NHS

North Central London Start Well programme: Decision Making Business Case- Maternity and neonatal services proposals

March 2025

North Central London Health and Care
Integrated Care System

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1. Foreword

North Central London Health Integrated Care Board is committed to understanding our local population to improve health outcomes and reduce inequalities. Our Population Health and Integrated Care Strategy has at its heart, an ambition to improve outcomes for residents of all ages in North Central London, in their local neighbourhoods, so they can have the best start in life, live more years in good physical and mental health, and ensuring a dignified death.

The Start Well programme is part of a bold vision to deliver this strategy. We know that pregnancy and birth are the foundations of a good start in life. Starting well in life reduces the chances of facing inequalities. As strategic commissioners for NCL, we want to ensure our maternity and neonatal services are the best they can be to support families through pregnancy and birth. It is important that pregnant women and people have a positive birth experience and ensure that everyone has access to the services they need no matter where they live or choose to deliver.

Through the Start Well programme we have worked together as a health and care system to identify the challenges we face in our maternity and neonatal services. Our local population is changing – the number of births in our five boroughs is declining and yet the proportion of babies being born with increasingly complex needs is rising. As they are currently set up, our services do not meet the long-term needs and best practice standards for pregnant women and people, and their babies.

The development of these proposals has been clinically led and informed by our understanding of our local population and the current experiences of pregnant women, people and their families. The proposed changes seek to fundamentally improve access, experience and quality of care – addressing the opportunities for improvement we identified in the case for change and improving services to the benefit of all NCL residents. Our work shows that by introducing a new care model and reducing the number of maternity and neonatal units, we can create a more resilient workforce with the right environment and infrastructure to deliver better quality care, outcomes, and experiences for patients.

The Start Well programme has been richly informed by the experiences of both service users and staff in North Central London. We undertook a formal public consultation over 14 weeks in late 2023 and early 2024 and have spent almost a year carefully considering and responding to the feedback from that consultation. We understand how vital these services are to our residents, which is why we have spent time carefully considering the feedback we received.

We would like to express our gratitude to everyone who has taken the time to get involved in this process, including members of the public who participated in the consultation and staff who have supported the programme in developing an optimal care model. We believe that we have identified the best option to deliver our new best practice care model that realises the opportunities to improve maternity and neonatal care across NCL for all our residents. If the changes are agreed, we know that implementing these proposals will take several years and will continue to approach this phase with same spirit that the programme has worked to date: in collaboration with staff and service users with a focus on clinical quality and improving outcomes.

Frances O'Callaghan
CEO, North Central London Integrated Care Board

Specialised commissioning

We are pleased to be jointly presenting the proposals outlined in this decision-making business case. The work that has gone into considering the best possible solutions to address the case for change in NCL has been robust and the proposals recognise the complex interconnectivity between services across the capital. NHS England's London Region team, as the current commissioner of neonatal services, fully supports the proposals put forward, and would continue to work with NCL through the next steps of this important programme of work.

Will Huxter
Regional Director of Commissioning
NHS England- London Region

Karen Bonner
Regional Chief Nurse
NHS England- London Region

Trust Chief Executives

The Start Well Programme has been driven by a commitment to reduce inequality and improve the outcomes, quality, and experience for pregnant women and people, babies and their families. The current set up of maternity and neonatal services will not meet the needs of pregnant women and people and their babies in the long term.

Although there is always more to do, we know that staff work incredibly hard, providing high quality care. Yet, the current infrastructure isn't set up to best support them to do so.

We believe that the case for change in maternity and neonatal services is compelling and represents a bold and collective call to action in a way that meets the needs of our population now and in the future. The proposals presented within this document are guided by best practice and they represent an opportunity to improve access to care, experience and importantly outcomes. There has been significant clinical input into this programme and careful consideration of a range of clinical views.

The consideration of such potentially significant changes to our services is something we have thought about long and hard. It has taken over three years to come to these recommendations, and the options have been developed following a thorough options appraisal process and formal public consultation, carefully listening to the views of staff and service users as part of the process.

We recognise that this is a difficult decision to make. These services are highly valued by local communities and no change is without impact. However, current arrangements cannot continue as they are and we believe that through these changes in the long term, we can improve outcomes and experience for all pregnant women and people, and their babies. We recognise that the outlined proposal will impact staff and together we are committed to supporting staff regardless of the outcome of the decision.

The NCL People Plan sets out how the ICS will together work to respond to national workforce challenges. Start Well is a way in which we could support our maternity and neonatal staff to work in an environment where they could provide the best possible care, where they are supported to develop and learn and have the resources they need to do their jobs. We believe that the proposals set out in this decision-making business case would, if implemented, enable our maternity and neonatal services to do this, as well as meeting the changing needs of our population into the future.

Peter Landstrom
Group Chief Executive
Royal Free London NHS Foundation Trust

David Probert
Chief Executive
University College London Hospitals NHS Foundation Trust

Dr Clare Dollery
Acting Chief Executive
Whittington Health NHS Trust

2. Executive summary

2.1 Introduction and context

North Central London (NCL) Integrated Care System (ICS), has developed a decision-making business case (DMBC) for the Start Well Programme for maternity and neonatal services, in partnership with NHSE Specialised Commissioning (the current commissioner of specialised maternity and neonatal services[1]).

The Start Well Programme is a collaborative piece of work that has meaningfully engaged partner organisations and clinical leaders from across NCL and neighbouring ICSs and providers. Throughout, the programme has maintained a population health approach, in line with the principles set out in our Population Health and Integrated Care Strategy. We have brought together a range of stakeholders and system partners to help understand the opportunities for improvement in maternity and neonatal care in NCL and to develop an approach to addressing these.

We published a case for change in summer 2022 which set out the opportunities for improvement, developed a care model for maternity and neonatal services and undertook an options appraisals process to evaluate the different options for the location of maternity and neonatal services in NCL. We published a pre-consultation business case (PCBC) in December 2023 and consulted the public on the proposals over a 14-week period from 11 December 2023 – 17 March 2024. We have developed this DMBC following careful consideration of the responses to our consultation and have identified a recommended option for implementation.

In NCL, maternity care and neonatal care is currently provided on five secondary care hospital sites (Barnet Hospital, North Middlesex University Hospital (North Mid), Royal Free Hospital, University College London Hospital (UCLH) and Whittington Hospital). Great Ormond Street Hospital (GOSH) provides neonatal care as a specialist provider and is outside the scope of this DMBC. Separate proposals for the standalone midwife-led birth centre (Edgware Birth Centre) located at the Edgware Community Hospital are also included as an addendum to this DMBC.

2.2 Case for change

We have identified a number of opportunities for improvement for maternity and neonatal services in NCL. We want all pregnant women and people to be able to access the right care in the right place at the right time and we know that the way services are currently organised does not deliver this vision.

- **Ensuring that maternity and neonatal services are, and continue to be, high-quality**:
  - **Ensuring equality in maternity service provision and experience:** currently there is variation in maternal outcomes across NCL and there is also some variation in the quality of maternity services provided and access. This means that not all pregnant women and people have the same outcomes, access and experience of services.
  - **Minimising avoidable admissions to neonatal units:** access to neonatal outreach programmes depends on where people live in NCL. The existing provision is inconsistent between our boroughs and does not represent equitable access. For example, in Islington,

[1] NHSE London Region Specialised Commissioning are delegating responsibility for the commissioning of relevant services to NCL ICB on 1 April 2025 - excludes open fetal surgery to treat fetuses with open spina bifida, drugs and devices.

phototherapy (used for the treatment of jaundice) is available in the community, whereas for babies living elsewhere in NCL, they would likely have to stay in hospital for treatment.

- **Ensuring that services are sustainable for the future, meeting population needs and providing an environment for staff to maintain their skills:**
  - **Addressing low and declining use of the Royal Free Hospital Special Care Unit (SCU) (level 1) unit:** Royal Free Hospital neonatal unit looks after fewer babies than the other units in NCL and does not accept babies born under 34 weeks' gestation. The number of admissions into this unit has been declining by 4% every year since 2018/19 (alongside reductions at some of our other units) and the occupancy of the unit in 2023/24 was 51%, meaning around half of its cots were not occupied on any given day. The current activity volumes at the SCU (level 1) unit do not meet the recommended standards set out by the British Association of Perinatal Medicine (BAPM). With a declining birth rate across NCL, there is a long-term sustainability challenge at the SCU (level 1) to ensure that staff working at the unit are able to maintain their skills and competencies.
  - **Reducing the under-utilisation of midwife-led units in NCL:** midwife-led units in NCL are not utilised in an equal way, with many pregnant women and people either choosing to deliver, or being recommended to deliver, in an obstetric-led setting. Data shows that for some sites in NCL, the utilisation of their alongside midwifery-led units was under 30% in 2021/22, whilst obstetric-led units were dealing with significant pressures. The number of vacancies at units also means that sometimes midwife-led units must temporarily close.
- **Ensuring that we have sufficient well-trained staff to deliver services:**
  - **Reducing challenges in recruiting midwives and neonatal nurses:** across our maternity sites in NCL there are challenges in recruiting and retaining maternity staff. There are currently high levels of staff vacancies in neonatal nursing, with a vacancy rate of 8% across NCL. The number of vacancies at units means that units cannot always open all their cot spaces, and some babies are having to be moved to neonatal cots outside of NCL.
  - **Addressing workforce vacancies and variation in access to allied health professionals (AHPs) across neonatal units:** there is a need to increase AHP provision across all NCL units. AHP staffing (dietetics, physiotherapists, occupational therapists and speech and language therapists) has been compared with the recommended professional body levels set out by BAPM and NCL is consistently under these recommended levels for all disciplines.
  - **Having the right maternity and neonatal estate to provide a positive patient experience:** hospital facilities should provide privacy, preferably labour rooms with ensuite bathrooms and space for the birth partner to join delivery when possible. Currently, the maternity and neonatal estate at Whittington Hospital does not meet modern standards for maternity and neonatal facilities. There is an estimated £12.4m in backlog maintenance at Whittington Hospital to maintain the existing estate, IT and equipment over a 30 year time period.

2.3 Care model

Our vision is to deliver best practice care that meets national quality guidance and an improved experience for those who use and work in our services. The design of the maternity and neonatal care model has been clinically led, drawing on national best practice and the latest clinical

guidance[2,3,4]. The care model addresses the opportunities for improvement outlined in the case for change and aims to improve the clinical outcomes, quality of care, access to services, and experience for service users and staff.

Our vision is to offer personalised care in the right setting, in modern, high-quality facilities. Evidence shows that key to delivering good outcomes and maintaining staff skills and competencies are neonatal units that see enough babies[5]. To achieve this, all our neonatal units in NCL would be an LNU (level 2) or NICU (level 3). These units would have 24/7 access to specialists who regularly treat and care for unwell babies. All units would be staffed with AHPs and neonatal nursing and medical staff, in line with recommended guidance, ensuring we are using our scarce workforce skills as efficiently and equitably as possible, and reducing the need to transfer babies between units or outside NCL. To facilitate babies being treated closer to home, community neonatal services would be available across all the boroughs in NCL.

The neonatal units would be co-located with an alongside midwife-led unit and obstetric-led unit, and home birth would continue to be offered in all boroughs. Pregnant women and people would continue to have the choice to deliver in a midwifery-led setting, a consultant-led setting or a home setting. For midwifery-led units, the environment would promote a non-medicalised birthing experience, including providing privacy and promoting a positive birthing experience within a relaxed environment that feels more like home.

2.4 Assurance prior to public consultation

We have undertaken a robust quality assurance process which underpins the programme and gives assurance to this DMBC. Prior to public consultation, the proposals were assured by:

- **NHS England London Regional Office:** assured the proposals against the government's four tests and NHSE test for proposed bed closures (where appropriate)[6], and for overall affordability
- **London Clinical Senate:** reviewed the case for change and the clinical model and provided recommendations that were addressed. Our response to these recommendations was included in the pre consultation business case (PCBC) and in this DMBC, where relevant.
- **London Mayor's office:** assessed our work against four of the Mayor's six tests[7]**.** Assessment against the final two tests has been undertaken as part of the DMBC assurance process.
- **Joint Health Overview and Scrutiny Committee (JHOSC):** reviewed the proposals for maternity and neonatal services and endorsed the plans for consultation and provided feedback on the consultation proposals that has been considered as part of the development of this DMBC

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[2] https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk

[3] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf

[5] https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf

[6] The five tests are 1. The proposed change can demonstrate strong public and patient engagement 2. The proposed change is consistent with current and prospective need for patient choice 3. The proposed change is underpinned by a clear, clinical evidence base 4. The proposed change to service is owned and led by the commissioners 5.the fifth test is only relates to proposals that include a significant reduction in bed numbers, which is not applicable

[7] The six assurance tests are 1. Health and Healthcare inequalities 2. Hospital beds 3. Financial investment and savings 4. Social care impact 5. Clinical support 6. Patient and public engagement

2.5 Consultation engagement and themes

We consulted on our proposals over a 14-week period (from 11 December 2023 to 17 March 2024). The consultation was preceded by extensive stakeholder engagement in the development of the PCBC, from the start of the programme in 2021.

We designed a detailed programme of consultation activities to provide information, reach out to local community and listen to the views of the local population and wider stakeholders. Our consultation activities were extensive and supported by the Start Well Programme team and, in some cases, voluntary organisations and specialist engagement organisations to support targeted engagement activities for specific groups.

As a result of our consultation activities, we had 3,112 questionnaire responses, of which:

- 2,031 came from members of the public
- 1,060 came from NHS staff
- 21 came from organisations

We also had 80 written submissions, of which 32 came from members of the public and 47 from NHS staff, stakeholder organisations and officials. We appointed an independent organisation to evaluate and write up the feedback gathered during consultation. An interim report was published on 17 July 2024 and a full evaluation report was published on 6 November 2024.

Across all engagement activities, a substantial majority of people agreed that changes are needed to address current challenges facing services, with 67% of questionnaire respondents either strongly agreeing or tending to agree. There was overall agreement with the proposal that all neonatal units in NCL should offer the same minimum level of neonatal care (i.e. at least level 2). There was less support for consolidating maternity and neonatal services from five to four sites. There were concerns raised around:

- Consolidation increasing service pressures, disruption of effective working relationships, and issues with capacity, staffing, and quality of care
- Longer travel times, unreliable public transport, congestion, and increased travel costs.

Those near all hospitals except the Royal Free Hospital supported option A (keeping provision at Whittington Hospital). Feedback included:

- Option A seen as the least disruptive option due to the quality and nature of services already provided; the established multi-disciplinary team/effective use of allied healthcare professionals (AHPs); that Whittington Hospital already has an LNU (level 2) and managing more births than Royal Free Hospital (including concern as to feasibility of uplifting Royal Free Hospital to a level 2 neonatal unit)
- The importance of co-location with other teams/services e.g., paediatrics, haemoglobinopathy, sickle cell, female genital mutilation team
- Strong existing links with community resources and UCLH, including maternity pathways, which would be lost under option B
- Serves a wide area with people living in areas of deprivation, with poorer birth outcomes, and younger populations (e.g., North Islington, Haringey)

Those respondents living closest to the Royal Free Hospital favoured continuing services there (option B). Feedback from these respondents included:

- Strong feedback (particularly from staff at the Royal Free Hospital) relating to services currently provided at the site relating to maternal medicine pathways and the importance of specialties that are already on-site to support high-risk pregnancies/births and manage perinatal emergencies (including haematology, renal services, HIV unit, fetal medicine, interventional radiology, surgical expertise, transplantation and rare diseases)

- There is joined up working between Royal Free Hospital and Barnet Hospital, with consistent policies between the two sites
- Royal Free Hospital was occasionally said to have better quality buildings than Whittington Hospital
- It is the hospital of choice, and caters for the specific needs, of the local Orthodox Jewish community

The above feedback, and more detailed consultation themes, were considered as part of the development of this DMBC.

2.6 Decision making

We are proposing two changes as part of our proposals: 1) implementation of a new model of care relating to the organisation of hospital-based maternity and neonatal services in NCL, and 2) the closure of the birthing suites at Edgware Birth Centre. This DMBC focuses on the options appraisal process for the proposed changes to hospital-based maternity and neonatal services. The proposals for Edgware Birth Centre can be found in the Edgware Birth Centre Addendum.

We have followed a robust options appraisal process to identify the best options for the location of maternity and neonatal services in NCL. This included identifying a long list of potential options and developing and evaluating the short list of options against agreed criteria. As a result of this process, the public consultation focused on two options:

- Option A (preferred option) would see obstetric-led birthing and the neonatal unit no longer provided at Royal Free Hospital
- Option B would see obstetric-led birthing and the neonatal unit no longer provided at Whittington Hospital

The option to maintain the status quo was not put forward as an option for public consultation. This was because the status quo is not sustainable in the long-term, particularly because:

- Maintaining the status quo does not meet the NCL ambition to deliver maternity and neonatal care in the right setting and at the right time.
- The SCU (level 1) at the Royal Free Hospital falls significantly below the upper threshold of respiratory care days set out by BAPM for an SCU[8].
- Across the five units, there are gaps in the workforce, which means we are not meeting quality standards.

The Programme had previously agreed that there should be four neonatal units in NCL, all of which would be designated either an LNU (level 2) or NICU (level 3). This would provide 24/7 access to specialist staff and also ensure that staff could maintain their skills and competencies. As each obstetric-led birthing unit needs a co-located LNU (level 2) or NICU (level 3), this means there would be four obstetric-led birthing units each with a co-located alongside midwife-led unit. Each of these would be co-located with a neonatal unit. This means there would be four neonatal units in NCL and one of these would also need to be a NICU (level 3) as there must be at least one NICU (level 3) unit in within a single operational delivery network.

We identified four options that could deliver the care model, closing the maternity unit at Barnet (option 1), North Mid (option 2), Whittington (option 3) or Royal Free (option 4). We undertook a robust process that evaluated each of the four options for quality of care, workforce, access to care, and affordability and value for money. We concluded that Options 1 and 2 were not implementable given the significant projected outflows of people to non-NCL units, which are

[8] BAPM. Service and Quality Standards for Provision of Neonatal Care in the UK. 2022.

unable to accommodate this additional activity. This position was confirmed by neighbouring providers and ICBs who have had Executive Director sit on the Start Well Programme Board and attended the options appraisal workshop. It was also confirmed by the Maternity and Neonatal CRG who stated that the significant outflows from NCL may undermine the viability of NCL providers and would make it harder to provide integrated care before, during and after giving birth. Options 1 and 2 would also result in longer travel times for patients to access services than options 3 and 4. Therefore, these options were not recommended to be taken forward for consultation. Option 3 and 4 were both implementable and both options were subsequently consulted on, with option 3 (known as option A in the consultation) being the preferred option.

Feedback from the public consultation and post-consultation assurance highlighted some concerns around modelling underpinning the evaluation, concern around the travel time analysis and put forward some ideas for other options. This feedback has been carefully considered, and the evaluation updated, where required.

Option A (maternity and neonatal services no longer provided at Royal Free Hospital) has been agreed as the recommended option for implementation. Reasons for recommending option A include:

- It would still be significantly less complex to implement option A than option B from a workforce and training perspective because the Royal Free Hospital currently has a SCU (level 1) neonatal unit whilst the Whittington Hospital already has an LNU (level 2)
- The projected patient flow to NWL in option A would be easier to manage than the projected flows to NEL in option B.

2.7 Potential impact of the recommended option

Under our recommended option, we would provide maternity and neonatal capacity to meet projected demand, and pregnant women and people would have access to the same level of care for neonatal provision across NCL. Our proposals are underpinned by a focus on pre- and post-natal care and would see the implementation of our new care model and changes to the location at which peri-natal care is provided.

Our recommended option would deliver the proposed maternity and neonatal care model and would therefore deliver a positive impact in terms of clinical care including care that ensures equity of provision and experience, services which are clinically sustainable, more up-to-date estate and buildings, training and development opportunities and capacity to meet projected demand in the context of a declining birth rate and increasing complexity of deliveries.

The integrated impact assessment (IIA), which sets out the potential impacts on quality and outcomes, accessibility and sustainability through in-depth analysis looking at areas such as travel time and demographics, patient engagement, and public health analysis, was updated following consultation. We considered feedback from consultation, including the potential increase in travel times that service users and their families could face as a result of the proposed changes to maternity and neonatal service, particularly those living in areas of deprivation, the potential impact on the Orthodox Jewish community and the potential impact on North West London residents.

Our recommended option would:

- Provide antenatal and postnatal services as close to home as possible. This would be in line with the ambitions set out in our Population Health and Integrated Care Strategy for NCL, ensuring all populations have access to the same services and information. The insights gained through developing these proposals has already leveraged work to reduce

inequalities across maternity and neonatal services including work to improve continuity of carer and work with specific communities such as Somali women who currently experience inequalities in access and outcomes

- Continue to offer the choice of home births for pregnant women and people who would prefer to deliver in a setting outside of a hospital
- Provide women and pregnant people, and their babies, with access to high-quality maternity and neonatal care and access to specialists, including allied healthcare professionals (AHPs), as well as equitable provision of neonatal community services through the roll-out of the virtual ward programme across all boroughs in NCL
- Provide a hospital environment that would ensure privacy and dignity for women and people giving birth
- Continue to deliver a high-quality NICU (level 3) with co-located obstetric-led birthing unit and alongside midwife-led unit at UCLH
- Deliver a high-quality LNU (level 2) with co-located obstetric-led birthing unit and alongside midwife-led unit at Barnet and North Mid and Whittington Hospital. The current SCU (level 1) unit and the co-located obstetric-led and alongside midwife-led birthing unit at the Royal Free Hospital would close. All four maternity and neonatal units would be staffed in line with workforce quality standards, which are not currently delivered across NCL. This would mean:
    - Midwifery, neonatal nurses and medical staff working at the Royal Free Hospital would move to other sites within NCL, enabling all four remaining maternity and neonatal units to be staffed in line with quality standards
    - Maintaining training placements in NCL where units remain open for neonatal nurses qualified in speciality, student nurses and midwives
    - The potentially impacted local catchment population may experience increased travel times for car, taxi and public transport by 4-6 minutes and increased taxi costs by ~£5.50 per average journey. We have developed mitigations to address this impact, as shown in section 9.5.6.
    - There would be a similar impact on travel times for people with protected characteristics and people who have vulnerabilities. Specific consideration would also be given to other access needs for people with protected characteristics and people who may have other vulnerabilities, including digital access, access to cars, physical on-site access and cultural and language barriers.

Impact	Mitigations for the recommended option
During implementation, we need to continue to understand the impact of our proposals and develop mitigations through further engagement with potentially impacted groups. It is particularly important to ensure we hear from groups that are less likely to engage, or where there are barriers for them to do so.	• Information about proposals should be clear and easy to understand. It would be translated into the most commonly spoken languages in NCL, with others available upon request. It would be made available in different formats (easy read / large print) to account for the spectrum of communication needs. • Information about proposals would be widely shared to ensure maximum engagement. This would build on existing partnerships to reach communities or utilise organisations who have existing routes to engage with groups. Consideration would be given to innovative mechanisms to obtain feedback and ensuring communication preferences of groups are considered. We would continue to engage with the range of service users identified through the IIA and consultation • There would be a focus during engagement on groups that are likely to be more materially impacted – be that geographically or because of any other characteristics that make them potentially more impacted by changes (e.g., have poorer outcomes from services or are more likely to need to use services that may be changing). • The programme would continue to review impact of possible changes on different groups and ensure any new impacts are included and mitigations developed to address negative impacts during implementation.
Changes need to be well communicated to residents. Mitigations would need to be put in place to ensure that all groups are informed of changes, and they understand their choices for maternity care. Clear information needs to be available to support and promote a choice of a maternity unit and birth setting that meets the needs of expectant parents.	• We would ensure there is accessible information about choices of maternity care online and that this information is available in non-digital formats for those who are less able to access the internet. • We would pursue uniformity in how information about maternity services is hosted on individual trust webpages to help users better navigate to the information that they need. • We would provide information in different formats to meet the communication needs of a range of service users, including different languages, easy read, large and small print, audio, braille and sign language. • We would build links with local community groups, particularly for more transient and migrant communities who may not engage as well with published material.

	• We would build community links with the Orthodox Jewish community to understand the best communication methods, work with local doula groups and advertise in community circulars • We would disseminate information through local community groups and local GPs to help ensure that pregnant women and people have accurate information regarding the service changes and what this means for them. • We would ensure there is suitable provision of on demand translation services for appointments and during intrapartum care.
There are some service users for whom changes may mean attending a different hospital than they are used to. This change may be difficult to manage for some service users, with particular needs such as people for whom English is a second language (which may include members of the Somali community), neurodivergent people and people with learning disabilities, and they would need extra support to manage this.	• We would offer women and pregnant people opportunities to visit unfamiliar sites outside of planned appointments or birth to familiarise themselves with the unit. • We would provide access to videos, pictures and additional information about the unfamiliar unit or what to expect in advance of appointments, in order that people can better prepare for their visit to the site. • We would offer detailed information about how to navigate to the right area of the hospital where appointments or admissions are scheduled, as part of communication with service users • Where possible, we would use innovative tools or technology to support wayfinding or giving directions within a hospital. • We would ensure all sites meet access standards, particularly for families with young children or where a family member may have a disability • We would ensure appointments are at the most appropriate times for service users where a family member has a disability, particularly children, to allow them to travel into central London at the most convenient time • We would ensure sensory adjustments can be put in place where appropriate in clinical areas, such as access to a private room and the ability to dim lighting. • Patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments. • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted. • We would work with the neonatal care coordinator as part of implementation to ensure that there is

	consistent information and support available to parents who have a child admitted to a neonatal unit.
Service users may need to travel to a hospital that they are unfamiliar with. Mitigations would be needed to ensure that people have information to plan their journeys to hospital.	• Clear information would be provided to service users about travel and transport options to all maternity units. • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted. • We would link to live journey planners such as TFL to ensure that accurate, up-to-date information about journeys can be accessed. • We would work with the neonatal care coordinator to ensure that there is information available to families about travel when their child is admitted to a neonatal unit.
The cost and time spent travelling to a hospital site would increase for some people, and we would want to deliver care as close to home as possible. This may be more of an issue for some groups such as people with disabilities or people living in areas of deprivation,	• Where possible, we would provide appointments in community settings, for example, family hubs and children's centres. • Virtual appointments would be offered, where appropriate and clinically recommended. • We would implement hospital at home / community neonatal care to help babies avoid admission to a neonatal unit or can be discharged as early as possible – reducing the burden of travel to visit babies during an admission to a neonatal unit.
There may be an impact on the cost of travel should changes be implemented. There would be some service users who may be more impacted by this than others (such as people living in areas of deprivation and people with disabilities who do not drive), and it would be important that any additional travel costs do not create a barrier to accessing care.	• We would raise awareness of schemes to support patients with travel costs, as well as how to make a claim, including: - Healthcare Travel Costs Scheme - financial assistance for patients (and their carers) who do not have a medical need for ambulance transport, but who require assistance with their travel. - ULEZ and Congestion Charge reimbursement schemes where applicable. - Blue badge schemes – these support key groups with travel and are increasingly being made available to those with a mental health condition. - Information about these schemes to be available in different languages and formats to suit needs of service users. • Information would be available on provider arrangements for the reimbursement of transport costs under the Healthcare Costs Travel Scheme, including location and opening hours of cashier kiosks. • A discussion about cost of travel would be included when booking appointments, to identify if cost of transport may impact on service users' ability to access care

	• We would support patients by working with charitable and voluntary and community sector partners to consider the feasibility of a pre-paid travel card for service users identified as being particularly impacted by the proposals for whom travel costs would limit their access to maternity care. • Arrangements for patients who have eligibility for hospital patient transport schemes would be continued. • We would ensure service users are aware of other financial support schemes available during pregnancy, such as NHS Healthy Start where they can get help to buy food and milk, and the maternity exemption certificate. • Neonatal care coordinators would ensure there is clear information about the financial support available to families when a child is admitted to a neonatal unit. This could include information about benefits people may be entitled to, and support from charities and other voluntary and community sector partners.
Access to parking spaces is variable across NCL sites. Parking has been raised as a particular consideration for parents who have a child admitted to a neonatal unit, given their need to visit their child on an ongoing basis and in some instances over an extended period. Mitigations would be needed to ensure that families can easily visit their child by car.	• We would ensure that there are consistent arrangements in place for families with a baby admitted to a neonatal unit in relation to parking. As part of this, we would work with charitable partners to see if we can explore providing a permit to allow discounted parking for the duration of the baby's admission. • Capacity would be put in place that meets demand to ensure fewer neonatal transfers out of NCL, thereby reducing the overall travel distance for families. • Particular consideration would be given to those with disabilities, ensuring access to disabled parking spaces. • We would promote other transport arrangements as an alternative to driving, where appropriate.
The IIA identifies a small impact on carbon dioxide emissions as a result of changes to journey times, as well as an impact of refurbishment of estate. Mitigations needed to address the impacts identified fall within the wider green agenda for the ICS and sites that are impacted. The NHS has a target to reach net zero by 2040 and the ICS and each	• Through the refurbishment that would be undertaken, buildings would increase their energy efficiency and thus have a positive impact in the longer term on energy usage. • Trusts would explore the possibility of using their own energy sources to provide energy to refurbished areas (for example, heat pumps). • Appropriate appointments would be provided in community settings or online which reduce the need to travel to a hospital site and would support a reduction in the overall number of journeys taken to access maternity care. • In line with national targets of a 40% reduction in nitrous oxide emissions, providers would determine

individual trust have their own plans to deliver this.	if it is possible to reduce waste that may be associated with leaks in pipes. • We would continue to work on the travel components of the ICS and local trust green plans and encourage active travel or travel via public transport where possible.
Women and people with complex (or pre-existing) health conditions are currently looked after under networked arrangements with input from both obstetric physicians and other specialists. Mitigations would be needed to ensure that pregnant women and people with complex (or pre-existing) health conditions could continue to access the specialist and obstetric care they need.	• Support clinicians to work together to deliver care within current networked arrangements, utilising technology and virtual appointments where appropriate to link in all relevant clinicians, to minimise the impact on pregnant women and people with complex (or pre-existing) health conditions that may need to access specialist and obstetric care at different sites and ensure care remains joined up • Provide clear information to service users about travel and transport options to all alternative units where they may need to access specialist or obstetric care to meet their specific needs. Ensuring that information is available in different languages that meets the needs of the population and is in accessible formats including non-digital to support those with poor digital access • We would offer women and pregnant people opportunities to visit unfamiliar sites outside of planned appointments or birth to familiarise themselves with the unit and patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments • Raise awareness of schemes to support patients with travel costs, as well as how to make a claim. Ensure that all information is available in different languages and formats to suit needs of service users. Including: - Healthcare Travel Costs Scheme - financial assistance for patients, who do not have a medical need for ambulance transport, and their carers but who require assistance with their travel - ULEZ and Congestion Charge reimbursement schemes where applicable - Blue badge schemes - support key groups with travel and increasingly being made available to those with a mental health conditions
There are specific mitigations that would need to be put in place for the population of Harlesden and Willesden.	The populations of Harlesden and Willesden in the London Borough of Brent have been identified as a vulnerable population who are potentially more impacted if Option A as the recommended option is implemented, given their proximity to the Royal Free Hospital site. Some specific mitigations that would be taken forward for this population have been developed:

	• **Communicating changes:** should changes be agreed, a specific communication campaign would be undertaken. We would work with providers in NWL and the NWL ICB alongside the Brent local authority to communicate with service users about the proposed changes, so they understand the impact and the timeline for implementation. This would factor in the most commonly spoken languages within this area, and also non-digital formats given the lower than average IT proficiency of this population • Supporting **continuity of carer:** we would explore with NWL partners the possibility to prioritise residents of Harlesden and Willesden for continuity of carer given the vulnerability of these service users, building on the existing community pathways: - London North West Hospitals Trust (LNWH) have community provision covering areas of Harlesden and Willesden. This means that those accessing one of their sites for maternity care will be supported antenatally and postnatally by staff from this Trust. In terms of how this provision is set up currently they provide: - Ante and post-natal continuity to all those that book. This means that service users will see the same midwife and team throughout the pre- and post-natal pathway - Appointments are provided in local family wellbeing centres and other community locations which means that for many service users they aren’t required to travel to hospital for all their antenatal care - They have a specific midwifery team that works with particularly vulnerable service users (e.g., those that are experiencing domestic violence or severe mental illness) - LNWH have provisions in place to support communication with service users who do not speak English, or where English is not their first language. They use a telephone interpreter service and also equip their staff with Card Medic (a resource that contains a series of common questions and phrases). They can also book a face-to-face interpreter where required. - LNWH work closely with local council in Brent, including the public health teams to support join up of pathways for universal services and to ensure any public health messaging or campaigns are aligned

	- All patient information materials are translated into local community languages • **Access to care:** We would work with NWL providers to ensure that maternity care continues to be provided as close to home as possible through community settings. We would produce accessible information about where residents can access care. • **Cost of travel:** Service users travelling by taxi may experience a slight increase in cost. We would work with NWL partners to ensure that NWL hospitals have clear arrangements in place for re-imbursement of expenses and other travel cost reimbursement (including transport and ULEZ reimbursement). These include schemes offered by NWL providers, as well as broader schemes such as NHS Health Start and those offered by the voluntary sector. We would ensure that accessible information is available for service users and also raise awareness of schemes to provide financial support including wider financial support schemes available during pregnancy such as NHS Healthy Start. Work with NWL partners to see if they would consider working with local VCS organisations who may be able to mitigate the impact for groups that are particularly vulnerable. • **Continuing engagement:** working with NWL partners we would continue to engage with residents of Harlesden and Willesden during implementation to understand any unanticipated impacts and develop further mitigations if necessary.
There are specific mitigations that would be put in place for the Orthodox Jewish community should a decision be taken in the future for the Royal Free Hospital to be the site that no longer provides maternity and neonatal care.	There is an Orthodox Jewish community within the current catchment of the Royal Free Hospital, and mitigations would be put in place to ensure that this group is not disproportionally impacted. These mitigations would continue to be iterated with the Orthodox Jewish community and its leaders throughout implementation to ensure key concerns are captured and mitigated against. It is important to note that for women in labour and their partners, travel to hospital by vehicle is permitted on Shabbat and religious festivals as this is considered a medical emergency. Should a woman give birth on Shabbat, or a religious festival their partner would often stay with them in hospital until discharge. Their partner may travel to and from home on foot during the day depending on other caring responsibilities. Consideration would need to be given to enable a family to stay in hospital rather than being discharged over Shabbat.

	Other sites in NCL currently provide maternity care to members of the Orthodox Jewish community and therefore have in place provision to support appropriate care. To ensure this care is built on, we propose establishing Trust-level task and finish groups that would undertake an 'as is' analysis to understand the important issues that need to be enhanced at each Trust. These task and finish groups would need to consist of both members of staff and representative members of the Orthodox Jewish community who would be able to provide input and feedback around culturally appropriate maternity and neonatal care, representatives could include birth coaches, faith leaders and chaplains working with the trust, VCSE organisations representing the community. This would have senior ownership at a Trust level and report into the wider programme's implementation governance structure. From the analysis, an action plan should be put in place to work through the issues identified. This action plan would describe key actions to be taken forward to build a partnership with the Orthodox Jewish community. These action plans would ensure that culturally and religiously appropriate maternity and neonatal care continues to be provided and built upon to build confidence of the community in the level of sensitive provision that is in place for service users. Trust-specific action plans may cover the following areas that would mitigate the impact of option A: • **Staff training:** Orthodox Jewish women may have specific needs during their maternity care. There would be staff training across all NCL maternity units to ensure an understanding of Orthodox Jewish community observances for maternity care including religious requirements around the observance of Shabbat (Sabbath) and Kosher food. Training would be co-developed either with a voluntary and community sector organisation or individuals from the Orthodox Jewish community and delivered to clinical and non-clinical staff across the service at all sites. • **Kosher food**: we would ensure all sites review the Kosher food that is currently available for pregnant women and people during labour and permit food to be brought in from outside the hospital. • **Communication:** through engagement with the Orthodox Jewish community, it has been identified that non-digital communication is more effective. We would ensure communication of changes, and subsequent communication about

	maternity care, are provided in a non-digital way. We would work with the community and voluntary and community sector partners to be more effective in reaching the Orthodox Jewish community in NCL. We would also use circulars that are produced and read by the local community for wider messaging. • **Religious requirements around the Observance of Shabbat and religious festivals:** specific considerations would be made around religious requirements around the observance of Shabbat. Shabbat protocols would be put in place with guidance produced for NHS staff and trusts on religious requirements. This would include a review of all NCL hospital site Shabbat rooms and other observance requirements to ensure they meet the needs of the community, allowing flexibility for any non-urgent care to take place outside of Shabbat, avoiding discharge on Shabbat and not using the call bell. • **Modesty**: Orthodox Jewish women may choose clothes that cover their elbows and knees, as well as a wig, scarf or other head covering. Long - sleeved gowns would be made available during birth at all hospitals to cover elbows and we would ensure that people are permitted to wear a hair covering. • **Clinical considerations**: some medical conditions have a higher prevalence within the Orthodox Jewish community. We would engage and communicate with the community to assure them that there are alternative specialist providers for these conditions such as UCLH and the specialist haematology service which could care for those with factor 11. Pathways and standard operating procedures would also be agreed with London Ambulance Service and Hatzola around emergency care in maternity services. The additional travel time to the Whittington Hospital compared to the Royal Free Hospital is 3 to 5 minutes. • **Providing care closer to home:** as part of our proposals, we would provide ante-natal and post-natal care as close to home as possible. • **Working relationships and trust**: work would continue to be undertaken with local voluntary and community sector organisations with reach into the community, and the North West network of Doulas to support effective working relationships are built up between the community and all NCL sites where maternity care is accessed by the Orthodox Jewish community.

	This would ensure that the necessary provision is in place for the community and there is an understanding of the role of birth coaches / doulas. Consideration would need to be given to enable a family to stay in hospital rather than being discharged over Shabbat given the longer journey from hospital to a potential alternative maternity unit. This may include the woman who is in labour or who has given birth and their partner or other birth partners. Mitigations include: • Partners need to have provision to remain comfortably on site, either in the labour room or ante / post-natal ward with the woman (this is already in place at UCLH, Barnet, North Mid and Whittington Health) • Appropriate Shabbat protocols and facilities should be in place at each hospital to allow partners to be observant should they remain on the hospital site • Discharge protocols that wherever possible avoid discharge over Shabbat and religious festivals
Mitigations would need to be in place for inclusion health groups such as traveller and homeless communities who may be negatively impacted by reduced availability of services locally	Inclusion health groups such as traveller and homeless communities are likely to be impacted by service changes. To ensure that the changes are communicated effectively to traveller and homeless communities, we would communicate using existing channels and voluntary and community sector partners. During implementation, we would ensure that changes are also available in other languages, and in formats that are appropriate (e.g., non-digital). We would continue to work with Local Authorities to help join up health and social care services and ensure that the needs of these groups continue to be met.

Mitigations have been developed to minimise the impact of the recommended option, particularly for the groups that were identified in the consultation feedback as potentially being impacted:

- **Orthodox Jewish community:** we received feedback from consultation regarding the potential impact of no longer delivering maternity and neonatal services at the Royal Free Hospital on the Orthodox Jewish community. Remaining units would work with the community to develop Trust-level action plan to build on existing provision of culturally and religiously sensitive care. Action plans may cover areas such as staff training, Kosher food, communication, religious requirements around the observance of Shabbat including families remaining in hospital and working relationships between the population and NCL hospitals Further potential mitigations have been detailed in the IIA. The proposed mitigations would be further tested with the Orthodox Jewish community and its leaders throughout implementation to ensure key concerns are captured and mitigated against. Agreed mitigations would be monitored and evaluated by a working group which would include members of Orthodox Jewish community
- **People living in areas of deprivation:** the potential impact of increased travel time and associated costs were raised during consultation, particularly for those living in areas of

deprivation. Further mitigations have been developed to support service users with travel costs including raising awareness of the Healthcare Travel Costs Scheme, ULEZ and congestion charge reimbursement and ensuring discussions are had around travel costs when booking appointments.
- **People who live in North West London (NWL):** people who live in North West London, particularly those who live in Harlesden and Willesden in the London Borough of Brent, have been identified as potentially more impacted by our proposals given their characteristics. Further mitigations have been developed for this population working alongside providers in NWL and NWL ICB including a specific communication campaign, exploring the possibility of prioritising residents for continuity of carer and having clear arrangements in place for reimbursement of expenses.

The Programme updated the interim IIA that was developed at the PCBC stage, considering feedback received during public consultation. In particular, potential negative impacts of implementing option A on health inequalities and on groups sharing protected characteristics have been identified through quantitative and qualitative analysis. A series of mitigations have been developed to minimise the potential negative impacts of the proposals that have been identified, and the full range of detailed mitigations can be found in the IIA. The potential impacts and proposed mitigations have been informed through feedback received during the public consultation and further engagement with a diverse range of stakeholders and further tested with the IIA Steering Group. These would continue to be iterated and reviewed during implementation.

For each potential negative impact identified, the IIA sets out proposed mitigations, and whether or not the proposed mitigations would eliminate the potential negative impact. Where there is a potential residual negative impact on a group after mitigation, the IIA seeks to identify what that residual negative impact would be.

The IIA documents how the ICB has met its public sector equality duty and its legal duties in regard to health inequalities. In reaching a decision on whether to proceed with Option A, the ICB Board will consider whether, where implementation would lead to negative impacts on any group sharing a protected characteristic that cannot be mitigated, there are good reasons for implementing option A that mean it should proceed, despite those disadvantages.

The recommendation in this DMBC is that the benefits of implementing Option A, as described throughout this document, mean that it should be implemented, despite the identified disadvantages.

2.8 Further assurance of our proposals

Following the consultation and development of this DMBC, further assurance has been undertaken on the proposals. This includes:

- **Mayor's tests:** following consultation, the Mayor's office reviewed the two tests on clinical support and patient and public engagement.
- **NHSE London Regional Office:** further work on the stranded costs for both options was undertaken following feedback in the NHSE stage 2 assurance prior to public consultation. We identified the stranded costs and mitigating actions for these and these have been assured by NHSE London Region.
- **Joint Health Overview and Scrutiny Committee (JHOSC):** the JHOSC reviewed the PCBC and shared recommendations as part of the consultation process and following

review of the interim analysis report. A further feedback letter was provided by the JHOSC following publication of the full consultation feedback report in Novmeber 2024. These recommendations have been addressed within this DMBC.

No further external assurance is required prior to decision-making.

2.9 Implementing the recommended option

We have developed a robust implementation plan and considered the enablers that would be required to support implementation of our proposals. This includes clinical pathways, workforce, digital, sustainability, finance, partnership working and stakeholder engagement:

- **Clinical pathways:** implementing the care model would require us to strengthen and implement a number of new pathways. Initial thinking and principles to guide implementation planning on areas raised during consultation such as out of hours interventional radiology, enhancing midwifery care, ante- and post-natal care and maternal medicine have been worked through alongside a consideration of the potential impact on other services such as emergency transport, the emergency department and gynaecology services. More detailed plans would be worked through as part of the implementation phase.
- **Workforce:** supporting and retaining our workforce through the next steps of the programme and the transition to new arrangements would be fundamentally important to the successful implementation of proposals. We recognise changes that take place over a long period of time can be particularly unsettling for staff. We have listened to the feedback from staff and want to ensure our workforce is provided with reassurance that we would be collaborating and working collectively to make sure that retaining our staff is the biggest workforce priority for us. We would do this by prioritising security of positions and supporting people to develop their careers within NCL. Building on the aims of 'One Workforce for NCL' as set out in our People Strategy[9], the proposed changes would reduce fragmentation and variation in staff experience across maternity and neonatal units and build and encourage collaboration. In order to address workforce challenges and develop appropriate workforce plans that would cover the duration of the implementation period, Chief People Officers from the Trusts impacted by the proposed service reconfigurations in NCL, along with nominated leads from their teams, have come together to form a Start Well Workforce Group. The Group has agreed consistent and collaborative approaches to address how we would make these changes while ensuring our staff continue to feel valued, informed and clearly communicated with at all sites, throughout the different stages of decision making and implementation. Our approach is intended to ensure that sustained high quality, safe services would be maintained throughout the various phases of implementation.
- **Digital:** we aim to promote the use of technology in line with the ICS vision of helping our residents to live the fullest lives possible and tackling health inequalities. By working in partnership to harness the latest digital technology and joined-up information, we would ensure pregnant women and people could access the right care quickly and effectively. In tandem with the NCL digital programme, work has been undertaken through a dedicated digital workstream in the NCL Local Maternity and Neonatal System (LMNS) to digitally transform maternity services by developing a clear strategy and improving data quality. Digital is a key consideration as part of the implementation of the Start Well programme to ensure that the proposed care model can deliver high quality, safe care by providing

[9] https://nclhealthandcare.org.uk/wp-content/uploads/2023/07/NCL-ICS-People-Strategy-FULL-Final.pdf

accurate information, improving data visibility at the point of care and being able to audit and plan services according to need through accurate reporting. We have identified a number of ways digital could support the implementation of the proposed care model.

- **Sustainability:** during implementation, we would seek to ensure that sustainability is embedded through all workstreams, and that opportunities are taken to make services as sustainable as possible. This would draw on the NCL ICS Green Plan[10], as well as each trust's own green agenda, which focus on carbon reduction strategies.
- **Finance:** delivering the required capacity and estate requirements is critical and the capital investment would be funded within the ICB CDEL envelope and through the organisations involved. Each provider that has a capital requirement would need an outline business case and full business case to be completed which would be managed by Trust teams and would be in line with the guidance set out by HMT Green Book and NHSE. As the capital requirements at Whittington exceed £25m, an outline business case and full business case in line with HMT Green Book would first require NHSE approval, whereas at sites where the investment required is less than £25m only Trust board approval is required[11]. Following NHSE approval, the OBC and FBC would require approval by HMT as the capital requirement exceeds £50m. The changes proposed would impact on patient flows from both NCL and NWL and would change where care is provided. We have agreed a principle of funding follows the patient to support the implementation of Start Well changes.
- **Partnership working:** existing collaborative working between UCLH and Whittington would continue and be further strengthened so that we ensure we make safe and effective use of capacity and provide high quality care and clinical pathways across the system. Barnet Hospital and North Mid would build on joint working arrangements as part of the wider Royal Free London hospital group arrangements. Ensuring we have effective partnership working between sites would help manage any risks in unexpected activity flows, make best use of our resources and continue to identify opportunities to strengthen pathways.
- **Stakeholder engagement:** working with trust communication teams, as well as partners in the community, we would extensively communicate the changes to both staff and impacted service users. This would need to be inclusive and co-ordinated, ensuring that those populations that are harder to reach receive the same information and that the information is accessible to all groups, including those with protected characteristics.

High-level risks and mitigations have also been considered alongside proposals for a risk management system. Key risks include:

Category	Risk	Mitigations required	Metrics to monitor
Quality	Quality and safety of current services at the closing unit is not maintained due to destabilisation through the implementation process	• Work with other units in NCL to help support the impacted unit and provide resource as needed • Ensure communication with staff impacted is clear and undertaken early. Provide reassurance there are opportunities to move to another unit and the benefits of the proposed changes.	• Bookings data • Deliveries and neonatal cots days by unit • Vacancy rates by staff group • Staff turnover • Training and education uptake • Staff sickness

[10] https://nclhealthandcare.org.uk/wp-content/uploads/2022/04/North-Central-London-Green-Plan-2022-2025.pdf

[11] https://www.england.nhs.uk/wp-content/uploads/2023/02/B1376i-capital-investment-and-property-business-case-approval-guidance.pdf

	During the transition, pregnant women and people do not choose to deliver at the closing unit and overwhelm the other units in NCL which are common in both options	• Ensure clear and early communications to the public which outline the timeline of proposed changes. Specifically engage with those who are booked in to deliver at the closing unit. • Monitor the activity and bookings at alternate units in NCL to ensure there is capacity to deal with any potential additional activity • Utilise existing collaborative working between units to help manage demand	• Bank and agency usage • Number of Opel escalations
Workforce	Units across NCL are unable to recruit as a result of the proposed changes	• Communicate the implementation timeline and future job prospects with potential candidates • Work with ICS to explore offering NCL roles, rather than organisational roles	
	Workforce decide to leave the closed unit and destabilise the unit	• Monitor the vacancy rates at the closed unit and other units • Staff from across the system support the closed unit should there be challenges in retaining existing staff	
Capital	Based on historic trends and economic instability inflationary impact may be higher than expected and result in understated capital estimates	• Prudent inflationary assumptions have been used • The Programme Board would continue to monitor any changes to the financial projections • Phasing of capital schemes could be updated if needed	• PUBSEC inflation values from NHSE • RICS inflation values for comparison to PUBSEC • Estimate value of capital programmes at each site • Progress of build programmes at each site
	Capital requirements may be higher and not affordable in the NCL ICB CDEL envelope	• Assumptions used in determining capital requirements have been prudent and account for the relative stage the capital plans are at. The cost per m^2 have been benchmarked against other schemes which have been recently delivered. All capital requirements include significant contingency values (between 30-40%).	

		• Phasing of capital schemes could be updated if needed	
	Capital requirements agreed may not be sufficient in the future and the builds at each site may be reduced which would impact on the quality of the estate	• All capital requirements include significant contingency values (between 30-40%) • Phasing of the capital schemes could be updated if needed	
Stranded costs	The value of stranded costs may be greater than as modelled. Also, some of the short- and medium-termed costs may not be able to be mitigated as modelled	• Prudent modelling of the stranded costs has been completed • Detailed analysis of short, medium and long term stranded costs has been undertaken • Stranded costs would be closely managed at the provider level to mitigate risk • Explore activity that could potentially replace maternity and neonatal on the site with a similar contribution. Provider and the ICB would need to agree the activity.	• Provider cost data (e.g. PLICS) reviewed through the finance and analytics group • Compare to detailed list of stranded costs identified at DMBC stage
Revenue affordability	The proposed changes to maternity and neonatal services may not be affordable from a revenue perspective	• The proposals are more affordable than maintaining the current position across NCL outlined by the positive BCR • Sensitivity analysis has been completed on the % of the benefits that would be realised, the PDCD % that is used and the capital costs	• Activity levels at providers

Oversight of the implementation process would be the responsibility of the Start Well Programme Board and supported by the Operational Oversight Implementation Group. As NHSE London Region Specialised Commissioning are delegating responsibility for the commissioning of most relevant services[12] to NCL ICB on 1 April 2025, oversight of the implementation process would be the responsibility of NCL ICB working in partnership with NHSE and other London ICBs and drawing on the skills and expertise of the Specialised Services Shared Commissioning Team (SSSCT).

[12] Excludes open fetal surgery to treat fetuses with open spina bifida, drugs and devices

2.10 Benefits

The proposed maternity and neonatal model of care is expected to deliver a range of benefits that ensure equity of provision and experience for patients, training and development opportunities for staff, services which are clinically sustainable, and more up-to-date estate and buildings. Our proposals would improve the quality of care and clinical outcomes and would consolidate our workforce to help units reach the workforce quality standards. These benefits would be felt and experienced by everyone, including patients, families, carers, staff and local communities. The total quantitative benefits for option A are £259.8m over a 30-year period. These benefits demonstrate how our proposals would address a number of the opportunities for improvement that were identified in our case for change.

It is integral that the experience of pregnant women and people and their families, who use maternity and neonatal services, are monitored and improvements to quality and safety are tracked. Benefits realisation needs careful management and close measurement. Benefits measures would focus on and record both outputs (e.g., reduced number of neonatal care days) and expected outcomes (e.g., improved patient experience) to demonstrate the success of delivery. A realistic list of measurable performance indicators would sit alongside the benefits outlined in the benefits framework. Benefits tracking is firmly embedded within performance management arrangements under business as usual. There would be strong clinical leadership of this benefits realisation to support successful delivery of the programme. Wherever possible, existing mechanisms and systems would be used to monitor the realisation of benefits, rather than creating an additional data burden.

The Start Well Programme Board would oversee the benefits tracking with the Operational Implementation Oversight Group reviewing the defined metrics and reporting into the Programme Board on the progress against these. The agreed framework is shown below.

Category	Benefit description	Outcome	Measure	Expected to be realised by	Frequency	Data source
Care that ensures equity of provision and experience	• Pregnant women, people and babies have access to the same services, including those from inequality groups. This includes community neonatal outreach services accessible across all boroughs and the same provision of neonatal care no matter which unit the baby is born in. • Provide a more personalised experience and ensure the individuals are supported and communicated with that best suits their own needs	Improved patient experience and outcomes	• Improve patient experience	Within 24 months of implementation of the new care model	Annual	CQC survey Healthwatch Friends and Family test
			• Reduce number of avoidable term admissions to a neonatal unit	Within 12 months of implementation of the new care model	Annual	BadgerNet / Epic
			• Increase CQC rating	Within 3 years post implementation of the new care model	Annual	CQC website
			• Reduce maternity and Newborn Safety Investigations (MNSI) referrals	Within 12 months of implementation of the new care model	Quarterly	Trust referrals to MNSI
		Reduced Maternity clinical negligence scheme premium for Trusts (CNST)	• Reduce maternity CNST premium per delivery	7 years post implementation of the new care model	Annual	Trust finance teams
		Reduced normal care days delivered in an acute setting through enhanced delivery of community services	• Reduce number of special care neonatal care days delivered in neonatal units	Within 6 months of implementation of the new care model	Quarterly	BadgerNet Epic (UCLH)
Services which are clinically sustainable	• Redesigning and reconfiguring our neonatal units in NCL, ensuring all units are either a designated LNU (level 2) or NICU (level 3).	Reduced neonatal transfers between units	• Reduce number of neonatal transfers for higher level of medical care	From go live of the new care model	Quarterly	Neonatal ODN
Capacity to meet projected demand	• Neonatal units are running at less than the 80% recommended occupancy rate	Reduced risk of separating women or person from their baby and improving their experience	• Reduced number of non intensive care days delivered at UCLH for babies that live outside the UCLH catchment	Within 12 months of implementation of the new care model	Quarterly	Epic / Neonatal ODN
			• Reduce number of in utero transfers	Within 12 months of implementation of the new care model	Quarterly	Neonatal ODN
Training and development opportunities	• Supporting training and development opportunities for staff through delivering sustainable volumes of neonatal activity at all neonatal units. • Reducing vacancies to make sure cots can be kept open and ensure there are sufficient staff (specialist nurses, allied healthcare professionals, etc) to provide expert care when required	No consultant workforce rota supporting the SCU (level 1) Consolidation of existing workforce into four units	• Improve staff experience	Within 24 months of implementation of the new care model	Annual	Staff survey National Education and Training Survey GMC training survey
			• Reduce staff turnover	Within 24 months of implementation of the new care model	Annual	Trust data
			• Increase number of neonatal nursing QIS	Within 24 months of implementation of the new care model	Annual	Neonatal ODN data
		Improved recruitment and retention	• Reduce vacancy rates	Within 24 months of implementation of the new care model	Annual	Trust data
			• Reduce agency and bank spend	Within 24 months of implementation of the new care model	Annual	Trust data
			• Reduce number of suspensions of alongside midwifery led service	Within 24 months of implementation of the new care model	Annual	Trust data
			• Improve safe staffing levels against standards	Within 24 months of implementation of the new care model	Annual	Trust data
			• Improve staff experience	Within 24 months of implementation of the new care model	Annual	Staff survey National Education and Training Survey GMC training survey
Up to date estate and buildings which are fit for purpose	• Investment in our existing maternity and neonatal estate so that all units are fit for purpose facilities and are designed to provide a positive birth experience • Any new capacity delivered will meet the latest space standards and this will have a role in delivering clinical benefits	Improved efficiencies	• Reduce backlog maintenance costs	Within 24 months of implementing of the new care model	Annual	Trust ERIC data
		Improved staff and patient experience by enhancing staff environment	• Increase friends and Family test score	Within 24 months of implementation of the new care model	Annual	Friends and Family Test
			• Improved staff survey results	Within 24 months of implementation of the new care model	Annual	Trust staff survey GMC staff survey
			• Improvement in how trainees rate the support and fairness of their working environment	Within 24 months of implementation of the new care model	Annual	National Education and Training Survey
			• Improved CQC Maternity survey results	Within 24 months of implementation of the new care model	Annual	CQC survey

2.11 Next steps and approvals

We have been developing the proposals which form this DMBC and the Edgware Birth Centre Addendum since November 2021, ensuring that there has been sufficient time and engagement to make sure that the proposed changes are as robust as possible. The proposals were submitted to NHSE for stage two of the national assurance process for service change and reconfiguration on 9 November 2023 and they gave formal approval for us to proceed to consultation. The consultation was undertaken between 11 December 2023 and 17 March 2024 and we have spent almost a year carefully considering and responding to the feedback from consultation.

The PCBC and Edgware Birth Centre Addendum was reviewed and supported by the London Joint Committee for specialised services and was ratified by two of the London Region Executives under their scheme of delegation, sitting within the Executive team. This DMBC has been further assured by NHSE London Region and a decision on the final option for implementation is being made on the basis of this DMBC and the Edgware Birth Centre Addendum by a meeting in public of the NCL ICB Board of Members alongside NHS England Specialised Commissioning as the current commissioners of neonatal services.

We would continue to work with key stakeholders including the JHOSC, patients and the public, staff and neighbouring ICBs as we move towards implementation. The IIA would also be revisited over the course of the implementation of the proposals, as part of an iterative process.

3. Introduction and context

3.1 Introduction

NCL ICB, as part of the wider NCL ICS, is a statutory organisation which holds responsibility for strategic commissioning of NHS services in NCL. NHS England London Region Specialised Commissioning is the statutory organisation responsible for commissioning neonatal services. Given the interdependency between maternity and neonatal services, NCL ICB and NHSE London Region Specialised Commissioning are jointly responsible for approving the recommendations in this DMBC. These proposals have been developed with a wide range of stakeholders, including NCL ICB, provider organisations, neighbouring ICSs and local stakeholders, alongside the public, patients and staff.

