

# Start Well Programme

Interim Integrated Impact  
Assessment (IIA)

Paediatric Surgery PCBC

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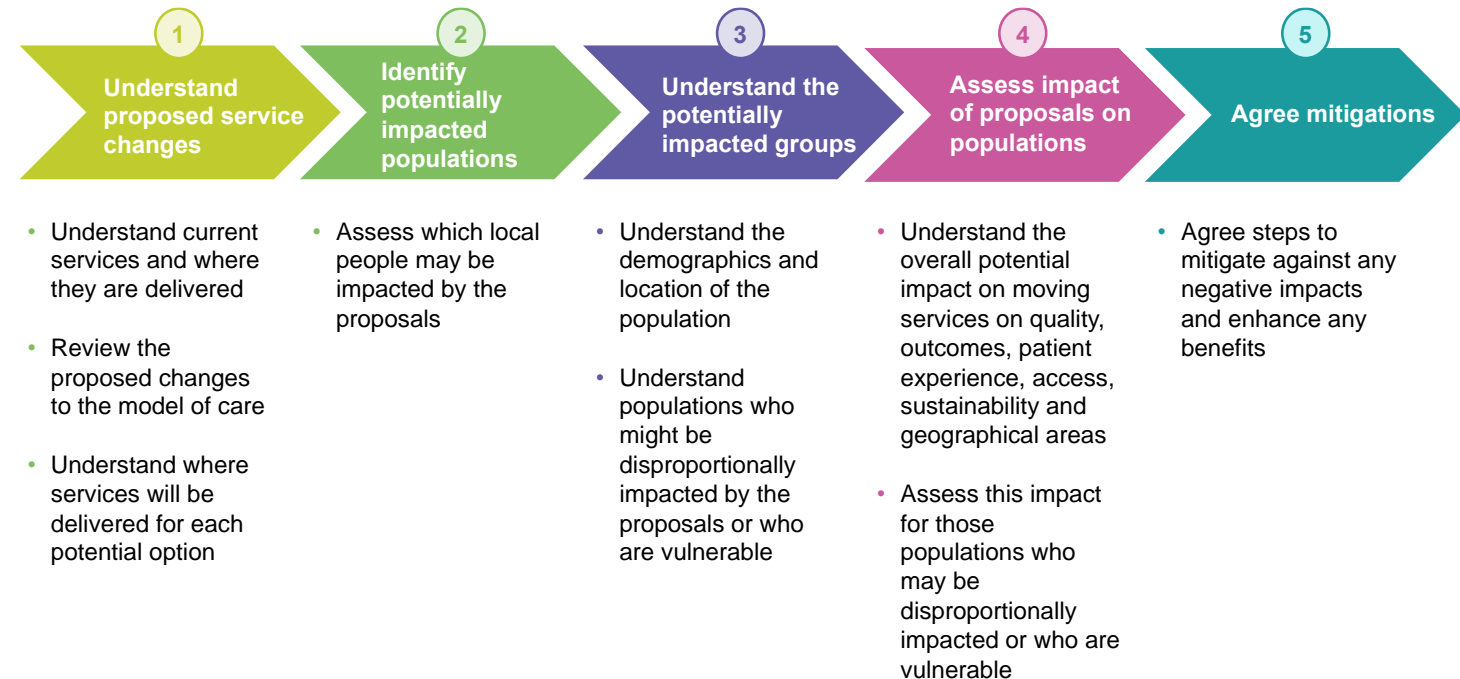
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# Executive summary

# We have developed an interim Integrated Impact Assessment (IIA) for the Start Well programme

- We have developed proposals for paediatric surgical 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 explores the impact of our proposals on people sharing protected characteristics and vulnerable groups
- A robust approach has been adopted for the development of the interim IIA. See right for the approach followed.
- 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

## Interim IIA process



# We have engaged with parents, carers and children and young people on our paediatric surgery proposals

## Engagement reach



Views on paediatric surgery were captured as part of our **engagement on the case for change** – through both **group discussions** and **questions in our survey**



An engagement session with **Great Ormond Street's Young People's Forum** where **18 children and young people** with **experience of care at GOSH** inputted into proposals and possible impact of implementing them.



