North Central London Integrated Care System

NCL Start Well programme

Context and objectives

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- Today's session is an opportunity to brief you on the proposals that have been developed as part of the Start Well Programme. This Programme of work was initiated in 2021 to ensure maternity, neonatal, children and young people's 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.
- This is a long programme of work, and no decision has been made on the changes. The ICB Board agreed at its meeting on Tuesday 5 December 2023 to initiate a 14-week consultation period, from 11 December 2023 until 17 March 2024. A decision on the proposals is not expected to be made until Autumn/Winter 2024/25.
- The programme has developed a set of proposals to improve maternity and neonatal and children's surgical services in NCL. The purpose of the briefing today is to:
  - Provide some context on the programme, outline the rationale for change and how the options have been developed
  - Describe the options being put forward for public consultation
  - Outline the potential impact these proposals may have on different populations, including Haringey
  - Capture your views and feedback on the approach to consultation and how best to engage with the populations in Haringey who may be potentially impacted
- The link to the consultation website where you can find more information and details about the programme is: nclhealthandcare.org.uk/start-well

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Background and context

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

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

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

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

How maternity and neonatal care is currently organised in North Central London

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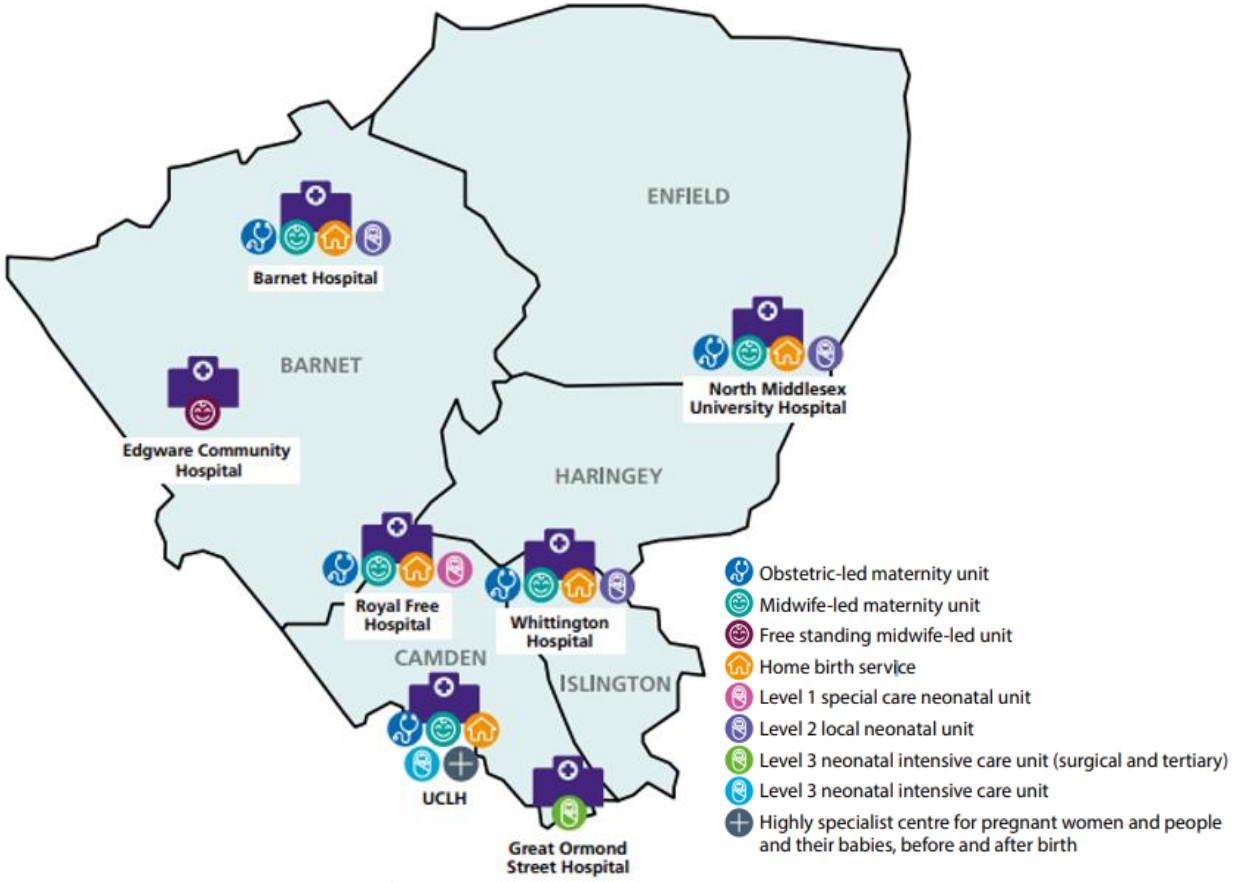

In our five boroughs we have **five maternity and neonatal units** and a **standalone midwifery led birth centre**:

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

Pregnant women and people can access maternity care at their unit of choice. This means people who live within Barnet, Camden, Haringey, Enfield or Islington may choose a hospital outside of these area and those who live outside the NCL boroughs can access maternity care at a hospital within NCL

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. These risks are actively mitigated by excellent staff and clinical processes; however, this does create increased pressure on staff to safely deliver the service

Maternity CQC re-inspections 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

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 mean fewer staff needing to move to a new location
- option B would mean some people would need to go to hospitals in North East London that would struggle to have capacity for this because of rising birth rates in some parts of North East London
- while option A would mean some people would need to go to hospitals in North West London, those hospitals have confirmed they have capacity for this as the number of births in North West London is falling

Future flows have been projected for each option, using an approach which considers choice

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Note: LSOA is a Lower Super Output Area and is the smallest granularity of geography that is used for travel time analysis. Typically, there are 1,000-2,000 residents within an LSOA.