3.2 Purpose and scope of the decision-making business case (DMBC)

The DMBC is a technical and analytical document that sets out the information necessary for the NCL ICB Board and NHSE London Region Specialised Commissioning to make an informed decision about the configuration of maternity and neonatal services in NCL following public consultation. It sets out the robust process that has been undertaken to identify the case for change and develop proposals, the findings from the public consultation and how we have responded, the recommended option for implementation and the implications of this option. We want this document to be as inclusive of everyone's experiences of healthcare as possible and it therefore refers to 'pregnant women and people' when describing those that use maternity services.

3.3 Previous publications

Prior to developing this DMBC, we have previously published several relevant documents:

- Case for change document, published[13] in June 2022 and case for change engagement report[14], published in September 2022, which described the response to the case for change engagement and key themes
- The ICB Board paper [15], published in November 2022, which approved the maternity and neonatal care model and agreed to commence the options appraisal
- The PCBC[16], published in December 2023, which built on the case for change
- The interim IIA[17], published in December 2023, which assessed the potential impact of each option
- Consultation documentation[18], published for the public consultation that ran from 11 December 2024 to 17 March 2024
- An independent consultation feedback report[19], published on 6 November 2024.

3.3.1 Case for change and engagement report

In June 2022, we published a case for change for maternity and neonatal services. This document set out the opportunities for improvement for maternity and neonatal services in NCL. This led to the development of clinical care model for maternity and neonatal services. The PCBC was subsequently developed which considered the case for change and assessed the benefits and limitations of the potential options to address this. This was published 28 November 2023 ahead of the ICB Board meeting on 5 December 2023.

3.3.2 Pre-consultation business case (PCBC)

The PCBC was the document on which we formally consulted on our proposals for change. The development of the PCBC was clinically led and informed by engagement with key stakeholders and the public. Governance groups were established to make recommendation that would be considered by the Programme Board as part of the decision-making process. These groups were supported by workstream to carry and provide expert input into key elements of the work. Key processes supported the development of the PCBC:

- **Development of the care model:** this was overseen by the Clinical Reference Group (CRG) which included defining the proposed care model for maternity and neonatal services taking into account pre-consultation engagement. The proposed care model was further developed based on areas identified following a review by the London Clinical Senate.
- **Options evaluation process:** which established a robust approach to identify and evaluate options to agree options for consultation and a preferred option
- **Public and stakeholder engagement:** which tested the case for change, model of care and options evaluation process. This included involvement of the Patient and Public Engagement Group (PPEG) in the options appraisal process.

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[13] https://nclhealthandcare.org.uk/wp-content/uploads/2022/07/NCL_Start-Well-Case-for-Change-FINAL.pdf

[14] https://nclhealthandcare.org.uk/wp-content/uploads/2022/09/Start-Well-engagement-report-September-2022.pdf

[15] https://nclhealthandcare.org.uk/wp-content/uploads/2024/01/221129_ICB-Board-paper_ALT-TEXT.pdf

[16] https://nclhealthandcare.org.uk/wp-content/uploads/2023/11/Maternity-and-Neonates-PCBC.pdf

[17] https://nclhealthandcare.org.uk/wp-content/uploads/2023/12/ALT-TEXT_Maternity-Neonates-IIA-1.pdf

[18] https://nclhealthandcare.org.uk/wp-content/uploads/2023/12/Start-Well_Consultation-Document_web-version.pdf

[19] https://nclhealthandcare.org.uk/wp-content/uploads/2024/11/Start-Well-Consultation-on-Maternity-and-Neonatal-Services-in-NCL-ORS-Full-Report-NOV-FINAL.pdf

This work culminated in an agreed PCBC and a 14-week public consultation which launched on 11 December 2023 and closed on 17 March 2024.

3.3.3 Consultation documentation and feedback report

The Start Well Programme public consultation on the options for delivering maternity and neonatal services to address the challenges identified in our case for change was launched on 11 December 2023, for 14 weeks, and closed on 17 March 2024. Proposals for consultation were put forward by NCL ICB and NHSE London Region Specialised Commissioning. The consultation was overseen by the Start Well Programme Board.

The aim of the consultation process was to:

- Provide clear and accessible information about proposals and how they had been developed
- Allow time and opportunities for feedback from staff, residents, and stakeholders
- Ensure diverse voices were heard
- Seek alternative proposals or new evidence
- Understand the pros, cons and unintended consequences of the proposals
- Explore mitigations for any potential disadvantages
- Find out what matters most to patients and how this might affect implementation
- Ensure feedback was recorded and could be analysed to support thoughtful decision-making

Consultation documentation in different formats were developed to support the consultation including a consultation document, consultation summary (available in other languages relevant to specific communities), easy read consultation document, consultation questionnaire, animation and posters.

The consultation was extensive and used a wide range of methods and materials to reach people and ensure that a wide range of views and feedback were captured. We designed a detailed programme of activities to provide information, and reach out to local communities and listen to the view of the local population and wider stakeholders. Through the consultation we wanted to understand the potential impact on different populations, based on the interim integrated impact assessment, and this drove our outreach and engagement approach to local communities. The objective of our engagement and consultation activity was to listen to affected groups, across a wide range of demographic characteristics, including ethnicity, to hear from them what they felt would be the impact of the proposed changes and their experiences and concerns. Our consultation activities were extensive and supported by the Start Well Programme team and in some cases voluntary organisations and specialist third party suppliers to support bespoke work with some specific groups. Further detail is described in section 7.8.

The consultation feedback report brought together all the outputs associated with the activities carried out as part of the consultation and was published on 6 November 2024. The report was developed by an independent organisation, Opinion Research Services (ORS). Alongside the feedback report, an engagement and reach report was published in July 2024 which outlined the consultation engagement approach and activities undertaken.

3.3.4 Integrated Impact Assessment (IIA)

To fully explore the impacts of our proposals and inform decision-making, an IIA was developed. The interim IIA was completed prior to consultation and formed the basis for the final IIA, which has been produced to support this DMBC (see section 9.4).

3.4 Decision-making business case (DMBC)

Following the public consultation, the programme has carried out extensive work to review and understand the feedback received through the consultation. The feedback and responses received from the public and stakeholders have been used within this DMBC to help determine the right solution for our local population. The process to robustly bring together this feedback involved several stages:

- Collate the feedback from consultation into the independent consultation feedback report
- Review and deliberation of the consultation findings
- Undertake further analysis and review to understand and explore the feedback and assess any impact on the proposals
- Update proposals following feedback and submit for decision-making

The IIA was updated alongside the DMBC to take account of feedback from the consultation. This includes refreshed travel time analysis based on 2024 travel times and more detailed mitigations on the potentially impacted populations. This findings of the updated IIA are described further in section 9.4.

3.5 Responding to the consultation feedback

In developing the DMBC, we have used the feedback from the consultation to help us identify the best option for the configuration of maternity and neonatal services for our population in NCL and those who choose to use NCL services. We have spent time carefully reviewing the feedback received from consultation and undertaking further work in response to this. The further work, and outputs of this in response to feedback, is set out in section 4.2, 5.2, 8.2, 9.2, 11.4.1, 11.5.1, 11.8.1, 12.1, 13.2.1.

3.6 Decision-making process

This DMBC includes a detailed description of how we have considered the feedback from consultation to determine the best option for the configuration of maternity and neonatal services for our population in NCL. This is set out in section 8.

4. Case for change

4.1 Introduction

Our ambition is to ensure that all pregnant women and people have access to high-quality care that meets their needs. We know that across our maternity and neonatal units there are areas to improve, and currently not all our units are delivering the best quality care for local people. To realise our ambition, there is a need for us to change how we deliver maternity and neonatal services across NCL to ensure that all pregnant women, people and babies have access to the same high-quality care. More detail on the case for change can be found here and in the PCBC here. The opportunities for improvement identified are shown in Figure 1 .

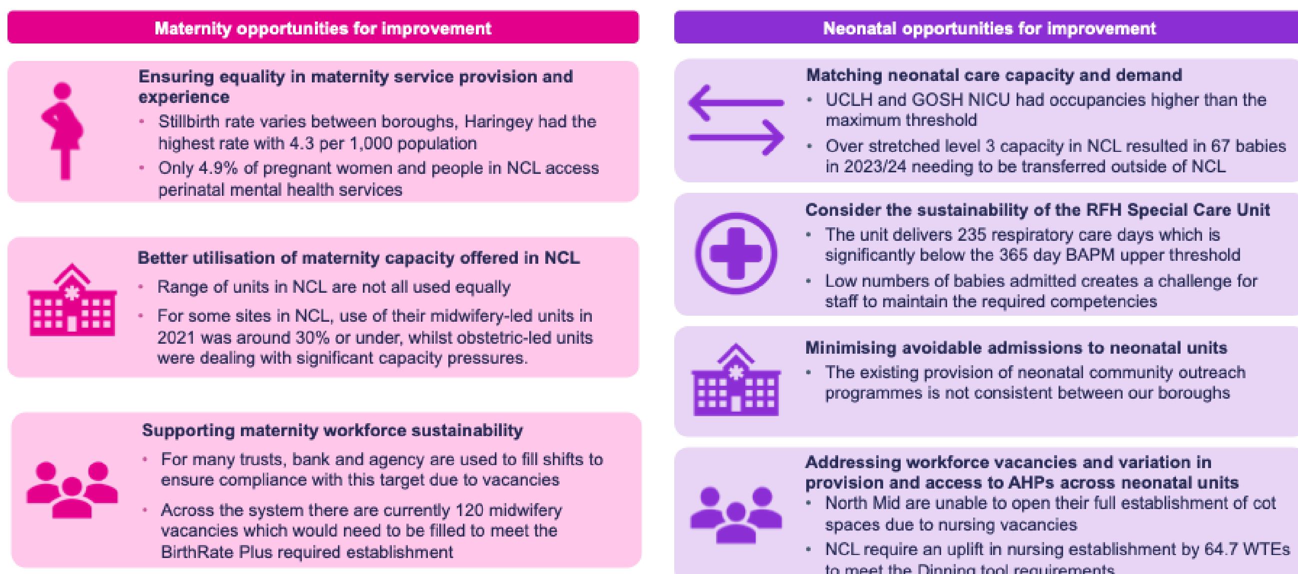

Figure 1: Opportunities for improvement

4.2 What we heard during consultation on our case for change

There was a substantial majority in support of our case for change as part of the feedback from consultation (see section 7.10.2 for further details) and our case for change remains unchanged since the PCBC was published in December 2023 (we have updated figures to the most recent data, where available).

4.3 Ensuring that maternity and neonatal services are, and continue to be, high-quality

We need to ensure that maternity and neonatal service are, and continue to be, high quality:

- **Ensuring equality in maternity service provision and experience**: currently there is variation in maternal outcomes across NCL and there is also some variation in the quality of maternity services provided. This means that not all pregnant women and people have the same outcomes and experience of services. The number of women and people accessing perinatal mental health care in all boroughs is below the NHS Long Term Plan ambition and, with the exception of Camden, also below the NCL 2020/21 ambition.
- **Minimising avoidable admissions to neonatal units**: maternity and neonatal services should be set up in a way that minimises separation of the woman or person that has given birth and their baby. However currently access to neonatal outreach programmes depends on where people live in NCL. The existing provision is inconsistent between our boroughs and does not represent equitable access. For example, in Islington, phototherapy (used for the treatment of jaundice) is available in the community, whereas for babies living elsewhere in NCL, they would likely have to stay in hospital for treatment.

4.4 Ensuring that services are sustainable for the future, meeting population needs and providing an environment for staff to maintain their skills

We need to ensure that services are sustainable for the future, meeting population needs and providing an environment for staff to maintain their skills

- **Addressing low and declining use of the Royal Free Hospital SCU (level 1) unit:** Royal Free Hospital neonatal unit looks after fewer babies than the other units in NCL and does not accept babies born under 34 weeks' gestation. The number of admissions into this unit has been declining by 4% every year since 2018/19 (alongside reductions at some of our other units) and the occupancy of the unit in 2023/24 was 51%, meaning around half of its cots were not occupied on any given day. The SCU (level 1) at the Royal Free Hospital falls significantly below the upper threshold of respiratory care days set out by BAPM for an SCU. With a declining birth rate across NCL, there is a long-term sustainability challenge at the SCU (level 1) to ensure that staff working at the unit are able to maintain their skills and competencies
- **Reducing the under-utilisation of midwife-led units in NCL:** midwife-led units in NCL are not utilised in an equal way, with many pregnant women and people either choosing to deliver, or being recommended to deliver, in an obstetric-led setting. Data shows that for some sites in NCL, the utilisation of their alongside midwifery-led units was under 30% in 2021/22, whilst obstetric-led units were dealing with significant pressures. The number of vacancies at units also means that sometimes midwife-led units have to temporarily close.

4.5 Ensuring that we have sufficient well-trained staff to deliver services

We need to ensure that we have sufficient well-trained staff to deliver services:

- **Reducing challenges in recruiting midwives and neonatal nurses:** across our maternity sites in NCL there are challenges in recruiting and retaining maternity staff. There are currently high levels of staff vacancies in neonatal nursing, with a vacancy rate of 8% across NCL. The number of vacancies at units means that units cannot always open all their cot spaces, and some babies are having to be moved to neonatal cots outside of NCL.
- **Addressing workforce vacancies and variation in access to allied health professionals (AHPs) across neonatal units:** there is a need to increase AHP provision across all NCL units. AHP staffing (dietetics, physiotherapists, occupational therapists and speech and language therapists), has been compared with the recommended professional body levels set out by BAPM and NCL is consistently under these recommended levels for all disciplines.

4.6 Having the right maternity and neonatal estate to provider a positive patient experience

We need to ensure that we have the right maternity and neonatal estate to provider a positive patient experience:

- **Improving hospital facilities and estates:** hospital facilities should provide privacy, preferably labour rooms with ensuite bathrooms and space for the birth partner to join delivery when possible[20]. Every pregnant woman and person should feel that they have choice and control over their labour and birth to the extent possible. The hospital environment and facilities need to be supportive of the needs of the family.
- **Meeting modern standards for estates and reducing backlog maintenance:** currently, the maternity and neonatal estate at Whittington Hospital does not meet modern standards for maternity and neonatal facilities. The maternity and neonatal services are located over

[20] https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_09-02_Final.pdf

four levels, in buildings from the late 19th century, with an estimated £12.4m in backlog maintenance at Whittington Hospital to maintain the existing estate, IT and equipment over a 30 year time period.

5. Care model

5.1 Introduction

We have set out a clinical care model to meet the needs of our population and deliver our vision to offer personalised care in the right setting, in modern, high-quality facilities. Care model development was overseen by the Maternity and Neonates CRG, which has membership from all NHS provider organisations across NCL, as well as other local and system partners. The guiding principles that underpinned the care model design included placing those using the services and their families at the centre, ensuring equity and consistent standards of care and making best use of our resources, people, places and money. A review by the London Clinical Senate as part of the assurance process supported the case for change and strong ambition for improvement.

5.2 What we heard during consultation on our care model

There was a substantial majority in support of our proposals for our model of care. We heard feedback about specific implementation issues which have all been discussed in more detail by the CRG as part of implementation planning. Further detail on the response to these areas of feedback can be found in section 11.4.1.

5.3 Vision for maternity and neonatal services

All pregnant women and people should have access to care that best suits their needs. Our vision for maternity and neonatal services in NCL is to deliver high-quality services which are safe, compassionate, personalised and family friendly. For babies, each neonatal unit should see the minimum number of admissions required by national guidelines, and, across NCL, families should have access to the same services, ensuring that care is delivered as close to home as possible. Staff should be able to maintain their skills and have access to training opportunities to support their development to maintain the high standards of care delivered.

Achieving this vision would reduce the variation in maternity and neonatal care delivered across units in NCL and improve outcomes and experience for pregnant women, people, babies and their families.

For maternity and neonatal services, our vision is to deliver high-quality, evidence-based, and clinically sustainable services that are personalised, with equity of access for all our local people. The new care models would:

- Consistently deliver care that meets the best practice recommendations set out in the Ockenden Maternity Review[21], Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK)[22] and the BAPM Standards[23]
- Reduce inequalities in access and provision of services
- Deliver improved quality of care, patient experience and patient outcomes
- Provide enhanced training and development opportunities for staff.

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[21] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

[22] https://www.npeu.ox.ac.uk/mbrrace-uk

[23] https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk

Developing the care models has been a collaborative exercise undertaken with a wide range of input from health and care stakeholders. Care model development has been overseen by the Maternity and Neonates Clinical Reference Group (CRG), which has membership from all NHS provider organisations across NCL, as well as other local and system partners. Over a five month period from July 2022 to November 2022, we engaged with over 100 individuals through two half day clinical workshops and dedicated task and finish groups. These focused task and finish groups explored areas such as training and education and maternal medicine. Themes from the case for change engagement were fed through to the groups to ensure this feedback informed the care model development.

The care models have been shared with a range of system stakeholders, and we have also sought patient and public feedback through two meetings of the PPEG. The guiding principles underpinning the care model design process included placing those using the services and their families at the centre, ensuring equity and consistent standards of care and making best use of our resources, people, places and money.

The care models were reviewed and recommended by the Start Well Programme Board, which includes senior specialised commissioning representatives alongside senior clinical leaders. The proposals for the maternity and neonatal care model were formally signed off by the NCL ICB Board in November 2022.

Implementation of the proposed maternity and neonates care model would be contingent on adoption of one of the proposed options in this DMBC.

5.4 Maternity care model

Our maternity care model would deliver equitable access and ensure our services are safe and compassionate. Improving quality is at the heart of our proposals and underpins our care model. An overview of the proposed maternity model is set out in Figure 2 and focuses on four elements:

- **Pre-conception and access to care:** personalised care for women or people considering pregnancy, focusing on increasing the chances of conception and reducing the chances of a miscarriage or stillbirth risks to the pregnant woman or person.
- **Antenatal care:** the care received from health professionals during pregnancy, which focuses on checking on the health of the baby and pregnant woman or person, providing accessible information and resources to help them to have a healthy pregnancy and discussing the options and choices for care during pregnancy, labour and birth, delivered as close as possible to home.
- **Birth:** providing choice to pregnant women and people best suited to their individual needs, ensuring safe, personalised and high-quality care. The focus of this DMBC is on this element of the pathway.
- **Postnatal care:** defined as the first six to eight weeks after birth. This care is a continuation of the care received throughout pregnancy, labour and birth. High-quality postnatal care ensures that the mother and baby are recovering well and can have a significant impact on the life chances and wellbeing of the women or person, baby and family.

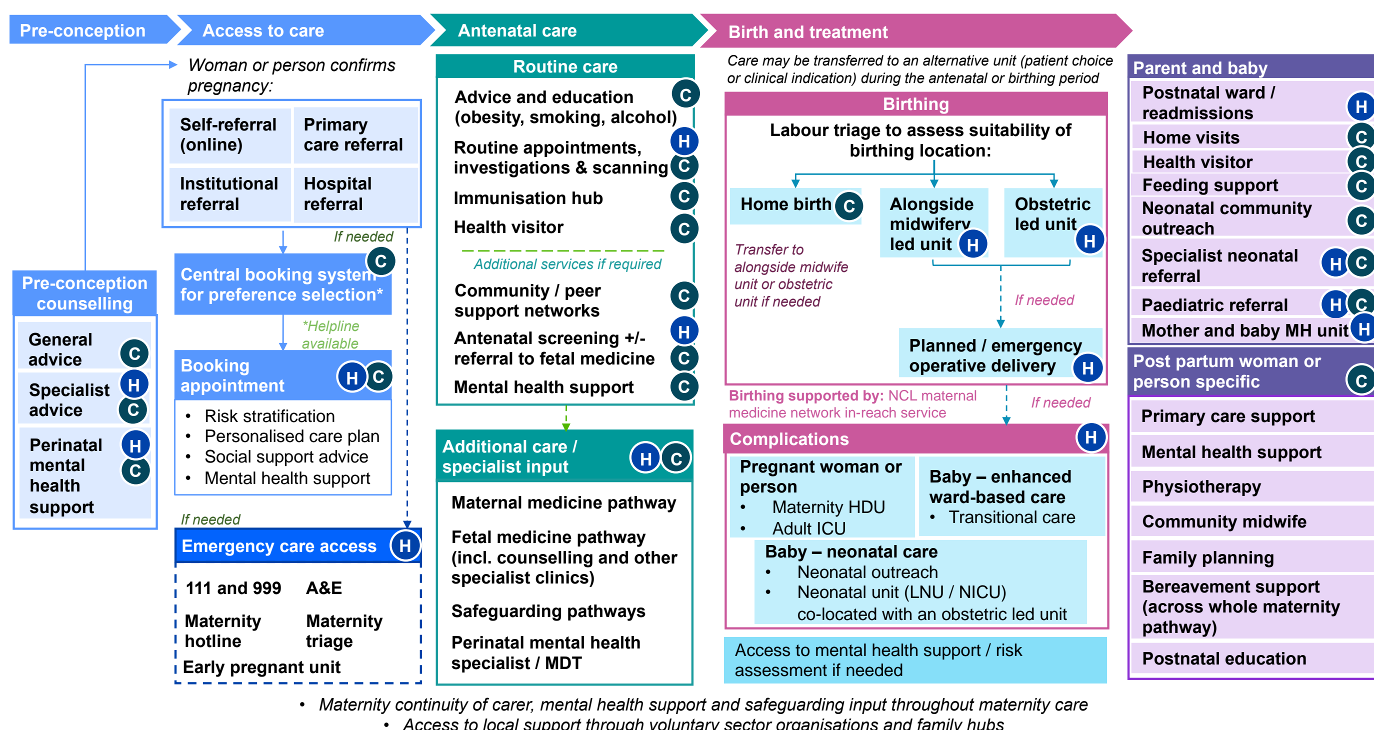

Figure 2: Maternity care model

Critical to, and underpinning our care model, is communication. We know from speaking with residents and patients that safe and compassionate care are paramount in maternity care. They felt that good communication was a vital component of good maternity services; information needed to be offered by health professionals at the right time, without patients having to ask a lot of questions. Further, it was important that health professionals took care to understand them and their needs and wishes – for example, where first languages were not English or where people had learning disabilities or differences. Across all elements of the proposed care model, we want to have compassionate and inclusive communication, where information is accessible in a wide range of languages, and cultural needs are considered and respected throughout. We are already working via the NCL local maternity and neonatal system (LMNS) with care professionals involved in maternity services to focus on this vital aspect of care.

5.4.1 Pre-conception and access to care

Whilst the proposals focus on the birth and treatment element of the maternity and neonatal pathway, it is important to acknowledge the pre-conception and access to care elements of the pathway. In NCL, our vision is that all women and people who are trying to conceive would have access to the right information to be able to make informed choices. Prospective parents would have access to pre-conception advice and counselling. This advice would be provided in the community but would draw on clinical input from hospitals as needed. This is especially important for people with existing medical conditions. A recent review and implementation of fertility policies in NCL has been concluded to ensure that there is equitable provision across the five boroughs[24].

5.4.2 Antenatal care

Antenatal care would be focused on providing proactive support and advice, using technology within community settings to ensure appointments are provided as close to home as possible.

[24] https://nclhealthandcare.org.uk/wp-content/uploads/2022/11/Fertility-policy-NCL-ICB-V1.0_250722-V2.pdf

These pathways are already in place in NCL and would continue to be available. By keeping these in NCL, it supports our residents and patients to easily navigate services. A wide range of support is available including:

- Advice and education (such as weight management, smoking cessation and alcohol advice)
- Routine appointments, investigations and scans, including detection of any maternal blood borne viruses
- Vaccination and immunisations for pregnancy programmes (pertussis, RSV and seasonal flu) delivered in maternity settings and GP practices (where possible)
- Antenatal screening (and referral to fetal medicine where necessary)
- Community and peer support networks
- Mental health and wellbeing support
- Safeguarding input throughout the maternity care journey, where necessary.

These services are offered as a mixture of face-to-face or virtual appointments, enabling choice for the woman or pregnant person. Pregnant women or people are made aware of services that are only accessible in either specific locations or face-to-face, to allow planning and minimise disruption to their routine, supporting freedom of choice and flexibility.

People are advised of the level of risk of potential harm during pregnancy and birth and are advised whether their birth should be consultant- or midwife-led, retaining choice for those women and pregnant people for whom either would be clinically safe. We recognise that women and pregnant people have differing needs depending on their own health and previous pregnancies. Women and pregnant people are advised of the level of clinical support that best meets these needs.

An important principle of our care model is that as much care is delivered as close to home as possible. Currently, community midwifery teams see patients in a number of out of hospital settings. These include community and family centres, as well as post-natal visits to the homes of new parents. The staffing model for care in the community is through borough-based community midwifery teams.

Antenatal appointments are currently delivered at all sites that support intrapartum care. This is often where scans and screening take place. This provides women and people with the opportunity to familiarise themselves with the site where they give birth. Under our new care model, we propose that the majority of appointments no longer take place at sites which do not support intrapartum care. These appointments would either be delivered at a local community-based site or would transfer to the site where the woman or person goes on to give birth. There may be some exceptions to this – for example, for women or people who have complex (or pre-existing) health conditions and who may require the input of other specialists in their care, in line with maternal medicine pathways.

Following consultation, we reviewed antenatal demand and capacity, including capacity and location of care available in the community, to ensure there is sufficient capacity in the right settings for all pregnant women and people. Further detail is shown in section 11.4.3.

If there are complications during the pregnancy, pregnant women and people would be able to access care at all hours via the maternity department. Any inpatient care would be provided on an antenatal ward. Further details on the potential impact of our proposals on early pregnancy units is shown in section 11.4.6.3.

5.4.3 Birth

Choice is an important aspect of maternity care, and the National Maternity Review stressed the importance of pregnant women and people being able to make an informed personalised choice about where they would prefer to give birth[25]. The review stated that pregnant women and people need to be supported to make decisions on whether they would like to give birth at home, in a midwife-led unit or in an obstetric unit, after a full discussion of the benefits and risks of each setting.

In the proposed care model, pregnant women and people would have the choice to deliver at three birth settings:

- **Home birth**: women and people who typically have a low risk of developing complications during delivery would have the support of two midwives at home if they opt for a home birth. When deciding on a home birth, the woman or person would be fully informed of the transfer times to a consultant-led obstetric unit if it were to be required.
- **Alongside midwifery-led unit**: women and people who have a lower risk of pregnancy complications may be advised to give birth in an alongside midwifery-led unit. The type of unit is typically on the same or next floor of the same building as the obstetric-led unit for quick access to specialists should further input be required. However, a midwifery-led unit facilitates a non-medicalised birthing experience, with a homely feel.
- **Obstetric-led unit**: pregnant women and people with moderate to high level of complexity would be advised to give birth at an obstetric-led unit that could provide sufficient care for all their needs. In line with national guidance, all obstetric-led units would be co-located with a neonatal unit, either a local neonatal unit (LNU) (level 2) or neonatal intensive care unit (NICU) (level 3). This would help to minimise transfers and avoid separation after birth. Many pregnant women and people give birth in an obstetric-led unit with little or no input from obstetricians because their birth progresses straightforwardly.

The Start Well Programme Board agreed in November 2022 that the proposed model of care would not include a standalone midwife-led birthing centre, for the following reasons (see the Edgware Birth Centre Addendum for more information):

- Falling demand for standalone midwife-led care due to falling birth rates in NCL and increasing complexity of births
- The very small number of women and people who use what is currently the only standalone midwife-led unit in NCL at Edgware Birth Centre
- The difficulty in significantly increasing the number of people using the birthing suites at Edgware Birth Centre
- The availability of midwives, which can often lead to short-term closures of the birthing suites at Edgware Birth Centre

Choice of birth location is an important aspect of maternity care. Ensuring that women and people are made aware of the options for their birth is an important aspect of our care model. To support this, the care model would ensure:

- There is access to impartial information regarding the options open to them, in a range of languages and formats.
- Information is made available locally to pregnant women and people in places where they could access it – for example, in primary care, family hubs, community spaces and antenatal clinics.

[25] https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

- Co-produced birth plans are personalised, and pregnant women and people have the space to freely discuss all options; included in this would be a discussion about risks related to all delivery options.
- NCL-wide training, education, tools, and resources to ensure midwives have the right skills and competencies to undertake open, supportive conversations around risk factors and choice and could confidently help pregnant women and people explore the range of options available to them.

5.4.3.1 *Home birth*

The option to give birth at home is a very important choice for pregnant women and people who wish to give birth in a non-medicalised setting. NCL is committed to offering choice, so that everyone who wishes to give birth at home has the option to do so.

Under our care model, dedicated home birth teams would continue to be available in all NCL boroughs, enabling pregnant women and people to give birth in familiar surroundings with the support from two midwives. To support those deciding whether home birth is the best option for them, open and honest conversations with midwifery and obstetric teams throughout the antenatal period would help identify individual levels of risk and therefore appropriateness of giving birth at home.

If there is a complication during a home birth delivery, the individual would be transferred via ambulance to the nearest obstetric-led maternity unit.

5.4.3.2 *Alongside midwife-led birthing unit*

The National Institute for Health and Care Excellence (NICE) recommends that for 45% of pregnant women and people who are at a low risk of complications, midwife-led care is the most appropriate choice of birth setting[26]. Should a complication occur during labour or delivery, the pregnant woman or person would be transferred to the obstetric-led unit, which would be near the midwife-led unit and would have medical workforce available all day, every day to provide the necessary support. The midwife-led unit would be staffed in line with the BirthRate Plus® recommendations[27]. These staffing levels are based on the case mix, the unit's physical space and local population demographics.

We know that currently the alongside midwife-led unit estate could be enhanced to make it 'less medicalised', and birth centres given a more unique identity that creates the feeling of separation from the obstetric unit. In line with the guidance, all birthing suites would have ensuite facilities and families would have access to support services.

We know that alongside midwife-led units currently face short-term closures due to staffing pressures. Even when midwife-led units are open they are often not fully utilised, with only 10% of all deliveries across NCL being in a midwifery-led unit. Through consolidation of the number of maternity units under our new model of care, we would aim to ensure that the choice of an alongside midwife-led unit could be facilitated on a more consistent basis. Further work would be done to safely increase the proportion giving birth in alongside midwife-led units and improve our ability to deliver choice.

5.4.3.3 *Obstetric-led unit*

Any individual identified as having a higher risk of complications during birth would be advised to give birth in an obstetric-led unit. All units would be staffed in line with the midwifery safe staffing

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[26] https://www.nice.org.uk/news/article/midwife-led-units-safest-for-straightforward-births

[27] https://birthrateplus.co.uk/ (safer midwifery staffing numbers)

guidance and the minimum required consultant labour ward presence, in line with the minimum requirements set out in the Ockenden Report[28].

Pregnant women and people and babies with identified additional care needs would be advised to deliver in obstetric-led birthing units where there is direct access to neonatal services should they be required.

5.4.4 Out of hours interventional radiology

Interventional radiology is required as part of the management of a very small number of women who are found to be at high risk of massive blood loss at delivery, usually due to the placenta being abnormally implanted. Specialist centres for the management of such cases have been established nationally, and UCLH provides this service for NCL. Interventional radiology teams may be on standby in case needed during the planned delivery of high risk women, or may occasionally undertake an intervention prior to delivery. Individuals would be risk stratified and provided with the information to understand the choices best suited to their needs.

Despite careful planning, unexpected complications during birth can occur. While postpartum haemorrhage (excessive bleeding which can sometimes happen after delivery of the baby) is a complication following delivery that occurs in around 5-10%[29] of deliveries, the vast majority of these cases are managed by the obstetric team in accordance with well-established protocols. Rarely, additional intervention is required to manage refractory bleeding,

Timely access to interventional radiology (IR) services for obstetric emergencies has been identified by the Royal College of Obstetrics and Gynaecology (RCOG) as an important specialist technique in the management of postpartum haemorrhage in these rare emergency situations. Timely access to support is important, and all sites providing maternity care in NCL would have access to interventional radiology 24 hours a day seven days a week, either on site or through networked arrangements out of hours.

In order to provide a safe treatment (usually an embolisation) to obstetric emergencies, the following would be in place in addition to an experienced interventional radiologist able to manage obstetric emergencies and specialist IR equipment within a theatre:

- The wider IR team, including nursing staff
- An obstetrician or gynaecologist, and potentially a neonatologist or paediatrician
- A vascular surgeon may very occasionally be required to attend the emergency.

The number of emergency obstetric cases needing access to interventional radiology is small. Royal Free and Barnet were the only sites where data was available, and there were fewer than ten cases that required this intervention between them in 2022/23. Clinicians have also reflected that these numbers have declined over recent years with improved obstetric management of emergencies.

In the future, through risk stratification pregnant women and people who are at risk of needing IR, for example those with abnormally invasive placenta, would be booked at UCLH as the maternal medicine centre where there would be co-location of IR and other specialist services. This means the number of pregnant women and people requiring this intervention at other sites is low.

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[28] Ockenden review: summary of findings, conclusions and essential actions. 2022.

[29] https://patient.info/doctor/postpartum-haemorrhage

Following consultation, we undertook further work on the potential impact of our proposals on out of hours interventional radiology. Further details are shown in section 11.4.6.6.

5.4.5 Postnatal care

Following birth, the woman or person and baby would receive a range of support through pathways based within NCL. Having these pathways and services locally across our boroughs makes it easier to navigate following delivery at an NCL site. Postnatal services available would include:

- Community midwife, home visits to provide physical review, feeding support, contraception education, advice and guidance, and handing care over to a health visitor at the appropriate time
- Postnatal education, including counselling for complications experienced during pregnancy, or discussing risk to the baby which would be preventable in future pregnancies, for example smoking and alcohol consumption
- Postnatal admission guidance for those who need to seek medical attention in the postnatal period
- Specialist neonatal referrals for babies who required neonatal care
- Paediatric referral for babies with ongoing needs
- Mental health support, including formal mental health services referral
- Specialist services follow-up for those who required it during their pregnancy
- Bereavement and loss support.

These would be delivered through a range of different methods, including home visits, virtual/group appointments and in community settings.

Following consultation, we undertook further work on the potential impact of our proposals on postnatal care. Further details are shown in section 11.4.3.

5.4.6 Maternal medicine

Individuals who have a pre-existing chronic or acute condition that requires more specialist input and management during pregnancy, would be referred to a maternal medicine clinic. Depending on the severity of their condition, they may require an onward referral to the maternal medicine centre (UCLH in NCL). At this unit, they would receive specialist maternal and fetal medicine input before, during and following pregnancy. This would be delivered in line with the NCL maternal medicine network pathways and follows the service specification as set out by NHSE[30]. Further details on the potential impact of our proposals on maternal medicine services can be found in section 11.4.4

5.4.7 Continuity of care

As was identified through the case for change, not all pregnant women and people have the same outcomes from maternity care in NCL. Our ambition is to improve and reduce differences in outcomes experienced and have a positive impact on health inequalities.

Midwifery continuity of carer (MCoC) is where the patient sees the same midwife or small team of midwives throughout their pregnancy and in the post-partum period. It allows pregnant women and people to build a relationship with their midwife and reduces the need to repeat medical information or traumatic experiences. Continuity has been shown to have several beneficial

[30] https://www.england.nhs.uk/publication/maternal-medicine-networks-service-specification/

outcomes, especially when prioritised for those at risk of poorer outcomes[31]. MCoC has been recognised nationally through the inclusion of maternity, and specifically the provision of continuity of carer, in the CORE20PLUS5 framework. This is reflected locally in the work of the LMNS, who are supporting Trusts with maintaining existing MCoC provision in line with safe minimum staffing requirements.

In line with the three-year delivery plan, the LMNS is also working with some Trusts to deliver an enhanced midwifery continuity of carer team model to three areas in NCL to target people from minority ethnic groups and those living in areas of deprivation. Funding has been received nationally to support with the provision of this enhanced offer. The funding is being used by local Trust enhanced midwifery continuity of carer teams to fund additional holistic support that reduces midwives' workload and releases additional time for the midwives to care for pregnant women and people. Some teams have used the funding for an additional maternity support worker and/or social prescribing role to support with the provision of holistic care to the pregnant women and people the team supports.

There is an aspiration that all pregnant women and people would have continuity of carer in the future; consolidation of our workforce to a smaller number of sites makes the likelihood of achieving this more feasible. Further information of the potential impact of our proposals on continuity of care can be found in section 11.4.2.

5.4.8 Perinatal mental health

Access to perinatal mental health services is a national priority and this is reflected within services in NCL. Throughout the pregnancy pathway, pregnant women and people would have access to specialist perinatal mental health services should they need additional support. There is also support provided by a perinatal provider collaborative across NCL and NEL for the inpatient elements of perinatal mental health care. Improving access to perinatal mental health is a key priority of the Mental Health Programme and investment has been made to start to improve access and address the longstanding inequities in provision between boroughs.

5.5 Neonatal care model

In NCL, we need to reorganise our provision of neonatal care to meet guidelines recommended by BAPM[32] and ensure we have sustainable neonatal units for the future. We want a neonatal care model that ensures the same provision of care no matter which unit the baby is born in. The neonatal pathway can be separated into four sections and the pathway has been driven by the service and quality standards set out in BAPM[33]. An overview of the proposed neonatal care model is set out in Figure 3.

[31] https://www.rcm.org.uk/media/2265/continuity-of-care.pdf

[32] BAPM. Service and Quality Standards for Provision of Neonatal Care in the UK. 2022. https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk

[33] https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/1494/BAPM_Service_Quality_Standards_FINAL.pdf

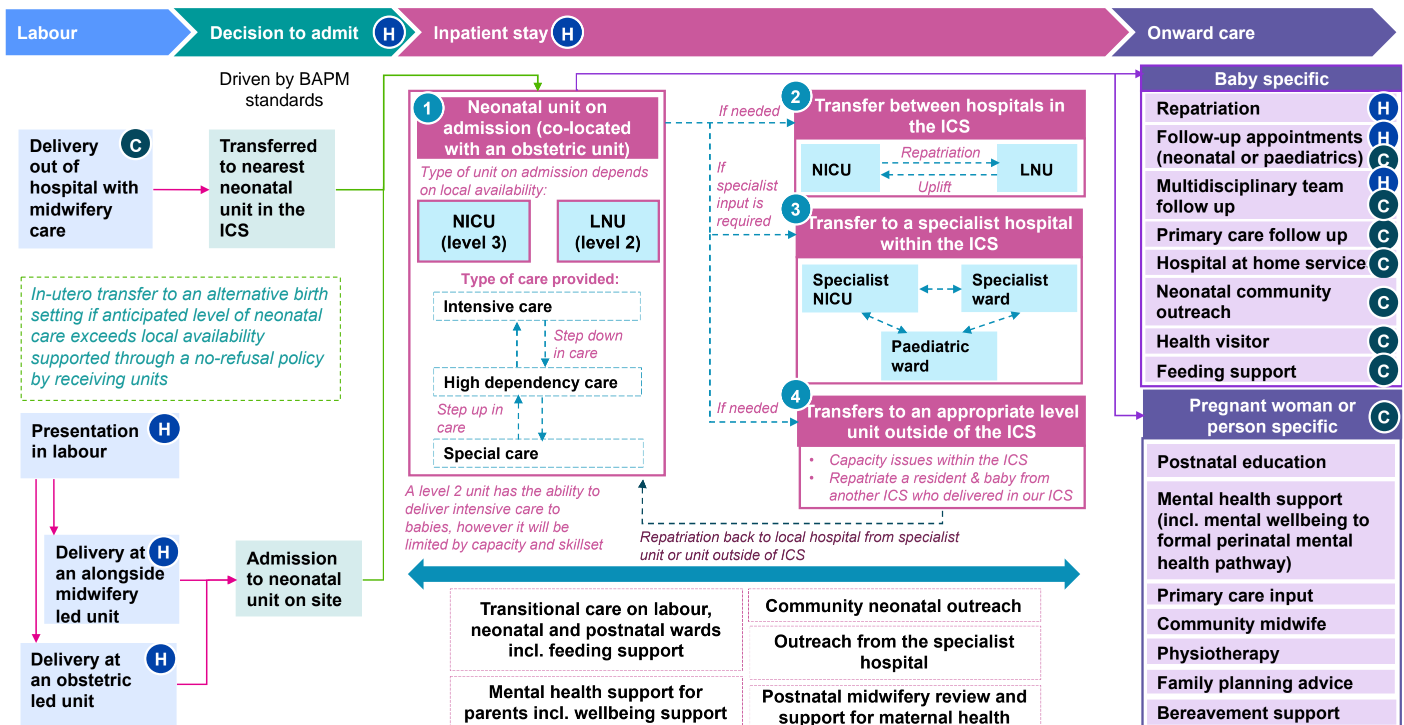

Figure 3: Neonatal care model

In developing the model, clinicians and the London neonatal operational delivery network (ODN) acknowledged that special care units (SCUs) (level 1) are more effective in a rural setting, to support repatriation of babies closer to home where travel times are much longer than in urban settings. The London ODN advised that SCUs (level 1) do not represent the optimum model of care in London. It has become increasingly difficult to ensure that medical staff in SCUs (level 1) maintain essential clinical skills, due to the low volume of complex care to which they are exposed. The view of the ODN is that these units are not sustainable in the long term. It was therefore agreed that in NCL all neonatal units should be either a local neonatal unit (LNU) (level 2) or neonatal intensive care unit (NICU) (level 3).

5.5.1 Labour and decision to admit to a neonatal unit

Pregnant women and people would be advised to deliver at a unit where the level of neonatal support available is in line with their baby's anticipated needs. Those whose babies are at high risk of requiring intensive care would deliver in an obstetric unit with a co-located NICU (level 3). If there was an unexpected complication (such as pre-term labour or a complication during labour), an in-utero transfer to an appropriate birth setting would ideally be undertaken.

Depending on the birth setting, a baby may be admitted to the neonatal unit on site, from either an obstetric-led unit or an alongside midwifery-led unit. Babies born at home who unexpectantly require an admission to a neonatal unit, would be transferred by ambulance to the nearest appropriate neonatal unit.

5.5.2 Inpatient stay

In the proposed care model, all hospital-based neonatal care would be delivered in either an LNU (level 2) or NICU (level 3). Babies admitted to these units may require special care, high-dependency care and/or intensive care and both types of units could deliver these three levels of care, although intensive care in an LNU (level 2) would only be provided on a short-term basis.

These neonatal units would mean that the highest quality of initial care is provided to all babies born in NCL, no matter which unit they are born in.

These units would be staffed in line with the BAPM guidance[34] and would include specialist medical workforce as well as nursing staff and AHPs. The specialist medical and nursing workforce would be available 24/7 so babies would have access to specialist care at all times of the day and all days of the week.

If a baby's care needs are beyond the capabilities of the neonatal unit at their place of birth, they may require a transfer to another unit within or outside the ICS, or to a specialist hospital. This would typically mean moving from an LNU (level 2) to a NICU (level 3). Our ambition is that NCL providers operate a 'say yes' policy for all transfers within NCL.

To allow baby and mother, person or parent to be close to their family and support network, babies would be repatriated back to their nearest neonatal unit at the earliest opportunity it is safe to do so. Babies requiring specialist care may be transferred to a specialist NICU (level 3), specialist ward or paediatric ward within a specialist hospital.

5.5.3 Onward care

Following discharge, the mother or person and baby would have access to a range of onward care support services. Access to these services means that babies would be able to be treated closer to home, reduce the time spent in hospital and prevent further admissions. Onward care services available would include:

- Community children's hospital at home services
- Neonatal community outreach
- Feeding support
- Postnatal education
- Mental health support, ranging from mental wellbeing to referral to specialist perinatal mental health services
- Community midwifery teams
- Family planning advice
- Bereavement and loss support

These services would be available across NCL and would be delivered through a range of different methods, including home visits, virtual/group appointment and in the community.

5.5.4 Neonatal workforce model

Neonatal units in NCL would be staffed in line with BAPM guidance[13] with the projected capacity modelled based on cot requirements at 80% occupancy. For the medical workforce this would be:

Consultant workforce

- LNU (level 2) unit: minimum of **7 WTE neonatal paediatricians/neonatal consultant**
- NICU (level 3) unit: minimum of **7 WTE consultant neonatologist.** A consultant neonatologist has a certificate of Completion of Training (CCT) in neonatal medicine.

Middle grade workforce

- LNU (level 2) unit: shared rota with paediatrics, comprising a minimum of **8 WTE**

[34] BAPM. Service and Quality Standards for Provision of Neonatal Care in the UK. 2022.

- NICU (level 3) unit: EWTD compliant rota with a minimum of **8 WTE staff.**

Neonatal nursing
In line with the BAPM guidance[35], neonatal nursing requirements would be based on the cot type as follows:
- Intensive care: 1:1 (one nurse for every baby)
- High dependency: 1:2 (one nurse for every two babies)
- Special care: 1:4 (one nurse for every four babies).

The units would also aim to meet the qualified in speciality (QIS) requirements outlined by the Department of Health, where 70% of staff on a neonatal ward should achieved QIS status by March 2024[36].

Allied health professionals
Units would aim to have the Allied Health Professional support in line with guidance as follows:
- LNU (level 2) WTE requirement per cot:
  - **Dietetics:** 0.1 (intensive care cot), 0.05 (high dependency cot), 0.03 (special care cot)
  - **Occupational therapist:** 0.05
  - **Physiotherapy:** 0.05
  - **Speech and language therapist:** 0.03.

- NICU (level 3) the WTE requirement per cot are:
  - **Dietetics:** 0.1 (intensive care cot), 0.05 (high dependency cot), 0.03 (special care cot)
  - **Occupational therapist:** 0.05
  - **Physiotherapy:** 0.05
  - **Speech and language therapist:** 0.04.

5.5.5 Clinical co-dependencies

High-quality maternity and neonatal services would be provided 24 hours a day, seven days a week. Consultant-led obstetric services would be supported by other services, in line with guidance set out in the South East Coast Clinical Senate publication - The Clinical Co-Dependencies of Acute Hospital Services -, including emergency medicine, critical care and general anaesthetics[37]. An overview of all clinical co-dependencies is set out in Figure 4.

[35] https://hubble-live-assets.s3.amazonaws.com/bapm/file_asset/file/101/BAPM_Guidance_on_Cot_Capacity_and_use_of_Nurse_Staffing_Standards_24-10-19.pdf

[36] https://www.hee.nhs.uk/sites/default/files/documents/RSM%20Neonatal%20QIS%20Review.pdf

[37] https://secsenate.nhs.uk/wp-content/uploads/2020/06/The-Clinical-Co-dependencies-of-Acute-Hospital-Services.pdf

Services should be co-located in same hospital	Service should come to patient, but could be provided by visiting/in reach	Ideally on same site but could alternatively be networked
Critical care adult	Acute and general medicine (within 4 hrs)	Urgent GI endoscopy
General anaesthetics	Respiratory medicine (within 4 hrs)	MRI scan
Neonatology	Medical gastroenterology (within 4 hrs)	Interventional radiology
X-ray and diagnostic ultrasound	Diabetes and endocrinology (within 4 hrs)	Dietetics
CT scan	Gynaecology (within 2 hrs)	
Urgent diagnostic haematology and biochemistry	General surgery (upper GI and lower GI) (within 2 hrs)	
	Urology (within 2 hrs)	
	Vascular (within 2 hrs)	
	Plastic surgery (within 24 hrs)	
	Acute cardiology (within 4 hrs)	
	Nephrology (not including dialysis) (within 4 hrs)	
	Neurology (within 4 hrs)	
	Clinical microbiology / infection service (within 4 hrs)	
	Physiotherapy (within 24 hrs)	
	Urgent mental health services (within 4 hrs)	

Figure 4: Obstetric service clinical co-dependencies

The proposed maternity and neonatal care model means that maternity care would be offered in an obstetric-led unit, an alongside midwife-led unit and in a home setting, and that neonatal care would be delivered in a neonatal intensive care unit (level 3), or local neonatal unit (level 2) as outlined in Figure 5.

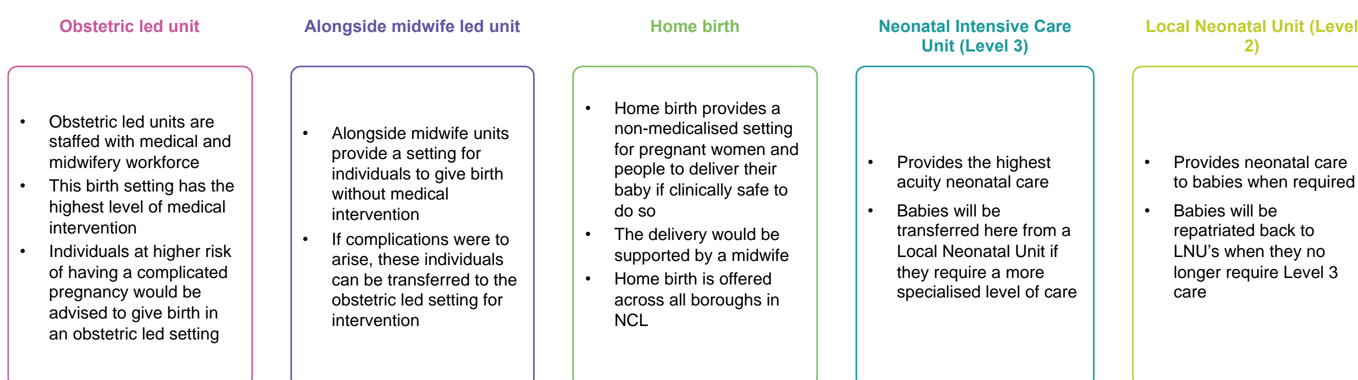

Figure 5: Overview of the type and location of maternity and neonatal units in NCL

5.6 Interdependency between obstetrics and gynaecology

Obstetric and gynaecology services are linked with one another through workforce. Doctors in obstetrics and gynaecology care for pregnant women and people and look after the sexual and reproductive health of women and people. When on call, doctors often cover both obstetrics and gynaecological emergencies out of hours and may have job plans which have include elements of both obstetrics and gynaecology service provision. Given this link, should any changes be made to obstetric services, there may be a resulting impact on gynaecology services at the site that no

longer supports intrapartum care. Following consultation, we undertook further work on the potential impact of our proposals on gynaecology. Further details are shown in section 11.4.6.2

6. Assurance prior to public consultation

6.1 Introduction

Prior to consultation, there was extensive assurance of our proposals, including from NHS England London Regional Office, the London Clinical Senate, London Mayor and the Joint Health Overview and Scrutiny Committee (JHOSC). The details of this assurance were set out in our PCBC and a summary is shown below.

6.2 NHS England London Regional Office

Any proposal for service change must satisfy the government's four tests, NHSE test for proposed bed closures (where appropriate), best practice checks and be affordable in capital and revenue terms. Prior to consultation, NHS England London Regional Office assessed that we met all these tests prior to formal public consultation:

1. **Strong public and patient engagement:** we undertook significant patient and public engagement during all phases of the programme
2. **Consistency with current and prospective need for patient choice:** our proposal would ensure that pregnant women and people would have the choice to deliver in a home setting, midwifery-led unit or obstetric-led unit
3. **A clear, clinical evidence base:** the PCBC was developed on the basis of clear, clinical evidence. The case for change, clinical model and process for developing and appraising options were all grounded in clinical evidence. The Clinical Reference Group (CRG), which had membership from across the five NCL potentially impacted trusts, as well as a range of other system leaders were involved in the options appraisals process. There was wider clinical engagement to develop the care model, which included:
    - Two half day workshops attended by nearly 90 individuals from both the NHS and local authorities
    - Nine dedicated task and finish groups
4. **Support for proposals from clinical commissioners:** NCL ICB and NHSE London Region Specialised Commissioning have led the development of the programme from the outset. The Start Well Programme has been progressed through the NCL ICB Board governance arrangements, in accordance with the organisation's constitution.
5. **Hospital bed numbers:** The proposed service change would not reduce hospital bed numbers and therefore the conditions set out by this test do not apply.

Prior to public consultation, NHSE **assured** the proposals set out in the PCBC and **assured** the financial proposals in terms of both capital and revenue affordability.

6.3 London Clinical Senate

We followed best practice for service change and sought advice from the London Clinical Senate on our proposals. The London Clinical Senate undertook a review of the care model and draft PCBC in two stages:

1. Initial review of our case for change and care model (July 2022)
2. Review of our draft PCBC (July 2023)

Following the full review, the Clinical Senate provided 28 recommendations. The PCBC responded to all 28 recommendations – either to address them or describe further work that would be undertaken for subsequent phases. The further work completed as part of this decision-making business case is shown in sections 4.2, 5.2, 8.2, 9.2, 11.4.1, 11.5.1, 11.8.1, 12.1 and 13.2.1. Based on the recommendations an action plan was developed by the programme team to address the recommendations of the Clinical Senate. The recommendations received fell into a number of categories and were subsequently reviewed and responded to by specific working groups.

- **Activity, capacity and finance modelling:** addressed through the Finance and Analytics Group
- **Workforce:** considered through the CRG and with the Start Well Workforce Working Group and Chief People Officers
- **Service model/patient pathways:** considered through the CRG and PPEG
- **Stakeholder engagement:** considered through the CRG and PPEG

The proposals in the PCBC were updated to reflect the comments and additional work undertaken as a result of the Senate report. The Senate confirmed that a further review of the final PCBC was not needed ahead of formal public consultation in December 2023.

6.4 London Mayor's six tests

The London Mayor has set out six key assurances needed to ensure the local population get the best healthcare possible. Prior to publication of the PCBC, the Mayor assessed our work against the first four of the six tests. A letter from the Mayor [38] stated his position on the proposals with regard to the first four tests and outlined his recommendations including:

- Describing quantifiable commitments and targeted interventions for reducing inequalities, demonstrate how the options appraisal process has been influenced by opportunities to improve the inequalities baseline
- Ensuring future population need aligns to demographic projections
- Additional modelling based on the people living in the impacted areas of NWL and how any need-related resource gaps would be addressed
- Confirming how stranded costs would be managed across the system and more detail on the financial flows
- Provide further detail on plans in place to achieve better join up between ICS led and local authority led services

Assessment against the final two tests has been undertaken as part of the DMBC assurance process. Further consideration to the Mayor's recommendations has been given as part of the development of this DMBC and our responses are shown in section 10.2.

6.5 Joint Health Overview and Scrutiny Committee (JHOSC)

We have engaged with the JHOSC throughout the Start Well programme. This has included updates on progress, the proposed changes, and engagement on the approach to public consultation which helped to inform our consultation approach. The letter from the JHOSC following consultation is shown in appendix A.

[38] https://www.london.gov.uk/sites/default/files/2024-03/003%2024.03.13%20FINAL%20Six%20Tests%20Letter%20-%20NCL%20Maternity%20and%20Neonatal%20Services%20%28003%29%20%282%29.pdf

7. Background to consultation

7.1 Introduction

The Start Well programme public consultation on the options for delivering maternity and neonatal services to address the challenges identified in our case for change was launched on 11 December 2023, for 14 weeks, and closed on 17 March 2024[39]. For the purposes of this consultation, the proposals were put forward by NCL ICB, on behalf of NCL ICS (comprising the boroughs of Barnet, Camden, Enfield, Haringey and Islington) and NHSE London Region Specialised Commissioning. The consultation was overseen by the Start Well Programme Board on behalf of all partners.

7.2 Meeting our legal duties

Under Section 14Z2 and Section 13Q of the NHS Act 2006, NHSE and the ICB have a duty to make arrangements to secure that individuals who use or may use NHS services, and their carers and representatives (if appropriate) are involved in the development and consideration of proposals that would impact on the manner in which the services are delivered or the range of health services available and in decisions that would have such impact. The ICB and NHSE have done this through the pre-consultation and formal consultation activities set out in this chapter.

The ICB has considered its duties under generally applicable law. In particular, the ICB has a duty to consult the local authority, under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, made under section 244 NHS Act 2006, where substantial development or variation changes are proposed to NHS services. The ICB has done this through its engagement with the Joint Health Overview and Scrutiny Committee as set out in section 7.8.11.1.

In addition, the ICB has complied with the Equality Act 2010. Our interim IIA formed an important part of ensuring we have met our legal duties under the Equality Act 2010, including the public sector equality duty. At the pre-consultation stage:

- We identified target populations who may be more impacted by proposals, with a focus on those with protected characteristics
- Based on this, we identified groups that we particularly wanted to hear from during the consultation
- The methodology, activity and reach report describes that we were successful in hearing from the full range of these groups (as set out in section 7.8.9)
- Their feedback has been reflected in an updated impact assessment and further informed our approach, in compliance with our legal duties under the Equality Act

We have delivered a best practice consultation, based upon the Start Well communication and engagement principles and ensured that all our statutory duties are met. The comprehensive feedback gathered has played a crucial role in shaping the final decisions on the proposed changes, ensuring that the services provided are safe, timely, and of outstanding quality for all local residents.

[39] The consultation included proposals set out in a separate business case around paediatric surgical services. These were separate proposals, and the outcomes were reported on separately. A separate decision on paediatric surgery will follow at a later stage.

7.3 Engagement principles

We continued to work to the programme's engagement principles throughout the public consultation. These were agreed through the communication leads working group and Start Well Programme Board:

- Work collaboratively, openly and transparently, involving residents.
- Ensure the experiences and aspirations of local people directly influence the programme.
- Make every effort to involve communities who experience poorer health outcomes and greater health inequalities.
- Work to flexible timelines to allow time for meaningful, authentic engagement, balanced against the need to maintain momentum.
- Use a variety of methods, tailoring our approach to be accessible to diverse communities and remove barriers to participation.
- Be inclusive and ensure a wide and diverse range of stakeholders have an opportunity to meaningfully contribute.
- Work in partnership with local voluntary, community and social enterprise sector (VCSE) organisations and councils and draw on their specialist engagement expertise and advice.
- Tell staff, families and pregnant women and people how their feedback has helped to shape the programme and informed decision making.

7.4 Pre-consultation engagement

The consultation was preceded by extensive stakeholder engagement in the development of the pre consultation business case, from the start of the review in 2021. This included engagement in the development of the case for change, care model and interim integrated impact assessment, as shown in Figure 6.

