

# Start Well Programme

Interim Integrated Impact  
Assessment (IIA)

Maternity and neonates PCBC

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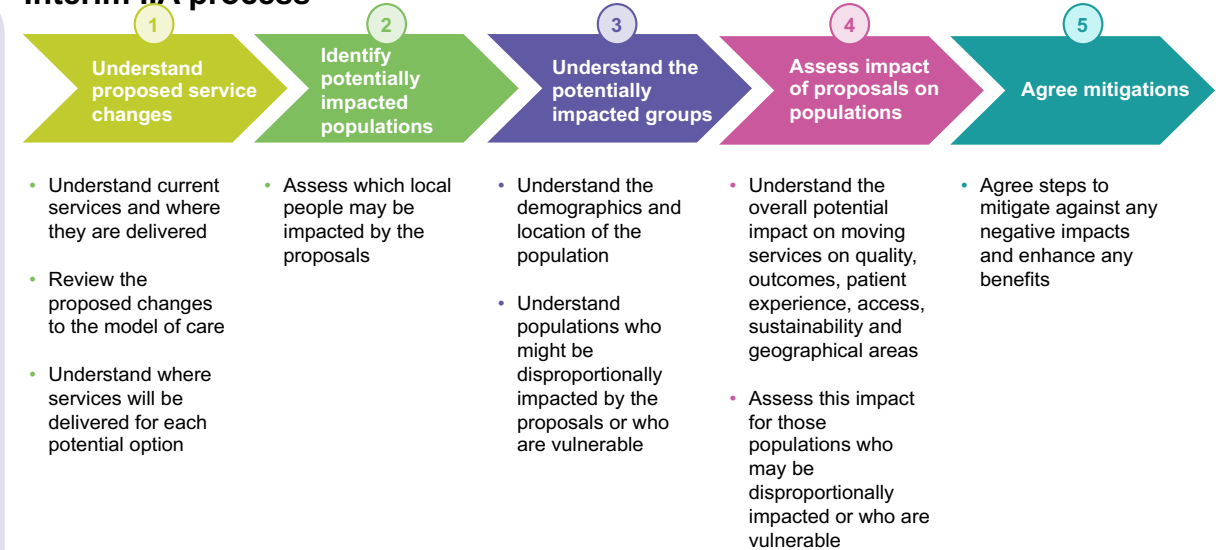
# Executive summary



## We have developed an interim integrated impact assessment (IIA) for the Start Well programme

- We have developed proposals for maternity and neonatal services in NCL as part of the Start Well programme
- The interim integrated impact assessment (IIA) is used to understand the potential impact of the proposals on local people
- The interim IIA allows us to explore the impact of our proposals on people with protected characteristics and groups with vulnerabilities
- A robust approach has been adopted for the development of the interim IIA, as outlined on the figure on the right
- We have assessed our proposals for clinical, accessibility, sustainability and geographical impact
- We have undertaken engagement about our proposals which have contributed to a better understanding of the impact of our proposals on service users
- The interim IIA engagement reached over 120 patients, residents and staff

### Interim IIA process



### People reached through interim IIA engagement

- Parents of children with learning difficulties and autism
- Parents with learning difficulties
- Women over 35
- Eastern European Forum
- African Health Forum
- Jewish women
- Lesbian women
- Muslim women
- Women who have given birth at Edgware
- Families who have experienced bereavement
- Women who are asylum seekers
- Specialist midwives who support women during pregnancy:
  - Experience of domestic violence
  - Severe mental illness
  - Homelessness
  - Female genital mutilation



# The interim IIA assesses our proposed options, which build on our case for change and proposed model of care

- The Start Well programme case for change highlighted opportunities for improvement in maternity and neonatal services in NCL
- We have developed a new model of care for maternity and neonatal services that address these opportunities
- We have developed two proposals for maternity and neonatal services. These proposals are independent from each other

## Case for change opportunities for improvement

**Maternity opportunities for improvement**

- Ensuring equality in maternity service provision and experience**
  - Stillbirth rate varies between boroughs, Haringey had the highest rate with 6.3 per 1,000 population
  - Only 4.9% of pregnant women and people in NCL access perinatal mental health services
- Better utilisation of maternity capacity offered in NCL**
  - Range of units in NCL are not all used equally
  - For some sites in NCL, use of their midwifery-led units in 2021 was around 30% or under, whilst obstetric-led units were dealing with significant capacity pressures.
- Supporting maternity workforce sustainability**
  - For many trusts, bank and agency are used to fill shifts to ensure compliance with this target due to vacancies
  - For our units to comply with the new staffing standards we need to recruit an additional 27 midwives across the system

**Neonatal opportunities for improvement**

- Matching neonatal care capacity and demand**
  - UCLH and GOSH NICU had occupancies higher than the maximum threshold
  - Over stretched level 3 capacity in NCL resulted in 40 babies in 2020/21 needing to be transferred
- Consider the sustainability of the RFH Special Care Unit**
  - The unit delivers 111 respiratory care days which is significantly below the 365 day BAPM upper threshold
  - Low numbers of babies admitted creates a challenge for staff to maintain the required competencies
- Minimising avoidable admissions to neonatal units**
  - The existing provision of neonatal community outreach programmes is not consistent between our boroughs
- Addressing workforce vacancies and variation in provision and access to AHPs across neonatal units**
  - North Mid are unable to open their full establishment of cot spaces due to nursing vacancies
  - NCL require an uplift in nursing establishment by 26.1 WTEs to meet the Dinning tool requirements

## Options for location of maternity and neonatal services

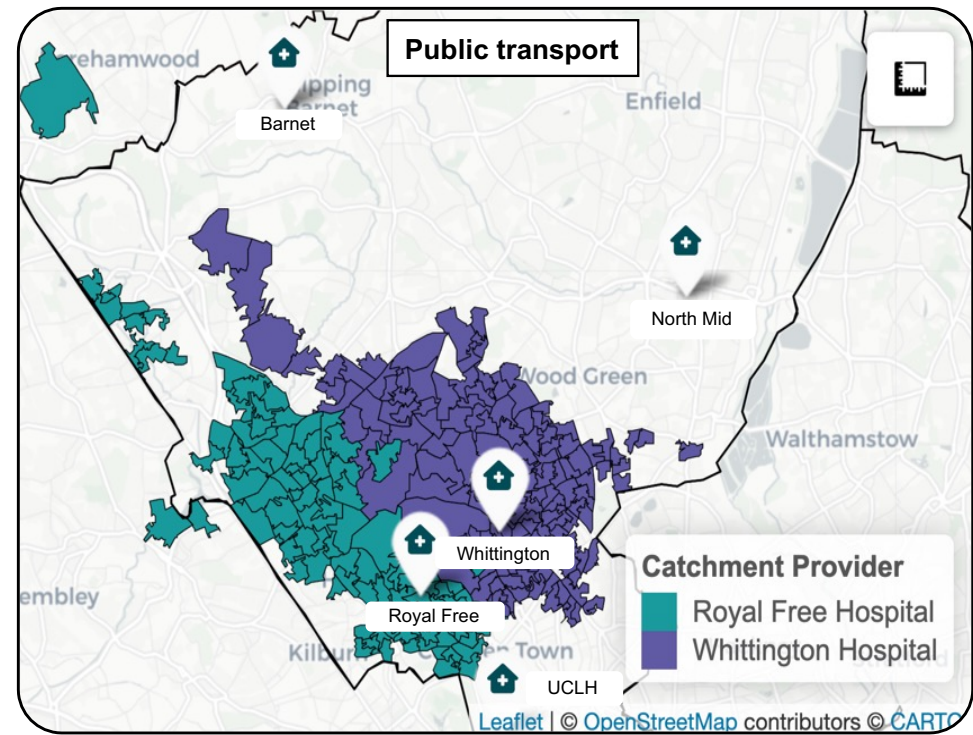
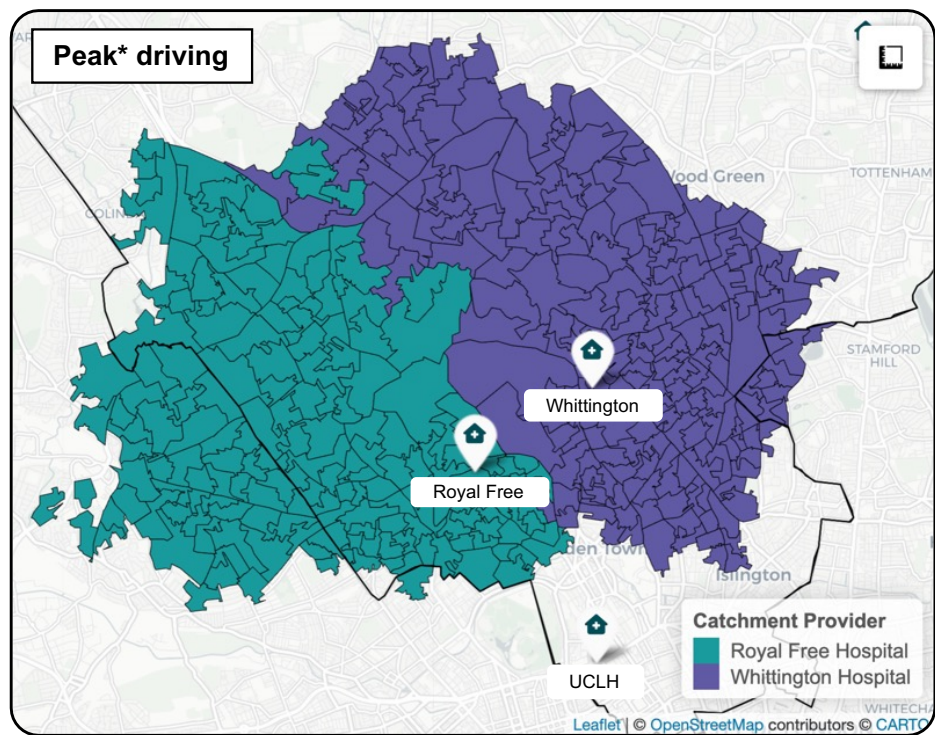
Option A: UCLH, North Mid, Barnet, Whittington		Option B: UCLH, North Mid, Barnet, Royal Free	
UCLH	Consultant-led obstetric unit with co-located NICU (level 3) neonatal intensive care unit and alongside midwife-led unit	UCLH	Consultant-led obstetric unit with co-located NICU (level 3) neonatal intensive care unit and alongside midwife-led unit
North Mid	Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit	North Mid	Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit
Barnet	Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit	Barnet	Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit
Whittington	Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit	Royal Free	Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit

- We developed and appraised options for the location of maternity and neonatal units in NCL, for which there are two proposed options for consultation (options A and B)
- We have assessed the impact of options A and B compared to current service provision



# For options A and B, we have identified the geographical area of people who may be impacted by our proposals

- We identified the geographical areas of people who would potentially be impacted by our proposals (the catchment population) based on travel times
- We looked at people who might be impacted by our proposals for changes to maternity and neonatal units when driving and when using public transport, there is a slightly smaller population that could potentially be impacted for option A (~373,000 people driving and ~230,000 people on public transport) versus option B (~378,500 people driving and ~298,000 people on public transport)
- We also looked at where people impacted by option A and option B would be likely to flow if their nearest unit (by travel time) were no longer available



\* Peak (private car / taxi) is defined as 9:00 on a Tuesday



## We have explored the demographics of people who may be impacted by our proposals

- We engaged extensively and undertook a public health-led literature review to identify people who may be impacted by our proposals.
- Our case for change identified vulnerable groups that may be disproportionately impacted by the proposals, we considered potentially impacted groups using the national CORE20PLUS5 framework (see slide 51 for a description of the framework) and there are nine protected groups that we must consider to fulfil our legal duties
- Our interim IIA is therefore focused on people who may be disproportionately impacted by our proposals. The populations considered are set out in the table below.

**Table showing the populations that have been identified for consideration in the interim IIA and how we identified those populations**

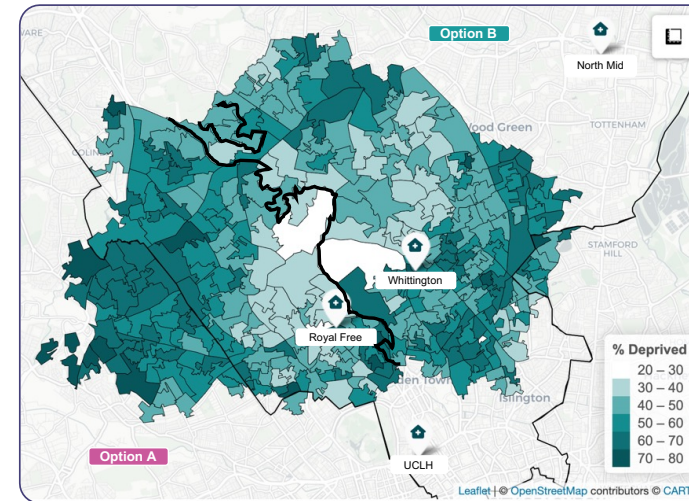
Potentially impacted populations	How we identified potentially impacted populations				Quantitative analysis possible?
	Protected characteristic	CORE20	Engagement	Case for change	
People living in areas of deprivation		✓	✓	✓	Y
People who are economically inactive					Y
People from ethnic minority groups	✓	✓	✓	✓	Y
People who have poor English proficiency (Including literacy)			✓		Y
People with poor health		✓			Y
Inclusion health groups		✓	✓	✓	
People who are LGBTQ+	✓		✓	✓	
People who are transgender	✓				
Religion	✓		✓		
Women and people of childbearing age (sex)	✓		✓		Y
Younger pregnant women and people	✓			✓	
Older pregnant women and people	✓		✓	✓	
Single pregnant women and people					Y
People with disabilities	✓		✓	✓	Y
People with learning disabilities		✓	✓		
People with serious mental illness		✓			



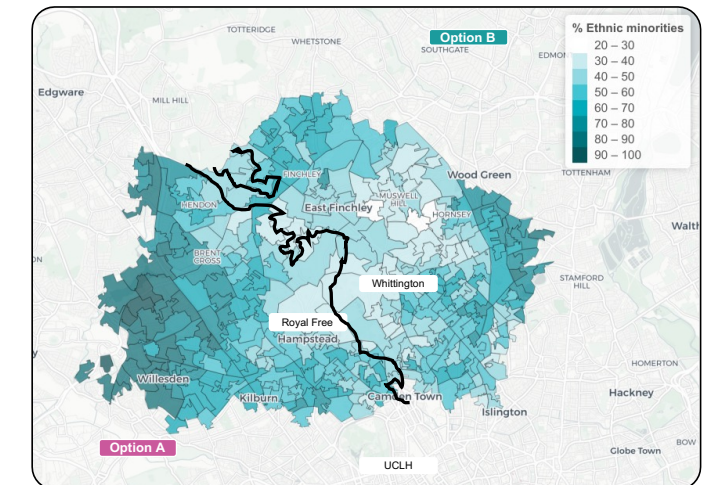
# People with protected characteristics and vulnerabilities may be impacted by the proposals (1/2)

- The largest number of **people living in areas of deprivation** are concentrated on the eastern (option B) and western (option A) parts of the catchment population
- There is a concentration of **people who are economically inactive** in the west of the catchment (option A) and around the Whittington Hospital (option B)
- The largest proportion of people from **ethnic minorities** are concentrated in the west around the Royal Free Hospital in Kilburn, Harlesden and Willesden
- The largest concentrations of people who have **poor English proficiency (including literacy)** are in the west (option A). There is also a large concentration of non-English speakers around Wood Green close to the Whittington Hospital (option B).
- People in **inclusion health groups** are concentrated to the south of the Whittington Hospital and to the east of the Royal Free Hospital plus in Harlesden and Willesden (option A).

People living in areas of deprivation  
Rate (%) of population



People from ethnic minority groups  
Rate (%) of population

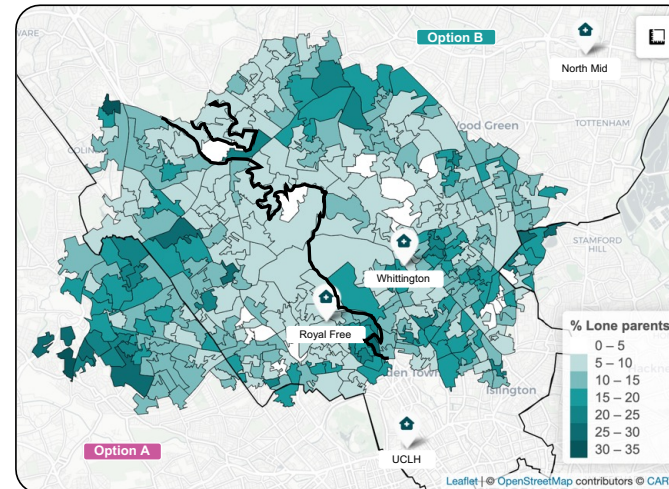




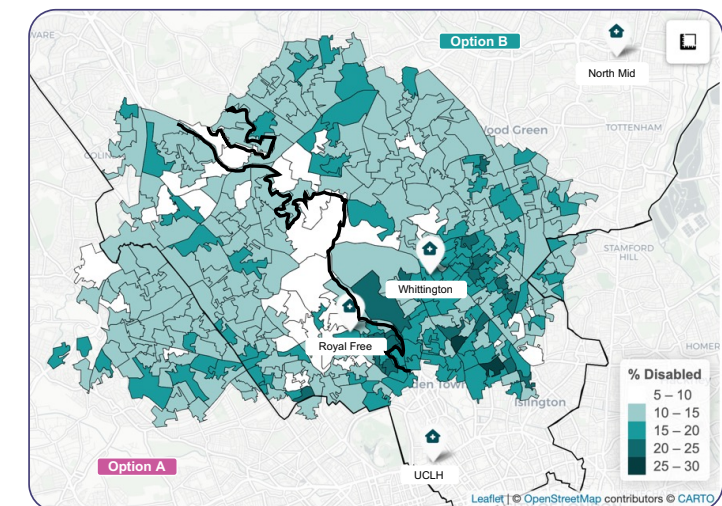
## People with protected characteristics and vulnerabilities may be impacted by the proposals (2/2)

- **Women of child-bearing age** are mostly evenly distributed across the catchment, although there is a concentration east of the Whittington Hospital
- There are pockets of **single-parent households where the single-parent is a mother** across the catchment population
- The largest concentration of **people with a disability** are between the Royal Free Hospital and the Whittington Hospital, with an above-average concentration of people with a disability around the Whittington Hospital, who would be impacted if option B were implemented
- **An additional eight groups** were explored using engagement and qualitative assessments only: transgender populations, religion, people who are LGBTQ+, younger pregnant women and people, older pregnant women and people, people with serious mental illness, people with learning disabilities and inclusion health groups

People with single parent (mother) households  
Rate (%) of population



People with disabilities  
Rate (%) of population





# Implementation of option A or B would improve quality and patient experience

## Quality and patient experience benefits of options A and B

- The proposed new care model would improve quality and experience for service users and staff
- The benefits of the care model align to the opportunities for improvement highlighted in the case for change

Category	Benefit description	Outcome
Care that ensures equity of provision and experience	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Provide a more personalised experience and ensure the individuals are supported and communicated with that best suits their own needs</li> </ul>	Improved patient experience and outcomes
		Maternity clinical negligence scheme for Trusts (CNST)
		Reduced normal care days delivered in an acute setting through enhanced delivery of community services
Services which are clinically sustainable	<ul style="list-style-type: none"> <li>• Redesigning and reconfiguring our neonatal units in NCL, ensuring all units are either a designated LNU (level 2) or NICU (level 3).</li> </ul>	Reduced neonatal transfers between units
Training and development opportunities	<ul style="list-style-type: none"> <li>• Supporting training and development opportunities for staff through delivering sustainable volumes of neonatal activity at all neonatal units.</li> <li>• 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</li> </ul>	No consultant workforce rota supporting the SCU (level 1)
		Consolidation of existing workforce into four units
		Improved recruitment and retention
Capacity to meet projected demand	<ul style="list-style-type: none"> <li>• Investing in additional capacity for neonatal and maternity services would ensure that there is enough capacity available</li> <li>• Neonatal units are running at less than the 80% recommended occupancy rate</li> </ul>	Reduced number of transfers to NIUC (level 3) outside of NCL through increase capacity in NCL
		Reduced risk of separating women or person from their baby and improving their experience
Up to date estate and buildings which are fit for purpose	<ul style="list-style-type: none"> <li>• 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</li> <li>• Any new capacity delivered will meet the latest space standards and this will have a role in delivering clinical benefits</li> </ul>	Improved efficiencies
		Improved staff experience by enhancing staff environment



# A potential impact of the proposals on the catchment population would be an average increase in taxi cost of ~£5

- **Significant engagement** was undertaken to identify the potential impact on access for each option
- We reviewed **four access statistics** (digital access, public transport accessibility, car ownership and parking spaces) and **five impact metrics** (travel time (peak/public transport), travel time (peak taxi/private car/), travel time (off-peak taxi/private car/ambulance), taxi costs and driving costs) to assess the potential impact of our proposals on access

<b>1 Digital access</b>	Poor digital access might create barriers for accessing care if people cannot access equipment or data	<b>1 Public transport travel time</b>	Additional public time to travel to sites can be difficult and might dissuade people who rely on public transport
<b>2 Public transport accessibility</b>	Lack of public transport accessibility may make it difficult for people without access to a car to access services	<b>2 Peak travel time</b>	Additional time to travel to sites can be difficult for people and might dissuade them from attending
<b>3 Car ownership</b>	Lack of car access may mean people find it difficult to access services, particularly if public transport is not good	<b>3 Off-peak travel time</b>	Additional time to travel to sites can be difficult for people and might dissuade them from attending
<b>4 Parking spaces</b>	Lack of parking might make accessing sites difficult, particularly for vulnerable populations (such as the disabled)	<b>4 Taxi costs</b>	People without access to a car may need to catch a taxi and high taxi costs may cause be unaffordable
		<b>5 Driving costs</b>	Long / expensive journeys might place financial strain on some households

## Average impact on catchment population by option

Moved unit		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>A</b>	Current	22.3	14.4	12.4	£17.55	£1.65
	Future	+6.3	+5.3	+6.7	+£4.90	+£0.46
<b>B</b>	Current	18.9	14.1	12.1	£16.10	£1.51
	Future	+7	+5.8	+5.4	+£4.43	+£0.42

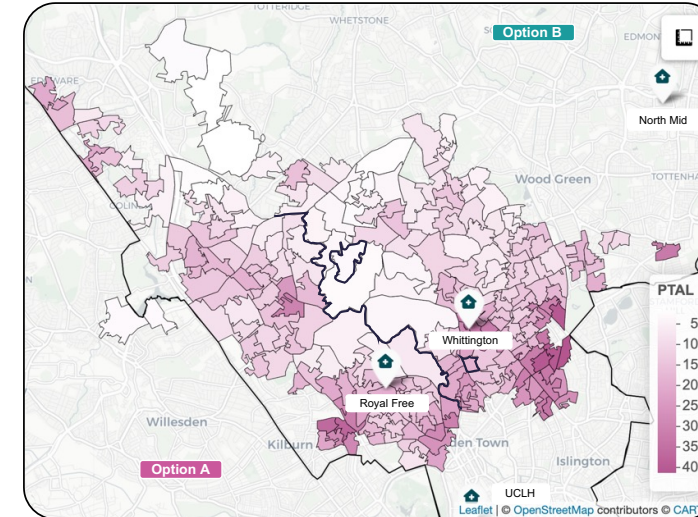
- A potential impact of the proposals on access for the catchment population would be an **average increase in taxi costs of ~£5 and a maximum of ~£11**, for options A and B
- There would be a **limited increase in average travel times** for peak, off-peak and public transport for options A and B. People in the catchment area would be able to reach a maternity unit:
  - within 30 minutes at peak driving time
  - within 25 minutes at off-peak driving time
  - with limited impact on public transport travel times, up to a maximum of 7 additional minutes



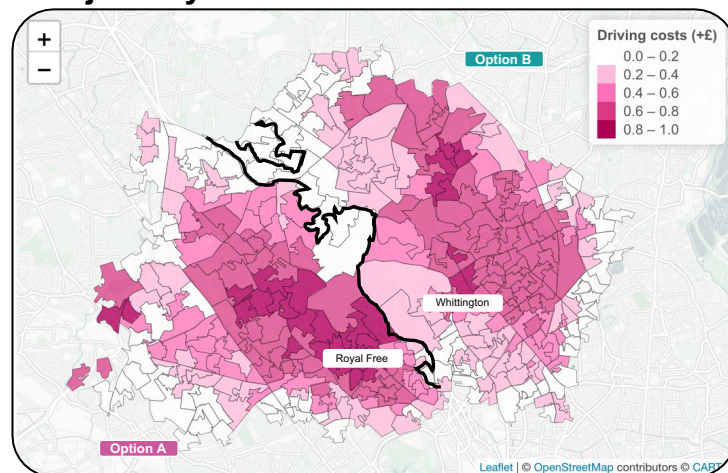
# People closest to the closing units may need to pay up to an additional £11 per taxi journey

- There would be a **similar number of on-site car parking spaces** retained for options A and B compared to the status quo
- Options A and B offer a **similar level of public transport accessibility** to each other. There is better public transport accessibility closer to the centre of London.
- **Average additional driving costs are minimal**, and similar for options A and B, with a maximum increase of less than £1 compared to current costs. The largest increase in driving costs would be for people who live closest to the potentially closing unit.

## Public transport accessibility



## Taxi journey costs



- **Average additional taxi costs are similar for options A and B**, around £4-£5 more. People closest to each of the potentially closing units may need to **pay up to an additional £11 per taxi journey** compared to now
- There is a **similarly high level of digital access within the catchment population** for options A and B
- **People have similar access to cars** for options A and B, around 50% of the population have access. Car ownership varies, with disabled populations substantially less likely to own a car, and a slightly lower population of people with disabilities in option A.



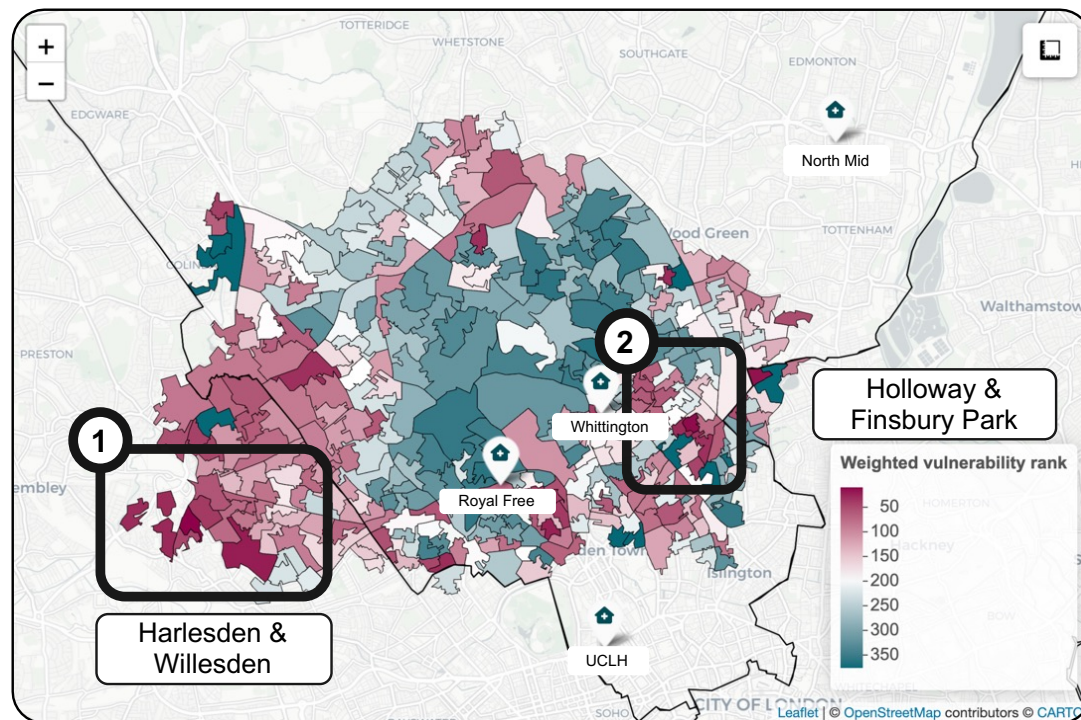
# There are some impacts on people with protected characteristics and people who have vulnerabilities

- The potential impact of our proposals on **people with protected characteristics** and **people who have vulnerabilities** has been reviewed and some areas identified where they may be disproportionately impacted
- There is an impact on some groups that may **need to be mitigated** because of the proposals, as shown in the table below
- **Further details of mitigations** that have been developed are shown later in this executive summary

		Potential impacts that may require mitigations
Protected characteristic	Race	<ul style="list-style-type: none"> <li>• No difference between the options</li> <li>• Language barriers would need to be addressed if people not proficient in English need to access an unfamiliar unit</li> <li>• The Somali communities in Finsbury Park and Kilburn may need to travel further or switch hospital compared to now</li> </ul>
	Age	<ul style="list-style-type: none"> <li>• No difference between the options</li> <li>• May need to attend more appointments throughout their pregnancy and could be impacted if were further away compared to now</li> </ul>
	Sex	<ul style="list-style-type: none"> <li>• No difference between the options</li> <li>• No specific mitigations required</li> </ul>
	People with disabilities	<ul style="list-style-type: none"> <li>• No difference between the options</li> <li>• People with a disability may have difficulty accessing services on an unfamiliar site compared to now</li> </ul>
	Being pregnant or on maternity leave	<ul style="list-style-type: none"> <li>• No difference between options</li> <li>• No specific mitigations required</li> </ul>
	Gender reassignment	<ul style="list-style-type: none"> <li>• No difference between the options</li> <li>• No specific mitigations required</li> </ul>
	Religion of belief	<ul style="list-style-type: none"> <li>• Greater impact on the orthodox Jewish population under Option A</li> <li>• Specific mitigations are being developed for this community</li> </ul>
	Sexual orientation	<ul style="list-style-type: none"> <li>• No difference between the options</li> <li>• No specific mitigations required</li> </ul>
	Being married or in a civil partnership	<ul style="list-style-type: none"> <li>• No difference between the options</li> <li>• No specific mitigations required</li> </ul>
Other	People living in areas of deprivation	<ul style="list-style-type: none"> <li>• People living in areas of deprivation in option B are nearer to the maternity unit that may move than option A, so the impact would be more significant for this population (people may pay up to £11 more to travel by taxi compared to now)</li> <li>• Potential overlap with race, other inclusion groups and disabilities</li> <li>• People living in areas of deprivation may have difficulties with cost of transport, digital exclusion and barriers for people who already have children compared to now</li> </ul>
	Other inclusion health groups	<ul style="list-style-type: none"> <li>• No difference between the options (potential overlap with race, deprivation and disabilities)</li> <li>• People in other inclusion groups may have difficulties with cost of transport, digital exclusion and language barriers compared to now</li> </ul>



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



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

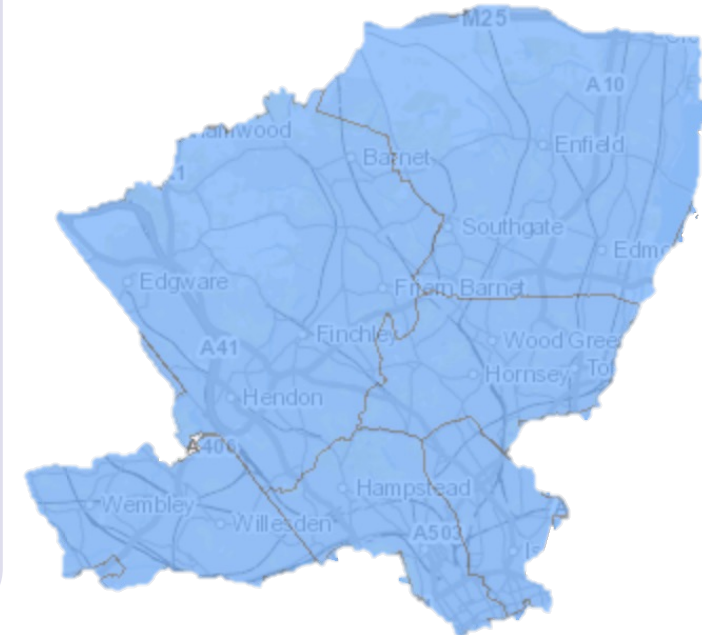
- **Two geographical areas** were identified as having residents who may be more vulnerable to the impact of our proposals because they face barriers to accessing services due to living in areas of deprivation and having high levels of poor general health
- As a result of the proposals, people in **Harlesden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



## There would be a small increase in emissions within air quality management areas

- The analysis identified **four sustainability metrics** to explore the potential sustainability impact: travel carbon impact, building carbon impact, protected air quality and anchor institutions
- There would be a small increase but similar **travel carbon impact** for options A and B due to the small increase in travel distances and increased vehicular emissions. This may need to be mitigated as options A and B are within air quality management areas (AQMAs)
- **Refurbishment carbon emissions** for Option A where the Whittington Hospital requires significant construction would be mitigated as part of their net zero strategy for their wider refurbishment programme
- In options A and B, there would be little impact on the hospitals as **anchor institutions** as the services represent a small percentage of the hospital's overall workforce

AQMAs associated with the catchment



### Total impact on the workforce

Current workforce by WTE that would be moved as a % of the total clinical workforce (2021/22)

Option	Total workforce moved (clinical staff only)	Percentage of total workforce
Option A	168.4	2.0%
Option B	127.3	3.6%

# Potential impact of option A

Option A					
Population	Quality	Access	Populations with protected characteristics and people who have vulnerabilities	Sustainability	Geographical populations
<p>There is a slightly smaller population that could potentially be impacted for option A (~373,000 people driving and ~230,000 people on public transport) compared to option B (~378,500 people driving and ~298,000 people on public transport)</p>	<p>Option A and B would deliver the proposed maternity and neonates care model, and would therefore deliver positive clinical impact:</p> <ul style="list-style-type: none"> <li>Care that ensures equity of provision and experience</li> <li>Services which are clinically sustainable</li> <li>Up to date estate and buildings which are fit for purpose</li> <li>Training and development opportunities</li> <li>Provide choice for pregnant women and people</li> </ul>	<ul style="list-style-type: none"> <li>Average increase in taxi costs would be £4.90 and the average increase in driving costs per journey is £0.46, with 50% car ownership compared to now.</li> <li>Average travel times would increase by 5.3 minutes by car and 6.29 minutes by public transport compared to now. People in the catchment population would be able to access services within 30 minutes at peak driving time and within 25 minutes at off-peak compared to now.</li> </ul>	<ul style="list-style-type: none"> <li>Greater impact on the orthodox Jewish population under Option A</li> <li>Ethnic minorities may face language barriers when travelling to, and accessing, a different hospital site</li> <li>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</li> <li>People with disabilities may have difficulties changing service location, especially without access to a car, compared to now</li> <li>People living in deprived areas may face difficulties with cost of transport, digital exclusion and already having children when travelling further or to a new site</li> <li>Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language when travelling further or to a new site</li> <li>The Bangladeshi and Pakistani population in Chalk Farm are close to a maternity unit that may move in this option, and therefore may be more impacted in terms of travel times compared to other groups</li> </ul>	<ul style="list-style-type: none"> <li>There is a small increase in carbon emissions of 216g per average journey as a result of slightly increased travel times compared to now</li> <li>There are substantial environmental gains to be made in making the building more energy efficient compared to now</li> <li>127 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</li> </ul>	<ul style="list-style-type: none"> <li>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 – also a high number of Black African and Caribbean and Bangladeshi and Pakistani people</li> <li>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, may not be as significantly impacted by increased taxi costs compared to now as those who reside closer to the maternity unit that may close.</li> <li>This population may face barriers to attending an unfamiliar site compared to now</li> </ul>

# Potential impact of option B

Option B					
Population	Quality	Access	Populations with protected characteristics and people who have vulnerabilities	Sustainability	Geographical populations
<p>There is a larger population that could potentially be impacted for option B (~378,500 people driving and ~298,000 people on public transport) compared to option A (~373,000 people driving and ~230,000 people on public transport)</p>	<p>Option A and B would deliver the proposed maternity and neonates care model, and would therefore deliver positive clinical impact:</p> <ul style="list-style-type: none"> <li>Care that ensures equity of provision and experience</li> <li>Services which are clinically sustainable</li> <li>Up to date estate and buildings which are fit for purpose</li> <li>Training and development opportunities</li> <li>Provide choice for pregnant women and people</li> </ul>	<ul style="list-style-type: none"> <li>Average increase in taxi costs would be £4.43 and the average increase in driving costs would be £0.42 per journey, with 47% car ownership compared to now.</li> <li>Average travel times would increase by 5.84 minutes by car and 6.97 minutes by public transport compared to now. People would be able to access services within 30 minutes at peak driving time and within 25 minutes at off-peak compared to now.</li> </ul>	<ul style="list-style-type: none"> <li>Ethnic minorities may face language barriers when travelling to, and accessing, a different hospital site</li> <li>Somali community in Finsbury Park who would access services at the Royal Free 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.</li> <li>People living in deprived areas 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)</li> <li>People with disabilities may have difficulties changing service location, especially without access to a car, compared to now</li> <li>People living in deprived areas may face difficulties with cost of transport, digital exclusion and already having children when travelling further or to a new site</li> <li>Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language when travelling further or to a new site</li> </ul>	<ul style="list-style-type: none"> <li>There is a small increase in carbon emissions of 195g per average journey as a result of slightly increased travel times.</li> <li>There are substantial environmental gains to be made in making the building more energy efficient</li> <li>168 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</li> </ul>	<ul style="list-style-type: none"> <li>Holloway and Finsbury Park was identified as a geography that could be particularly vulnerable to 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 Caribbean in it</li> <li>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</li> <li>This population may face barriers to attending an unfamiliar site compared to now</li> </ul>

# Several mitigations have been identified including some that are outside the scope of these proposals

Mitigations have been developed which address impacts identified both through the in-depth interim IIA analysis and the engagement with service users. There are several issues that we have heard through engagement, that we aim to address regardless of whether these proposals are implemented. These are being addressed through the NCL Local Maternity and Neonatal System (LMNS) equity and equality action plan. To address or reduce the potential negative impacts of the proposals identified in the sections above, so far as possible, we are considering several types of mitigations. We will consider the potential impacts of our proposals further, following consultation, and consider (a) whether any negative impact is justified as a proportionate means of achieving a legitimate aim and/or (b) can be addressed or reduced through mitigation measures.