Approach	Description
1 **For each LSOA identify the closest hospital for the catchment population**	• The catchment population for the patient flow analysis has been defined as all LSOAs in NCL where there was activity in the 2021/22 baseline year and any LSOAs for whom an NCL site is the closest hospital, this includes any populations living in neighbouring boroughs. • The neighbouring ICSs have been defined as all London ICSs plus Hertfordshire and West Essex ICS • The closest hospital is found using the Travel Time API (Google), calculating the travel time in minutes at peak time
2 **Calculate the number of deliveries at each in scope hospital in 21/22 by LSOA**	• The volume of activity at each of the in-scope hospitals has been calculated for each of the LSOAs in the catchment population • The hospitals that are in scope of this work are all acute NCL hospitals and the following neighbouring units: St Mary's, Chelsea and Westminster, Northwick Park, Homerton, Whipps Cross, Royal London, Princess Alexandra, Watford General, Newham, Luton and Lister Hospitals
3 **Understand in each LSOA the number of people giving birth at their closest unit or choosing to give birth elsewhere**	• It is modelled that **everyone in an LSOA flows to their nearest unit by travel time (car/driving at peak times)**. If this unit is modelled as closed, then the population will be modelled as flowing to the next nearest. • However, if over 80% of people in any LSOA are currently choosing to go to a unit further away than their nearest by travel time, then everyone in that LSOA is modelled to travel further to the unit of choice. • In each option, when a unit closes, everyone who was modelled to go to that unit is then modelled to **go to their nearest hospital instead**

We identified the people who may be impacted by the proposals

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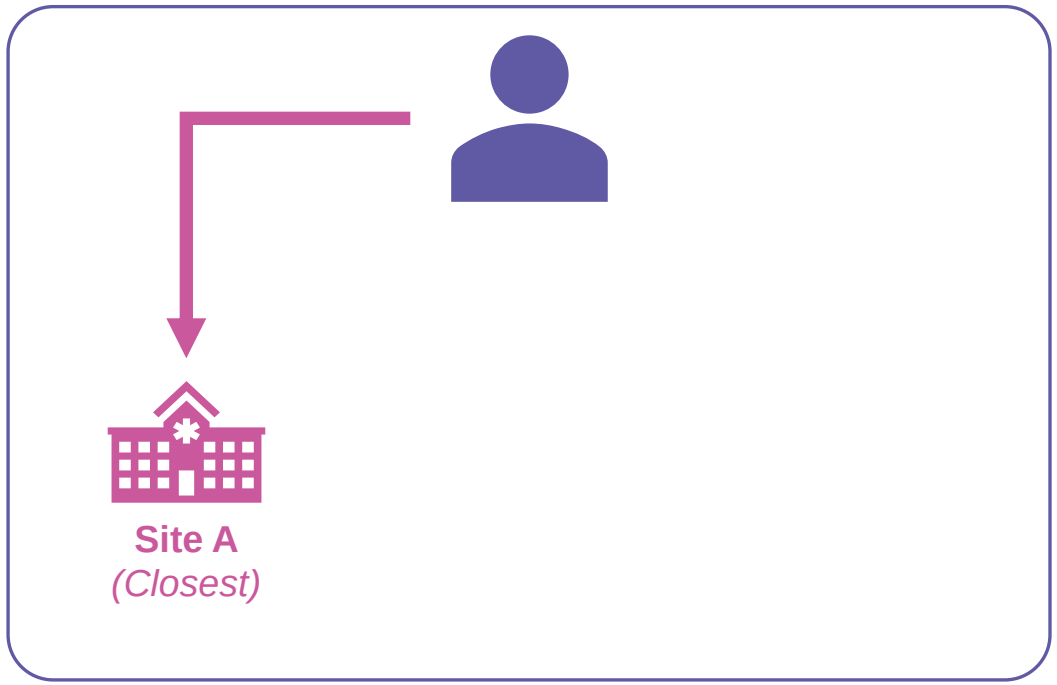
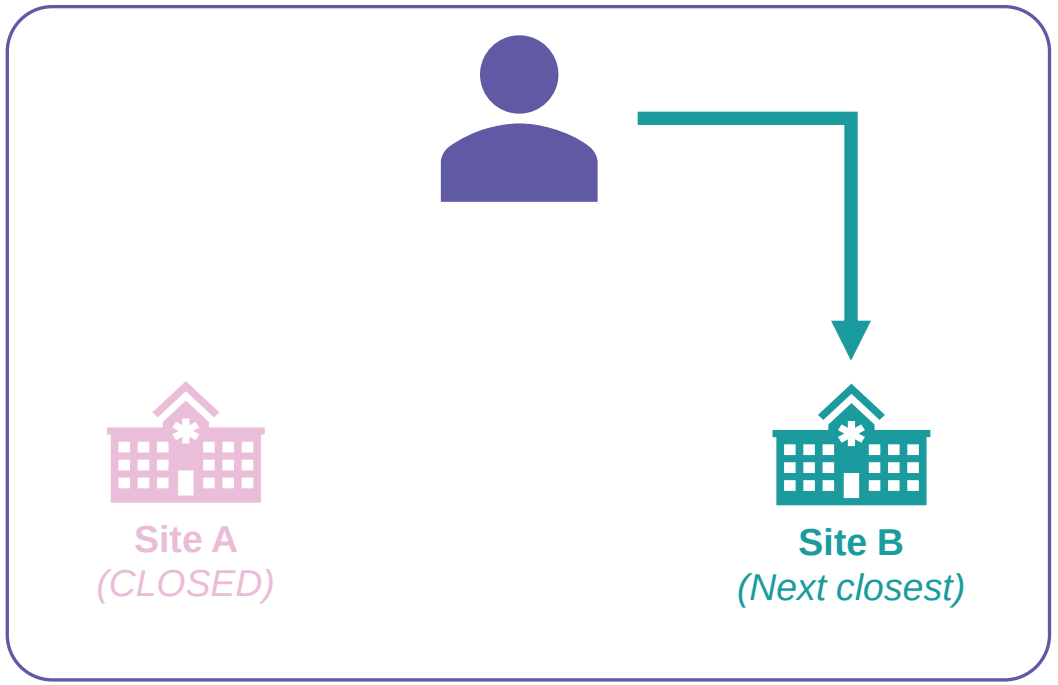
- We looked at where people currently live and identified geographies whose closest hospital is Royal Free (option A) or Whittington (option B)
- For the impacted populations we looked at what the next closest hospital would be and projected the activity to the next nearest unit. All activity in that LSOA is flowed to this hospital.
- This modelling is based on historic activity and a set of assumptions and therefore is indicative. Whilst the modelling approach has factored in choice there may be individuals within the impacted LSOAs who choose a hospital that is further away than the closest.