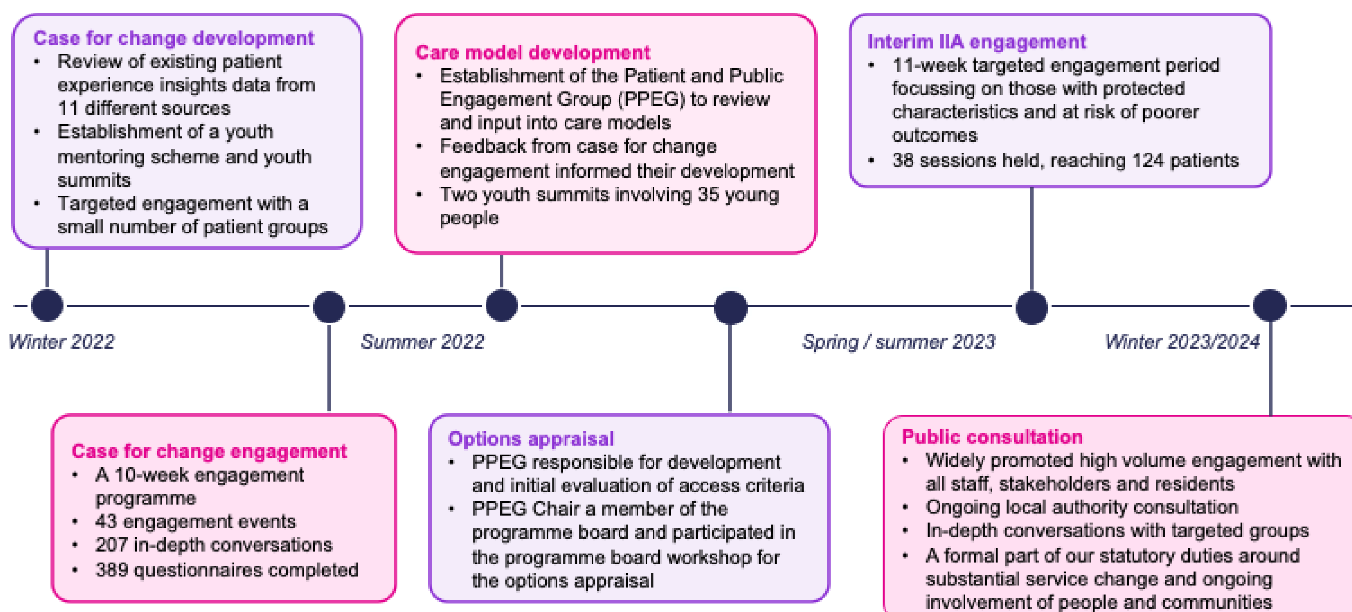

Figure 6: Pre-consultation activities

7.5 Aims of the consultation

During the consultation, we aimed to:

- Raise awareness of the public consultation and how to participate with staff, stakeholders, service users and the public in NCL and neighbouring areas

- Provide clear and accessible information about proposals and how they had been developed
- Provide a range of mechanisms and opportunities for staff, residents, and stakeholders to share their views
- Ensure diverse voices were heard and with a particular focus on people and communities with protected characteristics and those who may be more impacted by the proposals
- Seek alternative proposals or new evidence
- Understand the impacts, unintended consequences of the proposals and any possible mitigations to reduce negative impact
- Ensure feedback was recorded and could be analysed to support thoughtful decision-making

We achieved the aims of our consultation through:

- Developing a range of materials that explained the consultation proposals in an accessible way
- Ensuring feedback could be shared several ways: questionnaire, telephone, written response, at a focus group and through attending a public drop-in session
- Focussing resources and working with the voluntary sector to reach population groups identified as potentially more impacted through our interim impact assessments
- Widely promoting the opportunity to take part in the consultation through ICB and partner public channels, including social media, newsletters, and local media
- Engaging with staff working across services and in the wider NHS
- Targeted geographical focus groups and direct mailings to households likely to be more impacted
- Very targeted activities through specialist third party suppliers – to reach some health inclusion groups, including refugees, asylum seekers, and Gypsy, Roma, Traveller communities

7.6 Consultation plan

The consultation plan was developed in line with best practice. The plan was a working document that was iterated during the consultation as we monitored responses and participation. In developing the plan, we considered feedback from all our early engagement and interim IIA engagement activities. We developed the consultation with input from the JHOSC and agreed the consultation plan with them at their meeting on 30 November 2023.

In line with the consultation plan, we worked closely with partners to carry out the consultation activities and analyse the responses.

7.7 Consultation approach

A questionnaire was developed which was designed to gather feedback on the proposals. The questions were used as a framework for focus groups and meetings that were undertaken to gather feedback. At a high level, these questions covered:

- The **characteristics / demographics** of the person or organisation responding (e.g. gender, age, place of residence, capacity in which they were responding)
- Whether the **challenges described were recognised**, and the extent to which there was agreement that changes are needed to address them
- The **level of support for the proposal described**, and which of the options for maternity and neonatal services was preferred
- Any **alternative solutions** that could address the identified challenges
- Any **equalities impact** of the proposed changes

There were also other feedback mechanisms made available, including written submission, attendance at meetings / focus groups and drop-in feedback sessions which aimed to capture the same information as the questionnaire.

These questions allowed levels of support for the proposals to be assessed, and how this varied by type of stakeholder or place of residence, as well as providing an opportunity for stakeholders to suggest alternatives, describe impacts and raise any other concerns. Cumulatively, feedback from these questions ensure decision-makers are properly informed of the diversity of views from different stakeholders, in conjunction with a range of other available evidence, as they make final decisions on service change.

At the middle-point of the consultation, we conducted a review of progress against the priorities that were set out in our plan. This meeting was attended by the senior team overseeing the programme from the ICB, NHSE London Region and the independent contractor evaluating the consultation. This process helped to identify gaps in the responses or activities to date and led us to agree some priority actions for the remainder of the consultation period.

7.8 Delivering the consultation

7.8.1 Summary of consultation activities

The Start Well Programme consultation was extensive and aimed to gather people's views on the proposals over a 14-week period. We designed a detailed programme of activities to provide information, reach out to local community and listen to the view of the local population and wider stakeholders. Our consultation activities were extensive and supported by the Start Well Programme team and in some cases voluntary organisations for specific groups. These included:

- 199 meetings reaching just under 3,400 people including:
    - 32 in-depth staff sessions reaching 470 participants
    - 26 drop-ins reaching nearly 600 people
    - 46 targeted sessions reaching 503 people
    - 34 in targeted geographies reaching 582 residents
    - 8 GP meetings reaching 279 GP staff
- Social media promotion leading to over 720,000 impressions and 3,670 clicks through the consultation website
- 1,310 views of video content
- Almost 7,000 letters sent to target geographies identified by the interim IIA
- Print adverts in 13 local papers
- 40 items of news coverage
- 1:1 briefings with a wide range of key stakeholders

7.8.2 Consultation materials

In line with the consultation plan and principles, we developed a range of materials in different formats to support the consultation. These materials were designed to be accessible and ranged from being very detailed to summary versions that explained the proposals in brief. Materials were developed with the support of an external organisation that specialises in supporting organisations to engage and consult effectively. The materials were also reviewed as part of the NHSE Stage 2 assurance process. An overview of the range of materials developed are shown in Figure 7.

Materials	Description
Consultation document	Public-facing summary of the PCBC. Detailed document which outlined in full the proposal included in the consultation.
Summary consultation document	A shorter summary of the consultation document giving an overview of the proposals. The document was translated into eighteen of the most commonly used languages in NCL and NWL boroughs and other languages as requested during the consultation itself. Translations were available in: Albanian, Arabic, Bengali, Bulgarian, Farsi, French, Gujarati, Italian, Kurdish, Polish, Portuguese, Romanian, Somali, Spanish, Sylheti, Turkish, Ukrainian and Urdu.
Consultation leaflet	A much shorter document about the consultation that could be read quickly to understand the key information about the proposals and to signpost to further information if needed
Easy read consultation document	Document that was written to be more accessible and easier to understand. The document contained lots of images to explain the proposals and less text.
Consultation questionnaire	A questionnaire was developed which aimed to capture views of respondents on the proposals. The questionnaire was independently hosted on an independent organisation's website which was accessed through the ICB webpages. Physical copies of the questionnaire were also available with a freepost address to return. The questionnaire was translated into seven key community languages including: Polish, Turkish, Kurdish, Romanian, Somalian, Italian and Ukrainian. Further languages were available upon request.
Animation	A short animated video was developed that explained the maternity and neonatal services proposals. The video was less than three and half minutes long and explained the context for the consultation, rationale for why the changes are needed and the anticipated benefits.
Posters	Range of posters were designed to promote the consultation. These included an image, a description of the consultation, dates that the consultation was live and a QR code linking to the ICB website and consultation materials. The posters were distributed to high footfall areas where people may have an interest in the proposals and given out at events to people who expressed an interest in finding out more.
Leaflet with QR code	Small leaflet was designed that included a description of the consultation and a QR code linking to the ICB website where people could access more information and complete the questionnaire.
Communications toolkit	A toolkit was developed to support our partners in promoting the consultation. The toolkit contained a range of agreed text and wording that could be used to promote the consultation. This ranged from a long-form article to be used in newsletters, to much shorter news item and social media text and graphics. The toolkit was refreshed in the middle of the

	consultation to have content that promoted borough drop-in events, as well as text that could be shared via WhatsApp.
Frequently asked questions	Answers to some frequently asked questions were included on the ICB website. Responses covered content such as the process and timeline of the programme, some further information about the proposal themselves and how the proposal may impact on residents.

Figure 7: Overview of consultation materials

We hosted the core consultation materials on the NCL ICB website and had alternative text enabled for those who use screen readers. We printed physical copies and used these as supporting materials at events. We made materials available at key locations such as at each hospital for people to read and pick up. Physical copies could also be requested to be sent to individuals who contacted the consultation team.

7.8.3 NCL Integrated Care Board website

Our public-facing webpages were hosted on the NCL ICB website and an easy to read URL (nclhealthandcare.org.uk/start-well) was made and published on printed materials. Our website was used as the primary place where residents, services users and stakeholders were directed to information about the consultation, how they could give their feedback and where they could access the online questionnaire. In total over 6,300 individuals visited the consultation website home page over the 14-week period. Figure 8 shows the number of visitors to different pages on the consultation website through the consultation period.

Website page	Total views	Individual user views
Consultation home page	8,906	6,335
Key information page	1,257	919
Share your views page	922	677
Drop in sessions page	921	727
Additional document page	244	97

Figure 8: Website page visitors

7.8.4 Use of social media

We used social media in different ways to promote the opportunity to take part in the consultation. This included:

- Regular posting on the ICB, NHS Trusts and NHSE London social media accounts. This included X (formerly Twitter), Instagram and LinkedIn. Posts were planned at weekly

intervals with more frequent posting around particular milestones or when additional content was available.
- Video content featuring staff working in the services which encouraged people to take part in the consultation was shared on our YouTube channel which was promoted via social media
- A paid-for advertising campaign on Facebook and Google was undertaken to promote the consultation in the local area. This targeted all adults aged 18+ in Barnet, Brent, Camden, Enfield, Haringey, Harrow and Islington.
- A secondary paid-form social media advertising campaign was undertaken to promote the opportunity to take part in focus groups which targeted people from certain demographics (older and younger women)
- Promotion of the consultation via social media by external parties including local politicians, councils and voluntary sector organisations

Overall figures on the reach and engagement with the paid online advertising was:
- 702,583 impressions[40] (439,693 from Google display and 262,890 from Facebook)
- 3,356 clicks to consultation (1,368 from google display and 1,988 from Facebook)

Overall figures on the reach and engagement with the ICB's social media post was:
- 20,996 impressions to consultation (16,582 from X, 2,667 from Facebook and 2,667 from Instagram)
- 315 clicks to consultation (275 from X and 40 from Facebook)

Overall number of views of the videos uploaded to YouTube and shared via the website and social media posts was:
- 934 views of the Start Well consultation video outlining the proposals
- 376 views of the staff video content encouraging residents to take part

7.8.5 Use of other media

As part of our consultation plan it was agreed that we would use print and media in addition to social media to promote the consultation. This included paid-for advertising as well as earned media (promotion gained form methods other than paid advertising).

7.8.5.1 *Paid-for print advertising*

To promote the consultation to local residents, we took out either half or quarter page adverts in local papers:
- Camden New Journal
- Islington Tribune
- Islington Gazette
- Brent and Kilburn Times
- Ham and High
- Barnet Borough Times
- Enfield Independent
- Barnet Post
- Haringey Community Press
- Enfield Dispatch

[40] An impression is when a user sees an advertisement or social media post. It occurs any time a user opens an app or website and the post, advert or content is visible

Half or quarter page adverts were also taken out in three specialist local Jewish circulars/papers to promote the consultation to the Orthodox Jewish community:

- Hamodia
- The North London Circular
- The Jewish Tribune.

7.8.5.2 *Earned media*

The NCL ICB communications team worked with local media to encourage regular news articles about the consultation. To achieve this, the following activities were undertaken:

- A briefing for the local press was arranged to coincide with the ICB Board papers being published to share the aims of the programme and the proposals for the consultation that the ICB Board was being asked to consider at their meeting (28 November 2023)
- Press releases were shared on the following dates:
    - 29 November 2023: when papers were published for the ICB Board meeting, outlining the proposals for consultation
    - 11 December 2023: at the launch of the public consultation
    - 6 February 2024: a letter from NCL clinical leaders was shared with media outlets, encouraging feedback on the proposals
    - 12 March 2024: a reminder that residents had one more week to share their views on the proposals
    - 18 March 2024: sharing that the consultation had closed, thanking people for their input and outlining next steps
- In addition to this, four interviews were accepted for London radio and television. The Chief Medical Officer of NCL ICB (and Chair of the Start Well Programme Board) took part in these interviews representing the ICB.

This activity resulted in over 40 pieces of media coverage which ranged from articles in local and national papers as well as interviews on BBC London Radio and coverage on ITV London news.

7.8.5.3 *Promotional materials in key locations*

There were a number of materials which were made available to promote the consultation including a QR code that linked directly to the consultation website. This included:

- Posters, banners and leaflets at all the local hospital sites, targeted in locations likely to be used by those accessing maternity services (for example clinic areas)
- Posters and leaflets in local libraries, with a particular focus on areas close to the potentially impacted hospitals
- Posters and leaflets in local children's centres
- Posters left in voluntary sector organisations
- Posters left in faith venues

7.8.6 Promoting the consultation through local voluntary sector organisations and councils

During the consultation period, we wrote at least three times to over 300 relevant local voluntary and community sector organisations to inform them of the consultation and ways in which they could take part and ask them to also pass this on to their local networks and communities. We also circulated our communications toolkit which had consistent text and other content that could be used. This included newsletters, social media posts and text to share via WhatsApp.

We worked with colleagues in local councils (in all NCL boroughs, Brent and Harrow) to promote the consultation in local schools' bulletins. This was done on two occasions – at the start of the

consultation period and towards the end of the 14-week period. Brent council colleagues also supported the consultation by using the communications toolkit to promote the opportunities to take part through participation on their 'Have Your Say Platform' which promotes live consultations to residents.

7.8.7 Promotional events

During the consultation period the Programme team attended a number of promotional events aimed at encouraging engagement with the consultation. These were targeted in areas where it was likely potential service users may be and in certain geographies. These events included:

- Drop-ins at all hospital sites, in particular antenatal and children's clinics
- Drop-ins at local health centres in target geographies – the timing of attendance focussed on baby weighing clinics
- Attending 'stay and play' sessions at local children's centres – particularly in areas likely to be impacts by potential changes and in areas identified through the interim IIA
- Attendance at existing health promotion events organised by other organisation – such as community breakfast clubs, where residents could access health checks and advice

The programme team attended 64 events that fell into the above categories, reaching 1,425 people.

7.8.8 Open to all drop-ins

In addition to directing residents to the website for them to give their views via the questionnaire, we also provided the opportunity to discuss the proposals in person. In the second half of the consultation period, six open-to-all drop-in sessions were advertised and promoted. These sessions invited any residents to come along and talk to the team about the proposals, ask questions and give their views. A drop-in session was held in Barnet, Brent, Camden, Enfield, Haringey and Islington boroughs. The venues for each of these session were targeted in geographic areas that were identified as potentially impacted in the interim IIA. These drop-in session were advertised through social media, VCSE partners and on the website. A summary of the meeting dates and locations are shown in Figure 9.

Borough	Venue	Date
Barnet	Watling Community Association, HA8 0TR	29/02/2024
Brent	Harlesden Library, NW10 8SE	06/03/2024
Camden	Belsize Community Library, NW3 4XN	23/02/2024
Enfield	Edmonton Green Library, N9 0TN	04/03/2024
Haringey	Tottenham Community Sports Centre, N17 8AD	28/02/2024
Islington	Finsbury Park Trust, N4 2DA	20/02/2024

Figure 9: Open to all drop-in locations and dates

7.8.9 Targeted engagement activities

One of the key principles of the consultation was to reach the groups that were identified in the interim IIA as being potentially disproportionally impacted by the proposals. We identified these groups because they had protected characteristics, may have been potentially harder to reach through consultation activities and/or were potentially more materially impacted by the proposals. To identify these groups, we used a data driven approach to understand both the demographics and geography to identify who and how different groups may be impacted by the proposals. The list of groups that we took extra steps to reach is shown below and, in all categories, we targeted services or potential service users of childbearing age:

- Asian women and people (particularly Pakistani and Bangladeshi)
- Black African and Caribbean women and people
- Orthodox Jewish women and people
- Older women and people (35+)
- Women and people living in areas of deprivation
- Women and people who are carers
- Women and people with experience of mental health problems
- Women and people from LGBTQI+ communities
- Women and people with poor English proficiency and women and people with poor literacy
- Women and people with disabilities
- Women and people belonging to inclusion health groups such as people who are homeless, dependent on drugs and alcohol, asylum seekers and Gypsy, Roma and Traveller communities
- Women and people living in Harlesden and Willesden
- Women and people living in Holloway and Finsbury Park
- Younger women and people (under 20)

For these groups, our aim was to seek in depth qualitative feedback to both understand their views on the proposal but also to understand what the potential impact of our proposal might be on communities and what possible mitigations could be put in place. We would continue to engage with these groups during implementation.

7.8.9.1 *Targeted engagement approach*

A range of different approaches were taken to engage with the groups outlined in section 7.8.9.

- We contacted over 300 voluntary and community sector organisations in the consultation period to support us with setting up engagement opportunities. Many of the organisations had prior involvement with the programme and had supported pre-consultation engagement.
- Priority groups to engage with were shared at Council and other stakeholder meetings where people may have links into existing community groups and leads
- Programme attended existing forums such as multifaith forums to explore further opportunities for engagement or contacts within the identified communities
- Trust communications teams supported us in identifying past and current service users with lived experience who were happy to participate in either an interview or focus group
- We undertook social media advertising to recruit focus groups for both older and younger age demographics in our consultation catchment area

7.8.9.2 *Engagement undertaken with target groups*

We undertook engagement with a range of groups that were representative of the target populations. A full list of meetings and focus groups is outlined in appendix B and a summary of the activities carried out for target groups is shown in Figure 10.

Target group	Activities undertaken
Black African and Caribbean women and people	Focus groups held with: •Umoja •Phoenix Centre •Rise Project
Asian women and people (particularly Pakistani and Bangladeshi)	Focus groups held with: •Bengali Worker's Association •Wightman Road Mosque •Manor Garden's Centre
Women and people living in areas of deprivation	Promotion and engagement activities were targeted in areas of higher deprivation
Orthodox Jewish women and people	In depth engagement was undertaken in relation to the Orthodox Jewish community and is described in more detail in section 7.8.9.3.
Women and people with disabilities	• Focus groups held with: - Elfrida Society - A group for parents who have ADHD • Five 1:1 interviews with women who have complex (or pre-existing) health conditions • Meeting with staff from the Royal Association for Deaf People
Older women and people (35+)	• Two focus groups were undertaken following targeted advertising and online recruitment
Younger women and people (under 20)	• Youth Summit held to gather view of young people on the proposals • Recruitment campaign on social media to try to recruit a focus group which was not successful
Women and people with experience of mental health problems	• One online focus group • Five 1:1 interviews with services users with lived experience of mental illness and using mental health services
Women and people from LGBTQ+ communities	• Additional engagement was commissioned for this group. This is outlined in section 7.8.9.5.
Women and people who are carers	• A focus group was held with Barnet Mencap which was for parents with children who have additional needs
Pregnant women and people with complex (or pre-existing) health conditions	• Conducted five 1:1 interview with service users that had complex health conditions
Women and people with poor English proficiency and women and people with poor literacy	• Six focus group and meetings with women for whom English was not her first language with an interpreter available in all sessions.

	- Bengali Worker's Association - Phoenix Family Centre - Manor Garden's Centre - The Romanian and Eastern European Centre - House of Polish & European community - A stay and play for Turkish and Bulgarian families
Women and people living in Harlesden and Willesden	• Targeted activities were undertaken to engage with people living in these areas and is described in section 7.8.9.4
Women and people living in Holloway and Finsbury Park	• Targeted activities were undertaken to engage with people living in these areas and is described in section 7.8.9.4
Women and people belonging to inclusion health groups such as people who are homeless, dependent on drugs and alcohol, asylum seekers and Gypsy, Roma and Traveller communities	• Additional engagement was commission for this group and is described in section 7.8.9.5.

Figure 10: Summary of activities for target groups

7.8.9.3 *Engagement with the Orthodox Jewish community*

The interim IIA identified the Orthodox Jewish community as a specific population group that would potentially be impacted by the proposals under option A and therefore they were a group that we wanted to hear from in the consultation period. We had existing links with voluntary and community sector organisations who work with this community from work undertaken as part of the pre-consultation engagement. We recognised that many members of the Orthodox Jewish community do not have social media and may not be reached by the wider advertising that was being undertaken. Therefore, upon advice of a charity that works with the community, either quarter or half page advertisements were placed in local Jewish circulars/papers. These were Hamodia, The North London Circular and the Jewish Tribune.

In addition to this, we worked with community leaders to set up feedback opportunities that would allow both women with experience of maternity services, community leaders, and those working with the community, to provide their feedback and input into the proposals. This resulted in:

- Eight 1:1 in depth interviews conducted at a local synagogue with women who had experiences of local maternity services and/or recruited by doulas from the Orthodox Jewish community. In the interviews women shared their experiences, views on the proposals, impact of the options being considered and potential mitigations that could be put in place to reduce any potential negative impact of the proposals.
- Two roundtable meetings with members of the community and those that work closely with them to explore their views on the proposals and the potential impact on their community. The first was an initial scoping meeting and the second more in depth capturing views on the proposals. Included in this discussion were:
  - Community birth coaches (doulas) who support orthodox Jewish women during labour
  - A local Rabbi
  - Two Barnet local councillors
  - A community midwife working in the area

- Scientific advisor for a Jewish fertility charity
  - Doctors from the Orthodox Jewish community
  - An obstetrician from the Royal Free Hospital
  - The Chair of the Hatzola North West (Jewish ambulance service)
- Several individual written responses received from the Orthodox Jewish community which are detailed in the consultation feedback report in appendix C.

The feedback shared in these discussions was included in the independent analysis of the consultation responses, and alongside other feedback, was incorporated in the independent report. The detail of the feedback received, and our response can be found in section 7.10.

7.8.9.4 *Targeting residents living in potentially impacted geographies*

We identified the residents of Harlesden and Willesden, and Holloway and Finsbury Park as being potentially impacted by option A and option B respectively. We therefore prioritised efforts to gain feedback from residents living in these areas. We were seeking to both engage directly with residents through events and hear from residents through them responding to our questionnaire or writing to, emailing or telephoning us. In total we completed 20 events with these communities, 12 in Harlesden and Willesden and 8 in Holloway and Finsbury Park. Events included stay and plays at local children's centres, drop-ins at existing health promotion events, 'open to all' borough drop-ins and a focus group with residents, one in Harlesden and Willesden and one in Holloway and Finsbury Park.

To ensure a greater level of awareness of the proposals amongst residents, a letter was sent to just over a third of households living in these potentially impacted geographies. In total 6,975 households were included, 3,822 of which were in Harlesden and Willesden and 3,153 in Holloway and Finsbury Park. The letter was drafted by the programme team and was sent independently by ORS, the company doing the independent analysis of the consultation responses. The letter:

- Included a QR code that linked to the ICB website which hosted consultation materials and link to the questionnaire
- Had information on the back translated into the 18 most commonly used languages in our area, and included information about how the information about the consultation could be sought in other languages
- Explained the potential changes and invited residents to provide their feedback via the questionnaire

This letter was a targeted effort as part of a wider campaign to reach a wide breadth of people in our target areas and to gather a range of insights on our proposals. We were advised by the independent company that undertook the analysis of the feedback from consultation that a letter to a third of the local population in this geography would be robust and a statistically relevant sample. The ICB considered and accepted this advice and proceeded in that way. Regardless of if residents received a letter, all residents in these areas had the opportunity to respond to the proposals through a range of other mechanisms as described in this section 7.8.

7.8.9.5 *Very targeted engagement*

To ensure we successfully engaged with the range of population groups identified, we commissioned additional engagement which was undertaken by other organisations. This engagement. We undertook a range of specific engagement events with these groups, as set out in Figure 11.

Category	Groups included	Approach to engagement
People with certain demographics known to be particularly hard to reach via other engagement mechanisms	• Refugees and people seeking asylum • People who are homeless • LGBTQI+ people • Roma people	• An independent organisation (Verve Communications) was commissioned to undertake engagement with these groups • The ICB Programme team made a number of introductions to local contacts to support engagement with these groups. Verve followed up on these and subsequently set up engagement sessions • Given the nature of some of the groups involved, an amended topic guide was developed which focused on access to health services more generally that could be used to support groups in the event of proposed changes being agreed • A separate report was written up summarising the engagement and was sent for inclusion in the consultation feedback analysis

Figure 11: Summary of approach to very targeted engagement

7.8.10 Staff engagement

Staff working at hospitals in NCL, and those working in services potentially impacted by the proposals for change, were key groups we wanted to reach through the consultation period.

7.8.10.1 *Approach to staff engagement*

The approach to engaging with staff was managed through the local Trust communications leads and the communications leads working group that had been meeting throughout the pre-consultation period. Given their local knowledge and expertise, it was determined that this would be best way to reach the right staffing groups and set up mechanisms to provide feedback.

Front-line staff were engaged through specific meetings set up specifically to discuss the Start Well proposals, and through attendance at existing meetings with certain staff groups. Staff were also actively encouraged to provide individual feedback by responding to the questionnaire or providing separate written feedback. This was promoted through internal intranet pages and news stories at intervals throughout the consultation. This process was managed through Trust communication leads, using consistent messages and materials which were developed by the Programme team. A summary of the activities carried out by Trust teams to support with promotion of the consultation is shown in Figure 12.

Trust	Activities
Great Ormond Street Hospital for Children NHS Foundation Trust	• Nine internal intranet posts • Screensaver reminding staff to share their views, displayed on all Trust computers • Several 'all staff' emails and Trust-wide invitation to feedback sessions • Posting on social media including X and LinkedIn
North Middlesex University Hospitals NHS Trust	• Consultation promoted on four occasions through intranet or all staff briefings • Posts shared on social media channels on three occasions • Information shared in Chief Executive and Chair's report for Board papers three times
Royal Free London NHS Foundation Trust	• Five posts on Trusts intranet through the consultation period • Five articles on external website • Regular posting on X, Instagram and Facebook resulting in a reach of nearly 19,000 users • Included in three monthly stakeholder updates (~18- person distribution) • Included in the weekly roundup for governors throughout the consultation period • 16 email updates to all staff • Included in Chief Executive briefing to staff on four occasions • Banner included on intranet pages promoting the consultation
University College Hospitals NHS Foundation Trust	• Two news items on the external website as well as sharing of social media posts • An all staff briefing led by the Trust Executive Lead for the Programme • Three internal news stories via an all staff communication
Whittington Health NHS Trust	• News stories on public facing website on two occasions • Shared on the staff intranet and via all staff emails on four occasions • Mentioned in the Chief Executive's briefing every two weeks during consultation period • Regular posting on social media channels (at least once a week and once a day during final week) • Included in three external stakeholder bulletins with a distribution of around 2,900 people

Figure 12: Summary of activities carried out by Trust communications teams

We also held 31 facilitated feedback sessions with 462 attendees from providers across NCL, as shown in Figure 13.

Trust	Number of facilitated feedback sessions	Number of attendees
Great Ormond Street Hospital for Children NHS Foundation Trust	3	87
North Middlesex University Hospitals NHS Trust	1	15
Royal Free London NHS Foundation Trust – Barnet Hospital	1	2
Royal Free London NHS Foundation Trust – Royal Free Hospital	13	133
University College Hospitals NHS Foundation Trust	7	151
Whittington Health NHS Trust	6	74
Total	**31**	**462**

Figure 13: Summary of facilitated staff feedback sessions

In addition to the facilitated feedback sessions, we also attended promotional drop-in session at each of the hospital sites. These were aimed a widely promoting the consultation to both those using services as well as staff working across a range of services. In total over 590 people were reached through these hospital drop-ins, as shown in Figure 14.

Trust	Number of drop-in session	Number of attendees
Great Ormond Street Hospital for Children NHS Foundation Trust	2	18
North Middlesex University Hospitals NHS Trust	3	42
Royal Free London NHS Foundation Trust – Chase Farm	2	25
Royal Free London NHS Foundation Trust – Barnet Hospital	2	76
Royal Free London NHS Foundation Trust – Edgware Birth Centre	2	38
Royal Free London NHS Foundation Trust – Royal Free Hospital	8	140
University College Hospitals NHS Foundation Trust	3	101
Whittington Health NHS Trust	4	154
Total	**26**	**594**

Figure 14: Summary of staff drop-in sessions

7.8.10.2 *General practice*

General practice teams and colleagues were identified as key stakeholders in our consultation plan and as such efforts were made to ensure that they were aware of the proposals and had the opportunity to feedback. As shown in Figure 15, we attended:

- NCL GP Webinar to promote the consultation. This is an online meeting to which all NCL GPs are invited, and had attendance of nearly 80 GPs
- Borough-level GP meetings in order to promote the consultation and obtain feedback – this included: Camden, Harrow, Brent and Haringey
- NCL GP Provider Alliance Board meeting which has leadership representation from GP federations from across NCL

In addition to the events, an update was included in the NCL GP newsletter and website at the launch and mid-way through the consultation and a letter from the NCL ICB Chief Medical Officer was sent to all GPs (over 500 individuals) working in NCL to invite their feedback.

Date	Meeting name	Area	Number of attendees
21/12/2023	NCL Primary Care Operations Group	NCL-wide	38
04/01/2024	NCL GP Webinar	NCL-wide	78
11/01/2024	Haringey GP Collaborative meeting	Haringey	8
25/01/2024	NCL GP Provider Alliance Board	NCL-wide	15
31/01/2024	Camden GP Engagement Event	Camden	30
01/02/2024	NCL/UCLH General Practice Interface Meeting	Camden / Islington	16
08/02/2024	Brent GP Forum	Brent	60
13/02/2024	Harrow Primary Care Forum	Harrow	34
		Total	**279**

Figure 15: Summary of general practice consultation activities

7.8.10.3 *NCL Integrated Care Board staff*

Staff working for NCL ICB (around 700 members of staff) were also encouraged to provide their feedback on the proposals. We encouraged this in several ways:

- Close to the launch of the consultation Start Well was included as an agenda item for an all staff briefing – this had attendance of around 350 staff members
- Posters were put up in office locations
- The consultation was included as a news item on the internal intranet and remained on the home page of the intranet throughout the consultation period
- Staff were encouraged to include a banner at the bottom of their email signatures for the duration of the consultation that linked through to the website.

7.8.11 Other stakeholders

We identified a range of other key stakeholders to our consultation. These included local council and political stakeholders, wider NHS colleagues and health and care partners, and professional organisations such as Royal Colleges. We were keen to ensure that these stakeholders had the opportunity to input into the proposals and as such, stakeholder groups were written to on at least three occasions throughout the consultation period to inform them of the consultation proposals and ways in which they could provide feedback.

7.8.11.1 *Health Overview and Scrutiny Committees*

Through the consultation period, we sought feedback from Health Overview and Scrutiny Committees, in addition to attending the NCL JHOSC, through attending the following meetings:

- Barnet Adults and Health Overview and Scrutiny Committee
- Brent Community and Wellbeing Scrutiny Committee
- Camden Health and Adult Social Care Scrutiny Committee
- Haringey HOSC: Adult and Health Scrutiny Panel
- Islington Health and Care Scrutiny Committee
- Harrow Health and Wellbeing Board
- Enfield Health and Wellbeing Board was scheduled but the meeting in was subsequently stood down (and which included the update and link to consultation website papers were circulated)
- An update about the programme was also included in the inner NEL and outer NEL JHOSC papers during the consultation period (but meeting attendance was not requested).

In addition, the Chair of the Brent Community and Wellbeing Scrutiny Committee and NWL JHOSC was invited to attend the NCL JHOSC to provide insights from Brent to the discussions.

Written or questionnaire responses were provided by:

- Barnet Council (Barnet Adults & Health Overview and Scrutiny Sub-Committee)
- Brent Council (Cabinet Member for Public Health and Adult Social Care and Health and Wellbeing Board Chair)
- Camden Council
- Haringey Council and Haringey Health and Wellbeing Board
- Islington Council

7.8.11.2 *Members of parliament*

All local members of parliament of areas in North Central, North East, and North West London and Hertfordshire were invited to feedback on the consultation:

- A letter was sent, and briefings were offered when the papers for the ICB Board meeting were published
- A letter was sent to all MPs in north London and Hertfordshire at the launch of the public consultation, inviting feedback and encouraging sharing of the opportunity to participate with their constituents
- Reminder emails were sent with four and less than two weeks left of the consultant period describing how feedback could be provided

As a result of the information shared about the consultation, briefings were set up with six local MPs or their offices before or during the consultation. We received written responses to the consultation from four MPs and two prospective parliamentary candidates (now MPs).

7.8.11.3 *Local councillors*

Local councillors of Barnet, Brent, Camden, Enfield, Islington, Haringey and Harrow were invited to feedback:

- A letter was sent to all councillors and briefings were offered when the papers for the ICB Board meeting were published
- A letter was sent to all councillors in the NCL at the launch of the public consultation, inviting feedback and encouraging sharing of the opportunity to participate with their local residents and constituents
- Reminder emails were sent with four and less than two weeks left of the consultant period describing how feedback could be provided

As a result of the engagement:

- Briefings were held with Executive/cabinet lead members in Barnet, Brent, Camden, Islington and Haringey. This coincided with the papers being published for the ICB Board meeting.
- We attended the Health Overview and Scrutiny Committees in Barnet, Brent, Camden, Haringey and Islington
- We attended the Health and Wellbeing Board meeting in Harrow and were scheduled to attend at Enfield. This meeting was subsequently stood down and information about the consultation and how feedback could be provided was circulated as an alternative.
- We attended Council Children's Partnership Board meetings in Barnet, Haringey and Islington

7.8.11.4 *Council officers*

Chief Executives, Directors of Adult Social Care, Directors of Children's services and Directors of Public Health across all North London boroughs as well as Hertfordshire County Council were invited for feedback:

- A letter was sent at the launch of the public consultation inviting feedback and encouraging sharing of the opportunity to participate within local networks
- Reminder emails were sent with four and less than two weeks left of the consultant period describing how feedback could be provided
- We attended joint NHS and Council Borough Partnership Board meetings in Barnet and Enfield and the Start Well Board in Camden

7.8.11.5 *Greater London Authority General Assembly members*

Nine assembly members covering boroughs across North London were approached for feedback:

- A letter was sent at the launch of the public consultation inviting feedback and encouraging sharing of the opportunity to participate within local networks
- Reminder emails were sent with four and less than two weeks left of the consultant period describing how feedback could be provided
- We received written feedback to the consultation from two Assembly Members

7.8.11.6 *NHS Trusts outside NCL*

North London NHS Trusts (acute, community and mental health) outside NCL, in addition to some South London providers who may have a particular interest due to the specialist maternity services they provide, were approached for feedback:

- A letter was sent at the launch of the consultation to all North London NHS Trusts outside NCL, as well as two reminders through the consultation period
- Three south London providers (Guys and St Thomas' NHS Foundation Trust, Kings College London NHS Foundation Trust and St George's University Hospital NHS Foundation Trust) were contacted in the second half of the consultation period

7.8.11.7 *Relevant professional bodies and Royal Colleges*

A number of professional bodies and Royal Colleges were identified as stakeholders that may be able to provide expert input into the proposals. This included the Royal College of Paediatrics and Child Health, Royal College of Midwives, Royal College of Obstetrics and Gynaecology, Royal College of Nursing and Royal College of Anaesthetics. A full list of the organisations contacted can be found in appendix D. All organisations were contacted at the launch of the consultation and were offered a briefing about the proposal and invited to provide their feedback. Reminder emails were also sent on two further occasions through the consultation period.

7.8.11.8 *Education providers*

Education providers invited to feedback included contacts at NHSE Workforce, training and education providers such as postgraduate Deans and Heads of School, as well as university education providers that have relevant student placement in NCL sites. A letter was shared with the NHSE London workforce, training and education lead, who had been part of the Programme governance, to share with relevant contacts. A letter was also shared via an NHSE contact to the London Council of Deans distribution to inform University contacts.

7.9 Consultation evaluation

We appointed an independent organisation, Opinion Research Services (ORS), to evaluate and write up the feedback gathered during consultation. We published a full evaluation report on 6 November 2024. The feedback has been considered through the governance structure of the programme including by:

- Clinical Reference Group
- Patient and Public Engagement Group
- Finance and Activity Group
- Start Well Programme Board
- ICB Strategy and Development committee (full report prior to publication)

The publication of the report was communicated to stakeholders on publication including staff briefings, staff intranet news item (providers and ICB) and email communication to councillors, councils, MPs, voluntary sector organisations that supported the consultation and wider stakeholders.

7.10 Consultation responses

As a result of our consultation activities, we had 3,112 questionnaire responses, of which:

- 2,031 came from members of the public
- 1,060 came from NHS staff
- 21 came from organisations

We also had 80 formal written submissions, of which 32 came from members of the public and 47 from NHS staff, stakeholder organisations and officials.

7.10.1 Analysis of consultation responses

The ICB carefully considered and responded to the feedback from consultation, as set out in sections 4.2, 5.2, 8.2, 9.2, 11.4.1, 11.5.1, 11.8.1, 12.1, 13.2.1 This was supported by an analysis of consultation responses that was independently analysed by an independent company. In July 2024, we published a consultation methodology, activity and reach report that described the consultation activities and approaches taken alongside interim findings and, in November 2024, a detailed consultation report.

7.10.2 Key messages from consultation responses

Across all engagement activities, a substantial majority of people agreed that changes are needed to address current challenges facing services, with 67% of questionnaire respondents either strongly agreeing or tending to agree.

There was overall agreement with the proposal that all neonatal units in NCL should offer the same minimum level of neonatal care (i.e. at least level 2):

- Most respondents either strongly agreed or tended to agree with this proposal, including 81% of NHS staff working in NCL maternity, neonatal or children's surgical services and 66% of local residents
- Slightly lower agreement among those living near Royal Free Hospital (63%), service users/parents/carers (68%), and local residents (67%) compared to NHS staff

There was less support for consolidating maternity and neonatal services from five to four sites:

- Just under half (48%) of NHS staff members agreed:
    - higher agreement among neonatal staff, lower among maternity staff
- Around a quarter of service users/parents/carers agreed; over three fifths disagreed
    - higher disagreement (69%) among those near Royal Free Hospital, though widespread elsewhere
- There were concerns raised around:
    - consolidation increasing service pressures, disruption of effective working relationships, and issues with capacity, staffing, and quality of care
    - longer travel times, unreliable public transport, congestion, and increased travel costs.

Those near all hospitals other than the Royal Free Hospital supported option A (keeping provision at Whittington Hospital). Feedback included:

- Option A seen as the least disruptive option due to:
    - the quality and nature of services already provided;
    - the established multi-disciplinary team/effective use of Allied Health Professionals;
    - that Whittington Hospital already has an LNU (level 2) and
    - that Whittington Hospital is already managing more births than Royal Free Hospital (including concern as to feasibility of uplifting Royal Free Hospital to a level 2 unit)
- The importance of co-location with other teams/services e.g., paediatrics, haemoglobinopathy, sickle cell, female genital mutilation team
- Strong existing links with community resources and UCLH, including maternity pathways, which would be lost under option B
- Serves a wide area with areas of deprivation, with poorer birth outcomes, and younger populations (e.g., North Islington, Haringey) than the general population

Those respondents living closest to the Royal Free Hospital favoured option B where services would continue to be delivered at the Royal Free Hospital site. Feedback from these respondents included:

- Strong feedback (particularly from staff at the Royal Free Hospital) relating to services currently provided at the site relating to maternal medicine pathways and the importance of specialties that are already on-site to support high-risk pregnancies/births and manage perinatal emergencies (including haematology, renal services, HIV unit, fetal medicine, interventional radiology, surgical expertise, transplantation and rare diseases)
- There is joined-up working between Royal Free Hospital and Barnet Hospital, with consistent policies between the two
- Royal Free Hospital was occasionally said to have better quality buildings than Whittington Hospital
- It is the hospital of choice and caters for the specific needs of the local Orthodox Jewish community.

Our detailed response to issues raised during consultation is shown in sections 4.2, 5.2, 8.2, 9.2, 11.4.1, 11.5.1, 11.8.1, 12.1, 13.2.1.

8. Decision making

8.1 Introduction

To address the challenges identified in the case for change we are proposing to reconfigure services to provide high-quality and accessible care for our residents. The new care model we developed responded directly to our case for change, as set out in section 4. We developed and evaluated a set of options for the delivery of the proposed new care model within NCL.

8.2 What we heard during consultation and assurance on our options

What we heard	Our response to address the feedback
During consultation, respondents suggested closing the unit at Barnet or North Middlesex	This suggestion is not deliverable. Closing the unit at Barnet or North Mid is not possible because of the potential outflows to other hospitals that do not have capacity. See section 8.8.1 for more details.
During consultation, respondents suggested keeping all units open and upgrading the Royal Free Hospital to a level 2 unit	This suggestion is not deliverable. Keeping all units and upgrading the Royal Free Hospital to a level 2 unit is not possible because we do not have the workforce to staff more than four neonatal units. See section 8.5 for more details.
During consultation, respondents suggested spreading births more evenly and encouraging people from outside NCL to come to NCL units	This suggestion is not deliverable. Keeping all units and upgrading the Royal Free Hospital to a level 2 unit is not possible because we do not have the workforce to staff more than four neonatal units. See section 8.5 for more details.
During consultation, respondents suggested consolidating all births at a single specialist hospital	This suggestion is not deliverable. Consolidating all births at a single specialist hospital is not possible because of the travel times to a single unit and the cost of building a unit of sufficient size.
During consultation, some clinicians asked why potential outflows of births to hospitals in NWL had been included in the evaluation	The criteria around outflows of births was included in the evaluation because the implementation of Option B would be more difficult to manage than Option A due to the constraints with capacity in North East London. The rationale for including potential outflows of births to hospitals in NWL in the evaluation is shown in section 8.8.2.1.

During consultation, some clinicians asked why no other criteria such as interventional radiology and maternal medicine were included	To review the consultation feedback and understand fully the potential impact of the proposals on maternal medicine services, a Maternal Medicine Working Group was established in the post-consultation period. This group included a maternal medicine lead from each local maternity unit, the maternal medicine centre and from the maternal medicine network (MMN). The conclusion of this group was that both options would be implementable given that there are viable alternative pathways that could be put in place. Both options have been evaluated as delivering higher quality services in that they would be delivering the new care model. Although there would be an impact on maternal medicine as part of implementing our proposals, maternal medicine was not included as an evaluation criterion because: • Clinicians have agreed that both options are safe and implementable, so our focus was on whether we have a criteria to try and differentiate from a maternal medicine perspective between two safe and implementable options; • Maternal medicine are networked services across NCL, and we expect through implementation for this to continue – with the Maternal Medicine Network supporting any new pathway arrangements that may be required; and • Given the nature and range of the specialist pathways across NCL, and the networked nature of the services, there is not an appropriate quantifiable and differentiating criterion. In the pre-consultation phase, it was agreed not to include a criterion on out-of-hours interventional radiology (IR) as it is a networked service and therefore doesn't lend itself to being an options appraisal criterion. Optimum arrangements for put-of-hours IR would be considered through the implementation planning. This position was reviewed and re-confirmed by the CRG following consultation feedback. Our implementation plans for interventional radiology and maternal medicine are shown in sections 11.4.4 and 11.4.6.6.

During consultation, some people expressed concern about the accuracy of travel times used to evaluate the options.	The travel times have been calculated using industry-standard methodologies and validated data sources. They have been updated to 2024 as part of the development of this DMBC and the analysis shows a similar result to the analysis undertaken for the PCBC. The results have also been spot-checked against other travel data sources. The methodology for the travel analysis and the result of the analysis is shown in section 8.8.4.
Activity modelling is based on 2021/22 deliveries data so some respondents to the consultation expressed concerns on the outputs of the modelling being used for decision-making in 2025.	Activity modelling has been refreshed throughout the evaluation: • 2023/24 deliveries and neonatal care days activity data. Updated deliveries data was provided by Trust teams via the NCL ICB and neonatal care days from the Neonatal ODN. • demographic growth rate updated to include non-NCL boroughs/local authorities where there were more than 100 deliveries at NCL sites in 2023/24 • neonatal care day non-demographic growth rate has been calculated based on system-wide trends • updated the approach to modelling changes in complexity of future deliveries
Some respondents to the consultation suggested that activity modelling has not accounted for trends in activity and population changes across NWL boroughs	The updated approach to the demographic growth in the activity modelling means that NWL boroughs that have over 100 deliveries at NCL units have been included which therefore captures changes to these populations. The trends in activity for these populations have also been considered through non-demographic growth which uses the growth rate for the activity per woman of childbearing age for NWL residents. This is in the context of a 7% decrease in births across the population of NWL between 2019/20 and 2023/24.
During the targeted engagement period, a key issue raised across many groups and interviews was the potential for increased pressure on the remaining four units if one closes. Participants were worried that the current strain on services would only increase by consolidation into four sites, compromising quality of care for mothers and babies. Specifically, capacity at Barnet, reduction in neonatal cot capacity, and insufficient capacity at other sites were mentioned.	Capacity modelling for delivery suites and neonatal cot requirements was updated to reflect revised activity numbers and strengthened modelling approaches, as shown in appendix E. We have undertaken additional work to understand: • Theatre capacity requirements • Postnatal bed capacity requirements (see section 11.4.3) • Antenatal capacity requirements (see section 11.4.3) Capacity requirements have been calculated based on the projected flow of activity at each of

	the units that remain open. To ensure there is sufficient capacity at these sites, a level of contingency has been built into the modelling by using current activity rather than projected future activity (which is lower than current activity because of the falling birthrate), prudent occupancy assumptions and all capacity requirements have been rounded up where there were decimals. This approach was used for all delivery suite and neonatal cot capacity requirements. For neonatal cot capacity requirements, an 80% occupancy figure has been used to calculate the cot requirement which is in line with national guidance. This would ensure there is sufficient capacity across the system to meet neonatal demand and is a lower average occupancy than is currently seen across NCL. Based on the projected number of C-sections the total theatre requirement across NCL has been modelled. There would be 3 planned obstetric theatres, and 4 emergency obstetric theatres required across NCL to meet the projected demand. Each unit currently has two theatres so there would be sufficient capacity across the system. As a result of the modelling, all sites that would remain open would either maintain or increase their current capacity. This includes Barnet where an additional postnatal, delivery suite and cot capacity has been modelled in both options. The CRG and Finance and Analytics Group would continue to consider potential capacity challenges and required mitigations and would oversee the management of risk during implementation.
Clinical Senate recommended that we undertake further modelling around cot requirements as part of their assessment of our PCBC.	The cot capacity requirements have been refreshed based on 2023/24 activity data and an updated approach to projecting the neonatal care days in line with neonatal operational delivery network (ODN) recommendations. For neonatal cot capacity requirements, an 80% occupancy figure has been used to calculate the cot requirement which is in line with national guidance. This would ensure there is sufficient capacity across the system to meet neonatal demand and is a lower average occupancy than is currently seen across NCL. Appendix E has detail

	on the future capacity requirements for neonatal cots.
The Mayor's Office recommended that we demonstrate how the options appraisal process has been influenced by opportunities to improve the inequalities baseline and opportunities to improve support for maternity staff from minority ethnic groups, including strengthened anti-racist initiatives.	All options included in the consultation would deliver the new care model across all four sites. The care model has been designed to improve maternity and neonatal services across NCL, and opportunities to reduce inequalities through the design have been considered throughout the process (for example, our proposals around continuity of care which will support better outcomes for women and pregnant people in areas of deprivation (see section 5.4.7). It would also improve the workforce experience through improved staff retention and training and development opportunities. This is also a significant programme of work through the LMNS which has an equity and equality plan [41]

8.3 Engagement in options development and appraisal

During the PCBC we undertook a robust options development and appraisal process. To determine whether the options were viable and whether there was a preferred option, we considered four evaluation domains– quality of care, workforce, access to care and affordability & value for money. This was undertaken over a 5-month period (from January 2023 to May 2023) and involved the CRG, PPEG and Finance and Analytics Group.

Following consultation, these groups reviewed the feedback from consultation and updated evaluation. The updated evaluation was undertaken over a 5 month period (July - November 2024). The Programme Board considered the updated evaluations on 06 December 2024.

8.4 Reviewing the status quo

Our analysis during the options appraisal involved consideration of options against the maternity and neonatal services as they currently are configured (i.e., "the status quo".) The option to maintain the status quo was not put forward as an option for public consultation. This was because the status quo is not sustainable in the long-term, particularly because:

- Maintaining the status quo does not meet the NCL ambition to deliver maternity and neonatal care in the right setting and at the right time.
- The SCU (level 1) at the Royal Free Hospital falls significantly below the upper threshold of respiratory care days set out by BAPM for an SCU[42].
- Across the five units, there are gaps in the workforce, which means we are not meeting quality standards.

There is no new evidence to suggest that maintaining the status quo is a viable option.

8.5 Agreeing the number of maternity and neonatal units

The care model (as detailed in section 5.5) proposes that all neonatal care is delivered in either an LNU (level 2) or a NICU (level 3) at a maximum 80% occupancy rate. These neonatal units would

[41] https://nclhealthandcare.org.uk/our-working-areas/improving-maternity-and-newborn-services/

[42] BAPM. Service and Quality Standards for Provision of Neonatal Care in the UK. 2022.

be co-located with an obstetric-led maternity unit and an alongside midwife-led unit. This is to ensure equity of care for all babies, no matter where they are born.

To provide a high-quality, clinically sustainable service where staff can maintain their skills and competencies, there are minimum activity volumes that neonatal units should provide. NICUs (level 3) at a minimum must admit 100 very low birth weight babies and LNUs (level 2) must admit at least 25 very low birth weight babies[43]. In 2023/24, there were 220 very low birth weight admissions in NCL. This would suggest there is currently just sufficient activity in NCL to sustain five units.

However, units also need to be staffed 24/7 by specialist staff to ensure all babies have access to a specialist workforce at all times. At a minimum, each unit needs to have seven WTE neonatal paediatrician/neonatal consultants and at least eight WTE middle grade medical clinicians. Based on the current NCL workforce it is only possible to staff a maximum of four LNUs (level 2), as shown in Figure 16. It is not possible to recruit additional staff due to national shortages, with 6% of consultant posts unfilled nationally[44] and only 79.3% of neonatal nursing shifts staffed according to recommended levels [45].

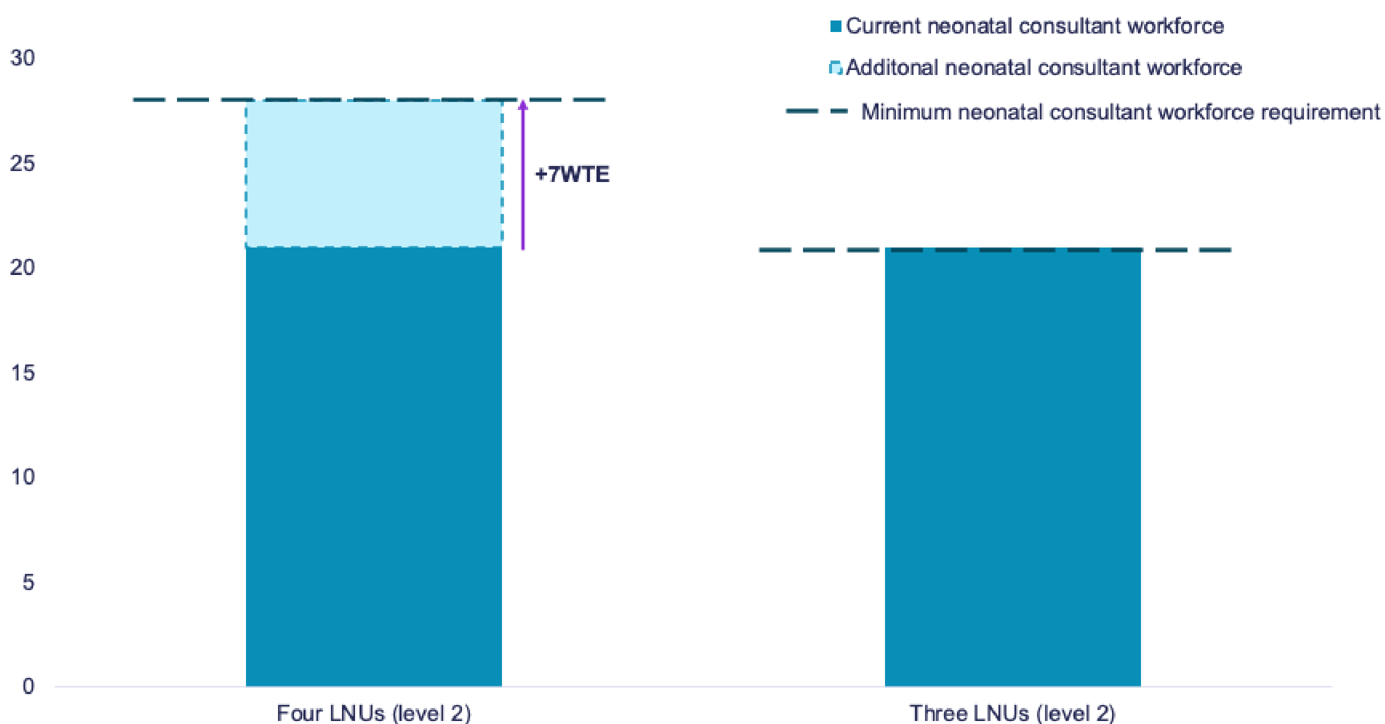

Figure 16: Neonatal consultant requirement based on the number of LNUs (level 2) in NCL

Based on this, the Programme had previously agreed that there should be four neonatal units in NCL, all of which would be designated either an LNU (level 2) or NICU (level 3). This would provide 24/7 access to specialist staff and also ensure that staff could maintain their skills and competencies. As each obstetric-led birthing unit needs a co-located LNU (level 2) or NICU (level 3), this means there would be four obstetric-led birthing units each with a co-located alongside midwife-led unit. Each of these would be co-located with a neonatal unit. This means there would

[44] https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf

[45] https://www.rcpch.ac.uk/sites/default/files/2024-10/nnap_summary_report_on_2023_data_0.pdf

be four neonatal units in NCL and one of these would also need to be a NICU (level 3) as there must be at least one NICU (level 3) unit in within a single operational delivery network.

The Programme previously reviewed this rationale as part of the development of the PCBC and there is no new evidence since then to suggest that there should not be four neonatal units in NCL.

8.6 Fixed points

In the PCBC phase, UCLH was identified as a fixed point because UCLH currently has a NICU (level 3), which is a regionally designated service. Moving this unit would be very difficult because of co-located services and current networks, as agreed by NHS specialised commissioning and all partners. There is no new evidence to suggest that UCLH should not be a fixed point.

8.7 Evaluating the options for consultation

We undertook a robust process that evaluated each of the four options for quality of care, workforce, access to care, and affordability and value for money. This evaluation was underpinned by a set of evaluation principles:

- The evaluation criteria should build on the case for change and be used once the options have been reduced to a manageable number
- The criteria must enable differentiating assessments of each option and there must be available data to make comparison. Evaluation against these criteria creates understanding of the relative benefits and drawbacks of each option.
- Typically, an evaluation question will be proposed, and a metric will be agreed to measure this question. If a direct measure cannot be identified, a proxy measure may be agreed.

Each option was evaluated using evaluation criteria of ++, +, /, -, - - based on the evidence presented.

The overall evaluation of the options for consultation that was agreed by the ICB Board as part of the PCBC in December 2023 is shown in Figure 17

	Criterion	1) UCLH, North Mid, Royal Free, Whittington	2) UCLH, Barnet, Royal Free, Whittington	3) UCLH, Barnet, North Mid, Whittington	4) UCLH, Barnet, North Mid, Royal Free
1	**Quality of care:** Activity outflows	- -	- -	/	-
2	**Workforce:** Implementation and delivery	- -	- -	+	-
2	**Workforce:** Training opportunities*	-	- -	/	- -
3	**Access to care:** Average and maximum travel time	- -	- -	-	-
3	**Access to care:** Core20 Average and maximum travel time	- -	- -	-	-
3	**Access to care:** General accessibility	- -	-	/	/
4	**Affordability and value for money:** Capital requirements	- -	- -	-	-
4	**Affordability and value for money:** Benefit cost ratio	-	-	-	-

Figure 17: Overall evaluation agreed in the PCBC (since updated for this DMBC for options 3(A) and 4(B) – see section 8.9)

As a result of this process, we concluded in the PCBC that:

- Options 1 and 2 were not implementable given the significant projected outflows of people to non-NCL units, which are unable to accommodate this additional activity. This position was confirmed by neighbouring providers and ICBs who have had Executive Director sit on the Start Well Programme Board and attended the options appraisal workshop. It was also confirmed by the Maternity and Neonatal CRG who stated that the significant outflows from NCL may undermine the viability of NCL providers and would make it harder to provide integrated care before, during and after giving birth. Options 1 and 2 would also result in longer travel times for patients to access services than options 3 and 4. Therefore, these options were not recommended to be taken forward for consultation.
- Option 3 and 4 were both implementable and both options were subsequently consulted on, with option 3 (known as option A in the consultation) being the preferred option.