There are several different impacts that may need mitigations if changes are implemented

- Communicating around implementation should changes be agreed
- Mitigations for those who may need extra support to access an unfamiliar hospital
- Information about how to travel to a hospital site
- Providing as much care locally as possible
- Support with the costs of travel to hospital
- Access to parking
- Access to midwifery-led care

There are several issues which may require actions outside of the scope of these proposals and are being addressed through the NCL LMNS

- Supporting staff training and understanding
- Service user involvement in maternity services
- Access to appropriate interpretation services
- Use of digital tools
- Supporting people with learning disabilities
- Provision of continuity of carer
- Personalised care and support plans
- Improving the quality of communication with service users
- Maternity data quality

Mitigations have been co-developed with both staff and patients:

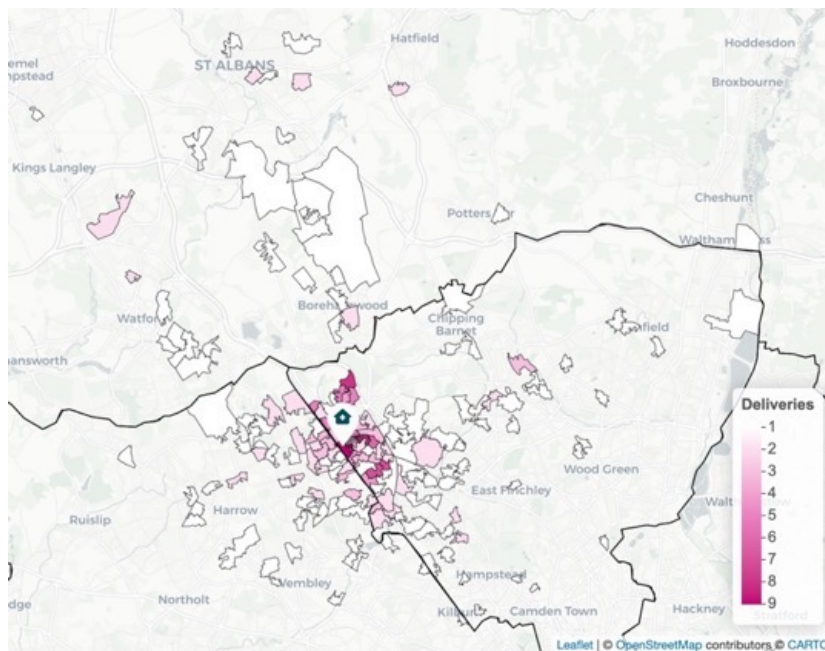
- Two system-wide workshops were held involving over 80 attendees including clinical staff, local authority reps and patients
- The Start Well patient participation and engagement group supported development of mitigations at two of their meetings

# Our proposals for Edgware Birth Centre means we need to consider people who may prefer to give birth out of hospital

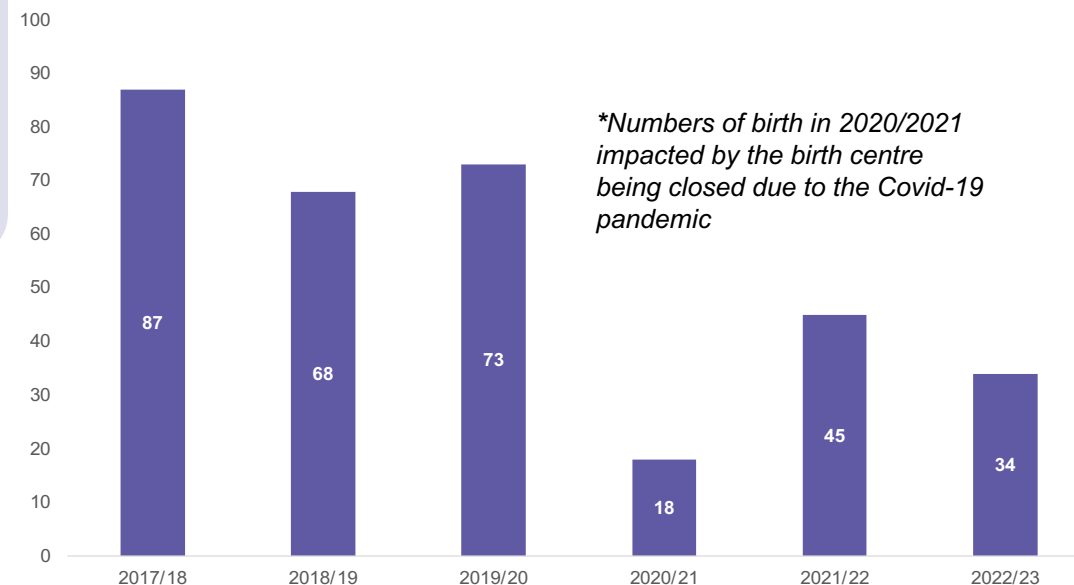
## North Central London Integrated Care System

- There were an extremely low number of deliveries at Edgware Birth Centre (EBC). In 2021/22, only 45 of just over 20,000 births in NCL units were delivered at EBC. The population who give birth at EBC are also extremely geographically disperse
- The number of births are so small and the geographical spread so wide, it is hard to say whether any group might be disproportionately impacted. Of the small number of people using the EBC, the only group that has been identified as possibly disproportionately impacted by the proposals are those for whom a hospital-based birthing experience may be stressful. We have considered them separately.

### Populations that have delivered at Edgware Birth Centre



### Number of births at Edgware Birth Centre



For people for whom a hospital-based birthing experience is not preferred, we would focus on:

- Investing in alongside midwife-led units
- Ensuring home birthing is consistently available as an alternative to hospital-based births
- Increasing the provision of continuity of carer for those that at highest risk of complications

## Mitigations related to proposals around Edgware Birth Centre have been developed



We would do the following to support our proposals around Edgware Birth Centre.

Further engagement to understand any impacts not yet identified associated with closing the delivery suites at Edgware. This would need to include those living in the local area, as well as across into neighbouring areas of Harrow and Hertfordshire.

Engagement with the local community to understand what maternity services could be provided at the site which would support improved access and care – for example antenatal classes tailored at the local population who may have complex needs

- For the small number of people for whom a hospital-based birthing experience is not preferred, we would focus on:
- Investing in co-located midwife-led units and making sure that the environment is set up in a way that facilitates the best outcomes for pregnant women and people who choose them
- Home birthing would remain a choice for pregnant women and people, and we would ensure that this is consistently available for those that would prefer a birth that is physically separated from a hospital site
- Freeing up room at Edgware would allow us to focus on increasing the provision of continuity of carer for local people at the highest risk of complications

## Access to midwifery-led care



A consistent offer and access to midwifery-led care is an important part of our care model. Should proposals around no longer supporting births at Edgware be implemented, there would need to be mitigations put in place to ensure that women for whom this is a preference can retain access to high-quality, consistently available midwifery-led care.

A review of the information made available to women at the point of booking to ensure that they are made aware of and are consistently offered the choice of midwifery-led care

A review of home birth provision and staffing of home birth teams across the sector to ensure equity of staffing in geographical areas. Currently there are some teams which staff much larger catchment areas than others, which can create gaps in provision and lead to challenges with recruitment

Consider how personalised care can be maximised in midwifery-led settings enabling women to feel cared for throughout their pregnancy

Ensuring midwifery-led birth centres are set up to provide the best possible birthing experience through a review of environment and staffing arrangements

Consider the identity of midwifery-led units, ensuring that they can be identified separately from labour wards to support women who may feel more anxious about a hospital-based birth

A review of staffing arrangements of midwifery-led units to ensure, that as much as possible, they can remain open at times when staffing is challenged and women who want to choose this as a birthing option are able to give birth there

# **Background to the interim Integrated Impact Assessment (IIA)**

# Summary: background to the interim Integrated Impact Assessment (IIA)

- We have developed proposals for maternity and neonatal services in NCL as part of the Start Well programme
- The interim integrated impact assessment (IIA) is used to understand the potential impact of the proposals on local people
- The interim IIA allows us to explore the impact of our proposals on people with protected characteristics and people who have vulnerabilities
- A robust approach has been adopted for the development of the interim IIA
- We have assessed our proposals for clinical, accessibility, sustainability and geographical impact
- We have undertaken engagement regarding our proposals which have contributed to a better understanding of the impact of our proposals on service users
- The interim IIA engagement reached over 120 patients, residents and staff

# We have developed proposals for maternity and neonatal services in NCL as part of the Start Well programme



North Central London  
Integrated Care System

## Background to Start Well Programme

- In November 2021, partner organisations in North Central London (NCL)'s Integrated Care System (ICS) formally launched **Start Well**, a long-term programme looking at **maternity, neonates, children and young people's services**
- A **case for change** was published in June 2022 which set out how services are currently delivered and highlighted some **opportunities for the future**
- **Engagement on the case for change** took place over Summer 2022 and a report summarising this was published in September 2022
- **New care models were developed** with a wide range of clinicians from organisations across the ICS as well as external stakeholders to respond to the opportunities identified in the case for change
- A paper on the **proposed future care models, potential implications and recommendations** was taken to the NCL ICB (Integrated Care Board) Board on 29 November 2022 and was approved
- An **options appraisal**, which is a formal process that considers **all viable options against the status quo** (how services are currently delivered) and their feasibility, was undertaken and options for consultation were identified
- The ICB is undertaking a **14-week public consultation** before any decisions to change services are taken, prior to the development of a decision-making business case (DMBC)

### Purpose

- NCL Start Well is undertaking **an interim Integrated Impact Assessment (IIA)** to assess and understand the potential impact of options A and B for consultation and identify **high level mitigations** to any potential negative impacts

# The integrated impact assessment is used to understand the potential impact of the proposals on local people



North Central London  
Integrated Care System

## Purpose of the Integrated Impact Assessment (IIA)

- Support the evaluation of the reasons for a proposed change to services and understand the potential impacts
- Help develop proposals, especially regarding health, accessibility and the environment
- Help decision makers and stakeholders be better informed about any decision that is made
- Ensures due attention is paid to the impact potential options have on equalities

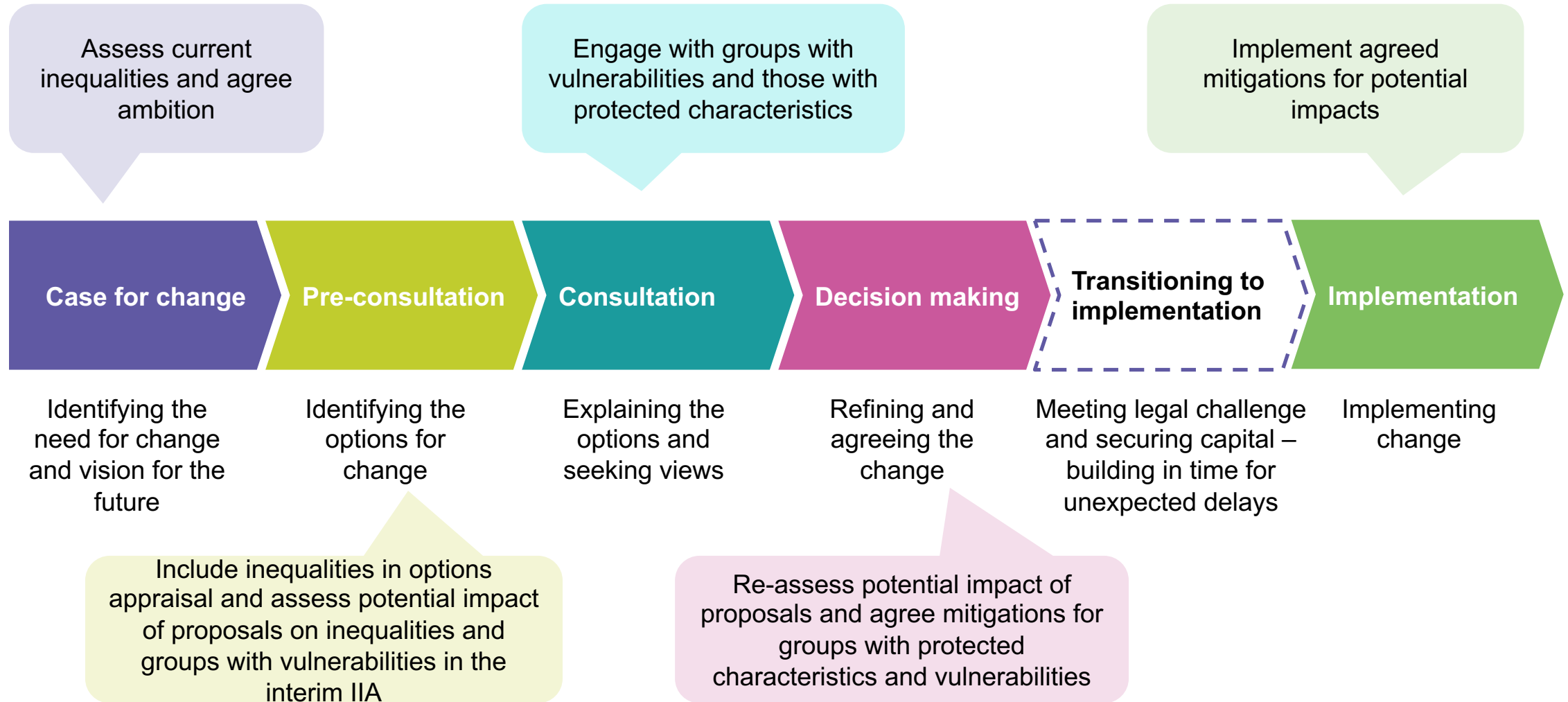
## Compliance with Public Sector Equality Duty (PSED)

- Have due regard to:
  - Eliminate unlawful discrimination, harassment and victimisation
  - Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
  - Foster good relations between people who share a relevant protected characteristic and those who do not share it

## Health and Care Act 2022

- NHSE, ICBs and NHS Trusts and Foundation Trusts are subject to the 'triple aim' duty in section 14Z34 of the Health and Care Act 2006 (as amended by the Health and Care Act 2022) which requires these bodies to have regard to 'all likely effects' of their decision in relation to:
  1. Health and wellbeing of people (including inequalities)
  2. The quality of health services provided to people (including inequalities in benefits from those services)
  3. Efficiency and sustainability in relation to the use of resources
- Each integrated care board must, in the exercise of its functions, have regard to the need to:
  - a. reduce inequalities between persons with respect to their ability to access health services, and
  - b. reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services (including the outcomes described in section 14Z34(3))

# The interim IIA allows us to explore the impact of proposals on inequalities and groups with vulnerabilities



## A robust approach has been adopted for the development of the interim IIA



- Understand current services and where they are delivered
- Review the proposed changes to the model of care
- Understand where services will be delivered for each potential option

- Assess which local people may be impacted by the proposals (catchment population)

- Understand the demographics and location of the population
- Understand populations who might be disproportionately impacted by the proposals or people who have vulnerabilities

- Understand the overall potential impact on moving services on quality, outcomes, patient experience, access, sustainability and geographical areas
- Assess this impact for those populations who may be disproportionately impacted or who have vulnerabilities

- Agree steps to mitigate against any negative impacts and enhance any benefits

# We have assessed our proposals for clinical, accessibility, sustainability and geographical impact

Assess impact of proposals on populations (including people who may be more vulnerable to the impact of our proposals)

## Clinical

The potential impact of the proposals on **quality, outcomes and patient experience**

We have explored the potential impact of **people sharing protected characteristics, vulnerable populations, capacity, mental health and perinatal care**

We have explored how our proposals will impact on the issues identified in our **case for change**

## Accessibility

The potential impact of the proposals on the ability of different groups to **access care**

We have explored the potential impact on **ease of accessing care** through different means (ambulance, public transport, taxi or car) and **limiting factors** such as lack of access to a private vehicle, lack of proficiency in English and poor digital skills

## Sustainability

The potential impact of the proposals on **sustainability** within health services

We have explored the potential impact on both **the environment and the wider community** by examining factors such as carbon emissions, and impact of hospitals as anchor institutions

## Geographic

The potential impact of the proposals on specific **geographic populations** with multiple risks of vulnerability

We have explored the potential impact on **geographic populations** and identified where there might be a significant impact on specific groups in certain geographic areas

# Through engagement, we sought to better understand the impact of proposals from a wide range of groups

## Groups scoped into Start Well maternity and neonatal interim IIA engagement

'Older' women (35+)	Women with physical disabilities	Asian women	Jewish women	People living in areas of deprivation
Parents who are carers	Women with long-term health conditions	Muslim women	Families who have experienced bereavement	People with poor literacy
Women with learning disabilities	Inclusion health groups (e.g., asylum, homelessness)	Parents with experience of neonatal care	Gypsy, Roma and Traveller communities	
Black women	People who are LGBTQ+ parents	Women who have given birth at Edgware	Eastern European women	

Groups were identified to be **scoped in** based on their **protected characteristics** as well as **evidence of poorer maternal outcomes and / or experience of maternity care**. This was identified through the **case for change** and a **subsequent evidence review** by the Camden Health and Wellbeing Team.

Some groups were included as they are **users of specific services** where there **may be changes proposed** (e.g., neonatal services and Edgware Birth Centre).

There were rich areas of feedback identified in the wider engagement report that relate more to how services are delivered as opposed to considerations for when services are changed. Actions are needed to address this feedback do not require a change to services to be delivered and therefore these are being taken forward through our local maternity and neonatal system (LMNS).

# The interim IIA engagement reached over 120 patients, residents and staff

## Interim IIA engagement reach



**38** engagement meetings facilitated



**124** patients, residents and staff have been involved



**9** sessions with parents who have recent experience of neonatal care



**5** meetings with specialist midwives supporting women with complex needs

## People reached through engagement:

- Parents of children with learning disabilities and autism
- Parents with learning disabilities
- Women over 35
- Eastern European Forum
- African Health Forum
- Jewish women
- Lesbian women
- Muslim women
- Women who have given birth at Edgware
- Families who have experienced bereavement
- Women who are asylum seekers
- Specialist midwives who support women during pregnancy:
  - Experience of domestic violence
  - Severe mental illness
  - Homelessness
  - Female genital mutilation

Engagement on the programme does not stop at this stage. We will engage with groups not reached through initial interim IIA engagement as well as other groups through consultation.

# Proposed service changes

## Summary: proposed service changes

- The Start Well programme case for change highlighted opportunities for improvement in maternity and neonatal services in NCL
- We have developed a new model of care for maternity and neonatal services that address these opportunities
- We developed and appraised options for the location of maternity and neonatal units in NCL
- We have developed two proposed options, options A and B, to implement the proposed new model of care

# Our case for change highlighted opportunities for improvement in maternity and neonatal services in NCL

## Maternity opportunities for improvement



### Ensuring equality in maternity service provision and experience

- Stillbirth rate varies between boroughs, Haringey had the highest rate with 6.3 per 1,000 population
- Only 4.9% of pregnant women and people in NCL access perinatal mental health services



### Better utilisation of maternity capacity offered in NCL

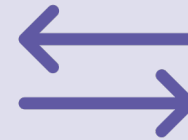
- Range of units in NCL are not all used equally
- For some sites in NCL, use of their midwifery-led units in 2021 was around 30% or under, whilst obstetric-led units were dealing with significant capacity pressures.



### Supporting maternity workforce sustainability

- For many trusts, bank and agency are used to fill shifts to ensure compliance with this target due to vacancies
- For our units to comply with the new staffing standards we need to recruit an additional 27 midwives across the system

## Neonatal opportunities for improvement



### Matching neonatal care capacity and demand

- UCLH and GOSH NICU had occupancies higher than the maximum threshold
- Over stretched level 3 capacity in NCL resulted in 40 babies in 2020/21 needing to be transferred



### Consider the sustainability of the RFH Special Care Unit

- The unit delivers 111 respiratory care days which is significantly below the 365 day BAPM upper threshold
- Low numbers of babies admitted creates a challenge for staff to maintain the required competencies



### Minimising avoidable admissions to neonatal units

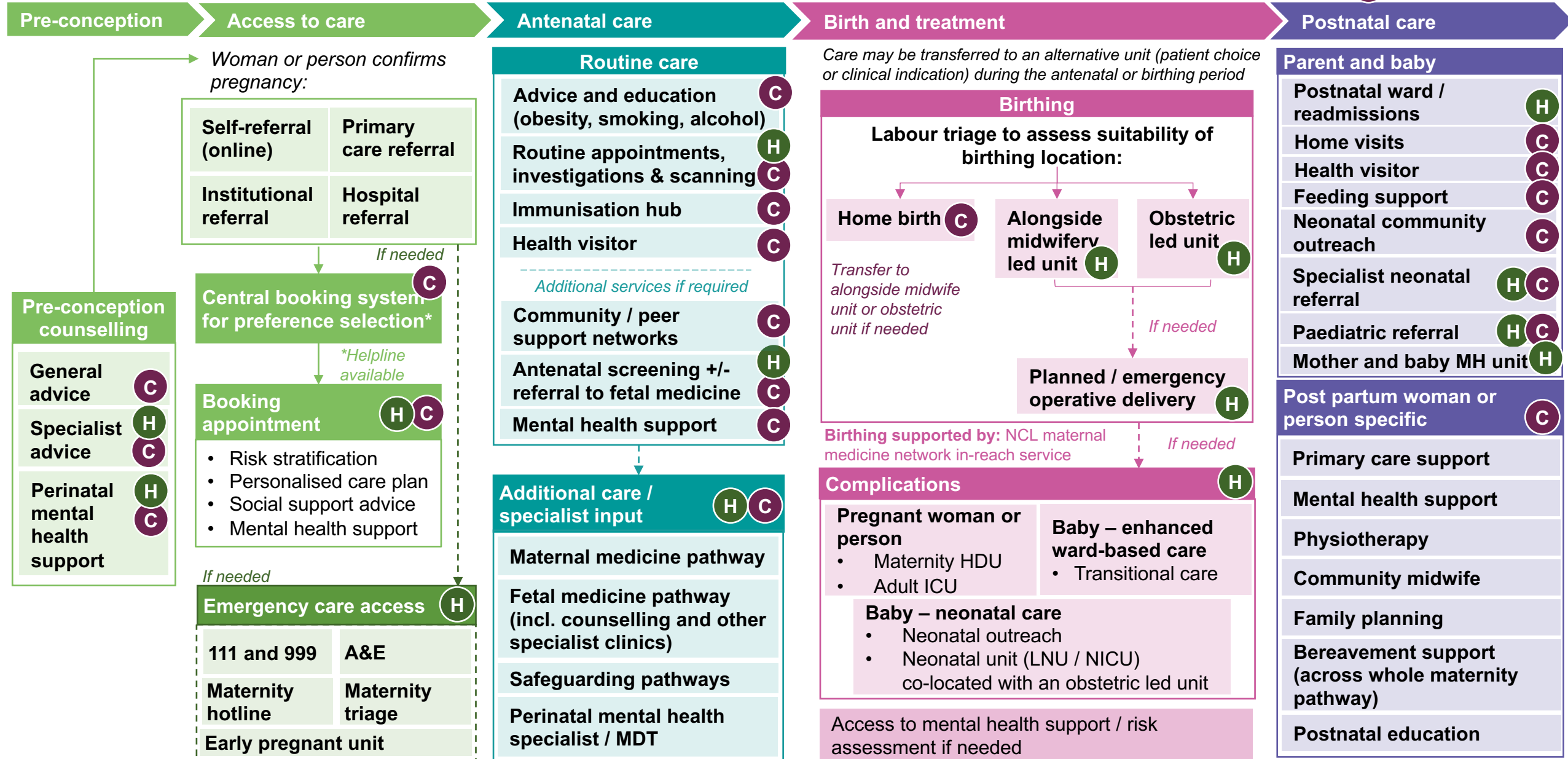
- The existing provision of neonatal community outreach programmes is not consistent between our boroughs



### Addressing workforce vacancies and variation in provision and access to AHPs across neonatal units

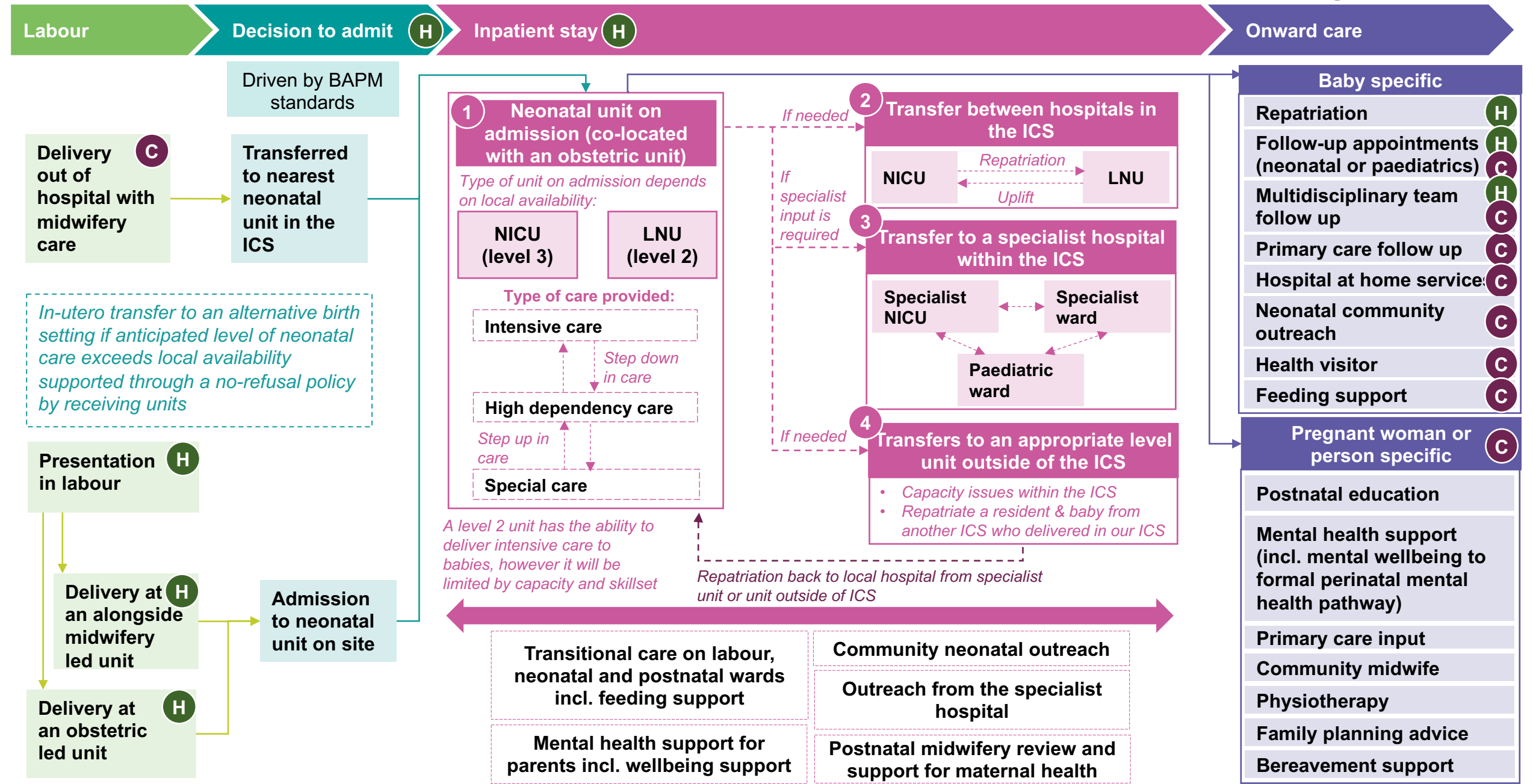
- North Mid are unable to open their full establishment of cot spaces due to nursing vacancies
- NCL require an uplift in nursing establishment by 26.1 WTEs to meet the Dinning tool requirements

# We have developed a new model of care for maternity services

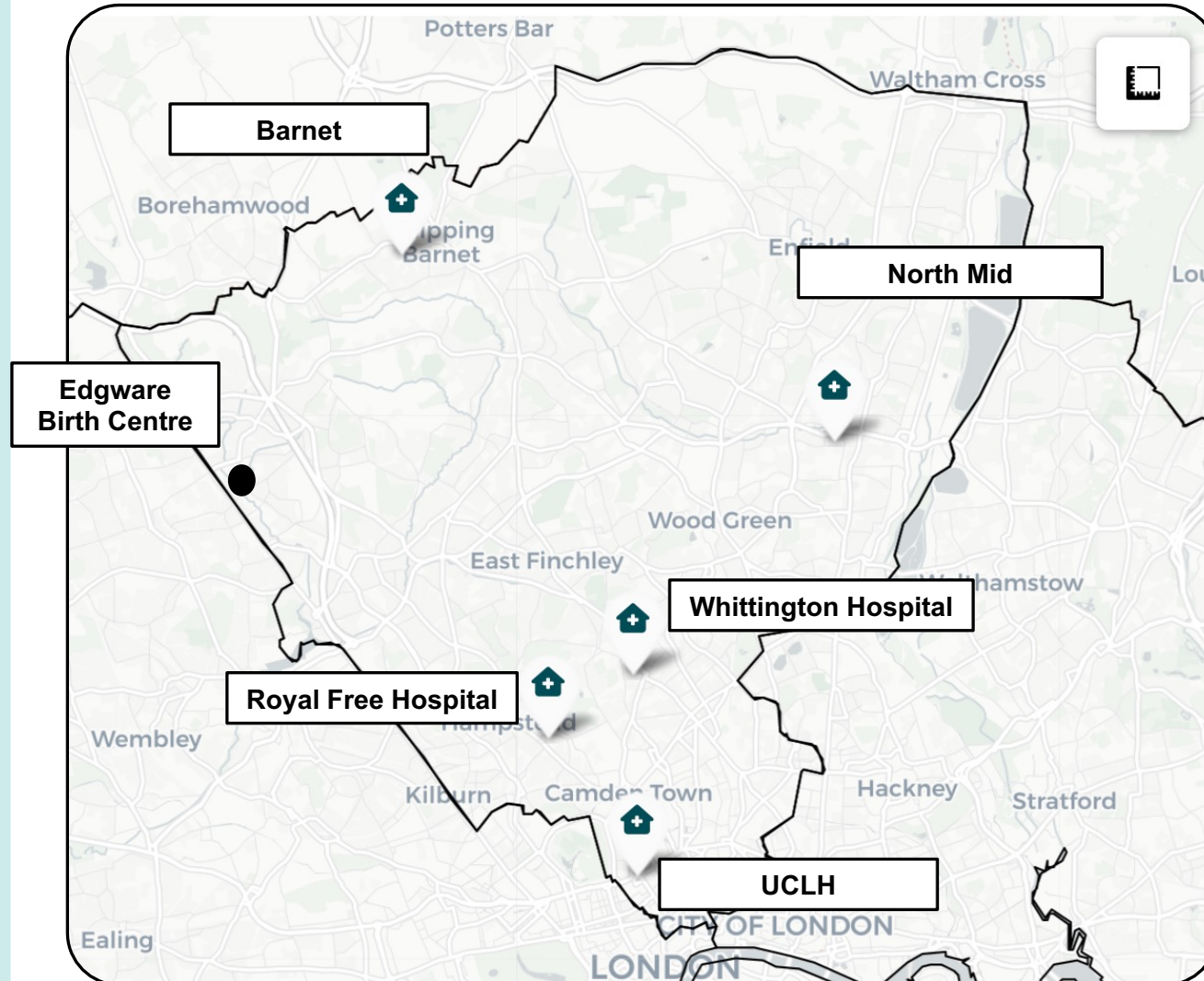


- Maternity continuity of carer, mental health support and safeguarding input throughout maternity care
- Access to local support through voluntary sector organisations and family hubs

# We have developed a new model of care for neonatal services



# We developed and appraised options for the location of maternity and neonatal units in NCL



We undertook a process to develop options for consultation on the location of maternity and neonatal units in NCL:

- Currently there are five obstetric-led maternity units and alongside midwife led units with co-located neonatal units at Barnet, North Mid, Royal Free Hospital, UCLH and Whittington Hospital. There is one standalone midwife-led unit at Edgware Birth Centre
- It is proposed that there will be four obstetric-led maternity units and alongside midwife led units co-located with four neonatal units in the future
- We propose closing the birthing suites (standalone midwife-led unit) at Edgware Birth Centre. This is being considered as a separate proposal. The potential impact of these proposals can be found on slide 163.
- The following pages will focus only on options for consultation around the number of maternity and neonatal units

# We have developed two proposed options, options A and B, to implement the proposed new model of care

## Option A: UCLH, North Mid, Barnet, Whittington

**UCLH**

Consultant-led obstetric unit with co-located NICU (level 3) neonatal intensive care unit and alongside midwife-led unit

**North Mid**

Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit

**Barnet**

Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit

**Whittington Hospital**

Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit

## Option B: UCLH, North Mid, Barnet, Royal Free

**UCLH**

Consultant-led obstetric unit with co-located NICU (level 3) neonatal intensive care unit and alongside midwife-led unit

**North Mid**

Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit

**Barnet**

Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit

**Royal Free Hospital**

Consultant-led obstetric unit with co-located LNU (level 2) and alongside midwife-led unit

- The difference between the options is that the Whittington Hospital retains its consultant-led obstetric unit with co-located local neonatal unit (level 2) in Option A and the Royal Free Hospital becomes a consultant-led obstetric unit with co-located Level 2 neonatal intensive care unit in Option B (the Royal Free Hospital currently has an obstetric and midwifery-led unit with co-located special care (level 1) neonatal unit)
- We have developed two proposals for maternity and neonatal services. These proposals are independent from each other. We developed and appraised options for the location of maternity and neonatal units in NCL, for which there are two proposed options for consultation (options A and B). We also have developed a proposal to close the birthing suites at Edgware Birth Centre (see slide 163). This interim IIA assess the impact on both proposals.