Proposals were reviewed and the **impact of implementing** them were discussed on **three occasions** by the **NCL Start Well patient participation and engagement (PPEG) group**



We held **three youth summits** with **60 young people** to identify impacted groups and **develop mitigations** to **reduce negative impacts** of implementing our proposals

**In total we spoke to 89 young people, parents, carers and residents**

# Our case for change highlighted opportunities for improvement, addressed by our new model of care

- The Start Well programme case for change highlighted opportunities for improvement for paediatric surgical services in NCL
- We have developed a new model of care for paediatric surgical services that address these opportunities for improvement

## Children and young people's opportunity for improvement



### Reducing long waits for elective recovery

- In NCL, 1 in 46 (32,000) children and young people are currently waiting for treatment
- For admitted care there are currently c.4,300 children and young people waiting for treatment at NCL sites



### Improving transition to adult services

- Across NCL there is a challenge in providing consistent care across transition into adult services
- There is no consistent definition across NCL around the age cut off for children's and young people's services



### Recruitment and retention of the paediatric workforce

- Vacancy rates are particularly high in paediatric nursing, ranging from 13-36% across NCL sites
- Often our own staff are having to work to provide cover for shifts



### Meet national recommendations for the environment for paediatric surgery

- Currently not all sites provide dedicated paediatric theatres or child friendly environments
- The impact of current estate and organisations means that some sites are struggling to manage their activity



### Increasing demand for emergency care

- NCL sites are providing emergency care to an additional 73 children and young people a day compared to 2016/17
- A higher number of low acuity cases are being treated in ED



### Improving long-term conditions management

- Some children and young people do not get enough managing their health and wellbeing, which can lead to unplanned time in hospital
- Children and young people with long term conditions who live in the most deprived areas are more likely to be admitted to hospital



### Organisation of paediatric surgical care

- There is variation between and within hospitals on whether a child can be treated on site, depending on the confidence and skills of adult surgeons and anaesthetists covering the emergency rota
- Children with lower complexity emergency cases are being transferred to specialist hospitals, causing treatment delays for some children



## We appraised options for the location of planned and emergency surgical services for children and young people

- The paediatric surgery care model proposes different types of units: local, specialist and centre of expertise
- We have one preferred option for consultation for the location of a centre of expertise: day case and the centre of expertise: emergency and planned inpatient that has been tested against the status quo.

### Preferred option for consultation

#### Centre of expertise: emergency & planned inpatient

**GOSH**

Delivers majority of surgical care for children under 3 years and under 5 years (general surgery and urology). Provides planned inpatient surgery for children age 1 years and over for low volume specialties.

#### Centre of expertise: day case

**UCLH**

Delivers all day case surgery for children age 1 and 2 years. Provides day case activity for all children age 3 years and over for low volume specialties.

# Implementation of the proposals would improve quality and patient experience

- 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
<b>Surgical care delivered in the right setting</b>	<ul style="list-style-type: none"> <li>• Children and young people access the surgical care that is aligned to their needs as quickly as possible. This may be in a local unit or in a more specialist setting.</li> <li>• Development of an emergency surgical assessment unit allows children to be seen and assessed without delay by specialist workforce who have the competencies and experience to make a decision</li> <li>• SAU on site at GOSH would enable some children and young people to be seen for a quick post operative assessment in the unit rather than be admitted into an inpatient bed. For unwell children needing a review following an inpatient stay at GOSH, they could be admitted directly to the SAU rather than going to the local ED and then transferred to GOSH for review.</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced emergency admissions</li> <li>• Increased daycase rate at GOSH</li> <li>• Reduced inpatient admissions at GOSH for assessments</li> <li>• Reduced transfers from local hospitals to GOSH</li> </ul>
<b>Clear emergency surgical pathways</b>	<ul style="list-style-type: none"> <li>• Clear emergency pathway with clear pathways for children and young people, dependent on the age and specialty. Clarity of pathways and will mean less time is spent by staff in local units finding a bed.</li> <li>• Reduce the number of transfers and the time it takes to transfer children and young people</li> </ul>	<ul style="list-style-type: none"> <li>• Reduce the number and time of transfers</li> <li>• Reduced transfers to units outside of NCL, keeping care as close to home</li> <li>• Improved staff productivity through less time spend organising transfers</li> </ul>
<b>Workforce</b>	<ul style="list-style-type: none"> <li>• Delivering care at fewer sites means that that best use is made of the scarce specialist paediatric surgeon and consultant paediatric anaesthetists workforce</li> <li>• Making sure that people who are anaesthetising children under the age of 3 see sufficient cases to maintain their skills and experience</li> </ul>	<ul style="list-style-type: none"> <li>• Improved staff experience</li> <li>• Improved recruitment and retention through training and development opportunities across NCL</li> </ul>
<b>Sustainable volumes of surgical activity</b>	<ul style="list-style-type: none"> <li>• Anaesthetists, junior doctors, specialist nurses and consultants within paediatric services can learn and practice the necessary skills to undertake paediatric surgery and maintain their competencies</li> <li>• Make sure that all children and young people are seen by specialist staff with access to specialist equipment by consolidating low volume daycase activity into a single Centre of Expertise</li> </ul>	<ul style="list-style-type: none"> <li>• Children and young people are seen by specialist staff Improved patient experience</li> <li>• Staff deliver enough activity to maintain their skills and competencies</li> </ul>
<b>Child friendly environment</b>	<ul style="list-style-type: none"> <li>• Children are operated in child friendly environments and dedicated paediatric surgical lists</li> </ul>	<ul style="list-style-type: none"> <li>• Improved patient, family and carer experience</li> </ul>