8.8 Reviewing the options evaluation following consultation

8.8.1 Outflows and travel times for options 1 and 2

The Programme reviewed the outflows and travel time analysis for options 1 and 2 based on:

- 2023/24 deliveries and neonatal care days activity data
- 2024 travel times which would impact the redistribution of activity in each option

The future activity projection and flows were modelled to take into account the next nearest unit, as well as choice of the catchment population. Choice has been defined as an individual not delivering at their nearest unit. The modelling has been undertaken using Lower Super Output Area (LSOA). Based on the updated analysis there would still be significant outflows to sites outside of NCL, as shown in Figure 18. This analysis showed that the projected outflow of patients from NCL was significant for options 1 and 2, with projected outflows of over 2,000 deliveries and over 1,500 neonatal care days. In addition, the majority of these outflows would be to a single other hospital, Watford General Hospital in Hertfordshire in option 1 and Whipps Cross Hospital in NEL in option 2. It was confirmed by Hertfordshire and West Essex ICS and NEL ICS that the relevant Trusts do not have the capacity to absorb this activity.

The analysis also showed that option 1 and 2 would have a greater increase in the average travel times as compared to the current average as shown in Figure 19 , particularly in respect to public transport. With an average increase of 17.3 minutes in option 1 and 11.3 minutes in option 2 as compared to 4.5 minutes and 8.1 minutes in option 3 and option 4 respectively.

Site	Option 1: North Mid, Royal Free, UCLH and Whittington	Option 2: Barnet, Royal Free, UCLH and Whittington
Northwick Park	488	8
St Mary's	10	0
Watford General	1,241	2
Hillingdon	7	6
Luton Hospital	79	8
Whipps Cross	17	1,901
Lister	438	10
Newham	3	24
Homerton	3	104
Princess Alexandra	191	70
West Middlesex	2	4
Other (N=10)	8	19
Total outflows	**2,488**	**2,156**

Figure 18: Updated projected outflows for option 1 and option 2

Option	Transport method	Average travel time to closest unit (mins)	Average travel time (mins) to next closest unit	Difference to current average
1) North Mid, Royal Free, Whittington and UCLH	Off-peak	15.2	20.8	+5.6
	Peak	19.4	25.4	+6.0
	Public	32.0	49.3	+17.3
2) Barnet, Royal Free, Whittington and UCLH	Off-peak	13.6	18.9	+5.2
	Peak	16.2	23.4	+7.2
	Public	32.0	43.3	+11.3
3) Barnet, North Mid, Whittington and UCLH	Off-peak	11.1	14.9	+3.8
	Peak	14.2	19.6	+5.4
	Public	32.2	36.7	+4.5
4) Barnet, North Mid, Royal Free and UCLH	Off-peak	10.1	15.0	+4.9
	Peak	13.4	19.9	+6.5
	Public	27.0	35.1	+8.1

Figure 19: Updated average travel times

The Programme Board agreed that based on the refreshed outflows analysis both options 1 and 2 remain not viable for the reasons outlined within the PCBC and it was recommended by the Programme Board that options 1 and 2 were not taken any further. This was agreed by the Programme Board on 4 October 2024 and additional work has only been undertaken on options A (3) and B (4).

This remainder of this section focuses on reviewing the evaluation of option A (formerly option 3) and option B (formerly option 4) in the light of feedback from public consultation, as they were the options put forward for public consultation.

8.8.2 Quality of care

Both options would see significantly improved quality of care as compared to the status quo as a result of implementing the new model of care detailed in section 5.

8.8.2.1 *Would there be significant outflow of activity from NCL?*

Evaluation prior to consultation
In the PCBC, the CRG considered the evaluation question "Would there be a significant outflow of activity from NCL?". This is because patients modelled to flow to providers outside of NCL would make it more challenging to integrate with other existing NCL pathways outside of hospital and make it more difficult to deliver the best quality or experience of care for NCL residents. Outflows of patients could also make NCL units less viable as they would be smaller than if the activity was retained in NCL and there may be capacity constraints on the non-NCL sites too. The evaluation looked at outflows of both deliveries and neonatal care days.

In option A, NWL ICS (St Mary's Hospital and Northwick Park Hospital) confirmed that the relevant providers would be able to provide services for the activity projected to flow to these units without requiring additional capacity and was therefore evaluated a '/'. In option B, NEL ICS (Homerton University Hospital) confirmed that the activity could be delivered in the ICS, however this would be more difficult to deliver than it would for providers in NWL. This is because there are existing capacity constraints in the unit at the Homerton, estate constraints to deliver additional capacity and an increasing birth rate in some boroughs in NEL. Option B was therefore evaluated a '-'.

New evidence considered
Taking into account feedback received during public consultation and the availability of more recent data the activity analysis has been refreshed since the PCBC and updated to reflect:

- 2023/24 deliveries and neonatal care days activity data
- 2024 travel times which would impact the redistribution of activity in each option
- Updated neonatal growth projection to a system wide assumption, rather than site based trends based on feedback received from the operational delivery network (ODN). Based on the updated activity projection the Programme took the 2023/24 care days rather than the 10-year projection which was taken in the PCBC. This aligns to the principle agreed in the PCBC to take the year with the highest volume of activity.

Updated evaluation: Would there be significant outflow of activity from NCL?
The projected delivery flows are shown in Figure 20. NWL ICS (St Mary's Hospital and Northwick Park Hospital) re-confirmed that the activity projected to flow into NWL would be able to be accommodated within the current physical capacity across NWL's maternity units and was therefore confirmed as a '/'. In option B, NEL ICS (Homerton University Hospital) re-confirmed that the activity could be delivered in the ICS, however this would be more difficult to deliver than it would for providers in NWL. This is because there are existing capacity constraints in the unit at the Homerton, estate constraints to deliver additional capacity and an increasing birth rate in some boroughs in NEL. Option B was therefore confirmed as a '-'.

	Option A: Barnet, North Mid, Whittington, UCLH	Option A: Barnet, North Mid, Royal Free, UCLH
Total projected deliveries (2023/24)	**19,107**	**19,107**
Northwick Park	308	19
St Mary's	245	8
Watford General	38	8
Hillingdon	16	4
Luton Hospital	16	2
Whipps Cross	15	57
Lister	13	8
Newham	11	22
Homerton	10	254
Princess Alexandra	7	10
West Middlesex	6	3
Other* (N=10)	17	24
Total outflows	**702**	**419**

*Note: the other providers included in the analysis are Kings, St Thomas' Hospital, Queen Elizabeth Hospital, Chelsea and Westminster Hospital, St Georges Hospital, Royal London, Princess Royal University Hospital, Kingston Hospital, St Helier Hospital, Croydon Hospital

Figure 20: Projected delivery outflows

The projected neonatal care day flows are shown in Figure 21. NWL ICS (St Mary's Hospital and Northwick Park Hospital) re-confirmed the activity projected to flow into NWL would be able to be accommodated within the current physical capacity across NWL's neonatal units and was therefore confirmed as a '/'. In option B, NEL ICS (Homerton University Hospital) re-confirmed that the activity could be delivered in the ICS, however this would be more difficult to deliver than it would for providers in NWL. This is because there are existing capacity constraints in the unit at the Homerton, estate constraints to deliver additional capacity and an increasing birth rate in some boroughs in NEL. Option B was therefore confirmed as a '-'.

	Option A: Barnet, North Mid, Whittington, UCLH	Option A: Barnet, North Mid, Royal Free, UCLH
Total projected neonatal care days (2023/24)	**31,831**	**31,651**
Northwick Park	311	38
St Mary's	247	16
Watford General	38	16
Hillingdon	17	8
Luton Hospital	17	4
Whipps Cross	16	112
Lister	14	16
Newham	11	44
Homerton	10	501
Princess Alexandra	7	20
West Middlesex	6	6
Other* (N=10)	14	45
Total outflows	**708**	**826**

*Note: the other providers included in the analysis are Kings, St Thomas' Hospital, Queen Elizabeth Hospital, Chelsea and Westminster Hospital, St Georges Hospital, Royal London, Princess Royal University Hospital, Kingston Hospital, St Helier Hospital, Croydon Hospital

Figure 21: Projected neonatal care day outflows

The evaluation of the outflows of deliveries and neonatal care days has not changed and the overall evaluation 'Would there be a significant outflow of activity from NCL?' for option A remains a '/' and for option B remains a '-', as shown in Figure 22.

Evaluation question	Quantification measure	Option A: Barnet, North Mid, Whittington, UCLH	Option B: Barnet, North Mid, Royal Free, UCLH
Would there be a significant outflow of activity from NCL?	Delivery outflows	/	-
	Neonatal care days outflows	/	-
Overall evaluation		/	-

Option A rationale
- Delivery outflows >100 but ≤1,000
- Neonatal care day outflow of >500 but ≤1,500
- As part of the PCBC development, NWL ICS confirmed St Mary's and Northwick Park have enough capacity for the additional projected activity
- NWL ICS have re-confirmed that based on the updated modelled outflows St Mary's and Northwick Park have enough capacity for the additional projected activity

Option B rationale
- Delivery outflows >100 but ≤1,000
- Neonatal care day outflow of >500 but ≤1,500
- As part of the PCBC development, NEL ICS indicated a rising birth rate and existing capacity challenges in NEL would make additional flows challenging at the Homerton
- NEL ICS have re-confirmed that based on the updated modelled outflows that it would still be challenging to deliver at Homerton due to rising birth rates and existing capacity challenges

Figure 22: Deliveries and neonatal care days outflow evaluation

8.8.3 Workforce

In the PCBC, the CRG considered two evaluation questions to assess the difference between the options with regards to workforce:

- How easy is it likely to be to implement the proposed care model?
- Does the option support training opportunities?

8.8.3.1 *How easy is it likely to be implement the proposed model of care?*

Clinicians considered how easy it is likely to be to implement the care model from a workforce perspective. Options that require the workforce to move to a different unit would be more difficult to implement. This included consideration of evaluation metrics around the workforce that would be required to deliver the agreed model of care (as detailed in section 5):

1. How many additional neonatal consultants are required to meet the consultant 24/7 workforce rota standard?
2. How many additional consultant presence labour ward hours per week are required to meet future activity requirements?
3. How many middle grades would need to move units to support the LNU (level 2) middle grade minimum rota requirements?
4. How many additional neonatal nurses are required to meet future neonatal cot requirements?
5. How many additional midwives are required to meet future activity requirements?

The workforce analysis was based on funded establishment in 2022.

How many additional neonatal consultants are required to meet the consultant 24/7 workforce rota standard?

Evaluation prior to consultation

In the PCBC, the CRG considered how many additional neonatal consultants would be required to meet the consultant 24/7 workforce rota standard. This is because any LNU (level 2) and NICU (level 3) would be required to have a minimum number of consultants to cover the on-call rota, to ensure there is access to specialist skills for sufficient hours in the day to improve quality and outcomes. Our model of care aspires to deliver the workforce standards set by BAPM[46].

For all options, there would be no additional recruitment required across NCL as there are more than the required 21 WTE neonatal paediatricians/neonatal consultants currently in post in NCL. However, at the Royal Free Hospital only one neonatal paediatrician/neonatal consultant is in post and therefore any option which includes the Royal Free Hospital would require workforce to move from other units. Six neonatal consultants would be required to move between sites in all options, with the exception of option 3.

New evidence considered
The evaluation measure has been updated to reflect the 2024 funded establishment.

Updated evaluation: How many additional neonatal consultants are required to meet the consultant 24/7 workforce rota standard?
Based on the updated workforce data, option A would still not require any additional neonatal consultants to meet the minimum rota workforce requirements and therefore the evaluation remains ‘+ +’. Option B would still require six neonatal consultants to move between the sites as Royal Free Hospital only has one neonatal paediatrician/neonatal consultant in post. Option B evaluation remains a ‘-’. The evaluation is shown in Figure 23.

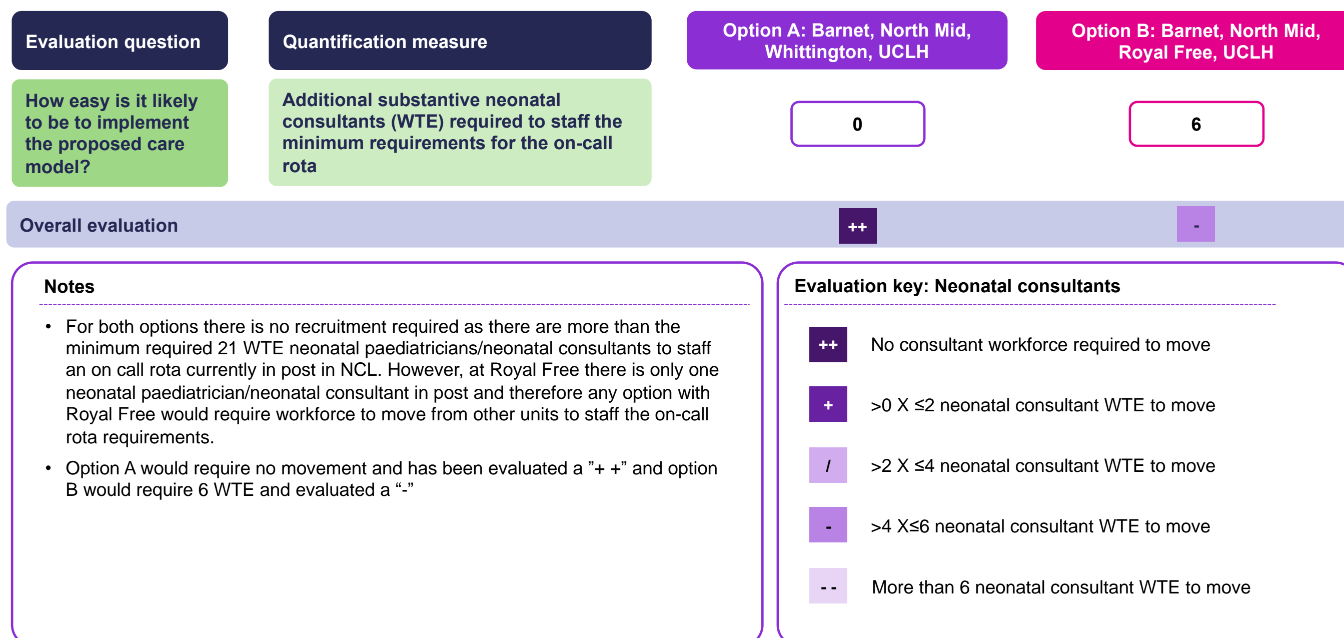

Figure 23: Additional neonatal consultant (WTE) to move option evaluation

How many additional consultant presence labour ward hours per week are required to meet future activity requirements?

Evaluation prior to consultation
In the PCBC, the CRG considered how many additional consultant presence labour ward hours per week are required to meet future activity requirements. Royal College of Obstetrician and

[46] https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk

Gynaecology (RCOG) stated that the number of consultant hours presence required on a labour ward is[47]:

- <4,000 deliveries: 84 hours present
- 4,000 – 5,000 deliveries: 98 hours present
- 5,000 – 6,000 deliveries: 168 hours present.

The additional number of hours of consultant presence on the labour ward per week that would be required under each option. Both option A and option B would require an overall increase in consultant hours per weeks as a result of an increase in future deliveries. Option B would have required a less significant increase and was evaluated as ‘-’. In option A, the additional increase is lowest, but an increase would be required, and the option was evaluated a ‘/’.

New evidence considered
Since the options appraisal, the implementation of the guidelines on consultant presence has evolved in the light of the Ockenden Review[48].

Updated evaluation: How many additional consultant presence labour ward hours per week are required to meet future activity requirements?
This evaluation measure was removed as recommended by the CRG.

How many middle grades would need to move units to support the LNU (level 2) middle grade rota requirements?

Evaluation prior to consultation
In the PCBC, the CRG considered how many middle grade doctors would need to move units to support the LNU (level 2) middle grade doctor rota requirements. This is because BAPM guidance states minimum rota requirements to ensure there is access to specialist skills for sufficient hours in the day to improve quality and outcomes[49]. The minimum rota requirements are:

- LNU (level 2): shared rota with paediatrics, comprising a minimum of eight whole time equivalent (WTE) middle grade staff
- NICU (level 3): European working time directive (EWTD)-compliant rota with a minimum of eight WTE middle grade staff.

Any option would require a minimum of 32 WTE middle grade doctors to cover the middle grade rota requirements across NCL, and there are currently 35.5 WTE middle grade doctors in NCL so no additional doctors would be needed.

For all options, no additional recruitment was required across NCL as there were more than the required 32 WTE neonatal middle grade doctors currently in post in NCL. However, at Royal Free Hospital there were no middle grade doctors in post and therefore eight WTE middle grade doctors would have been required to move to the Royal Free Hospital from other sites in any options that include the Royal Free Hospital. Any options with North Mid would require the movement of 0.5 WTE middle grade doctors as the unit had 7.5 WTE middle grade doctors.

Option B was evaluated ‘- -’ to account for the difficulty of moving workforce and the risk that workforce may choose to leave NCL rather than move hospital. Option A was evaluated with a ‘+’ as only 0.5 WTE middle grade doctors would be required to move site.

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[47] RCOG. Labour Ward Standards. https://www.rcog.org.uk/media/rz1b0z3o/labourwardsolutiongoodpractice10a.pdf

[48] Ockenden Report. 2022.

[49] BAPM Quality standards, 2022

New evidence considered
The current funded establishment WTE middle grade doctors by site has been refreshed and the gap at each site has been updated to reflect the current WTE supporting the middle grade rota. The current number and gap are shown in Figure 24.

Site	Funded establishment WTE supporting the middle grade rota (in post)	Gap to requirement (WTE)
Barnet	8	0
North Mid	9.9	0
Royal Free	0	-8
Whittington	8	0
UCLH	12	0

Figure 24: Middle grade doctors (WTE) in post and gap to minimum required numbers

Updated evaluation: How many middle grades would need to move units to support the LNU (level 2) middle grade rota requirements?
For both options, no additional recruitment would be required across NCL as there are more than the minimum required 32 WTE neonatal middle grade doctors currently supporting the middle grade rota in NCL. At Royal Free Hospital there are currently no middle grade doctors in post so option B would require the movement of 8 WTE middle grade doctors and has therefore been evaluated a '- -'. North Mid now have the minimum funded establishment whereas in the PCBC there was a gap to requirement of 0.5 WTE. Therefore, option A would now require no workforce to move so has been evaluated a '+ +'. The evaluation is shown in Figure 25.

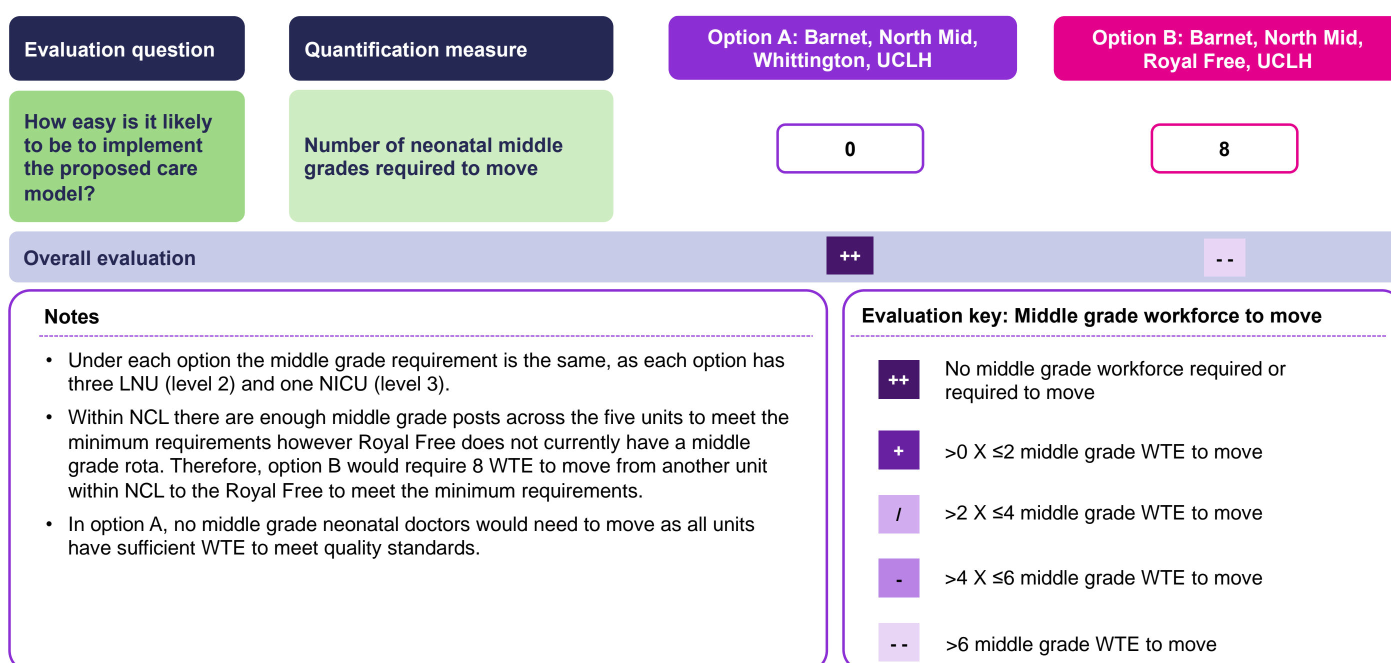


Figure 25: Number of neonatal middle grade doctors to move (WTE) option evaluation

How many additional neonatal nurses are required to meet future neonatal cot requirements?

Evaluation prior to consultation
In the PCBC, the CRG considered how many additional neonatal nurses would be required to meet future neonatal cot requirements. This is because BAPM guidance is that there should be a minimum nursing to baby ratio in neonatal settings, as follows[50]:

- **Intensive care:** 1:1 (one neonatal nurse for every baby)
- **High dependency:** 1:2 (one neonatal nurse for every two babies)
- **Special care: 1:4** (one neonatal nurse for every four babies).

317 WTE neonatal nurses were needed to deliver the agreed care model with 262 WTE neonatal nurses in post across NCL. The number of neonatal nurses that would need to move is also different between the options. Option A was evaluated a '-' as between 10 and 20 nurses would have to move. Option B was evaluated a '- -' as more than 20 nursers would have to move.

New evidence considered
- Updated neonatal nursing workforce data
- Updated future cot requirements based on the refreshed activity and capacity modelling

Updated evaluation: How many additional neonatal nurses are required to meet future neonatal cot requirements?

The BAPM guidance on minimum nursing to baby ratio remains the same. Based on the updated cot capacity we would need between 317 WTE and 322 WTE neonatal nurses to deliver the agreed care model (option dependent) and we currently have 301 WTE neonatal nurses in post across NCL. The number of neonatal nurses that would need to move in each option is shown in Figure 26.

Option	Future neonatal workforce requirements (WTE)	Current NCL neonatal nursing workforce in post (WTE)	Neonatal workforce available to move (WTE)	Future workforce requirement gap (WTE)
Option A: Barnet, North Mid, Whittington, UCLH	322	301	19	-21
Option B: Barnet, North Mid, Royal Free, UCLH	317	301	48	-16

Figure 26: Future neonatal nursing workforce requirement (WTE) for each option

Option A has been evaluated '-' as between 10 and 20 nurses would have to move and option B has been evaluated '- -' as more than 20 WTE would need to move. This evaluation is show in Figure 27.

[50] BAPM Quality standards, 2022

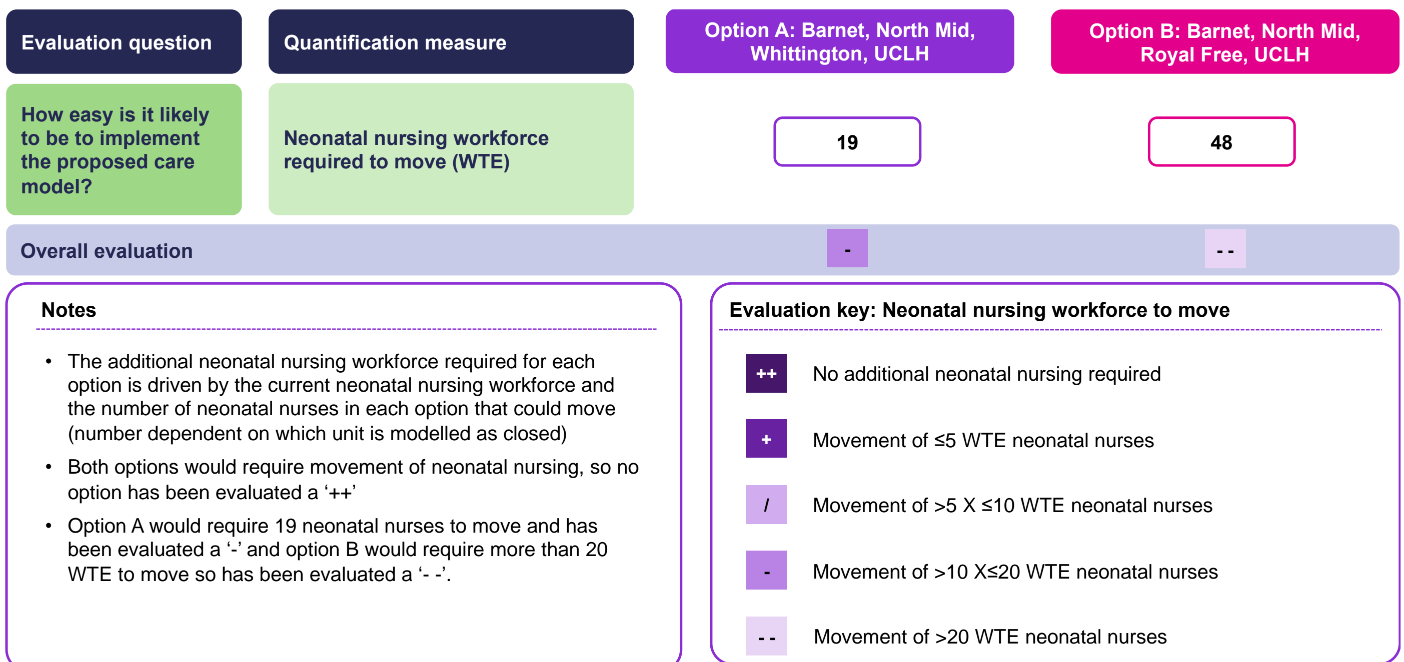


Figure 27: Additional neonatal nursing workforce required (WTE) option evaluation

Evaluation prior to consultation

In the PCBC, the CRG considered how many additional midwives would be required to meet future activity requirements. This is because BirthRate Plus guidance is that there should be a minimum midwife to babies ratio in obstetric-led birth settings, as follows[51]:

- Barnet, North Mid, Royal Free Hospital and Whittington Hospital: 1:24 (one midwife for every 24 babies). An average for units in NCL (excluding UCLH) was used as the future BirthRate Plus requirements may change as the activity and case mix may be different as a result of reconfiguration.
- UCLH: 1:23 (one midwife for every 23 babies).

Based on the BirthRate Plus ratios and the modelled deliveries 846 WTE midwives were calculated to deliver our new care model. Option A was evaluated a '-' as more than 50 WTE but less than 75 WTE would need to move. Option B was evaluated a '- -' as more than 75 WTE would need to move.

New evidence considered

- Most recent BirthRate plus requirements for UCLH. This is now 1:21 (one midwife for every 21 babies)
- Updated number of future deliveries

Updated evaluation: How many additional midwives are required to meet future activity requirements?

[51] BAPM Quality standards, 2022

Considering the revised BirthRate Plus assumptions in option A there would be 74 WTE required to move and in option B there would be 153 WTE required to move. This is shown in Figure 28.

Option	Future deliveries	Future midwifery workforce requirements (WTE)	Midwifery workforce required to move (WTE)
Option A: Barnet, North Mid, Whittington, UCLH	19,107	828	74
Option B: Barnet, North Mid, Royal Free, UCLH			153

Figure 28: Future midwifery workforce requirement (WTE) by option

Based on the new information option A would be evaluated as '-' because more than 50 but less than 74 WTE would be required to move and in option B requires 153 WTE to move which would be deliverable but difficult so is evaluated a '- -'. This evaluation is shown in Figure 29

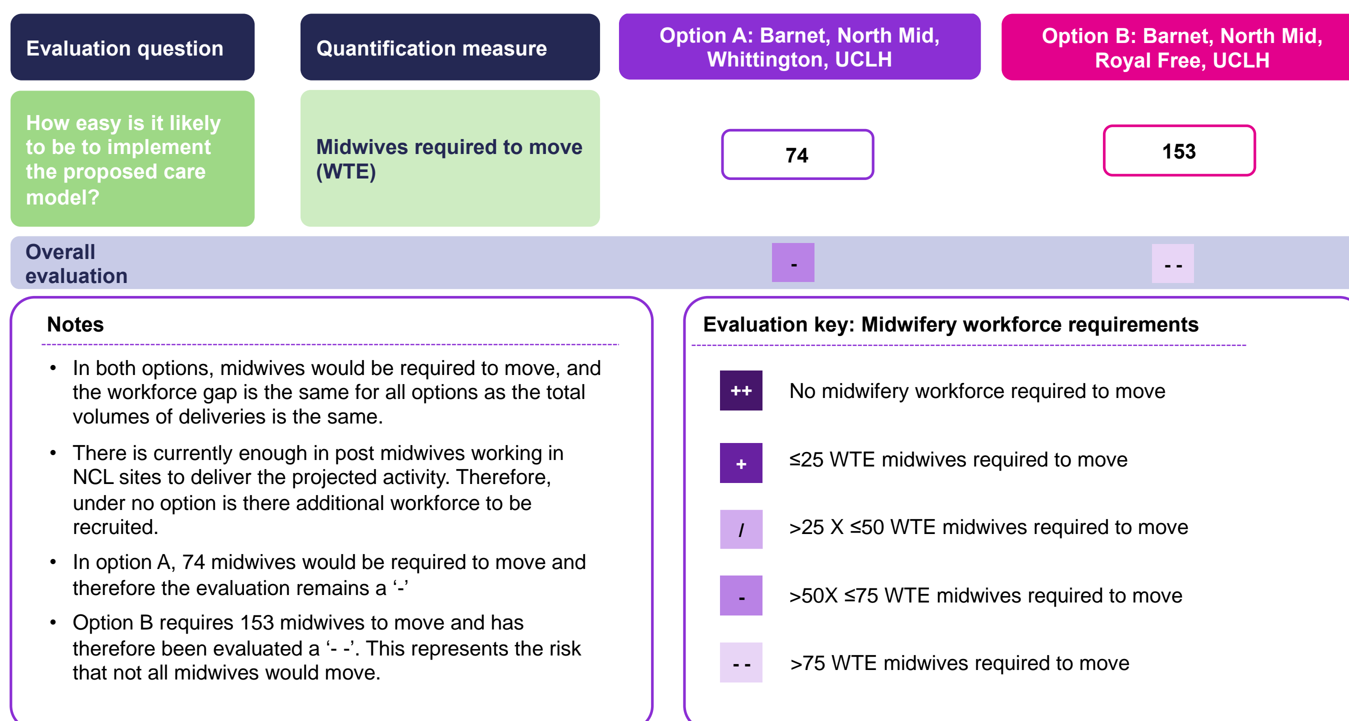


Figure 29: Midwives required to move (WTE) option evaluation

Overall evaluation: how easy is it likely to be to implement and deliver the proposed model of care?

Evaluation prior to consultation

In the PCBC the CRG reviewed the evaluation questions to assess how easy each option would be to implement and deliver the proposed model of care. The evidence is summarised below for each of the options that were considered viable and consulted on. Both options would deliver the care model and the associated benefits.

Option A was rated '+' overall because it would require:

- No neonatal consultant workforce to move units
- No middle grade doctors to move units
- The lowest increase in labour ward consultant hour presence
- Fewer neonatal nurses required to move (>10 WTE but <20 WTE)
- Between 50 and 75 midwives to move between units.

Option B was rated '-' overall because it would require:

- Neonatal consultant and middle grade workforce to move units
- Increase in labour ward consultant presence hours
- Neonatal nursing movement >20 WTE
- Over 75 midwives to move between units.

Updated evaluation: How easy is it likely to be to implement and deliver the proposed model of care?
The CRG reviewed the refreshed evaluation to assess overall how easy each option would be to implement and deliver the proposed care model.

Option A has been rated a '+' because:

- No neonatal consultant workforce would be required to move units
- No middle grade workforce would be required to move units
- Over 20 neonatal nurses would be required to move between units
- Between 50 and 75 midwives would need to move between units

Option B has been rated a '- -' because:

- 6 neonatal consultants would be required to move units
- 8 neonatal middle grade workforce would be required to move units
- Neonatal nursing movement >20 WTE
- Over 75 midwives to move between units.

The overall evaluation is show in Figure 30

Evaluation question	Quantification measure	Option A: Barnet, North Mid, Whittington, UCLH	Option B: Barnet, North Mid, Royal Free, UCLH
How easy is it likely to be to implement the proposed care model?	Additional neonatal consultants (WTE) to move	++	-
	Number of middle grades to move	++	- -
	Additional neonatal nursing workforce required (WTE)	-	- -
	Midwives required to move (WTE)	-	- -
Overall evaluation		+	- -

Option A rationale
- No neonatal consultants required to move units
- No middle grade doctors to move units
- Neonatal nursing movement of <20 WTE
- Between 50 and 75 midwives to move between units

Option B rationale
- Neonatal consultant and middle grade workforce to move units
- Neonatal nursing movement >20 WTE
- Over 75 midwives to move between units

Figure 30: Overall option evaluation: how easy is it to implement and deliver the proposed model of care

8.8.3.2 *Does the option support training opportunities?*

Clinicians considered whether each option would support training opportunities. This is because sites that offer a larger number of placements would have a bigger impact on training opportunities in the future if the unit was to close, and because other sites would need to increase the training placements offered and this may impact on future training opportunities in NCL. This included consideration of the following evaluation metrics on the impact of training opportunities:

1. What is the difference in total number of nursing student placements for neonates and maternity?
2. What is the difference in total number of neonatal nursing qualified in specialty (QIS) training placements?
3. What is the difference in total current number of student midwife placements?

What is the difference in total number of nursing student placement for neonates and maternity?

Evaluation prior to consultation

The CRG considered the current total number of nursing student placements for neonates and maternity. This is because any reduction in student nursing placements would have an impact on training opportunities in NCL. There is an ambition to keep trainees within NCL and clinicians agreed that people who train in NCL are more likely to continue to work here once trained.

Option A was evaluated a '/' as it would result in a reduction of between 10 and 30 placements. Option B was evaluated as a '- -' because there would more than a 50 placement reduction.

New evidence considered

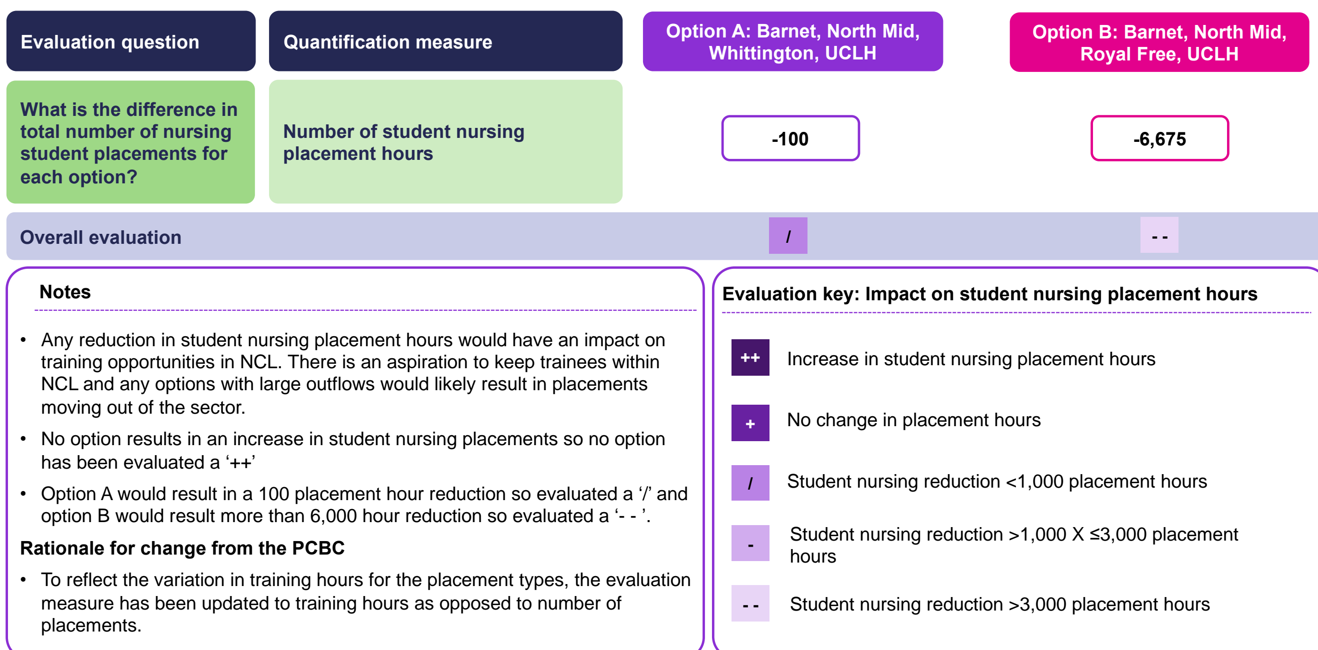
Reviewing the updated evidence the CRG recommended to amend the measure from the number of nursing student placements to number of nursing student placement hours delivered. This was because it was noted that different placements had different number of training hours. Therefore, to ensure the actual impact on training was captured it was agreed to use hours instead of number of placements. The reduction in student nursing placement hours is shown in Figure 31.

Option	Reduction in student nursing placement hours
Option A: Barnet, North Mid, Whittington, UCLH	-100 hours
Option B: Barnet, North Mid, Royal Free, UCLH	- 6,675 hours

Figure 31: Student nursing placement hour reduction

Updated evaluation: What is the difference in total number of nursing student placement for neonates and maternity

The CRG reviewed the data associated with the amended quantification measure and based on this evaluated option A as '/' as there would be a reduction of less than 1,000 student nursing placement hours. Option B has been evaluated a '- -' as there would be reduction of more than 3,000 student nursing placement hours. Despite the change in quantification measure, the evaluation of the two options remained the same as the PCBC. This evaluation is shown in Figure 32.



Source: Trust data returns

Figure 32: Student nursing placement options evaluation

What is the current total number of neonatal nursing qualified in specialty (QIS) training placements?

Evaluation prior to consultation

The CRG considered the current total number of neonatal nursing qualified in specialty (QIS) training placements. This is because any reduction in QIS nursing placements would have an impact on training opportunities, and there is an ambition to continue to train nurses to be specialists in delivering neonatal care within NCL.

Option A was evaluated a '+' because there was no change in the number of neonatal nursing QIS placements. Option B was evaluated a '- -' because there was a more than 5 placement reduction.

New evidence considered

The current neonatal nursing QIS placements for each site was reviewed in each option based on 2023/24 numbers (Figure 33).

Number of neonatal nursing QIS placements by site (2023/24)

Site	Neonatal nursing QIS placements
Barnet	7
North Mid	1
Royal Free	2
Whittington	7
UCLH	7
NCL total	24

Number of neonatal nursing QIS by option

Option	Neonatal nursing QIS placements
Option A: Barnet, North Mid, Whittington, UCLH	22
Option B: Barnet, North Mid, Royal Free, UCLH	17

Figure 33: Current neonatal nursing qualified in specialty (QIS) placements by hospital and for each option

Updated evaluation: What is the total number of neonatal nursing qualified in specialty (QIS) training placements?
The CRG reviewed the refreshed data and based on this evaluated option A has been evaluated a '/' as there would be a reduction of two placements. Option B has been evaluated a '- -' as there would be reduction of more than five placements. The updated evaluation is shown in Figure 34.

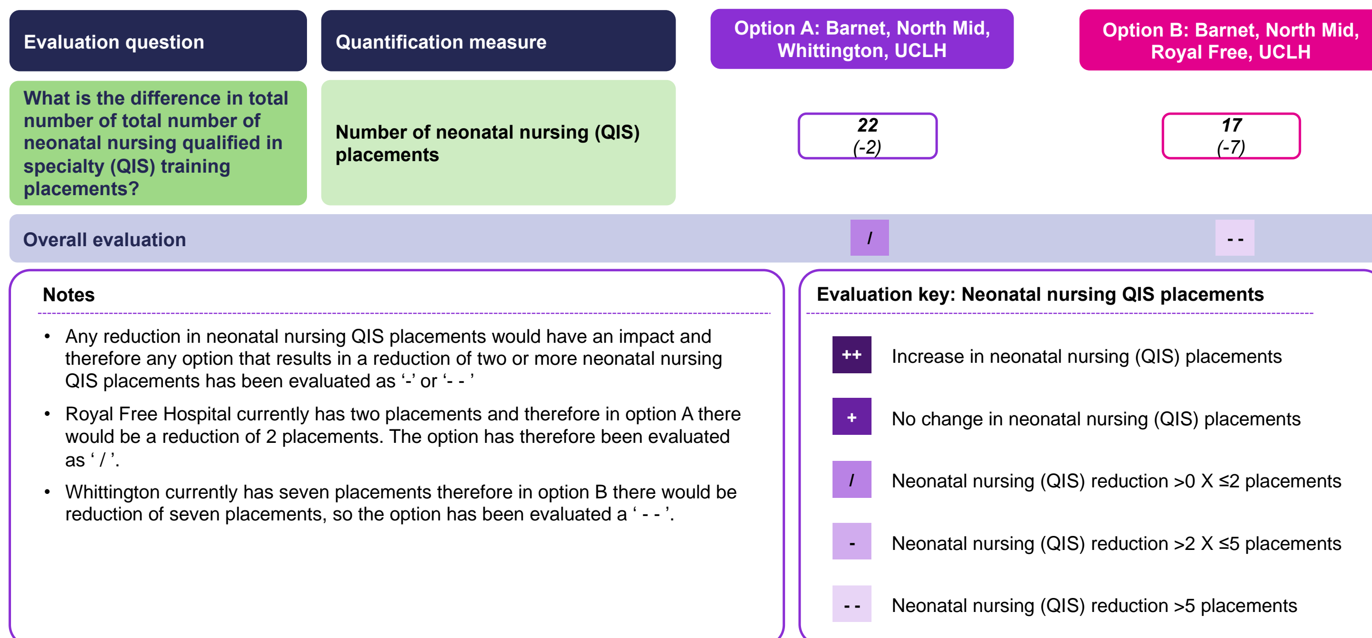


Figure 34: Number of neonatal nursing (QIS) placement option evaluation

What is the total current number of student midwife training placements?

Evaluation prior to consultation
The CRG considered the current total number of student midwife training placements. This was because any reduction in student midwife placements would have an impact on training opportunities in NCL. There is an ambition to keep trainees within NCL and clinicians agree that people who train in NCL are more likely to continue to work in NCL once trained.

Both option A and option B were evaluated a '/' because there was a student midwife placement hour reduction of more than 5% but less than 15%.

New evidence considered
The number of student midwife hours was updated to reflect the number of hours delivered in 2023/24. This current number of hours by site and the placement hours by option is set out in Figure 35.

Current number of student midwife placement hours by site

Site	Student midwife placement hours
Barnet	90,743
North Mid	65,960
Royal Free	43,052
Whittington	38,000
UCLH	89,700
NCL total	327,455

Number of student midwife placement hours by option

Option	Student midwife placement hours by option	Placement hour reduction (%)
Option A: Barnet, North Mid, Whittington, UCLH	284,403	-15%
Option B: Barnet, North Mid, Royal Free, UCLH	289,455	-13%

Source: Trust data returns (2024)

Figure 35: Current student midwife training placement hours for each option

Updated evaluation: What is the total current number of student midwife training placements?

Both option A and option B have been evaluated a '/' because there would be a student midwife placement hour reduction of more than 5% but less than or equal to 15%. This evaluation is shown in Figure 36.

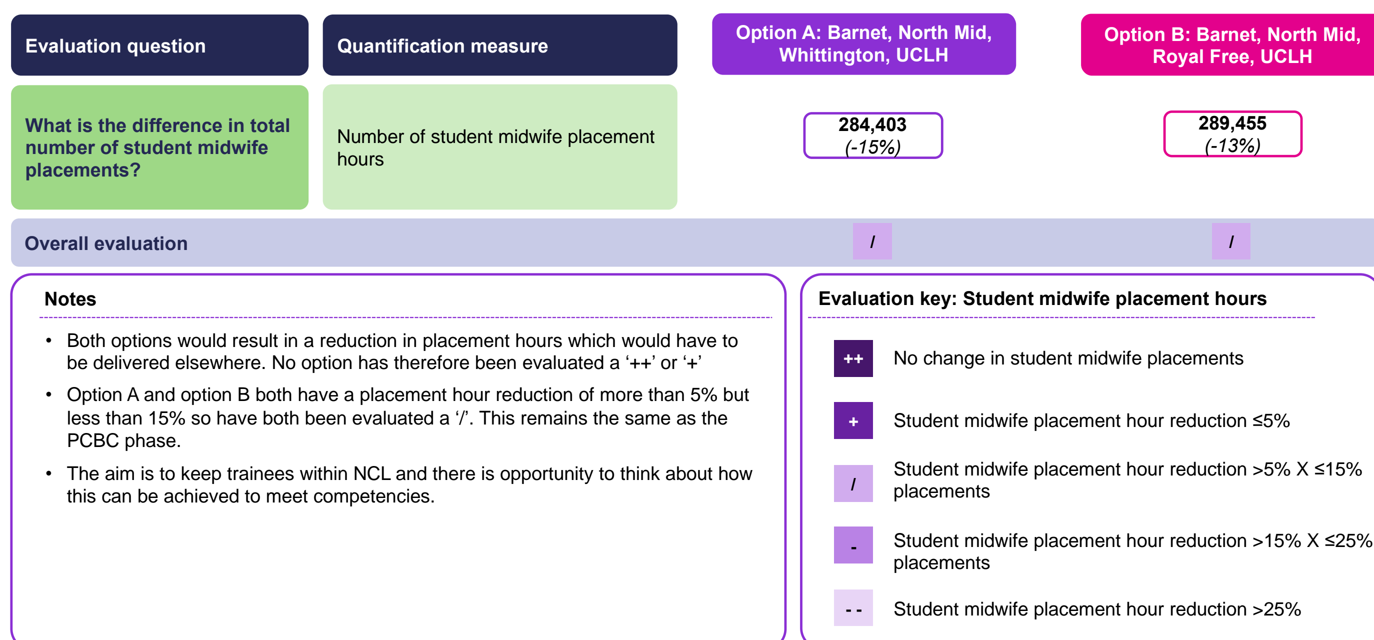


Figure 36: Student midwife placement options evaluation

Updated overall evaluation: does the option support training opportunities?

The CRG reviewed all the updated evaluations to assess overall if the option support training opportunities. The overall evaluation is shown in Figure 37.

Option A has been rated a '/' because:

- Reduction in staff nursing placement hours of less than 1,000 hours
- Reduction in QIS training placements of two placements
- Reduction in student midwife placement hours of more than 5% but less than or equal to 15%

Option B was rated a '- -' because:

- Reduction in staff nursing placement hours of more than 3,000 hours
- Reduction in QIS training placements more than 5 placements
- Reduction in student midwife placement hours of more than 5% but less than or equal to 15%

Evaluation question	Quantification measure	Option A: Barnet, North Mid, Whittington, UCLH	Option B: Barnet, North Mid, Royal Free, UCLH
Does the option support training opportunities?	What is the difference in total number of nursing student placement hours for each option?	/	- -
	What is the difference in total number of total number of neonatal nursing qualified in specialty (QIS) training placements?	/	- -
	What is the difference in total number of student midwife placements?	/	/
Overall evaluation		/	- -

Option A rationale

- Large reduction in student placements would be lost from NCL.
- Small reduction in the neonatal nursing QIS placements
- Small reduction in student midwife placement hours

Option B rationale

- Greatest reduction in neonatal nursing QIS placements and student nursing placements
- A smaller number of student midwife placements would be lost from NCL

Figure 37: Overall evaluation for support of training opportunities for the workforce

8.8.4 Access to care

The PPEG considered metrics to evaluate access to care. The PPEG agreed that although people may need to travel further to access the new model of care, this would likely be offset by improvements in quality, outcomes and patient experience.

The PPEG also agreed that, although the length of time it takes to travel to access services is important, there are other factors to consider, such as the cost of travel, and access to services once on site (which might include physical factors such as availability of parking and cultural/environmental factors such as neuro-divergent friendly environments and interpretation support). However, the PPEG recognised that most cultural and environmental factors would be the same for all options. Instead, these factors have been considered as part of the impact of the options which is outlined in the IIA. The PPEG therefore evaluated options in terms of travel to services and travel accessibility as these are differentiating between options. The detailed approach to travel times can be found in the IIA.

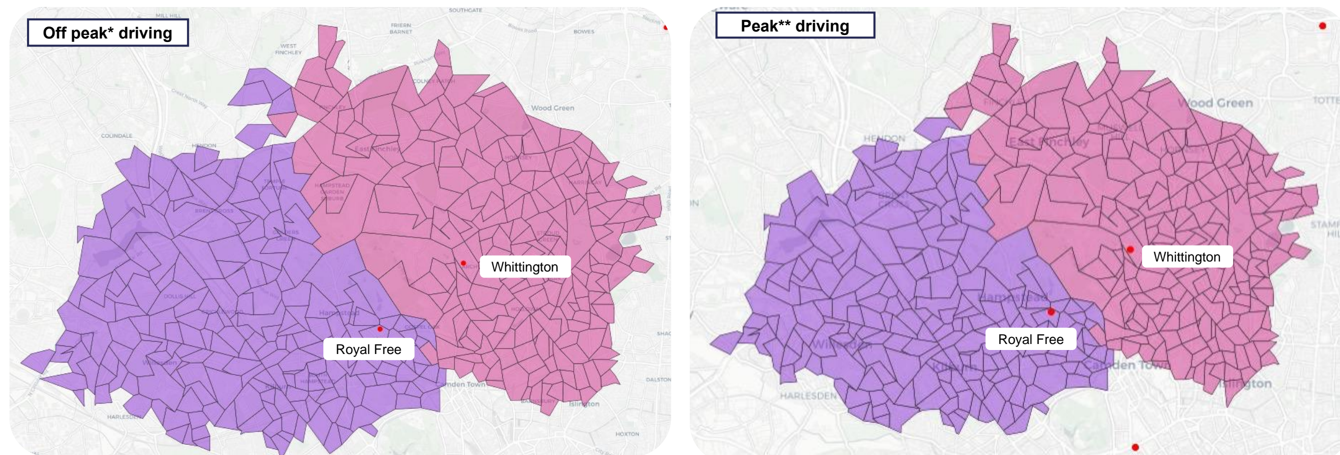
8.8.4.1 *What is the impact on the average and maximum travel times?*

Evaluation prior to consultation

The PPEG considered the evaluation question "What is the impact on the average and maximum travel times?". This is because it is important to understand how much further people may need to travel to access services and the impact on people who would have to travel the furthest (maximum travel times). The PPEG reviewed travel times compared to current travel times so the increase in travel time could be seen. The group looked at journeys by off-peak driving/taxi/ambulance, peak driving/taxi and public transport.

Option A and option B were both evaluated a '-' as the average or maximum increase was more than 2 minutes but less than or equal to seven.

New evidence considered
2024 travel times have been used to identify the catchment population – anyone for whom Royal Free Hospital or Whittington Hospital are the nearest by driving for peak and off-peak journeys (which include journeys by private car, ambulance and taxi). Using the latest travel times ensures that the latest road network and speed limits are reflected. The peak and off-peak impacted populations are show in Figure 38.



***Off peak (private car / taxi / ambulance) is defined as 03:00 AM on a Tuesday*

**Peak (private car / taxi) is defined as 08:30 AM on a Tuesday*

Figure 38: 2024 peak and off-peak catchment

The average additional travel time and the difference in maximum travel time for this catchment population based on 2024 travel times is shown in Figure 39.

Key: Low | Medium | High

Option	Transport method	Average travel time to closest unit (mins)	Average travel time (mins) to next closest unit	Difference for average	Maximum travel time to current closest unit	Future maximum travel time	Difference for maximum
Option A (Royal Free closes)	Off-peak	11.1	14.9	+ 3.8	20.3	22.2	+ 1.9
	Peak	14.2	19.6	+ 5.4	27.1	29.2	+ 2.1
	Public	32.2	36.7	+ 4.5	72.9	86.5	+ 13.6
Option B (Whittington closes)	Off-peak	10.1	15.0	+ 4.9	17.3	20.4	+ 3.1
	Peak	13.4	19.9	+ 6.5	23.5	27.4	+ 3.9
	Public	27.0	35.1	+ 8.1	43.9	59.1	+ 15.2

Figure 39: Average and maximum difference in travel times

Updated evaluation: What is the impact on maximum and average travel time for peak and off-peak journeys?

Based on the refreshed travel time analysis both option A and option B would result in an increase in off-peak travel times of more than two minutes but less than or equal to seven minutes. Therefore, both options have been evaluated a '-'. This evaluation is shown in Figure 40.

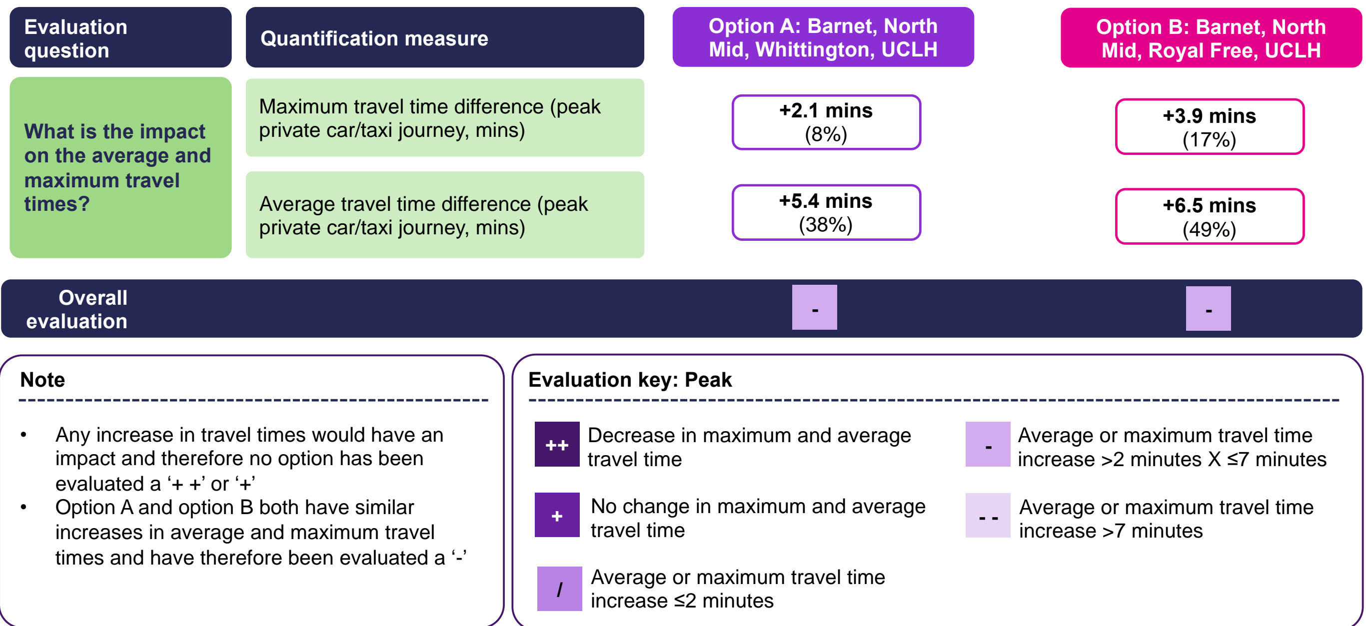


Figure 40: Maximum and average travel time different (peak) option evaluation

Both option A and option B would result in an increase in average and maximum travel times for off-peak journeys. Both options would result in an increase in average and/or maximum travel times of between two and seven minutes for off-peak. Based on the updated evaluation option A and option B are both evaluated a '-' which is shown in Figure 41.