# Identifying the potentially impacted catchment population

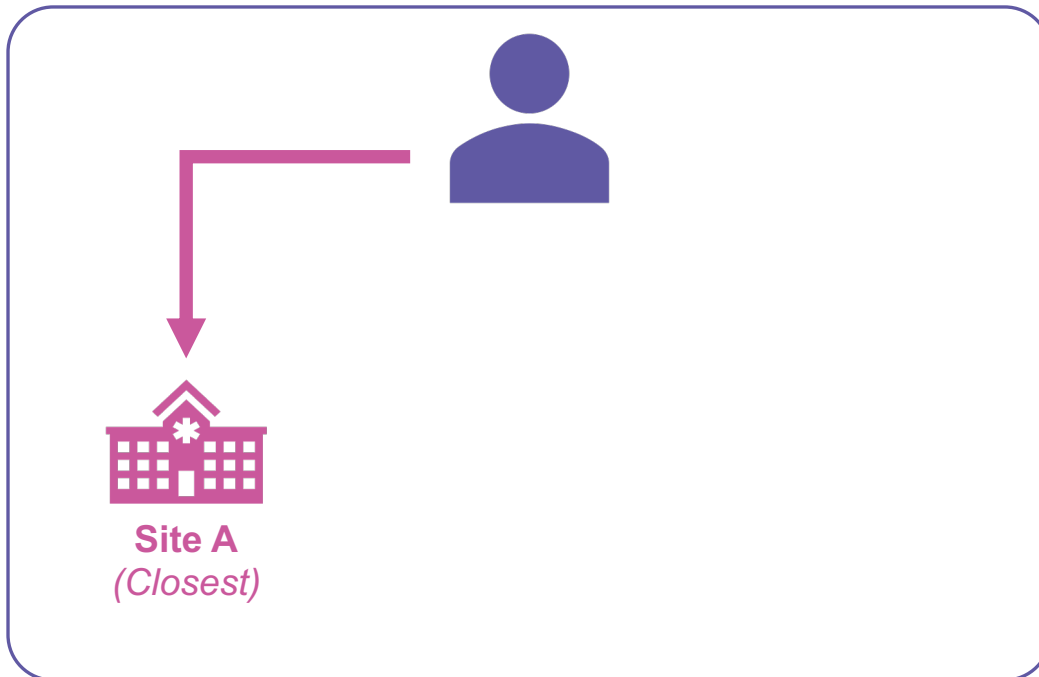
## Summary: identifying the potentially impacted catchment population

- We identified the geographical area of people who would potentially be impacted by our proposals (the catchment population) based on travel times. We identified the catchment population by identifying the geographies whose closest hospital based on travel time is currently Whittington Hospital or the Royal Free Hospital.
- We looked at people who might be impacted by our proposals for maternity and neonatal units when driving (or being driven). There is a slightly smaller population that could potentially be impacted for option A (~373,000 people) versus option B (~378,500 people)
- We looked at people who may be impacted by our proposals for maternity and neonatal units when using public transport. There is a smaller population that could potentially be impacted for option A (~230,000 people) versus option B (~298,000 people)
- We also looked at where people impacted by option A and option B would be likely to flow if their nearest unit (by travel time) were no longer available

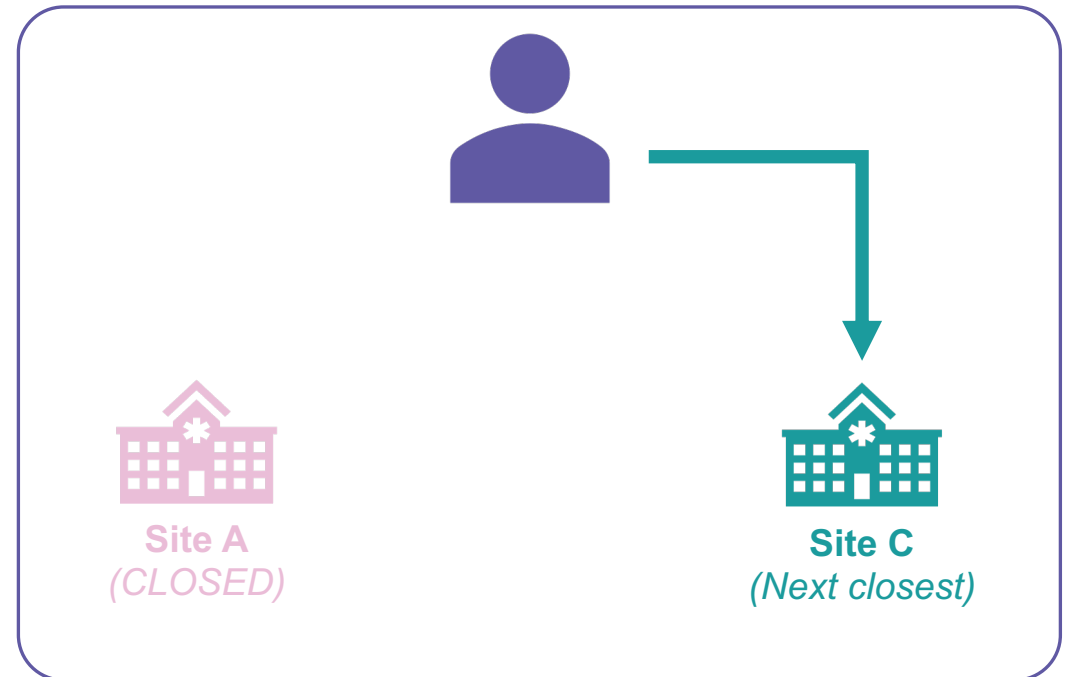
# We identified the people who may be impacted by the proposals (the catchment population) based on travel times

- We looked at where people live and identified populations whose closest hospital is Whittington Hospital (option A) or Royal Free Hospital (option B), who may be impacted by the proposals
- For the catchment populations we looked at what the next closest hospital would be and assessed what the travel impact would be by off-peak driving (car, taxi and ambulance), peak driving (car and taxi) and public transport
- We also looked at the other possible impacts on those catchment populations

Currently: where people go now (the closest)



Future: Predicted flow if maternity unit at Site A closed



# Several assumptions have been used to generate travel times

## 1. Analysis takes the population mid-point of each LSOA as the basis for measuring travel times

Lower Super Output Areas (LSOAs) are a geographic unit that comprise between 400 and 1,200 households and usually have a resident population between 1,000 and 3,000 persons.

An LSOA is a geographical area, rather than a discrete geographical point (such as a crossroads or station). In London, most LSOAs are small and have relatively evenly-spread populations. However, outside London, the LSOAs get larger, and the closest provider may change depending on which part of the LSOA is being travelled from, so the modelling uses the geographical point in the LSOA where the most people live (called “the population mid-point”).

## 2. Analysis uses weekday mornings as the definition of ‘peak time’ and 3:00 AM for ‘off-peak time’

TravelTime API’s “weekday mornings” (defined as 9:00 AM) was used for taxi / private car and public transport maps. Off-peak time was defined as 3:00 AM on a weekday and can be used as a proxy for ambulance travel times.

## 3. Analysis uses TravelTime API for calculating travel time between LSOA population mid-points and providers

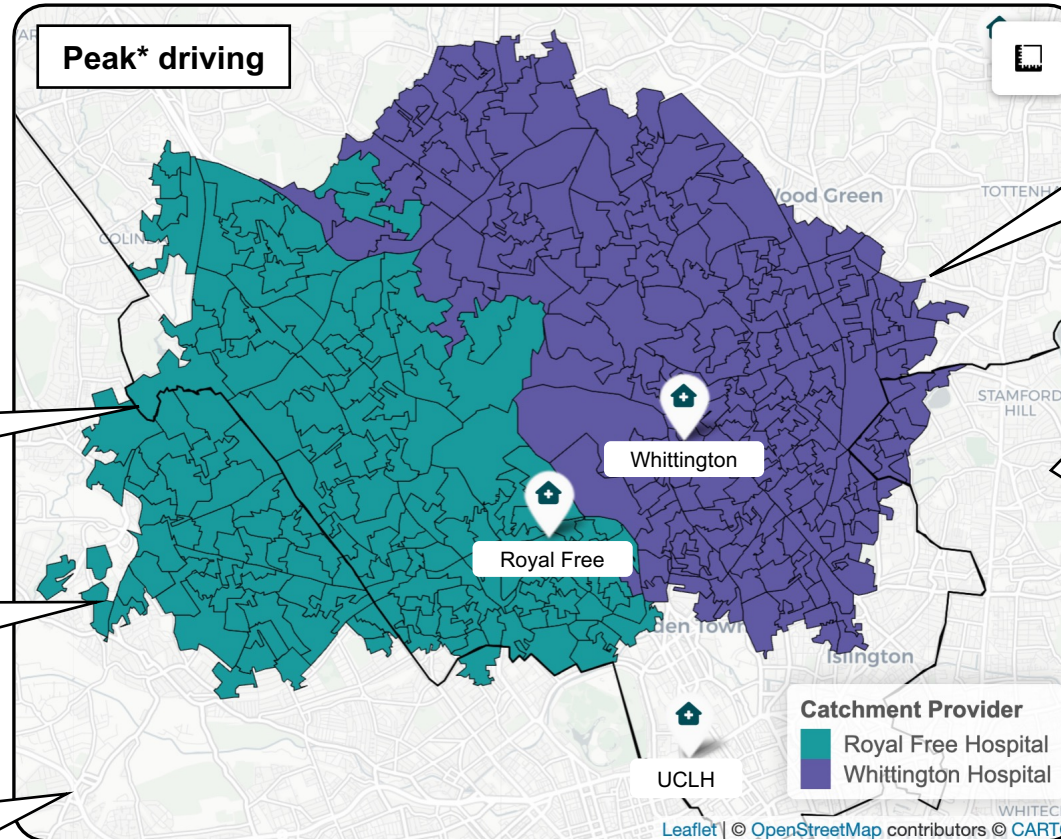
TravelTime API is a reliable tool for measuring travel time. It averages expected travel times from different sources to get a robust estimate of the time needed to travel from any two co-ordinates in Great Britain.

**A sample of LSOAs have been double-checked with results against other sites such as Google Maps to ensure accuracy**

# We looked at people who may be impacted by our proposals for maternity and neonatal units when driving

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

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



NCL integrated care system boundaries

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

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

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

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

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

\*Peak (private car / taxi) is defined as 9:00 AM on a Tuesday

\*\*LSOAs are lower super output areas and are populations of around 1,000 – 3,000 people that are used to do travel analysis

# We looked at people who may be impacted by our proposals for maternity and neonatal units when using public transport

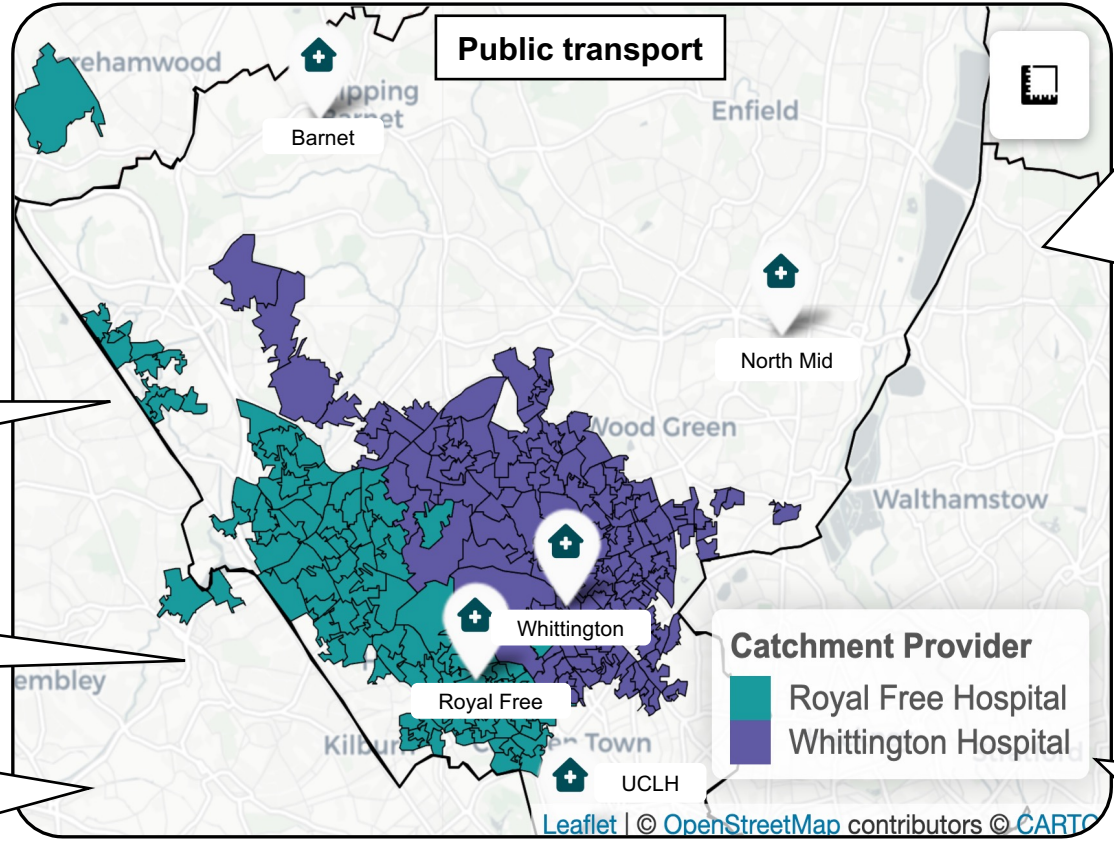
**Option A catchment includes**  
**Population:** 230K  
**Households:** 74.5k  
**LSOAs\*\*:** 114

**Option B catchment includes**  
**Population:** 298k  
**Households:** 97.5k  
**LSOAs\*\*:** 164

NCL integrated care system boundaries

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

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



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

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

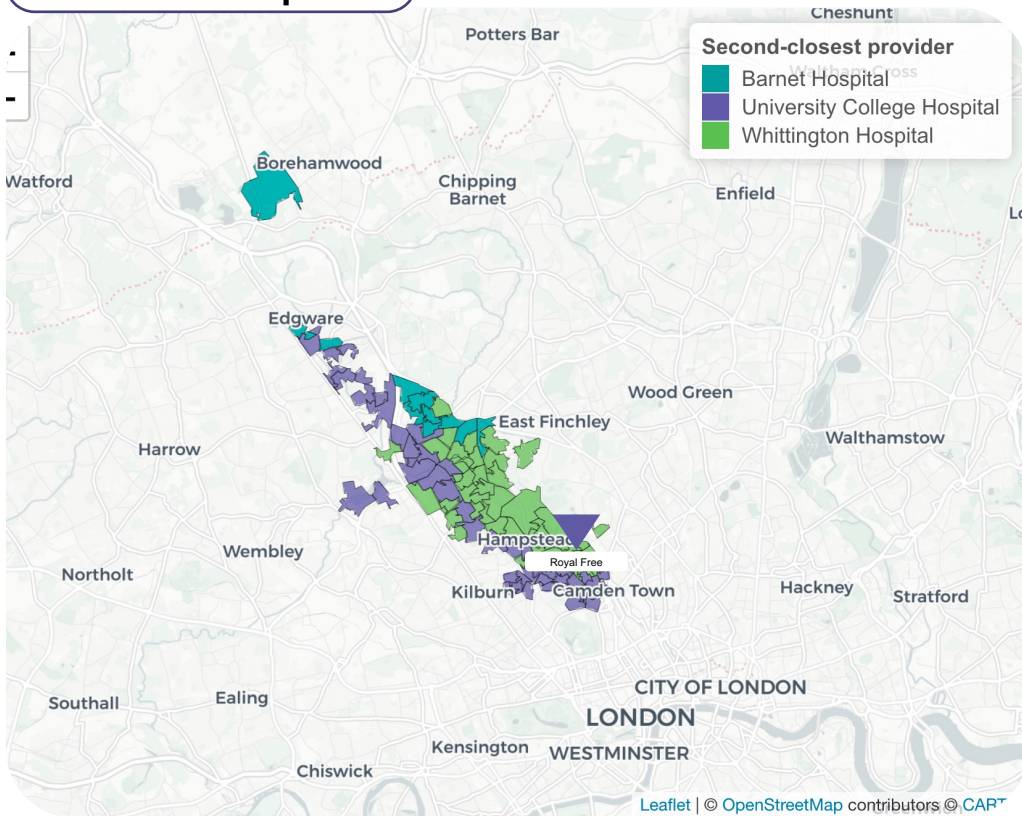
Whittington Hospital catchment area (people who are closest to the Whittington Hospital)

\*Peak (public transport) is defined as 9:00 AM on a Tuesday

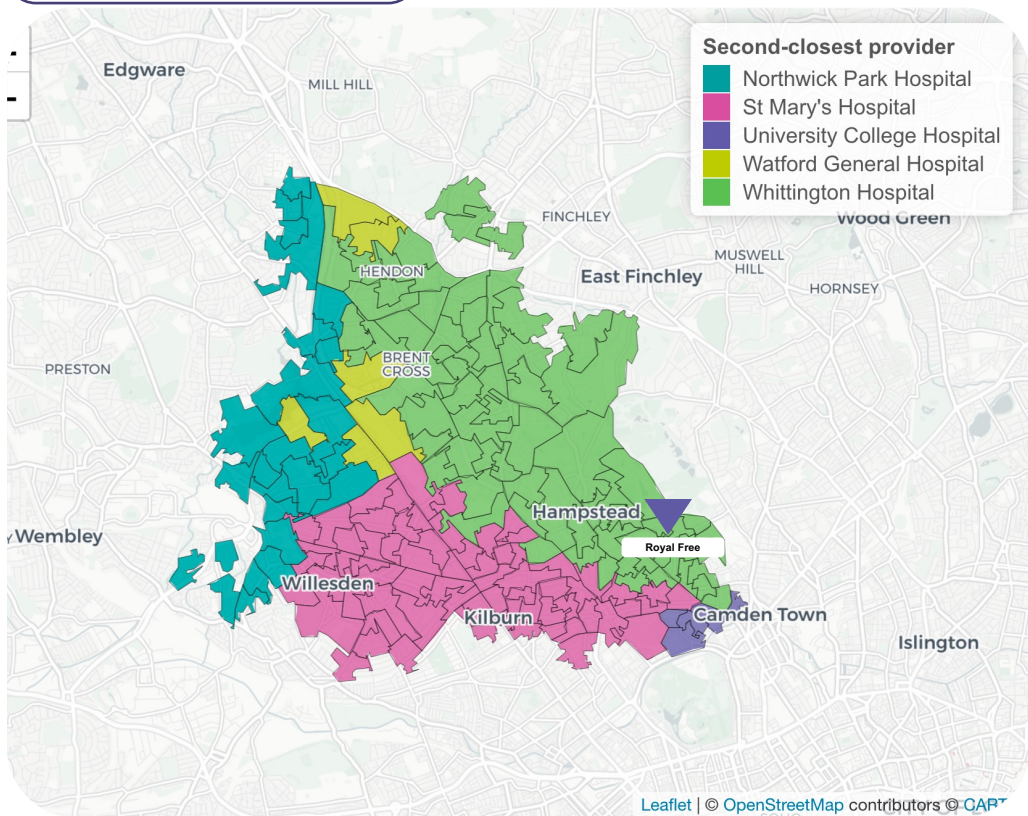
\*\*LSOAs are lower super output areas and are populations of around 1,000 – 3,000 people that are used to do travel analysis

# People impacted by option A would be likely to flow to other nearby hospitals

**Public transport**



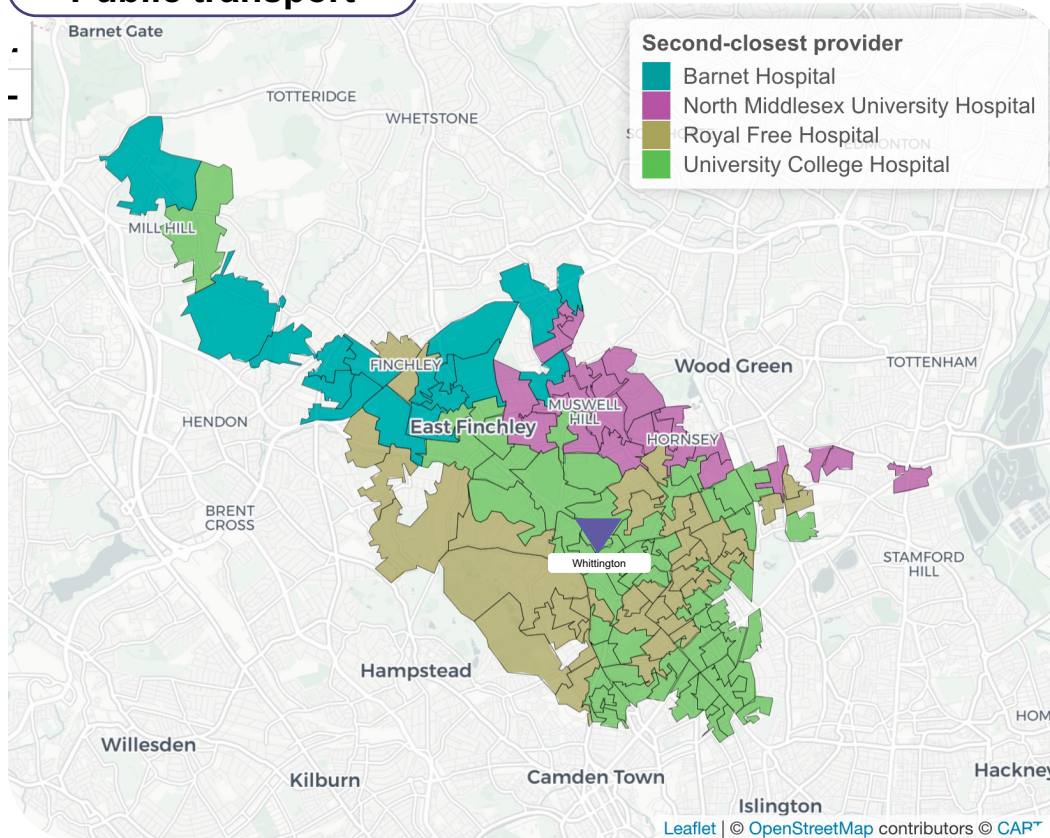
**Peak driving**



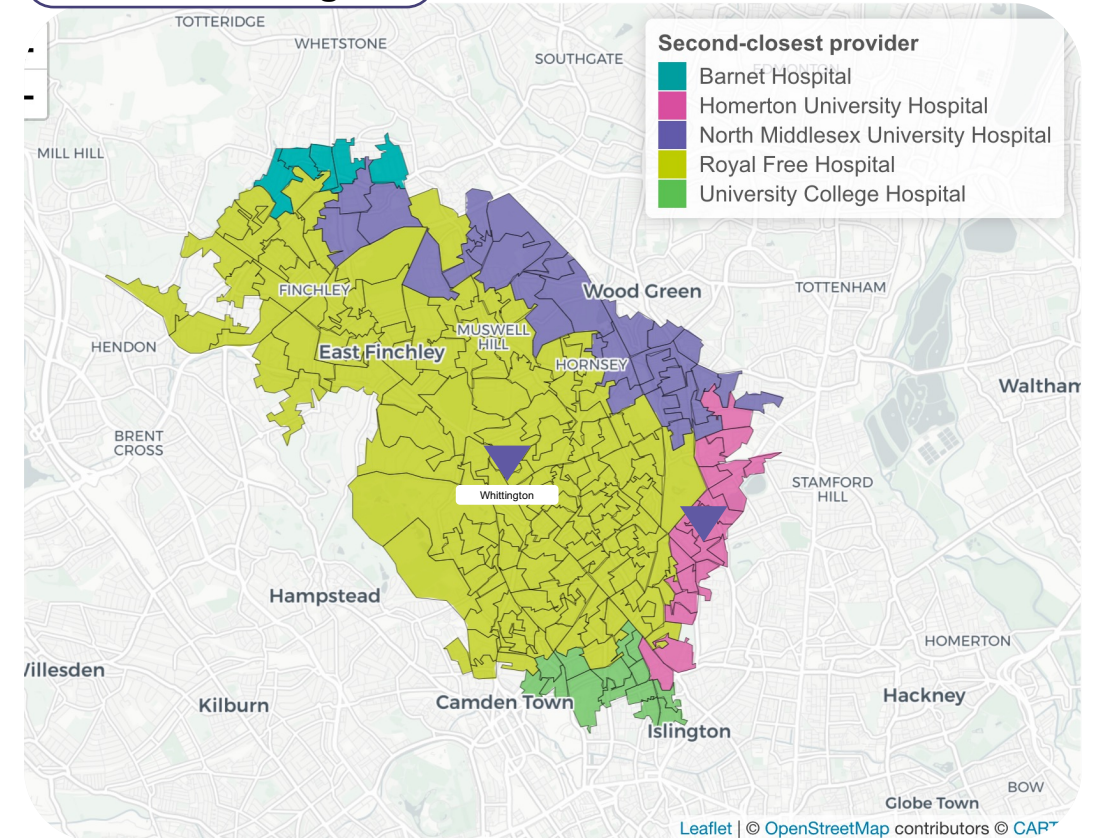
- The nearest alternative sites by public transport for people impacted by option A are the Whittington Hospital, UCLH and Barnet
- The nearest alternative sites by car/taxi for people impacted by option A are the Whittington Hospital, UCLH, Northwick Park hospital (in NWL), St Mary's Hospital (in NWL) and Watford Hospital (in Hertfordshire)

# People impacted by option B would be likely to flow to other nearby hospitals

## Public transport



## Peak driving



- The nearest alternative sites by public transport for people impacted by option B are the Royal Free Hospital, UCLH, Barnet and North Mid
- The nearest alternative sites by car/taxi for people impacted by option B are the Royal Free Hospital, UCLH, Barnet, Homerton University hospital (in NEL) and North Mid

# Understanding the potentially impacted catchment population

# Summary: understanding the potentially impacted catchment population (1/2)

- We engaged extensively and undertook a public health-led literature review to identify people who may be impacted by our proposals
- Our case for change identified vulnerable groups that may be disproportionately impacted by the proposals, we undertook a supplementary evidence review examining inequalities in maternal and neonatal outcomes in the UK, we considered potentially impacted groups using the national CORE20PLUS5 framework and there are nine protected groups that we must consider to fulfil our legal duties
- Our interim IIA is therefore focused on people who may be disproportionately impacted by our proposals
- Eight populations were analysed with quantitative data, alongside engagement and qualitative assessment, and the quantitative assessment was undertaken using available data sources:
  - The most **people living in areas of deprivation** are concentrated on the western part of the catchment for option A and the eastern part of the catchment for option B. The populations with the fewest people living in areas of deprivation lie around Hampstead and Highgate, which are relatively affluent areas. Whilst the deprived population around Whittington Hospital are relatively close to the hospital site. The people living in areas of deprivation for Royal Free Hospital are further away.
  - There is a concentration of people who are **economically inactive** in the west of the catchment (in the catchment for option A) and around the Whittington Hospital in Islington (the catchment for option B).
  - The largest proportion of **ethnic minorities** who could be impacted by potential changes are concentrated in the west around the Royal Free Hospital in Kilburn, Harlesden and Willesden.
  - The largest concentrations of people who have **poor English proficiency (including literacy)** are in the west, closer to the Royal Free Hospital (catchment for option A). There is also a large concentration of non-English speakers around Wood Green close to the Whittington Hospital (catchment for option B).
  - People with **poor health** are concentrated to the south of the Whittington Hospital and to the east of the Royal Free Hospital. There are also some pockets of people with poor health in the west of the catchment (impacted under option A) in Harlesden and Willesden.

## Summary: understanding the potentially impacted catchment population (2/2)

- The percentage of **women and people of childbearing age** is distributed across the catchment population for the Royal Free Hospital whilst there is a concentration of women and people of childbearing age east of the Whittington Hospital (impacted under option B).
  - There are pockets **single pregnant women and people** across the catchment population
  - The largest concentration of **people with disabilities** are between the Royal Free Hospital and the Whittington Hospital, with an above-average concentration of people with disabilities around the Whittington Hospital
- It is worth noting that the demographics of the catchment population is slightly different for each option

# We engaged extensively to identify people who may be impacted by our proposals

- A 10-week case for change engagement period took place in summer 2022 to identify whether the themes highlighted from the case for change resonated with patients, residents, staff and wider stakeholders
- The engagement established what was important in planning good care and worked in partnership with local authority, voluntary and community sector partners and established patient groups and networks
- Forty-three events took place with 389 questionnaires completed, and 207 in-depth conversations took place
- Diverse communities and groups with specific insights were targeted to ensure a wide range of views were captured

People who have vulnerabilities or disproportionately impacted by our proposals were identified through the case for change and engagement:

- People from ethnic minority groups
- Specific age groups
- People living in areas of deprivation
- Single pregnant women and people
- Women or people with specific religions or faiths
- Women or people with disabilities
- Women or people with learning disabilities
- People who are transgender or people who are LGBTQ+

# Our case for change identified people with vulnerabilities who may be disproportionately impacted by the proposals



People with **physical and learning disabilities** because:

- Some pregnant women and people have **poorer maternal outcomes** and are at higher risk of **maternal mortality** and **severe maternal morbidity**
- Those with disabilities may experience **inequitable access** to care

**People who are LGBTQ+** and **people who are transgender** because:

- There may be **poorer maternal outcomes**
- They may experience **discrimination** or **stigma** that act as barriers to accessing healthcare and increased risk of mental health conditions

**People living in areas of deprivation** (defined as the 20% most deprived in NCL) because:

- There are **higher stillbirth rates**, particularly for those living in **Haringey**
- There is a **higher prevalence** of health behaviours which could negatively impact on maternal health outcomes such as **smoking and obesity**

**Older or younger** pregnant women and people because:

- Those who are **older may have higher maternal mortality rates** and are **less likely to receive the recommended care** for older pregnant women and people
- Younger pregnant women and people have **adverse maternal outcomes**, a **higher caesarean section rates** in under 20s and number of **teenage suicide rates after pregnancy** is higher
- Single pregnant women and people **access maternity services later** in pregnancy and are **less likely to have complete antenatal and postnatal care**

**Specific people from ethnic minority groups** because:

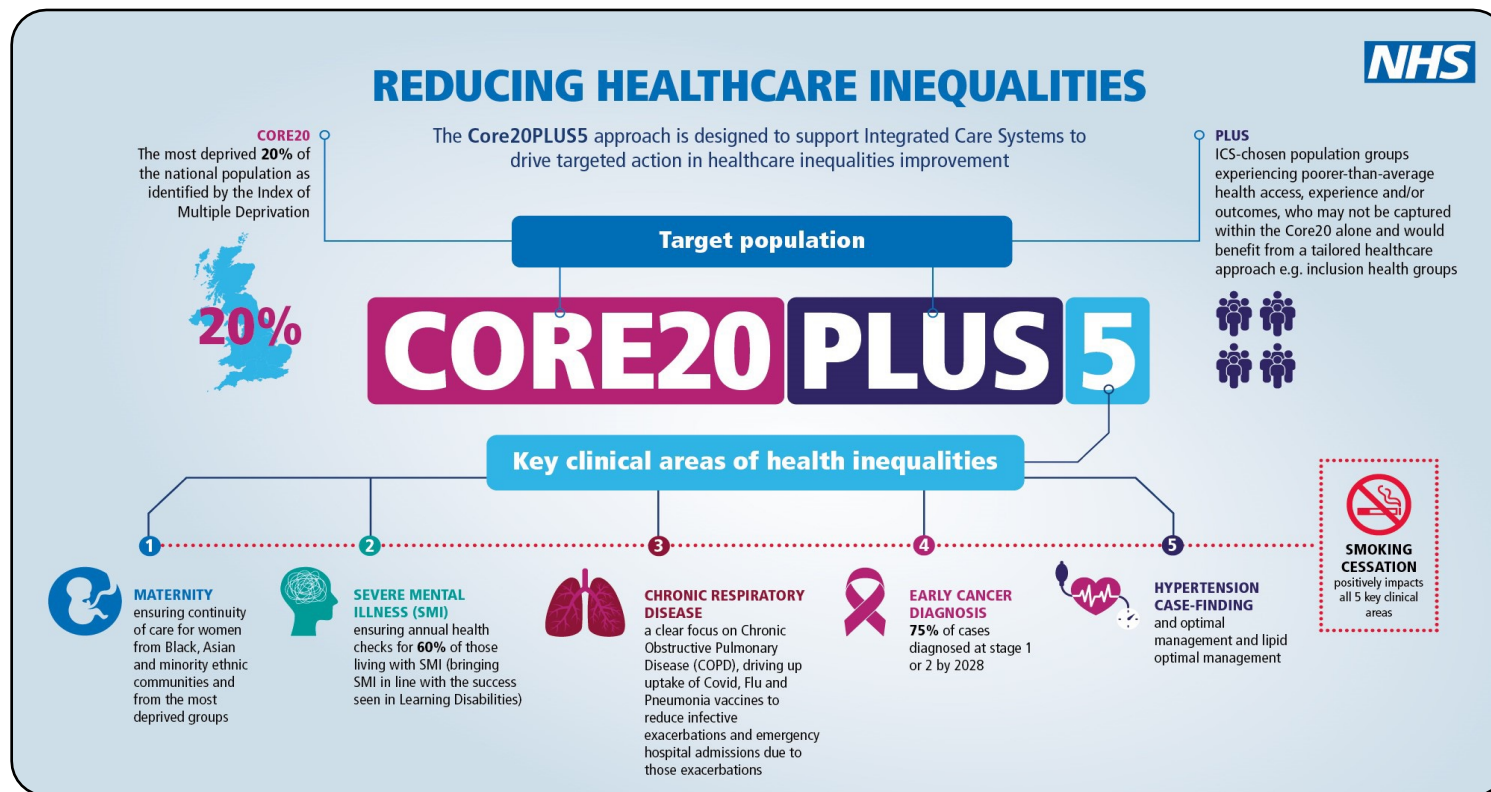
- Black and Asian people have **higher maternal mortality** rates
- A higher proportion of Muslim and Jewish women and people have **poor experience of maternity services** or poorer maternal outcomes due to **delayed booking of antenatal appointments**, missed opportunities for **early health promotion and screening**
- Gypsy, Roma and Traveller communities have **higher maternal mortality** and **stillbirth rates** and **poorer maternal outcomes**
- Some communities may experience **racial discrimination**

**Inclusion health groups** such as **homeless people, migrants, asylum seekers, substance misusers** because:

- Pregnant women and people who are **homeless have poorer maternity outcomes**
- Pregnant women and people who **misuse substances** are at **greater risk of poor maternal health outcomes and obstetric complications**
- Pregnant women and people who are **migrants** tend to **book and access antenatal care later** than recommended. They have **poorer maternal and birth outcomes, higher mortality rates and obstetric complications.**

A subsequent evidence review undertaken by public health professionals from Camden Local Authority examining inequalities in maternal and neonatal outcomes in the UK confirmed the groups which were identified.

# We considered potentially impacted groups using the national CORE20PLUS5 framework



“CORE20” represents the most deprived 20% of the population as identified by the indices of multiple deprivation.

The ‘PLUS’ adult populations refers to population groups identified as having poorer-than-average health access and outcomes outside of the CORE20 group. In NCL these groups have been identified as:

- Inclusion health groups\*
- Key black and specific ethnic minority groups
- People with severe mental illness
- People with learning disabilities

“5” is five national clinical areas of focus which are maternity, severe mental illness, chronic respiratory\*\* disease, early cancer diagnosis and hypertension case finding

\*Inclusion health is an umbrella term used to describe people who are **socially excluded**, who typically experience multiple overlapping risk factors for **poor health**, such as poverty, violence and complex trauma.