Currently: where people go now (the closest)



Future: Predicted flow if maternity unit at Site A closed



The proposals in option A would result in 2,560 deliveries being being moved to another unit

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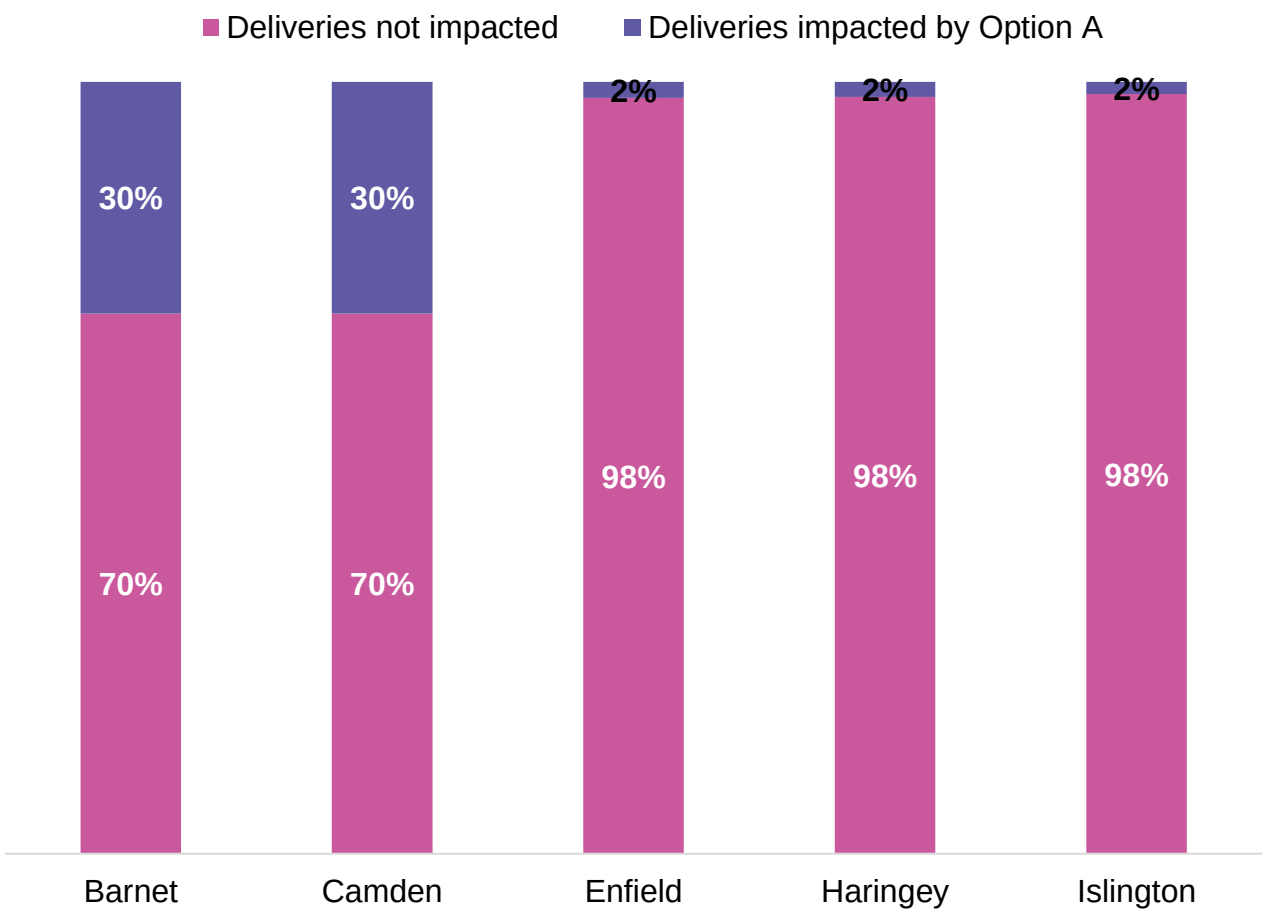
- Based on future activity modelling, in option A, 2,560 deliveries are would be moved from the Royal Free Hospital to another unit. This includes units that may be outside of NCL.
- Of the 2,560, 73% (1,860) are NCL residents and the remaining 27% (700) are non-NCL residents.
- Of the NCL residents impacted:
  - 1,211 live in Barnet
  - 475 live in Camden
  - 77 live in Enfield
  - 61 live in Haringey
  - 36 live in Islington
- The proportion of total deliveries impacted by NCL borough is set out in the graph to the right