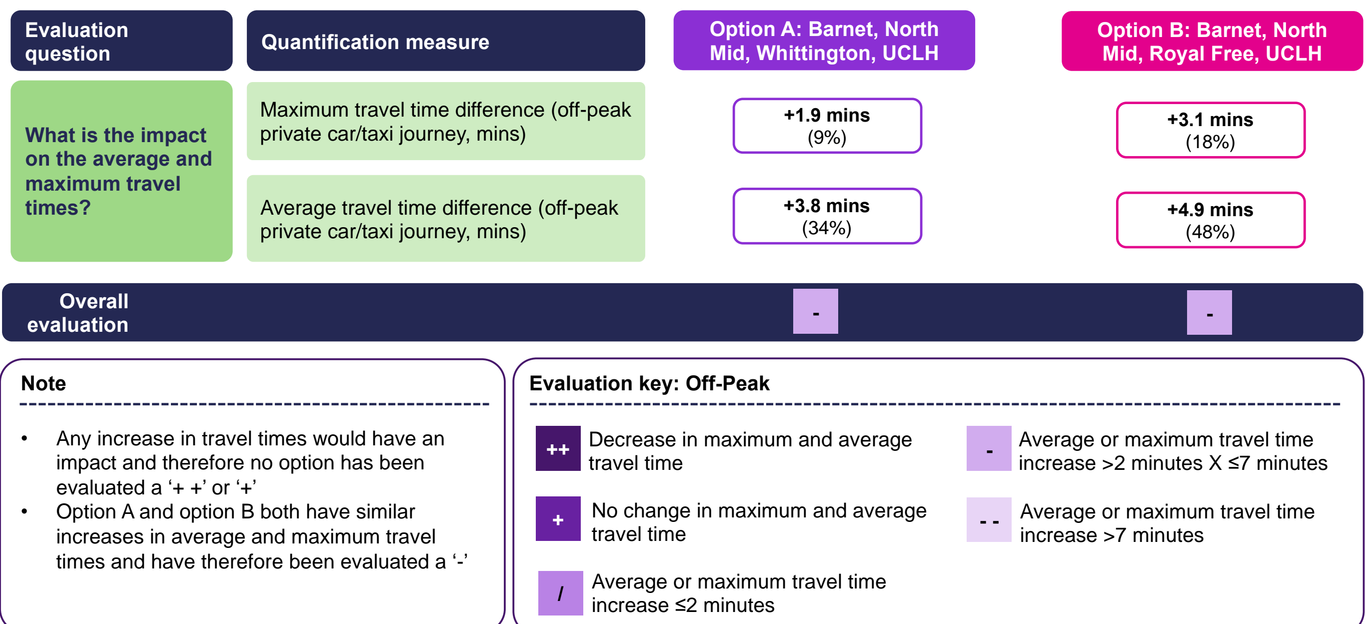
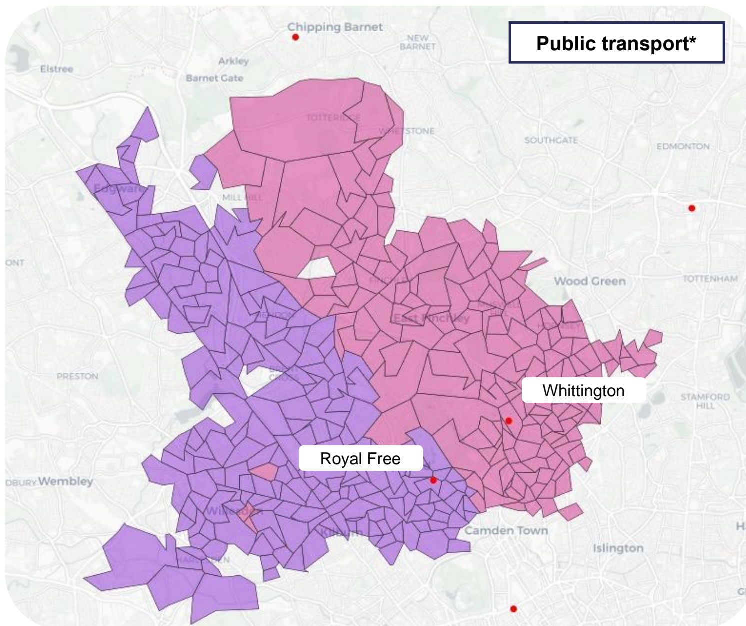


Figure 41: Maximum and average travel time difference (off-peak) option evaluation

Maximum and average travel time for public transport

The impacted population based on public transport is show in in Figure 42.

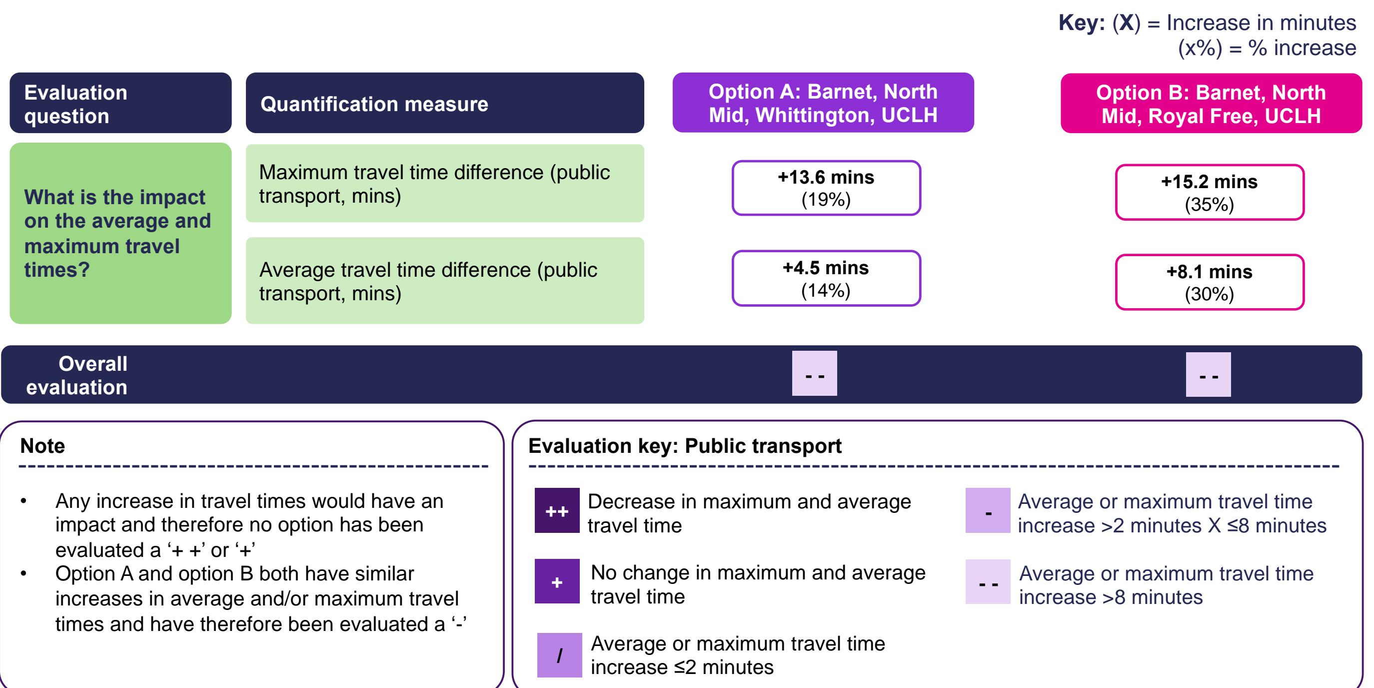


*Public (public transport) is defined as 12:00 PM on a Tuesday

Figure 42: 2024 public transport catchment

New evidence considered
The maximum and average travel time for journeys by public transport for people for whom either Royal Free Hospital or Whittington Hospital are the closest by public transport using 2024 travel times was considered by the PPEG.

Updated evaluation: Maximum and average travel time for public transport
Both option A and option B would result in an increase in average and/or maximum travel times by public transport of more than 8 minutes. Therefore, both options have been evaluated a '- -'. The updated evaluation is shown in Figure 43.



Key: (**X**) = Increase in minutes
(x%) = % increase

Evaluation question	Quantification measure	Option A: Barnet, North Mid, Whittington, UCLH	Option B: Barnet, North Mid, Royal Free, UCLH
What is the impact on the average and maximum travel times?	Maximum travel time difference (public transport, mins)	**+13.6 mins** (19%)	**+15.2 mins** (35%)
	Average travel time difference (public transport, mins)	**+4.5 mins** (14%)	**+8.1 mins** (30%)
Overall evaluation		- -	- -

Note

- Any increase in travel times would have an impact and therefore no option has been evaluated a '+ +' or '+'
- Option A and option B both have similar increases in average and/or maximum travel times and have therefore been evaluated a '-'

Evaluation key: Public transport

- ++ Decrease in maximum and average travel time
- \+ No change in maximum and average travel time
- / Average or maximum travel time increase ≤2 minutes
- \- Average or maximum travel time increase >2 minutes X ≤8 minutes
- \- - Average or maximum travel time increase >8 minutes

Figure 43: Maximum and average travel time difference (public transport) option evaluation

Refreshed overall evaluation: what is the impact on average and maximum travel times?
The PPEG reviewed all the evaluation questions to assess the overall impact on average and maximum travel times:

- Option A was evaluated a '-' overall because the off-peak and peak average and/or maximum travel times would increase by more than two minutes but less than 7 minutes. Average and/or maximum travel times by public transport would increase by more than 8 minutes.
- Option B was evaluated a '-' overall because the off-peak and peak average and/or maximum travel times would increase by more than two minutes but less than 7 minutes. Average and/or maximum travel times by public transport would increase by more than 8 minutes.

The overall evaluation is shown in Figure 44.

Evaluation question	Quantification measure	Option A: Barnet, North Mid, Whittington, UCLH	Option B: Barnet, North Mid, Royal Free, UCLH
What is the impact on maximum and average travel times?	Average and maximum travel time for off peak journeys	-	-
	Average and maximum travel time for peak journeys	-	-
	Average and maximum travel time public transport journeys	- -	- -
Overall evaluation		-	-

Option A rationale
- Increase in average or maximum travel time greater than 2 minutes but less than 6 minutes for peak and off-peak
- Increase in average or maximum travel time greater than 2 minutes but less than 8 minutes for public transport

Option B rationale
- Increase in average or maximum travel time greater than 2 minutes but less than 6 minutes for peak and off-peak
- Increase in average or maximum travel time greater than 8 minutes for public transport

Figure 44: Overall evaluation for average and maximum travel times

8.8.4.2 *Is there an impact on travel times for people living in areas of deprivation?*

Evaluation prior to consultation
The PPEG considered the evaluation question "Is there an impact on travel time for people living in areas of deprivation?". This is because it is important to understand how much further people living in areas of deprivation may need to travel to access services and the impact on people living in areas of deprivation who would have to travel the furthest (maximum travel times). The PPEG reviewed travel times compared to current travel times so the increase in travel time could be seen and looked at journeys for people living in areas of deprivation by off-peak driving/taxi/ambulance, peak driving/taxi and public transport. People living in areas of deprivation is defined as households living in the most deprived 20% of the national population, as shown in Figure 45.

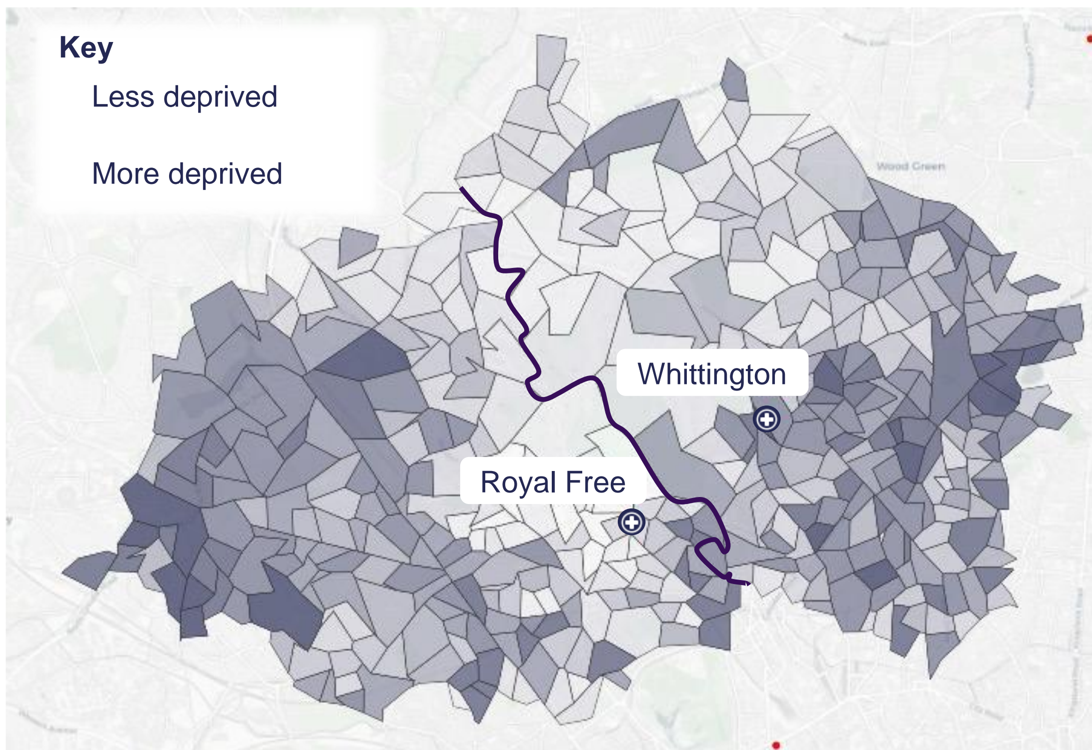


Figure 45: People living in areas of deprivation

New evidence considered
The PPEG reviewed the average additional travel times for people living in areas of deprivation on 2024 travel times and the updated catchment population. The refreshed data is show in Figure 46.

Key: Low | Medium | High

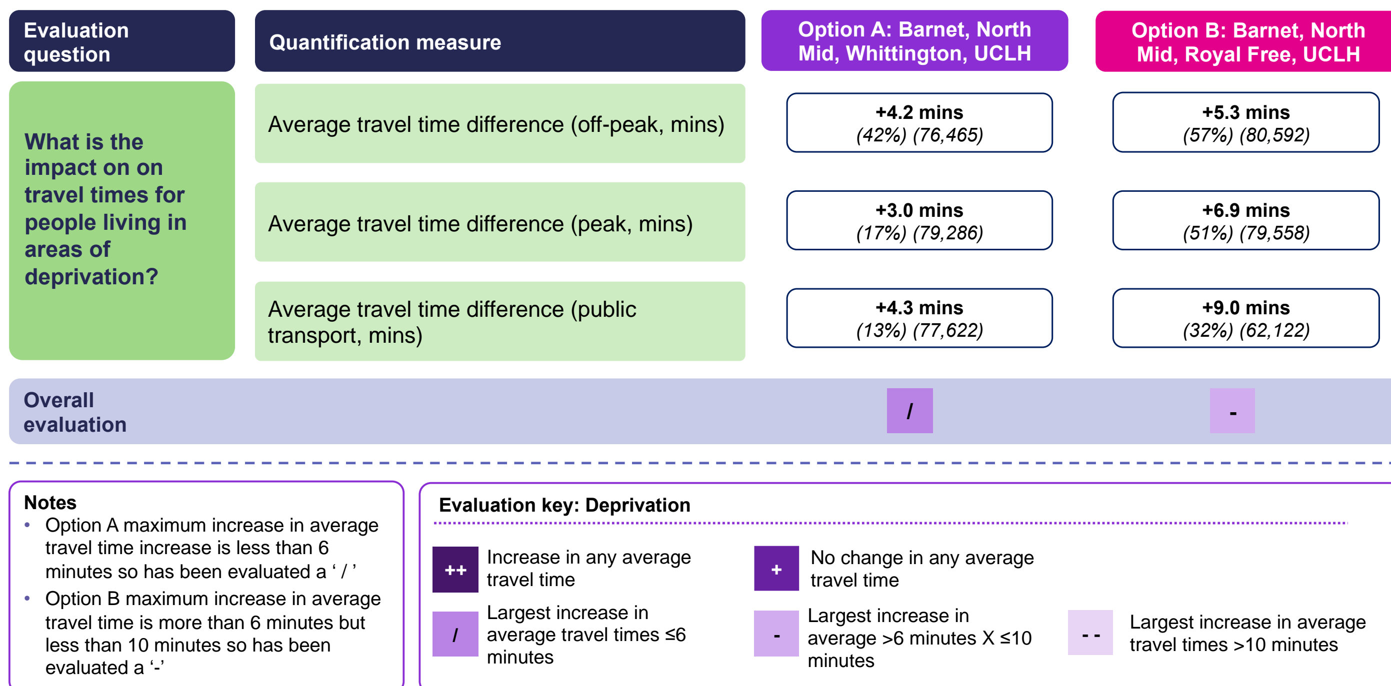
Option	Transport method	Number of deprived households within catchment*	Current Core20 average travel time (mins)	Core20 average travel time (mins) in the option	Difference to current Core20 population (mins)
Option A: Barnet, North Mid, Whittington, UCLH	Off-peak	76,465	10.1	14.3	+ 4.2
	Peak	79,286	17.7	20.7	+ 3.0
	Public	77,622	33.0	37.3	+ 4.3
B) UCLH, Barnet, North Mid, Royal Free	Off-peak	80,592	9.3	14.6	+ 5.3
	Peak	79,558	13.5	20.4	+ 6.9
	Public	62,122	28.3	37.3	+ 9.0

* These households are defined as being deprived in 1 or more dimensions by ONS and are therefore not all necessarily Core20. The 4 dimensions are education, employment, health and housing.

Figure 46: Average travel time for people living in areas of deprivation

Updated evaluation: Is there an impact on travel times for people living in areas of deprivation?
Both options would result in an average increase in the travel time for people living in areas of deprivation. Option A was evaluated a '/' because the largest increase in average travel times

would be less than 6 minutes. Option B was evaluated a '-' because the largest increase in average travel time would be more than 6 minutes but less than 10 minutes. The updated evaluation is shown in Figure 47.



Evaluation question	Quantification measure	Option A: Barnet, North Mid, Whittington, UCLH	Option B: Barnet, North Mid, Royal Free, UCLH
What is the impact on on travel times for people living in areas of deprivation?	Average travel time difference (off-peak, mins)	**+4.2 mins** *(42%) (76,465)*	**+5.3 mins** *(57%) (80,592)*
	Average travel time difference (peak, mins)	**+3.0 mins** *(17%) (79,286)*	**+6.9 mins** *(51%) (79,558)*
	Average travel time difference (public transport, mins)	**+4.3 mins** *(13%) (77,622)*	**+9.0 mins** *(32%) (62,122)*
Overall evaluation		/	-

Figure 47: Average travel time difference for people living in areas of deprivation option evaluation

8.8.4.3 *What is the impact on travel accessibility?*

Evaluation prior to consultation

The PPEG considered the evaluation question "What is the impact on travel accessibility?". To measure the potential impact the PPEG considered the number of dedicated maternity car parking spaces as people need to be able to park if they arrive at the hospital in labour. None of the sites have dedicated maternity car parking spaces and the PPEG therefore considered the total parking spaces available under each option as a proxy measure. The PPEG also considered the ease of public transport accessibility. This is because a 45-minute reliable and frequent bus journey may be more accessible than an infrequent and unreliable 30-minute bus journey. The PPEG reviewed the 2015 PTAL (Public Transport Accessibility Levels[52]) score to assess public transport accessibility.

New evidence considered

Updated maternity and neonatal catchment population was considered when understanding the ease of public transport accessibility.

Updated evaluation: What is the impact on the travel accessibility?

The PPEG reviewed the updated data and both option A and option B were evaluated a '/' because there would be a change in the available parking spaces of less than 450 and/or public transport accessibility would be more than 10. The updated evaluation is shown in Figure 48.

[52] https://data.london.gov.uk/dataset/public-transport-accessibility-levels

Evaluation question	Quantification measure	Option A: Barnet, North Mid, Whittington, UCLH	Option B: Barnet, North Mid, Royal Free, UCLH
What is the impact on travel accessibility?	Available parking spaces in closed unit	374	110
	Public transport accessibility (0 = worst)	15.0	17.1
Overall evaluation		/	/

Notes

- Option A and B public transport accessibility is more than 10 and have been evaluated as ' / ' and a change in parking spaces of between 0 and 450

Evaluation key: Accessibility

Key	Description
++	Change in available parking spaces in closed unit and accessibility > 10
+	No change in available parking spaces in closed unit and accessibility > 10
/	Change in available parking spaces in closed unit between 0 and 450 or accessibility > 10
-	Change in available parking spaces in closed unit between 450 and 650 or accessibility between 10 and 5
- -	Change in available parking spaces in closed unit > 650 or accessibility < 5

Figure 48: Travel accessibility option evaluation

8.8.5 Affordability and value for money

The Finance and Analytics Group considered two evaluation questions to assess the affordability and value for money for each option as compared with the status quo:

- What is the capital investment required for each option?
- What is the benefit cost ratio (BCR) for each option?

8.8.5.1 *What is the capital investment required for each option?*

Evaluation prior to consultation

The Finance and Analytics Group considered the evaluation question “What is the capital investment required for each option?”. This is because it is important to understand the capital implications of the proposed service change to ensure that it is affordable and therefore able to be consulted on.

In the PCBC phase the Finance and Analytics Group considered the incremental capital investment required for each option, based on the additional capacity required to deliver the projected activity. The capital required was submitted by each organisation using a standardised template. To ensure like for like comparability and consistency a common set of assumptions were agreed and applied.

The capital investment required for the additional capacity required to deliver the projected activity was calculated for each option. In addition, the lifecycle costs over a 30-year time period for estate, equipment and IT were also included. These figures were discounted in line with the HMT guidance. The business-as-usual costs for the unit closed in each option were removed from the total capital requirements as it was assumed in any option that this would not be spent if the maternity and neonatal unit were to close.

All options resulted in a capital investment therefore no option was evaluated a ‘+ +’ or a ‘+’. Options A and B were evaluated a ‘-’ as they would result in capital investment requirement of less than £50 million but more than £25 million.

New evidence considered

- Maternity and neonatal activity data was updated to 2023/24 as the most recent full financial year of data that is available resulting in incremental capital requirements being reviewed and updated to account for the updated capacity requirements
- The inflation assumption was updated to reflect the April 2024 PUBSEC assumptions
- The do-nothing capital costs for the unit that would close in each option have not been subtracted from the total cost of the option as was done in the PCBC. Although it is recognised that the existing lifecycle costs would not be spent at the unit that would close, subtracting this value would underplay the total capital that would be required due to the proposed Start Well programme changes not being cash releasing.

Updated evaluation: What is the capital investment required for each option?
The Finance and Analytics Group reviewed the updated capital requirements for each option. Option A would require a capital investment over £50 million and has been evaluated a '- -'. Option B would require a capital investment of more than £25 million but less than £50 million so has been evaluated a '-'. The evaluation is shown in Figure 49.

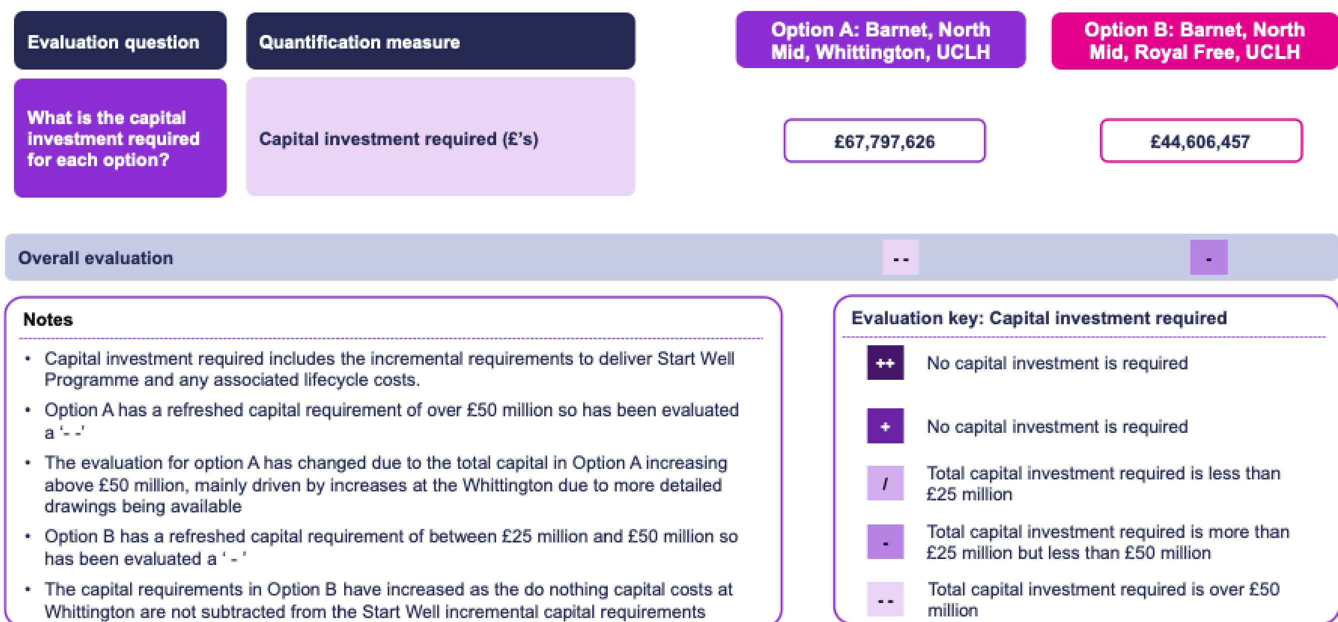


Figure 49: Capital investment requirement refreshed option evaluation

8.8.5.2 *What is the benefit cost ratio (BCR) for each option?*

Evaluation prior to consultation
The Finance and Analytics Group considered the evaluation question "What is the benefit cost ratio (BCR) for each option?". The BCR is used to understand the value for money (VfM) of the proposed service changes in each option. BCR has been used as it is a requirement of the Green Book[53] and has been recognised as best practice for service changes.

The BCR calculation looks at the cash-releasing benefits of the proposed services changes in each option to compare against the costs of the proposed changes. The benefits were considered at a whole system level over a 30-year period.

[53] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1063330/Green_Book_2022.pdf

The Finance and Analytics group reviewed a number of benefits and the monetisable benefits used in the BCR calculation and the costs. The benefits and costs were set out over a 30-year period. All options were evaluated a '-' as the BCR was more than 1 but less than 2.

New evidence considered

- Updated capital costs and charges have been updated to reflect the revised capital requirements
- Further work was undertaken on the stranded costs based on 2024 information and consideration of the potential mitigations for the costs that were identified
- Benefit calculations have been updated to reflect 2024 workforce requirements including the resources and financial implications of meeting safe staffing standards across all units. Future maternity workforce requirements have been modelled in line with Royal College guidance and the Ockenden Report for obstetricians and BirthRate Plus ratios for midwives. Future neonatal workforce requirements have been modelled based on the minimum standards set out in BAPM Quality Standards
- Benefit calculations have been updated to reflect the latest CNST contributions

Updated evaluation: What is the benefit cost ratio (BCR) for each option?
The finance and analytics group reviewed the updated costs and benefits shown in Figure 50.

Benefit cost ratio

Benefit cost ratio of the maternity and neonatal proposals, £s (discounted)

Option	Discounted total benefits (£s)	Discounted total costs (£s)	Benefit Cost Ratio
Option A: Barnet, North Mid, Whittington, UCLH	£259,827,334	£109,003,361	2.38
Option B: Barnet, North Mid, Royal Free, UCLH	£266,087,387	£109,847,540	2.42

Figure 50: Benefits and costs by option

Based on the updated figure, both option A and option B were evaluated a '/' because the BCR is more than 2 but less than 4. The evaluation is shown in Figure 51.

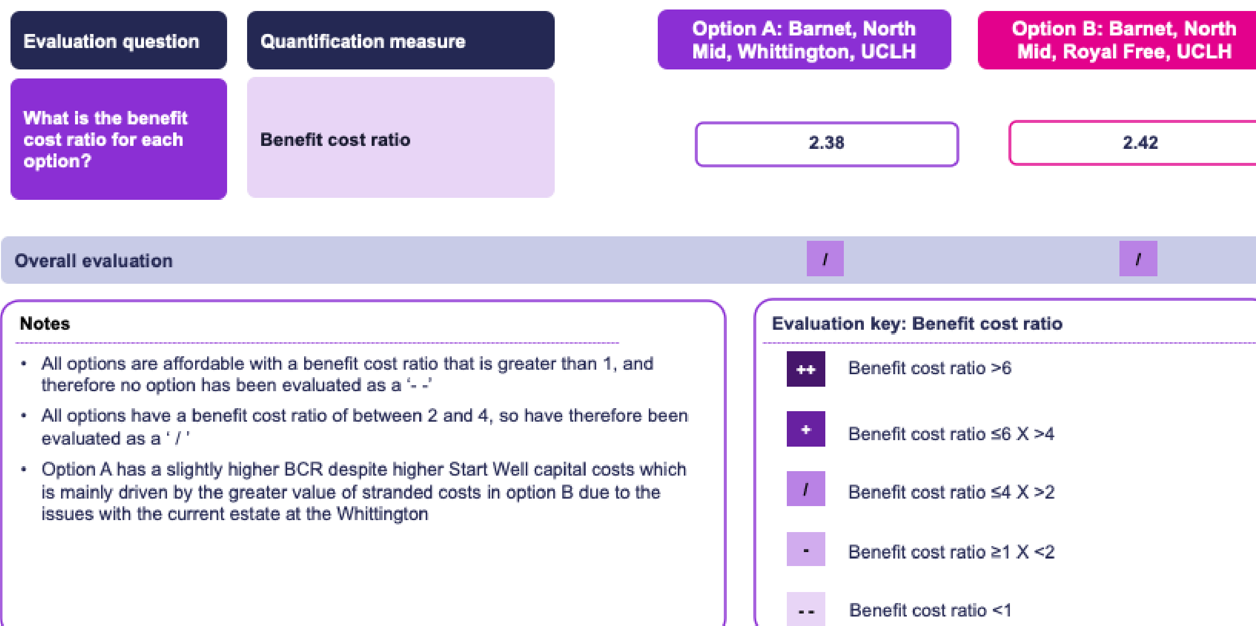


Figure 51: BCR updated option evaluation

8.9 Recommended option for implementation

The Programme consulted on two options with option A (unit at Royal Free Hospital closes) as the preferred option because it would be easier to implement from a workforce perspective and because the potential outflow of some patients to units outside NCL would be easier to manage and provide more benefits for those patients.

Considering the new evidence, including latest data and the consultation feedback the Programme Board reviewed the refreshed evaluations for option A and option B as shown in Figure 52.

		A) UCLH, Barnet, North Mid, Whittington	B) UCLH, Barnet, North Mid, Royal Free
1	**Quality of care:** Activity outflows	/	-
2	**Workforce:** Implementation and delivery	+	- -
	Workforce: Training opportunities	/	- -
3	**Access to care:** Average and maximum travel time	-	-
	Access to care: Core20 Average and maximum travel time	/	-
	Access to care: General accessibility	/	/
4	**Affordability and value for money:** Capital requirements	- -	-
	Affordability and value for money: Benefit cost ratio	/	/

Figure 52: Updated evaluation matrix

The Programme Board considered the consultation feedback responses, how these had been addressed and the refreshed evaluations. It is recommended by the Programme Board that option A be the option to take forward for implementation. Reasons for recommending option A include:

- It would still be significantly less complex to implement option A than option B from a workforce and training perspective because the Royal Free Hospital currently has a SCU (level 1) neonatal unit whilst the Whittington Hospital already has an LNU (level 2)
- The projected patient flow to NWL in option A would be easier to manage than the projected flows to NEL in option B.

9. Potential impact of the recommended option

9.1 Introduction

We are proposing option A as the recommended option to implement. The reasons for this are set out in section 8.9. We have updated the interim IIA to reflect the latest evidence and data for both options which can be found in the IIA. The detail of the potential impact related to option A (the recommended option) is described in this section.

9.2 Feedback from consultation and assurance

What we heard	Our response
During consultation, people fed back concerns around increased travel times and travel costs. In the questionnaire, ~16% of comments from individuals described concerns around increased travel distance, cost and decreased access. These themes were reiterated during in-person engagement, e.g., feedback that it is difficult to travel into central London with children with a disability.	We updated the travel time analysis using 2024 data to reflect latest road structures and speed limits and reviewed the impact of each option based on the updated travel analysis, as shown in section 8.8.4. The travel analysis calculates the time and distance from each LSOA in the catchment to specific hospital sites depending in the analysis needed. This analysis has been undertaken for all LSOAs within the catchment which include the impacted populations by geography. PPEG reviewed the updated travel times and discussed potential mitigations for travel and access, as shown in section 9.5. We have worked with potentially affected groups and providers to develop more detailed mitigations for travel impact as part of the IIA. This includes mitigations for additional travel time and cost and notifying London Ambulance Service about the potential changes and possible impact on emergency maternity transfers. These mitigations include raising awareness of schemes to support service users with travel costs, ensure there are conversations

	around travel costs at booking, provide information about trust-level arrangements for the reimbursement of transport costs and work with charitable and voluntary and community sector (VCS) partners to consider the feasibility of a pre-paid travel card for some service users. We would also continue to offer antenatal care in the community and enhance neonatal care provision at home so that there is access to this in all boroughs. This would also help to mitigate the need for additional travel. Detailed mitigations can be found in the IIA. Through delivery of the care model, we would aim to keep as much in the community as possible through delivering services in existing centres including GP and children's centres, negating the need to travel to hospital for every appointment. This would be particularly important for families with children who have a disability that would need to travel into central London. Further mitigations also include offering appointments at the most suitable time and ensuring there is sufficient disabled parking available.
During consultation, concerns around impact were raised regarding: • Residents from low socioeconomic background (areas of high deprivation) • Residents who do not speak English • People with disabilities who may not be able to drive • Orthodox Jewish communities	The impact on travel times has been extensively explored as part of the IIA for different population groups. The impact on accessibility has been explored for all groups for whom concerns were raised for regarding the proposals. Since consultation, we have updated the IIA with up-to-date ONS data and included additional demographic information for people outside NWL. Further detail on the IIA is shown in section 9. *Orthodox Jewish communities* The potential impact of the proposed service changes on the Orthodox Jewish community were considered during the public consultation. Detailed feedback regarding the potential impact of no longer delivering maternity and neonatal services at the Royal Free Hospital on this population and potential mitigations have been detailed in the IIA. Mitigations include remaining units working with the community to develop Trust-level action plan to build on existing provision of culturally and religiously

	sensitive care. Action plans may cover areas such as staff training, Kosher food, communication, religious requirements around the observance of Shabbat (Sabbath) including families remaining in hospital and working relationships between the population and NCL hospitals. Following a decision, the proposed mitigations would be further tested with the Orthodox Jewish community and its leaders throughout implementation to ensure key concerns are captured and mitigated against. Agreed mitigations would be monitored and evaluated by a working group which would include members of Orthodox Jewish community *Residents from low socioeconomic background and people with disabilities* The impact of increased travel time and associated costs have been outlined during consultation, particularly for those living in areas of deprivation and those with disabilities who may not drive. Mitigations have been developed to support service users with travel costs including raising awareness of the Healthcare Travel Costs Scheme, ULEZ and congestion charge reimbursement and ensure discussions are had around travel costs when booking appointments. *People with poor English proficiency* A key consideration for those with poor English proficiency, which may include members of the Somali community are understanding the changes and the impact of them on their choices of maternity care. In order to support service users, we would produce communications materials in a range of languages which would describe the changes and timeline for their implementation. We would also ensure that providers have patient information translated (as is the case now), and there is suitable provision of translation services for appointments and during intrapartum care which is currently a big focus of work for the LMNS.

The Mayor's office recommended that we provide clear evidence that we have used disaggregated local data to identify and understand the main baseline health care inequalities within the current services and pathways of care. Where data abilities are limited, there should be a commitment to rectify this. The Mayor's Office recommended that we describe quantifiable commitments for reducing these inequalities, targeted interventions that will enable a step change and the metrics that will be used to track progress. The Mayor's Office recommended that we more clearly articulate how service changes will improve outcomes for marginalised groups.	NCL Local Maternity and Neonatal System (LMNS) published an Equity and Equality Action plan in spring 2024[54]. This paper outlined the key outcomes we are planning to deliver as a system, and the immediate actions required to meet the outcomes. This plan is a refresh of the Action Plan that was first written in 2022. Key areas of focus include improved data quality, continued implementation of enhanced continuity of carer for target groups, strengthening co-production and enhancing the working of the MNVPs. The document also sets out improvement plans to improve culture and staff wellbeing. This includes supporting trusts to embed NHSE The Capital Midwife Anti-Racism Framework.
The Clinical Senate recommended that we further articulate the impact of the changes on improving service provision and population outcomes, including further specificity on how inequities and inequalities will be positively addressed for the most vulnerable populations e.g., prioritising continuity of care and local access as part of their assurance of our PCBC.	In line with the NCL Local Maternity and Neonatal System Equity and Equality Action plan we would continue to focus on the delivery of an enhanced midwifery continuity of carer model to target people from the minority ethnic groups and those areas of those living in the most deprived area. Implementation of the care model would ensure that all populations would have access to the same care and, as described in the care model, care would be delivered as close to home as possible.
The Mayor's office recommended that we correct the language used in PCBC about IMD deciles.	The DMBC and IIA have been updated to correct the language used in PCBC about IMD deciles.
The Mayor's office recommended that we add detail on environmental impact mitigations specifically for maternity and neonatal care.	The IIA and section 9.5.4 outline the potential sustainability impact and a set of mitigations. These mitigations have been updated to include additional detail to support sustainability through expanding neonatal community care provision to reduce the need for families to travel to hospital and provide appropriate appointments online or in the community for maternity care.
The Mayor's office recommended that we quantify the proportions of NWL residents affected by our proposals and detail mitigations for longer travel times and costs for NWL residents.	8% of women of childbearing age in North West London are affected by the proposed changes. Mitigations in relation to potential increased travel time and costs are shown in section 9.5.6. Further details are in the IIA.
During consultation, it was suggested that women from some minority ethnic groups	The potential impact on pregnant women and people with complex (or pre-existing)

[54] https://nclhealthandcare.org.uk/wp-content/uploads/2024/09/NCL-LMNS-Equity-and-Equality-Action-Plan-2024.pdf

could be disproportionately affected if [maternity and neonatal services at the Royal Free Hospital are closed], as they are statistically more likely to experience poorer maternal outcomes, especially those linked to other serious and long-term health conditions such as diabetes.	health conditions who are likely to use maternal medicine services was considered, as shown in section 9.5.6 and in the IIA. Proposed mitigations for issues identified are: • Support clinicians to work together to deliver care within current networked arrangements, utilising technology and virtual appointments where appropriate to link in all relevant clinicians, to minimise the impact on pregnant women and people with complex (or pre-existing) health conditions that may need to access specialist and obstetric care at different sites and ensure care remains joined up. • Provide clear information to service users about travel and transport options to all alternative units where they may need to access specialist or obstetric care to meet their specific needs. Ensuring that information is available in different languages that meets the needs of the population and is in accessible formats including non-digital to support those with poor digital access • We would offer women and pregnant people opportunities to visit unfamiliar sites outside of planned appointments or birth to familiarise themselves with the unit and patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments • Raise awareness of schemes to support patients with travel costs, as well as how to make a claim. Ensure that all information is available in different languages and formats to suit needs of service users. Including: - Healthcare Travel Costs Scheme - financial assistance for patients, who do not have a medical need for ambulance transport, and their carers but who require assistance with their travel

	- ULEZ and Congestion Charge reimbursement schemes where applicable - Blue badge schemes - support key groups with travel and increasingly being made available to those with a mental health conditions

9.3 Our recommended option

Under our recommended option, we would improve quality and provide maternity and neonatal capacity to meet projected demand with pregnant women and people having access to the same level of neonatal provision. Our proposals are underpinned by a focus on pre- and post-natal care, including:

- Expanding the current hospital at home service for neonates to all boroughs within NCL so that care is being delivered closer to home
- A focus on personalised care and treating all women and people with kindness and respect
- A focus on provision of midwifery continuity of carer (as staffing allows) to those at risk of adverse outcomes
- Ensuring that all women and people have access to the same services regardless of their background
- Availability of consistent, clear and accessible information about birth choices to support an informed choice of the most appropriate birth setting for the pregnant woman or person
- The development of a personalised care plan at the point of booking which details preferences around pregnancy and birth
- Access to digital maternity notes and health records
- Antenatal advice and support for the pregnant woman or person in key areas, such as smoking cessation, weight management and alcohol use
- Input from maternal medicine specialists where required
- Post-natal breastfeeding support from healthcare professionals
- Support from specialist perinatal mental health services before, during and after pregnancy, if needed.
- Integrate with community and local ‘place’ based teams to support a seamless pathway

The recommended option would see the implementation of our new care model and changes to the location at which peri-natal care is provided (the impact on quality is shown in section 9.5.1). This includes the:

1. Consolidation of obstetric- and midwifery-led maternity units from five sites to four. This would mean provision of maternity services at Barnet, North Mid, Whittington and UCLH
2. Consolidation of neonatal units from five sites to four, and there no longer being any SCU (level 1) units in NCL, in line with trends across the rest of London. This means there would be a LNU (level 2) unit at Barnet, North Mid, Whittington and a NICU (level 3) unit at UCLH.
3. The current SCU (level 1) unit and the co-located obstetric-led and alongside midwife-led birthing unit at the Royal Free Hospital would close. All four maternity and neonatal units at Barnet, North Mid, Whittington and UCLH would be staffed in line with workforce quality standards, which are not currently delivered across NCL.
4. Continuing provision of a NICU (level 3), an obstetric and midwifery-led unit at UCLH, alongside the maternal medicine centre and fetal medicine services for NCL.

5. Most specialist maternal medicine services currently provided at Royal Free Hospital would be delivered at UCLH as the maternal medicine centre. There would be some services that would continue to be delivered at units outside of NCL and there would be one new pathway for haemodialysis in pregnancy (approximately one person a year) that would be developed.
6. Choice of birthing at home, at an alongside midwife-led unit or in an obstetric-led unit.

9.4 Integrated impact assessment (IIA)

The integrated impact assessment (IIA) is a continuous process that assesses and explores evidence in relation to any potential positive and negative impacts on the population from proposed changes to services. The IIA has been developed to support evaluation of the options and to discharge our legal duties. The development of the IIA is overseen by an independently chaired Steering Group that includes expertise from local NHS organisations, Local Authority's and local public health departments. The interim IIA, found here, was developed prior to formal public consultation. It set out the potential impacts on quality and outcomes, accessibility and sustainability through in-depth analysis looking at areas such as travel time and demographics, patient engagement, and public health analysis and was published alongside the PCBC.

The NCL Local Maternity and Neonatal System published an Equity and Equality Action Plan in spring 2024[55]. This document builds on an action plan first written in 2022 and has in part been informed by the Start Well case for change. The document sets out the key outcomes we are planning to deliver, and the immediate actions required to meet the outcomes. Outcomes include improved perinatal health and wellbeing, providing more personalised care, strengthening co-production, ensuring effective shared learning across the system, and supporting a happier workforce. Some key focus areas include review of maternal deaths, improving data quality, reducing still births, development of a maternal medicine network, improving language services, implementation of a perinatal pelvic health service, provision of personalised care and support plans, improving maternal mental health and undertaking a review of admissions to NICUs.

9.4.1 Updated integrated impact assessment

The IIA has been updated to support this DMBC based on:

- **Refreshed data analysis using more recent data were available:** since the publication of interim IIA, more recent travel times data is available based on 2024 speed limits and road structures. Data analysis has also been updated to reflect the new catchment population.
- **Additional analysis on deprivation** to reflect feedback on the Core20 population and approach from the Mayor's assurance
- **Consultation feedback:** the final IIA now incorporates any additional impacts and more detailed mitigations on the potential disbenefits for the recommended option. The public consultation included targeted engagement with specific population groups identified in the interim IIA report. This included the Orthodox Jewish community, those living in Core20 areas and populations living in Harlesden and Willesden, and Holloway and Finsbury Park.
- **Additional mitigation development:** for the recommended option based on feedback received

The refreshed IIA includes detailed analysis and information on both options as it supports decision-making. This section of the DMBC onwards focusses on the recommended option but detailed information on both options can be found in the IIA.

[55] https://nclhealthandcare.org.uk/wp-content/uploads/2024/09/NCL-LMNS-Equity-and-Equality-Action-Plan-2024.pdf

9.4.2 Defining service users who may be impacted

To define who may be impacted by proposed changes we have used travel times. Where currently the Royal Free Hospital would be someone's nearest maternity unit, either by driving or public transport, they are defined as being potentially impacted under the option where Royal Free Hospital no longer provides maternity and neonatal care. People who live in these areas would be classified as being within an 'impacted population'. In addition to this, from reviewing our case for change, a subsequent public health evidence review and through engagement and consultation, we identified groups where there is evidence of differential outcomes or experience of maternity and neonatal services. This supported us to identify a priority list of groups that we sought to engage with and understand the impact of changes on them in a more detailed way.

Given the geographical location of Royal Free Hospital and the use of travel times to inform our approach, there are different geographical areas that have been included in our analysis. The impacted populations, based on either driving or public transport, are identified in Figure 53 and Figure 54.

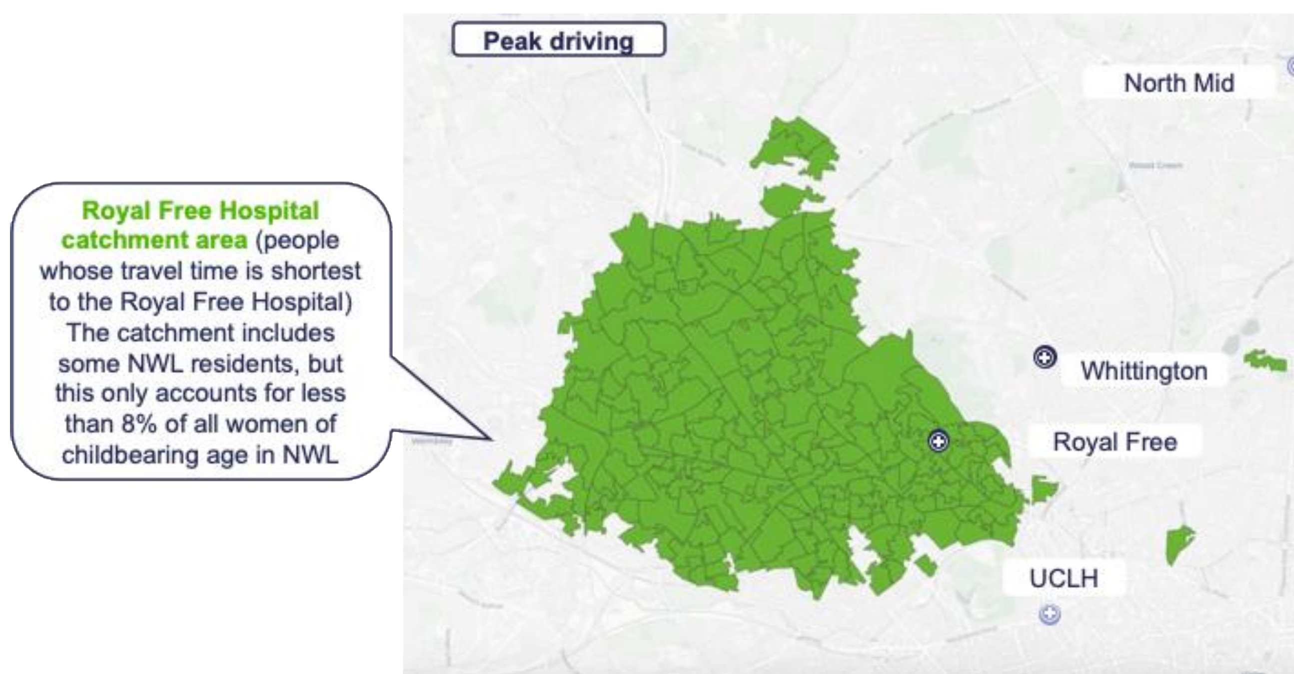


Figure 53: Updated impacted population for the recommended option for driving at peak time

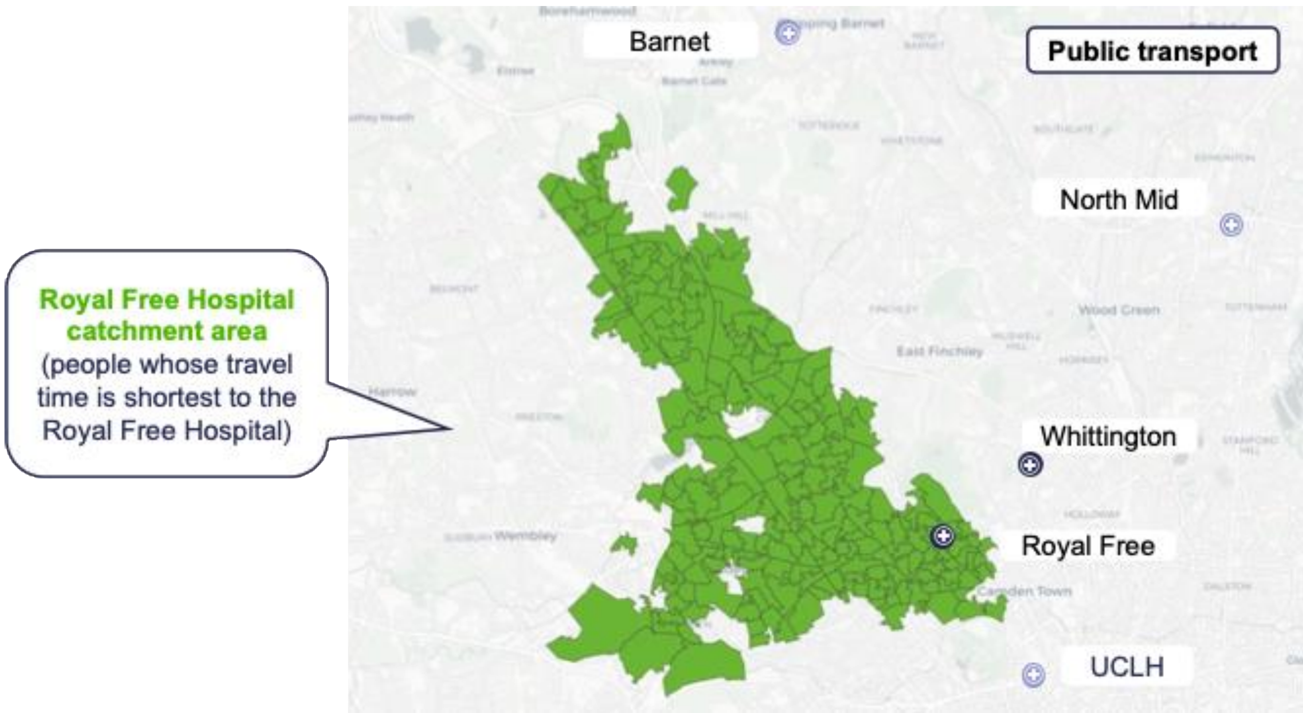


Figure 54: Updated impacted population for the recommended option for public transport

In addition to geography the IIA considers the different characteristics that local populations may have. Given our duties under the Equity Act 2010 and in order to ensure that we consider the different needs of service users we considered the feedback received during public consultation and reviewed if there were any additional populations which we had not considered. Figure 55outlines the population groups we identified and considered through the updated IIA.

Those with protected characteristics under the Equalities Act 2010	Other groups known to experience inequalities in health status, access to health care, where there is evidence of adverse maternity or neonatal outcomes or were identified in the public consultation
• Age • Sex • Race and ethnicity • Disability • Pregnancy and maternity • Marriage and civil partnership • Gender reassignment • Religion or belief • Sexual orientation	• People with poor English proficiency • People with a poor level of literacy • Carers, including parents of children with disabilities or long-term conditions • Residents from low socioeconomic background (areas of high deprivation) • Residents in neighbouring systems (NWL or NEL) • Somali residents • Orthodox Jewish communities • Pregnant women and people with complex (or pre-existing) health conditions) • Inclusion health groups, including people experiencing homelessness; drug and alcohol dependence; vulnerable migrants; Gypsy, Roma and Traveller communities; sex workers; people in contact with the justice system; and victims of modern slavery

Figure 55: Population groups identified and considered through the IIA

9.4.3 Demographics of the impacted population

The populations potentially impacted by the proposed changes are diverse. They have a range of different needs to be considered should changes be implemented. The characteristics of the potentially impacted population for the recommended option are:

- The percentage of women of child-bearing age is evenly distributed across the catchment population for the Royal Free Hospital
- The Core20 areas have been used to define those that are living in areas of deprivation. The Core20 population live in the most deprived 20% of areas nationally. These populations are concentrated to the west of the impacted catchment in Brent.
- There are people who are considered to have poor English proficiency (including literacy) and they are concentrated to the west of the Royal Free Hospital in Brent.
- People with poor health are concentrated to the east of the Royal Free Hospital around Gospel Oak and Kentish Town. There are also some pockets of people with poor health in the west of the catchment in Harlesden and Willesden.
- The largest concentration of people with disabilities is between the Royal Free Hospital and the Whittington Hospital, on the very eastern edge of the impacted population
- People from minority ethnic groups:
    - Black and Caribbean populations are located in the west of the impacted population
    - Bangladeshi and Pakistani populations that are impacted by the recommended option are located to the west and south of the Royal Free Hospital.
- The local Orthodox Jewish community is concentrated to the north and west of the Royal Free Hospital, in and around Golders Green and Hendon

Through analysis, we have identified Harlesden and Willesden as a geographical area that may have residents who could be more impacted by the proposed changes if they were implemented (Figure 56) Harlesden and Willesden has been identified because:

- 6% of people have poor English proficiency (including literacy)
- 23% of people live in Core20 areas
- 13% are people who are economically inactive
- 80% are people from minority ethnic groups

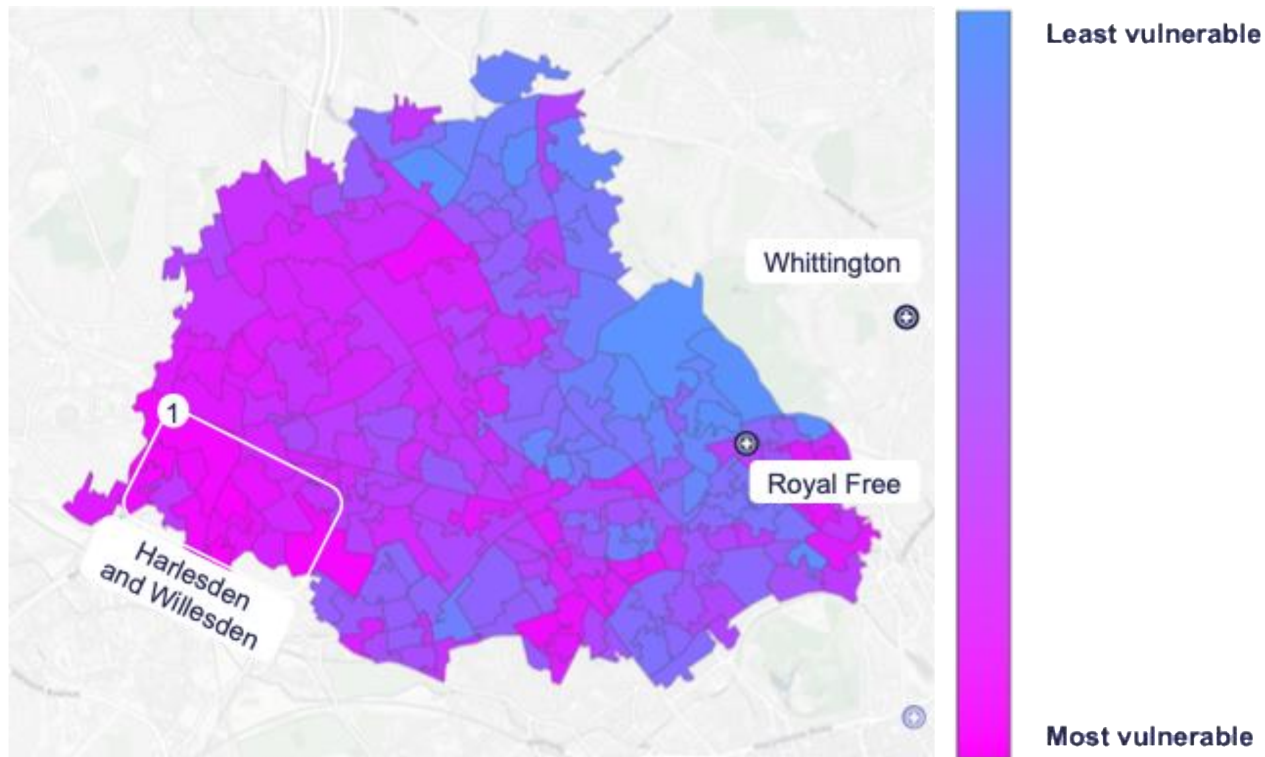


Figure 56: Geographical areas with residents who may be more vulnerable to the impact of changes if the recommended option (Harlesden and Willesden) was implemented

9.5 Assessment of the potential impact

The impact assessment aims to explore what we believe could be the impact of implementing the recommended option on the potentially impacted population. We have reviewed both accessibility (e.g., travel times) and wider potential impacts of changes on specific population groups.

9.5.1 Potential impact on quality and outcomes

Our recommended option would deliver the proposed maternity and neonatal care model and would therefore deliver positive impact in terms of clinical impact compared to now. Clinicians have determined the following clinical impacts:

- **Care that ensures equity of provision and experience**
  - Our care model has been designed to ensure that all pregnant women, people and babies have access to the same services. This includes community neonatal outreach services accessible across all boroughs and the same provision of neonatal care no matter which unit the baby is born in. The insights gained through developing these proposals has leveraged work to reduce inequalities across maternity and neonatal services including work to improve continuity of carer and work with specific communities such as Somali women who currently experience inequalities in access and outcomes. We expect that the care model would provide a more personalised experience than now and ensure that individuals are supported and communicated with and given information that best suits their own needs.
  - Our care model would also enable all units in NCL to meet clinical standards around staffing. Currently, there are standards that are not being met and meeting these standards would require an uplift in staffing across the sector. Through consolidation of the number of units that we have in NCL, there is an opportunity to reach these staffing standards through using our workforce more effectively.

- All pregnant women and people would have the choice to have midwifery-led or obstetric-led care, across either a home birth, midwife-led unit or birth at an obstetric-led unit. Through implementing the changes and consolidating staff across fewer units, we would hope to be able to provide a more consistent offer of midwifery-led care across NCL and have services align to the choices and needs of our population.

- **Services which are clinically sustainable**
  - Redesigning and reconfiguring our neonatal units in NCL would ensure that all units are either a designated LNU (level 2) or NICU (level 3). Reducing the number of neonatal units from five to four would allow units to meet the minimum activity requirements set out in national clinical standards.
  - Would resolve the current issues identified with running a SCU (level 1) at the Royal Free Hospital, which include low occupancy, insufficient activity and high levels of transfers.
  - Having a high-quality sustainable workforce, who are supported and offered training opportunities, would directly impact on the quality of care provided. Our care model delivers the minimum workforce requirements outlined in national guidance, which they don't do now, and we believe that the consolidation of these services would better facilitate enhanced training opportunities for staff. Enhanced training opportunities would help to support recruitment and retention of our workforce in NCL.