\*\*Chronic respiratory disease, early cancer diagnosis and hypertension case finding are not directly impacted by our proposals and therefore have not been assessed further

# There are nine protected groups that we must consider to fulfil our legal duties

## Protected characteristic groups:

**Race (inc. colour, nationality, ethnic or national origin)**

**Age**

**Sex (male/female)**

**People with disabilities**

**Being pregnant or on maternity leave**

**Gender reassignment**

**Religion or belief**

**Sexual orientation**

**Being married or in a civil partnership**

The NCL ICB is required by the Equality Act 2010 not to discriminate unlawfully against people with 9 "protected characteristics" (listed to the left). For each of these groups, we have considered whether the proposals would have a disproportionately negative impact and, if so, whether this can be justified or mitigated. We have also had due regard to the objectives set out in Public Sector Equality Duty.

We have not identified any potential disproportionate impact from being married or in a civil partnership, and this has not been raised as a potential issue in engagement, therefore this has not been assessed further than looking at single-person households

# Our integrated impact assessment is focused on people who may be disproportionately impacted by our proposals



Potentially impacted populations	How we identified potentially impacted populations				Quantitative analysis possible?
	Protected characteristic	CORE20	Engagement	Case for change	
People living in areas of deprivation		✓	✓	✓	Y
People who are economically inactive					Y
People from ethnic minority groups	✓	✓	✓	✓	Y
People who have poor English proficiency (Including literacy)			✓		Y
People with poor health		✓			Y
Inclusion health groups		✓	✓	✓	
People who are LGBTQ+	✓		✓	✓	
People who are transgender	✓				
Religion	✓		✓		
Women and people of childbearing age (sex)	✓		✓		Y
Younger pregnant women and people	✓			✓	
Older pregnant women and people	✓		✓	✓	
Single pregnant women and people					Y
People with disabilities	✓		✓	✓	Y
People with learning disabilities		✓	✓		
People with serious mental illness		✓			

# Eight populations were analysed where quantitative data was available



Eight populations were analysed using quantitative data alongside stakeholder engagement to assess whether they may be impacted by the proposals, and other groups were analysed qualitatively, as shown in slides 85-111.

**1**  
**People living in areas of deprivation**

People living in areas of deprivation have worse outcomes and poorer maternal health. They also face barriers to accessing healthcare (e.g. due to cost of travel)

**2**  
**People who are economically inactive**

People who are economically inactive may face barriers to accessing healthcare (e.g. due to cost of travel)

**3**  
**People from ethnic minority groups**

People from ethnic minority groups have worse outcomes, poor experience of accessing care and may experience racial discrimination

**4**  
**People who have poor English proficiency (including literacy)**

People with who are not proficient in English may have difficulty travelling to, and accessing health services

**5**  
**Poor general health**

People with poor general health may require more complex care and may have difficulty accessing services

**6**  
**Women and people of child-bearing age**

Women and people of a child-bearing age will be impacted by any changes to maternity services

**7**  
**Single pregnant women and people**

Single pregnant women and people might find accessing healthcare difficult due to childcare requirements

**8**  
**People with disabilities**

People with disabilities may have difficulty in travelling to services and accessing sites. They may have health conditions that impact on pregnancy,

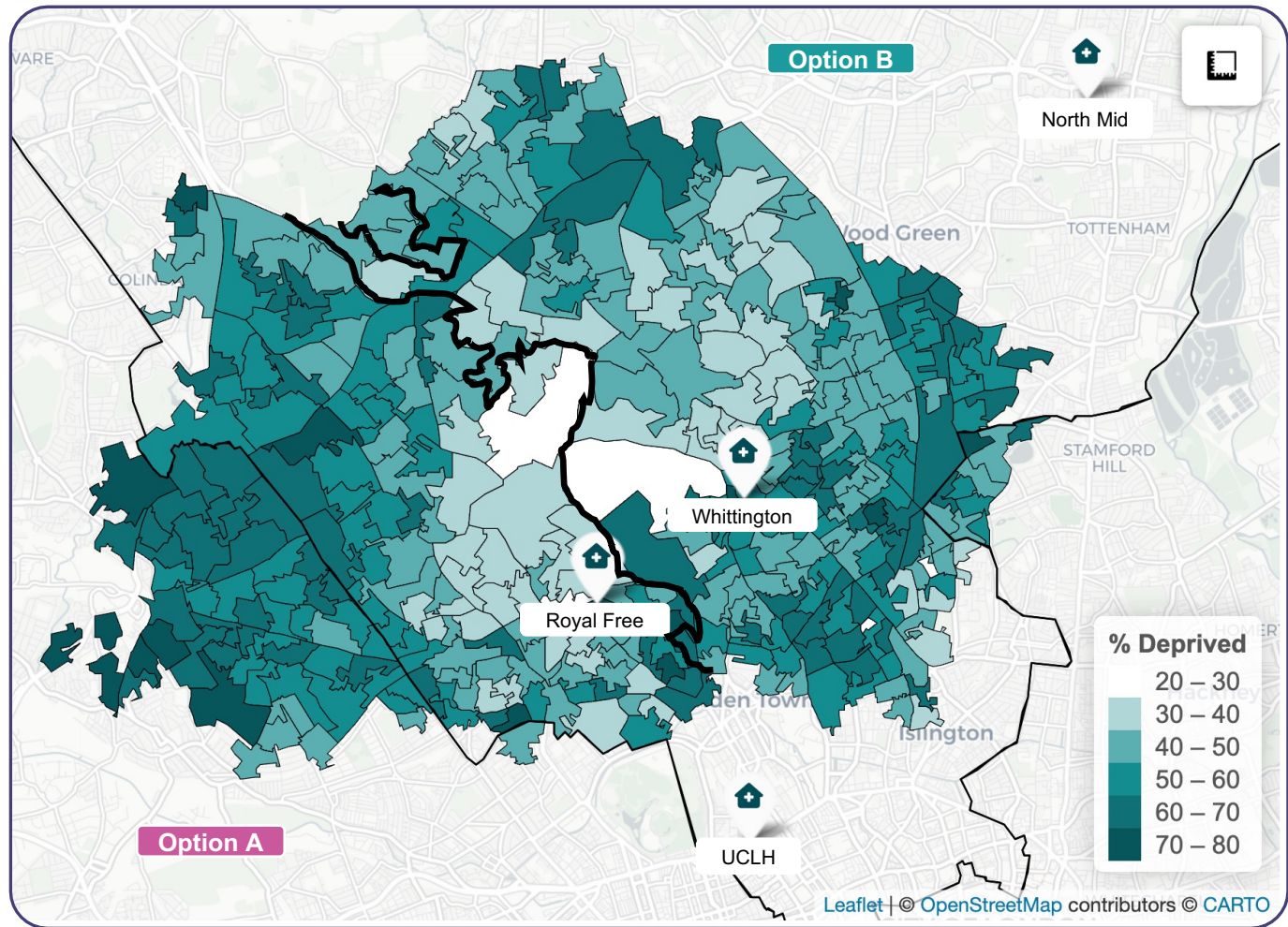
# The demographics of the catchment population is slightly different for each option

Catchment area		People living areas of deprivation	People who are economically inactive	People from ethnic minority groups	People who have poor English Proficiency (including literacy)	Women and people of child-bearing age	People with poor general health	Single pregnant women and people	People with disabilities
Option A	Peak	52%	19.4%	63.1%	4.4%	43.3%	4.3%	12.0%	12.8%
	Public transport	49%	17.9%	55.7%	3.2%	45.1%	3.9%	11.0%	11.6%
Option B	Peak	49%	17.3%	52.1%	3.4%	47.8%	4.5%	12.1%	14.2%
	Public transport	49%	17.1%	49.4%	3.0%	48.3%	3.0%	11.7%	14.7%

- These eight demographic metrics are intended to provide an overview of the characteristics of the catchment population for each option.
- Within the peak driving catchment area, 122,000 households are closer to the Royal Free Hospital and would be potentially impacted by option A whilst 146,000 households are closer to the Whittington Hospital and would be potentially impacted by option B.
- Within the public transport catchment area, 74,500 households are closer to Royal Free Hospital and would be potentially impacted by option whilst 97,500 households are closer to the Whittington Hospital and would be potentially impacted by option B.

# Demographics: People living in areas of deprivation

**People living in areas of deprivation**  
Rate (%) of people living in areas of deprivation



## Definition

Deprivation is defined as any household which is deprived in any of the seven domains of deprivation in the Indices of Multiple Deprivation (IMD)

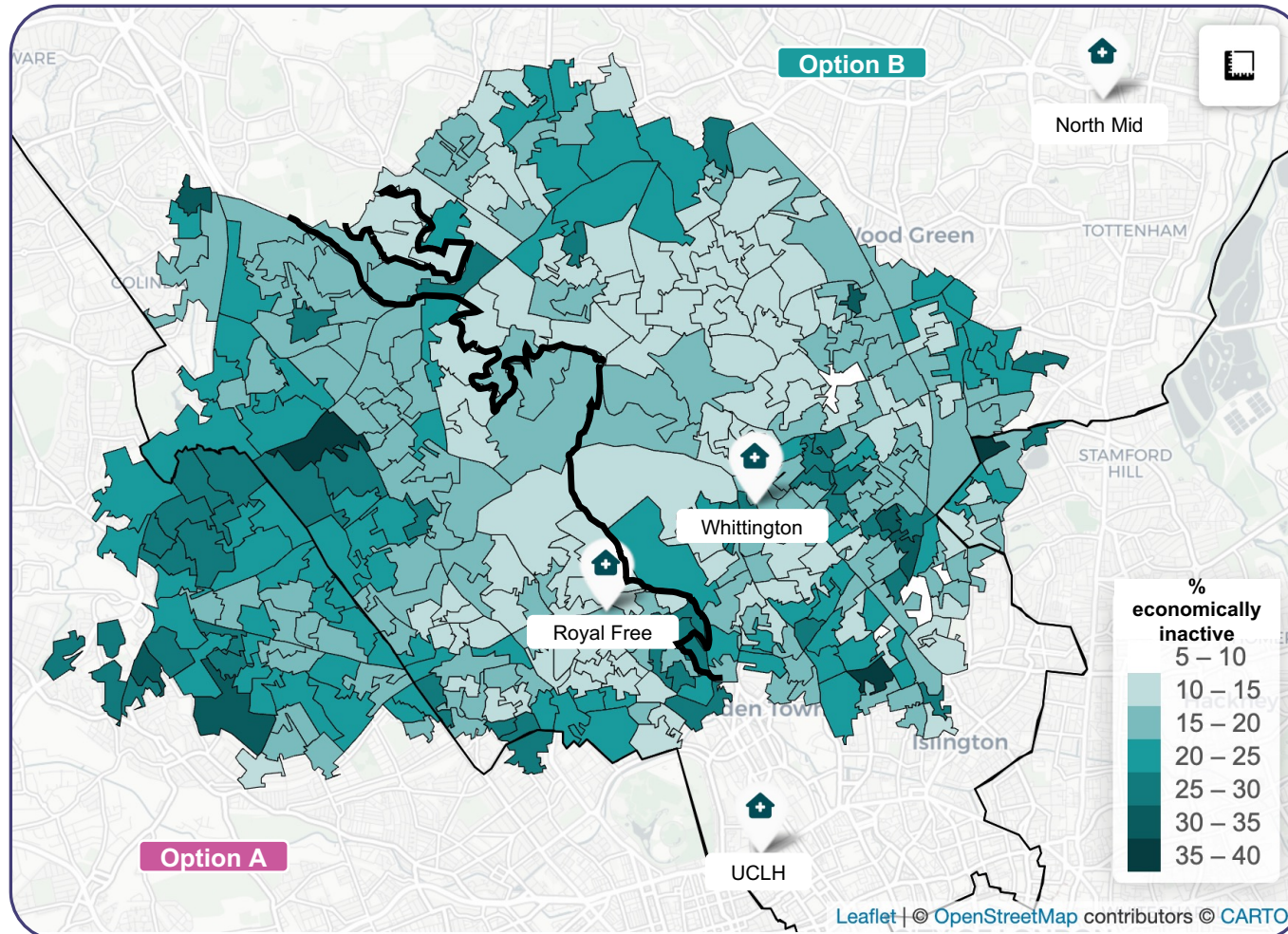
## Observations

The most people living in areas of deprivation are concentrated on the eastern (impacted by option B) and western (impacted by option A) parts of the catchment area (peak catchment). The areas with the fewest people living in areas of deprivation lie around Hampstead and Highgate, which are relatively affluent areas.

Whilst people living in areas of deprivation around the Whittington Hospital are relatively close to the hospital site, the people living in areas of deprivation for Royal Free Hospital are further away.

# Demographics: People who are economically inactive

People who are economically inactive  
Rate (%) of economically inactive population



## Definition

People who are economically inactive are defined by the Office of National Statistics (ONS) as any non-retired, non-student individuals who are economically inactive

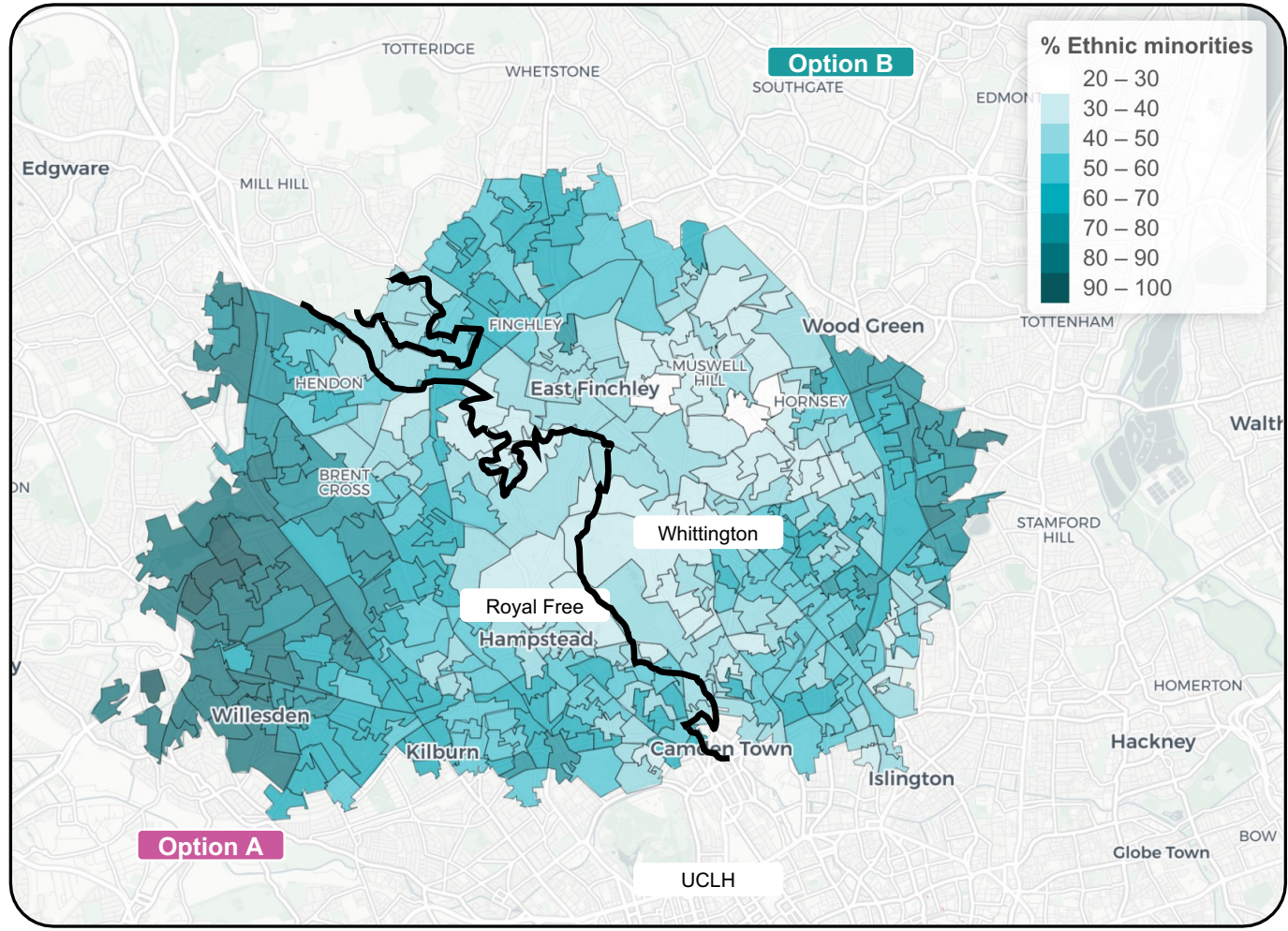
## Observations

There is a concentration of people who are economically inactive in the west of the catchment (in the catchment for Option A) and around the Whittington Hospital in Islington (the catchment for option B).



# Demographics: People from ethnic minority groups

**People from ethnic minority groups**  
*Rate (%) of people from ethnic minority groups*



## Definition

People from ethnic minority groups are defined as any individual who did not tick “white - British” in the 2021 census.

## Observations

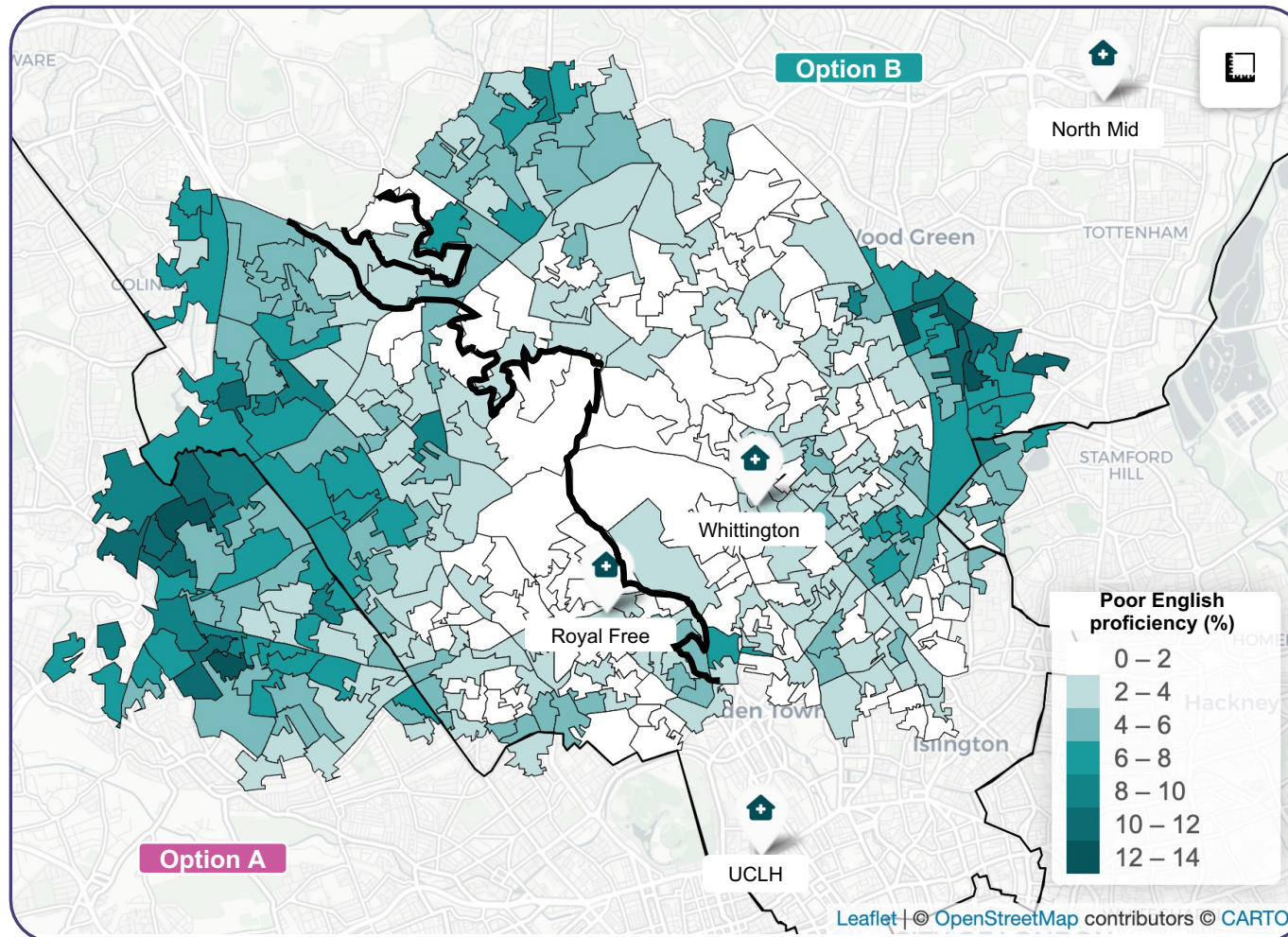
The largest proportion of people from ethnic minority groups who could be impacted by potential changes are concentrated in the west around the Royal Free Hospital in Kilburn, Harlesden and Willesden

Source: ONS, Traveltime API, CF Analysis (2023)

# Demographics: People who have poor English proficiency (including literacy)

## People who have poor English proficiency (including literacy)

Rate (%) of people who have poor English proficiency (including literacy)



### Definition

English proficiency is an ONS self-reported statistic for individuals whose main language was not English and is defined as any individual who does not speak English "Well" or "Very Well"

### Observations

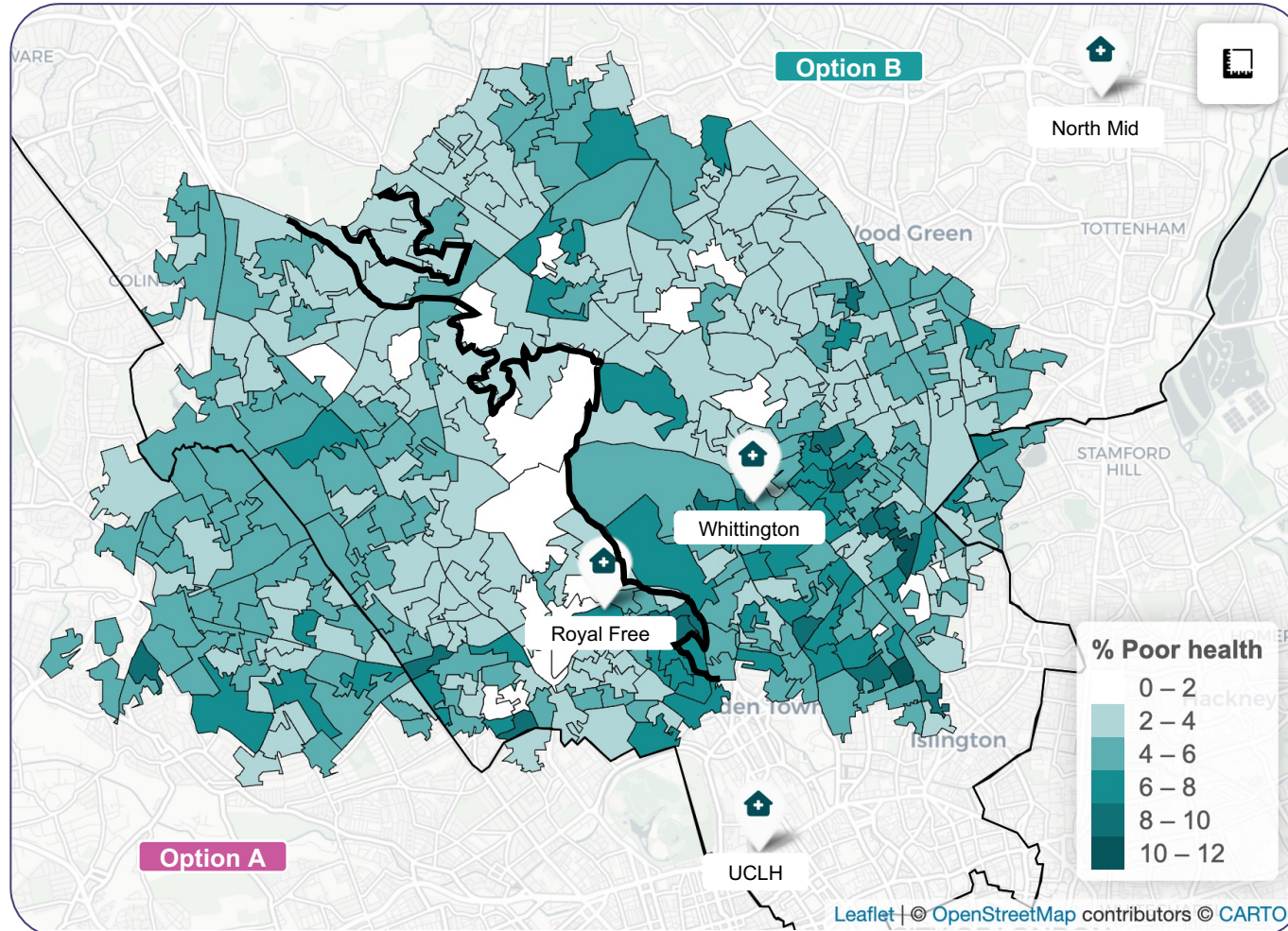
The largest concentrations of people with poor English proficiency (including literacy) are in the west, close to the Royal Free Hospital. These people would be impacted under option A.

There is also a large concentration of non-English speakers around Wood Green close to the Whittington Hospital. These people would be impacted under option B.

# Demographics: People with poor health

## People with poor health

Rate (%) of population with poor health



### Definition

Poor health is a census self-defined statistic where: “Respondents were asked to assess their general health on a five-point scale: “Very good”, “Good”, “Fair”, “Bad”, or “Very bad”. Individuals who rated “Bad” or “Very Bad” were considered to have “poor health”.

### Observations

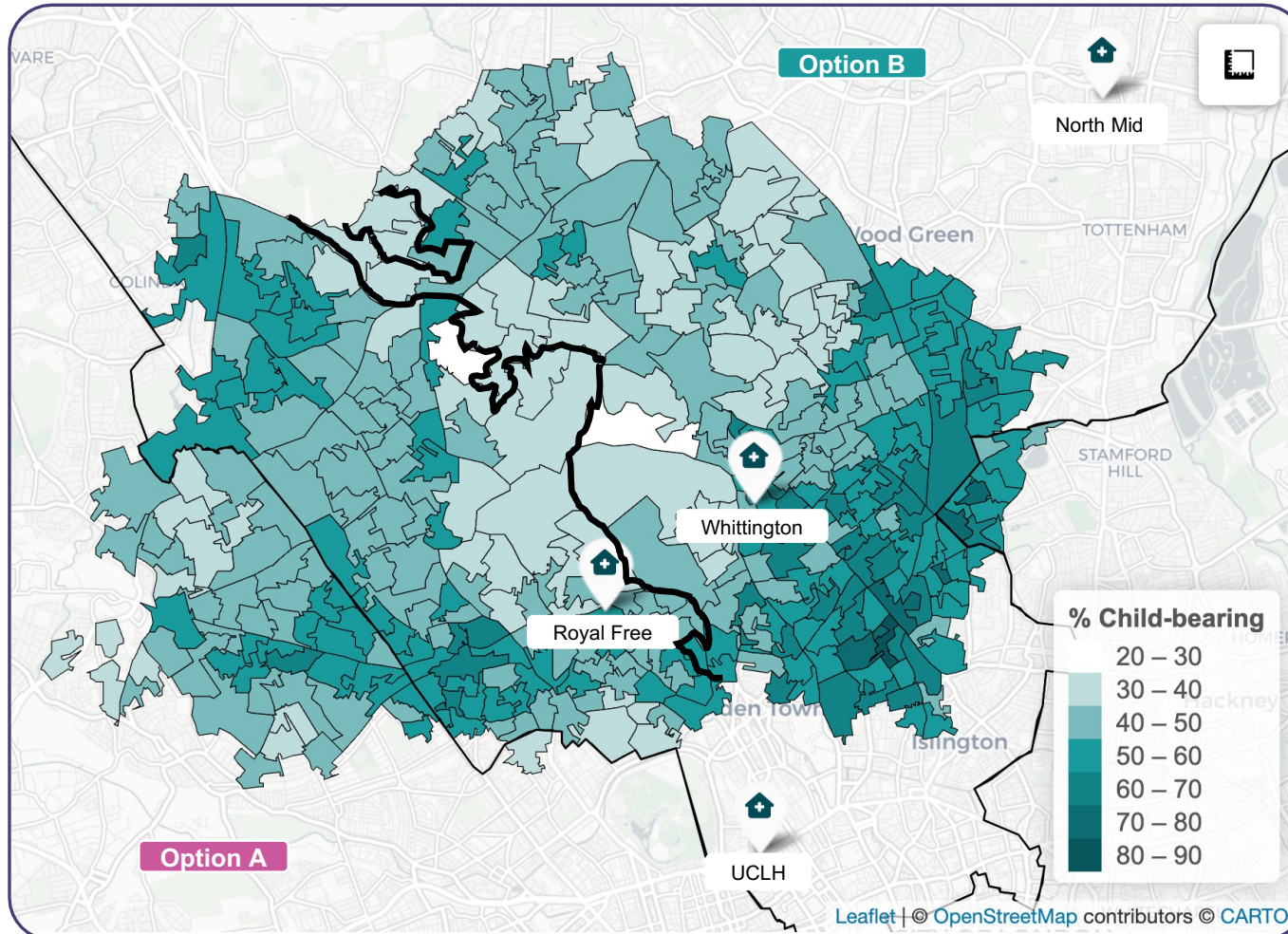
People with poor health are concentrated to the south of the Whittington Hospital (impacted by option B) and to the east of the Royal Free Hospital (impacted by option A).

There are also some pockets of people with poor health in the west of the catchment (impacted by option A) in Harlesden and Willesden.



# Demographics: Women and people of child-bearing age

**Women and people of child-bearing age population**  
Rate (%) of women and people of child-bearing age population



## Definition

Women and people of child-bearing were defined as any self-described woman\* in the 2021 census that is between the ages of 16 to 45.

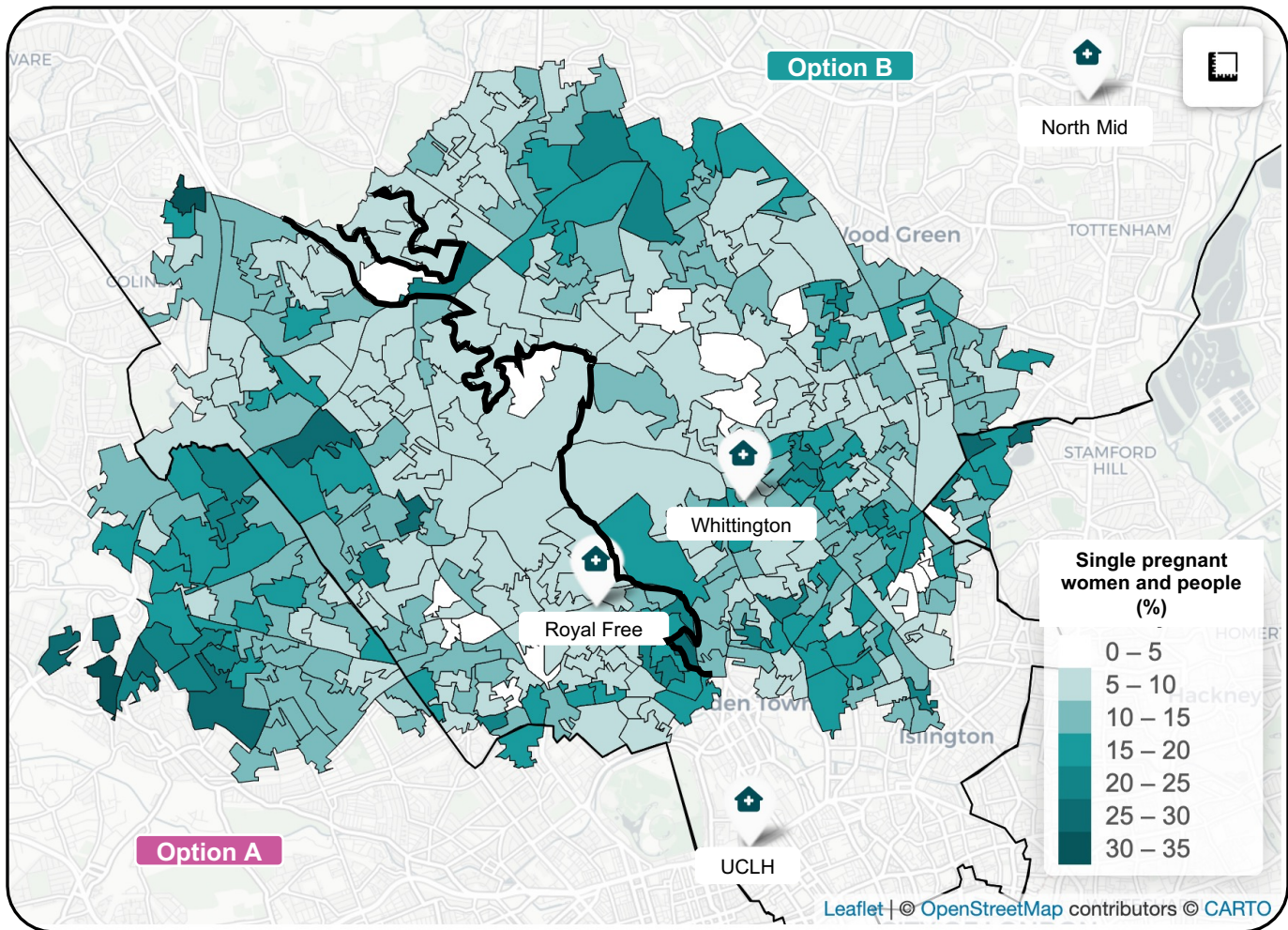
## Observations

The percentage of women of child-bearing age is distributed across the catchment population for the Royal Free Hospital (option A) whilst there is a concentration of women of child-bearing age east of the Whittington Hospital (impacted under Option B).

*\*There are issues in data collection for people who are transgender, making any collection of age versus gender identity difficult. As such, this metric uses the ONS self-defined terms of “man” or “woman”*

# Demographics: Single pregnant women and people

Population of single pregnant women and people  
Rate (%) of population that are single pregnant women and people



## Definition

Single pregnant women and people were defined using ONS census data as any single-parent households where the single-parent is a mother.