Proportion of activity which may being impacted by borough



In Option A 98% of activity for Haringey would remain at the same hospital

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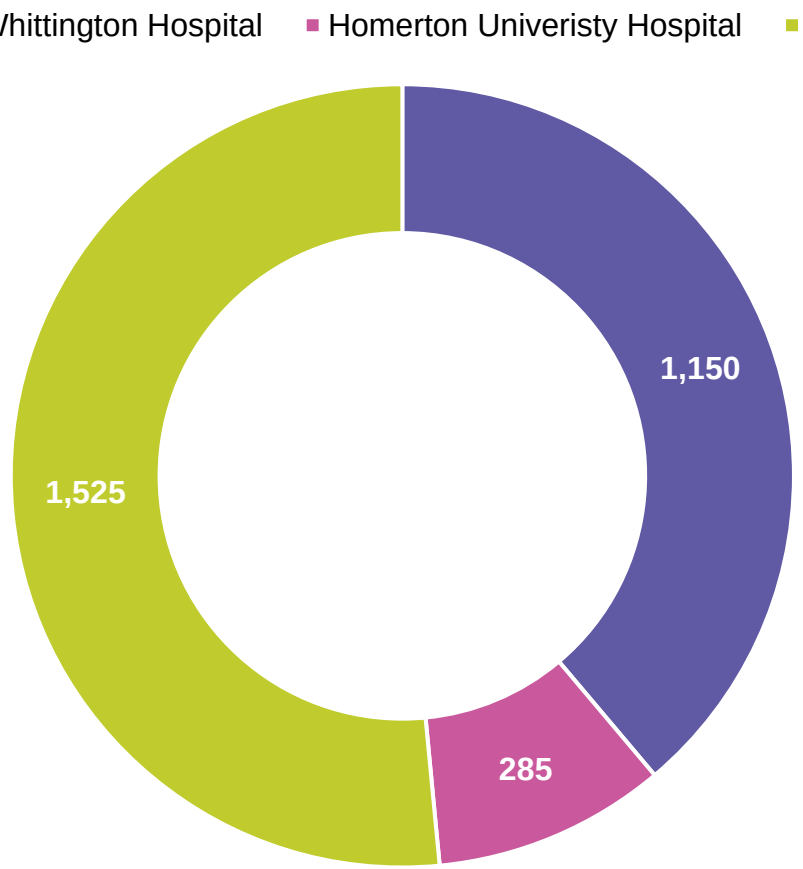
- Based on future activity modelling, in option A, 98% of deliveries for individuals who live in Enfield, would remain at the same unit. This includes individuals who live in Haringey but are actively choosing to deliver at a unit further away than the closest.
- 2% of individuals would be required to deliver at a different unit if the Royal Free Hospital was modelled as closed (61 deliveries in total)
- The impacted individuals have been projected to flow to the closest hospital by car/driving which would be either:
  - Whittington Hospital (+26 deliveries)
  - North Mid (+34 deliveries)
  - Homerton University Hospital (+1 delivery)
- The graph to the right highlights in option A where **all deliveries** for individuals who live in Haringey would be. This includes deliveries where the unit would not change.

Option A: Projected deliveries by site for all Haringey borough residents



The proposals in option B would result in 3,391 deliveries being being moved to another unit

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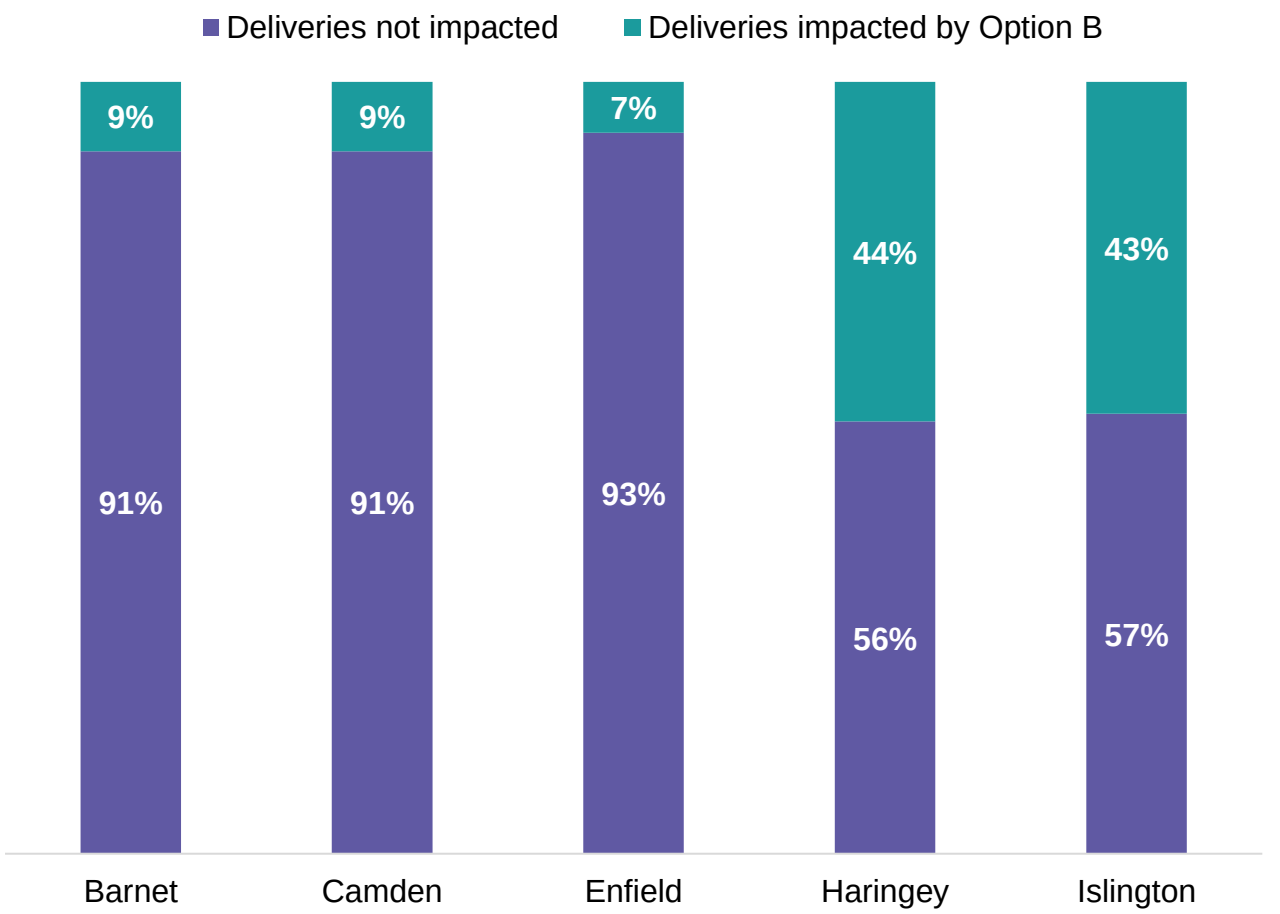
- Based on future activity modelling, in option B, 3,391 deliveries would be moved from the Whittington Hospital to another unit. This includes units that may be outside of NCL.
- Of the 3,391, 88% (2,978) are NCL residents and the remaining 11% (413) are non-NCL residents.
- Of the NCL residents impacted:
  - 360 live in Barnet
  - 151 live in Camden
  - 230 live in Enfield
  - 1,294 live in Haringey
  - 943 live in Islington
- The proportion of total deliveries impacted by borough is set out in the graph to the right