- **More up-to-date estate and buildings**
  - Investment in our existing maternity and neonatal estate so that all units meet more up-to-date building standards and are designed to provide a positive birth experience. Any new capacity delivered would aim to meet the latest space standards and this would have a role in delivering clinical benefits, improving efficiencies, supporting the reduction of the risk of hospital-acquired infection and delivering an attractive working environment for staff.

- **Training and development opportunities**
  - Supporting training and development opportunities for staff through delivering sustainable volumes of neonatal activity at all neonatal units. Developing this expertise within the workforce and providing these opportunities would help to improve recruitment and retention of the workforce compared to now.
  - Reducing vacancies compared to now to make sure cots could be kept open and ensuring there are sufficient staff (specialist nurses, allied healthcare professionals, etc.) to provide expert care when required.

- **Capacity to meet projected demand**
  - Investing in additional capacity for neonatal and maternity services would ensure that there is enough capacity available so that neonatal units are running at the 80% recommended occupancy rate and there are fewer refusals to admit due to not having enough space. This would reduce the likelihood for transferring babies to units outside of NCL.
  - All units being an LNU (level 2) or NICU (level 3) would reduce the number of transfers of babies from a SCU (level 1) and would minimise the separation of the woman or person that has given birth and their baby, especially transfers to units outside of NCL.

9.5.2 Potential impact on accessibility

The potential impact of the recommended option on accessing care at the next closest hospital other than the Royal Free Hospital is summarised in the IIA, Figure 57 and includes:

- Potential increase in average car travel times by around 5 minutes for the potentially impacted populations after the proposed changes compared to current travel time[56]
- For travel by public transport, there is an average increase of around 4 minutes 30 seconds for the potentially impacted populations
- The potentially impacted population would be able to access an obstetrician-led maternity unit with either an LNU (level 2) or NICU (level 3) neonatal unit within 25 minutes from their home when driving at peak time
- There is a potential increase in average taxi costs of £5.54 with a maximum increase of up to £28 per taxi journey for people living closest to Royal Free Hospital. There could be a potential for driving costs to increase by £0.63 on average. This is likely to impact people living in areas of deprivation more than other population groups.

Recommended option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
	Current	32.2	14.2	11.1	£17.59	£2.01
	Future	+ 4.5	+ 5.4	+ 3.8	+ £5.54	+ £0.63

Figure 57: Impact on accessibility for the recommended option

We have undertaken travel time and cost analysis for potentially vulnerable populations, which can be found in the IIA. Through this we have identified that there is not an increased impact of travel time or cost as compared to the general population, but the impact of the additional time or cost for groups with vulnerabilities may require mitigations given the additional needs they have.

Through both analysis and engagement with service users, we have sought to understand the wider access impact of implementing changes. The impacts we have identified to date have been highlighted below:

- **Communicating and understanding the changes:** for groups who are not proficient in English or who have additional needs such as learning disabilities, it may be difficult to understand changes being made and therefore how to access the maternity and neonatal care they need
- **Access and travel:** increased travel cost and journey times could impact on service users' ability to access care. This includes navigating to an unfamiliar hospital, cost of transport, travelling with other children to appointments, and availability of parking spaces.
- **Site accessibility:** wayfinding around an unfamiliar hospital and the physical accessibility of a hospital site may make it difficult for some service users to access services at an alternative maternity unit
- **Complex (or pre-existing) health conditions:** some groups may need to attend hospital on a more frequent basis due to an underlying health condition that impacts on the complexity of their pregnancy. This could mean that they are more impacted by changes as

[56] Average travel time calculated by the difference between the current travel time to Royal Free Hospital compared to the hospital each LSOA population is expected to access care at in the future for the catchment population

they may need to access specialist and obstetric care on a different hospital site and may have to travel to a hospital that is not their next nearest.

9.5.3 Potential impact on inequality groups

From undertaking both analysis and engagement, we have identified the potential impacts for the recommended option on different groups within our potentially impacted populations. The benefits of the proposal are set out in section 12. In the table below, we have drawn out the groups we have considered and section 9.5.6 highlights the mitigations that have been developed for these impacts.

Recommended option potentially impacted population
Overall, there are 98,000 people living within the peak driving population and 91,000 people in the public transport catchment area.
On average, there is a potential increase in taxi costs of £5.54 for this population and they have a public transport accessibility score of 15.0. Increased taxi costs may be particularly impactful for this population as the average car ownership rate is quite low at 48%. The areas with people who are experiencing socio-economic deprivation, predominantly in Harlesden and Willesden, are further away from the maternity unit that may move, so the impact would not be as significant for this population compared to those who live close to the maternity unit.
Harlesden and Willesden was identified as a geography that could be particularly vulnerable to the proposed changes in Option A compared to now, with poor health outcomes, poor digital access, and poor English proficiency. This population also a high number of Black African and Black Caribbean people in it alongside Bangladeshi and Pakistani people. This population may face barriers to attending an unfamiliar site. This population, by public transport, are already able to access either Northwick Park Hospital or St Mary's Hospital more quickly than the Royal Free Hospital. Travel to hospital by taxi, if required, would cost an additional £2-3 per journey for these groups. People living in Harlesden and Willesden have additional needs compared to the rest of the catchment population. They may be impacted by additional travel costs, accessing a hospital site if they have a disability or are not proficient in English, finding care for dependents if they are a single parent and support with accessing online information and appointments due to low digital proficiency.
People who live in Chalk Farm and Camden Town are close to the Royal Free Hospital maternity unit that may move, compared to other potentially impacted populations, and therefore there may be more of an impact for them in terms of travel times, although the public transport accessibility is better in this area making travel to another nearby site easier. There is evidence that Bangladeshi and Pakistani people may experience worse maternity outcomes than the rest of the population [57]. There may be an impact around wayfinding, language and wider health needs given evidence of higher prevalence of conditions such as diabetes in this community.

[57] https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_FINAL_-_WEB_VERSION.pdf

There is a significant Orthodox Jewish community, for whom changes may be impactful given specific needs they have around maternity care. There is a view that the community has ties with the Royal Free Hospital built up over time, the religiously and culturally sensitive care provided there and the proximity of the hospital, particularly impacting visitors arriving on foot on religious festivals [58] and Shabbat.
Pregnant women and people with the most complex (or pre-existing) health conditions who attend Royal Free Hospital would need to access their obstetric care at a different site to their specialist care in the future, which would mean accessing an unfamiliar unit and this may result in less joined up care. Some of these pregnant women and people may need to access obstetric care at a unit that is not their next closest, because of their needs, which means they would need to travel further than the general population Some minority ethnic groups and people living in areas of deprivation associated with poorer maternity outcomes are likely to be disproportionately represented amongst those with the most complex (or pre-existing) health conditions, although these are very small numbers.
Black Somali is not a standard minority ethnic group within ethnicity recording, however, where this is recorded, over 90% of Somali communities live in the 40% most deprived areas of NCL, with 50% living in the 20% most deprived areas. This community is therefore potentially vulnerable to service changes due to their ability to afford additional travel costs, language and wider health needs. Analysis shows that there are Somali populations in the potentially impacted population located in Harlesden and Willesden rather than in NCL.

In addition to the above identified impacts, we also have considered the impact on other groups for whom the data is not as readily available but who may experience different outcomes from maternity care. Populations that were identified in the interim IIA were targeted in the public consultation engagement to understand the potential impact of the proposals:

- **Older and younger pregnant women and people** are likely to have worse outcomes in childbirth compared to the general population. They may need to attend more appointments throughout their pregnancy and could be more impacted if these were further away.
- **People with learning disabilities** experience poorer maternal wellbeing and pregnancy outcomes. They may find navigating changes to services and accessing an unfamiliar hospital site more difficult. The public consultation found that this population may find the experience of care at a different site challenging if they are already comfortable with staff and have good support, as routine is particularly important.
- **People with serious mental illness** may have additional needs throughout their maternity care and may find navigating changes to services and accessing an unfamiliar hospital site more difficult.
- **People who are LGBTQI+** who are pregnant, and their partners, may have different needs during pregnancy, and engagement has shown that they can experience lack of inclusivity of language used throughout maternity care. The public consultation also found that the needs of this population were often overlooked and that assumptions were often made regarding their pregnancy and relationships, particularly for transgender men who reported

[58] We use the term religious 'Festivals' following feedback from the Orthodox Jewish community that this term is more appropriate in this context than religious 'Holidays'

they often have to educate a midwifery team which could be particularly impactful if they have to access care at an alternative unit.
- People within **inclusion health groups** such as people who are homeless, dependent on drugs and alcohol, asylum seekers and Gypsy, Roma and Traveller communities, are known to experience poorer maternity outcomes. These groups may face barriers in terms of the cost to access care, digital exclusion and lack of proficiency in English. There may be further impacts of the proposals regarding difficulties understanding how services work and how to access the care that is needed.
- People who are **carers** for either children or adults with additional needs may need additional support to access maternity services, such as specific appointment times.
- People with **poor literacy** or who **do not speak English** may face barriers to understanding changes to services and travel, as well as accessing information about their care.
- There are **potentially vulnerable people** who access specific services that may change which we have considered - for example, there are midwifery teams that support vulnerable women and people at Royal Free Hospital and it would be important to maintain continuity of care as any changes are implemented, to facilitate the building up of trust between staff and service users.
- Some pregnant women and people with **complex (or pre-existing) health conditions** who attend Royal Free Hospital may need to access their obstetric care at a different site to their specialist care in the future, which would mean accessing an unfamiliar unit. In either option, this may result in less joined up care. Some of these pregnant women and people may need to access obstetric care at a unit that is not their next closest, because of their needs, which means they would need to travel further than the general population. Some minority ethnic groups and people living in areas of deprivation associated with poorer maternity outcomes are likely to be disproportionately represented amongst those with the most complex (or pre-existing) health conditions, although these are very small numbers.

9.5.4 Potential impact on sustainability

The NHS has set a clear and ambitious target to become net zero by 2040[59] and in line with this, NCL ICS has published a Green Plan[60] which aims to improve health and wellbeing through sustainable healthcare. The Green Plan is a coordinated effort across the system to align priorities to maximise impact. The Greener NCL Programme is clinically-led and brings together hospital trusts, primary care, local authorities and voluntary and community organisations and groups.

When considering changes to services, it is therefore important that we not only consider the impact of any resulting carbon impact from implementing changes, but also how to use the change to ensure we go further in making services more sustainable in the future. This section outlines what we anticipate the impact on sustainability of the recommended option. In section 11.7, we outline the considerations for implementing the proposals from a sustainability perspective.

Four sustainability impact metrics have been reviewed to explore the potential sustainability impact:
- **Travel carbon impact:** additional distance travelled might result in higher carbon emissions, which needs to be examined from a net-zero standpoint

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[59] https://www.england.nhs.uk/greenernhs/national-ambition/

[60] https://nclhealthandcare.org.uk/wp-content/uploads/2022/04/North-Central-London-Green-Plan-2022-2025.pdf

- **Protected air quality:** the carbon impact from different options may have an adverse impact on air quality
- **Building carbon impact:** building and refurbishing buildings causes carbon emissions, which are harmful to the environment
- **Anchor institutions:** local hospitals are anchor institutions that support local communities and removal of services may impact adversely on local communities

These metrics provide an understanding of the impact on sustainability for the recommended option. The impact on sustainability is outlined in Figure 58:

- **Carbon impact and protected air quality:** there is a small potential increase in carbon emissions, with an additional 251g per average journey, as a result of slightly increased travel times. This may need to be mitigated further as the option impacts on services within air quality management areas (AQMAs) for NO2 emissions and vehicular particulates.
- **Building carbon impact:** there would be a carbon impact due to refurbishing buildings in the recommended option, but there would also be substantial environmental gains to be made in making the building more energy efficient, in line with government policy.
- **Anchor institution:** an estimated 214.2 WTE staff may move between hospital sites and the estate would be retained and repurposed so there is likely to be little impact on hospitals as anchor institutions.

Impact	Travel carbon impact	Protected air quality	Building carbon impact	Anchor institution
Recommended option	+251g per average journey	AQMA: NO2 and vehicular particulates	Additional refurbishment as part of Whittington's net zero strategy	214.2 WTE moved (nurses, midwives, consultants & middle level)

Figure 58: Sustainability impact for the recommended option

9.5.5 Differences on the potential impact between options

The impacts that potentially have a materially worse impact in option A compared to option B (and would need to be mitigated as far as possible) relate to:

- the Orthodox Jewish community due to the ties with the Royal Free Hospital built up over time, the religiously and culturally sensitive care provided there and the proximity of the hospital, particularly impacting visitors arriving on foot on religious festivals and Shabbat
- the Somali community in Kilburn who may face additional difficulties travelling to, and accessing, their closest hospital which would change from the Royal Free Hospital to Northwick Park Hospital or St Mary's Hospital
- the Bangladeshi and Pakistani population in Chalk Farm are close to a maternity unit that may move, and therefore may be more impacted in terms of travel times compared to other groups
- people living in Harlesden and Willesden with poor health outcomes, poor digital access, and poor English proficiency. This population also a high number of Black African and Black Caribbean people in it alongside Bangladeshi and Pakistani people. This population may need to switch the hospital where they access services

The impacts that potentially have a materially worse impact in option B compared to option A relate to:

- the Somali community in Finsbury Park who would access services at the Royal Free Hospital rather than the Whittington Hospital. Given their proximity to the Whittington Hospital, they may be impacted by the relatively higher increases in taxi costs to an alternative maternity unit compared to now
- people living in areas of deprivation around Whittington Hospital who are nearer to the maternity unit that may move (these people may pay up to £11 more to travel by taxi). These populations and those that are economically inactive may face difficulties with cost of transport, digital exclusion and already having children when travelling further or to a new site
- people living in Holloway and Finsbury Park with poor health outcomes, poor digital access, and poor English proficiency - this population has a high number of Black African and Caribbean in it - who may need to switch the hospital where they access services. These people are also likely to be more impacted by increased travel time and cost compared to now, although public transport accessibility in this area is better

All other impacts that have been identified do not have a materially different impact between options. A detailed breakdown of this analysis can be found in the IIA and a summary of the impact of both options can be found in the table below.

Impact	Option A	Option B
Population	• There is a slightly smaller population that could potentially be impacted for option A when driving (~98,000 people) compared to option B (~113,000 people) but there is a larger impacted population for public transport in option A (~91,000 people) compared to option B (~66,000 people) • There is a larger proportion of people from minority ethnic groups and the Orthodox Jewish community in option A compared to option B	• There is a larger population that could potentially be impacted for Option B for those driving (~113,000 people) compared to Option A (~98,000 people). There are fewer people impacted for Option B via public transport in Option B (~66,000 people) compared to Option A ~91,000 people) • There is a larger proportion of people that live in areas of deprivation in option B compared to option A
Quality	Option A and B would deliver the proposed maternity and neonates care model, and would therefore deliver positive clinical impact: • Care that ensures equity of provision and experience • Services which are clinically sustainable • More up to date estate and buildings which are fit for purpose • Training and development opportunities	Option A and B would deliver the proposed maternity and neonates care model, and would therefore deliver positive clinical impact: • Care that ensures equity of provision and experience • Services which are clinically sustainable • More up to date estate and buildings which are fit for purpose • Training and development opportunities

	• Provide choice for pregnant women and people	• Provide choice for pregnant women and people
Access	• Average increase in taxi costs would be £5.54 and the average increase in driving costs per journey is £0.63, with 48% car ownership compared to now. • Average travel times would increase by 5.4 mins by car and 4.5 mins by public transport compared to now. People in the catchment population would be able to access services within 30 mins at peak driving time and within 23 mins at off-peak.	• Average increase in taxi costs would be £4.38 and the average increase in driving costs would be £0.50 per journey, with 45% car ownership compared to now. • Average travel times would increase by 6.5 mins by car and 8.1 mins by public transport compared to now. People in the catchment population would be able to access services within 28 mins at peak driving time and within 21 mins at off-peak compared to now.
Sustainability	• There is an increase in carbon emissions of 251g per average journey as a result of slightly increased travel times • There are environmental gains to be made in making the building more energy efficient compared to now • 214 WTE of staff moved between sites, with the estate being retained and repurposed so there is likely to be little impact on hospitals as anchor institutions	• There is an increase in carbon emissions of 181g per average journey as a result of slightly increased travel times. • There are environmental gains to be made in making the building more energy efficient • 290 WTE of staff moved between sites, with the estate being retained and repurposed so there is likely to be little impact on hospitals as anchor institutions
Populations with protected characteristics and people who have vulnerabilities	• Greater impact on the Orthodox Jewish community compared to option B due to the ties with the Royal Free Hospital built up over time, the religiously and culturally sensitive care provided there and the proximity of the hospital, particularly impacting visitors arriving on foot on religious festivals and Shabbat. • People from minority ethnic groups may face language barriers when travelling to, and accessing, a different site	• People from minority ethnic groups may face language barriers when travelling to, and accessing, a different hospital site • Somali community in Finsbury Park who would access services at the Royal Free Hospital rather than the Whittington Hospital. Given their proximity to the Whittington Hospital, they may be impacted by the relatively higher increases in taxi costs to an alternative maternity unit compared to now.

	• Somali community in Kilburn may face difficulties travelling to, and accessing, their closest hospital which would change from the Royal Free Hospital to Northwick Park Hospital or St Mary's Hospital • People with disabilities may have difficulties changing service location, especially without access to a car, compared to now • People living in areas of deprivation and those that are economically inactive may face difficulties with cost of transport, digital exclusion and there may be barriers for those that already have children as a result of the additional travel time or travelling to an unfamiliar site • People in poor health may have more complex pregnancies that require additional antenatal appointments during pregnancy which would therefore cause a greater travel time and cost impact of accessing services at an alternative unit • Some pregnant women and people with complex (or pre-existing) health conditions who attend Royal Free Hospital would need to access their obstetric care at a different site to their specialist care in the future, which would mean accessing an unfamiliar site. In either option this may result in less joined up care. • Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language • The Bangladeshi and Pakistani population in Chalk Farm are close to a maternity unit that may move in Option A, and therefore may be	• People living in areas of deprivation in Option B are nearer to the maternity unit that may move, so the impact would be more significant for this population compared to Option A (people may pay up to £11 more to travel by taxi). These populations and those that are economically inactive may face difficulties with cost of transport, digital exclusion and there may be barriers for those that already have children as a result of the additional travel time or travelling to an unfamiliar site • People with disabilities may have difficulties changing service location, especially without access to a car, compared to now • People in poor health may have more complex pregnancies that require additional antenatal appointments during pregnancy which would therefore cause a greater travel time and cost impact of accessing services at an alternative unit • Some pregnant women and people with complex (or pre-existing) health conditions who attend Royal Free Hospital would need to access their obstetric care at a different site to their specialist care in the future, which would mean accessing an unfamiliar site. In either option this may result in less joined up care. • Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language when travelling further or to a new site

	more impacted in terms of travel times compared to other groups	
Geographical populations	• Harlesden and Willesden was identified as a geography that could be particularly impacted by the proposed changes in Option A compared to now, with poor health outcomes, poor digital access, and poor English proficiency. This population also a high number of Black African and Black Caribbean people in it alongside Bangladeshi and Pakistani people. • This population, by public transport, are already able to access Northwick Park Hospital and St Mary's Hospital more quickly than the Royal Free Hospital. Therefore, they may not be significantly impacted by increased transport costs compared to now. • This population may face barriers to attending an unfamiliar site	• Holloway and Finsbury Park was identified as a geography that could be particularly impacted by the changes in Option B, with poor health outcomes, poor digital access, and poor English proficiency - this population has a high number of Black African and Black Caribbean in it • This population is located close to the maternity unit that may move, and are therefore likely to be more impacted by increased travel time and cost compared to now, although public transport accessibility in this area is better than for Option A • This population may face barriers to attending an unfamiliar site compared to now

9.5.6 Mitigations for potential disbenefits

The work on the IIA, and particularly our engagement with service users and consultation feedback, has supported the identification of impacts that would require mitigation for the recommended option. These focus on areas such as support for people accessing an unfamiliar hospital site and the cost of travel. The full list of mitigations for the potential impact of the recommended option can be found in the IIA.

Impact	Mitigations for the recommended option
During implementation, we need to continue to understand the impact of our proposals and develop mitigations through further engagement with potentially impacted groups. It is particularly important to ensure we hear from groups that are less likely to engage, or where there are barriers for them to do so.	• Information about proposals should be clear and easy to understand. It would be translated into the most commonly spoken languages in NCL, with others available upon request. It would be made available in different formats (easy read / large print) to account for the spectrum of communication needs. • Information about proposals would be widely shared to ensure maximum engagement. This would build on existing partnerships to reach communities or utilise organisations who have existing routes to engage with groups. Consideration would be given to innovative mechanisms to obtain feedback and ensuring communication preferences of groups are considered. We would continue to engage with the range of service users identified through the IIA and consultation • There would be a focus during engagement on groups that are likely to be more materially impacted – be that geographically or because of any other characteristics that make them potentially more impacted by changes (e.g., have poorer outcomes from services or are more likely to need to use services that may be changing). • The programme would continue to review impact of possible changes on different groups and ensure any new impacts are included and mitigations developed to address negative impacts during implementation.
Changes need to be well communicated to residents. Mitigations would need to be put in place to ensure that all groups are informed of changes, and they understand their choices for maternity care. Clear information needs to be available to support and promote a choice of a maternity unit and birth setting that meets the needs of expectant parents.	• We would ensure there is accessible information about choices of maternity care online and that this information is available in non-digital formats for those who are less able to access the internet. • We would pursue uniformity in how information about maternity services is hosted on individual trust webpages to help users better navigate to the information that they need. • We would provide information in different formats to meet the communication needs of a range of service users, including different languages, easy read, large and small print, audio, braille and sign language. • We would build links with local community groups, particularly for more transient and migrant

	communities who may not engage as well with published material. • We would build community links with the Orthodox Jewish community to understand the best communication methods, work with local doula groups and advertise in community circulars • We would disseminate information through local community groups and local GPs to help ensure that pregnant women and people have accurate information regarding the service changes and what this means for them. • We would ensure there is suitable provision of on demand translation services for appointments and during intrapartum care.
There are some service users for whom changes may mean attending a different hospital than they are used to. This change may be difficult to manage for some service users, with particular needs such as people for whom English is a second language (which may include members of the Somali community), neurodivergent people and people with learning disabilities, and they would need extra support to manage this.	• We would offer women and pregnant people opportunities to visit unfamiliar sites outside of planned appointments or birth to familiarise themselves with the unit. • We would provide access to videos, pictures and additional information about the unfamiliar unit or what to expect in advance of appointments, in order that people can better prepare for their visit to the site. • We would offer detailed information about how to navigate to the right area of the hospital where appointments or admissions are scheduled, as part of communication with service users • Where possible, we would use innovative tools or technology to support wayfinding or giving directions within a hospital. • We would ensure all sites meet access standards, particularly for families with young children or where a family member may have a disability • We would ensure appointments are at the most appropriate times for service users where a family member has a disability, particularly children, to allow them to travel into central London at the most convenient time • We would ensure sensory adjustments can be put in place where appropriate in clinical areas, such as access to a private room and the ability to dim lighting. • Patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments. • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted.

	• We would work with the neonatal care coordinator as part of implementation to ensure that there is consistent information and support available to parents who have a child admitted to a neonatal unit.
Service users may need to travel to a hospital that they are unfamiliar with. Mitigations would be needed to ensure that people have information to plan their journeys to hospital.	• Clear information would be provided to service users about travel and transport options to all maternity units. • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted. • We would link to live journey planners such as TFL to ensure that accurate, up-to-date information about journeys can be accessed. • We would work with the neonatal care coordinator to ensure that there is information available to families about travel when their child is admitted to a neonatal unit.
The cost and time spent travelling to a hospital site would increase for some people, and we would want to deliver care as close to home as possible. This may be more of an issue for some groups such as people with disabilities or people living in areas of deprivation,	• Where possible, we would provide appointments in community settings, for example, family hubs and children's centres. • Virtual appointments would be offered, where appropriate and clinically recommended. • We would implement hospital at home / community neonatal care to help babies avoid admission to a neonatal unit or can be discharged as early as possible – reducing the burden of travel to visit babies during an admission to a neonatal unit.
There may be an impact on the cost of travel should changes be implemented. There would be some service users who may be more impacted by this than others (such as people living in areas of deprivation and people with disabilities who do not drive), and it would be important that any additional travel costs do not create a barrier to accessing care.	• We would raise awareness of schemes to support patients with travel costs, as well as how to make a claim, including: - Healthcare Travel Costs Scheme - financial assistance for patients (and their carers) who do not have a medical need for ambulance transport, but who require assistance with their travel. - ULEZ and Congestion Charge reimbursement schemes where applicable. - Blue badge schemes – these support key groups with travel and are increasingly being made available to those with a mental health condition. - Information about these schemes to be available in different languages and formats to suit needs of service users. • Information would be available on provider arrangements for the reimbursement of transport costs under the Healthcare Costs Travel Scheme, including location and opening hours of cashier kiosks. • A discussion about cost of travel would be included when booking appointments, to identify if cost of

	transport may impact on service users' ability to access care • We would support patients by working with charitable and voluntary and community sector partners to consider the feasibility of a pre-paid travel card for service users identified as being particularly impacted by the proposals for whom travel costs would limit their access to maternity care. • Arrangements for patients who have eligibility for hospital patient transport schemes would be continued. • We would ensure service users are aware of other financial support schemes available during pregnancy, such as NHS Healthy Start where they can get help to buy food and milk, and the maternity exemption certificate. • Neonatal care coordinators would ensure there is clear information about the financial support available to families when a child is admitted to a neonatal unit. This could include information about benefits people may be entitled to, and support from charities and other voluntary and community sector partners.
Access to parking spaces is variable across NCL sites. Parking has been raised as a particular consideration for parents who have a child admitted to a neonatal unit, given their need to visit their child on an ongoing basis and in some instances over an extended period. Mitigations would be needed to ensure that families can easily visit their child by car.	• We would ensure that there are consistent arrangements in place for families with a baby admitted to a neonatal unit in relation to parking. As part of this, we would work with charitable partners to see if we can explore providing a permit to allow discounted parking for the duration of the baby's admission. • Capacity would be put in place that meets demand to ensure fewer neonatal transfers out of NCL, thereby reducing the overall travel distance for families. • Particular consideration would be given to those with disabilities, ensuring access to disabled parking spaces. • We would promote other transport arrangements as an alternative to driving, where appropriate.
The IIA identifies a small impact on carbon dioxide emissions as a result of changes to journey times, as well as an impact of refurbishment of estate. Mitigations needed to address the impacts identified fall within the wider green agenda for the ICS and sites that are impacted. The NHS has a target to reach net zero by	• Through the refurbishment that would be undertaken, buildings would increase their energy efficiency and thus have a positive impact in the longer term on energy usage. • Trusts would explore the possibility of using their own energy sources to provide energy to refurbished areas (for example, heat pumps). • Appropriate appointments would be provided in community settings or online which reduce the need to travel to a hospital site and would support a reduction in the overall number of journeys taken to access maternity care.

2040 and the ICS and each individual trust have their own plans to deliver this.	• In line with national targets of a 40% reduction in nitrous oxide emissions, providers would determine if it is possible to reduce waste that may be associated with leaks in pipes. • We would continue to work on the travel components of the ICS and local trust green plans and encourage active travel or travel via public transport where possible.
Women and people with complex (or pre-existing) health conditions are currently looked after under networked arrangements with input from both obstetric physicians and other specialists. Mitigations would be needed to ensure that pregnant women and people with complex (or pre-existing) health conditions could continue to access the specialist and obstetric care they need.	• Support clinicians to work together to deliver care within current networked arrangements, utilising technology and virtual appointments where appropriate to link in all relevant clinicians, to minimise the impact on pregnant women and people with complex (or pre-existing) health conditions that may need to access specialist and obstetric care at different sites and ensure care remains joined up • Provide clear information to service users about travel and transport options to all alternative units where they may need to access specialist or obstetric care to meet their specific needs. Ensuring that information is available in different languages that meets the needs of the population and is in accessible formats including non-digital to support those with poor digital access • We would offer women and pregnant people opportunities to visit unfamiliar sites outside of planned appointments or birth to familiarise themselves with the unit and patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments • Raise awareness of schemes to support patients with travel costs, as well as how to make a claim. Ensure that all information is available in different languages and formats to suit needs of service users. Including: - Healthcare Travel Costs Scheme - financial assistance for patients, who do not have a medical need for ambulance transport, and their carers but who require assistance with their travel - ULEZ and Congestion Charge reimbursement schemes where applicable - Blue badge schemes - support key groups with travel and increasingly being made available to those with a mental health conditions
There are specific mitigations that would need to be put in place for the population of Harlesden and Willesden.	The populations of Harlesden and Willesden in the London Borough of Brent have been identified as a vulnerable population who are potentially more impacted if Option A as the recommended option is implemented, given their proximity to the Royal Free

	Hospital site. Some specific mitigations that would be taken forward for this population have been developed: • **Communicating changes:** should changes be agreed, a specific communication campaign would be undertaken. We would work with providers in NWL and the NWL ICB alongside the Brent local authority to communicate with service users about the proposed changes, so they understand the impact and the timeline for implementation. This would factor in the most commonly spoken languages within this area, and also non-digital formats given the lower than average IT proficiency of this population • Supporting **continuity of carer:** we would explore with NWL partners the possibility to prioritise residents of Harlesden and Willesden for continuity of carer given the vulnerability of these service users, building on the existing community pathways: - London North West Hospitals Trust (LNWH) have community provision covering areas of Harlesden and Willesden. This means that those accessing one of their sites for maternity care will be supported antenatally and postnatally by staff from this Trust. In terms of how this provision is set up currently they provide: - Ante and post-natal continuity to all those that book. This means that service users will see the same midwife and team throughout the pre- and post-natal pathway - Appointments are provided in local family wellbeing centres and other community locations which means that for many service users they aren't required to travel to hospital for all their antenatal care - They have a specific midwifery team that works with particularly vulnerable service users (e.g., those that are experiencing domestic violence or severe mental illness) - LNWH have provisions in place to support communication with service users who do not speak English, or where English is not their first language. They use a telephone interpreter service and also equip their staff with Card Medic (a resource that contains a series of common questions and phrases). They can also book a face-to-face interpreter where required. - LNWH work closely with local council in Brent, including the public health teams to support join up of pathways for universal services and

	to ensure any public health messaging or campaigns are aligned - All patient information materials are translated into local community languages • **Access to care:** We would work with NWL providers to ensure that maternity care continues to be provided as close to home as possible through community settings. We would produce accessible information about where residents can access care. • **Cost of travel:** Service users travelling by taxi may experience a slight increase in cost. We would work with NWL partners to ensure that NWL hospitals have clear arrangements in place for re-imbursement of expenses and other travel cost reimbursement (including transport and ULEZ reimbursement). These include schemes offered by NWL providers, as well as broader schemes such as NHS Health Start and those offered by the voluntary sector. We would ensure that accessible information is available for service users and also raise awareness of schemes to provide financial support including wider financial support schemes available during pregnancy such as NHS Healthy Start. Work with NWL partners to see if they would consider working with local VCS organisations who may be able to mitigate the impact for groups that are particularly vulnerable. • **Continuing engagement:** working with NWL partners we would continue to engage with residents of Harlesden and Willesden during implementation to understand any unanticipated impacts and develop further mitigations if necessary.
There are specific mitigations that would be put in place for the Orthodox Jewish community should a decision be taken in the future for the Royal Free Hospital to be the site that no longer provides maternity and neonatal care.	There is an Orthodox Jewish community within the current catchment of the Royal Free Hospital, and mitigations would be put in place to ensure that this group is not disproportionally impacted. These mitigations would continue to be iterated with the Orthodox Jewish community and its leaders throughout implementation to ensure key concerns are captured and mitigated against. It is important to note that for women in labour and their partners, travel to hospital by vehicle is permitted on Shabbat and religious festivals as this is considered a medical emergency. Should a woman give birth on Shabbat, or a religious festival their partner would often stay with them in hospital until discharge. Their partner may travel to and from home on foot during the day depending on other caring responsibilities. Consideration would need to be given to

	enable a family to stay in hospital rather than being discharged over Shabbat. Other sites in NCL currently provide maternity care to members of the Orthodox Jewish community and therefore have in place provision to support appropriate care. To ensure this care is built on, we propose establishing Trust-level task and finish groups that would undertake an 'as is' analysis to understand the important issues that need to be enhanced at each Trust. These task and finish groups would need to consist of both members of staff and representative members of the Orthodox Jewish community who would be able to provide input and feedback around culturally appropriate maternity and neonatal care, representatives could include birth coaches, faith leaders and chaplains working with the trust, VCSE organisations representing the community. This would have senior ownership at a Trust level and report into the wider programme's implementation governance structure. From the analysis, an action plan should be put in place to work through the issues identified. This action plan would describe key actions to be taken forward to build a partnership with the Orthodox Jewish community. These action plans would ensure that culturally and religiously appropriate maternity and neonatal care continues to be provided and built upon to build confidence of the community in the level of sensitive provision that is in place for service users. Trust-specific action plans may cover the following areas that would mitigate the impact of option A: • **Staff training:** Orthodox Jewish women may have specific needs during their maternity care. There would be staff training across all NCL maternity units to ensure an understanding of Orthodox Jewish community observances for maternity care including religious requirements around the observance of Shabbat (Sabbath) and Kosher food. Training would be co-developed either with a voluntary and community sector organisation or individuals from the Orthodox Jewish community and delivered to clinical and non-clinical staff across the service at all sites. • **Kosher food**: we would ensure all sites review the Kosher food that is currently available for pregnant women and people during labour and permit food to be brought in from outside the hospital. • **Communication:** through engagement with the Orthodox Jewish community, it has been

	identified that non-digital communication is more effective. We would ensure communication of changes, and subsequent communication about maternity care, are provided in a non-digital way. We would work with the community and voluntary and community sector partners to be more effective in reaching the Orthodox Jewish community in NCL. We would also use circulars that are produced and read by the local community for wider messaging. • **Religious requirements around the Observance of Shabbat and religious festivals:** specific considerations would be made around religious requirements around the observance of Shabbat. Shabbat protocols would be put in place with guidance produced for NHS staff and trusts on religious requirements. This would include a review of all NCL hospital site Shabbat rooms and other observance requirements to ensure they meet the needs of the community, allowing flexibility for any non-urgent care to take place outside of Shabbat, avoiding discharge on Shabbat and not using the call bell. • **Modesty**: Orthodox Jewish women may choose clothes that cover their elbows and knees, as well as a wig, scarf or other head covering. Long - sleeved gowns would be made available during birth at all hospitals to cover elbows and we would ensure that people are permitted to wear a hair covering. • **Clinical considerations**: some medical conditions have a higher prevalence within the Orthodox Jewish community. We would engage and communicate with the community to assure them that there are alternative specialist providers for these conditions such as UCLH and the specialist haematology service which could care for those with factor 11. Pathways and standard operating procedures would also be agreed with London Ambulance Service and Hatzola around emergency care in maternity services. The additional travel time to the Whittington Hospital compared to the Royal Free Hospital is 3 to 5 minutes. • **Providing care closer to home:** as part of our proposals, we would provide ante-natal and post-natal care as close to home as possible. • **Working relationships and trust**: work would continue to be undertaken with local voluntary and community sector organisations with reach into the community, and the North West network of Doulas to support effective working

	relationships are built up between the community and all NCL sites where maternity care is accessed by the Orthodox Jewish community. This would ensure that the necessary provision is in place for the community and there is an understanding of the role of birth coaches / doulas. Consideration would need to be given to enable a family to stay in hospital rather than being discharged over Shabbat given the longer journey from hospital to a potential alternative maternity unit. This may include the woman who is in labour or who has given birth and their partner or other birth partners. Mitigations include: • Partners need to have provision to remain comfortably on site, either in the labour room or ante / post-natal ward with the woman (this is already in place at UCLH, Barnet, North Mid and Whittington Health) • Appropriate Shabbat protocols and facilities should be in place at each hospital to allow partners to be observant should they remain on the hospital site • Discharge protocols that wherever possible avoid discharge over Shabbat and religious festivals
Mitigations would need to be in place for inclusion health groups such as traveller and homeless communities who may be negatively impacted by reduced availability of services locally	Inclusion health groups such as traveller and homeless communities are likely to be impacted by service changes. To ensure that the changes are communicated effectively to traveller and homeless communities, we would communicate using existing channels and voluntary and community sector partners. During implementation, we would ensure that changes are also available in other languages, and in formats that are appropriate (e.g., non-digital). We would continue to work with Local Authorities to help join up health and social care services and ensure that the needs of these groups continue to be met.

The Programme updated the interim IIA that was developed at the PCBC stage, considering feedback received during public consultation. In particular, potential negative impacts of implementing option A on health inequalities and on groups sharing protected characteristics have been identified through quantitative and qualitative analysis. A series of mitigations have been developed to minimise the potential negative impacts of the proposals that have been identified, and the full range of detailed mitigations can be found in the IIA. The potential impacts and proposed mitigations have been informed through feedback received during the public consultation and further engagement with a diverse range of stakeholders and further tested with the IIA Steering Group. These would continue to be iterated and reviewed during implementation.

For each potential negative impact identified, the IIA sets out proposed mitigations, and whether or not the proposed mitigations would eliminate the potential negative impact. Where there is a

potential residual negative impact on a group after mitigation, the IIA seeks to identify what that residual negative impact would be.

Impact of recommended option	Mitigations	What we think
Average increase in taxi costs would be £5.54 and the average increase in driving costs per journey is £0.63, with 48% car ownership compared to now.	• Ensure that patients understand what is available to help with the cost of travel to hospital such as a discussion at time of booking and providing information on Trust-level arrangements. • Ensure that any additional travel costs do not create a barrier to accessing care including supporting patients with travel costs through Healthcare Travel Costs Scheme and working with charitable partners and the voluntary sector	• We believe that the mitigations would reduce the potential impact, especially as the additional driving costs are small
Average travel times would increase by 5.4 mins by car and 4.5 mins by public transport compared to now. People in the catchment population would be able to access services within 30 mins at peak driving time and within 23 mins at off-peak.	• Aim to deliver as much care as close to home as possible to minimise travel times and where possible, provide virtual appointments when clinically recommended	• We believe that the mitigations would reduce the potential impact especially as the additional travel times are small
There is an increase in carbon emissions of 251g per average journey as a result of slightly increased travel times	• Appropriate appointments would be provided in community settings or online which reduce the need to travel to a hospital site and would support a reduction in the overall number of journeys taken to access maternity care. • Expansion of neonatal community care through hospital at home as part of the proposed neonatal care model would reduce the need for families to travel to hospital therefore reducing carbon emissions • Through the refurbishment that would be undertaken,	• We believe that the mitigations would reduce the potential impact

	buildings would increase in their energy efficiency which would offset some impact of increasing emissions	
214 WTE of staff moved between sites, with the estate being retained and repurposed so there is likely to be little impact on hospitals as anchor institutions	• Whilst some workforce would be moved, the overall impact as a proportion of the total available workforce, meaning the impact on the resources available to local communities, would be likely to be relatively small. • We believe no mitigations are necessary as the number is so small it would not impact the local community	• We believe no mitigations are necessary
People with disabilities may have difficulties changing service location, especially without access to a car, compared to now	• When scheduling appointments, steps would be taken to ensure service users who have a disability, or those with a family member who have a disability, particularly children, are offered appointments at the most suitable time to allow them to travel into central London when it is most convenient	• We believe that the mitigations would remove/reduce the potential impact
People from single parent households may have difficulties travelling further if they already have children compared to now	• When scheduling appointments, steps would be taken to ensure single parents who already have children are offered appointments at the most suitable time to allow them to travel into central London when it is most convenient	• We believe that the mitigations would remove/reduce the potential impact
People living in areas of deprivation and those that are economically inactive may face difficulties with cost of transport, digital exclusion and already having children	• Ensure that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care	• We believe that the mitigations would remove/reduce the potential impact

	• We would ensure appointments are at the most appropriate times for service users • We would ensure there is accessible information about choices of maternity care available in non-digital formats for those who are less able to access the internet	
People in poor health may have more complex pregnancies that require additional antenatal appointments during pregnancy which will therefore cause a greater travel time and cost impact of accessing services at an alternative unit	• Aim to deliver as much care as close to home as possible to minimise travel times and where possible, provide virtual appointments when clinically recommended • Ensure that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care	• We believe that the mitigations would reduce the potential impact
Pregnant women and people with the most complex (or pre-existing) health conditions who attend Royal Free Hospital would need to access their obstetric care at a different site to their specialist care in the future, which would mean accessing an unfamiliar unit. In either option, this may result in less joined up care Some of these pregnant women and people may need to access obstetric care at a unit that is not their next closest, because of their needs, which means they would need to travel further than the general population Some minority ethnic groups and people living	• Support clinicians to work together to deliver care within current networked arrangements, utilising technology and virtual appointments where appropriate to link in all relevant clinicians, to minimise the impact on pregnant women and people with complex (or pre-existing) health conditions that may need to access specialist and obstetric care at different sites and ensure care remains joined up. • Provide clear information to service users about travel and transport options to all alternative units where they may need to access specialist or obstetric care to meet their specific needs. Ensuring that information is available in different	• We believe that the mitigations would reduce the potential impact

in areas of deprivation associated with poorer maternity outcomes are likely to be disproportionately represented amongst those with the most complex (or pre-existing) health conditions, although these are very small numbers	languages that meets the needs of the population and is in accessible formats including non-digital to support those with poor digital access • We would offer women and pregnant people opportunities to visit unfamiliar sites outside of planned appointments or birth to familiarise themselves with the unit and patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments • Raise awareness of schemes to support patients with travel costs, as well as how to make a claim. Ensure that all information is available in different languages and formats to suit needs of service users. Including: - Healthcare Travel Costs Scheme - financial assistance for patients, who do not have a medical need for ambulance transport, and their carers but who require assistance with their travel - ULEZ and Congestion Charge reimbursement schemes where applicable - Blue badge schemes - support key groups with travel and increasingly being made available to those with a mental health conditions	
Greater impact on the Orthodox Jewish community compared to option B due to the ties with the Royal Free Hospital built up over	• Remaining units would work with the community to develop Trust-level action plan to build on existing provision of	• We believe impacts related to the provision of religiously and culturally sensitive care can be fully mitigated at alternative

time, the religiously and culturally sensitive care provided there and the proximity of the hospital, particularly impacting visitors arriving on foot on religious festivals and Shabbat.	culturally and religiously sensitive care • Action plans may cover areas such as staff training, Kosher food, communication, religious requirements around the observance of Shabbat including families remaining in hospital and working relationships between the population and NCL hospitals • Following a decision, the proposed mitigations would be further tested with the Orthodox Jewish community and its leaders throughout implementation to ensure key concerns are captured and mitigated against. Agreed mitigations would be monitored and evaluated by a working group which would include members of Orthodox Jewish community	units in NCL through the measures identified and careful close working with the Orthodox Jewish community • We believe the impact regarding the religious requirements of the observance of Shabbat for families staying in hospital can be fully mitigated through the measures identified and careful close working with the Orthodox Jewish community • Members of the Orthodox Jewish community currently access maternity care, and other forms of care, from other hospital sites within NCL, so we know that it is possible to mitigate these impacts, and we need to learn from and build on these experiences • However, we acknowledge that for those who wish to visit someone in hospital on Shabbat or visitors who need to leave hospital on Shabbat, there may be impacts that cannot be mitigated. Specifically, those walking to and from the hospital are likely to have to walk further, as overall travel times will be greater. Further, Royal Free Hospital is in an eruv (enabling some relaxation of the prohibition of carrying items outside the house on Shabbat),

		whereas other hospitals are not. • We will continue to work with the community to mitigate the impact of these issues as far as possible, including by scheduling procedures around Shabbat wherever possible, but they cannot be completely eliminated.
People from minority ethnic groups may face language barriers when travelling to, and accessing, a different site	• Clear information would be provided to service users about travel and transport options to all maternity units. • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted	• We believe that the mitigations would reduce the potential impact
Somali community in Kilburn may face difficulties travelling to, and accessing, their closest hospital which would change from the Royal Free Hospital to Northwick Park Hospital or St Mary's Hospital	• Patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments • We would offer detailed information about how to navigate to the right area of the hospital where appointments or admissions are scheduled, as part of communication with service users • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted	• We believe that the mitigations would reduce the potential impact
The Bangladeshi and Pakistani population in Chalk Farm are close to a maternity unit that may move in Option A, and	• Aim to deliver as much care as close to home as possible to minimise travel times and where possible, provide virtual	• We believe that the mitigations would reduce the potential impact

therefore may be more impacted in terms of travel times compared to other groups	appointments when clinically recommended • Ensure that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care	
Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language	• Ensure that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care • We would ensure there is accessible information about choices of maternity care available in non-digital formats for those who are less able to access the internet • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted	• We believe that the mitigations would reduce the potential impact
Harlesden and Willesden was identified as a geography that could be particularly vulnerable to the proposed changes in Option A compared to now, with poor health outcomes, poor digital access, and poor English proficiency. This population also a high number of Black African and Black Caribbean people in it alongside Bangladeshi and Pakistani people. This population may face barriers to attending an unfamiliar site.	• Some specific mitigations that would be taken forward for this population are around the communication of changes being available in accessible formats and in different languages, supporting continuity of carer in the community to deliver care as close to home as possible, supporting populations with the cost of travel • Working with NWL partners we would continue to engage with residents of Harlesden & Willesden during implementation to understand any	• We believe that the mitigations would reduce the potential impact

	unanticipated impacts and develop further mitigations if necessary	

The IIA documents how the ICB has met its public sector equality duty and its legal duties in regard to health inequalities. In reaching a decision on whether to proceed with Option A, the ICB Board will consider whether, where implementation would lead to negative impacts on any group sharing a protected characteristic that cannot be mitigated, there are good reasons for implementing option A that mean it should proceed, despite those disadvantages.

The recommendation in this DMBC is that the benefits of implementing Option A, as described throughout this document, mean that it should be implemented, despite the identified disadvantages.

10. Further assurance of our proposals

10.1 Introduction

Ahead of consultation the proposals underwent an assurance process. This included London Clinical Senate, NHSE, the Mayor's tests and the Joint Health Overview and Scrutiny Committee (JHOSC). Further detail on the previous assurance can be found in section 6.

Following consultation, further assurance has taken place:

- Mayor's tests
- NHSE (on the financial aspects)
- JHOSC

No further external assurance is required.

10.2 Mayor's tests recommendations and responses

The London Mayor's six tests[61] are applied to major service reconfigurations in London alongside the five tests from the Department of Health and Social Care and NHSE, and the statutory consultation processes which accompany large scale change. These tests are initially applied at the point of public consultation, and then subsequently to the DMBC:

1. **Health and healthcare inequalities:** The impact of any proposed changes to health services in London must not widen health inequalities. Plans must set out how they will narrow the gap in health equality across the capital.

[61] https://www.london.gov.uk/programmes-strategies/health-and-wellbeing/champion-challenge-collaborate

2. **Hospital beds:** Given that the need for hospital beds is forecast to increase due to population growth and an ageing population, any proposals to reduce the number of hospital beds will need to be independently reviewed to ensure all factors have been taken into account. Any plans to close beds must be an absolute last resort and must meet at least one of the NHS' 'common sense' conditions.
3. **Financial investment and savings:** Sufficient funding (both capital and revenue) is identified and available to deliver all aspects of the proposals
4. **Social care impact:** Proposals must take into account the full financial impact any new models of healthcare, including social care, would have on local authority services, particularly in the broader context of the funding challenges councils are already facing.
5. **Clinical support:** Proposals must demonstrate widespread clinical engagement and support, including from frontline staff
6. **Patient and public engagement:** Proposals must show meaningful patient and public engagement, including with marginalised groups

The Mayor assessed the Start Well proposals against the first four tests in advance of the PCBC publication. Following consultation, the Mayor's office reviewed the final two tests on clinical support and patient and public engagement. The Mayor's recommendations and our response are shown in sections 4.2, 5.2, 8.2, 9.2, 11.4.1, 11.5.1,11.8.1, 12.1, and 13.2.1.

10.3 NHSE assurance

During the NHSE stage 2 assurance prior to consultation, there was feedback from NHSE asking for more detail on the stranded costs and any mitigating actions to address these as part of the development of this DMBC.

Based on this feedback, further work on the stranded costs for both options was undertaken. The stranded costs identified and mitigating actions for these for the recommended option is shown in Figure 59.

		Recommended option		
Category	**Expenditure type**	**Stranded value**	**What is included**	**Rationale as to why it is stranded**
CNST	CNST	£3,796,378	• 60% of the overall CNST costs which relates to the quality and historical claims aspect of the CNST maternity premium	No mitigations identified

Figure 59: Stranded costs and mitigations identified for the recommended option

The further detail on stranded costs was provided to NHSE and they outlined that they were assured with the financial aspects of the proposals. The assurance letter can be found in appendix F.

10.4 Joint health overview and scrutiny committee (JHOSC)

Prior to the public consultation, the JHOSC received information about the proposals for maternity and neonatal services and the consultation process at a meeting in November 2023. Following this

a series of recommendations were made by the JHOSC. Following the consultation process an interim analysis report was shared and discussed at a meeting in July 2024. Following this, further areas of clarification were shared with the Programme by the JHOSC. The table below outlines the recommendations received and our response to these. See appendix A for a copy of the letter from the JHOSC.

Theme	Recommendations	Our response
Estate	Provide more detailed information on the estate improvement plans as a result of the additional capital investment	The capital requirements and indicative scheme timelines can be found in section 11.8.2. The ambition is that any new estate would be HBN compliant. Section 11.8.2 describes in more detail the estate improvements.
Quality of care	Outline the measures being taken to address the issues highlighted by the CQC	Section 11.9 outlines the partnership working approach between Trusts to support quality improvement. All sites would deliver the best practice care model which has been designed to improve the quality of care. Capital investment into the estate, particularly at the Whittington Hospital would help address the environment issues highlighted by the CQC. The NCL LMNS Equity and Equality Plan[62] outlines the actions to improve the quality of maternity and neonatal services across NCL. This plan has incorporated the opportunities for improvement identified in the Start Well case for change.
Access to care	Difficulties of travelling further and the negative impact of longer journey times, increased costs and reassurance on the additional parking facilities	The IIA outlines refreshed analysis of the potential impact on travel times and travel costs, and a summary is shown in section 9.5.2. Mitigations for the potential impact of increased costs are detailed in the IIA and in section 9.5.6. These have been further developed based on feedback from the Patient and Public Engagement Group and feedback received from the public consultation. Mitigations regarding access to parking spaces across NCL sites have been developed to ensure that the impact of the proposed changes are minimised. Detail of the mitigations can be found in the IIA and in section 9.5.6.
Care model	Provide further detail to outline the delivery of	The CRG reviewed the antenatal services and agreed that delivery of

[62] https://nclhealthandcare.org.uk/wp-content/uploads/2024/09/NCL-LMNS-Equity-and-Equality-Action-Plan-2024.pdf

	antenatal services and how these would be integrated with the services that they receive at the hospital	antenatal services would no longer be delivered at any site where intrapartum care is no longer provided. Some more specialist clinics for pregnant women and people may remain and this would be worked through in more detail during implementation. Where possible, appointments would be delivered in the community and closer to home. A description of the antenatal pathway is shown in section 5.4.2.
	Outline approach to centres regarding pregnant women and people with complex (or pre-existing) health conditions and potential reduced access to certain specialist services	The maternal medicine working group reviewed the potential impact and pathways for pregnant women and people with complex (or pre-existing) health conditions. The working group agreed that all pathways would still be safe for all options. Access to services would be supported through a hybrid model, including specialist clinicians at outpatient appointments. Digital technology would be an enabler to support this. More detail is shown in section 9.5.6.
Workforce	More detailed modelling on staffing levels and how any risk of staff not moving units would be managed	Future workforce requirements have been modelled based on 2024 workforce establishment and safer staffing guidance. The outputs of this have been assured by NHSE London Region (appendix F). The workforce risks and potential mitigations have been discussed with the CRG and the Programme Board and are outlined in more detail in section 11.11.2.
Activity modelling	Concerns that patient flow modelling methods could be over-reliant on assumption that patients would opt for the next nearest site and there would be unanticipated pressures on sites	Activity modelling has been refreshed using 2024 travel times. The modelling approach also considers patient choice based on choices seen in 2023/24. Capacity requirements have been calculated using a set of prudent assumptions to build in a level of flex in the system to help mitigate the risk. This includes basing projected activity on the highest volume of activity, rounding all capacity requirements up and using a prudent occupancy assumption for neonatal cots.

		Further discussion on partnership working to support any risks in sites managing unexpected flows has been explored with Executive Leads and detail on the potential future ways of working is outlined in section 11.9.
IIA	Potential impact on the Orthodox Jewish community	During public consultation, we engaged with the Orthodox Jewish community, and worked with community leaders to support both women with experience of maternity services, community leaders, and those working with the community, to provide their feedback and input into the proposals. The potential impact of the proposed service changes on the Orthodox Jewish community were discussed extensively during the public consultation. Detailed consideration of the potential impact of no longer delivering maternity and neonatal services at the Royal Free Hospital on this population and potential mitigations has been included in the IIA. Remaining units would work with the community to develop Trust-level action plan to build on existing provision of culturally and religiously sensitive care. Action plans may cover areas such as staff training, Kosher food, communication, religious requirements around the observance of Shabbat including families remaining in hospital and working relationships between the population and NCL hospital, as shown in section 9.5.6. Following a decision, the proposed mitigations would be further tested with the Orthodox Jewish community and its leaders throughout implementation to ensure key concerns are captured and mitigated against. Agreed mitigations would be monitored and evaluated by a working group which would include members of Orthodox Jewish community.

11. Implementing the recommended option

11.1 Introduction

The information set out in this section outlines our implementation plans as well as the enablers that would be required to support implementation of our recommended option. This includes workforce, clinical pathways, finance, digital, sustainability and communication and engagement. High-level risks and mitigations have also been considered.

11.2 Governance arrangements to support implementation

As NHSE London Region Specialised Commissioning are delegating responsibility for the commissioning of relevant services[63] to NCL ICB on 1 April 2025, oversight of the implementation process would be the responsibility of NCL ICB.

The Start Well Programme Board would oversee the development and implementation of the proposals. The Programme Board would provide senior leadership and oversight across workstreams and report to NCL ICB Board. Throughout implementation, it would meet regularly to provide direction, ensure central co-ordination, and manage risks and interdependencies. The Start Well Programme Board includes representatives from the ICB, providers, NHSE London Region Specialised Commissioning, local authorities, and neighbouring ICS regions. As the programme moves into implementation, current membership would be reviewed.

Executive Leads from each provider organisation have been supporting Start Well and would take accountability for the implementation for their organisation, alongside a named senior operational lead from each hospital site. The group would provide an informal touchpoint for the Programme, ensuring regular communication of progress, Trust risks and problem solving. They would be responsible for developing effective working relationships across NCL, and neighbouring ICSs as needed for planning and implementing the changes. Trusts would be expected to progress with internal implementation planning, whilst linking into both system-wide governance but also taking forward work that needs to happen jointly with other sites in NCL.

The Maternity and Neonatal Operational Implementation Oversight Group would be operationally focused and would have oversight of the implementation of the proposals. They would review outputs from the dedicated expert working groups which would report into this group. The group would also monitor operational risks and escalate any barriers to progress to the Programme Board.

Building on the workstream groups that have been established through the previous phases of the programme, several workstreams would support the implementation phase and these groups would feed into the Operational Implementation Oversight Group. This would include, for example clinical, workforce and finance groups. Where possible, existing ICS governance would also be used to support aspects of implementation – for example through the NCL LMNS. The exact groups would be worked through further should a decision be made to implement the proposals, however a set of principles for these have been agreed as follows:

- Frequency of group meetings may change as implementation timeline progresses
- There may be sub-groups that are required as offshoots of these for specific areas
- Where possible we would link into existing system governance e.g., through the LMNS

[63] Excludes open fetal surgery to treat fetuses with open spina bifida, drugs and devices

- These groups may be replicated within Trusts or at a multi-site level, with information feeding two ways between them
- Scope of work needed at a system level vis-à-vis site, bilateral or Trust groups to be worked through in more detail
- There may be joint working between groups needed at times
- Join up of work of these groups would be overseen by an Operational Implementation Oversight Group
- Review of existing groups and membership to be undertaken for implementation phase

Clear roles and responsibilities would be identified, with clear links between ICB and Trust implementation groups to ensure that implementation plans and management of risk across the system are aligned. The implementation plans for changes to individual sites would be developed by providers and would feed into the overarching plan across the ICS.