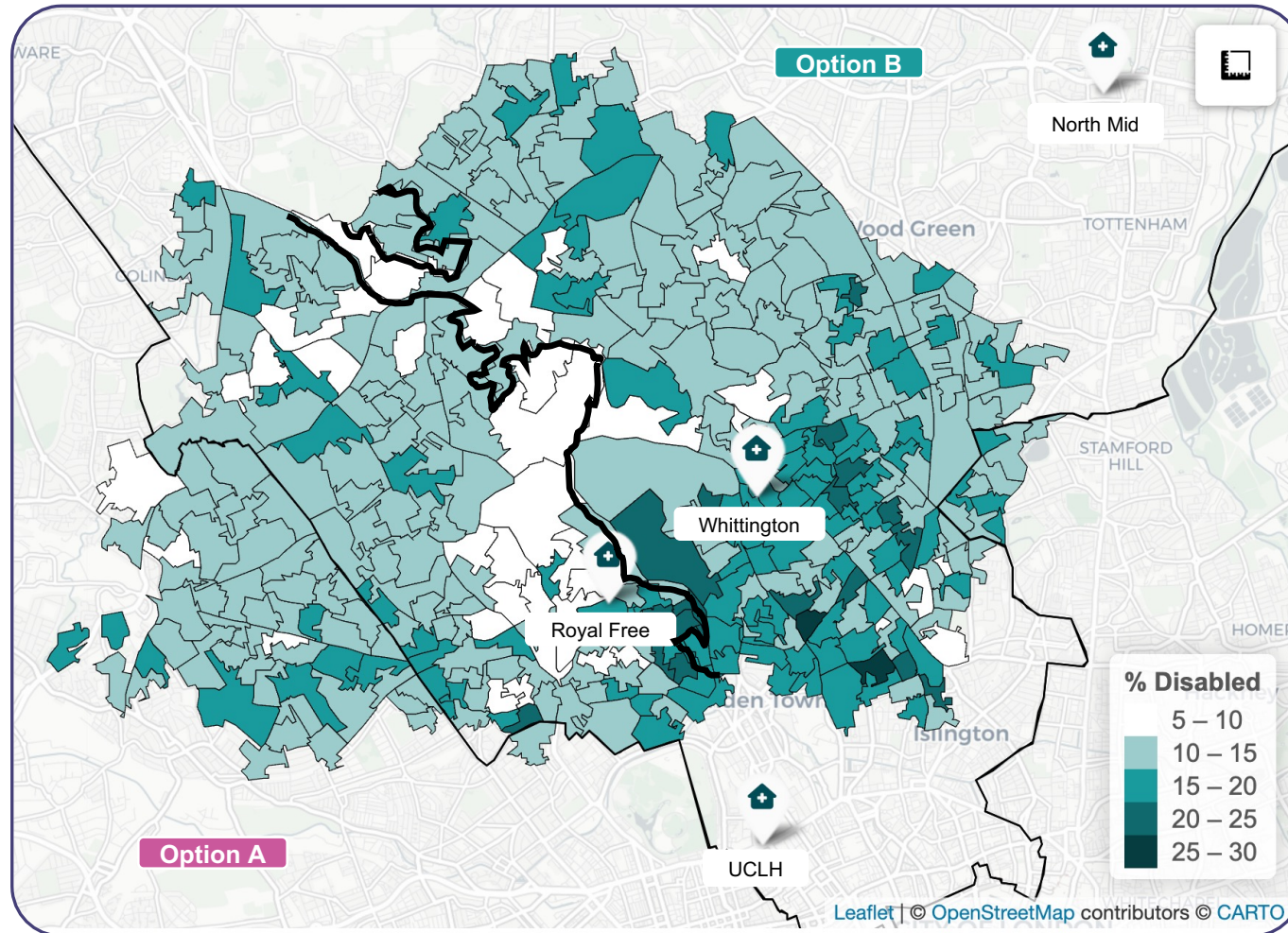
## Observations

There are pockets of single pregnant women and people across the catchment population.

# Demographics: People with disabilities

## People with disabilities

Rate (%) of people with disabilities



### Definition

People with disabilities are defined by the Office of National Statistics (ONS) as: *“People who assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses are considered disabled”* across all ages

### Observations

The largest concentration of people with a disability are between the Royal Free Hospital and the Whittington Hospital, with an above-average concentration of around the Whittington Hospital, who would be impacted should option B be implemented.

There are areas (specifically around Hampstead) where there is a below-average level of people with disabilities.

# Potential impact of proposals on quality and outcomes

## Summary: potential impact of proposals on quality and outcomes

- The proposed new care model would improve quality and experience for service users and staff, and would be delivered under options A and B
- The benefits of the care model align to the opportunities for improvement highlighted in the case for change

# The proposed new care model would improve quality and experience for service users and staff

## Maternity and neonatal care model benefits



### Equality

Equality of access to maternity services with care delivered in the community or virtually where possible



### Training and development opportunities

Supporting training and development opportunities for staff through delivering sustainable volumes of neonatal activity at all neonatal units



### Clinically sustainable services

Ensuring all units are either a designated LNU or NICU. Reducing the number of neonatal units to four will allow units to meet the minimum activity requirements set out in national clinical standards



### Environment

Ensuring all units are fit for purpose facilities and are designed to provide a positive birth experience



### Capacity

Investing in additional capacity for neonatal and maternity services to ensure that there is enough capacity available so that units are running at less than the 80% recommended occupancy rate

# The benefits of the care model align to the opportunities for improvement highlighted in the case for change

Category	Benefit description	Outcome
<b>Care that ensures equity of provision and experience</b>	<ul style="list-style-type: none"> <li>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.</li> <li>Provide a more personalised experience and ensure the individuals are supported and communicated in a way that best suits their own needs</li> </ul>	Improved patient experience and outcomes
		Maternity clinical negligence scheme for Trusts
		Reduced normal care days delivered in an acute setting through enhanced delivery of community services
<b>Services which are clinically sustainable</b>	<ul style="list-style-type: none"> <li>Redesigning and reconfiguring our neonatal units in NCL, ensuring all units are either a designated LNU (level 2) or NICU (level 3).</li> </ul>	Reduced neonatal transfers between units
<b>Training and development opportunities</b>	<ul style="list-style-type: none"> <li>Supporting training and development opportunities for staff through delivering sustainable volumes of neonatal activity at all neonatal units.</li> <li>Reducing vacancies to make sure cots can be kept open and ensure there are sufficient staff to provide expert care when required</li> </ul>	No consultant workforce rota supporting the SCU
		Improved recruitment and retention
<b>Capacity to meet projected demand</b>	<ul style="list-style-type: none"> <li>Investing in additional capacity for neonatal and maternity services would ensure that there is enough capacity available</li> <li>Neonatal units are running at less than the 80% recommended occupancy rate</li> </ul>	Reduced number of transfers to NICU (level 3) outside of NCL through increase capacity in NCL
		Reduced risk of separating women or person from their baby and improving their experience
<b>Up to date estate and buildings which are fit for purpose</b>	<ul style="list-style-type: none"> <li>Investment in our existing maternity and neonatal estate so that all units are fit for purpose facilities and provide a positive birth experience</li> <li>Any new capacity delivered will meet the latest space standards and this will have a role in delivering clinical benefits</li> </ul>	Improved efficiencies
		Improved staff experience by enhancing staff environment

# Potential impact of proposals on accessibility on the catchment population

# Summary: potential impact of the proposals on accessibility

- **Significant engagement** was undertaken to identify the potential impact on access for options A and B
- We reviewed **four access statistics** (digital access, public transport accessibility, car ownership and parking spaces) and **five impact metrics** (travel time (peak/public transport), travel time (peak taxi/private car), travel time (off-peak taxi/private car/ambulance, taxi costs and driving costs) to assess the potential impact of our proposals on access
  - A potential impact of the proposals on access for the catchment population would be an **average increase in taxi costs of almost £5**
  - There would be a **limited increase in average travel times** for peak, off-peak and public transport for options A and B. People would be able to access services within 30 minutes at peak driving time for options A and B. People would be able to access services within 25 minutes at off-peak driving time for options A and B. There is limited impact on public transport travel times for options A and B, up to a maximum of 7 additional minutes
  - There would be a **similar number of on-site car parking spaces** retained for options A and B compared to the status quo
  - The catchment population for options A and B have a **similar level of public transport accessibility**. People generally have better public transport accessibility closer to the centre of London
  - **Average additional driving costs would be minimal**, and similar for options A and B, with a maximum increase of under £1. The largest increase (less than £1) in driving costs would be for people who live closest to the potentially closing maternity and neonatal unit
  - **Average additional taxi costs would be similar for options A and B** and around £4-£5 more. People closest to each of the potentially closing sites may need to **pay up to an additional £11 per taxi journey**.
  - There is a **similar, high, level of digital access** within the catchment population for options A and B
  - **People have similar access to cars** for options A and B, with around 50% of the population having access to a car. Car ownership varies, with disabled populations substantially less likely to own a car and a slightly higher disabled population in option A
- Engagement found people may have issues with **travel times, travel cost, parking and wayfinding**

# Significant engagement was undertaken to identify the potential impact on access for options A and B

Following engagement, four access statistics and five impact metrics were identified to review the potential impact of the proposals on access across different demographic groups.

- |   |   |   |   |
|---|---|---|---|
| <b>1</b><br><b>Digital access</b>                 | Poor digital access might create barriers for accessing care if people cannot access equipment or data                | <b>1</b><br><b>Public transport travel time</b> | Additional public time to travel to sites can be difficult and might dissuade people who rely on public transport |
| <b>2</b><br><b>Public transport accessibility</b> | Lack of public transport accessibility may make it difficult for people without access to a car to access services    | <b>2</b><br><b>Peak travel time</b>             | Additional time to travel to sites can be difficult for people and might dissuade them from attending             |
| <b>3</b><br><b>Car ownership</b>                  | Lack of car access may mean people find it difficult to access services, particularly if public transport is not good | <b>3</b><br><b>Off-peak travel time</b>         | Additional time to travel to sites can be difficult for people and might dissuade them from attending             |
| <b>4</b><br><b>Parking spaces</b>                 | Lack of parking might make accessing sites difficult, particularly for vulnerable populations (such as the disabled)  | <b>4</b><br><b>Taxi costs</b>                   | People without access to a car may need to catch a taxi and high taxi costs may be unaffordable                   |
|   |   | <b>5</b><br><b>Driving costs</b>                | Long / expensive journeys might place financial strain on some households   |

# A potential impact of the proposals on the catchment population would be an average increase in taxi costs of ~£5

## Catchment population

Access statistics for catchment population

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces retained
A	96.0%	13.63	51.9%	110
B	96.0%	14.35	48.4%	374

## Impact on catchment population

Average impact across catchment population

Moved unit		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ambulance travel times (mins)	Taxi costs	Driving costs
A	Current	18.0	14.4	12.4	£17.55	£1.65
	Future	+6.3	+5.3	+6.7	+£4.91	+£0.46
B	Current	18.9	14.1	12.1	£16.10	£1.51
	Future	+7	+5.8	+5.4	+£4.43	+£0.42

## Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi by 4-6 min and by public transport by 6-7 min
- A potential impact would be an increase in average taxi costs of up to £5

## Difference between options

- Options A and B would have **similar impacts** on their respective catchment populations

There would be a limited increase in average travel times for peak, off-peak and public transport for options A and B



North Central London  
Integrated Care System

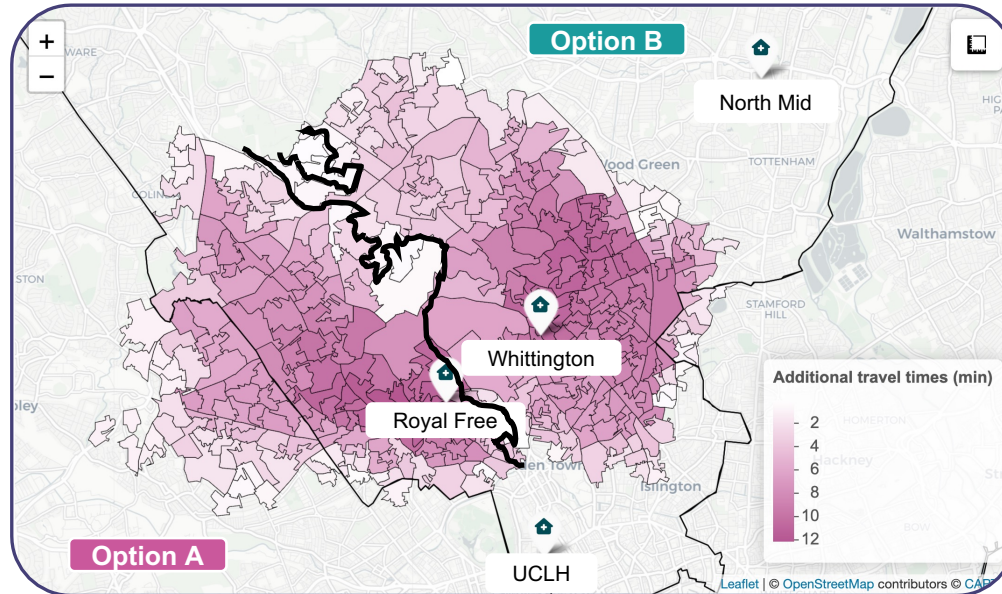
Option	Transport method	Average travel time to current closest unit (mins)	Average travel time (mins) to next closest unit	Difference for average (mins)	Maximum travel time to current closest unit (mins)	Maximum travel time (mins) to next closest unit	Difference for maximum (mins)
Option A: Barnet, North Mid, Whittington, UCLH	Off-peak	12.4	19.1	6.7	23	24.7	1.7
	Peak	14.4	19.7	5.3	26.9	29.5	2.6
	Public transport	22.3	28.6	6.3	66.2*	69.6*	3.4
Option B: Barnet, North Mid, Royal Free, UCLH	Off-peak	12.1	17.5	5.4	22.2	23.4	1.2
	Peak	14.1	19.9	5.8	25.9	28.3	2.4
	Public transport	18.9	25.9	7	36.8	38.3	1.5

\* Second highest travel time used as longest is the LSOA that has a mid-point on Hampstead Heath and was almost 2 hours

# People would be able to access services within 30 minutes at peak driving time for options A and B

## New travel time

*New travel time (mins) for peak driving by option*



- These maps show the new travel time if options A or B were implemented (a darker colour represents **longer travel times**)
- In option A, the population closest to the Royal Free Hospital would have **increased travel times of 5.3 minutes on average**, with a maximum of 29.5 minutes in total
- In option B, the population closest to the Whittington Hospital would have **increased travel times of 5.8 minutes on average** with a maximum of 28.3 minutes in total

## Additional travel time

*Average & max travel time (mins) - peak driving*

	Option A	Option B
Current average travel time (min)	14.4	14.1
Average travel time under option (min)	19.7	19.9
Difference in average travel time (min)	5.3	5.8
Current maximum travel time (min)	26.9	25.9
Maximum travel time under option (min)	29.5	28.3
Difference in maximum travel time (min)	2.6	2.4



There would be a similar number of on-site car parking spaces retained for options A and B compared to status quo

### Available parking spaces on-site

*Available parking spaces on-site*

Site	On-site parking spaces*
Royal Free Hospital	374
Barnet	898
North Mid	605
Whittington Hospital	110
UCLH	105
<b>Total</b>	<b>2,092</b>

### Available parking spaces on-site per option

*Available parking spaces on-site (total spaces)*

Option	On-site parking spaces retained*	Total number of spaces across all sites in option
<b>Option A:</b> Barnet, North Mid, Whittington, UCLH	110	1,718
<b>Option B:</b> Barnet, North Mid, Royal Free, UCLH	374	1,982

There is a similar number of car parking spaces retained for options A and B.

\* The parking spaces have been used as a proxy for the ease of parking and may include staff spaces where these are not specified separately



# The catchment population for options A and B have a similar level of public transport accessibility

## Public transport accessibility

*Average public transport accessibility within catchment area*

Option	Public transport accessibility
Option A catchment population	13.6
Option B catchment population	14.3

- The catchment population for options A and B have similar public transport accessibility, with option B being slightly better connected due to the location of King’s Cross station and the surrounding public transport network.

## Public transport accessibility

Whilst travel times capture the distance it takes to get from point A to point B, it does not fully capture the **ease of doing so**. For instance, **service reliability** is not captured. A 45-minute reliable and frequent bus journey is very different from an infrequent and unreliable 30-minute bus journey.

The analysis used the **2015 PTAL** (Public Transport Accessibility Levels) score in order to assess public transport accessibility. Ranked from 0 to 100 (**where 0 is the worst and 100 is the best**) it measures:

- Walking time from the population centre to public transport access points
- The reliability of the service modes available
- The number of services available within the catchment area
- The level of service at the public transport access points

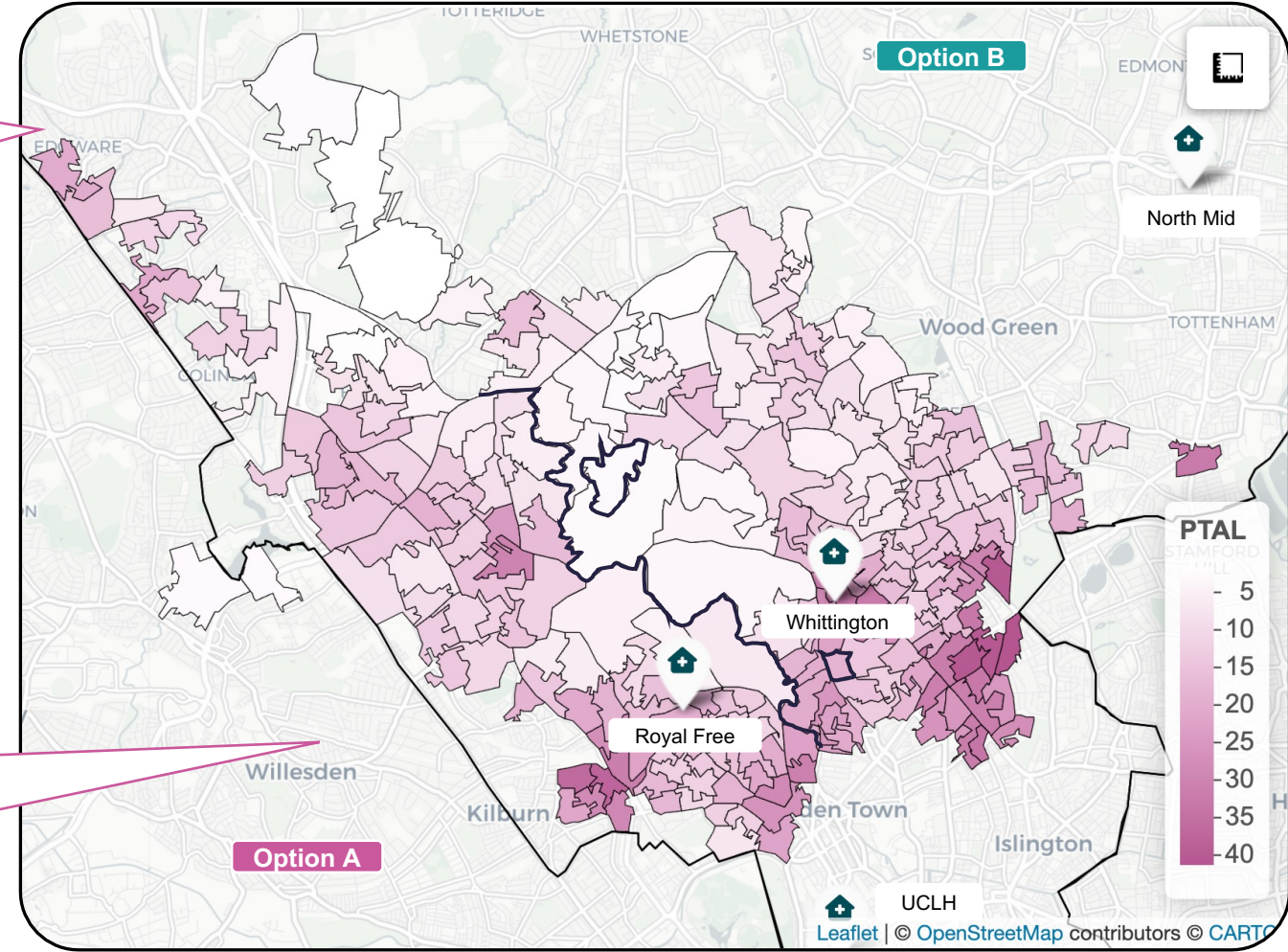
The analysis then examines how **well-connected the catchment areas of the providers are, in each option**.



# People generally have better public transport accessibility closer to the centre of London

Areas in the north of the catchment population have poorer public transport infrastructure than towards the south, reflecting potential accessibility issues

Central London has a dense network of public transport options, and this is reflected in the relatively high public transport accessibility scores for the southernmost areas of the catchment population





## Average additional driving costs would be minimal, and similar for options A and B, with a maximum increase under £1

### Driving costs

Average additional driving costs (£) for options A and B

Option	Average additional cost per journey (£) compared to now	Maximum additional cost per journey (£) compared to now
<b>Option A:</b> Barnet, North Mid, Whittington, UCLH	+ £0.46	+£0.99
<b>Option B:</b> Barnet, North Mid, Royal Free, UCLH	+ £0.42	+£0.94

Given the relatively close locations of both sites, the difference in additional cost is relatively minor

### Driving costs

- The average cost of travel was calculated using NimbleFinn's 2023 calculation of the average cost of running a car per mile of £0.47/mile. This cost has been multiplied with the average additional time for travel from **every LSOA to their nearest unit in each option**.
- The result is the **average additional cost of driving (£) per LSOA**.
- Driving costs may also be impacted by the **ULEZ charge** which is £12.50 per day
- The result is also weighted by the various **mixture of populations** in each LSOA to account for **deprived or groups with vulnerabilities**

Average cost of running a car per mile  
(£0.47 per mile)



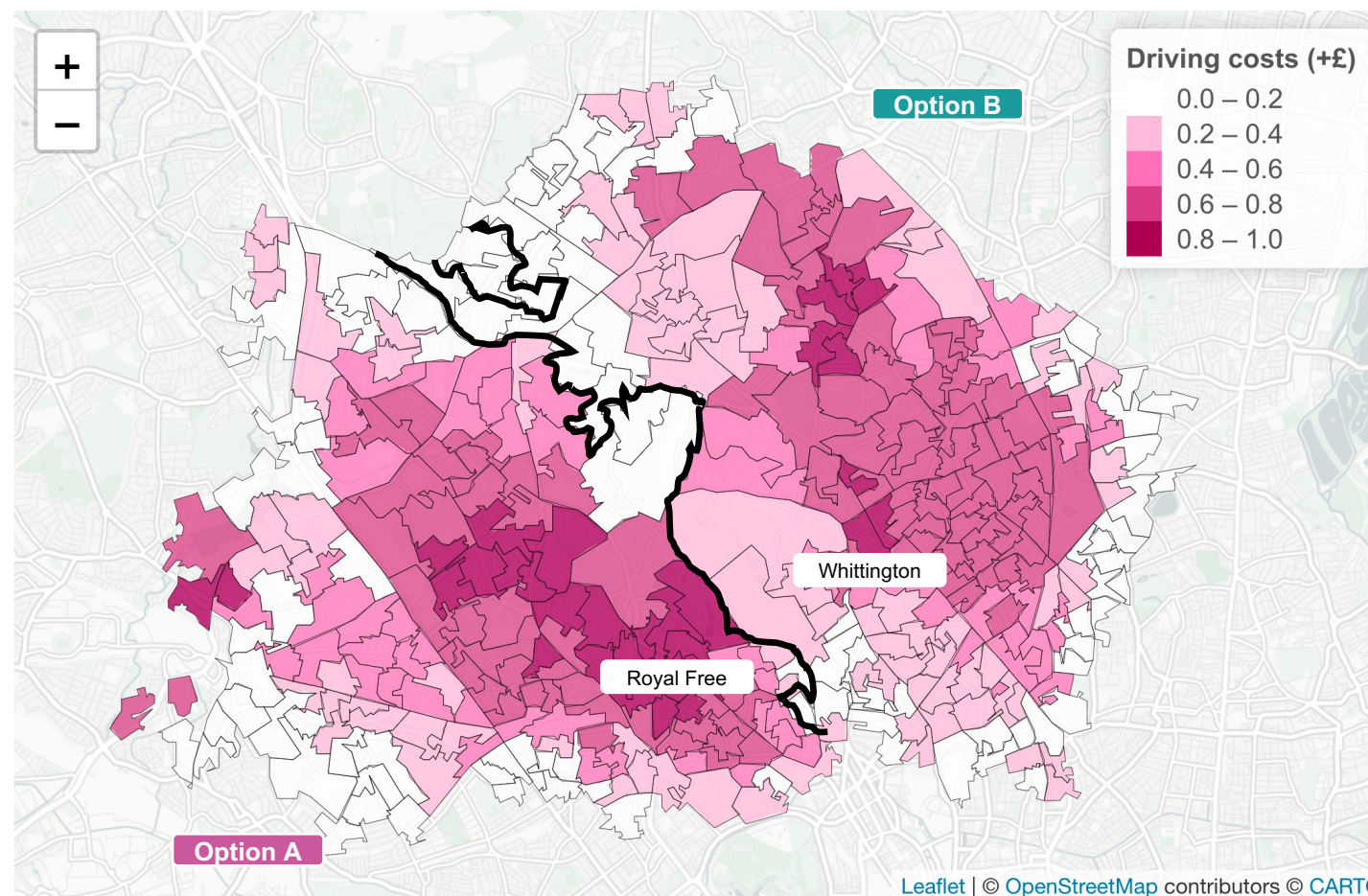
Average additional distance of travel (mile)



## The largest increase (less than £1) in driving costs would be for people living closest to potentially closing unit

The largest increase in driving costs would be for people living closest to the potentially closing maternity and neonatal unit although this would be less than £1 per journey under options A and B.

The cost difference is relatively small because the distances travelled are relatively small as well.



UCLH



# Average additional taxi costs would be similar for options A and B, and around £4 - £5 more

## Taxi costs

Average additional taxi costs (£) for options A and B

Option	Current average cost per taxi	Average additional cost per taxi (£) compared to now	Maximum additional cost per taxi (£) compared to now
Option A	£17.55	+ £4.90	+£10.56
Option B	£16.10	+ £4.43	+£10.03

## Taxi costs

The average cost of travel by taxi was calculated using NimbleFinn’s 2023 calculation of the average cost of running a taxi per mile of £5.0/mile. This cost has been multiplied with the average additional time for travel from **every LSOA to their nearest unit in each option.**

The result is the **average additional cost of driving (£) per LSOA.** The result is then weighted by the various **mixture of populations** in each LSOA to account for **deprived or vulnerable groups**

Average cost of a taxi  
(£5 per mile)



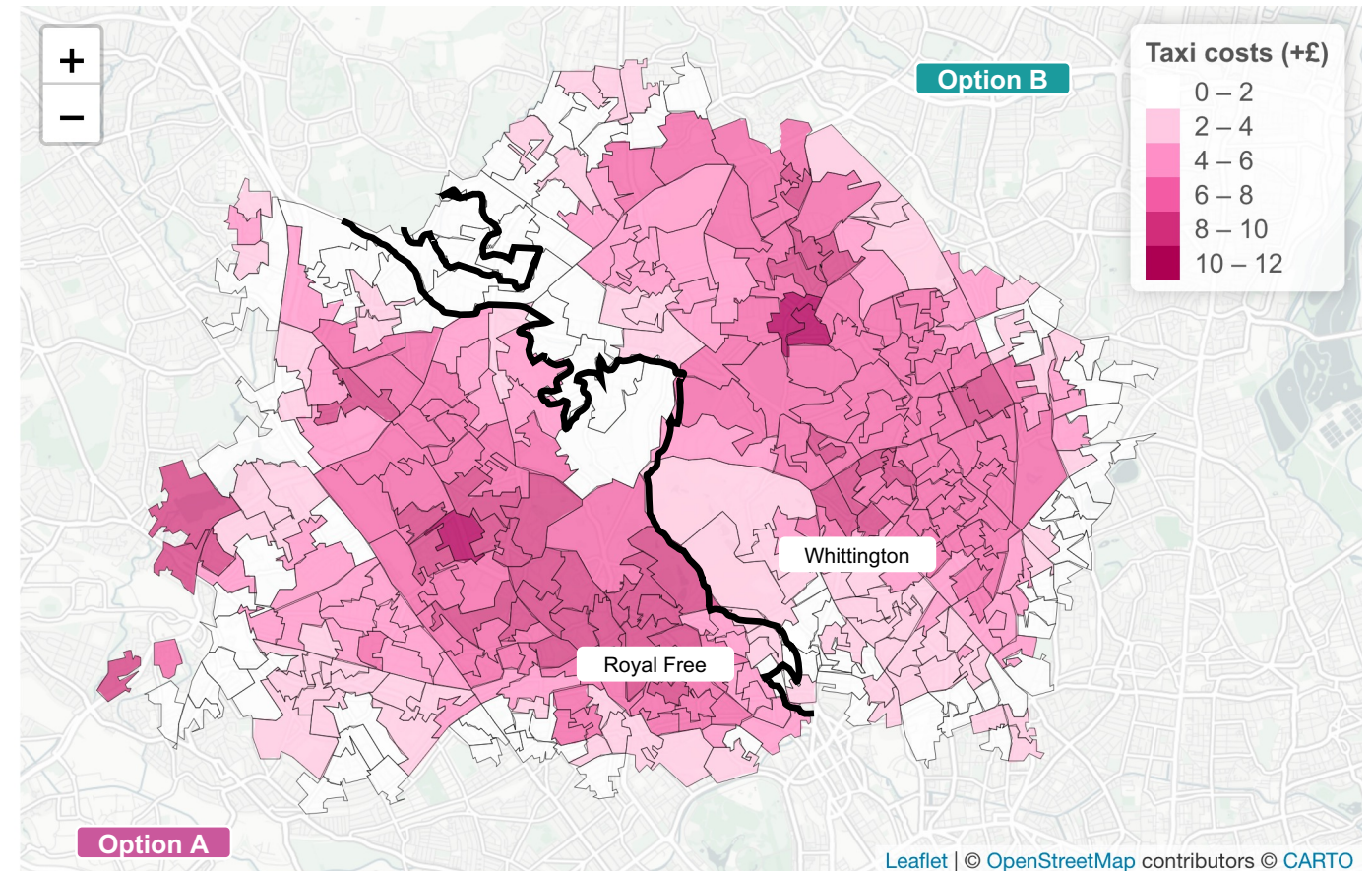
Average additional distance of travel (mile)



## People closest to each of the potentially closing sites may need to pay up to an additional £11 per taxi journey

The average increase in taxi costs is £4-5 per journey, which is substantial, but similar between both option A and B.

People closest to each of the potentially closing sites may need to pay up to an additional £11 per taxi journey, which would have a significant impact on the most financially vulnerable





## There is a similar, high, level of digital access within the catchment population for options A and B

### Digital access

*Mean digital propensity scores for options A and B*

Option	Digital propensity index (DPI) of catchment population
<b>Option A:</b> Barnet, North Mid, Whittington, UCLH	96.0%
<b>Option B:</b> Barnet, North Mid, Royal Free, UCLH	96.1%

### Digital Propensity Index (DPI)

The ONS launched the Digital Propensity Index (DPI) in 2021 as a method of measuring the ease of accessing public online resources. It measures the number of people who are more comfortable with paper-only communications and attempts to account for various degrees of uncertainty in order to measure the degree of uptake of online resources.

This DPI has been used to measure the average digital propensity of the catchment population in each option. This indicates how easily the population can access digital services such as online appointment, e-prescriptions and video-conferencing



People have similar access to cars for options A and B, with around 50% of the population having access to a car

### Car ownership

Average rate (%) of car access (2023 ONS estimate from 2021 data)

Option	Car ownership rates (%)
<b>Option A:</b> Barnet, North Mid, Whittington, UCLH	52%
<b>Option B:</b> Barnet, North Mid, Royal Free, UCLH	48%

### Car ownership

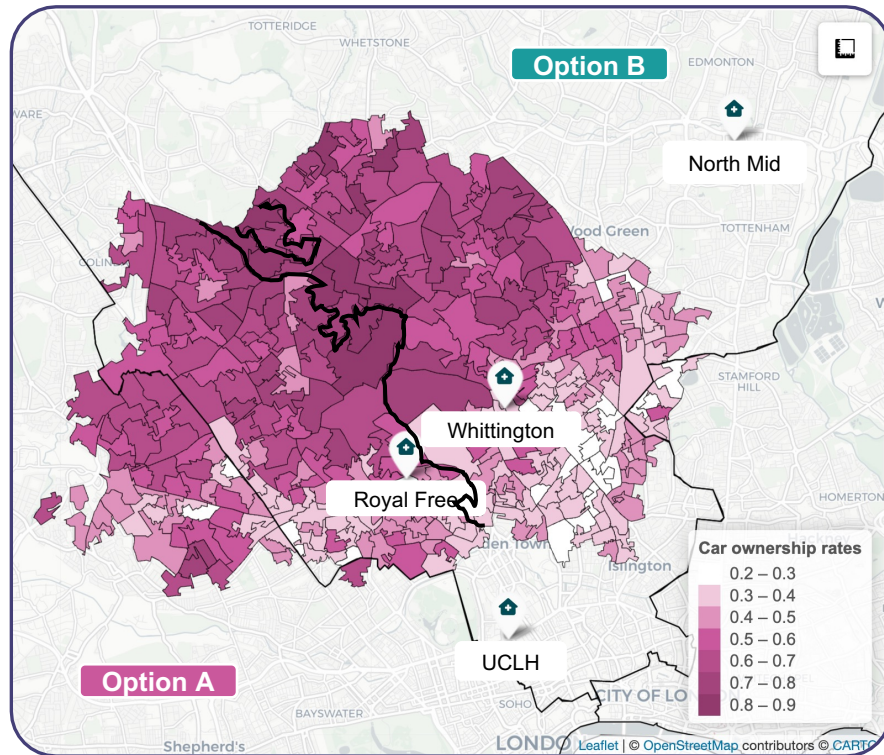
The ONS measures rates of vehicle access (defined as any household that owns any number of vehicles) per LSOA, with estimates for 2023 taken from the 2021 census.

*Note: car access rates measure household access to a vehicle of any type, be it van or car. However, this neglects the household size and specific situations per household. For example, a household with only one car and a person who uses it for work would be similar to a household without any cars in terms of access to healthcare during working hours.*

# Car ownership varies, with people with disabilities substantially less likely to own cars

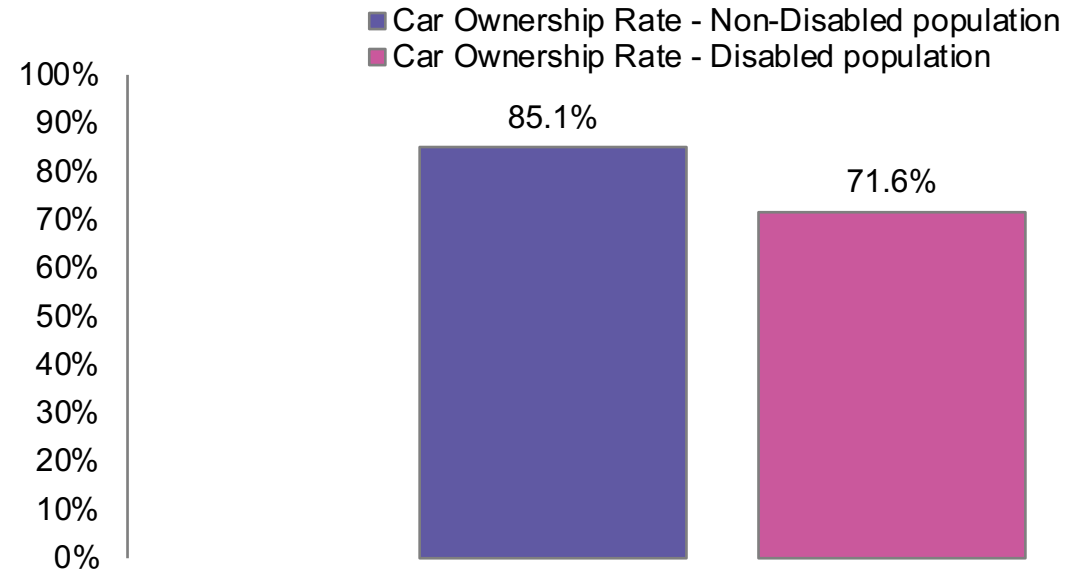
## Car ownership

Car ownership rate (2021) by LSOA



## Car ownership for people with disabilities

Catchment vehicle ownership rates (2021) with disability under equality act



The percentage of the impacted population with disabilities for option B (Whittington Hospital) is **13.0%** whilst the percentage for option A (Royal Free Hospital) is **14.5%**



## Engagement found people may have issues with travel times, travel cost, parking and wayfinding

### Getting to hospital

- Generally, people preferred maternity services which were close to home, to mitigate the need to travel for care
- When people did have to travel, they reported issues with travel times, the cost of travel and difficulties with finding parking spaces if they drove.
- For people who felt ill during their pregnancy, travel could be difficult; people cited travelling at rush hour could be uncomfortable on public transport
- Some people chose to walk to hospitals if they could, to overcome the problem of cost, crowding and parking
- Travelling after having had a c-section, particularly when visiting a baby in a neonatal unit was difficult - particularly if on public transport

### Access within hospital

- Parents sometimes found signage in hospitals difficult to understand, often using words and acronyms which were unfamiliar to them
- This was especially a problem in settings parents had not visited before. Generally, once people knew their way around a hospital, they did not need to read the signs, so the language became less important. This was highlighted to be a particular problem for people who don't speak English or who had learning disabilities
- In locations where mobile reception was poor parents said they found it difficult to communicate with partners

Engagement on the integrated impact assessment was done with 124 people during 2023 and focussed on groups that were identified through the case for change as facing differential outcomes / inequalities

# **Potential impact of proposals on protected characteristics and people who have vulnerabilities**

# Summary: potential impact of the proposals on protected characteristics and people who have vulnerabilities



- The impact of the proposals on groups who share protected characteristics and people who have vulnerabilities has been reviewed, in line with legal duties, and it is similar to the potential impact on the general catchment population
- We identified some groups sharing a protected characteristics, or who may be more vulnerable to the impact of our proposals:
  - **Race:** Somali pregnant women and people have very poor outcomes and may need to travel further or switch hospitals in Finsbury Park (option B) and Kilburn (option A). There is little difference between options A and B for people from ethnic minority groups, but they may require mitigations to be put in place to address language and cultural barriers
  - **Age:** younger and older pregnant women and people may need to attend more appointments throughout their pregnancy and could be impacted if these were further away
  - **People with disabilities:** people with disabilities may need additional support to access services on an unfamiliar site for options A and B. Some people may find it more difficult to attend a unit that is further away, or on a different site, on a more frequent basis due to an underlying health condition that impacts on the complexity of their pregnancy.
  - **Religion:** the Orthodox Jewish community have specific requirements, with a greater impact in option A on this community because they live near to the unit that may close. Specific mitigations are being developed with this group
  - **People living in areas of deprivation:** the main impact on access for people living in deprived areas, people who are economically inactive and people with poor health is an average increase in taxi costs of almost £5 and lower car ownership than average. There is little difference between options A and B for people living in deprived areas, but these people may face barriers to travelling further or accessing a different site due to cost of transport, digital exclusion and already having children in both options compared to now
  - **Other inclusion health groups:** groups such as homeless people, refugees, victims of domestic abuse and travellers have been considered. There is little difference between options A and B for other inclusion health groups, but these people may face barriers to travelling further or accessing a different site due to barriers for cost of transport, digital exclusion and language barriers would need to be addressed in both options compared to now
- Further details of mitigations that have been developed are shown on slides 134 - 147

# The impact of the proposals on protected characteristics and people who have vulnerabilities has been reviewed



- There is a duty under the Equality Act 2010 to have due regard to the need to:
  - Eliminate unlawful discrimination, harassment and victimisation
  - Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
  - Foster good relations between people who share a relevant protected characteristic and those who do not share it.
- Where there is quantitative data available, we used this data to review the impact on groups with protected characteristics and people who have vulnerabilities such as living in a deprived area, travellers, single parent families and homeless people (there may be some overlap between the groups, for example, people who have poor English proficiency are likely to overlap with people who belong to an ethnic minority, and we have assessed where this may be the case). The outcome of this quantitative analysis is shown on some of the following slides. We have also used engagement and qualitative assessment.
- We have not identified any potential disproportionate impact from being married or in a civil partnership, and this has not been raised as a potential issue in engagement, therefore this has not been assessed further than looking at single-person households
- Our analysis shows where people with protected characteristics and people who have vulnerabilities may be disproportionately impacted by the proposals.