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

- We engaged extensively with several groups of people to understand 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 and there are nine protected groups that we must consider to fulfil our legal duties
- The interim IIA is therefore focused on people who may be disproportionately impacted by our proposals. The populations considered are set out in the table.

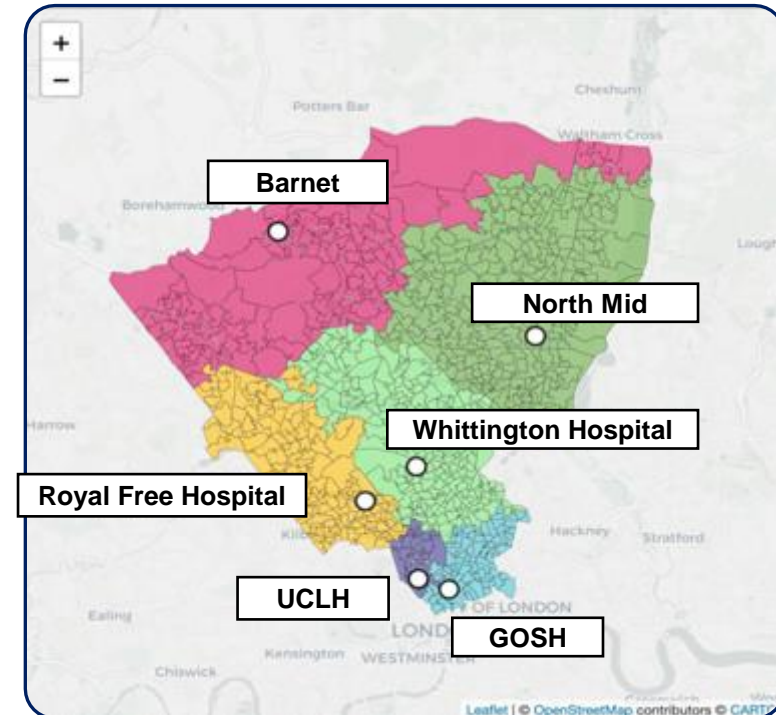
**Table showing the populations that have been identified for further consideration in the interim IIA and how we identified those populations**

Potentially impacted populations	How we identified potentially impacted populations				Quantitative analysis possible?
	Protected characteristic	CORE20	Engagement	Case for change	
Children and young people living in areas of deprivation		✓	✓	✓	Y
Children and young people from economically inactive households					Y
Children from ethnic minority groups	✓	✓	✓	✓	Y
Children who have poor English proficiency (or their parents)					Y
Children with poor health		✓			Y
Children and young people from inclusion health groups		✓		✓	
Children with disabilities	✓			✓	Y
Children from single parent households					Y
Children with special educational needs and disabilities		✓			
Looked after children and care leavers		✓			

## We identified the people who may be impacted by our proposals for planned care

- We looked at people who might be impacted by our proposals for changes to paediatric day case, planned inpatient and emergency surgical services (the catchment population)
- We found different catchment populations for :
  - Planned care:** day case (going to UCLH) and planned inpatient care (going to GOSH)
  - Emergency care** (going to GOSH) because children and young people having day case and planned inpatient care will travel direct to UCLH or GOSH for their procedure whilst, in an emergency, children and young people will go to their local hospital first (as they do now) before being transferred to GOSH, if required. Further information on the potential impact of the proposals can be found on slides 117 - 121
  - The catchment for day case (UCLH) and planned inpatient care (GOSH) surgical activity is all LSOAs within NCL
- We identified the people who may be impacted by the proposals for planned care using travel times and we used several assumptions to generate these travel times

### Planned care (day case and planned inpatient) catchment



The proposals would not change how children and young people access emergency care in the first instance, therefore this interim IIA analysis is more focused on the proposed changes to paediatric surgical day case and planned inpatient care (planned care).

# Significant engagement was undertaken to identify the potential impact on access

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.

