation

The programme has benefited from substantial input from service users and local communities and public consultation will expand the reach of the engagement to date

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Case for change development

- Review of existing patient experience insights data from 11 different sources
- Establishment of a youth mentoring scheme and youth summits
- Targeted engagement with a small number of patient groups

Care model development

- Establishment of the Patient and Public Engagement Group (PPEG) to review and input into care models
- Feedback from case for change engagement informed their development
- Two youth summits involving 35 young people

IIA Engagement

- 11-week targeted engagement period focussing on those with protected characteristics and at risk of poorer outcomes
- 38 sessions held, reaching 124 patients

Case for change engagement

- A 10-week engagement programme
- 43 engagement events
- 207 in-depth conversations
- 389 questionnaires completed

Options appraisal

- PPEG responsible for development and initial evaluation of access criteria
- PPEG Chair a member of the programme board and participated in the programme board workshop for the options appraisal

Public Consultation (TBC)

- Widely promoted high volume engagement with all staff, stakeholders and residents
- Some in-depth conversations with targeted groups
- A formal part of our statutory duties around major service change and ongoing involvement of people and communities

Subject to ICB Board approval we are proposing a 14-week public consultation from mid-December

North Central London Integrated Care System

We are proposing a **14-week consultation** to gather views from service users, stakeholders, residents and staff. The suggested dates for the consultation are **11 December – 17 March** (subject to ICB Board approval).

Development of the consultation plan

The Consultation Plan is a working document which details the purpose, scope and plan of how we will deliver this public consultation.

The proposals are being put forward NCL Integrated Care Board, on behalf of the Integrated Care System and its partner organisations.

The plan has been reviewed by our Programme Board, NHSE at a formal assurance meeting, and Healthwatch representatives. The plan will be iterative, and we will monitor progress throughout the consultation to ensure we are meeting our objectives.

The consultation will be overseen by the Start Well Programme Board, and we will provide regular updates on planning and delivery. Responses will be independently collected and analysed by an external organisation in line with best practice.

At the end of the consultation period, we will have an independently drafted report detailing the feedback received during the 14-week period.

Key Legal Duties

This consultation will fulfil our duty under the

- **NHS Act 2006** (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022)
  - to ensure that people who use NHS services are involved in the development and consideration of proposals for change in the way services are provided and decisions about how they operate
  - to consult local authorities
  - To regard the need to reduce health inequalities in access and outcomes
  - consider the 'triple aim' with regard to the health and wellbeing of people, quality of services and efficient and sustainable use of resources
- **Equality Act 2010** (Public Sector Equality Duty) to demonstrate how we have taken account of the nine protected characteristics and given regard to:
  - Eliminate discrimination, harassment and vicitmisation
  - Advance equality of opportunity
  - Foster good relations
- **The Gunning Principles for a fair consultation**

Through consultation we are seeking to gather views from a diverse range of voices

North Central London Integrated Care System

As well as our direct consultation with JHOSC and borough specific health and well being boards we will deliver a 14-week formal public consultation, in line with best practice that complies with our legal requirements and duties. Our aims are:

- To inform stakeholders about how proposals have been developed in a clear, simple and accessible way that allows for 'intelligent consideration'
- Provide adequate time and opportunities for staff, residents and stakeholders to give their views on proposals, and the potential impacts
- Ensure a diverse range of voices are heard
- Seek alternative proposals or evidence not yet considered
- Understand the advantages and disadvantages of the proposed change and any unintended consequences
- Explore what mitigations might be used to reduce the impact of disadvantages
- Find out what matters most to patients and how this might affect implementation
- Provide analysis of responses to enable conscientious consideration before a decision is made

Consultation aims

Raise awareness of consultation with staff, patients, service users and residents and encourage to participate

Remind people that their views matter and encourage them to share feedback through direct engagement

Encourage participation from a diverse range of voices by providing adequate time and opportunities for people to respond

Focus resources on hearing from people with protected characteristics and more impacted groups

Provide staff engagement mechanisms all for health and care staff in NCL during the consultation period.