# Some groups are likely to be disproportionately impacted by the proposals

## Potential impacts that may require mitigations

		Potential impacts that may require mitigations
Protected characteristic	Race	<ul style="list-style-type: none"> <li>No difference between the options</li> <li>Language barriers would need to be addressed if people not proficient in English need to access an unfamiliar unit</li> <li>The Somali communities in Finsbury Park and Kilburn may need to travel further or switch hospital compared to now</li> </ul>
	Age	<ul style="list-style-type: none"> <li>No difference between the options</li> <li>May need to attend more appointments throughout their pregnancy and could be impacted if were further away compared to now</li> </ul>
	Sex	<ul style="list-style-type: none"> <li>No difference between the options</li> <li>No specific mitigations required</li> </ul>
	People with disabilities	<ul style="list-style-type: none"> <li>No difference between the options</li> <li>People with a disability may have difficulty accessing services on an unfamiliar site compared to now</li> </ul>
	Being pregnant or on maternity leave	<ul style="list-style-type: none"> <li>No difference between options</li> <li>No specific mitigations required</li> </ul>
	Gender reassignment	<ul style="list-style-type: none"> <li>No difference between the options</li> <li>No specific mitigations required</li> </ul>
	Religion of belief	<ul style="list-style-type: none"> <li>Greater impact on the orthodox Jewish population under Option A</li> <li>Specific mitigations are being developed for this community</li> </ul>
	Sexual orientation	<ul style="list-style-type: none"> <li>No difference between the options</li> <li>No specific mitigations required</li> </ul>
	Being married or in a civil partnership	<ul style="list-style-type: none"> <li>No difference between the options</li> <li>No specific mitigations required</li> </ul>
Other	People living in areas of deprivation	<ul style="list-style-type: none"> <li>People living in areas of deprivation in option B are nearer to the maternity unit that may move than option A, so the impact would be more significant for this population (people may pay up to £11 more to travel by taxi compared to now)</li> <li>Potential overlap with race, other inclusion groups and disabilities</li> <li>People living in areas of deprivation may have difficulties with cost of transport, digital exclusion and barriers for people who already have children compared to now</li> </ul>
	Other inclusion health groups	<ul style="list-style-type: none"> <li>No difference between the options (potential overlap with race, deprivation and disabilities)</li> <li>People in other inclusion groups may have difficulties with cost of transport, digital exclusion and language barriers compared to now</li> </ul>



# There is an average increase in taxi costs of almost £5 for people from ethnic minority groups

## People from ethnic minority groups

Access statistics for people from ethnic minority groups

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces
A	96.0%	14.22	50.1%	110
B	96.1%	17.71	45.0%	374

## Impact on people from ethnic minority groups

Average impact people from ethnic minority groups

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off- peak car/taxi travel times (mins)	Taxi costs	Driving costs
A	Current	17.45	15.23	13.00	£18.86	£1.76
	Future	+6.27	+5.07	+6.97	+\$4.89	+\$0.46
B	Current	18.45	14.45	12.41	£16.24	£1.53
	Future	+6.79	+5.65	+5.19	+\$4.23	+\$0.40

## Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (peak) by 5-6 minutes, by 5-7 minutes (off-peak) and by public transport by 5-7 min which is similar to the catchment population
- A potential impact would be an increase in average taxi costs of £4-5 which is similar to the general population. Car ownership for option B is slightly lower than average for people from ethnic minority groups (45% compared to 48.4%)
- Public transport accessibility is slightly higher for ethnic minorities than for the general catchment population (A: 14.22 compared to 13.63, B: 17.71 compared to 14.35)

## Difference between options

- Options A and B would have **similar impacts** on people from ethnic minority groups
- Option A has a **higher car ownership** and slightly **lower public accessibility** alongside a **slight increase in average taxi costs**



## There is an average increase in taxi costs of around £4 for people who have poor English proficiency

People who have poor English proficiency (including literacy)  
 Access statistics for people who have poor English proficiency

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces
A	95.9%	13.92	50.1%	110
B	96.1%	16.22	44.2%	374

Impact on people who have poor English proficiency (including literacy)  
 Average impact people who have poor English proficiency

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi travel times (mins)	Taxi costs	Driving costs
A	Current	19.37	16.84	14.37	£19.53	£1.84
	Future	+5.56	+4.63	+6.91	+£4.48	+£0.42
B	Current	19.83	15.58	13.42	£17.12	£1.61
	Future	+6.05	+5.24	+4.80	+£3.92	+£0.37

### Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (peak) by 4-5 minutes, by 5-7 minutes (off-peak) and by public transport by 5-7 min, which is similar to the catchment population
- A potential impact would be an increase in average taxi costs of around £4 which is similar to the general population, although car ownership is slightly lower than for the catchment population (A: 50.1% compared to 51.9%, B: 44.2% compared to 48.4%)
- Public transport accessibility is slightly higher for those not proficient in English than for the catchment population for option B (16.22 compared to 14.35)

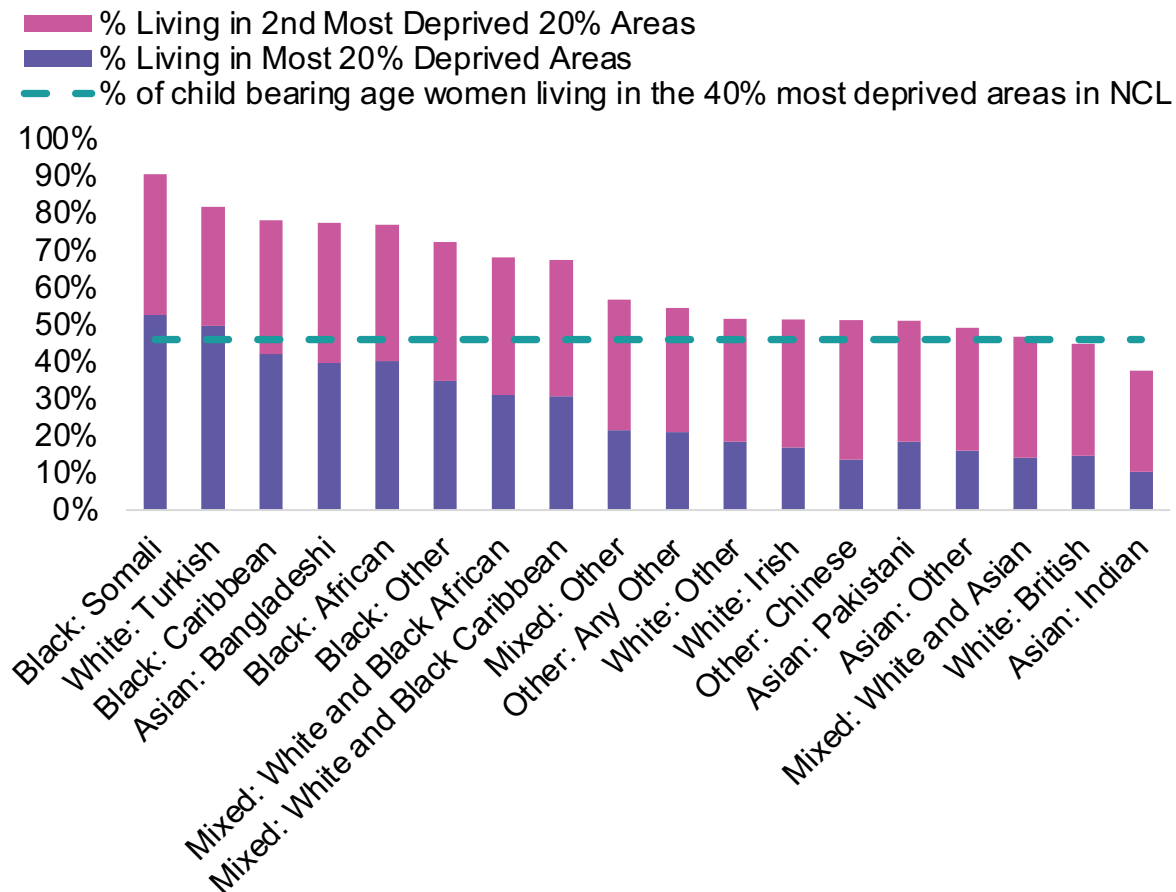
### Difference between options

- Options A and B would have **similar impacts** on people not proficient in English (including literacy)
- Option A has a **higher car ownership, lower public transport accessibility** alongside a **higher increase in average taxi costs**. The lower car ownership for option B means they may be more impacted by taxi costs
- This population may also be impacted by **language barriers** whilst accessing services on an unfamiliar site

# Somali pregnant women and people have poor outcomes and may need to travel further or switch hospital



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## Population

- 91% of women and people of childbearing age of Somali ethnicity live in the 40% most deprived areas in NCL and 50% live in the 20% most deprived areas

## Impacts

- There is a large Somali community in Finsbury Park which would be impacted by option B and would access services at the Royal Free 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.
- There is a smaller Somali community in Kilburn that would be impacted by option A. Their closest hospital would change from the Royal Free Hospital to Northwick Park Hospital or St Mary's Hospital.
- Continuity of care between caregiver and receiver has been shown to lead to better outcomes and safety for mother and baby



## There is little difference between options A and B for ethnic minorities but language and cultural barriers

### Feedback from interim IIA engagement

- Language barriers and lack of interpretation impact on people's experience of care and perceived outcomes
- There was a feeling that people were treated differently as they didn't speak English
- Lack of interpretation available meant they did not always know what was happening around them and did not feel involved in their maternity care
- There was a desire to have female interpreters, and this was not always available
- Cultural differences were not always understood or accommodated by staff

From work to date, there appears to be **no difference between the options for people from ethnic minority groups**. Mitigations for **language barriers** where people are not proficient in English would need to be addressed as proposals are implemented, and for people from ethnic minority groups who live in areas of deprivation (see slides 134 - 147).

Particular attention would need to be paid to the **Somali communities in Finsbury Park and Kilburn** who may need to travel further or switch hospital. We will continue to engage with this group during consultation and beyond.

# Older and younger pregnant women and people may need to attend more appointments during their pregnancy



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## Service provision and outcomes

- Both older and younger pregnant women and people are likely to have worse health outcomes in childbirth
- Older age is a key factor in determining potential complications at birth, with the maternal mortality rate being four-fold higher for women aged over 40 compared with women aged 20-24 years old
- Evidence suggests that pregnancy in adolescents has been associated with adverse maternal outcomes and in NCL there is a higher proportion of pregnant women and people aged under 20 that have a caesarean section
- Younger pregnant women and people may not have a support network
- Both older and younger pregnant women and people may need to attend more appointments throughout their pregnancy and could be impacted if these were further away

## Feedback from interim IIA engagement

- Older mothers who took part in the engagement were happier to travel than other groups of people, saying that they would prefer to travel further for their first choice of maternity care, based on previous experience or recommendations for others

## Potential impacts that may require mitigation

- From work to date, there appears to be **no difference between options A and B** for older and younger pregnant women. They may need to attend more appointments throughout their pregnancy and **could be impacted if these were further away**. We will continue to engage with this group during consultation and beyond.



# There is an average increase in taxi costs of almost £5 for women and people of child-bearing age

## Women and people of child-bearing age

Access statistics for women and people of child-bearing age

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces
A	96.0%	14.69	49.3%	110
B	96.2%	15.96	44.8%	374

## Women and people of child-bearing age

Average impact across women and people of child-bearing age

Option	Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi travel times (mins)	Taxi costs	Driving costs	
A	Current	17.3	14.21	12.22	£17.81	£1.63
	Future	+6.28	+5.33	+6.97	+£5.02	+£0.46
B	Current	18.39	14.02	12.06	£15.75	£1.48
	Future	+6.99	+5.81	+5.36	+£4.29	+£0.42

### Impact of the proposals compared to now

- The impact of the proposals would be to increase travel time by car/taxi (peak) by ~6 minutes, by 5-7 minutes (off-peak) and by public transport by ~ 7 minutes under options A and B, which is similar to the catchment population
- A potential impact would be an increase in average taxi costs of £4-5, which is similar to the catchment population

### Difference between options

- Options A and B would have **similar impacts** on women and people of child-bearing age although the impact would be greater on people living nearer to a current site
- Option A has **higher car ownership** and **lower public accessibility** alongside a **larger increase in average taxi costs**. Those impacted under option B may be more impacted by increasing taxi costs due to lower car ownership.



# There is an average increase in taxi costs of almost £5 for disabled populations, who have lower car access

## People with disabilities

Access statistics for people with disabilities

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces
A	95.8%	14.31	49.2%	110
B	95.9%	15.35	45.4%	374

## Impact on people with disabilities

Average impact for people with disabilities

Option	Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi travel times (mins)	Taxi costs	Driving costs	
A	Current	17.28	14.24	12.17	£17.08	£1.61
	Future	+6.25	+5.10	+6.75	+£4.79	+£0.45
B	Current	18.26	13.61	11.71	£15.58	£1.46
	Future	+7.03	+5.93	+5.34	+£4.40	+£0.41

### Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (off-peak) by 5-6 minutes, by 5-7 minutes (off-peak) and by public transport by 6-7 min, which is similar to the catchment population
- A potential impact would be an increase in average taxi costs of £4-5 which is similar to the NCL population, car ownership is slightly lower than average people with disabilities (A: 49.2% compared to 51.9%, B: 45.4% compared to 48.4%)
- Public transport accessibility is slightly higher than average for people with disabilities (A: 14.31 compared to 13.63, B: 15.35 compared to 14.35)

### Difference between options

- Options A and B would have **similar impacts** on people with disabilities although the impact would be greater on people living nearer to a unit where services may change
- The population impacted by option A has a **higher car ownership** and slightly **lower public accessibility** alongside a **slight** increase in average taxi costs
- Some people may need to attend hospital on a more frequent basis due to an underlying health condition that impacts on the complexity of their pregnancy

# People with learning disabilities may need additional support to access care where service location changes



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## People with learning disabilities

### Population

- It is estimated that nationally 1 in 7 people have learning disabilities to some extent<sup>1</sup>
- This equates to approximately 13,600 women and people of childbearing age who would be impacted in option A and 16,600 in option B

### Service provision and outcomes

- Populations with learning disabilities may have some difficulty in accessing care, especially with regards to getting to services or communication with staff
- These populations may also face discrimination whilst accessing healthcare

### Potential impacts that may require mitigation

- People with learning disabilities may find it difficult to access a new unit (if the site providing the service changes), both travelling to the unit and whilst on site
- Additional communication and support for this group would be required to support continued access to services
- No differential impact has been identified between options A and B

# People with serious mental illness may need additional support to access care where service location changes



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## People with serious mental illness

### Population

- It is estimated that anywhere between 3-6% of the population may have an SMI (Serious Mental Illnesses).
- Within the catchment area, this would correspond to roughly 2,800-6,000 people in option A and 3,500 to 7,000 people in option B

### Service provision and outcomes

- People with serious mental illness may require carer support or consideration for those who provide care for them
- Often these are family members who may have limited access to cars or who struggle to access public transport
- In addition, populations with serious mental illnesses may face discrimination or difficulty in accessing healthcare

### Potential impacts that may require mitigation

- People with serious mental illness may find it difficult to access a new unit (if the site providing the service changes), both travelling to the unit and whilst on site
- Additional communication and support for this group would be required to support continued access to services
- No differential impact has been identified between options A and B



## There is little difference between the options for people with disabilities

### Feedback from interim IIA engagement (learning disability and autism)

- Information was not always available in formats they required such as easy read, including on how to find hospital sites and clinics.
- Travelling to unfamiliar places was difficult, and often there was little information to help with this.
- Travel and transport could sometimes present problems. Issues such as transport not arriving, taxis or public transport not being able to accommodate wheelchairs
- Not having sufficient information on how to get to unknown or unfamiliar locations
- Double appointments might be needed for some parents with disabilities

### Feedback from interim IIA engagement (mental health)

- Valued being seen by the same midwife throughout their pregnancy and delivery

### Feedback from interim IIA engagement (deaf)

- Virtual appointments challenging - may require additional time in appointments to allow time for interpretation
- Information was not always available in appropriate formats
- Availability of the right interpretation did not always happen

From work to date, there appears to be **no difference between the options for people with disabilities**. Mitigations for **people changing the place where they access services** would need to be addressed as proposals are implemented. We will continue to engage with this group during consultation and beyond.



# For the people who are transgender, the potential impacted is very small, but they have very complex needs

## Population

- The overall transgender population in the UK is 0.1%, with the ratio of female to male (FtM) people in the transgender population being typically around 30%<sup>1</sup>
- An estimate of the number of FtM people of childbearing age that are potentially impacted by the proposals is therefore around 30 people for option A and around 35 people for option B

## Service provision and outcomes

- People who are transgender (FtM) populations may have complex medical needs and thus require specialist expertise. They may also require separate facilities.
- People who are transgender face significant discrimination and stigma that act as barriers to accessing healthcare and increase the risk of mental health issues

## Impacts

- The new model of care will improve quality and outcomes for all population groups
- Consistent support and engagement would need to be provided to ensure the impact on the FtM people who are transgender is understood and mitigated

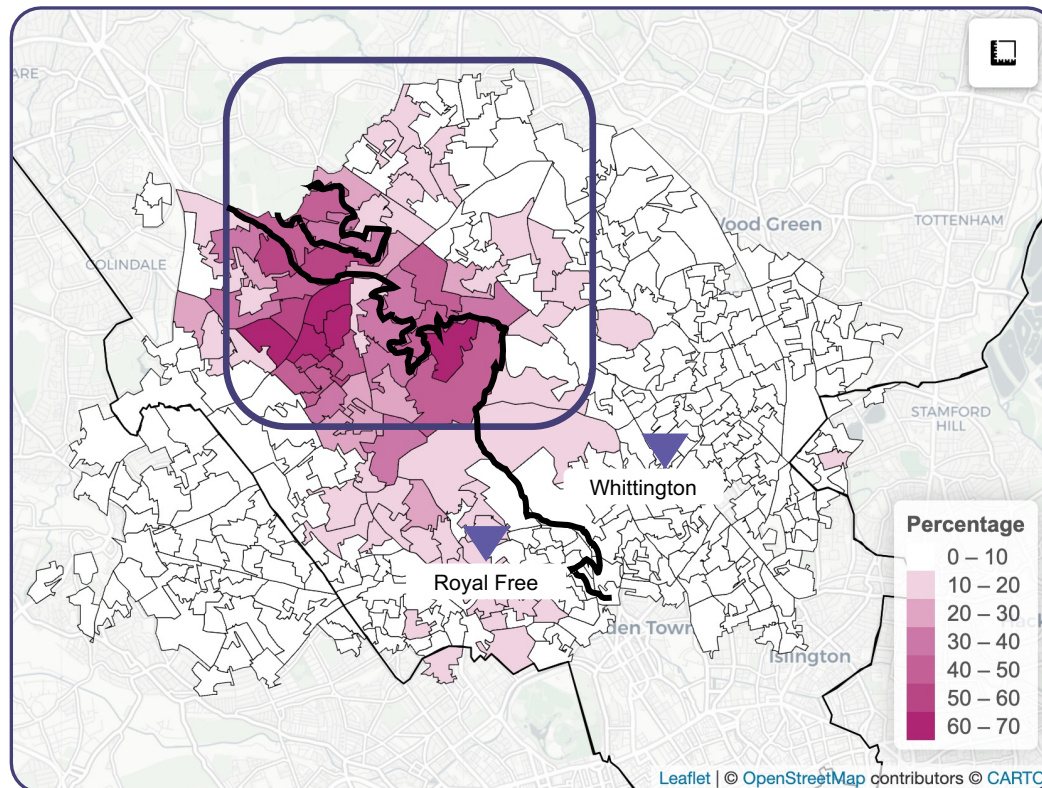
From work to date, there appears to be **no difference between the options for people who are transgender, and no specific mitigations** are required. We will engage more directly with this group during consultation and beyond.

# The Orthodox Jewish community have specific requirements, with a greater impact in option A (1/2)

Through the case for change development and the engagement process, we have heard that the proposed changes would have limited impact on different religious groups with the exception of the Orthodox Jewish community

## Jewish Population

*Proportion of Jewish populations*



Orthodox Jewish populations have specific needs:

- 1. Food requirements:** Orthodox Jewish populations have strict Kosher requirements. From engagement, it was found that hospitals are not always adequately prepared to provide for varying dietary requirements
- 2. Shabbat observance:** Many Orthodox Jewish populations have restrictions on electricity usage on the Shabbat, requiring Shabbat-compliant lifts and potentially restricting travel on public transport.
- 3. Digital access:** feedback from engagement highlighted that people from this community are less likely to have smartphones. This may impact on the way they interact with maternity services and receive information about their care

These populations are currently within Royal Free Hospital catchment area and would be impacted should Option A be implemented. Most of them have been modelled to access maternity care at Whittington Hospital under this option.

As per the ONS, the different sects of Judaism can be identified by the self-reporting of Judaism as “Ethnicity” or “Religion”. To best isolate the Orthodox, we identified Jewish populations by religion.



## The Orthodox Jewish community have specific requirements, with a greater impact in option A (2/2)

### Feedback from interim IIA engagement

- Lack of access to smartphones or computer, paper communication being preferred
- Information on public websites isn't effective and paper options are best
- Kosher food was not always available for Orthodox Jewish women
- Care closer to home was preferred as costs and travel time sometimes prevented people from attending appointments
- Observance of Shabbat could mean that visitors would not be able to travel to visit patients if they were beyond walking distance, so care closer to home was preferred

There would be **greater impact on the orthodox Jewish population under Option A** – potential mitigations are shown on slide 144-145 and **specific mitigations** are being developed in discussions with the orthodox Jewish community. We will continue to engage with this group during consultation and beyond.



# The potentially impacted people who are LGBTQ+ is very small but have very complex needs

## Population

- The proportion of people who identify as lesbian, gay or bisexual in London is 3.8%, which equates to approximately 17,000 people in the catchment population

## Service provision and outcomes

- Lesbian, gay or bisexual people may have different needs to the general population and tend to have disproportionately worse health outcomes and experiences of healthcare

## Impacts

- The new model of care will ensure that there is quality improvement for all population groups
- Mental health support and counselling will be available where required

## Feedback from interim IIA engagement

- Assumptions made by staff about a male being involved in maternity care
- Participants said they felt there was a lack of inclusivity of language on information, forms and posters

From work to date, there appears to be **no difference between the options for people who are LGBTQ+** and **no specific mitigations** are required. We will continue to engage with this group during consultation and beyond.

# There is an average increase in taxi costs of almost £5 for people living in areas of deprivation



North Central London  
Integrated Care System

## People living in areas of deprivation

Access statistics for people living in areas of deprivation

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces
A	95.9%	13.82	50%	110
B	96.0%	16.44	46%	374

## Impact on people living in areas of deprivation

Average impact for people living in areas of deprivation

Moved unit	Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi travel times (mins)	Taxi costs	Driving costs	
A	Current	18.07	15.02	12.83	£17.86	£1.68
	Future	+6.10	+4.99	+6.81	+£4.71	+£0.44
B	Current	18.57	14.00	12.04	£15.94	£1.50
	Future	+6.89	+5.80	+5.24	+£4.35	+£0.41

## Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (peak) by 5-6 min, by 5-6 minutes (off-peak) and by public transport by 6-7 min, which is similar to the catchment population
- This proposal may lead to an increase in average taxi costs of £4-5 which is similar to the catchment population but may cause financial hardship for this group. Car ownership is slightly lower than average for the deprived population (A: 49.7% compared to 51.9%, B: 49.5% compared to 48.4%), which means people in this group may be slightly more likely to use taxis
- Public transport accessibility is slightly higher for people living in areas of deprivation than for the catchment population (A: 14.03 compared to 13.63, B: 15.36 compared to 14.35)

## Difference between options

- Options A and B would have **similar impacts** on people living in areas of deprivation
- The population impacted by option A has **slightly lower accessibility to public transport** than option B, with a **slightly higher increase in average taxi costs** but this may be offset by **slightly higher car ownership**



# There is an average increase in taxi costs of almost £5 for people who are economically inactive

## People who are economically inactive

Access statistics for people who are economically inactive

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces
A	95.9%	14.09	50.1%	110
B	95.9%	15.41	45.1%	374

## Impact on people who are economically inactive

Average impact for people who are economically inactive

Moved unit	Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi travel times (mins)	Taxi costs	Driving costs	
A	Current	17.71	15.08	12.87	£17.84	£1.68
	Future	+6.17	+4.94	+6.78	+£4.69	+£0.44
B	Current	18.45	14.01	12.05	£15.87	£1.49
	Future	+6.79	+5.76	+5.21	+£4.29	+£0.40

## Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (peak) by 5-6 minutes, by 5-7 minutes (off-peak) and by public transport by 5-7 min, which is similar to the catchment population
- The biggest impact would be an increase in average taxi costs of £4-5 which is similar to the catchment population but may cause financial hardship for this group. Car ownership for option B is lower than average for people who are economically inactive (41.5% compared to 48.4%)
- Public accessibility is slightly higher for people who are economically inactive than for the catchment population (A: 14.09 compared to 13.63, B: 15.41 compared to 14.35)

## Difference between options

- Options A and B would have **similar impacts** on people who are economically inactive
- Option A has a **higher car ownership** and slightly **lower public accessibility** alongside a **slight increase in average taxi costs**. The impact of taxi costs may be more impactful under option B due to lower car ownership.



## There is an average increase in taxi costs of almost £5 for people with poor health

### People with poor health

Access statistics for people with poor health

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces
A	95.7%	14.44	48.4%	110
B	95.8%	15.92	44.3%	374

### Impact on people with poor health

Average impact across people with poor health

Moved unit	Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi travel times (mins)	Taxi costs	Driving costs	
A	Current	16.95	14.62	12.43	£17.24	£1.62
	Future	+6.22	+4.93	+6.81	+£4.69	+£0.44
B	Current	18.08	13.56	11.69	£15.48	£1.45
	Future	+6.89	+5.93	+5.30	+£4.36	+£0.41

### Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (peak) by 4-6 minutes, by 5-7 minutes (off-peak) and by public transport by 5-7 min, which is similar to the catchment population
- This biggest impact would be an increase in average taxi costs of £4-5 which is similar to the catchment population. Car ownership is lower than average for people with poor health (A: 48.4% compared to 51.9%, B: 44.3% compared to 48.4%)
- Public transport accessibility is slightly higher for people with poor health than for the catchment population (A: 14.3 compared to 13.63, B: 15.92 compared to 14.35)

### Difference between options

- Options A and B would have **similar impacts** on people with poor health
- Option A has a **higher car ownership**, slightly **lower public accessibility** alongside a slightly **higher increase in average taxi costs**
- This population may also be impacted by **physical barriers** whilst accessing services on site such as requiring step-free access



## There is little difference between the options for people living in deprived areas but barriers for cost of transport, digital exclusion and people with children

### Feedback from IIA engagement (deprived)

- Digital exclusion may be a factor for those that can't afford data/wifi
- SMS is often possible but opening links from these can be difficult without data/wifi
- Non-attendance of appointments can be high

### Feedback from IIA engagement (people who already have children)

- Travel was a consideration for people who had children; they either needed to take the children with them to appointments or have them looked after
- The time needed for journeys, the difficulties of taking buggies on public transport and looking after young children were cited as issues by some people
- People who were unable to use public transport and did not have access to a car sometimes took taxis to hospital appointments, but this was costly and unaffordable for many people

From work to date, there appears to be **no difference between the options for people who live in deprived areas**. Mitigations for the **cost of transport, digital exclusion and people who already have children** need to be addressed as proposals are implemented, We have developed some initial mitigations, shown on slides 134 - 147. We will continue to engage with this group during consultation and beyond.



## Groups such as homeless people, refugees, victims of domestic abuse and travellers have been considered

### Inclusion health groups

#### Population

- There are a variety of different inclusion health groups including homeless people, refugees, those fleeing domestic abuse, Gypsy and Roma traveller communities and those that misuse substances
- These populations tend to be very small and dispersed

#### Service provision and outcomes

- Many people in these populations find it difficult to access care consistently, which has an impact on their health outcomes and healthcare experience
- Evidence suggest that these communities consistently have poorer maternal health outcomes including maternal mortality

#### Potential impacts that may require mitigation

- Additional communication and support for this group would be required to support continued access to services
- No differential impact has been identified between options A and B



# There is an average increase in taxi costs of almost £5 for single carers

## Single carers

Access statistics for single

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces
A	95.8%	13.89	49.6%	110
B	95.9%	15.35	44.9%	374

## Impact on single carers

Average impact across single carers

Moved unit	Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi travel times (mins)	Taxi costs	Driving costs	
A	Current	16.96	15.74	13.28	£17.91	£1.62
	Future	+6.22	+4.65	+6.81	+£4.50	+£0.42
B	Current	18.08	14.02	12.06	£15.87	£1.49
	Future	+6.86	+5.75	+5.36	+£4.33	+£0.41

## Impact of the proposals

- The impact of the proposals would be to increase average travel time by car/taxi (off-peak) by 4-6 minutes, by 5-7 minutes (off-peak) and by public transport by 5-7 min
- This biggest impact would be an increase in average taxi costs of £4-5 which may cause financial hardship, especially as car ownership is lower than average for single carers (A: 49.6% compared to 51.9%, B: 44.9% compared to 48.4%)
- Public transport accessibility is slightly higher for single carers than for the catchment population for option B (15.35 compared to 14.35)

## Difference between options

- Options A and B would have **similar impacts** on single carers
- Option A has a **higher car ownership, slightly lower public accessibility** alongside a **slight increase in average taxi costs**



## There is little difference between the options for other inclusion health groups but barriers for cost of transport, digital exclusion and language

### Feedback from interim IIA engagement (homelessness)

- Travel to appointments can be problematic because of their lifestyles and non-attendance is high
- A specialist midwife suggested that taking services to homeless people would overcome some of the problems

### Feedback from interim IIA engagement (domestic abuse)

- Some people may change phone / numbers frequently so may prefer not to receive digital comms or use online services

### Feedback from interim IIA engagement (asylum seekers)

- Language barrier and availability of interpretation services impacted engagement with maternity and neonatal care

From work to date, there appears to be **no difference between the options for other inclusion health groups**. Mitigations for the **cost of transport, digital exclusion and language barriers** need to be addressed as proposals are implemented. We have developed some initial mitigations, shown on slides 134-147 . We will continue to engage with this group during consultation and beyond.