Proportion of activity which may being impacted by borough



In Option B 56% of activity for Haringey would remain at the same hospital

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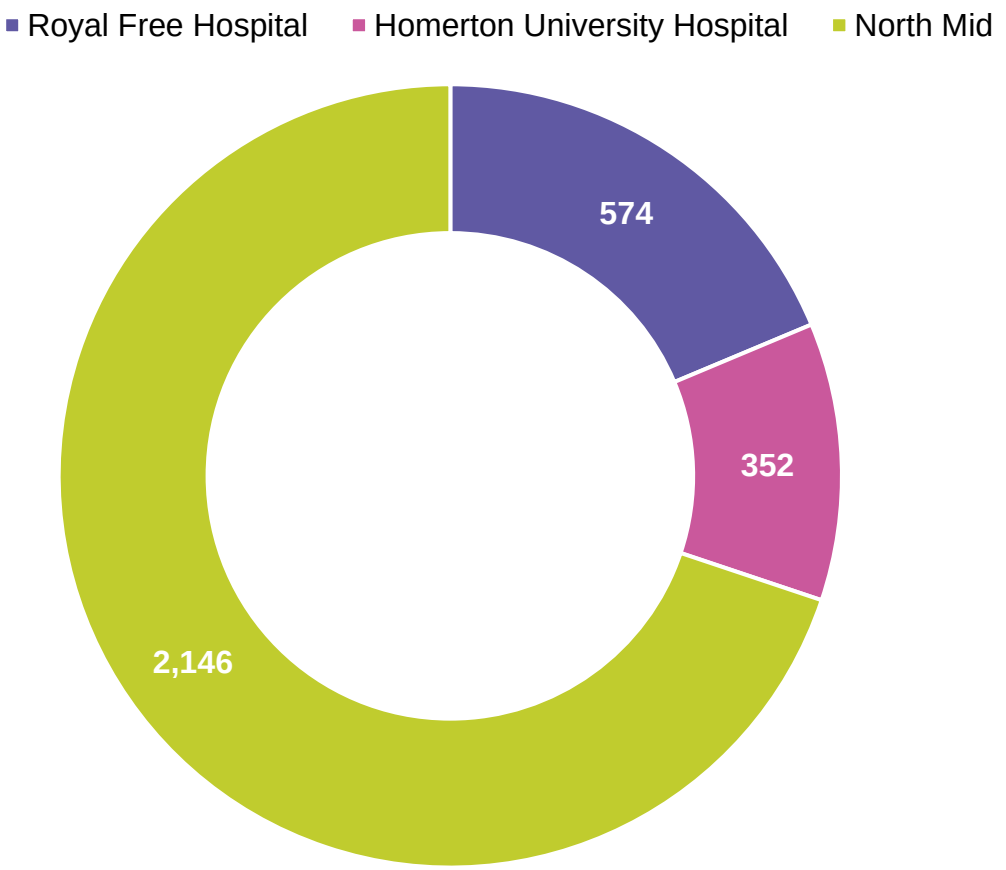
- Based on future activity modelling, in option B, 56% of deliveries for individuals who live in Haringey, would remain at the same unit. This includes individuals who live in Haringey but are actively choosing to deliver at a unit further away than the closest.
- 44% of individuals would be required to deliver at a different unit if the Whittington Hospital was modelled as closed (1,294 total deliveries).
- The impacted individuals have been projected to flow to the closest hospital by car/driving which would be either:
  - Royal Free Hospital (+411 deliveries)
  - North Mid (+794 deliveries)
  - Homerton University Hospital (+89 deliveries)
- The graph to the right highlights in option B where **all deliveries** for individuals who live in Haringey would be. This includes deliveries where the unit would not change.

Option B: Projected deliveries by site for all Haringey borough residents



Two specific geographical areas were identified as being more vulnerable to the impact of our proposals