A draft programme governance structure for this phase is shown in Figure 60

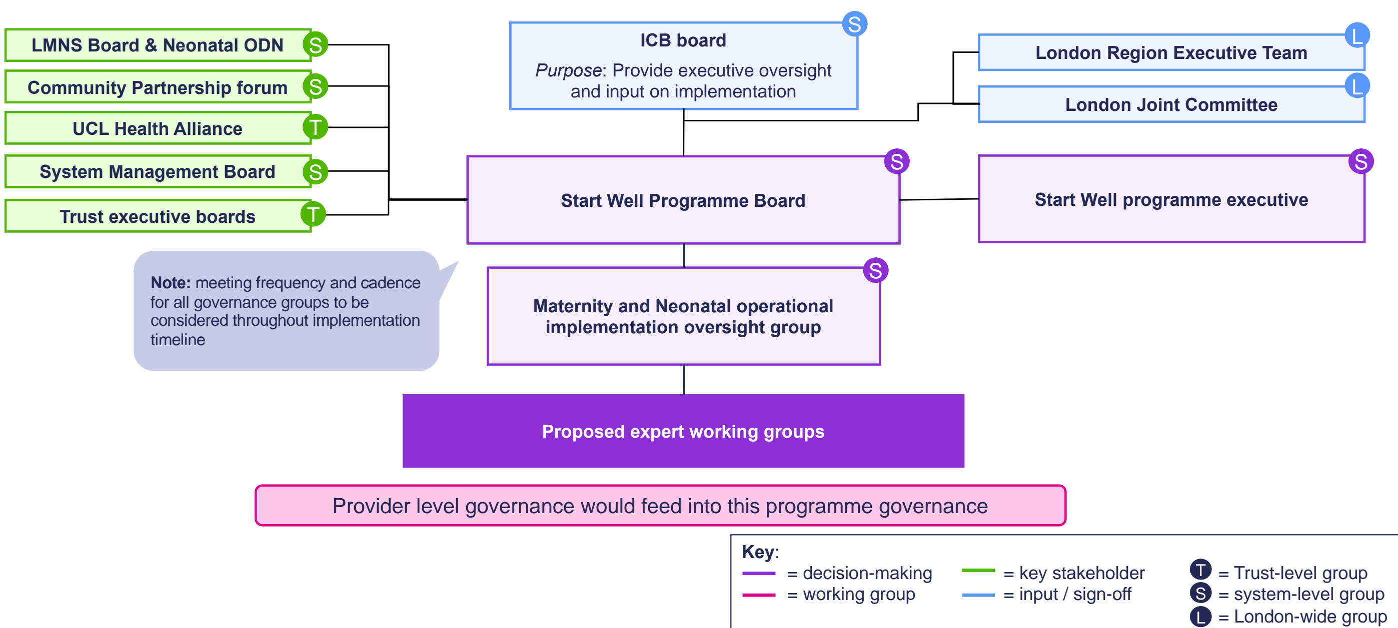

Figure 60: Implementation governance structure

11.3 Key enablers for implementation

There are several key enablers that are vital for the implementation of our recommended option. These include clinical pathways, workforce, digital, finance, partnership working and communication and engagement. Workforce underpins the delivery of our plans, and our recommended option would require some staff to change their site of work. Careful planning would seek to ensure that we are able to support our workforce through transition and that the risks of implementation for all impacted units are managed.

Key to the Programme's work to date has been the engagement and input from both staff and service users. Throughout implementation, we would seek to continue to involve a range of stakeholders and service users in the development of plans. This would ensure that our plans are informed by expertise and experience, which in turn would ensure plans are fit for purpose and could be implemented successfully. There would be elements of these implementation plans that would need to be owned locally. This would ensure that they are informed by local knowledge and

would ensure that important linkages between local care providers such as primary care, community services and social services are maintained as changes are implemented.

11.4 Clinical pathways

Implementing the care model would require us to strengthen and implement a number of new pathways. Proposals for some of these areas where we have received specific feedback is outlined below but more detailed plans would be worked through as part of the implementation phase with oversight from the expert clinical working group.

11.4.1 Feedback from consultation and assurance

What we heard	How we addressed this feedback
During consultation, people asked for further detail around how antenatal and postnatal inpatient care would be delivered with capacity concerns for antenatal wards and postnatal beds from clinical staff.	The CRG have developed a more detailed understanding of antenatal and postnatal pathways, including further analysis to predict antenatal and postnatal demand. The CRG agreed that, generally, antenatal services would no longer be delivered at the Royal Free Hospital. This is because it would be very difficult to have antenatal care at a different site to intrapartum care due to the difficulties in sharing information between providers and the workforce that would be required at the site that no longer provided maternity and neonatal services. Some more specialist clinics for women with conditions that lead to a more complex pregnancy may remain and this would be worked through in more detail during implementation. Where possible appointments would be delivered in the community and closer to home. A description of the antenatal pathway is outlined in section 5.4.2 We have included 4 additional antenatal clinic rooms and 5 additional postnatal beds in option A and 7 additional antenatal clinic rooms and 5 additional postnatal beds in option B. This additional capacity has been included in the capital modelling shown in section 11.8.2.
During consultation, people asked for more clarity around the location of Early Pregnancy Units, and whether one would be provided on the site no longer providing perinatal and neonatal care.	We have worked to explore the feasibility of maintaining an EPU at the Royal Free Hospital, and to ensure that there continues to be local provision of these key services. In the case that the maternity unit at Royal Free Hospital does close, we propose that Royal Free Hospital retain their EPU. Further detail can be found in section 11.4.6.3.
During consultation, people asked for more information on the impact on London Ambulance Service for emergency transfers.	We have worked with the maternity lead at the London Ambulance Service (LAS) to understand the potential impact on LAS emergency transfers as a result of a maternity unit closing. LAS only transfer pregnant women and people to hospitals which have obstetric-led units. The closure of the Royal Free Hospital maternity unit should result in fewer LAS transfers between units due to their being local neonatal units (LNU) (level 2) at all sites in NCL. It should be noted that there are current clinical exceptions in place between LAS and the Royal Free Hospital in relation to pregnant women and people. For example, women and pregnant people with babies under

	34 weeks in gestation are not conveyed to the Royal Free Hospital because it does not have a local neonatal unit (LNU) (level 2). During implementation, LAS would manage this in line with other changes to services. They would be able to remove the Royal Free Hospital as one of the obstetric hospital options to which patients could be conveyed. This would then be reflected on their in-ambulance digital terminal to ensure that crews do not take pregnant women to the Royal Free Hospital once the changes had been implemented. LAS have a standard way of communicating these types of changes internally and this involves communicating with ambulance staff, for example through huddles, maternity training sessions, and bulletins. We would continue to liaise with LAS through their lead midwife as the implementation plans progress to ensure that they are informed of progress and key dates around any changes to services taking effect.
During consultation, people asked for further detail on the interdependency of services such as gynaecology and community midwifery. The Mayor's Office recommended that we add detail on how staff training and access to gynaecology care would be managed. For gynaecology, it requested we outline further detail on the sustainability of emergency and out of hours gynaecology care, job planning, cross-site working, co-ordination with London Ambulance Service and access to Early Pregnancy Units. The Clinical Senate recommended that we do further work to decouple the obstetric workforce from the gynaecology workforce on emergency presentations and understand the impact on the workforce who might continue to work across both specialities as part of their assessment of our PCBC.	The potential impact on gynaecology services has been discussed with the CRG and set of principles to support implementation has been developed related to clinical services the workforce and pathways. We would seek to maintain elective gynaecology care provision at the Royal Free Hospital site. There would also be provision of early pregnancy related services which are generally cared for under a gynaecology services (see section 11.4.6.3 for more detail). The provision and scope of emergency care would be worked through in more detail in implementation, working with LAS to ensure that there are clear pathways and standard operating procedures (SOPs) defining what care could be delivered on site. As part of implementation we would work with local 'place' teams in each borough - both within the ICB and as part of the providers that support this infrastructure to ensure that important linkages are maintained and enhanced. As we look at community midwifery boundaries and services available in the community there is an opportunity for place teams to influence the approach and integrate with neighbourhood teams. Consultant job plans would be revised on an individual basis and this could include further cross-site working within a single organisation or joint contracts between providers to support the retention of skills within NCL. Through implementation we would support trainees with consultant oversight and opportunities to explore both obstetrics and gynaecology across sites. Further detail on gynaecology services are set out in section 11.4.6.2.
The Mayor's Office recommended that we quantify what is required (resources and financial implications)	The future workforce requirements for all staffing groups have been calculated based on national best practice standards, including BAPM neonatal standards, Royal College of Obstetrics and Gynaecology and Birthrate Plus

to meet safe staffing standards (based on Birthrate Plus standard)	ratios. Where necessary, the projected activity at each unit was used to calculate the resource requirement. The financial implication of this workforce requirement has been calculated using mid-point NHS employers pay scale salaries and London weighting.
The Mayor's Office recommended that we describe the potential implications of the changes on EDs, particularly where maternity services aren't offered. The Clinical Senate recommended that we clarify the implications for other services e.g., Emergency Department presentations if Early Pregnancy Assessment Units close as part of their assessment of our PCBC.	London Ambulance Service (LAS) would no longer convey pregnant women and people to Royal Free Hospital, and therefore there is only a small remaining risk at Royal Free Hospital's emergency department (ED) of walk-ins. To mitigate this risk, we would put up clear signage on-site and around the site about the facilities available and which unit people should go to instead and ensure that other healthcare providers such as GP practices update their websites and leaflets. We would continue to work with trusts' comms teams as part of implementation to communicate the change effectively to staff and service users, including non-digital communication where possible. We would also review standard operation procedures (SOPs) so that in the event that walk-ins occur, staff know how to manage emergency cases. This would include agreeing pathways with other units which have on-site maternity care, and accounting for any changes to SOPs as RFH retain their early pregnancy unit (EPU). As part of implementation planning, we would continue to build on existing models from elsewhere in London, e.g., Ealing Hospital (LWNH).
The Mayor's Office recommended that we set targets for midwife continuity of carer including specific target date for increasing midwife continuity of carer for target vulnerable groups and interim targets for improving midwife continuity carer overall. The Clinical Senate recommended that we further articulate the impact of our proposals on improving service provision and population outcomes, including the impact of more care and assessment being provided closer to home (community or virtual) and integration with place-based services including primary care and pre-natal, post-natal and health visiting, pre-surgery, post-surgery as part of their assessment of our PCBC.	The NCL LMNS Equity and Equality Action plan[64] published in spring 2024 outlines the current plans for midwifery continuity of carer. Within NCL, all Trusts have stated they cannot meet safe minimum staffing requirements for further roll out of midwifery continuity of carer (MCoC) but can meet the safe minimum staffing requirements for existing MCoC provision. Therefore, further roll-out is currently paused but there would be continued support for trusts at the current level of provision in line with national guidance. The active teams in NCL target the provision of MCoC to women and birthing people from minority ethnic groups, and those living in areas of deprivation. The expected benefits, and measures to monitor the impact, in respect to improved patient outcomes and experience have been outlined as part of the benefits framework in chapter 12. The measures have been agreed by the CRG.
During consultation, people asked for more detail on pathways for out of hours interventional radiology (IR)	The CRG have reviewed and outlined the proposed out of hours IR arrangements for the recommended option. Detail on the out of hours interventional radiology pathways is set out in section 11.4.6.6.
Staff working at the Royal Free Hospital highlighted that they offer several services to support maternal health, including specialist transplant	The CRG set up a dedicated maternal medicine working group to better understand the feedback around maternal medicine under the proposed care model. The working group reviewed the impact and pathways for pregnant

[64] https://nclhealthandcare.org.uk/wp-content/uploads/2024/09/NCL-LMNS-Equity-and-Equality-Action-Plan-2024.pdf

services, and the National Haemophilia Centre that further work was required to understand the potential impact of the proposals on these women and pregnant people. The mayor's office recommended that we quantify the impact of our proposals on women and pregnant people who use specialist clinics.	women and people with complex (or pre-existing) health conditions. Access to services would be supported through a hybrid model including specialist clinicians at outpatient appointments. Digital technology would be an enabler to support this. For the recommended option, further work was undertaken on potential new pathways/ways of working for maternal medicine, as shown in section 11.4.4.

11.4.2 Enhancing midwifery-led care

Access to midwifery-led care is a key component of the holistic care model and midwifery-led care provides clinical benefits for women and people who have uncomplicated pregnancies. We know that currently, midwifery-led intrapartum care in NCL is not as well utilised as it could be. This may be as a result of both maternal choice and risk factors as well as staffing challenges across services compromising the availability of services.

Through consolidation of the number of maternity units under our new model of care, our ambition is to ensure that the choice of an alongside midwife-led unit could be facilitated on a more consistent basis. In addition to this, there is further work that would be done to increase the utilisation of these units, such as ensuring that all NCL units meet the Midwifery Unit Standards[65], better promotion of the benefits of these units for those with the right risk profile and working with service users to ensure that units meet holistic needs.

The NCL LMNS Equity and Equality Action plan[66] published in spring 2024 outlines the current plans for midwifery continuity of carer. Within NCL, all Trusts have stated they cannot meet safe minimum staffing requirements for further roll out of midwifery continuity of carer (MCoC) but can meet the safe minimum staffing requirements for existing MCoC provision. Therefore, further roll-out is currently paused but there will be continued support for trusts at the current level of provision.

The active teams in NCL target the provision of MCoC to women and birthing people from the global majority, and those living in the most deprived areas. The three-year delivery plan for maternal and neonatal services (NHS England 2023) has also recommended piloting and evaluating new service models designed to reduce inequalities, including enhanced MCoC. NCL LMNS has received funding to support teams working in more deprived areas.

An evaluation will be carried out to review its effectiveness and consider whether this can be replicated across NCL. It has also been agreed that closer attention should be given to North Mid as this is the NCL Trust with the highest proportion of women and birthing people from the global majority and those living in areas of deprivation. The LMNS will also continue to monitor the provision of midwifery continuity of carer via the NCL dashboard and support the national team to review staffing levels and plan for the delivery of MCoC at full scale when it becomes viable.

11.4.2.1 *Ensuring all NCL units meet the midwifery unit standards*

As part of the London-wide maternity transformation programme, there is work underway to assess compliance of all midwife-led units MLUs against midwifery unit standards. This work includes a gap analysis which would then inform an implementation plan to be overseen through

[65] https://www.midwiferyunitnetwork.org/wp-content/uploads/PDFs/LY1309BRO-MUNEt-Standards-PRINT-opt.pdf

[66] https://nclhealthandcare.org.uk/wp-content/uploads/2024/09/NCL-LMNS-Equity-and-Equality-Action-Plan-2024.pdf

local maternity and neonatal governance (the NCL local maternity and neonatal system (LMNS)). There are 29 standards that are split into 10 themes as shown in the table below.

Theme	Standards
Theme 1: Bio-psycho-social model of care	• Standard 1: The midwifery unit has a written and public philosophy of care setting out shared values and beliefs
Theme 2: Equality, diversity and social inclusion	• Standard 2: The midwifery unit has a policy relating to respect, diversity and inclusion
Theme 3: Working across professional and physical boundaries	• Standard 3: There is a shared written commitment to mutual respect and cross-boundary working across the whole maternity service • Standard 4: The midwifery unit has a linked lead midwife, obstetrician and neonatologist • Standard 5: There is a clear policy and procedures for transfers
Theme 4: Women's pathways of care	• Standard 6: The midwifery unit commits to a philosophy of providing information as early as possible, and keeping decisions open • Standard 7: The midwifery unit is a hub integrated with the local community • Standard 8: The midwifery unit pathway is open to all women for personalised and individualised care • Standard 9: The midwifery unit has clear referral pathways
Theme 5: Staffing and workload	• Standard 10: Essential staffing includes a core staff team and midwifery leadership on site to promote high standards, a sense of ownership and an appropriate philosophy of care • Standard 11: Assessment of workload should include all activities on the midwifery unit, not just the intrapartum care and number of births
Theme 6: Knowledge, skills and training	• Standard 12: There is a written agreed list of knowledge and skills required of midwives in order to work in a midwifery unit • Standard 13: The midwifery unit has plans for education and continuing professional development • Standard 14: The midwifery unit has a framework for preceptorship and orientation
Theme 7: Environment and facilities	• Standard 15: The midwifery unit offers an environment that promotes a bio-psycho-social model of care and building relationships • Standard 16: The midwifery unit offers an environment which supports mobilisation and active birth • Standard 17: The midwifery unit offers an environment that protects and promotes relaxation, privacy and dignity • Standard 18: The physical layout and design of the midwifery unit conveys the bio-psycho-social values of the care model • Standard 19: The midwifery unit is visible and accessible in the community
Theme 8: Autonomy and accountability	• Standard 20: The midwifery unit has a policy acknowledging midwives' autonomy and accountability • Standard 21: The midwifery unit has a policy acknowledging women's autonomy
Theme 9: Leadership	• Standard 22: There is a visible and consistent leadership within the midwifery unit

	• Standard 23: The midwifery unit has high-quality transformational leadership • Standard 24: There is a multidisciplinary and service users advisory group, which sets out a vision for the midwifery unit
Theme 10: Clinical governance	• Standard: 25 The midwifery unit has evidence-based guidelines, policies and procedures subject to regular review • Standard 26: The midwifery unit has guidance on eligibility criteria and choice of place of birth • Standard 27: The midwifery unit demonstrates commitment towards continuous improvement • Standard 28: The midwifery unit has a robust information system • Standard 29: The midwifery unit includes plans for communication and marketing

11.4.2.2 *Promotion of the benefits of these units for those with the right risk profile*

Linked to standard number 29 of the midwifery unit standards, it is important that those using services understand the offer of a midwifery led unit for their birth. This includes what kind of environment it offers, and the known benefits of this type of unit for birth. We would:

- Ensure there is accessible information about midwifery-led units available through a number of channels such as GP practices, antenatal classes and local children's centres
- Update Trust websites with the latest information relating to the midwifery-led units, including pictures and/or videos to support visualising what the environment is like
- Explore patient videos for those who have used midwifery-led units to describe their experience to support women as they are deciding their preferred birth setting
- Ensure discussions about choice of birth setting are data and outcomes driven to support informed decision making
- Ensure for those being triaged during labour that this happens in the most appropriate setting
- Understand good practice in this area from other parts of the country where there may be higher rates of midwife-led births
- Explore the feasibility of offering a tour of the birthing centres for service users to see the environment as part of their decision to choose a particular birth setting

11.4.2.3 *Working with service users to ensure midwife-led units meet their needs*

Midwifery-led care should be personalised to meet the needs of service users. Given the range of population groups that use services at NCL units, further work with different communities would be done to ensure that MLUs meet the needs of a range of service users. We would undertake targeted work with the local maternity and neonatal system and maternity and neonatal voices partnerships to understand how units could be tailored towards the needs of local communities. This would include:

- Ensuring that the consistent agreed risk criteria across NCL is consistently implemented to ensure units could be safely accessed by the widest range of service users
- Ensuring that feedback from service users (such as the annual CQC maternity survey) informs practice on midwifery-led units and that they are flexible enough to accommodate different birthing preferences and cultural considerations
- Working in partnership with MNVPs to support this work and undertake targeted specific engagement around the use of midwifery-led units

11.4.2.4 *Environment of midwifery-led units*

In line with theme 7 of the standards, we would ensure that the environment of all midwife led units promotes the best possible birthing experience. As part of implementing the standards, we would ensure that all the units offer home-like comforts such as:

- Soft lighting, warm colours, and comfortable furniture to make the space feel more inviting
- Ensuring each birthing room provides privacy, with efforts made to minimise noise and disturbances
- Access to birthing pools to facilitate water births
- Soft flooring and mats to allow for more comfortable movement and different birthing positions
- Relaxation tools such as birthing balls, beanbags, birthing stools and floor mats
- Facilities should offer Bluetooth speakers or sound systems for playing calming music

11.4.2.5 *Access to home birth services*

In the future, there would continue to be provision for home births across all NCL boroughs staffed by community midwifery teams as is currently the case. We would consider how to ensure the home birth provision could be made more consistently available and increase the utilisation of this service. This would be done through:

- A review of community midwifery boundaries to ensure that the home birth teams' geographical boundaries are of a similar size to each other
- Having clear information for service users about the option of home birth as well as potential benefits for those who meet the clinical risk profile
- Gathering feedback from service users and monitor outcomes from home birth teams to ensure that they continue to meet the needs of service users
- Exploring the possibility of consistent or shared training for home birth teams to ensure that staff across NCL are supported in their roles
- Sharing any good practice of home birth teams via the NCL local maternity and neonatal system (LMNS).

11.4.3 Ante- and post-natal care across NCL

The CRG agreed that the majority of ante- and post-natal appointments would no longer take place at Royal Free Hospital which would no longer support intrapartum care. These appointments would either be delivered at a local community-based site or would be delivered at the site where the woman or person gives birth. There may be some exceptions to this – for example, for women or people who have complex (or pre-existing) health conditions and who may require the input of other specialists in their care, in line with maternal medicine pathways. Where activity is suitable, i.e. midwifery led appointment, additional antenatal activity would be provided in community settings so that care is provided as close to home as possible.

Data quality issues meant it was not possible to model additional antenatal capacity requirements however it was agreed by the CRG that there was antenatal care activity currently delivered in a hospital-setting that could be moved into a community setting.

Postnatal care would only be provided at sites that deliver intrapartum care and would therefore no longer be provided at Royal Free Hospital. As a result of the additional deliveries, there would be additional postnatal bed capacity at Barnet Hospital and Whittington Hospital:

- Barnet: 2 additional postnatal beds
- Whittington: 3 additional postnatal beds

There would be sufficient existing postnatal capacity at North Mid and UCLH to deliver the additional projected postnatal care activity.

11.4.4 Maternal medicine

Maternal medicine services provide advice and planned care for women with pre-existing medical conditions before, during and after pregnancy. The services also provide advice and planned antenatal, intrapartum and postpartum care for women with medical conditions that arise during pregnancy. In NCL, the Maternal Medicine Network (MMN) is responsible for ensuring that all women and people in the network receive timely specialist care and advice before, during, and after pregnancy. The NCL MMN is currently made up of:

- Maternal Medicine Centre (MMC): UCLH
- Local maternity units: Barnet, North Mid, Royal Free and Whittington

The national specification for maternal medicine[67] outlines that specialists are generally based at a single hub site. However, the nature of specialist service provision across London means that, to make the best use of a range of specialisms and to ensure specialist support is available close to home for service users, NCL has implemented maternal medicine outreach clinics across all hospital sites which are supported by the network.

The MMC at UCLH provides regional clinical leadership on the identification, referral and management of pregnant women and people with the most complex (or pre-existing) health conditions and are responsible for reporting to the regional maternal medicine group for assurance and oversight. Local units have their own maternal medicine frameworks that are supported by the LMNS and wider MMN so cases can be managed locally where possible, and where required, specific cases can be escalated to system-level in line with clinical governance processes. At a system-level the MMN uses regular multi-disciplinary team meetings to develop specific patient plans, escalate concerns and get specialist input, for example for cardiac patients.

Within maternal medicine services, medical conditions are classified as category A, B or C depending on complexity:

- **Category A:** medical conditions that can be managed using local expertise and evidence based maternity care within a local maternity unit. Example conditions include uncomplicated asthma and uncomplicated rheumatoid arthritis.
- **Category B:** complex medical conditions where a MMC provides clinical review (either virtually or face-to-face according to clinical need) and on-going advice and guidance to a local maternity unit. Example conditions include kidney transplant and Addison’s disease.
- **Category C:** highly complex medical conditions where care in pregnancy is led by the MMC during pregnancy and includes plans for delivery. Example conditions include sickle cell disease and beta thalassaemia major.

It should be noted that categories are in place as a guide only. Where there is expertise to manage a pregnant women or person locally, someone with a category C condition could continue to be managed locally without the need for the MMC at UCLH to take over their care. An example of this is haematology, where most people are managed locally.

There are a number of pathways which are managed on a pan-London basis due to the conditions being relatively rare and the availability of expertise. This includes acute liver failure, pulmonary hypertension, acute stroke and elevated myocardial infarction.

[67] https://www.england.nhs.uk/publication/maternal-medicine-networks-service-specification/

11.4.4.1 *Addressing the issues raised in consultation*

During the consultation, we heard concerns that maternal medicine had not been considered sufficiently by the Programme as part of the development of the PCBC. Consultation respondents highlighted the following pathways needed to be considered in more detail, although it was noted that care for many of the people with more complex conditions is already delivered at the maternal medicine centre (MMC) at UCLH:

- Liver transplant
- Renal transplant
- Dialysis services
- Cardiology
- Pulmonary hypertension
- Haemophilia
- HIV
- Rheumatology
- Neurology

Many of the above pathways were noted to have joint obstetric/specialist clinics at the Royal Free Hospital site which support women during pregnancy and would be impacted if the Royal Free Hospital maternity and neonatal unit is closed.

Work had already been completed to consider the potential impact of the proposals on maternal medicine prior to consultation. However, to consider the consultation feedback and further understand the potential impact of the proposals on maternal medicine services, a Maternal Medicine Working Group was established in the post-consultation phase. This group included a maternal medicine obstetric lead from each local maternity unit, the maternal medicine centre and the multidisciplinary leadership team from the maternal medicine network (MMN). To support these conversations, MMN data was collated on the number of women cared for on different maternal medicine pathways. The potential impact on women and pregnant people on the maternal medicine pathway has also been considered in the integrated impact assessment and further detail is shown in section 9.5.6.

11.4.4.2 *Antenatal pathway of care for maternal medicine*

Clinicians agreed that the antenatal pathway of care for maternal medicine would be developed to ensure that the input from the specialist multidisciplinary team is maintained. Excellent care is currently provided at Royal Free Hospital and implementation of our proposals would ensure that this level of care is maintained. To ensure that individuals continue to receive input from specialist teams, it was agreed that: Appointments would continue to be provided, where possible, at Royal Free Hospital (which would no longer provide intrapartum care) for input from medical specialty teams. Appointments would generally be scheduled with obstetricians and maternal medicine physicians at the site where the person is scheduled to give birth to create familiarity with the unit. The MMN would consider how to make the best use of technology such as video appointments to facilitate both specialist and obstetric input

These pathways of care would be supported by specialist cross-site multi-disciplinary teams. Local sites would continue to have a maternal medicine midwife to support join up of care and the network is supported by pan-NCL multi-disciplinary team (MDT) meetings (for example one focussing on cardiology cases) which have input from specialists, maternal medicine physicians, obstetricians and anaesthetists.

11.4.4.3 *Maternal medicine speciality pathways*

Each potentially impacted maternal medicine specialty pathway was reviewed by clinicians. The detail of this review can be found in appendix G. For most specialties, UCLH, as the maternal medicine centre, would provide the obstetric input for women and pregnant people on a maternal medicine pathway where they cannot be cared for in their local maternity unit. This builds on current pathways that see most of the women and pregnant people with the most complex conditions on maternal medicine pathways already giving birth at UCLH. This would include the following specialties:

- Dermatology
- Endocrine
- Gastroenterology
- Haematology
- Musculoskeletal
- Neurology
- Oncology
- Respiratory
- Rheumatology

There is one specialty where women and pregnant people are currently managed by a maternal medicine centre outside of NCL, and this would also continue:

- **Cardiology (~36 women and pregnant people per year currently seen at Royal Free Hospital across all categories):** currently category C conditions are managed by UCLH with input from cardiologists from Barts Health. For women needing cardiac surgical input, the current pathway is to refer to Guy's and St Thomas' (GSST). Under the proposals this would continue to happen as it currently does.

There are some specialties that would require a change in the current ways of working:

- **Renal (~33 women and pregnant people per year seen at Royal Free Hospital across all categories):** Royal Free Hospital has a specialism around renal and is the dialysis centre in NCL. Any woman who falls pregnant whilst on dialysis, or as a result of pregnancy need ongoing dialysis until they are able to deliver, would benefit from treatment and delivery in a unit that has a co-located maternity and dialysis unit. This is a very small number of women, estimated as one case every two years. UCLH does not have a dialysis unit and therefore an out of sector pathway would need to be established. It is proposed that these patients would be transferred to Queen Charlotte's Hospital in Hammersmith for their obstetric care.

- **Liver disease (~17 women and pregnant people per year seen at Royal Free Hospital across all categories):** there are women and pregnant people with liver disease who need more specialist care (particularly, cirrhotic and transplant patients). Antenatally, these patients may currently have input from a liver specialist at Royal Free Hospital. It was agreed that most of these women could be cared for under the proposed antenatal pathways. It was also discussed that during the intrapartum period, the biggest risk for these women and pregnant people is a potential bleed of oesophageal varices. If this complication arose, then this would be managed via the gastroenterology team that is already in place at UCLH.

11.4.4.4 *Conditions for success*

To ensure that the expert input and excellent care provided by specialists at the Royal Free Hospital is maintained during and after the implementation of these proposals, several conditions of success have been identified. Through this process, we want to ensure that all pregnant women and people have access to specialist care, if required. To do this there are a number of areas that

would need to be strengthened including existing governance arrangements and the pathways in place so that we could provide specialist access across all sites in NCL, if required.

- **Specialty input:** a full range of medical expertise is needed to manage women and pregnant people with the most complex conditions, and the proposed antenatal pathways would ensure that this is not lost. In addition to the proposed antenatal care model, there would also need to be immediate support for more complex deliveries for the rare occasions where this might be required. To support this, we would look to retain obstetric expertise from Royal Free Hospital within NCL and use joint honorary contracts for specialist clinicians with the MMC to allow ease of input into antenatal or intrapartum care as required.
- **Clearly defined pathways and support standard operating procedures (SOPs):** as they are now, network pathways would be clearly defined for each condition with a particular focus on any changes as a result of our proposals, including any pathways that may need to be referred out of NCL. To support this, detailed SOPs would be developed for each pathway which would set out the process where more specialist in-reach is required to the maternal medicine centre. This would build on existing processes in place across the network. The SOPs would be developed with the MMN and would include information around referral pathways for condition and category type and information about how to refer to either the MMC or non-NCL site where relevant. SOPs should also outline emergency presentations for particular conditions and acute referral pathways should be managed.
- **Digital interoperability and use of technology:** some level of digital interoperability is required between Trusts to allow ease of multi-disciplinary team review and/or patient transfer, if necessary. Virtual appointments would also facilitate ease of specialty input for cases which require non-obstetrician expertise.

11.4.4.5 *Network oversight and governance*

During implementation, the maternal medicine network (MMN) would have an important role to ensure continuity of care and safe services are maintained. It is intended that the NCL MMN will establish a governance group, the Maternal Medicine Strategic Oversight Group, that will report into the LMNS Board and we would use this group to support the oversight of this work. The maternal medicine network Clinical Leads would be involved, and we may require an additional implementation subgroup of the Strategic Oversight Group that would focus on these changes specifically. The network currently supports multi-disciplinary working across NCL sites which would continue during transition and that these would be enhanced to ensure that there would be the clinical input from clinicians outside of the maternal medicine network as required.

11.4.4.6 *Oversight and governance*

Recognising the potential vulnerability of the women and pregnant people who require maternal medicine services, we have already put in place new working arrangements, via the NCL LMNS, to support the development of maternal medicine services in NCL. A series of recommendations have been agreed with the maternal medicine centre (MMC) to improve governance, quality, funding and staffing including:

- A review of clinical governance across the NCL maternal medicine network. This will include benchmarking governance at all maternal medicine sites to identify opportunities for improvement.
- Developing NCL maternal medicine standard operating procedures for identifying and escalating issues across all sites
- Developing key performance indicators that feed into a single NCL-wide maternal medicine dashboard
- Gathering and assessing feedback about the maternal medicine service from other sites and sharing learnings across the system

- Exploring approaches for gathering patient experience feedback and embedding the service user voice, such as linking with maternity and neonatal voices partnerships (MNVPs)
- Exploring with Regional Network whether there is an opportunity to develop a unified way of prescribing with drugs for all sites
- Formalising thinking on how training should be funded

A revised governance structure is being developed and will be put in place over 2025/26 to reflect the importance of the maternal medicine agenda, with a new Maternal Medicine Strategic Oversight Group put in place reporting to the ICB LMNS Board. Implementation of the Start Well proposals would be an important part of the role of the Maternal Medicine Strategic Oversight Group in partnership with the maternal medicine network.

11.4.5 Ambulance transfers

London Ambulance Service (LAS) only transfer pregnant women and people to hospitals that have obstetric-led units, and between units if an emergency transfer is required. The closure of the Royal Free Hospital maternity unit would result in fewer LAS transfers between units due to there being local neonatal units (LNU) (level 2) at all sites in NCL. It should be noted that there are current clinical exceptions in place between LAS and the Royal Free Hospital in relation to pregnant women and people. For example, women and pregnant people with babies under 34 weeks in gestation are not conveyed to the Royal Free Hospital because it does not have a local neonatal unit (LNU) (level 2).

During implementation, LAS would manage changes in line with other changes to services. They would remove the Royal Free Hospital as one of the obstetric hospital options to which patients could be conveyed. This would then be reflected on their in-ambulance digital terminal to ensure that crews do not take pregnant women and people to the Royal Free Hospital once the changes had been implemented.

LAS have a standard way of communicating these types of changes internally. This involves communicating with ambulance staff, for example through huddles, maternity training sessions, and bulletins.

We would continue to liaise with LAS through their lead midwife as the implementation plans progress to ensure that they are informed of progress and key dates around any changes to services taking effect

11.4.6 Other co-located services at the Royal Free Hospital

We have considered the potential impact of our proposals on other co-located services at the Royal Free Hospital including the emergency department, gynaecology services, the early pregnancy unit, the tongue-tie service, the neonatal retinopathy of prematurity screening and out-of-hours interventional radiology. We have also considered the potential impact of any changes to these services in the integrated impact assessment.

11.4.6.1 *Emergency Department*

We have considered the potential impact to the emergency department at Royal Free Hospital if maternity and neonatal services were no longer provided. LAS would no longer convey pregnant people to Royal Free Hospital, and therefore there would only be a small remaining impact on Royal Free Hospital's ED where there would be a need to manage the risk of pregnant women and people turning up to ED as walk-ins. To mitigate this risk, we would put up clear signage on-site

and around the site about the facilities available and which unit people should go to instead and ensure that other healthcare providers such as GP practices update their websites and leaflets. We would continue to work with Trusts' comms teams as part of implementation to communicate the change effectively to staff and service users, including non-digital communication where possible. We would also review standard operating procedures (SOPs) so that in the event that walk-ins occur, staff know how to manage emergency cases. This would include agreeing pathways with other units which have on-site maternity care, and accounting for any changes to SOPs required for the Early Pregnancy Unit that would be retained on site at Royal Free Hospital. As part of implementation planning, we would continue to build on existing models from elsewhere in London, e.g., Ealing Hospital (LWNH).

11.4.6.2 *Gynaecology services*

We have developed a set of principles to manage the gynaecology services at Royal Free Hospital. Gynaecology services would remain on site and more detailed pathways would be worked through during implementation. The detail below outlines the principles in respect to the clinical services, clinical pathways and workforce.

Clinical services

- **Ensure changes are clinically sustainable** – gynaecology services at the Royal Free Hospital would need to be clinically sustainable, with careful consideration given to having the workforce available to support services.
- **Agree provision of early pregnancy-related services** – in the early part of pregnancy, women and people are generally cared for under a gynaecology service, with services being delivered in an early pregnancy unit. Some pregnancy-related services, including EPUs, would continue to be delivered at the Royal Free Hospital.
- **Maintain elective care provision** – at the Royal Free Hospital, sufficient capacity would be accounted for to meet the demands for elective gynaecology activity.
- **Maintain cross-site working** – some services, such as gynaecological cancer screening, currently operate through cross-site networks and partnerships. These would be maintained and strengthened where possible.
- **Agree provision of emergency care** – as part of implementation planning, the scope of care that can be provided on site to pregnant women and people presenting to Royal Free Hospital would be agreed, and clear alternative pathways developed.

The detail on clinical services would be worked through in more detail as part of implementation.

Clinical pathways

- **Clarify emergency pathways –** we would work with the London Ambulance Service (LAS) and other stakeholders to ensure that there are clear pathways for emergency gynaecology presentations across NCL, and standard operating procedures (SOPs) defining what care could be delivered on-site. Patient transport would be considered as part of the pathway planning.
- **Engage with stakeholders regarding referral pathways –** as referral pathways can start from non-hospital environments, e.g., self-referrals or GP referrals, we would engage with primary and community care to ensure any changes are understood.
- **Communicate pathway changes to patients –** where pathways change significantly for patients, specific comms would be circulated to service users.

Workforce

- **Consultant job plans** – these would be revised on an individual basis, recognising the differential impact arising from different splits of work between obstetrics and gynaecology. Revised job planning could include further cross-site working within a single organisation, or

joint contracts between providers to support the retention of skills within NCL. We would also continue working with the workforce group to agree consistent arrangements for any TUPE transfers.

- **Support trainees** – implementation would need to ensure that trainees continue to be supported with consultant oversight and opportunities to gain exposure to both obstetrics and gynaecology across sites. This could include:
  - scope what the Royal Free Hospital currently offers in terms of basic and advanced level education opportunities
  - greater cross-site working to maximise access to training opportunities. If working patterns move to be cross-site, trainee facilities would be considered as part of planning e.g., parking spaces, lockers
  - move trainees to a weekly rota where they stay at the same site for 1-2 weeks to focus on a particular specialty (whilst maintaining trainee access to modules at other sites)
  - review proportion of senior clinicians who work at each site to ensure sufficient consultant support for juniors, and follow Royal College guidance about the number of trainees per consultant

If trainees do not have the opportunity to work an obstetrics on-call and a gynaecology on-call rota for each placement, they would be supported to get access to required experience to complete competencies over the duration of their placement.

11.4.6.3 *Early pregnancy units (EPUs)*

An early pregnancy unit (EPU) would still be provided at the Royal Free Hospital site. There are examples of other hospitals in London that have a gynaecology service without an on-site maternity unit. However, there are further details we would consider during implementation, including:

- **Clinical cutoff for service users:** currently Royal Free Hospital accept women up to 16 weeks, in line with NICE guidance. In line with other EPUs without on-site maternity unit, such as Ealing Hospital, we would expect the cut-off to reduce to up to 13 weeks, to ensure that any clinical risks are mitigated. The cut-off would be agreed as part of implementation planning.
- **Responsibility for patients:** as part of implementation, we would agree at what stage of pregnancy service users could move from being looked after by gynaecologists to obstetricians. We would also work to ensure that there is effective transfer of patient information from gynaecology to obstetrics for patients who start their pregnancy with support through the EPU.
- **Agreeing standard operating procedures (SOPs) for specific conditions and pathways:** we would work with clinical colleagues (including at London Ambulance Service) to identify and agree SOPs for specific conditions that may require pathways to be updated including onward referrals, e.g., ectopic pregnancies.

11.4.6.4 *Outpatient tongue tie service*

Tongue tie is where the piece of skin connecting the tongue to the bottom of the mouth is shorter or tighter than usual. In babies it may not cause any problems, but it can cause difficulties with breast or bottle feeding. Treatment may include a procedure to cut the piece of skin connecting the tongue to the bottom of the mouth. There is a tongue tie outpatient clinic located at the Royal Free Hospital which is staffed by specially trained midwives who undertake this treatment in babies. The service is supported by the paediatric doctors which cover the site. They are called upon in an emergency should it be needed after a procedure.

It is important that provision of this service is retained within NCL, and further work would be undertaken during implementation to understand the optimum arrangements for this clinic. Outside of the staff that support the clinic, there is no interdependency between the tongue tie service and on-site maternity services. Therefore our intention is to retain the clinic at the Royal Free Hospital.

11.4.6.5 *Neonatal retinopathy of prematurity screening*

Babies born prematurely (under 32 weeks) are at risk of developing Retinopathy of Prematurity (ROP), an eye condition which affects the blood vessels of the retina. Screening for this is undertaken by an ophthalmologist while babies are admitted to a neonatal unit. Screening for ROP is currently supported across all NCL neonatal units by the ophthalmology team from Royal Free Hospital. If our recommended option is agreed, there is no anticipated impact on this screening as it already takes place on an outreach basis by clinicians, and this would continue.

11.4.6.6 *Out of hours interventional radiology*

UCLH would be the accepting site for out of hours obstetric emergencies from the other NCL sites (Barnet, North Mid and Whittington). This means that Barnet and North Mid would transfer to UCLH, rather than Royal Free Hospital, as is currently the case.

Given that UCLH is already the centre for the more complex cases, and the number of emergency transfers for interventional radiology is very low, this would not significantly impact on the workload of UCLH. It may result in fewer than 5 additional people transferred to UCLH a year for out-of-hours interventional radiology (data shows less than five such cases going to Royal Free Hospital in 2022/23). We would expect most women and pregnant people who may need IR whilst giving birth to be picked up antenatally and give birth at UCLH.

Individuals would be transferred in line with the existing out-of-hours interventional radiology network pathway, if required. All sites would continue to have on-site IR cover on Monday to Friday between 9am and 5pm.

11.5 Workforce

Supporting and retaining our workforce through the next steps of the programme and the transition to new arrangements would be fundamentally important to the successful implementation of proposals. We recognise changes that take place over a long period of time can be particularly unsettling for staff. We have listened to the feedback from staff and want to ensure our workforce is provided with reassurance that we would be collaborating and working collectively to make sure that retaining our staff is the biggest workforce priority for us. We would do this by prioritising security of positions and supporting people to develop their careers within NCL.

Building on the aims of ‘One Workforce for NCL’ as set out in the NCL People Strategy[68], the proposed changes would reduce fragmentation and variation in staff experience across maternity and neonatal units and would build and encourage collaboration. This would help to reduce local competition for staff with skills and experience that are in short supply both nationally and internationally.

In order to address workforce challenges and develop appropriate workforce plans that would cover the duration of the implementation period, Chief People Officers from the Trusts impacted by the proposed service reconfigurations in NCL, along with nominated leads from their teams, have come together to form a Start Well Workforce Group, with one of the CPOs taking a system role for this work and joining the Programme Board. The Group has agreed consistent and

[68] https://nclhealthandcare.org.uk/wp-content/uploads/2023/07/NCL-ICS-People-Strategy-FULL-Final.pdf

collaborative approaches to address how we would make these changes while ensuring our staff continue to feel valued, informed and clearly communicated with at all sites, throughout the different stages of decision making and implementation.

Our approach is intended to ensure that sustained high quality, safe services would be maintained throughout implementation.

11.5.1 Feedback from consultation and assurance

We have already made efforts to ensure that staff have been involved in developing the proposals through careful communication and engagement as outlined in section 7.

During the consultation, people, including staff at potentially impacted trusts, were invited to contribute and feedback on the proposals being put forward. Feedback from the consultation related to workforce, and how we have addressed this, is shown in the table below.

What we heard	How we have addressed the feedback
During consultation, people asked for more detailed modelling on staffing levels and how any risk of staff not moving units would be managed	Future workforce requirements have been modelled based on 2024 workforce establishment and safer staffing guidance. The workforce risks and potential mitigations have been discussed with the CRG and are outlined in more detail in section 11.11.
During consultation, there were questions about the future of maternity training and maintaining positive training environments were also raised during consultation.	The CRG reviewed refreshed analysis and data for training placements to evaluate the potential impact on training, as shown in section 8.8.3.2. The NCL Chief People Officer group explored the practicalities and principles that would be required for implementing a new workforce model and identified risks and mitigations, as shown in section 11.4. We have identified a senior People professional within the ICB to support the programme around next steps, as shown in section 11.4. As part of the implementation planning a set of principles have been agreed through the Start Well Workforce Group which are endorsed by the Chief People Officers, as shown in section 11.5.2. This includes the ambition to retain staff in NCL organisations and make plans to enable flexibility of working moving across organisations within NCL.
In the consultation questionnaire, 56 respondents mentioned the potential impact on staff and staffing levels. Across both options, comments mentioned potential staff burnout from increased pressures at remaining four centres.	We have provided the NCL Staff Partnership Forum with a high level briefing on the programme. We expect to engage with staff networks and local Staff Partnership Forums at provider level to scope potential mitigations as part of implementation planning. We would

	continue to work with Trust CPOs to create a clear risk mitigation process for implementation, as well as agreeing the principles for implementation depending on which option is chosen.
In community events, concerns raised included redundancies, retention, whether staff would want to relocate, and how these changes will work in the context of other recruitment and staffing challenges	We reviewed our workforce information to understand any current workforce gaps and future workforce requirements at each unit. The number of funded staff establishment was updated to be reflective of the funded establishment position in March 2024 and the updated baseline was used to inform the potential impact on workforce and ease of implementation in the refreshed evaluation. Future workforce modelling provided reassurance that the workforce establishment across the system ensures safe staffing and is sufficient for some workforce groups, however other staffing groups, neonatal nurses and AHPs, would require an expansion in the funded establishment. During implementation, support would be made available to staff to support them through the transition. Further mitigations for potential workforce risks, including the risk that some staff might not want to move, have been captured in section 11.11.
The Mayor's Office recommended that we add detail about transfer of neonatal nurses and assess the impact of the change on units outside of NCL who have higher vacancy levels	Implementation of the recommended option would result in the transfer of neonatal nurses to units within NCL and potentially outside NCL where activity is projected to flow and there are vacancies. The potential transfer of neonatal nurses would be in line with the principles developed by the Chief People Officers and outlined in section 11.5.2. Opportunities to work in alternative units would be discussed with individuals and would align to career development and retention opportunities.
The Mayor's Office recommended that we add detail about workforce consolidation	Workforce requirements were modelled using the latest safer staffing guidance and updated funded establishment baseline. The future workforce requirements have been assured by NHSE London Region, see appendix F.
The Clinical Senate recommended that we ensure that new roles identified through the long-term workforce plan are considered as part of their assessment of our PCBC.	Workforce requirements and planning would take into account the opportunities for expanding the use of newer roles described in the NHS Long Term Workforce Plan. These are most likely to include, but not limited to, Advanced Practice Clinicians and Nursing

	Associate. The Anchor organisation status of Trusts within NCL enables. The long term nature of the Start Well Programme means that there are opportunities to increase social mobility and representation from local populations by developing access through healthcare apprenticeships.
During consultation, people asked for more detailed modelling on staffing levels and how any risk of staff not moving units would be managed	Future workforce requirements have been modelled based on 2024 workforce establishment and safer staffing guidance. The workforce risks and potential mitigations have been discussed by the CRG and are outlined in more detail in section 11.11.

11.5.2 Key workforce related principles

Whilst further work would be required to develop detailed plans, an initial set of commitments has been agreed through the Start Well Workforce Group, which has been endorsed by the relevant organisations' Chief People Officers. All future work would be undertaken with these commitments in mind:

- Maintaining **safe staffing** levels throughout all phases of implementation would be a key priority to ensure staff are safe to deliver high quality care to pregnant women and people, families and their babies
- Maintaining **high quality** services that meet professional standards throughout the change programme would be essential
- **Retaining staff** in the organisations within NCL is of the utmost importance. Any approaches taken would aim to ensure that staff feel valued and reassured about the options and opportunities for their continued future as a member of the NHS workforce in NCL. We would share **vacancy information and work collaboratively** to ensure these are filled.
- **Workforce data would be shared** in a transparent and consistent manner, and in compliance with data protection legislation, to enable workforce planning to deliver safe care
- Wherever possible plans would be made that enable **flexibility for staff** to ensure both their needs and those of the patients are met
- **Consistent messages to Trade Unions** would be provided through engagement and consultation in local Trust staff side forums and the NCL Joint Staff Side Forum
- Ensure **regular clear communications and engagement with staff** who are likely to be impacted by these changes takes place and that the messages are consistent across impacted organisations
- We would aim to agree common **learning and development opportunities** are provided across organisations to staff impacted by the changes, so we ensure staff are continuously developed and provided with the skills and experience needed during the changes
- We would aim to review the **wellbeing offers** that are provided in organisations for impacted staff by these changes, ensuring support is prioritised for this group
- Wherever possible, **costs related to workforce related matters would be minimised**

11.5.3 Workforce as a driver for change

Our workforce challenges are reflective of a wider national challenge including expected gaps in the future skills mix for certain specialties without changes in ways of working, as shown in section 4.5.

During implementation, we would consider in more detail local and jointly developed plans between the Trusts involved. It is well understood that there are challenges with workforce supply nationally, particularly for midwives and neonatal nurses, so all parties would want to ensure we are fully focussed on ways to both support and retain our workforce. There would be opportunities to consider skill mix, types of role and ways of working in all specialty areas; maternity, obstetrics, AHPs and neonatology, which provides exciting potential for us to develop our services, and for our staff to develop their careers within NCL. Development of these options would be led through discussions driven by clinicians and professional leads in the relevant supporting groups.

11.5.4 Developing detailed workforce plans

It would be incumbent Trusts to develop specific workforce plans, covering activities such as recruitment and retention campaigns, consideration of the impact on training posts, learning and development offers, redesign of roles and skill mix to deliver services. These activities would not be undertaken in isolation. The nominated CPO Start Well lead would support work with colleagues across the impacted Trusts and the ICB to develop plans in a collaboration.

Some key areas have been agreed through the Start Well Workforce Group and endorsed by the Chief People Officers as those that would most effectively be delivered on the basis of consistent and collaborative approaches:

Planning for implementation

- **Workforce profile development** – joint work to develop an understanding of the workforce profile for each Trust and professional group impacted by the changes so that specific issues, such as age profile and retirement, could be planned for and addressed at the earliest opportunity.

- **Workforce data sharing** – to enable effective workforce planning there is an agreement in principle to sign up to a data sharing agreement and agree common data sets, recognising the need to comply with data protection legislation. Wherever possible the data shared would be integrated with activity data both historical and real time to enable appropriate planning to meet staffing needs at all sites.

- **Education, learning and career development** – to support the aim of retaining staff in NCL, there is an agreement with the Start Well Workforce Group and relevant professional education teams, OD and clinically led groups that would prioritise common learning and development offers and establish clear career pathways. This would mean that staff who would be impacted could see how changes could lead to opportunities to develop in different, new or enhanced roles across organisations in NCL. Work would be undertaken with professional education leads and key teams to ensure that education programme criteria and continuity of training would be maintained, alongside provision of opportunities to further increase knowledge, skills and experience for staff at whatever stage of their career.

- **Access to wellbeing support** – all organisations that would be impacted by the changes would have similar support offers in place for staff who may be affected by the change and the feeling of insecurity that may bring. These would include access to Employee

Assistance services, Occupational Health, Well Being Apps, Freedom to Speak up Guardians and Trade Union member support services.

Implementing workforce changes

- **Organisational change consultations** – it is agreed that, where any formal staff consultation is required around workforce changes, the impacted organisations would follow consistent approaches to engagement with their workforce consultation forums to ensure smooth and safe transitions of services for the benefit of both staff and patients.

11.5.5 Training and education

We aim to make every unit in NCL a good place to work and train. Through the proposed changes, we would be able to enhance the experience of our trainees. We are committed to continue to provide training and development opportunities across all sites in NCL. Continued liaison with education staff would maintain continuity of training and optimise opportunities for staff to further improve skills and experience. Where specific workforce has been identified as being potentially impacted, we have outlined below the approach to implementation.

11.5.5.1 *Approach to implementation for all resident doctors*

Resident doctors are an important and valued part of our workforce. We would support resident doctors across specialties, both for those working directly in these services and those working in services that support them.

The long lead time for implementation means we would have sufficient time to plan carefully and minimise disruption for resident doctors. We would continue to involve NHSE Training Education leads, Heads of School, Training Programme Directors and Trust medical education departments in implementation planning.

Our primary focus would be on maximising training opportunities and minimising disruption during transition. We recognise the importance of keeping resident doctors involved throughout implementation planning. Where possible, we would involve resident doctors or their representatives at relevant points in implementation planning.

For certain specialties, a pan-London view would be considered (e.g., some anaesthetics trainees also rotate in North East London).

11.5.5.2 *Anaesthetic training*

To minimise the potential impact on anaesthetic training we would:

- Review rotations to ensure that resident doctors would continue to have and obstetric placement at each stage of anaesthetic training in line with College requirements
- Work with other NCL hospitals during implementation planning to support trainees in achieving the required obstetric competencies
- Involve head of school and training programme directors during implementation planning and consider rotation start dates to minimise disruption

Royal Free Hospital has a range of specialties on site that support anaesthetics training, so in principle may be able to retain its existing resident doctor posts.

11.5.5.3 *Paediatric training*

Royal Free Hospital manages a training rota for resident doctors at level ST1-3. As part of their duties, they support the current special care unit (SCU). For those on a paediatric training

programme, this is part of their service commitment only, and does not represent part of their training. Royal Free Hospital currently do not have any support from middle-grade doctors. This is because of the low utilisation of the neonatal unit and because Royal Free Hospital currently only have an SCU (level 1) so resident doctors do not have significant exposure to neonates during on-site training.

Royal Free Hospital also hosts resident doctors at FY2 doctors and at ST1-3 on General Practice training programmes. Both groups currently contribute to the cover of the SCU, but this activity is not required for their training and reduces their exposure to other training opportunities.

As part of implementation, we would continue to work with the Head of School for Paediatrics and the Trust's training and education leads to ensure that we continue to provide high-quality training for all resident doctors, recognising these differ for different groups. As a valuable part of the workforce, these resident doctors have an important role in delivering inpatient, outpatient, emergency and community paediatric care. We would ensure that all resident doctor posts are retained where possible, with scope to adjust paediatric rotas and rotations across hospitals to align with activity requirements and access to LNU (level 2) neonatal units where required for training purposes. We would address any implications for paediatric training early in implementation planning, including agreeing who in the governance structure would be responsible for implementing relevant mitigations.

11.5.5.4 *Neonatal nurses*

Implementation of the recommended option would result in the transfer of neonatal nurses to units within NCL and potentially outside NCL where activity is projected to flow and where there are vacancies. The potential transfer of neonatal nurses would be in line with the principles developed by the Chief People Officers and outlined in section 11.5.2. Any potential availability of the neonatal nursing workforce to units outside of NCL could potentially have a positive impact on neighbouring units where there are existing vacancies.

11.5.5.5 *Allied Health Professionals (AHPs)*

Additional recruitment across AHPs would be required if the recommended option was implemented. The Neonatal ODN have an existing strategy to support local units to increase the number of AHPs across neonatal units. Through implementation, we would work with the specialist lead AHPs to continue this effort at local units that remain open.

11.6 Digital

We aim to promote the use of technology in line with the ICS vision of helping our residents to live the fullest lives possible and tackling health inequalities. By working in partnership to harness the latest digital technology and joined-up information, we would ensure pregnant women and people could access the right care quickly and effectively. In tandem with the NCL digital programme, work has been undertaken through a dedicated digital workstream in the NCL Local Maternity and Neonatal System (LMNS) to digitally transform maternity services by developing a clear strategy and improving data quality.

The current maternity and neonatal digital landscape is a relatively complex one, with multiple systems across the trusts. Some sites are more digitally advanced and operate with a single electronic patient record system across the organisation whereas others are more fragmented with multiple systems being used across perinatal services, supported by manual processes. The range of IT systems across NCL means that we need to target a consistent baseline of data available across all trusts, that is supported by operational interoperability both within and across the trusts. This would support the sharing of data which is currently a challenge.

Digital is a key consideration as part of the implementation of the Start Well programme to ensure that the care model can deliver high quality, safe care by providing accurate information, improving data visibility at the point of care and being able to audit and plan services according to need through accurate reporting. Improving the digital landscape would allow us to support strategic priorities using high quality data and efficient, accurate reporting.

Through the LMNS digital workstream, we have considered how interoperability could be improved and a standardised data set for maternity agreed. We have developed a set of opportunities for improvement, which were co-created as part of this work by clinical, managerial and digital colleagues from across all trusts and the ICB.

We have identified a number of ways digital could support the implementation of the proposed care model. Some areas are being considered or progressed as part of system digital and data plans, some have dependencies on pan-London work – others we would consider as and when funding becomes available. The areas identified include:

- Become paperless and improve community IT connectivity
- Automate production of data to improve data quality and increase efficiency
- Create a standardised ICS system wide data repository for perinatal data
- Develop standard reporting within the Trusts and across the system
- Improve operational access to systems within Trusts
- Improve operational visibility of information between trusts and organisation
- Develop ICS-wide best practice and improvement platform
- Invest in the required supporting enablers for success

The ICB is working through the baseline report to understand it and to agree an action plan to begin addressing the recommendations as part of an NCL wide approach through the LMNS.

The programme would also support the work that has been done to prioritise specific opportunities to allow for smooth implementation:

1. Eliminating paper collection of information from perinatal services to reduce clinical risk
2. Additionally, all Trusts should identify the areas where paper is being used in the workflows and work with the EPR providers to eliminate this manual process, including providing/developing offline functionality for community midwives to be able to treat patients and record their care efficiently
3. To improve reporting processes at trusts and across the ICS to aid with auditing and service planning. Agree the 40 key NCL LMNS metrics for reporting and ensure trusts record these metrics mandatorily with 100% data completion.
4. Opportunity for Trusts to ensure that interfaces ‘pulling’ data are automatic, to the agreed standard and is stored in their local data warehouses.
5. Consider developing a centralised data warehouse for perinatal data, that is hosted by the ICB and holds the key perinatal data. This would allow for the data to be used to support key strategic priorities and enable system-wide working and reporting.

This work is aligned to wider LMNS Equality and Equity action plan, with maternity and neonates data included as a key consideration.

11.7 Sustainability

In section 9.5.4, we show the potential impact of the recommended option from a sustainability perspective. During implementation, we would seek to ensure that sustainability is embedded

through all workstreams, and that opportunities are taken to make services as sustainable as possible. This would draw on the NCL ICS Green Plan[69], as well as each trust's own green agenda, which focus on carbon reduction strategies. Delivering this change could provide a real opportunity for our services to be made more sustainable. Areas that we would explore during implementation include:

- How greener staff and patient (where appropriate) travel to hospital could be promoted.
- Ensuring that appointments would be offered in community settings or virtually, to reduce emissions from travel to hospital sites.
- How building work required to implement changes could be done in the most sustainable way.
- Considering how any new building capacity could be made as energy efficient as possible.
- Ensuring that building capacity would be used effectively - we know that some of our capacity is currently underutilised, and if this could be repurposed or used differently it would have a positive impact on sustainability.
- Considering how emissions from leaking anaesthetic gases, particularly nitrous oxide - otherwise known as 'gas and air' - could be minimised. This may involve providers considering how their gas is supplied.
- Climate resilience of services considering our changing climate, and how these could be mitigated against - for example trust contingency plans around flooding or heatwaves.