# Accessibility summary: potential impact of the proposals across the quantitative analysis (option A)



Demographics	IT access	Public accessibility	Additional public transport travel times (mins)	Current public transport travel times (min)	Additional peak travel times (mins)	Current peak travel times (mins)	Additional off-peak travel times (mins)	Current off-peak travel times (mins)	Car ownership	Additional taxi costs	Current taxi costs	Additional driving costs	Current driving costs	Parking spaces
Option A Catchment population	96.0%	13.63	+6.29	17.97	+5.26	14.39	+6.7	12.40	51.9%	+\$4.91	£17.55	+\$0.46	£1.65	
Women and people of childbearing age	96.0%	14.69	+6.28	17.30	+5.33	14.21	+6.97	12.22	49.3%	+\$5.02	£17.81	+\$0.46	£1.63	
People living in areas of deprivation	95.9%	14.03	+6.10	18.07	+4.99	15.02	+6.81	12.83	49.7%	+\$4.71	£17.86	+\$0.44	£1.68	
People with disabilities	95.8%	14.31	+6.24	17.28	+5.10	14.24	+6.75	12.17	49.2%	+\$4.79	£17.08	+\$0.45	£1.61	
People who are economically inactive	95.9%	14.09	+6.17	17.71	+4.94	15.08	+6.78	12.87	50.1%	+\$4.69	£17.84	+\$0.44	£1.68	110
People from ethnic minority groups	96.0%	14.22	+6.27	17.45	+5.07	15.23	+6.97	13.00	50.1%	+\$4.89	£18.86	+\$0.46	£1.76	
People with poor health	95.7%	14.44	+6.22	16.95	+4.93	14.62	+6.81	12.43	48.4%	+\$4.69	£17.24	+\$0.44	£1.62	
Single pregnant women and people	95.8%	13.89	+5.85	18.48	+4.65	15.74	+6.81	13.28	49.6%	+\$4.50	£17.91	+\$0.42	£1.62	
People with poor English proficiency	95.9%	13.92	+5.56	19.37	+4.63	16.84	+6.91	14.37	50.1%	+\$4.48	£19.53	+\$0.42	£1.84	

# Accessibility summary: potential impact of the proposals across the quantitative analysis (option B)



North Central London  
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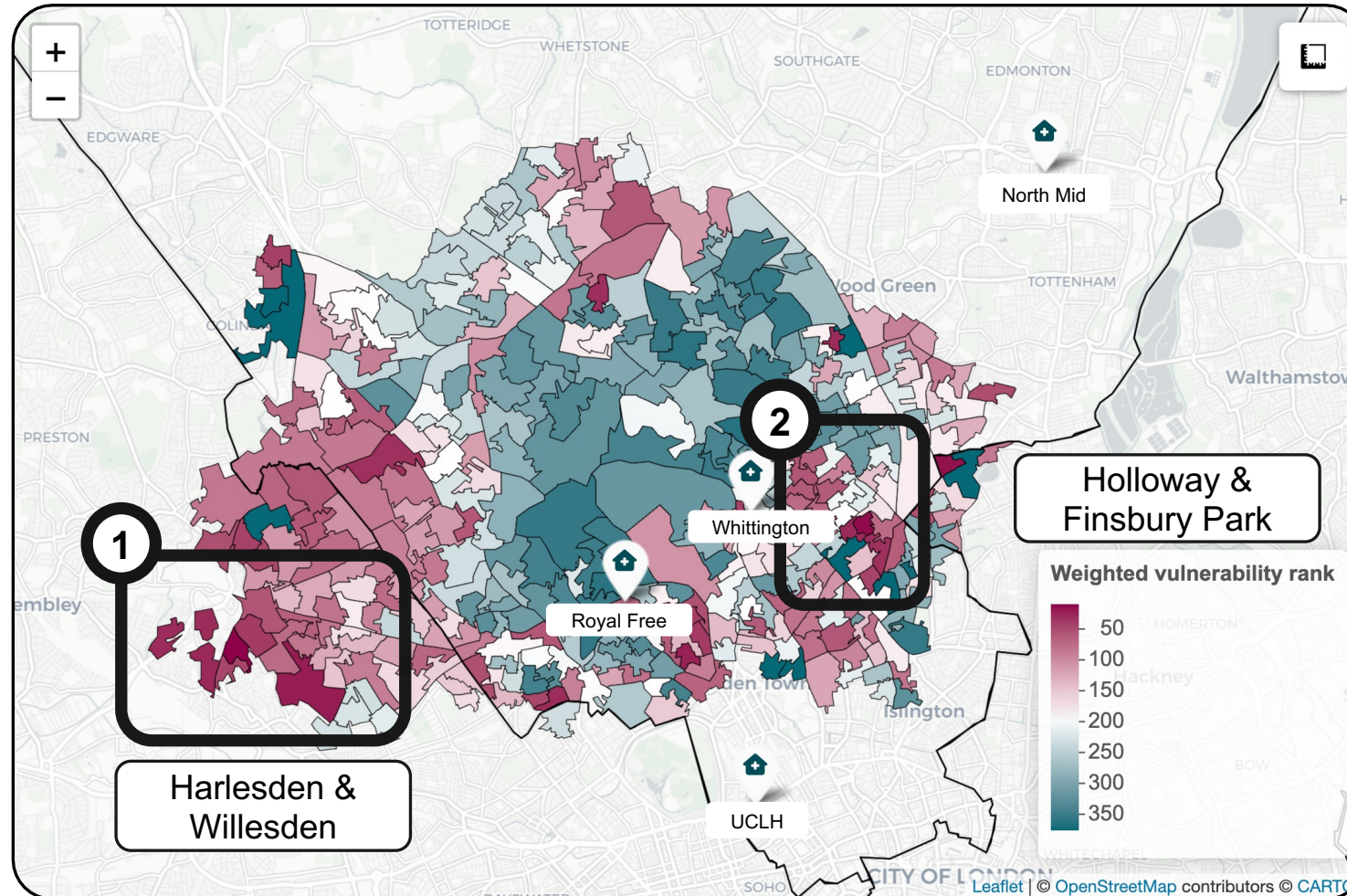
Demographics		IT access	Public accessibility	Additional public transport travel times (mins)	Current public transport travel times (min)	Additional peak travel times (mins)	Current peak travel times (mins)	Additional off-peak travel times (mins)	Current off-peak travel times (mins)	Car ownership	Additional taxi costs	Current taxi costs	Additional driving costs	Current driving costs	Parking spaces
Option B	Catchment population	96.1%	14.35	+6.97	18.94	+5.84	14.06	+5.4	12.1	48.4%	+£4.43	£16.10	+£0.42	£1.51	374
	Women and people of childbearing age	96.2%	15.96	+6.99	18.39	+5.81	14.02	+5.36	12.06	44.8%	+£4.29	£15.75	+£0.42	£1.48	
	People living in areas of deprivation	96.0%	15.36	+6.89	18.57	+5.80	14.00	+5.24	12.04	45.5%	+£4.35	£15.94	+£0.41	£1.50	
	People with disabilities	95.9%	15.35	+7.03	18.26	+5.93	13.61	+5.34	11.71	45.4%	+£4.40	£15.58	+£0.41	£1.46	
	People who are economically inactive	95.9%	15.41	+6.87	18.45	+5.76	14.01	+5.21	12.05	45.1%	+£4.29	£15.87	+£0.40	£1.49	
	People from ethnic minority groups	96.1%	17.71	+6.79	18.77	+5.65	14.45	+5.19	12.41	45.0%	+£4.23	£16.24	+£0.40	£1.53	
	People with poor health	95.8%	15.92	+6.89	18.08	+5.93	13.56	+5.30	11.69	44.3%	+£4.36	£15.48	+£0.41	£1.45	
	Single pregnant women and people	95.9%	15.35	+6.89	18.46	+5.75	14.02	+5.36	12.06	44.9%	+£4.33	£15.87	+£0.41	£1.49	
	People with poor English proficiency	96.1%	16.22	+6.05	19.83	+5.24	15.58	+4.80	13.42	44.2%	+£3.92	£17.12	+£0.37	£1.61	

# **Potential impact of areas that may be more vulnerable to the impact of our proposals**

## Summary: potential impact on areas that may be more vulnerable to the impact of our proposals

- Two geographical areas were identified as being more vulnerable to the impact of our proposals because they face barriers to accessing services as they live in areas of deprivation and have high levels of poor general health. These are: Harlesden and Willesden (option A) and Holloway and Finsbury (option B). This is because:
  - There are Black and Caribbean populations concentrated in these geographies, which are also areas of deprivation, and there is evidence they have poorer maternity outcomes and poor general health
  - Harlesden has a large proportion of Bangladeshi and Pakistani populations, who also live in areas of deprivation, who have poor general health and are more likely to have worse maternal health outcomes
- As a result of the proposals, people in this Harlesden and Willesden (option A), and Holloway and Finsbury (option B) may need additional support to:
  - Access the hospital site if they are disabled/in poor health or are not proficient in English
  - Travel to hospital by taxi, if required, as it will cost an additional £4-5
  - Access services online as they may have low digital proficiency
  - Care for other family members as they may be a single parent
- Further work will be done with these populations during consultation to identify potential additional impacts and develop mitigations, if required

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



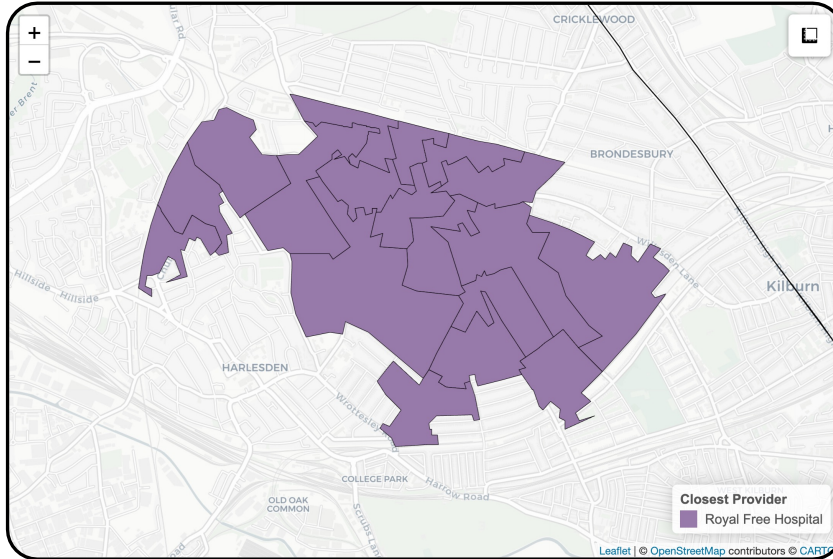
Weightings were used to identify populations that may be particularly vulnerable to the proposed service change

1. **Harlesden and Willesden** were identified as a population whose closest unit was the Royal Free Hospital and therefore would be particularly impacted in option A
2. **Holloway and Finsbury Park** are closest to the Whittington Hospital and are therefore most likely to be impacted by the proposed service changes in option B

We used an index with an equally weighted average of the rank of the percentage of ethnic minorities, deprivation and poor health outcomes by LSOA where 1 = worst, 400 = best to identify particularly vulnerable populations



# Harlesden and Willesden was identified as a geography with residents who may have vulnerabilities in Option A



## Population characteristics

- 13% of people are disabled with 45% reporting to be in poor health
- 6.7% are not proficient in English
- 61.1% of people live in a deprived population and 23% are people who are economically inactive
- 14.8% of parents are alone
- 51.1% of people have access to a car
- 76.2% are people from ethnic minority groups
- the birthrate for this population was 3 per 100 in 2022

## Impact on transport access to maternity care

For most of this population, their closest hospital would change from the Royal Free Hospital to Northwick Park Hospital or St Mary's Hospital in Option A (although their travel time by public transport is already shorter to these hospitals)

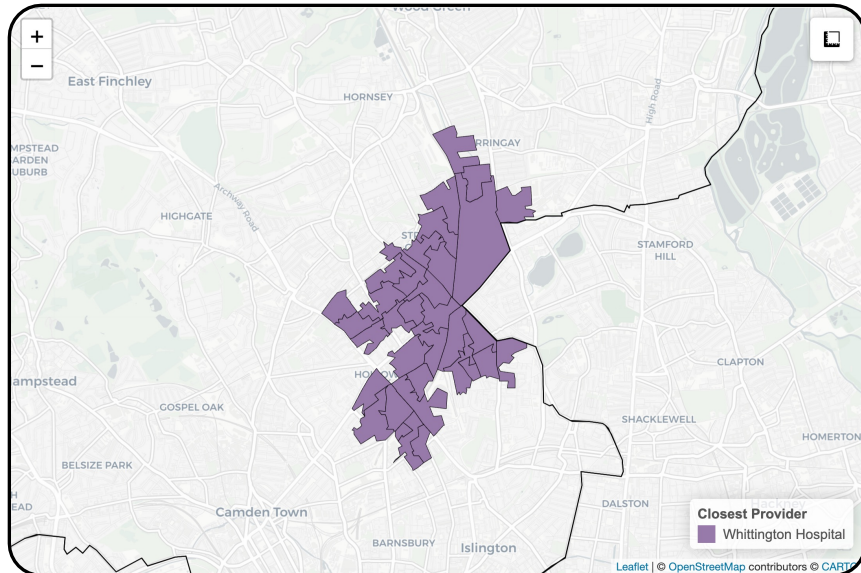
- **Public transport:** Would have to travel an additional 7 minutes despite having good access to public transport
- **Private transport:** Travelling by car would take on average an additional 8 minutes. Taxi costs would increase by £4-5 per journey

## As a result of the proposals (option A), people in this Harlesden and Willesden may need additional support to:

- Access the hospital site if they are disabled/in poor health or are not proficient in English
- Travel to hospital by taxi, if required, as it will cost an additional £4-5
- Access services online as they may have low digital proficiency
- Care for other family members as they may be a single parent



## Holloway and Finsbury was identified as a geography with residents who may have vulnerabilities in Option B



### Impact on transport access to maternity care

For most of this population, their closest hospital would change from Whittington Hospital to the Royal Free Hospital in option B, with some being closer to North Middlesex Hospital and Homerton Hospital

- **Public transport:** Would have to travel an additional 7 minutes despite having good access to public transport
- **Private transport:** Travelling by car would take on average an additional 8 minutes. Taxi costs would increase by £4-5 per journey

### Population characteristics

- 15.1% of people are disabled with 5.1% reporting to be in bad general health
- 4.0% are not proficient in English
- 52.4% of people live in a deprived population and 19% are people who are economically inactive
- 12.1% of parents are alone
- 35.8% of people have access to a car
- 56.8% of people in this area are from ethnic minority groups
- the birthrate for this population was 2 per 100 in 2022

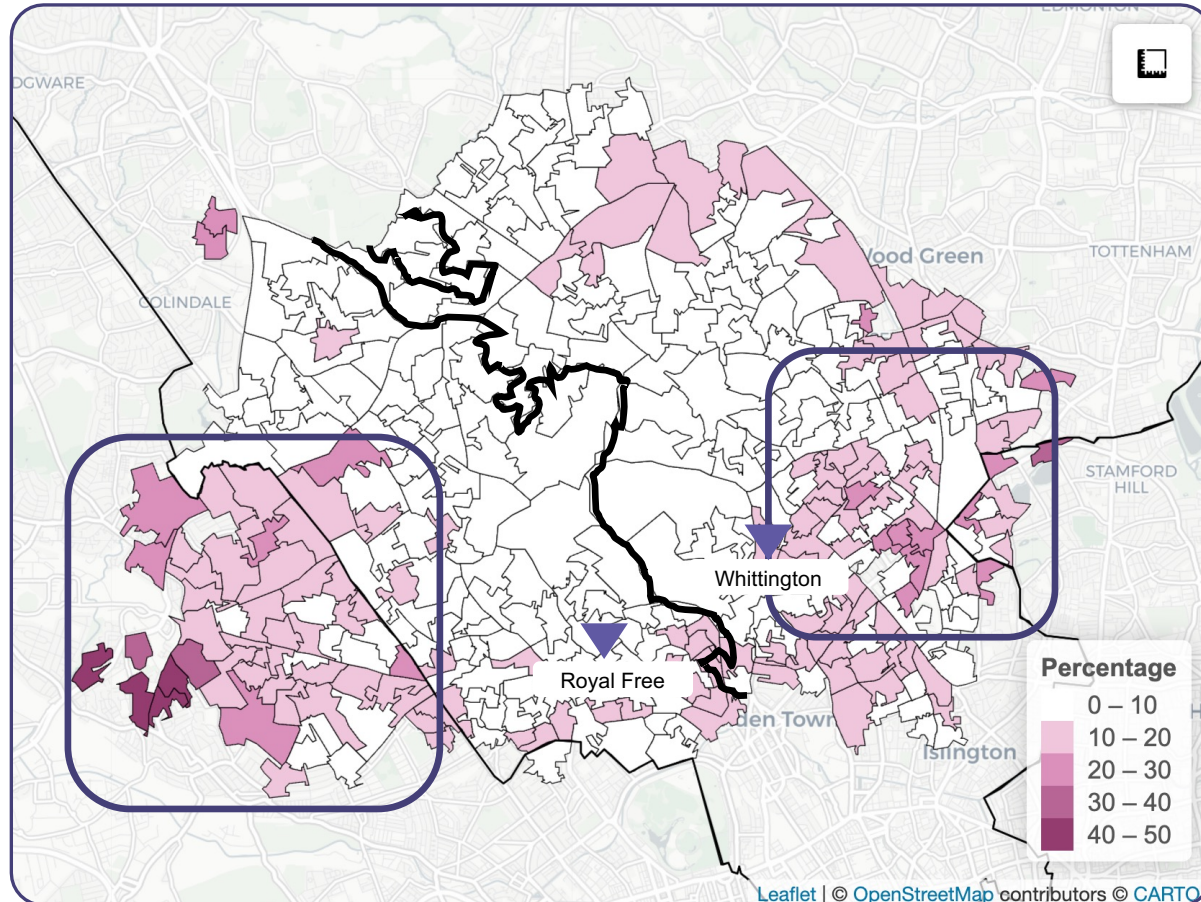
### As a result of the proposals (option B), people in Holloway and Finsbury may need additional support to:

- Access the hospital site if they are disabled/in poor health
- Travel to hospital by taxi, if required, as it will cost an additional £4-5
- Access services online as they may have low digital proficiency
- Care for other family members as they may be a single parent

# There is a concentration of Black African and Black Caribbean people in the vulnerable geographies

## Black African and Black Caribbean populations

*Proportion of Black African and Black Caribbean populations*



There is evidence that Black African and Black Caribbean populations have poorer maternity outcomes. Their populations are largely concentrated around Finsbury and around Harlesden and Willesden.

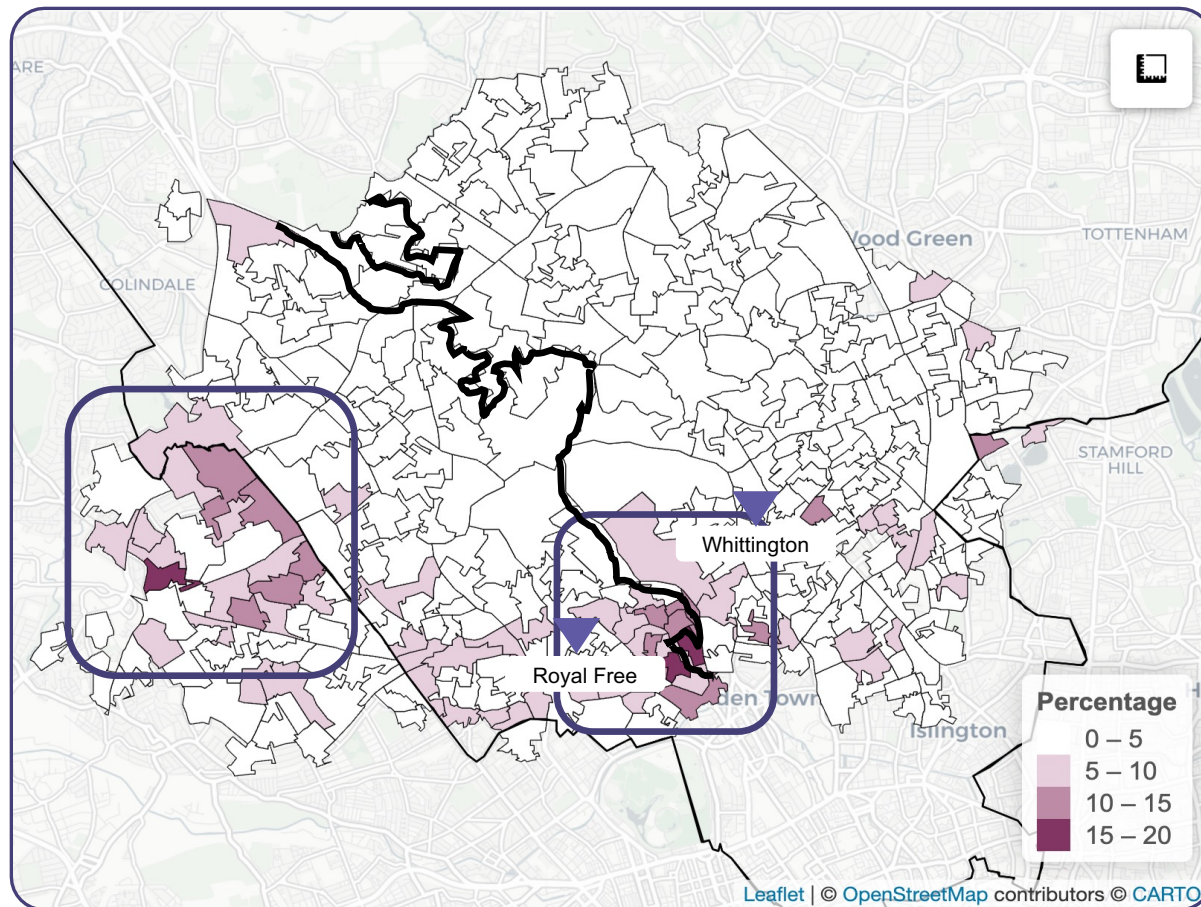
For option A, the Black African and Black Caribbean vulnerable population in Harlesden and Willesden may be negatively impacted as their local maternity unit would move from the Royal Free Hospital to St Mary’s Hospital or Northwick Park Hospital.

For option B, the Black African and Black Caribbean vulnerable population in Finsbury may be negatively impacted as their local maternity unit would move from the Whittington Hospital to the Royal Free Hospital.



# Harlesden has large Bangladeshi and Pakistani populations who may have poor maternal health outcomes

**Asian (Bangladeshi and Pakistani) populations**  
*Proportion of Bangladeshi and Pakistani populations*



Asian (and particularly Bangladeshi and Pakistani populations) have been identified in the case for change as more likely to have worse health outcomes from maternity care.

Their population is largely concentrated around Harlesden and Willesden, and around Camden Town and Chalk Farm.

The populations that live in Harlesden and Willesden are within the Royal Free Hospital's catchment area and means they would be impacted if Option A is implemented. If option A is implemented, they are likely to move to using services at St. Mary's Hospital or Northwick Park.

Those that live in Camden and Chalk Farm are between the Whittington Hospital and Royal Free Hospital's catchment and is likely to move to the opposite site in either option.

There are two areas of relatively high concentration of Asian (Bangladeshi and Pakistani) populations.

One of which is in the Harlesden and Willesden, and another is near Camden town.

# Potential impact of proposals on sustainability

## Summary: potential impact of the proposals on sustainability

- Following engagement, the analysis identified four sustainability metrics to explore the potential sustainability impact: travel carbon impact, building carbon impact, protected air quality and anchor institutions
- There is a small, similar travel carbon impact for options A and B due to the small increase in travel distances and increased vehicular emissions may need to be mitigated as options A and B are within air quality management areas (AQMA)
- Refurbishment carbon emissions for the Whittington Hospital and Royal Free Hospital would be mitigated as part of their net zero strategy for their wider refurbishment programme
- In options A and B, there would be little impact on the hospitals in their wider role as anchor institutions compared to now
- We have started to consider how potential negative impacts for sustainability can be mitigated. These mitigations are set out on slide 141.

# The proposals may impact on sustainability with a small increase in emissions within air quality management areas



Impact	Travel carbon impact	Protected air quality	Building carbon impact	Anchor institution
<b>Option A</b>	+ 216 g per average journey	AQMA: NO2 and vehicular particulates	Additional refurbishment as part of Whittington's net zero strategy	127.3 WTE moved (nurses, midwives, consultants & middle level)
<b>Option B</b>	+195 g per average journey	AQMA: NO2 and vehicular particulates	Additional refurbishment as part of Royal Free Trust net zero strategy	168.4 WTE moved (nurses, midwives, consultants & middle level)

These metrics provide an understanding of the impact on sustainability for each option:

- There would be a small but similar carbon impact for options A and B due to the slight increase in travel distances and mitigations have started to be explored as options A and B are within air quality management areas (AQMA) for NO2 emissions and vehicular particulates (see slide 141)
- There may be some carbon impact due to refurbishing buildings in both option A and B but there are substantial environmental gains to be made in making the building more energy efficient, in line with government policy
- In option A and B, the number of people that would be moved between sites would be small and the estate would be retained and repurposed, so there would likely be little impact on hospitals as anchor institutions

# The analysis identified four sustainability metrics to explore the potential sustainability impact

Metric	Rationale	Methodology	Source
<b>Travel carbon impact</b>	The additional distance travelled might result in higher carbon emissions which needs to be examined from a net-zero standpoint.	The mean additional carbon output in kgs per journey was examined for each option	Travel time API (2023), EPA.gov (2018)
<b>Protected air quality</b>	The carbon impact from different options may have an adverse impact on air quality	Areas were reviewed for air quality management areas (AQMAs) and for type of pollutants	Local authorities that are air quality management areas (AQMAs), DEFRA (ongoing)
<b>Building carbon impact</b>	Building and refurbishing buildings causes carbon emissions which are harmful to the environment	Long-term strategy and spending plans were examined to determine any additional carbon costs for estates that would be undertaken	NA
<b>Anchor institutions</b>	Local hospitals are anchor institutions that support local communities and removal of services may impact adversely on local communities	Engagement was undertaken to determine amount of workforce impacted in each option as an impact on local anchor institutions	NA



# There is a small yet similar travel carbon impact for options A and B due to the small increase in travel distances

## Distances and Co2 cost per journey

*Increase in average distance per average journey and average increase in Co2 cost per journey*

Option	Average increase in distance travelled per journey (miles)	Average increase in carbon emissions per journey (g)
<b>Option A:</b> Barnet, North Mid, Whittington, UCLH	1.0	216
<b>Option B:</b> Barnet, North Mid, Royal Free, UCLH	0.9	195

Average additional distance from LSOA to provider



Average Car Carbon Emissions (g of CO2 per mile)

*The calculations were made by assuming each mile travelled by car is associated with a fixed Carbon cost (of 222.1g/mi) based on assumptions of average car emissions, this gives us the average figure shown above*



## Mitigations to limit increased vehicular emissions would need to be explored as options are within AQMAs

### AQMAs (Air Quality Management Areas)

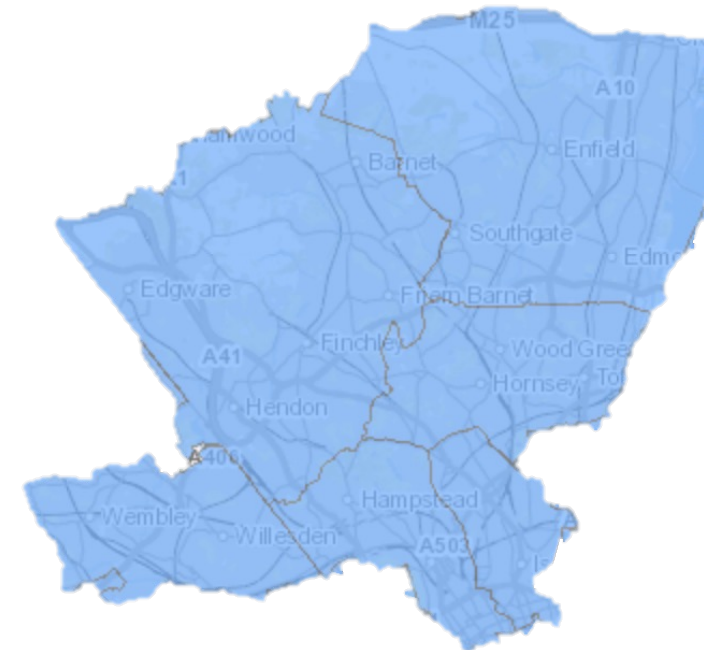
*“Since December 1997, each local authority in the UK has been carrying out a review and assessment of air quality in their area. This involves measuring air pollution and trying to predict how it will change in the next few years. The aim of the review is to make sure that the national air quality objectives will be achieved throughout the UK by the relevant deadlines. These objectives have been put in place to protect people's health and the environment.*

*If a local authority finds any places where the objectives are not likely to be achieved, it must declare an Air Quality Management Area there. This area could be just one or two streets, or it could be much bigger.*

*Then the local authority will put together a plan to improve the air quality - a Local Air Quality Action Plan.”*

London is also an ultra-low emission zone (ULEZ) where cars must meet stringent exhaust emission standards or their drivers need to pay to drive in the area

### AQMAs associated with the catchment



DEFRA outlines that the areas that may be impacted by the proposals have an AQMA associated with them. We have started to consider mitigations for the potentially increased emissions as a result of slightly longer travel times, as shown on slide 141.

## In options A and B, there would be little impact on the hospitals as anchor institutions

Anchor institutions are defined by the King’s Fund as *“large organisations that are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support their local community’s health and wellbeing and tackle health inequalities, for example, through procurement, training, employment, professional development, and buildings and land use”*

In options A and B, **no buildings** will be closed. Whilst some workforce will be moved, the overall impact as a proportion of the total available workforce, meaning the impact on the resources available to local communities, is **likely to be relatively small**.

### Total impact on the workforce

*Current workforce by WTE that would be moved as a % of the total clinical workforce (2021/22)*

Option	Total workforce moved (clinical staff only)	Percentage of total workforce
<b>Option A:</b> Barnet, North Mid, Whittington, UCLH	127.3	2.4%
<b>Option B:</b> Barnet, North Mid, Royal Free, UCLH	168.4	3.6%

It is assumed that 46% of the total maternity staff at Royal Free London Trust are at the Royal Free Hospital (the rest being at Barnet Hospital), with this split based on non-elective admissions activity in 2021/22

# Potential impact of proposals by option

# Potential impact of option A

Option A					
Population	Quality	Access	Populations with protected characteristics and people who have vulnerabilities	Sustainability	Geographical populations
<p>There is a slightly smaller population that could potentially be impacted for option A (~373,000 people driving and ~230,000 people on public transport) compared to option B (~378,500 people driving and ~298,000 people on public transport)</p>	<p>Option A and B would deliver the proposed maternity and neonates care model, and would therefore deliver positive clinical impact:</p> <ul style="list-style-type: none"> <li>Care that ensures equity of provision and experience</li> <li>Services which are clinically sustainable</li> <li>Up to date estate and buildings which are fit for purpose</li> <li>Training and development opportunities</li> <li>Provide choice for pregnant women and people</li> </ul>	<ul style="list-style-type: none"> <li>Average increase in taxi costs would be £4.90 and the average increase in driving costs per journey is £0.46, with 50% car ownership compared to now.</li> <li>Average travel times would increase by 5.3 minutes by car and 6.29 minutes by public transport compared to now. People in the catchment population would be able to access services within 30 minutes at peak driving time and within 25 minutes at off-peak compared to now.</li> </ul>	<ul style="list-style-type: none"> <li>Greater impact on the orthodox Jewish population under Option A</li> <li>Ethnic minorities may face language barriers when travelling to, and accessing, a different hospital site</li> <li>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</li> <li>People with disabilities may have difficulties changing service location, especially without access to a car, compared to now</li> <li>People living in deprived areas may face difficulties with cost of transport, digital exclusion and already having children when travelling further or to a new site</li> <li>Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language when travelling further or to a new site</li> <li>The Bangladeshi and Pakistani population in Chalk Farm are close to a maternity unit that may move in this option, and therefore may be more impacted in terms of travel times compared to other groups</li> </ul>	<ul style="list-style-type: none"> <li>There is a small increase in carbon emissions of 216g per average journey as a result of slightly increased travel times compared to now</li> <li>There are substantial environmental gains to be made in making the building more energy efficient compared to now</li> <li>127 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</li> </ul>	<ul style="list-style-type: none"> <li>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 – also a high number of Black African and Caribbean and Bangladeshi and Pakistani people</li> <li>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, may not be as significantly impacted by increased taxi costs compared to now as those who reside closer to the maternity unit that may close.</li> <li>This population may face barriers to attending an unfamiliar site compared to now</li> </ul>

# Potential impact of option B

Option B					
Population	Quality	Access	Populations with protected characteristics and people who have vulnerabilities	Sustainability	Geographical populations
<p>There is a larger population that could potentially be impacted for option B (~378,500 people driving and ~298,000 people on public transport) compared to option A (~373,000 people driving and ~230,000 people on public transport)</p>	<p>Option A and B would deliver the proposed maternity and neonates care model, and would therefore deliver positive clinical impact:</p> <ul style="list-style-type: none"> <li>Care that ensures equity of provision and experience</li> <li>Services which are clinically sustainable</li> <li>Up to date estate and buildings which are fit for purpose</li> <li>Training and development opportunities</li> <li>Provide choice for pregnant women and people</li> </ul>	<ul style="list-style-type: none"> <li>Average increase in taxi costs would be £4.43 and the average increase in driving costs would be £0.42 per journey, with 47% car ownership compared to now.</li> <li>Average travel times would increase by 5.84 minutes by car and 6.97 minutes by public transport compared to now. People in the catchment population would be able to access services within 30 minutes at peak driving time and within 25 minutes at off-peak compared to now.</li> </ul>	<ul style="list-style-type: none"> <li>Ethnic minorities may face language barriers when travelling to, and accessing, a different hospital site</li> <li>Somali community in Finsbury Park who would access services at the Royal Free 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.</li> <li>People living in deprived areas 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)</li> <li>People with disabilities may have difficulties changing service location, especially without access to a car, compared to now</li> <li>People living in deprived areas may face difficulties with cost of transport, digital exclusion and already having children when travelling further or to a new site</li> <li>Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language when travelling further or to a new site</li> </ul>	<ul style="list-style-type: none"> <li>There is a small increase in carbon emissions of 195g per average journey as a result of slightly increased travel times.</li> <li>There are substantial environmental gains to be made in making the building more energy efficient</li> <li>168 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</li> </ul>	<ul style="list-style-type: none"> <li>Holloway and Finsbury Park was identified as a geography that could be particularly vulnerable to 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 Caribbean in it</li> <li>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</li> <li>This population may face barriers to attending an unfamiliar site compared to now</li> </ul>

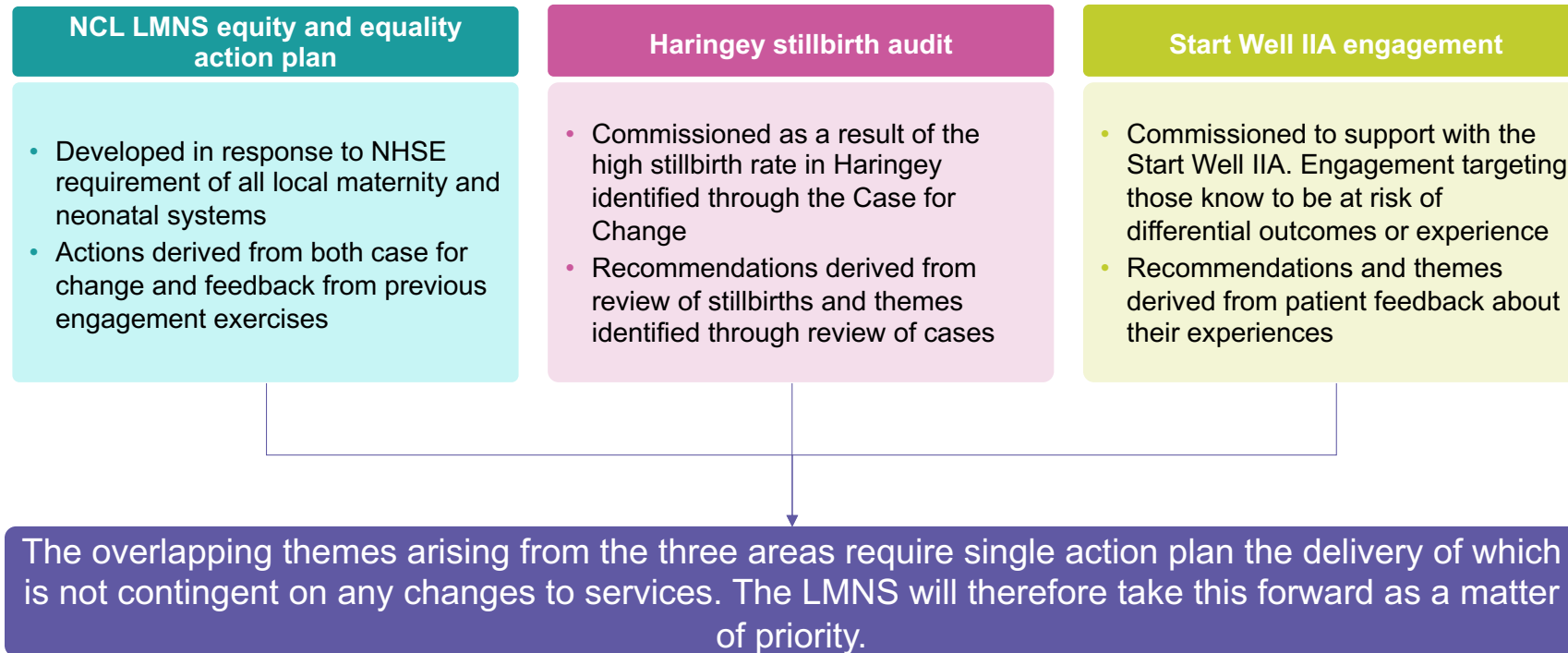
# Mitigations

# Summary: mitigations

- There are several issues that we have heard through engagement, that we aim to address regardless of whether these proposals are implemented
  - Communicating around implementation should changes be agreed
  - Mitigations for those who may need extra support to access an unfamiliar hospital
  - Information about how to travel to a hospital site
  - Providing as much care locally as possible
  - Support with the costs of travel to hospital
  - Access to parking
  - Access to midwifery-led care
- To address or reduce the potential negative impacts of the proposals identified in the sections above, so far as possible, we are considering the following broad types of mitigations:
  - Supporting staff training and understanding
  - Service user involvement in maternity services
  - Access to appropriate interpretation services
  - Use of digital tools
  - Supporting people with learning disabilities
  - Provision of continuity of carer
  - Personalised care and support plans
  - Improving the quality of communication with service users
  - Maternity data quality
- We will consider the potential impacts of our proposals further, following consultation, and consider (a) whether any negative impact is justified as a proportionate means of achieving a legitimate aim and/or (b) can be addressed or reduced through mitigation measures

# We have been through a detailed process to review potential mitigations

Mitigations have been developed which address impacts identified both through the in-depth IIA analysis and the engagement with service users. There are several issues that we have heard through engagement, that we aim to address regardless of whether these proposals are implemented. These are being addressed through the NCL Local Maternity and Neonatal System (LMNS) equity and equality action plan. To address or reduce the potential negative impacts of the proposals identified in the sections above, so far as possible, we are considering several types of mitigations. We will consider the potential impacts of our proposals further, following consultation, and consider (a) whether any negative impact is justified as a proportionate means of achieving a legitimate aim and/or (b) can be addressed or reduced through mitigation measures.