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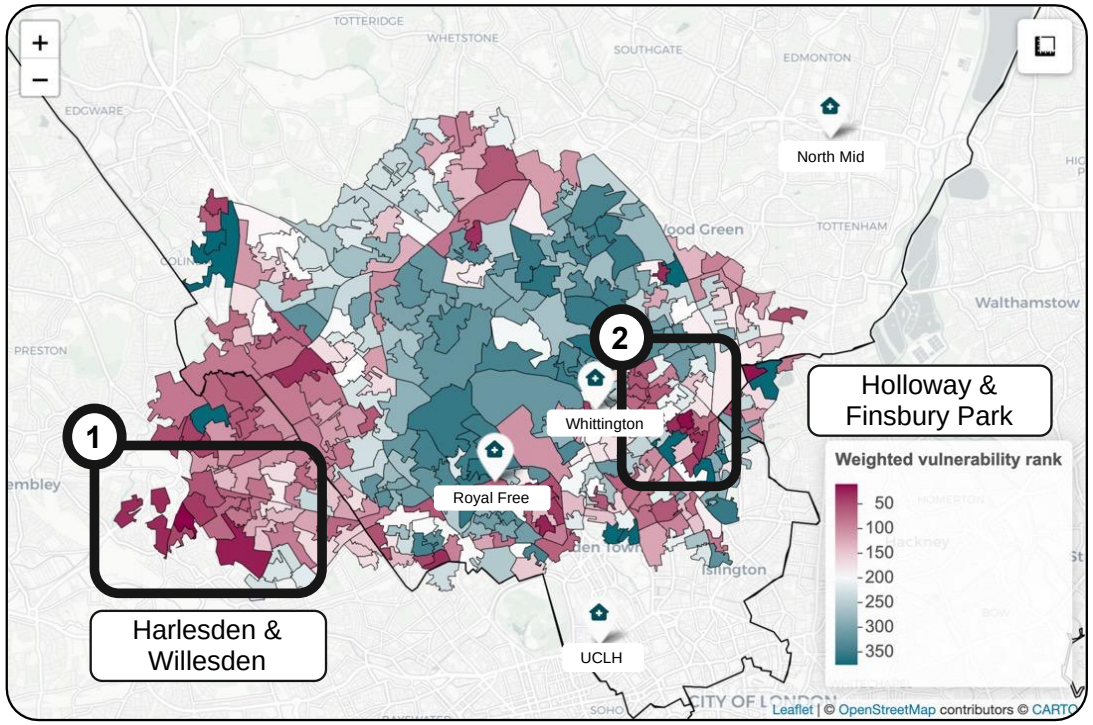

Weightings were used to ranks all LSOAs from highest to lowest against a range of metrics including ethnic minorities, deprivation and poor health outcomes where 1 = worst, 400 = best. A weighted average was then developed for each LSOA and used to identify populations who may be more vulnerable to the impact of our proposals

- **Two geographical areas** were identified as having residents who may be more vulnerable to the impact of our proposals because they face barriers to accessing services due to living in areas of deprivation and having high levels of poor general health
- As a result of the proposals, people in **Harlesden and Willesden** (option A), and **Holloway and Finsbury** (option B) may need additional support to:
  - **Access the hospital site** if they are disabled/in poor health or are not proficient in English
  - **Travel to hospital by taxi**, if required, as it will cost an additional £4-£5 per journey
  - **Access services online** as they may have lower digital proficiency
  - **Care for other family members** as they may be a lone parent
- **Black African and Black Caribbean** populations are concentrated in these geographies and have poorer maternity outcomes
- Harlesden has a large proportion of **Bangladeshi and Pakistani** populations, who are more likely to have worse maternal health outcomes

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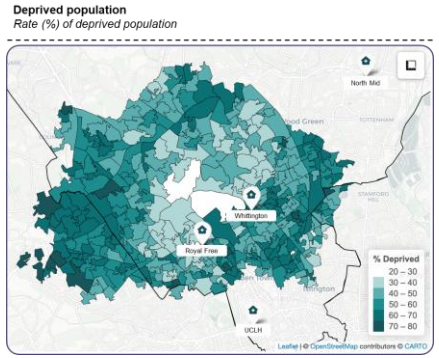
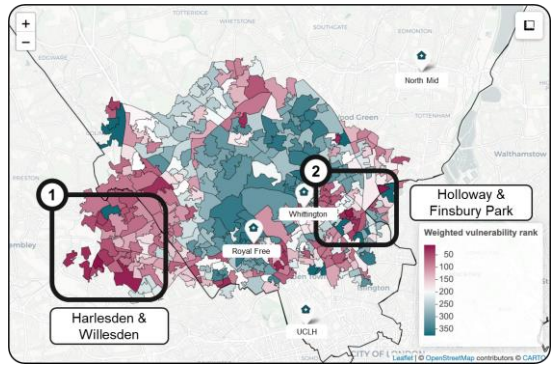
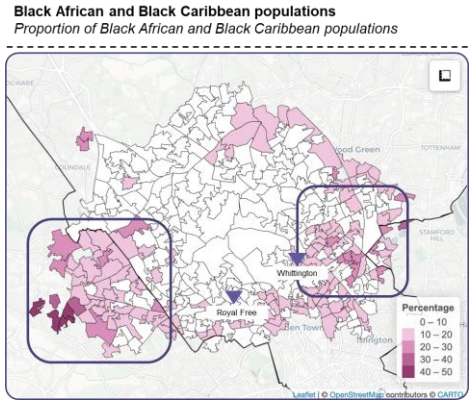
Women and people who live in deprived areas: there is a link between people living in deprivation and adverse outcomes from maternity and neonatal care. People living in these areas may be particularly impacted by increased taxi costs if either option A or B were to be implemented.