11.8 Finance

11.8.1 Feedback from consultation and assurance

What we heard	How we addressed the feedback
The Mayor's Office recommended that we confirm how stranded costs would be managed within the local health economy.	Royal Free London would work to mitigate short and medium term costs that are identified as a result of no longer providing maternity and neonatal services. Short term costs would be managed through actions that could be completed within a year, such as contract renegotiation, or they are costs which are variable with activity and can therefore be stopped as activity stops. Potential mitigations for the medium term (up to 5 years) costs have been developed to eliminate these costs and ensure they are not stranded. These include reviewing equipment lifespan contracts and aligning workforce to the activity through turnover and staff contracts given the long programme lead in time. Potential mitigations for long-term overheads costs have been outlined at

[69] https://nclhealthandcare.org.uk/wp-content/uploads/2022/04/North-Central-London-Green-Plan-2022-2025.pdf

	Royal Free Hospital in option A as it is assumed that these costs would not be realised if another service were to move into the vacated unit space. This would be managed by Royal Free London through exploring activity which could potentially replace maternity and neonates on the site which has a similar contribution, involving the ICB. Management of long-term CNST stranded costs would be agreed in discussion with the affected Trust. Further detail on stranded costs is shown in section 11.8.4.
The Mayor's Office recommended that we provide further detail on financial flows across the wider health economy and confirm that funding is in place at NWL provider level to meet the needs of people living in Harlesden and Willesden, informed by the additional modelling requested.	The changes proposed would impact on patient flows from both NCL and NWL and would change where care is provided. We have agreed a principle of funding follows the patient to support the implementation of Start Well changes. It therefore naturally follows that we would need to adjust the activity plans and financial values for those providers who would see their activity increase or decrease brought about by the changes to ensure that the services, wherever they are delivered and whoever they are delivered by, are funded sustainably. Whilst the final approach for agreeing the revisions to activity and finance plans is still to be agreed it is likely that this would involve re-baselining contract values based on predicted activity changes and then adjust them retrospectively for actual activity seen for a period of time noting that overall the funding envelope is not expected to increase until there is certainty that activity is correctly, safely and sustainably funded at each site where care is provided. The principles that are set out in section 11.8.5.
The Mayor's Office recommended that we perform additional modelling to robustly explore the knock-on effects resulting from removal of obstetrics services and potential relevant allied services; use this to demonstrate the impact on wider hospital services.	The potential stranded costs associated with removing obstetric services have been calculated using PLICS data. Mitigations can be found in section 11.8.4.
The Mayor's Office recommended that we perform additional modelling based on people living in the impacted areas of NWL ICS, confirm that this modelling has been	Activity and capacity modelling approach was updated to reflect the projected demographic changes of non-NCL boroughs and local authorities which had

used to inform conversations with providers in NWL and demonstrate that these providers will have sufficient resource to cater for the relevant population need. If need-related resource gaps are identified, detail should be provided on how these will be addressed.	over 100 deliveries across any NCL units in 2023/24 and therefore includes populations beyond NWL. These populations are Hertsmere, Brent, Hackney, Harrow, Waltham Forest, Broxbourne, St Albans, Westminster, Welwyn Hatfield and Tower Hamlets, and the projected population changes have been applied at a local authority level. The non-demographic growth assumption for deliveries has been refreshed to project deliveries at a borough and age band level using the updated populations. The updated approach projects the expected proportion of delivery types forward over 10 years and applies these projected proportions to the projected deliveries to provide a strengthened understanding of future complexity. Refreshed modelling has outlined the potential flow of activity to NWL providers in the recommended option and NWL have confirmed they have sufficient capacity across the ICS to accommodate this flow.
The Mayor's Office recommended that we describe how to join up funding made available from standards review as well as Start Well-specific investment with implementation plans	The future staffing would be in line with best practice standards, aligned to Ockenden and saving babies lives. There would be a greater likelihood to meet standards with 4 units rather than 5 and investment at RFH would transfer as deliveries flow to other units.
The Mayor's Office recommended that we perform sensitivity checks on the approach to modelling future births and neonatal complexity	As part of the modelling, we performed sensitivity analysis on using different demographic growth data sources (GLA as compared to ONS). This analysis outlined that using the GLA data source for demographic growth would still reduce the number of deliveries across NCL.

11.8.2 Capital requirements

Delivering the required capacity and estate requirements is critical and the capital investment would be funded within the ICB CDEL envelope and through the organisations involved. The capital requirement and draw down in the recommended option can be seen in Figure 61.

	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	Total 30-year forecast
Total	**£4,874,056**	**£13,011,230**	**£18,342,283**	**£13,998,902**	**£10,142,238**	**£9,436,946**	**£85,403,555**

Figure 61: Capital requirements and phasing for the recommend option (cash terms)

Each provider that has a capital requirement would require an OBC and FBC to be completed which would be managed by Trust teams and would be in line with the guidance set out by HMT Green Book and NHSE. As the capital requirements at Whittington Hospital exceed £25m, an OBC and FBC in line with HMT Green Book would first require NHSE approval, whereas at sites where the investment required is less than £25m only Trust board approval is required. Following NHSE approval, the OBC and FBC would require approval by HMT as the capital requirement exceeds £50m.

11.8.3 Transition costs

The impact of the proposal has been modelled to show that the changes would be affordable. As changes are made, there would be expected to be some costs associated with transition. These include:

- Programme team of £1.0m to support decision making and implementation of the programme over at least 24 months
- Communication and engagement of £0.2m to communicate the proposed changes to the public and community workforce.

The expected capital costs to deliver the enabling schemes are captured within the capital costs. At this stage, there are no double running costs which have been identified that would impact on the financial case. Any double running costs would be identified during implementation planning from a clinical, workforce and operational perspective. The management of any identified double running costs would be considered by the Finance and Analytics Group in partnership with other relevant working groups.

11.8.4 Stranded costs

The total stranded costs associated with maternity and neonatal services at the Royal Free Hospital have been identified and are split between short term (less than a year), medium term (up to 5 years), and long term (up to 10 years). The finance and analytics group agreed which of these costs would be stranded and developed potential mitigations for the other costs. The value of annual stranded costs at the Royal Free Hospital would be £3.8m.

The Finance and Analytics Group agreed that given the lead in time for the proposed changes of the work, any short term costs that were identified for maternity and neonatal services were not stranded and work would be done to eliminate these costs. The group agreed that short term costs could be mitigated as they either require an action which could be completed within a year such as contract renegotiation or they are variable with activity and could therefore be stopped as activity stops.

Potential mitigations for the medium term (up to 5 years) overhead costs have been developed to eliminate these costs and ensure they would not be stranded. These include reviewing equipment lifespan contracts and aligning workforce to the activity through turnover and staff contracts given the long programme lead in time. These costs would therefore not be stranded.

Potential mitigations for long-term (up to 10 years) overheads costs have been reviewed and it was agreed that the Royal Free London would explore activity which could potentially replace maternity and neonatal on the site with a similar contribution. Royal Free London and the ICB would need to agree the activity in order to mitigate the overhead. The mitigations have been developed and included below in Figure 62.

Category	Expenditure type	Time stranded	Potential mitigations identified
Direct	Depreciation	Medium	Review lifespan of each of equipment contracts, review subletting or transferring asset to sites that remain open or writing off asset depending on useful life
	Pay	Medium	Review the actual split of workload between paediatrics and neonates along with requirements to fulfil ED presence to confirm if this can be mitigated and look at natural turnover and staff contracts to align only to remaining activity
Overheads	Overheads	Medium and long	Royal Free London (RFL) to explore activity which could potentially replace maternity and neonates on the site with a similar contribution. RFL and the ICB need to agree the activity in order to mitigate the overhead
CNST	CNST	Long	No mitigations identified

Figure 62: Potential mitigations for stranded costs

The long term clinical negligence scheme for trusts (CNST) costs have been included as stranded with no potential mitigations identified due to the long lead in time of historic claims that contribute to the CNST premiums. These annual stranded costs have been included in the benefit cost calculation, as shown in section 8.8.5.2. Only 60% of the annual CNST has been included, which reflects the aspect of the premium that is based on historic claims, the remaining 40% has been included as a short term cost that would not be realised as the site would no longer deliver maternity services.

11.8.5 Contracting

The changes proposed would impact on patient flows from both NCL and NWL and would change where care is provided. We have agreed a principle of funding follows the patient to support the implementation of Start Well changes. It therefore naturally follows that we would need to adjust the activity plans and financial values for those providers who would see their activity increase or decrease brought about by the changes to ensure that services, wherever they are delivered and whoever they are delivered by, are funded sustainably. Whilst the final approach for agreeing the revisions to activity and finance plans is still to be agreed it is likely that this would involve re-baselining contract values based on predicted activity changes and then adjust them retrospectively for actual activity seen for a period of time noting that overall the funding envelope is not expected to increase until there is certainty that activity is correctly, safely and sustainably funded at each site where care is provided.

11.9 Partnership working

Across NCL there are existing partnership arrangements between providers who collaborate as part of the NCL Local Maternity and Neonatal System (LMNS), implementing local and national safety initiatives to reduce still births, neonatal deaths and maternal mortality and morbidity. Collaborative working between providers helps to ensure safe and effective management of the capacity across units.

As part of implementation existing collaborative working arrangements would continue and there is an opportunity to strengthen these to ensure we could safely manage demand across NCL and work together to improve the quality of our maternity and neonatal services.

11.9.1 Whittington and UCLH collaborative working

UCLH and Whittington collaborate together as part of the NCL Local Maternity and Neonatal System (LMNS) implementing local and national safety initiatives to reduce still births, neonatal deaths and maternal mortality and morbidity. There is a focus on specialist care pathways for babies requiring enhanced level 3 neonatal services, promoting access to personalised care and access of services of vulnerable families, and those requiring maternal medicine and fetal medicine specialist teams. The space provides opportunities for sharing learning from incidents and good practice pathway and identifying new areas for quality improvement across the sector.

UCLH and Whittington clinical teams have been working collaboratively for a number of years and in particular during the Covid pandemic. The partnership has been strengthened around key pathways including maternity, uro-gynaecology and fetal medicine. Whittington provide post-natal community midwifery in Islington and Haringey for women who have chosen to give birth at UCLH.

The aim of the maternity collaboration is to provide the best care locally for mothers and babies and this would continue. This includes the safe and effective management of capacity across both sites. The collaboration ensures that:

- there is sufficient capacity for women and babies with complex specialist needs[70] and those requiring level 3 neonatal care to give birth at UCLH;
- patients booked at UCLH which require services provided at Whittington have the additional choice of Whittington as a site of care provision;
- preterm babies less than 27 weeks are transferred from Whittington to UCLH
- there is streamlining of termination services with Whittington providing a surgical miscarriage and abortion service for UCLH

11.9.1.1 *C-section pathway*

Given the pressure for specialist capacity at UCLH, both teams introduced a new joint pathway for planned caesarean sections in 2023 with some mutual aid provided during the Covid pandemic. This involves joint booking of obstetric patients with information given to both UCLH and Whittington patients about shared pathways detailing a low risk twin pathway which may involve UCLH patients being transferred to Whittington for consultations and delivery. Similarly higher risk patients at Whittington are involved in a pathway which may involve delivery at UCLH. To facilitate the transfer of care read only access of UCLH Electronic Patients Records is available to Whittington clinical teams.

An important element of the pathway is that the teams set expectations early with patients about ways of working between both organisations and what this may mean for their pathway / delivery. A range of communication tools are deployed to help ensure mothers and their families are aware of the pathway including patient leaflets and information on the trust's website.

11.9.1.2 *Fetal medicine*

The Whittington Preterm Birth Prevention Clinic occurs in the fetal medicine unit and is currently delivered by two consultant obstetricians. The service has been designed in alignment with the UCLH service led by the Professor in Obstetrics and Maternal Fetal Medicine and the Saving Babies Lives Care Bundles.

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[70] Specialist needs include abnormally invasive placenta (AIP) cases

The teams closely collaborate over complex cases for tertiary advice and refer to UCLH for patients requiring transabdominal cerclage. As part of the preterm network the teams regularly meet for joint learning opportunities. Surgical miscarriage and abortion care for pregnancy or fetal complications is provided by Whittington for UCLH. This pathway was set up for the management of second trimester surgical terminations of pregnancy (up to 23+6 weeks) across NCL.

11.9.1.3 *Joint approach to theatre capacity*

The collaboration has been considering how to manage theatre capacity across both trusts in an effective way. This has included forward planning around capacity and likelihood of periods of high demand and how this could be managed between the sites proactively.

The Trusts have sought opportunities to build collaborative pathways for gynaecology procedures with Whittington providing mutual aid to UCLH as the obstetric service is supported by a strong gynaecology service. Additional lists are planned once Whittington has completed its theatre upgrade (expected in April 2025).

11.9.1.4 *Future plans*

The maternity collaboration has achieved a great deal demonstrating how well the teams already work together for the benefit of the local population. We would continue to build on exciting collaborative arrangements to ensure that mothers receive excellent care in the most appropriate location. Future plans would include:

- expanding the planned C-section pathway between UCLH and Whittington
- establishing a new planned induction pathway to transfer patients from UCLH to have their end of pregnancy care at Whittington
- building on current patient records access ultimately aiming for a shared patient record.
- offering joint antenatal education to patients
- development of a joint perinatal pelvic floor service with Whittington urogynaecology involvement
- expanding the surgical miscarriage and abortion care services between Whittington and the fetal medicine service
- developing a formal pre-term pathway between Whittington and UCLH to allow seamless transfers between sites and reduce the distance for patients to travel
- greater collaboration and formalising pathways for sickle cell pregnant patient
- designing a joint clinic for post preterm birth preconceptual counselling for families affected by preterm birth

The collaborative is committed to the closer alignment of services to ensure the best pathway for mothers and babies. The aim is a seamless experience so mothers and babies are confident they would receive the same care at both places so demand could be effectively managed in the south of NCL.

11.9.1.5 *Governance arrangements*

Existing governance arrangements are in place and this would continue. The joint work on maternity pathways reports into Whittington and UCLH's collaboration board which meets bi-monthly and is chaired jointly by the Chief Executive Officers for both Trusts. Theatre capacity is overseen by the Southern Surgical Hub which is responsible for the management of planned pathways across the two Trusts. The meeting is held monthly and is jointly chaired by Whittington's Chief Operating Officer and UCLH's Medical Director.

Quality oversight and assurance is provided by the NCL LMNS and UCLH and Whittington teams ensuing that there are:

- standardised clinical guidelines and policies aligned across both hospitals based on the latest research and evidence
- escalation policies for emergencies.
- consistent approaches to safeguarding and risk assessment

11.9.2 Barnet Hospital and North Mid

The Royal Free London merger with North Mid on 1January 2025 enables the organisation to go further and faster in providing better, more sustainable, and equitable services, including working together beyond hospitals and organisational boundaries. There is an opportunity through this merger to reduce waiting times faster through combining and sharing resources to treat more patients, provide more specialist care locally and extend some pathways into community services to provide more co-ordinated care for patients. Patients will also have greater access to the latest medical research and local people will get more help to spot, prevent, and address health problems earlier, with services better designed to meet local needs.

The merger provides a significant opportunity to expand the number of Clinical Pathway Groups (CPGs) at North Mid and optimise and standardise the way care is delivered across the Trust. CPGs have been pivotal in reducing unwarranted variation and improving clinical outcomes at Royal Free London. For example, the neonatal CPG's work led to a dramatic reduction in the number of babies being separated from their mothers after birth. The team developed a criteria-based standardised assessment tool to support decision making. The new pathway resulted in a 34% reduction in neonatal unit admissions. This means over 300 more babies per year are able to stay with their mothers rather than be admitted to the neonatal unit. A shared electronic patient record will be a critical enabler for our CPG plans.

Group members 'health units' (North Mid, Royal Free Hospital, Barnet, Chase Farm Hospital) have strong local clinical leadership. Each member has a local executive committee and its own chief executive responsible for local performance and quality, reporting into the group trust board. The local chief executives are also voting members of the group trust board. This clinical operating model ensures we maximise the advantages of being part of a group where clinically appropriate while supporting strong clinical and operational leadership at site level. Services are managed in one of two ways:

- **within the health unit**: services are managed on the site where they are delivered by the health unit executive team e.g. emergency department.
- **across health units**: one health unit is responsible for managing the service across the group on multiple sites e.g. maternity services. The clinical operating model will have North Mid health unit managing children's services across the group, and Barnet health unit will manage women's services across the group.

This enables delivery of the best care possible for patients, while realising the benefits of working as a group and reduce variation in patient outcomes and experience.

In July 2024 North Mid joined the Maternity Safety Support Programme (MSSP) following the CQC rating of maternity services as in adequate. The MSSP was set up nationally in 2018 in response to the Secretary of State request for targeted support for units that were rated inadequate by the CQC and in light of the national drivers (e.g. MTP/ Kirkup Inquiry/SATH). The aim of the MSSP programme is to support Trusts to instil 'sustained quality & safety changes leading to improved outcomes'.

North Mid's maternity services, as part of the Royal Free London group, is working in partnership with the MSSP to improve the quality of care and outcomes for the population that they serve.

11.10 Stakeholder engagement

Working with trust communication teams, as well as partners in the community, we would extensively communicate the changes to both staff and impacted service users. This would need to be inclusive and co-ordinated, ensuring that those populations that are harder to reach receive the same information and that the information is accessible to all groups, including those with protected characteristics. Our communications and engagement would include the following groups:

- **Patients, public and wider stakeholders:** to ensure that patients and wider stakeholders (such as MPs and local authorities) are well informed about what changes are proposed and how it would impact on them and could contribute to co-design of the implementation plans as appropriate. We would focus on specific groups that we have identified as being potentially impacted by the proposals including the Orthodox Jewish community, the population of Harlesden and Willesden and pregnant women and people with complex or high risk pregnancies (see the integrated impact assessment for more details).
- **Providers:** would be taking a lead in the planning and implementation of service change, particularly to support service change impacts that need to be implemented smoothly across multiple trusts.
- **NHS staff:** would be actively engaged to support and retain them throughout implementation of our proposals. We want to ensure our workforce is provided with reassurance that we would be collaborating and working collectively to make sure that retaining our staff is the biggest workforce priority for us. We would also build awareness of the proposals and to consider and promote their central role in making these changes happen, so that they could contribute to co-design of the implementation plans as appropriate.
- **Clinicians:** would need to be actively involved in the planning and implementation of service change to ensure patient safety is not compromised as changes are made. They would also need to contribute to co-design of the implementation plans as appropriate.
- **Other stakeholders:** to actively engage with other relevant stakeholders including neighbouring ICBs, the Health Overview and Scrutiny Committees, Members of Parliament, local councillors, council officers, Greater London Authority General Assembly members, relevant professional bodies and education providers.

11.11 Implementation risks

11.11.1 Approach to risk management

Effective risk management is imperative not only to provide a safe environment and improved quality of care for patients and staff, but also for the management and planning of publicly accountable health services. The consolidation of clinical services across organisations brings risks which would need to be carefully managed throughout implementation and beyond.

The risk management process involves the identification, evaluation, and mitigation of risk as part of continuous practice aimed at reducing the incidence and impact of risks, which may include

risks related to patients, people, performance, and partnerships. Risk management is therefore a fundamental part of both the operational and strategic thinking of every part of service delivery.

Risk management would be undertaken on an ongoing basis to monitor the transition and early years of implementation. It would be integral to ensure that risks are managed both at an ICS and trust level and that there is connectivity between risk registers held between organisations. This would ensure that ambitions can be met, any unintended consequences can be highlighted, with mitigating actions swiftly agreed.

11.11.2 Programme risks

Service change brings a number of operational risks that would need to be monitored and carefully managed. Risks have been identified across all levels within the Programme and have been captured on a central risk register which is owned by the Programme team. During implementation the Start Well Programme Board would review the risks to delivery on a regular basis and own the risk register, supported by the Maternity and Neonatal Operational Implementation Oversight Group who would own the operational risks.

The table sets out the key risks identified to date and proposed mitigations.

Category	Risk	Mitigations required	Metrics to monitor
Quality	Quality and safety of current services at the closing unit is not maintained due to destabilisation through the implementation process	• Work with other units in NCL to help support the impacted unit and provide resource as needed • Ensure communication with staff impacted is clear and undertaken early. Provide reassurance there are opportunities to move to another unit and the benefits of the proposed changes.	• Bookings data • Deliveries and neonatal cots days by unit • Vacancy rates by staff group • Staff turnover • Training and education uptake • Staff sickness • Bank and agency usage • Number of Opel escalations
	During the transition, pregnant women and people do not choose to deliver at the closing unit and overwhelm the other units in NCL which are common in both options	• Ensure clear and early communications to the public which outline the timeline of proposed changes. Specifically engage with those who are booked in to deliver at closing unit. • Monitor the activity and bookings at alternate units in NCL to ensure there is capacity to deal with any potential additional activity • Utilise existing collaborative working between units to help manage demand	
Workforce	Units across NCL are unable to recruit	• Communicate the implementation timeline and	

	as a result of the proposed changes	future job prospects with potential candidates • Work with ICS to explore offering NCL roles, rather than organisational roles	
	Workforce decide to leave the closed unit and destabilise the unit	• Monitor the vacancy rates at the closed unit and other units • Staff from across the system support the closed unit should there be challenges in retaining existing staff	
Capital	Based on historic trends and economic instability inflationary impact may be higher than expected and result in understated capital estimates	• Prudent inflationary assumptions have been used • The Programme Board would continue to monitor any changes to the financial projections • Phasing of capital schemes could be updated if needed	• PUBSEC inflation values from NHSE • RICS inflation values for comparison to PUBSEC • Estimate value of capital programmes at each site • Progress of build programmes at each site
	Capital requirements may be higher and not affordable in the NCL ICB CDEL envelope	• Assumptions used in determining capital requirements have been prudent and account for the relative stage the capital plans are at. The cost per m^2 have been benchmarked against other schemes which have been recently delivered. All capital requirements include significant contingency values (between 30-40%). • Phasing of capital schemes could be updated if needed	
	Capital requirements agreed may not be sufficient in the future and the builds at each site may be reduced which would impact on the quality of the estate	• All capital requirements include significant contingency values (between 30-40%) • Phasing of the capital schemes could be updated if needed	
Stranded costs	The value of stranded costs may be greater than as modelled. Also, some of the short- and medium-termed	• Prudent modelling of the stranded costs has been completed • Detailed analysis of short, medium and long term	• Provider cost data (e.g. PLICS) reviewed through the finance and analytics group

	costs may not be able to be mitigated as modelled	stranded costs has been undertaken • Stranded costs would be closely managed at the provider level to mitigate risk • Explore activity that could potentially replace maternity and neonatal on the site with a similar contribution. Provider and the ICB would need to agree the activity.	• Compare to detailed list of stranded costs identified at DMBC stage
Revenue affordability	The proposed changes to maternity and neonatal services may not be affordable from a revenue perspective	• The proposals are more affordable than maintaining the current position across NCL outlined by the positive BCR • Sensitivity analysis has been completed on the % of the benefits that would be realised, the PDCD % that is used and the capital costs	• Activity levels at providers

11.12 Implementation timeline

The feedback from the consultation has shown that there is support for our case for change and care model for maternity and neonatal services. Through a robust evaluation process, we have identified the best solution to address the challenges and deliver our ambition. We have tested the proposal through public consultation and further work has been undertaken to understand the feedback received, determine if this impacted our evaluation of the options and how the proposal should be implemented.

Trusts across NCL would be asked to implement the recommended option and maternity and neonatal services at Royal Free Hospital would be closed. We would continue to have a role in ensuring that all Trusts implement the recommendations, the mitigations developed as part of the IIA and continue to monitor the impacts on the community.

Implementation would be overseen by the Start Well Programme Board and operational oversight through the Operational Implementation Oversight Group. As NHSE London Region Specialised Commissioning are delegating responsibility for the commissioning of most relevant services[71] to NCL ICB on 1 April 2025, oversight of the implementation process would be the responsibility of NCL ICB working in partnership with NHSE and other London ICBs and drawing on the skills and expertise of the Specialised Services Shared Commissioning Team (SSSCT). Dedicated expert workstream groups would be mobilised to work through specific aspects of the implementation plan including workforce, finance, digital and patient engagement and IIA mitigations. Further detail on the governance structure to support implementation is set out in section 11.2.

A high level implementation plan is outlined in Figure 63.

[71] Excludes open fetal surgery to treat fetuses with open spina bifida, drugs and devices

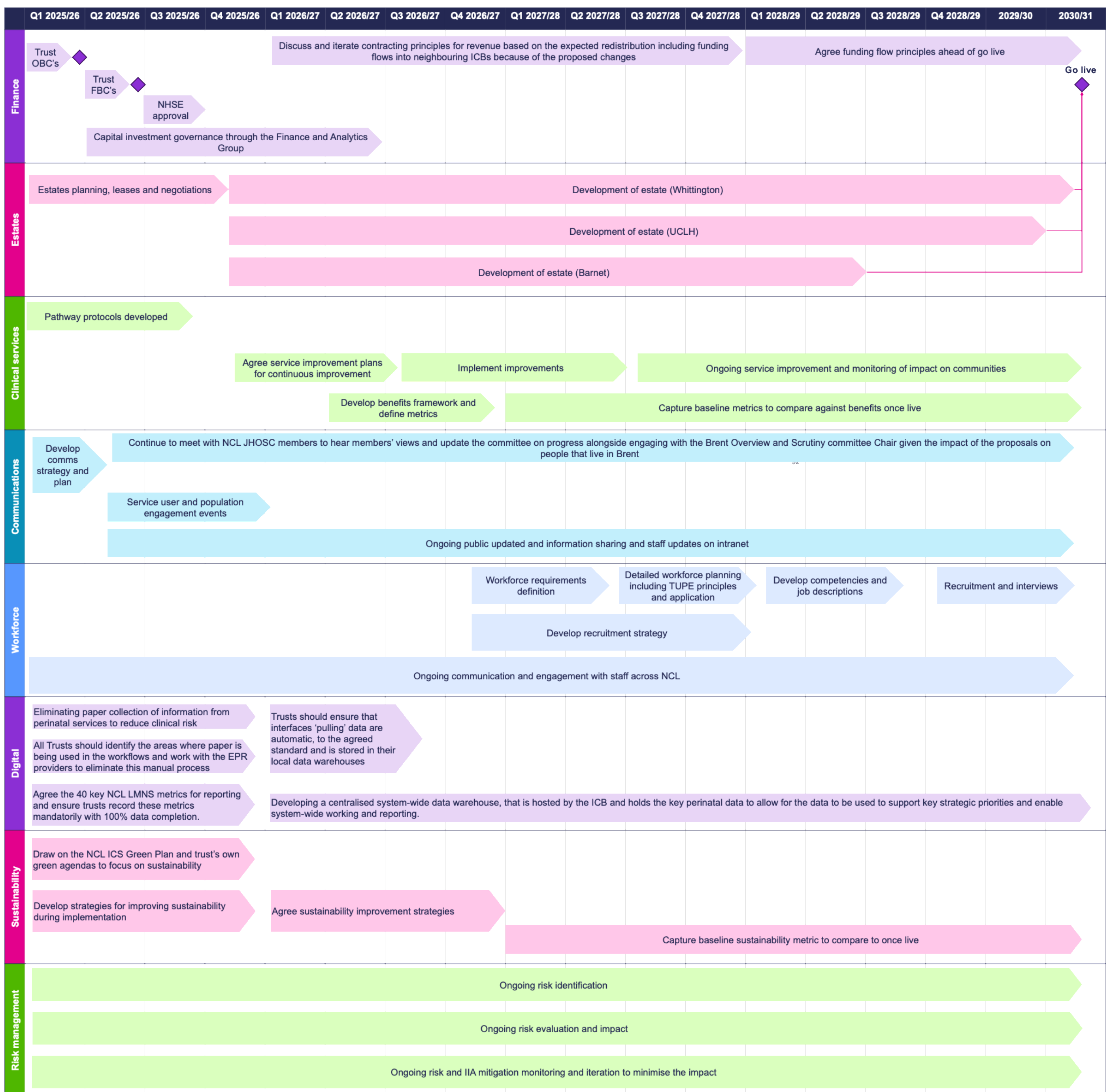

Figure 63: High level implementation plan

12. Benefits

Delivering our vision would change the way in which maternity and neonatal services are organised and delivered. The proposed care model would deliver a range of benefits. These benefits would be felt by those who use our services, their families, staff and the local populations we serve. Reconfiguring our services, investing in our estate and providing improved training opportunities would help us realise our ambition of delivering high-quality care for everyone, improving health outcomes and would ensure future sustainability of maternity and neonatal services.

The expected benefits outlined demonstrate how our proposals for services would address the opportunities for improvement highlighted in the case for change. We expect these proposals would deliver positive impacts in terms of clinical benefits, economic, workforce and estate benefits.

12.1 Feedback from consultation and assurance

Feedback from the consultation and assurance related to benefits and how we have addressed this feedback is shown in the table below.

What we heard	How we have addressed the feedback
Clinical Senate recommended that we define metrics to measure quality and safety (as key drivers of change) and outline approach to monitor metrics as part of their assessment of our PCBC.	A benefits realisation framework has been developed and agreed by the Programme (outlined in section 12.9). The framework includes the proposed measures to monitor quality and safety and how these would be reported and monitored. Proposed quality and safety measures include still birth rate, rate of hypoxic-ischemic encephalopathy (HIE), CQC rating and number of avoidable neonatal admissions. Where possible the metrics would be split by ethnicity and IMD decile.
The Mayor's Office recommended that we define quality metrics to measure quality and safety and the approach to continuously monitor these.	

12.2 Benefits framework

The benefits framework enables the quantification and monitoring of the successful delivery of benefits from the changes that are implemented. It is important to translate the proposals into specific benefits, so that the public can have a better understanding of what would be achieved and improvements from the Start Well programme can be measured. The benefits framework aligns to the opportunities for improvement outlined in the case for change:

1. Ensuring equality in maternity service provision and experience
2. Ensuring choice is maintained for our local population
3. Matching the capacity and choice to the current and future needs of our local population
4. Sustainability of the Royal Free Hospital SCU (level 1)
5. Addressing workforce vacancies and improving recruitment and retention
6. Having the right maternity and neonatal estate.

Setting out the benefits framework also demonstrates that clear benefits could be realised through the proposals and that consideration has been given to how this would be achieved. The benefits set out have been informed and tested with clinicians through the Maternity and Neonatal CRG, and the finance and analytics group (where the benefits are cash-releasing).

12.3 Process taken to develop the benefits framework

The CRG and Finance and Analytics Group have led the benefits planning and realisation. These build on the benefits identified in the PCBC. Following consultation further work has been undertaken to define the measures to track the expected outcomes, proposed data sources, and the proposed approach to tracking and reporting of the anticipated benefits. The proposed framework has been tested with the CRG, Finance and Activity Group and agreed by the Programme Board.

12.4 High-level benefits

Our recommended option would deliver the proposed maternity and neonatal care model and would therefore deliver positive impact in terms of clinical impact compared to now. The main benefits of the proposals would be:

- **Care that ensures equity of provision and experience**
    - Our care model has been designed to ensure that all pregnant women, people and babies have access to the same services. This includes community neonatal outreach services accessible across all boroughs and the same provision of neonatal care no matter which unit the baby is born in. The insights gained through developing these proposals has leveraged work to reduce inequalities across maternity and neonatal services including work to improve continuity of carer and work with specific communities such as Somali women who currently experience inequalities in access and outcomes. We expect that the care model would provide a more personalised experience than now and ensure that individuals are supported and communicated with and given information that best suits their own needs.
    - Our care model would also enable all units in NCL to meet clinical standards around staffing. Currently, there are standards that are not being met and meeting these standards would require an uplift in staffing across the sector. Through consolidation of the number of units that we have in NCL, there is an opportunity to reach these staffing standards through using our workforce more effectively.
    - All pregnant women and people would have the choice to have midwifery-led or obstetric-led care, across either a home birth, midwife-led unit or birth at an obstetric-led unit. Through implementing the changes and consolidating staff across fewer units, we would hope to be able to provide a more consistent offer of midwifery-led care across NCL and have services align to the choices and needs of our population.

- **Services which are clinically sustainable**
    - Redesigning and reconfiguring our neonatal units in NCL would ensure that all units are either a designated LNU (level 2) or NICU (level 3). Reducing the number of neonatal units from five to four would allow units to meet the minimum activity requirements set out in national clinical standards.

- Would resolve the current issues identified with running a SCU (level 1) at the Royal Free Hospital, which include low occupancy, insufficient activity and high levels of transfers.
- Having a high-quality sustainable workforce, who are supported and offered training opportunities, would directly impact on the quality of care provided. Our care model delivers the minimum workforce requirements outlined in national guidance, which they don't do now, and we believe that the consolidation of these services would better facilitate enhanced training opportunities for staff. Enhanced training opportunities would help to support recruitment and retention of our workforce in NCL.

- **More up-to-date estate and buildings**
  - Investment in our existing maternity and neonatal estate so that all units meet more up-to-date building standards and are designed to provide a positive birth experience. Any new capacity delivered would aim to meet the latest space standards and this would have a role in delivering clinical benefits, improving efficiencies, supporting the reduction of the risk of hospital-acquired infection and delivering an attractive working environment for staff.

- **Training and development opportunities**
  - Supporting training and development opportunities for staff through delivering sustainable volumes of neonatal activity at all neonatal units. Developing this expertise within the workforce and providing these opportunities would help to improve recruitment and retention of the workforce compared to now.
  - Reducing vacancies compared to now to make sure cots could be kept open and ensuring there are sufficient staff (specialist nurses, allied healthcare professionals, etc.) to provide expert care when required.

- **Capacity to meet projected demand**
  - Investing in additional capacity for neonatal and maternity services would ensure that there is enough capacity available so that neonatal units are running at the 80% recommended occupancy rate and there are fewer refusals to admit due to not having enough space. This would reduce the likelihood for transferring babies to units outside of NCL.
  - All units being an LNU (level 2) or NICU (level 3) would reduce the number of transfers of babies from a SCU (level 1) and would minimise the separation of the woman or person that has given birth and their baby, especially transfers to units outside of NCL.

12.5 Detailed benefits

Benefits can be a combination of cash-releasing, quantifiable but not cash-releasing, and qualitative. Cash-releasing benefits identify where money can be reallocated or the cost of delivering a service is reduced. Non-cash-releasing benefits are efficiency savings such as staff time saved, but the cost of delivering the services may stay the same[72].

[72] https://digital.nhs.uk/services/personal-health-records-adoption-service/personal-health-records-adoption-toolkit/benefits-of-personal-health-records/financial-benefits-of-personal-health-records#:~:text=cash%2d%20Releasing%20benefits%20are%20there,release%20money%20back%20to%20%20budgets

Where it has been possible to do so, benefits have been quantified in terms of cash-releasing or non-cash-releasing. An overview of the expected benefits is outlined in the table below.

Category	Benefit description	Outcome	Benefit type	Option A (annual saving)	Option B (annual saving)
Care that ensures equity of provision and experience	• Pregnant women, people and babies, particularly those from inequality groups, have access to the same services. This includes community neonatal outreach services accessible across all boroughs and the same provision of neonatal care no matter which unit the baby is born in. • Provide a more personalised experience and ensure the individuals are supported and communicated with that best suits their own needs	Improved patient experience and outcomes (including for inequality groups)	Qualitative	-	-
		Reduced maternity clinical negligence scheme premium for trusts (CNST)	Cash-releasing	£8,148,824	£7,130,290
		Reduced normal care days delivered in an acute setting through enhanced delivery of community services	Cash-releasing	£700,781	£700,781
Services which are clinically sustainable	• Redesigning and reconfiguring our neonatal units in NCL, ensuring all units are either a designated LNU (level 2) or NICU (level 3).	Reduced neonatal transfers between units	Cash-releasing	£8,424	£8,424

Training and development opportunities	• Supporting training and development opportunities for staff through delivering sustainable volumes of neonatal activity at all neonatal units. • Reducing vacancies to make sure cots can be kept open and ensure there are sufficient staff (specialist nurses, allied healthcare professionals, etc) to provide expert care when required	No consultant workforce rota supporting the SCU (level 1) Consolidation of existing workforce into four units	Cash-releasing	£14,677,768	£14,997,696
		Improved recruitment and retention	Non cash-releasing	-	-
Capacity to meet projected demand	• Neonatal units are running at less than the 80% recommended occupancy rate	Reduced risk of separating women or person from their baby and improving their experience	Qualitative	-	-
Up to date estate and buildings which are fit for purpose	• Investment in our existing maternity and neonatal estate so that all units are fit for purpose and are designed to provide a positive birth experience • Any new capacity delivered would better meet the latest space standards and this would have a role in	Improved efficiencies	Cash-releasing	£6,192,544	-
		Improved staff experience by enhancing staff environment	Qualitative	-	

	delivering clinical benefits				

12.6 Patient experience and quality outcomes benefits

In addition to what has been outlined, it is integral that the experience of women and people and their families, who use maternity and neonatal services, are monitored and improvements to quality and safety are tracked. There are several existing mechanisms which may support with this:

- The Friends and Family test - this is used by trusts and commissioners to monitor patient feedback.
- The CQC maternity survey - this is an annual survey conducted by the CQC as part of the NHS Patient Survey Programme[73]. The feedback gained through this is reviewed at an NCL level through the LMNS. We would continue to review the outcome of the survey and anticipate seeing an improvement in the individual trust feedback following implementation.
- Working with the maternity and neonatal voice partnerships (MVNPs) to gain insights into experience. The MVNPs have an integral role in representing the voice of service users in maternity services. We would work with the MVNPs to co-create a plan to gain insights from families about their experiences, with a particular focus on the groups that have been identified through the work on the integrated impact assessment (IIA) who are at risk of poorer outcomes and experience from maternity care.
- The local maternity and neonatal service (LMNS) Perinatal Quality Oversight Group meets regularly to review outcomes data and quality and safety reports and incidents. This group would be integral to the creation of a framework to monitor quality and patient experience improvements in services as a result of implementing the changes.

12.7 Benefits realisation

Benefits realisation needs careful management and close measurement. Benefits measures would focus on and record both outputs (e.g., reduced number of neonatal care days) and expected outcomes (e.g., improved patient experience) to demonstrate the success of delivery. A realistic list of measurable performance indicators would sit alongside the benefits outlined in the benefits framework. It is recognised that there can sometimes be a ‘dip’ in performance during implementation and that some changes may not always be viewed positively by individual patients or staff. However, patient safety would remain paramount.

Benefits tracking is firmly embedded within performance management arrangements under business as usual. There would be strong clinical leadership of this benefits realisation to support successful delivery of the programme. Wherever possible, existing mechanisms and systems would be used to monitor the realisation of benefits, rather than creating an additional data burden.

[73] https://www.cqc.org.uk/publications/surveys/nhs-patient-survey-programme-outline-programme-publication-dates

12.8 When benefits could expect to be realised

An implementation timeline has been included in this DMBC (see section 11.12). Whilst different elements of the proposals have differing associated timescales, some changes to services could start as soon as possible, and realisation of benefits would follow. However, all benefits would be likely to be maximised after the plans are fully implemented which is a number of years into the future dependent on capital works.

It is sometimes difficult to isolate benefits from specific changes, but measuring benefits alongside implementation plans would help. Some improvements may be attributable to several factors, but not seeing improvements against a particular measure may not necessarily mean that the changes have been unsuccessful. Other factors may have arisen which mean improvements are not seen but the benefits framework would allow investigation and rectification, if required.

12.9 Monitoring of benefits realisation

Monitoring the expected benefits would be part of implementation, with:

- Clinically-led, clear and comprehensive implementation plans
- A pragmatic benefits realisation framework, with associated governance arrangements and processes to:
  - Formally track progress of benefits realisation
  - Identify actions in response to any benefits not being realised
  - Define reporting requirements visible to all organisations involved, patients and the public.

The Start Well Programme Board would oversee the benefits tracking with the Operational Implementation Oversight Group reviewing the defined metrics and reporting into the Programme Board on the progress against these.

Further work to develop the approach to benefits realisation has been undertaken. This includes finalising the measures to track the outcomes, defining the data sources and agreeing the frequency to collate the measure. Benefits would also be tracked with regard to inequality groups such as people living in areas of deprivation (CORE20) and people from minority ethnic groups (where data allows). Metrics for the mitigations shown in section 9.5.6 would be developed to be tracked alongside the benefits. The agreed framework is shown in Figure 64. This has been reviewed and tested with the CRG, Finance and Analytics Group and Programme Board.

Category	Benefit description	Outcome	Measure	Expected to be realised by	Frequency	Data source
Care that ensures equity of provision and experience	• Pregnant women, people and babies have access to the same services, including those from inequality groups. This includes community neonatal outreach services accessible across all boroughs and the same provision of neonatal care no matter which unit the baby is born in. • Provide a more personalised experience and ensure the individuals are supported and communicated with that best suits their own needs	Improved patient experience and outcomes	• Improve patient experience	Within 24 months of implementation of the new care model	Annual	CQC survey Healthwatch Friends and Family test
			• Reduce number of avoidable term admissions to a neonatal unit	Within 12 months of implementation of the new care model	Annual	BadgerNet / Epic
			• Increase CQC rating	Within 3 years post implementation of the new care model	Annual	CQC website
			• Reduce maternity and Newborn Safety Investigations (MNSI) referrals	Within 12 months of implementation of the new care model	Quarterly	Trust referrals to MNSI
		Reduced Maternity clinical negligence scheme premium for Trusts (CNST)	• Reduce maternity CNST premium per delivery	7 years post implementation of the new care model	Annual	Trust finance teams
		Reduced normal care days delivered in an acute setting through enhanced delivery of community services	• Reduce number of special care neonatal care days delivered in neonatal units	Within 6 months of implementation of the new care model	Quarterly	BadgerNet Epic (UCLH)
Services which are clinically sustainable	• Redesigning and reconfiguring our neonatal units in NCL, ensuring all units are either a designated LNU (level 2) or NICU (level 3).	Reduced neonatal transfers between units	• Reduce number of neonatal transfers for higher level of medical care	From go live of the new care model	Quarterly	Neonatal ODN
Capacity to meet projected demand	• Neonatal units are running at less than the 80% recommended occupancy rate	Reduced risk of separating women or person from their baby and improving their experience	• Reduced number of non intensive care days delivered at UCLH for babies that live outside the UCLH catchment	Within 12 months of implementation of the new care model	Quarterly	Epic / Neonatal ODN
			• Reduce number of in utero transfers	Within 12 months of implementation of the new care model	Quarterly	Neonatal ODN
Training and development opportunities	• Supporting training and development opportunities for staff through delivering sustainable volumes of neonatal activity at all neonatal units. • Reducing vacancies to make sure cots can be kept open and ensure there are sufficient staff (specialist nurses, allied healthcare professionals, etc) to provide expert care when required	No consultant workforce rota supporting the SCU (level 1) Consolidation of existing workforce into four units	• Improve staff experience	Within 24 months of implementation of the new care model	Annual	Staff survey National Education and Training Survey GMC training survey
			• Reduce staff turnover	Within 24 months of implementation of the new care model	Annual	Trust data
			• Increase number of neonatal nursing QIS	Within 24 months of implementation of the new care model	Annual	Neonatal ODN data
		Improved recruitment and retention	• Reduce vacancy rates	Within 24 months of implementation of the new care model	Annual	Trust data
			• Reduce agency and bank spend	Within 24 months of implementation of the new care model	Annual	Trust data
			• Reduce number of suspensions of alongside midwifery led service	Within 24 months of implementation of the new care model	Annual	Trust data
			• Improve safe staffing levels against standards	Within 24 months of implementation of the new care model	Annual	Trust data
			• Improve staff experience	Within 24 months of implementation of the new care model	Annual	Staff survey National Education and Training Survey GMC training survey
Up to date estate and buildings which are fit for purpose	• Investment in our existing maternity and neonatal estate so that all units are fit for purpose facilities and are designed to provide a positive birth experience • Any new capacity delivered will meet the latest space standards and this will have a role in delivering clinical benefits	Improved efficiencies	• Reduce backlog maintenance costs	Within 24 months of implementing of the new care model	Annual	Trust ERIC data
		Improved staff and patient experience by enhancing staff environment	• Increase friends and Family test score	Within 24 months of implementation of the new care model	Annual	Friends and Family Test
			• Improved staff survey results	Within 24 months of implementation of the new care model	Annual	Trust staff survey GMC staff survey
			• Improvement in how trainees rate the support and fairness of their working environment	Within 24 months of implementation of the new care model	Annual	National Education and Training Survey
			• Improved CQC Maternity survey results	Within 24 months of implementation of the new care model	Annual	CQC survey

Figure 64: Benefits realisation framework

We recognise the importance of continuing to monitor key quality metrics during and after implementation. This would include metrics such as still birth rates, neonatal mortality, maternal

deaths, unexpected maternal admissions to intensive care, rates of hypoxic ischaemic encephalopathy and unexpected transfers between sites. These metrics would be monitored by the local maternity and neonatal service (LMNS). Any issues raised would be reported into the Start Well Programme Board to support monitoring of the Start Well programme

13. Next steps and approvals

This DMBC is the result of over three years of evidence development, assurance and review of proposals to deliver a solution that addresses our case for change and delivers our maternity and neonatal care model. On approval of this DMBC, we plan to move to the implementation phase of the agreed option.

The feedback from the consultation has shown that there is clear support for the case for change and our care model. As commissioners, we believe that we have identified the best option to deliver the care model and address the opportunities for improvement identified. This has been driven by a robust process which has considered the evidence and been tested through public consultation. Further work has been undertaken to ensure that we have fully understood and responded to the themes from public consultation, and how this has been considered in agreeing the preferred option and how the option should be implemented.

13.1 Regulatory assurance

We have been developing the proposal for this DMBC and the Edgware Birth Centre Addendum since November 2021, ensuring that there has been sufficient time and engagement to make sure that the proposed changes are as robust as possible. It was submitted to NHSE for stage two of the national assurance process for service change and reconfiguration on 9 November 2023 and they gave formal approval for us to proceed to consultation. The consultation was undertaken between 1 December 2023 and 17 March 2024 and we have spent almost a year carefully considering and responding to the feedback from consultation.

The PCBC and Edgware Birth Centre Addendum was reviewed and supported by the London Joint Committee for specialised services and was ratified by the London Region Executive. This DMBC has been further assured by NHSE London Region and a decision on the final option for implementation is being made on the basis of this DMBC and the Edgware Birth Centre Addendum by a meeting in public of the NCL ICB Board of Members alongside the named delegated decision-makers from NHSE specialised services.

13.2 Next steps for stakeholder engagement

13.2.1 Feedback from consultation and assurance

Feedback from the consultation and assurance related to next steps for stakeholder engagement and how we have addressed this feedback is shown in the table below.

What we heard	How we have addressed the feedback
Clinical Senate recommended that we further develop implementation plans to provide opportunities for service users to co-design and influence the ways services are delivered at Place and Neighbourhood level as part of their assessment of our PCBC.	Throughout the Programme we have sought service user input through the Patient and Public Engagement Group. Under the implementation governance structure, we would continue to actively involve service users through the implementation process with a proposed patient engagement working group.
Clinical Senate recommended that we further develop implementation plans that avoid disrupting relationships with local	We have worked closely with local authorities in developing these proposals.

authorities and their teams (e.g., Health Visiting) as part of their assessment of our PCBC.	We would continue to do this as we progress with implementation planning.
The Mayor's Office recommended that we provide details for plans in place to achieve better join up between ICS led and local authority led neonatal and maternity services, for people living in all ICSs affected by the changes (especially Brent) and highlight where further work is needed.	As is the case now, join up between services that support women and people during pregnancy would be integral to the success of the care model and a holistic approach to care. This includes primary, secondary and community care as well as local authority services. Through the development of the ICS's approach to 'place' and neighbourhood teams, we see that there is a role for these more local units of care to work effectively together to ensure seamless pathways. As part of implementation we would work with local 'place' teams in each borough - both within the ICB and as part of the providers that support this infrastructure to ensure that important linkages are maintained and enhanced. As we look at community midwifery boundaries and services available in the community there is an opportunity for place teams to influence the approach and integrate with neighbourhood teams. This would ensure that important local nuances are reflected in services that are provided but also enhance the experience for both patients and staff. This would: • Ensure as much care as possible takes place in community settings, reducing the need for travel to hospital for antenatal appointments • Allow staff and patients to be aware of and linked with other local services that can support women and people through their pregnancy, for example local mental health services, and council support services • This may support long term engagement of patients with health services for them in the future and their children, advancing their knowledge and understanding of how local services work • Mean that community staff are not required to travel long distances for appointments to see patients as they are more focussed in a neighbourhood locality

	As part of implementation we would work with NWL to understand how to support joined up care.

13.2.2 Joint Health overview and scrutiny committee (JHOSC)

We have consulted directly with local authorities on our proposals via the NCL JHOSC, the Brent Communities and Wellbeing Scrutiny Chair was invited to the NCL JHOSC meetings in both November 2023 and July 2024. This is as required by our Section 244 duty under the National Health Service (as amended by the Health and Social Care Act 2021) which requires NHS bodies to consult relevant local authority overview and scrutiny committees on any proposals for substantial variations or substantial developments of health services.

We would continue to meet with NCL JHOSC members during implementation to hear members' views, answer questions, and update the committee on progress. Given there is an impact from our proposals for people who live in Brent, we would also continue to engage with the Brent Communities and Wellbeing Scrutiny committee Chair as part of our implementation engagement.

13.2.3 Patients and the public

If a decision is agreed by the ICB Board, a comprehensive communications plan has been developed to support the communication of this decision. The plan has the following key objectives:

- Ensure transparency and clarity to maintain trust and confidence in the decision-making process that has been undertaken.
- Provide clear, timely, and accessible communication to all stakeholders, including patients, residents, staff, and partner organisations.
- Provide information about the likely implementation timeline and provide reassurance about the impact on those using services during the transition period
- Collaborate with all involved partners (NHS Trusts, NHSE, local Councils and VCSE organisations) to ensure that messaging remains consistent.
- Provide communication materials in a variety of formats and through a range of channels, including opportunities for staff to meet with senior managers and ask questions
- Communicate clearly the next steps, and where responsibility and accountability sits as we move towards implementation

We would continue to work with the established communication and engagement group which brings together communications leads from each impacted Trust. We would create and disseminate accessible communication materials, with translation and other formats available to support the needs of our diverse communities. These materials would outline how this decision has been reached, the reasons that the decision has been made, the likely impact on patients and residents and information about the timeline of potential changes and key milestones. We would use a variety of different communications channels, many of which were established during the public consultation, to share information. These channels include websites, social media, local press, and asking partners such as local charities and councils to share through their networks. We would continue to work together as the detailed implementation planning develops. We would ensure, service users and wider stakeholders are kept informed of key milestones and are given plenty of advance notice if any changes may impact how or where people access services. We would also work with relevant patients and members of the public to co-produce implementation plans, where appropriate.

A detailed communication and engagement plan would be developed for the implementation period, owned by the communications and engagement group. This would ensure that there is a consistent of approach, and this would be complimented by communications professionals being included in internal Trust implementation governance. It would be very important to ensure that service users are regularly updated, know where to go for accurate information and feel reassured that appropriate mitigations are being put in place to support service users. We would be drawing on lessons from other large reconfiguration programmes, who have successfully managed communications around this kind of transition.

13.2.4 Staff

Effective support for and communication with staff during the potential implementation period would be a key part of ensuring that we continue to deliver high-quality, safe services during transition. We want as many maternity and neonatal staff as possible to continue their careers in NCL. We would support staff to transition to work at an alternative unit once the proposals are fully implemented, and a key success factor in achieving this would be making sure we communicate with and support staff effectively.

A similar approach would be taken to communicate with staff impacted by the proposed changes as to with stakeholders and service users. In addition to the objectives outlined above, we would want to ensure that staff hear regularly through their employer organisation to reduce uncertainty and build trust. We would:

- Provide clear and timely information on next steps and the timetable for implementation
- Signpost the support is available through transition, such as HR/OD support
- Provide mechanisms for staff to ask questions and seek clarification
- Opportunities for staff to get involved in some aspects of the implementation

Working with the communication and engagement group, with representatives from Trusts, we would prepare specific communications materials for staff. These would outline the decision and rationale for changes, key timelines and milestones from a staff point of view and detail the support that would be available to them during the transition period. As has been the case throughout the programme, we would ensure that consistent materials are available and shared at similar times with all impacted staff. We would need to keep the approach under review through the implementation timeline to ensure updates are being shared in the most appropriate way at the right intervals.

Given the length of the implementation timeline, we would also explore how we can provide regular updates to staff and a range of inclusive communication channels to ensure that updates are shared throughout. We would look to make use of updates via email, staff intranets, newsletters, face to face and online meetings / Q&As and ensuring managers are equipped with the latest information to share with staff during routine team meetings and management meetings. There would be a need to offer particular support to staff at the site that is subject to closure. We would work with both workforce, communications and senior leadership to ensure is in place. This could include emotional support, ways to manage stress and uncertainty, providing clarity for potential impact on individuals, offers of training and team development. Trust internal implementation groups would include workforce and communications representation who would be responsible for taking forward any strategies at a Trust level, responding to feedback and needs of staff.

13.2.5 Neighbouring Integrated Care Boards

Throughout its course, the programme has had continued involvement from neighbouring ICBs through representation on the programme board and other governance groups, such as the CRG. During implementation we would build on this approach and the established working relationships to ensure that this involvement is maintained. Given the impact of the recommended option on NWL, it is likely that there would need to be a greater level of representation and involvement from their representatives. For the implementation phase we would:

- Continue to have NWL represented at our Programme Board
- Review governance groups and membership and ensure that there is appropriate NWL representation at each of these
- Work with the NWL communications team to ensure that updates relating to implementation of proposals are widely accessible to residents of NWL
- Ensure that providers in NWL are kept up to date with progress of implementation and any impacts for them (e.g., planning for increased staffing around additional births once proposals are fully implemented)
- Ensure that mitigations identified for residents of NWL are put in place

13.3 Developing further business cases

On approval of the DMBC by the NCL ICB Board and NHSE London Region Specialised Commissioning, relevant outline business cases and full business cases would be finalised for approval by Trust Boards, NHSE and HMT (for schemes over £50m).

13.4 Next steps for the Integrated Impact Assessment (IIA)

The NCL ICB and NHSE London Region Specialised Commissioning commissioned an interim independent IIA in 2023 to assess the potential impact of the proposals, which has been updated as part of this DMBC process. The IIA has been used to understand the potential impact of the proposals on local residents and explores the impact of our proposals on inequalities. The IIA report sets out an assessment of the potential impacts which may be experienced because of the proposed changes to maternity and neonatal services across NCL and, in line with commissioners' public sector equality duty, helps to ensure that genuine consideration is given to equality as part of the decision-making process.

The IIA would be revisited over the course of the implementation of the proposals, as part of an iterative process.

14. Glossary

	Meaning
AHP	Allied Health Professionals (physiotherapy, occupational therapy, dietetics, speech and language therapy, psychologists and pharmacists)
AQMAs	Air quality management areas
BAPM	British Association of Perinatal Medicine
BAU	Business as usual
BCR	Benefit cost ratio

BirthRate Plus	Midwifery-specific, national tool that gives the intelligence and insights needed to be able to model midwifery numbers, skill mix and deployment and to inform decision making about safe and sustainable services
CAG	Clinical Advisory Group
CDEL	Capital departmental expenditure limit
CEO	Chief executive officer
CFC	Case for change
CNST	Clinical Negligence Scheme for Trusts
Core20PLUS5	National NHS England approach to inform action to reduce healthcare inequalities at both national and system level
CQC	Care Quality Commission
CRG	Clinical Reference Group
CYP	Children and young people
CYPMN Board	Children, Young People, Maternity and Neonatal Board
DHSC	Department of Health and Social Care
DMBC	Decision-Making Business Case
DoF	Directors of Finance Group
EBC	Edgware Birth Centre
FBC	Full business case
FFT	Family and Friends Test
GIRFT	Getting it Right First Time
GLA	Greater London Authority
GMC	General Medical Council
GOSH	Great Ormond Street Hospital for Children NHS Foundation Trust
HBN	Health Building Note
HES	Hospital Episode Statistics is a database containing details of all admissions to hospital, A&E attendances and outpatient appointments at NHS hospitals in England
HMT	His Majesty's Treasury
Home birth	A birth that takes place in a residence rather than in a hospital or a midwife-led unit
HRA	Human Rights Act
ICB	Integrated Care Board
ICS	Integrated Care System
IIA	Integrated Impact Assessment
IMD	Index of Multiple Deprivation, a UK government qualitative study of deprived areas in English local councils.
IR	Interventional Radiology
ITU	Intensive Care Unit
JHOSC	Joint Health and Overview Scrutiny Committee, with representatives from each of the borough Health Overview and Scrutiny Committees
LD	Learning Disability
LMNS	Local Maternity and Neonatal System
LNU	Local Neonatal Unit
LOS	Length of Stay. How long a patient is in hospital and is calculated subtracting the day of admission from day of discharge
LSOA	Lower Super Output Area
M&M	Mortality and morbidity
MDT	Multi-disciplinary team
MFF	Market forces factor

Midwife-led unit	A maternity unit where care is delivered by midwives
MMBRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MP	Member of Parliament
MVNP	Maternity and Neonatal Voices Partnership
NCCR	Neonatal Critical Care Review
NCL	North Central London
NCPs	National Car Parks
NEL	North East London
NICU	Neonatal Intensive Care
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Health and Clinical Excellence
NO2	Nitrous oxide
North Mid	North Middlesex University Hospital NHS Trust
NTS	Neonatal transfer service
NWL	North West London
OBC	Outline business case
Obstetric led unit	A maternity unit within a hospital where doctors are available to provide medical care if needed
OD	Organisational Development
ODN	Operational Delivery Network
ONS	Office of National Statistics
PCBC	Pre consultation business case
PPEG	Patient and Public Engagement group
PTAL	Public Transport Accessibility Levels
QIS	Qualified in specialty
RCD	Respiratory care days
RCOG	Royal College of Obstetricians and Gynaecologists
Royal Free	Royal Free London NHS Foundation Trust comprising of Barnet Hospital, Royal Free Hospital and Chase Farm Hospital
RTT	Referral to treatment
SLT	Speech and language therapist
SMB	System Management Board
SCU	Special Care Unit
SRO	Senior responsible officer
TFL	Transport for London
UCLH	University College London Hospitals NHS Foundation Trust
ULEZ	Ultra Low Emission Zone
VCSE	Voluntary, community and social enterprise
Whittington Health	Whittington Health NHS Trust
WTE	Whole time equivalent