Capture stakeholder attitudes of key groups and influencers on the proposals and the consultation process

Our consultation approach includes a focus on the groups identified through our IIA

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We will:

- Build on previous engagement contacts, over 300 organisations will be contacted to take part in the consultation
- Conduct comprehensive stakeholder mapping to identify groups to engage with, prioritising those identified by the IIA or with protected characteristics or at greater risk of health inequality
- Focus on geographical areas where there may be particular impacts
- Ensure we develop a range of opportunities for stakeholders to respond to the consultation
- Identify the best ways of reaching and engaging priority groups
- Provide an easy read version of documents, different formats and translated versions relevant to the community
- Make sure there is equality monitoring of participants to ensure the views received reflect the whole of the local population
- Target activity to the local geographical areas most impacted
- Arrange any events and meetings in accessible venues and offer interpreters, translators and hearing loops where required
- Inform partners, including councils and VCSE organisations, of the consultation and share our plans for engagement.

Resident groups we will be targeting through the consultation

- Black African (including Somali) and Black Caribbean women
- Asian women and people of childbearing age who (with a particular focus on Pakistani and Bangladeshi women)
- People living in areas of deprivation
- Orthodox Jewish women
- People with disabilities
- People living in Harlesden and Willesden
- People living in Holloway and Finsbury
- Older women of childbearing age (40+)
- Younger women of childbearing age (under 20)
- Women with mental health problems
- People from LGBTQ+ communities
- People who are carers
- People with poor English proficiency
- People with poor literacy
- People belonging to inclusion health groups such as people who are homeless, dependent on drugs and alcohol, asylum seekers and Gypsy, Roma and Traveller

Consultation promotion and questionnaire

North Central London Integrated Care System

We will promote and encourage participation in the consultation in a number of ways:

- **Displays:** in key locations we will promote the opportunity to respond to the consultation such as in NCL hospitals and clinics and other healthcare settings such as GP surgeries and pharmacies
- **Online promotion:** social media channels, such as Facebook, Instagram, X and Linkedin, will be used to reach out to potential participants in the consultation. Branded graphics will be produced that are aligned with the look and feel of printed consultation materials and shared by partner organisations
- **Partner channels:** all providers and partners such as councils will be asked to profile the consultation on their websites and through newsletters and other public facing channels and drive traffic to the NCL ICB website. We will ask for support from councils in accessing channels that will reach families, such as school newsletters and information going to women and family centres
- **VCSE networks:** we will provide content including information and visual materials and ask colleagues in voluntary and community sector organisations to use their channels to promote the consultation.
- **Media:** We will seek to promote the consultation through earned (free) or paid-for content in local newspapers, newsletters and local radio.

Consultation questionnaire

In line with best practice, we have commissioned an experienced independent organisation to collate and analyse responses to the consultation.

This includes the hosting of a questionnaire that will cover the three components of our proposals:

- Maternity and neonatal services proposals
- Edgware birthing suites proposals
- Surgery for babies and children

The response to the questionnaire will be monitored throughout the consultation period and included in the eventual evaluation report that will be compiled taking into account the range of feedback obtained through consultation.

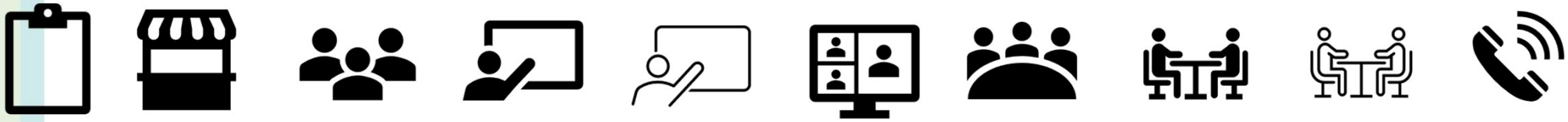
We will tailor our engagement techniques during the consultation period

North Central London Integrated Care System

- Broad range of techniques will be used, tailored to each audience and their level of interest.
- Opportunities online and face to face
- Working with third-party advocates (VCSE) to reach communities who may not engage directly
- Materials in accessible formats including Easy Read and translations
- Mechanisms in place to capture and analyse outputs.