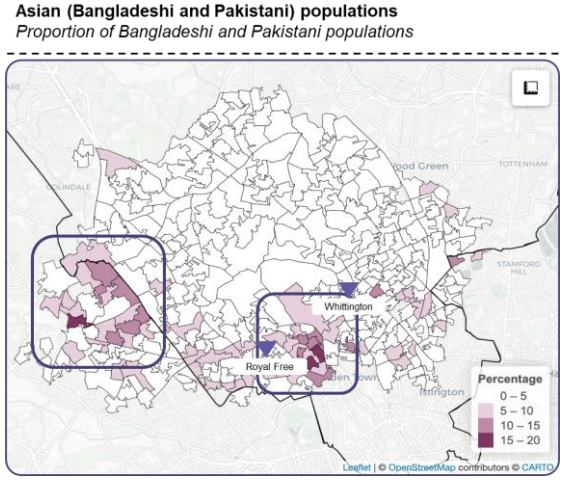
People living in geographic areas who may have vulnerabilities: we identified two neighbouring areas with a higher concentration of people who may be vulnerable to service changes. **Harlesden and Willesden** would be more impacted by option A and **Holloway and Finsbury Park** would be more impacted 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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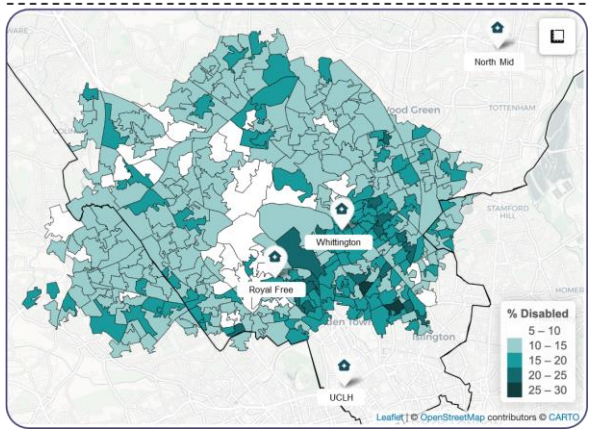
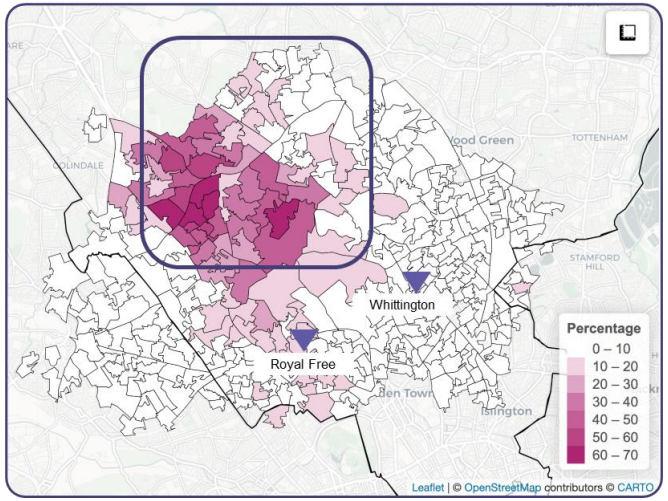
Women and people of childbearing age with disabilities (including learning disabilities): people with disabilities may be more impacted by proposed changes due to challenges navigating to an unfamiliar hospital site, taxi costs due to lower car ownership and the physical accessibility of hospital sites.

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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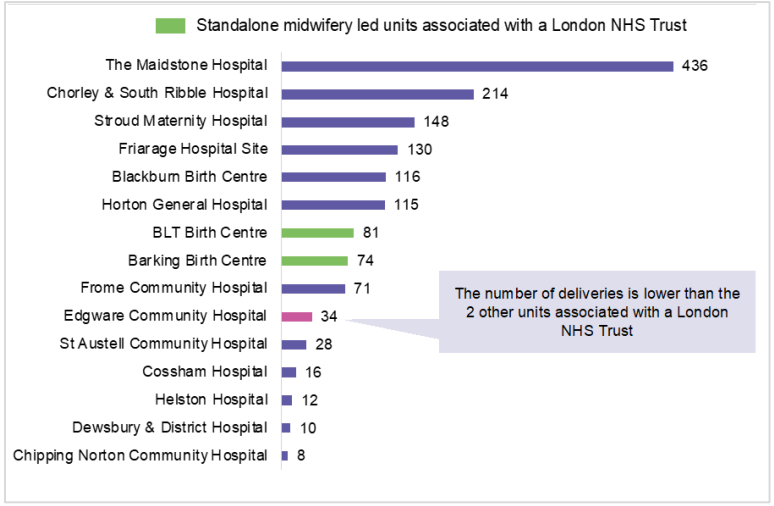
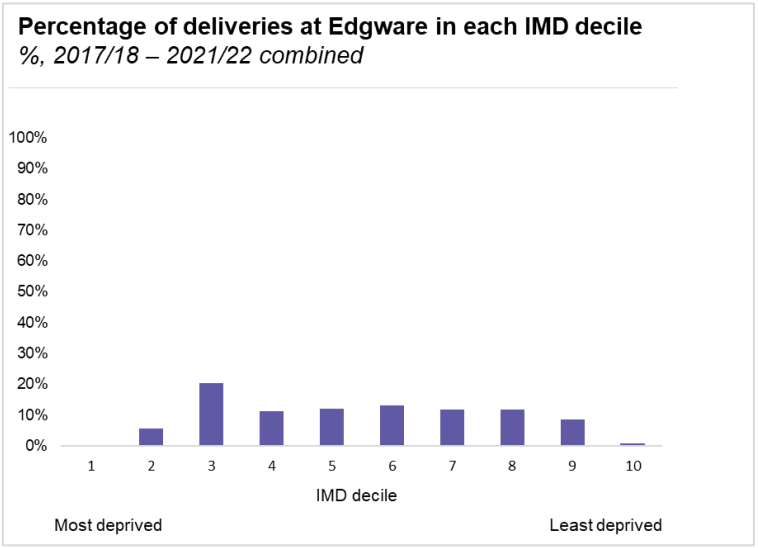
Case for change for Edgware Birth Centre

- 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.