Mitigations have been co-developed with both staff and patients:

- Two system-wide workshop were held involving over 80 attendees including clinical staff, local authority reps and patients
- The Start Well patient participation and engagement group supported development of mitigations at two of their meetings

# To address or reduce the potential negative impacts of the proposals, we are considering several types of mitigations



North Central London  
Integrated Care System



As the programme progresses, we need to **continue to understand the impact of proposals** 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.



Should a decision be taken to implement changes made, **changes need to be well communicated to residents**. Mitigations will 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 both **choice of maternity unit** and **birth setting** to meet the needs of expectant parents. (See slide 135)



There are some service users for whom **changes may mean attending a different hospital than they are used to**. This change may be more **difficult** for some service users, and they would need **extra support to manage this**. (See slide 136)



Should a decision be taken to implement any changes, it may result in service users going to a different hospital they are unfamiliar with. This may lead to **changes to journeys to hospital that people are used to**. Mitigations would be needed to ensure that people have **information to plan their journeys to hospital**. (See slides 137)



There may be an impact on the **cost of travel** should changes be implemented – **particularly for people who travel by taxi**. There will be some service users who are more impacted by this than others, and it is important 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**. (See slide 139)



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 may be needed around **parking to ensure that families can easily visit their child by car**. (See slide 140)



Access to a **consistent offer of midwifery-led care** is an important part of our care model. Should proposals around no longer supporting births at Edgware be implemented, there would need to be mitigations put in place to ensure that women for whom this is a preference can **retain access to high-quality consistently available midwifery-led care**. (See slide 143)

# There are specific mitigations that may be needed depending which option is implemented

In addition to the mitigations that have been suggested should either option be implemented, some specific mitigations have been identified based on the analysis included in the impact assessment

## Option A

- There are specific mitigations that would need to be put in place for the population of **Harlesden and Willesden** should a decision be taken in the future for option A to be implemented
- There are specific mitigations that would need to be put in place to support 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.

## Option B

- There are specific mitigations that would need to be put in place for the population of **Holloway and Finsbury** should a decision be taken in the future to implement option B.
- There are specific mitigations that would need to be put in place for **disabled populations** who live close to the Whittington Hospital should a decision be taken in the future for Whittington Hospital to be the site that no longer provides maternity and neonatal care.

# Ongoing input into and feedback on our proposals



As the programme progresses, 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 should be translated into the most commonly spoken local languages, with others available upon request. It should be made available in different formats (easy read / large print) to account for the spectrum of communication needs

Information about proposals needs to be widely shared to ensure maximum engagement. This should build on existing partnerships to reach communities or utilise organisations who have existing routes to engage with groups. Consideration should be given to innovative mechanisms to obtain feedback, and ensuring communication preferences of groups are considered

Ambition to engage with the range of service users identified through the interim IIA, and hear from those that we were less successful in engaging with during the engagement for the interim IIA

There should 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 more impacted by changes (e.g., have poorer outcomes from services or are more likely to need to use services that may be changing). Response rates will be actively reviewed during the consultation to enable additional focus require on groups where response rate may be lower.

The programme should continue to review impact of possible changes on different groups and ensure any new impacts are included and mitigations developed to address negative impacts.

## Communicating around implementation should changes be agreed



Should a decision be taken to implement changes, changes need to be well communicated to residents. Mitigations will 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 need of expectant parents.

Ensure there is accessible information about choices of maternity care online and this information is available in non-digital formats for those who are less able to access the internet

Uniformity in how information about maternity services is hosted on individual Trust webpages would help users better navigate to the information that they need.

Providing 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.

Building links with local community groups, particularly for more transient and migrant communities who may not engage as well with published material

Disseminating 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.

# Mitigations for those who may need extra support to access an unfamiliar hospital



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, and they would need extra support to manage this.

Offering opportunities to visit the site outside of planned appointments or birth to familiarise expectant parents with the unit.

Providing access to videos, pictures and additional information about the unit or what to expect in advance of appointments in order that people can better prepare for their visit to the site

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

Consider innovative tools or technology to support wayfinding or giving directions within a hospital

Ensure all sites meet access standards particularly for families with young children or where a family member may be disabled

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

Consider patients needs around appointment times, and where possible offer appointments that may better meet the needs of those travelling to hospital for appointments

Working with neonatal care coordinators 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

## Information about how to travel to a hospital site



Should a decision be taken to implement any changes be made in future, it may result in service users going to a different hospital they are unfamiliar with. This may lead to changes to journeys to hospital that people are used to. Mitigations would be needed to ensure that people have information to plan their journeys to hospital.

Provide clear information to service users about travel and transport options to all maternity units

Make this information available in different languages and formats to suit the range of communication needs of service users likely to be impacted.

Link to live journey planners such as TFL to ensure that accurate up to date information can be accessed about journeys

Working 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

# Providing as much care locally as possible



Where possible, in order to mitigate the cost and time spent travelling to a hospital site, we would want to deliver as much care as close to home as possible.

Provision of appropriate appointments in community settings for example, family hubs and children's centres.

Offer of virtual appointments where appropriate and clinically recommended.

Implementation of hospital at home / community neonatal care to ensure 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

# Support with the costs of travel to hospital



There may be an impact on the cost of travel should changes be implemented. There will be some service users who are more impacted by this than others, and it is important 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.

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, 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

To be available in different languages and formats to suit needs of service users

Provide information about Trust-level arrangements for the reimbursement of transport costs under the Healthcare Costs Travel Scheme, including location and opening hours of cashiers kiosks

Include a discussion about cost of travel during the booking of appointments to identify if cost of transport may impact on the service users ability to access maternity care

Support partners in working with charitable and VCS partners to consider the feasibility a pre-paid travel card to service users identified as vulnerable for whom travel costs would limit their access to maternity care

Continue arrangements for patients who have eligibility for hospital patient transport schemes

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

Working with neonatal care coordinators to ensure there is clear information about the financial support available to families through a child's admission to a neonatal unit. This could include information about benefits people may be entitled to, and also support from charities and other VCS partners

## Access to parking



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 may be needed around parking to ensure that families can easily visit their child by car.

Ensure that there are consistent arrangements in place for families with a baby admitted to a neonatal unit in relation to parking. Consider the provision of a permit to allow discounted parking for the duration of the baby's admission.

Putting in place capacity that meets demand to ensure less neonatal transfers out of the catchment area therefore reducing the overall travel distance for families

Particular consideration should be given to those with disabilities to ensure access to disabled parking spaces

Consider the promotion of other transport arrangements as an alternative to driving where appropriate

NCL/Trusts could explore with NCPs (National Car Parks) for lower/ discounted rates for maternity/neonatal services that do not have a car park on site



The impact assessment 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 to deliver the capacity needed. 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 individual Trust has their own plans to deliver on this.

Through the refurbishment that will be undertaken, buildings will increase in their energy efficiency and thus have an impact in the longer term on energy usage

Trusts to explore the possibility of using their own energy sources to provide energy to refurbished areas (for example heat pumps)

Providing appropriate appointments in community settings or online which negate the need to travel to a hospital site will 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, Trusts need to review their use to determine if it is possible to reduce waste that may be associated with leaks in pipes.

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

# Care for women who may have more complex pregnancies



Women and people with complex medical needs are looked after under networked arrangements with input from both obstetric physicians and other specialists. Under options A and B, mitigations may be needed to ensure that people with complex pregnancies can continue to access the specialist care they need

Detailed condition specific pathway reviews to be undertaken during planning for implementation when a preferred option has been reached, led by the NCL Maternal Medicine Network. This would need to determine:

- The areas of specialism that are provided at the site no longer supporting intrapartum care, and determining what the optimum pathway would be in the future
- The level of input from other non-obstetric specialists required both during intrapartum care and antenatally
- Consideration given to continuing some appointments at the site which no longer support births should this be the most appropriate model
- The possibility of specialists providing in-reach to another hospital site to support patients with additional needs during their intrapartum care should it be required

## Access to midwifery-led care



A consistent offer and access to midwifery-led care is an important part of our care model. Should proposals around no longer supporting births at Edgware be implemented, there would need to be mitigations put in place to ensure that women for whom this is a preference can retain access to high-quality consistently available midwifery-led care.

A review of the information made available to women at the point of booking to ensure that they are made aware of and are consistently offered the choice of midwifery-led care

A review of home birth provision and staffing of home birth teams across the sector to ensure equity of staffing in geographical areas. Currently there are some teams which staff much larger catchment areas than others which can create gaps in provision and lead to challenges with recruitment

Consider how personalised care can be maximised in midwifery-led settings enabling women to feel cared for throughout their pregnancy

Ensuring midwifery-led birth centres are set up to provide the best possible birthing experience through a review of environment and staffing arrangements

Consider the identity of midwifery-led units, ensuring that they can be identified separately from labour wards to support women who may feel more anxious about a hospital-based birth

A review of staffing arrangements of midwifery-led units to ensure that as much as possible they can remain open at times when staffing is challenged and women who want to choose this as a birthing option are able to give birth there

## Site specific mitigations for option A



There are specific mitigations that would need to be put in place for the population of Harlesden and Willesden should a decision be taken in the future for option A to be implemented.

The populations of **Harlesden and Willesden** in the borough of Brent have been identified as a vulnerable population who are potentially more impacted should option A be implemented given their proximity to the Royal Free site. Some specific mitigations that would need be taken forward for this population are:

- **Engagement during the public consultation:** we would seek as part of consultation to engage with residents of this area to understand the impact of changes and any other mitigations that would need to be considered through implementation
- **Communicating changes:** should changes be agreed, a specific communication campaign should be considered. This would need to factor in the most commonly spoken languages within this area, and also non-digital formats given lower than average IT proficiency of the population
- **Continuity of carer:** given population risk factors deprivation, ethnic diversity and ill-health, NCL integrated care system would look to work with NWL integrated care system to ensure that the population are considered to be prioritised to receive continuity of carer in their maternity pathway – we think that there could be a benefit to these patients to access maternity care within their borough as it will mean increased provision of continuity post-natally
- **Cost of travel:** when travelling by taxi, increased costs have been identified. We would look to put in place a range of mitigations identified under the proposals more generally but in a targeted way and ensure that NWL hospitals also have clear arrangements in place for: re-imburement of expenses and other travel cost reimbursement (such as Congestion Charge and ULEZ reimbursement). We would also look to local VCS organisations who may be able to support further with the cost of travel expenses for groups that are particularly vulnerable

# Site specific mitigations for option A



There are specific mitigations that would need to 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 population who are within the current catchment of the Royal Free Hospital. Should this site no longer provide maternity care and neonatal care, mitigations would be needed to ensure that this group are not detrimentally impacted:

- **Staff training:** Jewish women may have specific needs during their maternity care. Staff training will be needed to ensure requirements, for example Kosher food and Shabbat, are understood would need to be put in place at sites anticipated to care for this population in the future
- **Kosher food:** Ensuring all sites are set up to provide Kosher food for the pregnant woman or person during labour and permit food being brought from outside the Trust.
- **Communication:** through engagement with the Orthodox Jewish community it has been identified that non-digital communication is more effective. Consideration should be given to ensuring communication of changes and subsequent communication about maternity care can be provided in a non-digital way. Working with community and VCS partners may be particularly effective in reaching the Orthodox Jewish community in NCL
- **Observance of Shabbat:** specific considerations need to be made around observance of Shabbat. This may include avoiding discharge and not using the call bell. Sites need to ensure that appropriate protocols are in place to ensure that Shabbat can be observed by families receiving maternity care
- **Modesty:** Orthodox women may choose clothes that cover their elbows and knees, as well as a wig, scarf or other head covering. Long-sleeved gowns should be made available during birth and permit the mother to wear a hair covering

# Site specific mitigations for option B



There are specific mitigations that would need to be put in place for the population of Holloway and Finsbury should a decision be taken in the future to implement option B.

The populations of **Holloway and Finsbury** in the borough of **Islington** have been identified as a vulnerable population who are potentially more impacted should option B be implemented given their proximity to the Whittington Hospital. Some specific mitigations that would need to be taken forward for this population are:

- **Engagement during the public consultation:** we would seek as part of consultation to engage with residents of this area to understand the impact of changes and any other mitigations that would need to be considered through implementation
- **Communicating changes:** should changes be agreed, a specific communication campaign should be considered. This would need to factor in the most commonly spoken languages within this area, and also non-digital formats given lower than average IT proficiency of the population
- **Continuity of carer:** given population risk factors of deprivation and ethnic diversity, NCL integrated care system would look to work to ensure that the population are considered to be prioritised to receive continuity of carer in their maternity pathway. This would need to include a review of the catchment areas for community midwifery, to ensure coverage across Islington as well as ensuring that borough-based community antenatal provision are maintained.
- **Cost of travel:** when travelling by taxi, increased costs have been identified. We would look to put in place a range of mitigations identified under the proposals more generally but in a targeted way and ensure that hospitals (some of which are in NEL) have clear arrangements in place for: re-imbursalment of expenses and other travel cost reimbursement (such as Congestion Charge and ULEZ reimbursement). We would also look to local VCS organisations who may be able to support further with the cost of travel expenses for groups that are particularly vulnerable

## Site specific mitigations for option B



There are specific mitigations that would need to be put in place for disabled populations who live close to Whittington Hospital should a decision be taken in the future for Whittington Hospital to be the site that no longer provides maternity and neonatal care.

The interim IIA identifies the largest concentration of disabled people between the Royal Free Hospital and Whittington Hospital, with an above average concentration around the Whittington Hospital. The ONS defines disability as “people who assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses are considered disabled”. In order to put effective mitigations in place, we need to better understand the type of disabilities that there are within this population. Through the consultation, and further engagement with local groups we would seek to do this and develop specific mitigations that will support individuals to continue to access maternity and neonatal care.

# Improving patient experience and reducing differential outcomes

# There are multiple strands of work which point to similar actions needed across maternity services to address differential outcomes and experience

## NCL LMNS equity and equality action plan

- Developed in response to NHSE requirements of all local maternity and neonatal systems
- Actions derived from both case for change and feedback from previous engagement exercises

## Haringey stillbirth audit

- Commissioned as a result of the high stillbirth rate in Haringey identified through the Case for Change
- Recommendations derived from review of stillbirths and themes identified through review of cases

## Start Well interim IIA engagement

- Commissioned to support with the Start Well IIA. Engagement targeting those known to be at risk of differential outcomes or experience
- Recommendations and themes derived from patient feedback about their experiences

The overlapping themes arising from the three areas require a single action plan, the delivery of which is not contingent on the outcome of the proposals set out in this document. The LMNS will therefore take this forward as a matter of priority.

We will be looking at a number of themes from our engagement exercise which require actions to address



Supporting staff training and understanding



Improving the quality of communication with service users



Service user involvement in maternity services



Improving maternity data quality



Access to appropriate interpretation services



Provision of continuity of care



Use of digital tools



Use of personalised care and support plans



Supporting people with learning disabilities

# Supporting staff training and understanding



Ensuring that staff understand and are equipped to care for individuals who have different needs is integral to ensuring high quality patient experience and outcomes. Engagement highlighted that there are areas where either a lack of understanding or knowledge of an individual's requirements for their maternity care impacted on the experience of patients. Working through the LMNS to develop mitigations to improve knowledge and understanding of staff may be needed to address this.

The undertaking of a training needs analysis to understand what training is needed across NCL sites which will support staff to provide more personalised care

Using specialist staff, for example learning disability nurse specialists, to deliver training across sites to raise awareness of how to support women with specific conditions or needs in their maternity care

Ensuring that mechanisms are in place to share learning at both an NCL and regional level

Delivery of cultural understanding and/or unconscious bias training for maternity and neonatal staff across NCL particularly in relation to communities who are known to have an increased likelihood of adverse outcomes

Consider how staff could be better supported and encouraged to take up training that is available

Work with MVPs to incorporate 'lived experiences' storytelling and language and sensitivity into regular training – this may include powerful birth stories from individuals

Increasing awareness of staff of the range of personalised care that may be needed by different service users

Increased joint working between maternity units in NCL to make best use of the breadth of knowledge available, increased consistency in training and to share lessons learned

Using existing LMNS forums to share learning from incidents where it has been found to be a lack of account taken for someone's needs and preferences during maternity care

# Service user involvement in maternity services



There is already established mechanisms for patients to be involved in maternity services through the maternity voices partnerships (MVP). There may be a need to consider how the voices of service users can be further incorporated into maternity services, ensuring that groups that are at higher risk of poorer outcomes are heard from. Mitigations in this area could include:

A review of current engagement mechanisms with MVPs to understand how service users' voices are being shared with maternity services. This should also include working with the neonatal ODN on how to incorporate feedback from parents with experience of neonatal care to create maternity and neonatal voices partnerships.

Ensure that communication with service users is a two way process, including demonstrating how feedback has been taken into account in the delivery of services.

Consider the use of other existing forums and mechanisms which may already be in place at a local level to gain feedback from communities that may be less likely to engage - for example Enfield Community Champions have been effective in other areas.

## Access to appropriate interpretation services



For those that don't speak English or who have other communication needs, the importance of an appropriate interpreter throughout their maternity care cannot be underestimated. Engagement highlighted that where this was not present, service users felt that they were not listened to, and their preferences around maternity care was not understood. There are also specific cultural issues for maternity care in relation to preferences around having a female interpreter which need to be considered. The actions that are needed in this area are:

Ensure that a discussion and documentation of interpretation requirements takes place as early as possible in maternity care and arrangements are put in place to ensure appropriate interpretation can be provided

Commission a review of the current interpretation services across maternity care and seek recommendations for an optimum delivery model

Consider the development of a set of standards to apply to interpretation services across all maternity and neonatal care

Consider the use of innovative interpretation mechanisms or examples of best practice in other maternity units or services and how these could be applied within NCL maternity and neonatal units

## Use of digital tools



Use of and access to digital tools such as apps can be effective in supporting families through their maternity care. In NCL, an app called Mother and Baby has recently been rolled out which signposts to information, allows you to enter your appointment details and enter details of your personalised care and support plan. Given the era that women of current childbearing age have grown up in, many will be adept at using digital tools, however consideration needs to be given to ensure that as many people as possible can benefit from their use:

Ensure Trust websites are accessible through large print and read aloud options

Further development of the mother and baby app - such as translation into different languages and ensuring that linked materials are also available in different languages

Ensure there are mechanisms for people to receive information in a non-digital way

Consider what can be done to promote digital inclusion, for example through loan of equipment, providing free wifi

Consider the role of social prescribing in maternity care, and how women can be directed to undertake their own research about pregnancy, the maternity pathway and advice

Consider the use of social media for different groups, and target information sharing on platforms known to be used by different communities - tailoring messaging to meet their preferences

# Supporting people with learning disabilities



The engagement highlighted that sometimes people with learning disabilities felt they could be better supported in their maternity and neonatal care. There are initiatives already in place which aim to ensure that people with learning disabilities can share information about their needs and preferences through a learning disability passport. Actions that are needed to ensure that the right support is in place are:

Ensuring that a learning disability passport is in place throughout maternity and neonatal care across all providers

Work across NCL to ensure maternity information is available in Easy Read format

Involvement of disability specialist staff such as clinical nurse specialists in maternity care

Continuing to work with and hear from people with learning disabilities to ensure their needs around maternity care are understood and can be put in place

Consideration given to longer appointments for people with learning disabilities

## Provision of continuity of carer



Continuity of carer for maternity care has been highlighted as a key driver of improved outcomes. It has been identified as a national priority as one of the five clinical areas in the CORE20PLUS5 framework. However, since the Ockenden report many Trusts in NCL have paused further roll out of continuity teams to ensure that wards can be safely staffed. The provision of continuity is a key feature of our new care model - with a particular focus on prioritising service users who are at highest risk of adverse outcomes. The LMNS has a workstream around continuity and personalisation and a clinical lead who is supporting Trusts with implementing continuity as staffing allows. Areas that need to be considered based on the engagement findings are:

Trusts continuing to focus on roll out of continuity of carer as their staffing allows in line with advice from NHS England

Use data to inform how continuity can most effectively be targeted at women who are at highest risk of an adverse outcome from their maternity care

Review outcome of maternity support worker and social prescribing pilot around continuity of care

# Personalised care and support plans



Personalised care and support plans are currently used in maternity services in NCL. They are intended to ensure that clinical teams can access information about a person's medical history as well as their preferences around birth. It is important that these are used in a consistent way across services:

A review of the use of personalised care and support plans to understand if the way they are currently set up are appropriate for different groups and communities

A review of the use of personalised care and support plans to understand if the way they are currently set up meets the needs of different groups and communities, and takes into account the range of different needs that may need to be catered for as part of maternity care

Working with Trusts to ensure that they are accessible to professionals at all appointments and during birth

Consideration as to how the information on a personalised care and support plan can be made available across Trusts should the provider of maternity care change during the pathway

# Maternity data quality



Ensuring that the ICS has access to high quality data relating to maternity care is fundamental to understanding and therefore improving outcomes.

Maternity data and data quality to be included as a significant priority within the wider ICS digital strategy

Maternity units working with the LMNS must ensure that there is a consistent data set across maternity care, and this must include ethnicity and language reporting to ensure that information about outcomes can be monitored. Within this, ensure that there is visibility of the CORE20PLUS groups within maternity data sets to ensure that outcomes can be tracked effectively.

Work to how the LMNS and Trusts use the data submitted as part of the national maternity services data set to inform practice and priorities

Consider how HealthIntent can be used to enhance maternity care

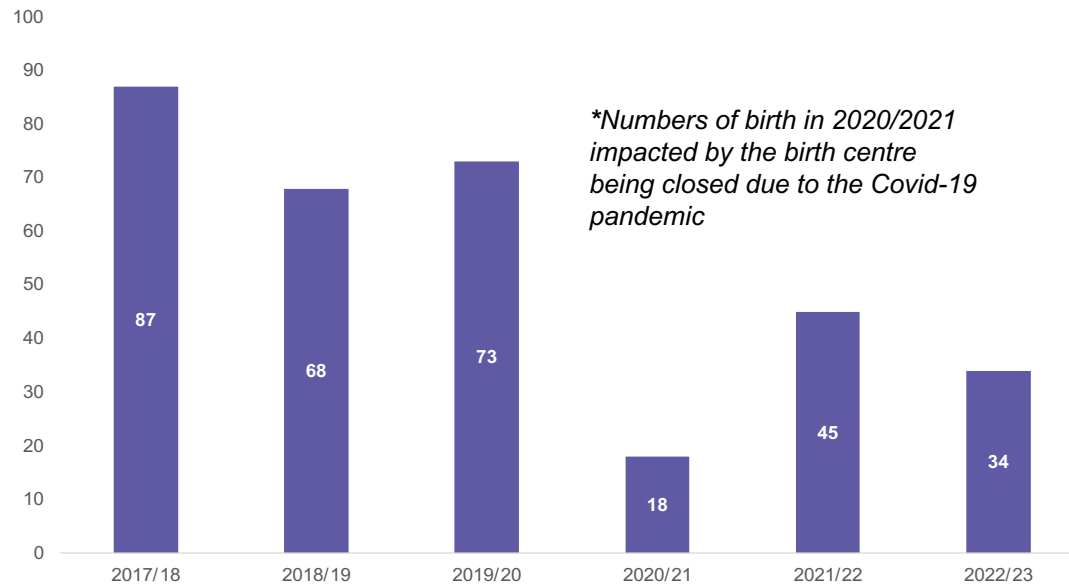
# Edgware Birth Centre

# A very small number of women and pregnant people give birth at Edgware Birth Centre

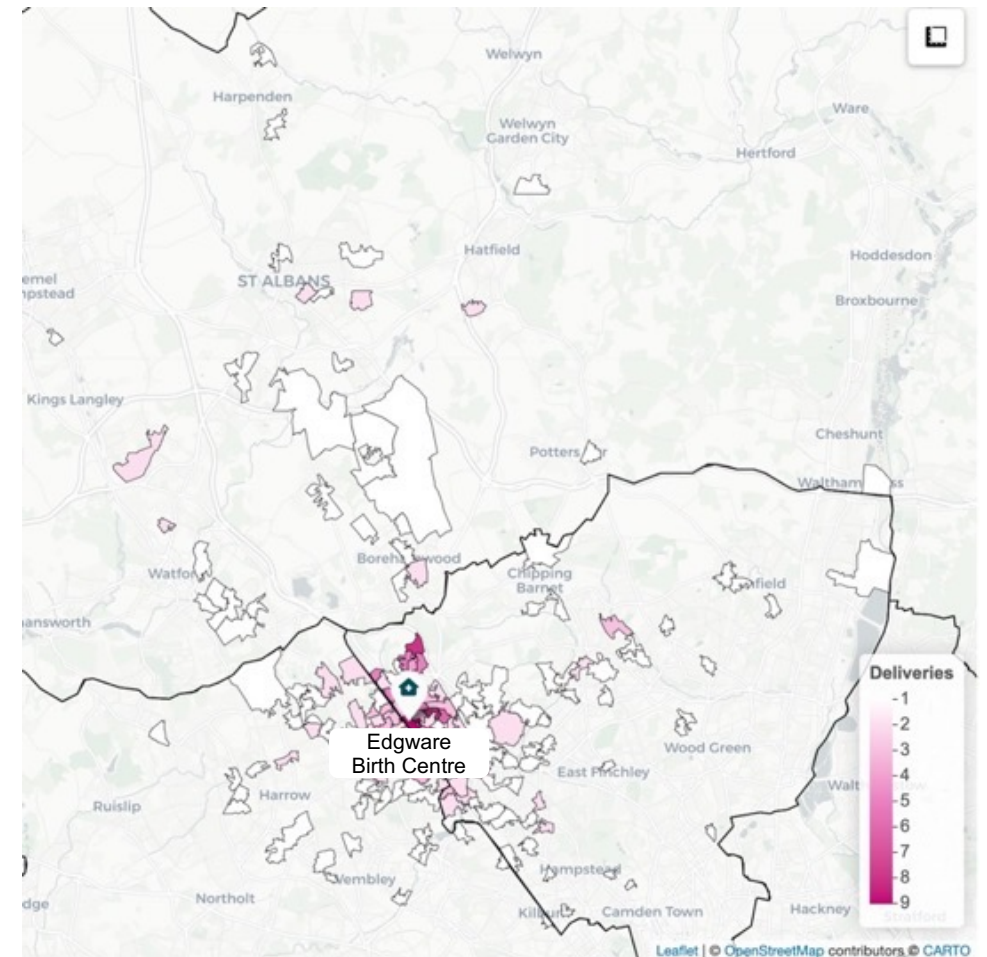


- Our proposals for Edgware Birth Centre (EBC) would impact on people who might have wanted to give birth at the unit. This is anticipated to be a very small number given only 34 pregnant women and people gave birth there in 2022/23.
- The population who give birth at EBC are also extremely geographically dispersed.
- The number of births are so small and the geographical spread so wide, it is hard to say whether any group might be disproportionately impacted.

**Number of births at Edgware Birth Centre**



**Populations that have delivered at Edgware between 2017/18 and 2021/22**



# We considered whether our proposal for Edgware Birth Centre would disproportionately impact groups sharing a protected characteristic and other vulnerable groups

		Potential impacts that may require mitigations
Protected characteristic	Race	<ul style="list-style-type: none"> <li>No evidence to suggest there would be a differential impact. This is because of the low number of women and people who use the unit.</li> </ul>
	Age	<ul style="list-style-type: none"> <li>Women and pregnant people are more likely to use a standalone birthing centre for a second or subsequent birth, so while the closure of the birthing suites reduces choice for all service users, this may have a disproportionate impact on older service users.</li> </ul>
	Sex	<ul style="list-style-type: none"> <li>No evidence to suggest there would be a differential impact</li> </ul>
	People with disabilities	<ul style="list-style-type: none"> <li>People with some disabilities may find a non-hospitalised environment less stressful so may be disproportionately impacted by the closure of the birth suites.</li> </ul>
	Being pregnant or on maternity leave	<ul style="list-style-type: none"> <li>No evidence to suggest there would be a differential impact</li> </ul>
	Gender reassignment	<ul style="list-style-type: none"> <li>No evidence to suggest there would be a differential impact</li> </ul>
	Religion of belief	<ul style="list-style-type: none"> <li>No evidence to suggest there would be a differential impact</li> </ul>
	Sexual orientation	<ul style="list-style-type: none"> <li>No evidence to suggest there would be a differential impact</li> </ul>
	Being married or in a civil partnership	<ul style="list-style-type: none"> <li>No evidence to suggest there would be a differential impact</li> </ul>
Other	People living in areas of deprivation	<ul style="list-style-type: none"> <li>No evidence to suggest there would be a differential impact</li> </ul>
	Other inclusion health groups	<ul style="list-style-type: none"> <li>People who have undergone some types of trauma may be more comfortable in a non-hospitalised environment</li> </ul>

## We undertook further engagement with people who have used Edgware Birth Centre

### Feedback from IIA engagement

- Praise for more individualised approach than in hospital-based services
- Having antenatal appointments and giving birth in the same location was reassuring for people, it reduced anxiety and nervousness
- Parents said they trusted the staff and felt that the staff trusted them
- Parents did not report choosing the birth centre due to its proximity to their home. They did not consider travel to be a problem; some said that parking at the birth centre was easier than at hospitals.

## Mitigations related to proposals around Edgware Birth Centre have been developed



We would do the following to support our proposals around Edgware Birth Centre

Further engagement to understand any impacts not yet identified associated with closing the delivery suites at Edgware. This would need to include those living in the local area, as well as across into the neighbouring areas of Harrow and Hertfordshire.

Engagement with the local community to understand what maternity services could be provided at the site which would support improved access and care – for example antenatal classes tailored at the local population who may have complex needs

For the small number of people for whom a hospital-based birthing experience may not be their preference, we would focus on:

- Investing in co-located midwife-led units and making sure that the environment is set up in a way that facilitates the best outcomes for pregnant women and people who choose them
- Home birthing would remain a choice for pregnant women and people, and we would ensure that this is consistently available for those that would prefer a birth that is physically separated from a hospital site
- Freeing up room at Edgware Birth Centre would allow us to focus on increasing the provision of continuity of carer for local people at the highest risk of complications

# Appendix

# Our analysis utilised a simple weighting to determine the impact of travel time on selected populations

## Method and limitations

This methodology applies a simple weighting based on the Office of National Statistics (ONS) estimates of populations in each lower super output area (LSOA) to the metric of choice.

This, however, has limitations. Whilst it works well for universal metrics such as travel times (because we assume on average that everyone in a specific LSOA will be impacted the same amount) it relies on some assumptions when population-specific metrics are used.

Take for example car access: the analysis explores car access rates per LSOA, but not subset by the type of population. Therefore, when this weighing is applied, the analysis assumes that the car ownership rate of in a certain LSOA is the same for every subgroup.

In other words, if an LSOA had a car ownership rate of 70%, then this methodology assumes that the deprived population in this LSOA will have on average have car ownership rate of 70% as well.

## Formula for weighing

$$m_w = \frac{\sum_{L=0}^L m_L * p_L}{\sum_{L=0}^L p_L}$$

*m<sub>L</sub>* is the metric of interest per LSOA  
*p<sub>L</sub>* is the population of interest per LSOA  
*m<sub>w</sub>* is the weighted metric  
*L* represents an LSOA

In the below case, the analysis assumes that there are three LSOAs of equal populations which, in one option, have an additional travel time of 10 minutes, 5 minutes, and 3 minutes.

Averaging gives an average of 6 minutes of travel time. However, if certain populations are heterogeneously distributed (eg: assuming the LSOAs have 100, 200 and 1,000 people living in areas of deprivation respectively) then the method gives a weighted travel time of 3.85 minutes.

## Example calculation

$$m_w = \frac{(10.0 * 100) + (5.0 * 200) + (3.0 * 1000)}{(200 + 100 + 1000)},$$
$$m_w = 3.85$$

## The quantitative assessment was undertaken using available data sources

Population	Metric	Source
People living in areas of deprivation	This metric examines the proportion of households in an LSOA that are deprived in any seven indices of multiple deprivation categories	ONS (2019)
People who are economically inactive	This metric examines the proportion of the population in any LSOA that is categorised as not economically active	ONS (2021)
People from ethnic minority groups	This metric examines the proportion of the population in an LSOA that self identifies as belonging to an ethnic minority (any categorisation on the census that is not white or mixed)	ONS (2021)
People with poor English proficiency (including literacy)	This metric examines the proportion of the population in an LSOA that has poor / no proficiency in English	ONS (2021)
People with poor health	This metric examines the proportion of the population in any LSOA that self-reports "bad" or "very bad" general health	ONS (2021)
Women and people of child-bearing age	This metric examines the proportion of women per LSOA that are within the age of 16-45	ONS (2021)
Single pregnant women and people	This metric examines the proportion of single mothers in each LSOA	ONS (2021)
People with disabilities	This metric examines the proportion of the population in any LSOA that self identifies as disabled under the equality act	ONS (2021)

# We quantitatively assessed the impact of our proposals on people who have vulnerabilities, where the data exists



Population	Metric	Source
People from ethnic minority groups	This metric examines the proportion of the population in an LSOA that self identifies as belonging to an ethnic minority (Any categorisation on the census that is not White or Mixed)	ONS (2021)
People living in areas of deprivation	This metric examines the proportion of households in an LSOA that are deprived in any seven Indices of Multiple Deprivation categories	ONS (2019)
People with disabilities	This metric examines the proportion of the population in any LSOA that self identifies as disabled under the equality act	ONS (2021)
People who are economically inactive	This metric examines the proportion of the population in any LSOA that is categorised as not economically active	ONS (2021)
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Women of child-bearing age	This metric examines the proportion of women per LSOA that are within the age of 16-45	ONS (2021)
Single pregnant women and people	This metric examines the proportion of single mothers in each LSOA	ONS (2021)

# We reviewed four access statistics and five impact metrics to assess the potential impact of our proposals on access



Metric	Methodology	Source
Digital access	This metric examines the average digital propensity index (a measure of digital literacy) for the catchment population in each option	ONS Digital Propensity index (2021)
Public transport accessibility	This metric examines the average public transport accessibility index (measuring ease of accessing public transport) for the catchment population in each option	PTLA (2015/16)
Car ownership	This metric examines the mean vehicle access rates (car or van) for the catchment population in each option	ONS (2021)
Parking spaces	This metric examines the available site parking spaces in sites that may close for each option	ERIC (2021/22) data
Travel time (peak public transport)	This metric examines the additional time taken per catchment to travel to their closest site (by peak public transport journeys)	Travel time API (2023)
Travel time (peak taxi / private car)	This metric examines the additional time taken per catchment to travel to their closest site (by peak private car / taxi journeys)	Travel time API (2023)
Travel time (off-peak taxi / private car/ ambulance)	This metric examines the additional time taken per catchment to travel to their closest site (by off-peak private car / taxi journeys / ambulance)	Travel time API (2023)
Taxi costs	This metric examines the average additional taxi cost (£) per car journey for each option by using estimated taxi cost per mile from NimbleFins	Travel time API (2023), Nimblefins (2023)
Driving costs	This metric examines the average additional driving cost (£) per car journey for each option	Travel time API (2023), Nimblefins (2023)