Light engagement → **Deeper engagement**

Survey distributed on email	Drop in event/stall: face to face	Attendance at meeting: short agenda slot	Presentation and feedback: Start Well Team	Presentation and feedback: commissioned	Small group discussion online	Small group discussion: face to face	Interactive workshop: Start Well Team	Interactive workshop: commissioned	Telephone / online interviews



This type of engagement will be **promoted widely** to allow **a range of people to participate** in the consultation and give their views

This type of engagement will **focus on groups with protected characteristics** to understand their views and impact of the options in a meaningful way

Stakeholder Engagement

North Central London Integrated Care System

Formal Committees

- Update to **JHOSC** to share plans for consultation at formal committee meeting on 30 November 2023
- Briefings offered to **NCL Health and Wellbeing Boards after board decision**
- Briefing to JHOSC chairs for **NWL and NEL**. Will also attend Brent JHOSC and North East London Inner JHOSC during consultation period
- Direct consultation with JHOSC on our proposals

Elected representatives

- **Letters with an update and offer of briefing** prior to December Board sent to all **NCL MPs,**
- **Council** leaders/Cabinet leads for health and CYP/ and HWBB Chairs briefed on advice and with support from local authority colleagues.
- **Letters confirming board decision to launch consultation to NCL MPs, Council** leaders/Cabinet leads for health and CYP/ and JHOSC and HWBB Chairs on 11 December

Other stakeholders

Invitation to take part in consultation will be sent to:

- Unions / staff side
- Healthwatches and VCSE
- Directors of public health
- Directors of children's services
- Primary care
- Royal Colleges and education providers
- Neighbouring ICS areas
- Specialised commissioning
- Mayor's office
- Local media

Staff Engagement

North Central London Integrated Care System

Information sharing

- **Progress updates** in internal Trust channels explaining proposals and consultation timeline
- **Coordinated email from Exec leads** to be shared to confirm the **outcome of the ICB Board meeting**
- **Staff messages** promoting awareness of proposals and consultation and invite participation
- **Frequently asked questions** updated regularly on staff intranets

Briefings

- **Coordinated staff briefings** led by Start Well Executive Leads to begin w/c 27 November (when papers for the Board are made public).
- A **presentation will be provided** to support briefings to **ensure consistency of messaging**

Feedback

- **Staff invited** to fill in questionnaire
- **Alternative mechanisms** to ask questions and respond to the consultation

We are seeking JHOSC endorsement of our consultation plan

North Central London Integrated Care System

Today we are seeking support for our consultation plan. JHOSC members are asked to:

- Provide any feedback on our consultation plan
- Support the approach we are taking with our public consultation activity, as outlined in the plan
- Indicate how the JHOSC would like to be engaged with through the consultation period to ensure views on the proposals are captured

North Central London Integrated Care System

Next steps

Next Steps

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Subject to decision by the ICB Board on 5th December the next steps would be:

- Work with an independent partner to evaluate consultation responses.
- Following the consultation period, we will publish an evaluation of the responses, in a report produced by this independent organisation, this will include who we reached during the consultation.
- Subject to the outcome of the consultation, we will **review, improve or amend our proposals.**
- Feedback received will inform and influence our future decision-making, the next steps of the programme and how plans will be implemented.
- Following consultation and depending on the responses we expect the ICB Board on behalf of the Integrated Care System, alongside specialised commissioning who commission neonatal services and some specialist surgery for children, after consideration of the consultation outcome. to make a decision on the proposals to implement by the end of 2024 or early 2025.