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Surgery for babies and children

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

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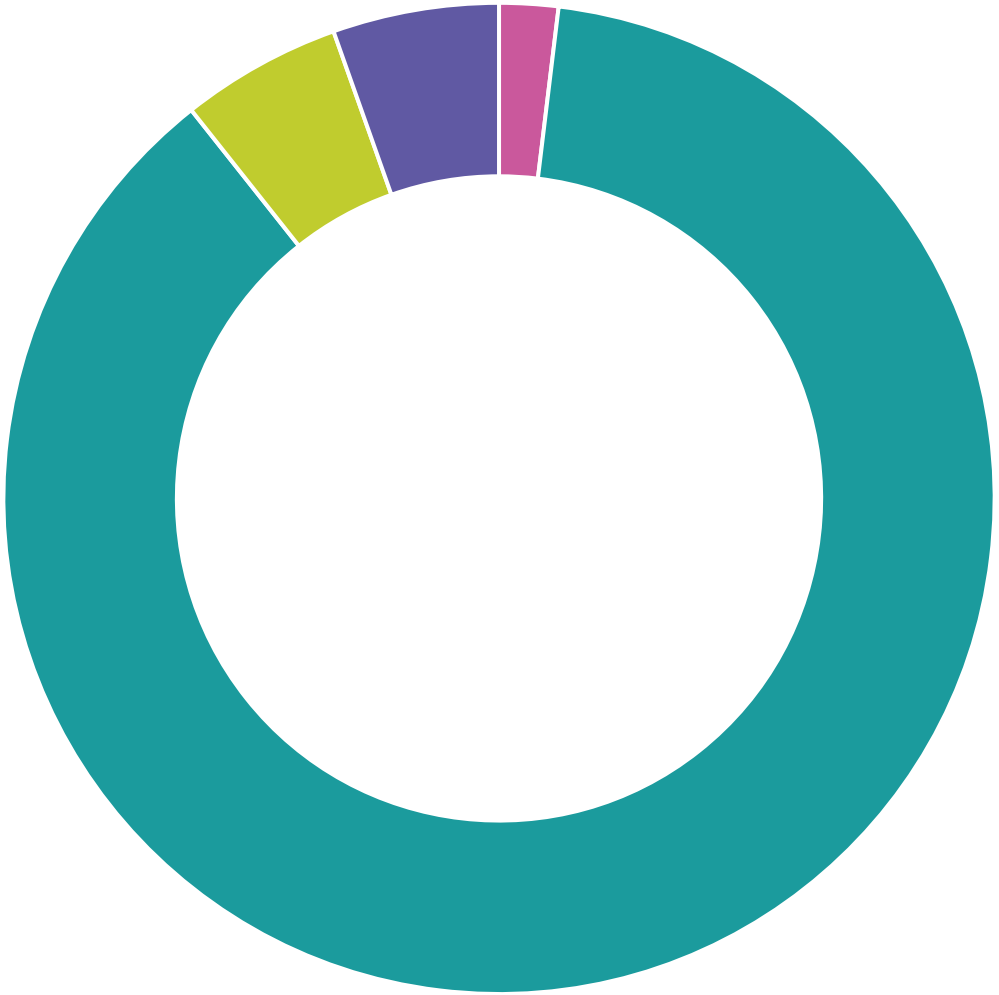
Centre of Expertise: Daycase – c.300 children
Bringing together planned daycase activity

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.

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The 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

- 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

14-week public consultation from mid-December 2023

North Central London Integrated Care System

Approval given to commence a 14-week consultation to gather views from service users, stakeholders, residents and staff, running from **11 December – 17 March 2024.**

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 consultation is being jointly run by NCL Integrated Care Board, on behalf of the Integrated Care System and its partner organisations, and NHS England as the commissioner of some specialised neonatal and surgical services.

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 victimisation
  - 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

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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

Consultation materials and promotion

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Consultation materials

We have developed materials that explain the proposals and rationale in a clear and accessible way.

Information is available on our website and in hard copy, with an easy read, different formats and translated versions

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

This includes 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

We are asking for each of these elements:

- To what extent do you agree/disagree with our proposals
- What are the main disadvantages and how could we address these?
- Are there any other solutions or information we should consider?

We will promote and encourage participation in the consultation in several 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 materials

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.

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.

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

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Our approach does the following:

- Builds on previous engagement contacts, over 300 VCSE organisations will be contacted to take part in the consultation
- Work with partners, including councils and VCSE organisations, ICBs in neighbouring areas
- Prioritising groups identified by the interim IIA or with protected characteristics or at greater risk of health inequality
- Targeted engagement in geographical areas where there may be particular impact drawn out in the interim IIA, including areas outside of North Central London
- Identify the best ways of reaching and engaging priority groups i.e. through third parties and trusted partners
- Ensure we develop a range of opportunities for stakeholders to respond to the consultation
- Arrange any events and meetings in accessible venues and offer interpreters, translators and hearing loops where required
- Make sure there is equality monitoring of participants to ensure the views received reflect the local population

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 Park
- 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

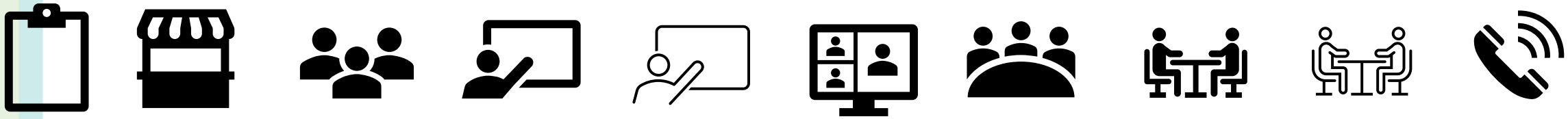
We will tailor our engagement techniques during the consultation period

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 and those identified by the IIA as potentially being more impacted** to understand their views and impact of the options in a meaningful way

North Central London Integrated Care System

Next steps

Next Steps

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Consultation input	• We would welcome your support and suggestions in terms of who we should reach out to and are very happy to come along to meetings and events • Please share the opportunity to take part in the consultation with your networks
Evaluating responses to the consultation	• We are working with an independent partner to evaluate consultation responses. • We will continue assess our approach and review demographic information on responses to date. • 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.
After consultation	• Feedback will inform future decision-making, the next steps and how plans would be implemented. • Following consultation, we expect NCL ICB Board, on behalf of NCL Integrated Care System and alongside NHS England who commission neonatal and specialist surgical services for children, after consideration of the consultation outcome, to make a decision by the end of 2024 or early 2025.