**1**  
**Digital access**

Poor digital access might create barriers for accessing care if people cannot access equipment or data

**2**  
**Public transport accessibility**

Lack of public transport accessibility may make it difficult for people without access to a car to access services

**3**  
**Car ownership**

Lack of car access may mean people find it difficult to access services, particularly if public transport is not good

**4**  
**Parking spaces**

Lack of parking might make accessing sites difficult, particularly for vulnerable populations (such as the disabled)

**1**  
**Public transport travel time**

Additional public time to travel to sites can be difficult and might dissuade people who rely on public transport

**2**  
**Peak travel time**

Additional time to travel to sites can be difficult for people and might dissuade them from attending

**3**  
**Off-peak travel time**

Additional time to travel to sites can be difficult for people and might dissuade them from attending

**4**  
**Taxi costs**

People without access to a car may need to catch a taxi and high taxi costs may be unaffordable

**5**  
**Driving costs**

Long / expensive journeys might place financial strain on some households

## Potential impacts of the proposals are an average increase in peak car/taxi travel time of 27 minutes and car/taxi costs of ~£22 to UCLH for day cases

- **Engagement** was undertaken to identify the potential impact of the proposals on access for planned care
- 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

### Average impact on planned care catchment population

Centre of expertise		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ambulance travel times (mins)	Taxi costs	Driving costs
UCLH	Current	22.85	15.64	12.86	£13.55	£1.27
	Future	+12.7	+26.88	+23.99	+£22.13	+£2.10

- A potential impact of the proposals on access for the day case catchment population at UCLH would be an **increase in average travel times** for peak, off-peak and public transport of:
  - 27 minutes at peak driving time
  - 24 minutes at off-peak driving time
  - 13 minutes by public transport

## Potential impacts of the proposals are an average increase in peak car/taxi travel time of 31 minutes and car/taxi costs of ~£22 to GOSH for planned inpatient care

- **Engagement** was undertaken to identify the potential impact of the proposals on access for planned care
- 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

### Average impact on the planned care catchment population

Centre of expertise		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ambulance travel times (mins)	Taxi costs	Driving costs
GOSH	Current	22.90	15.74	12.85	£13.85	£1.30
	Future	+17.67	+30.80	+23.71	+£22.08	+£2.08

- A potential impact of the proposals on access for the planned inpatient care catchment population of GOSH is an **increase in average travel times** for peak, off-peak and public transport for:
  - 31 minutes at peak driving time
  - 24 minutes at off-peak driving time
  - 18 minutes for public transport



# People furthest away from GOSH and UCLH may have to pay an additional £40 per taxi journey for planned care

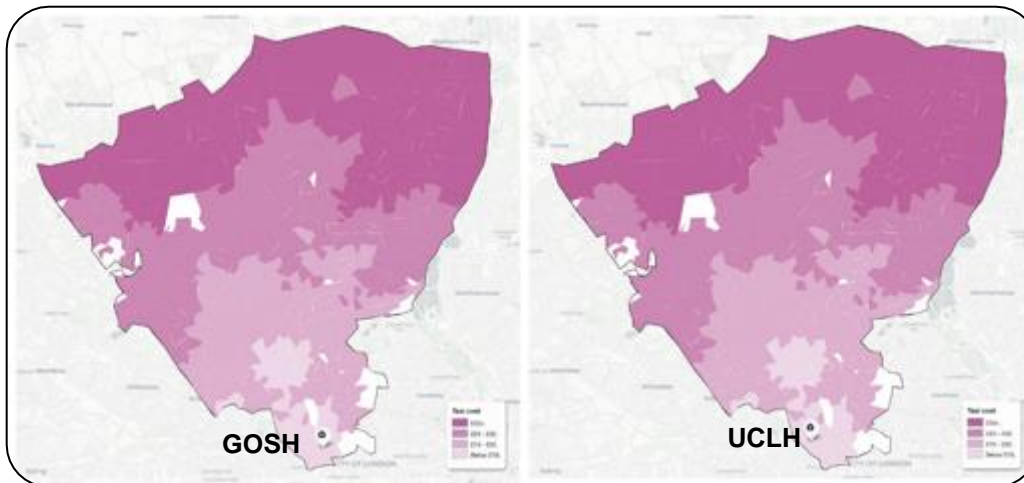


North Central London  
Integrated Care System

- There is a small number of **car parking spaces** available at UCLH (day cases) and no car parking spaces available at GOSH (planned inpatient care)
- **Public transport accessibility** is similar for UCLH (day cases) and GOSH (planned inpatient care). People have better public transport accessibility closer to the centre of London
- **Average additional driving costs would be around £2 per journey for both GOSH (planned inpatient care) and UCLH (day cases).** The largest increase (~£3) in driving costs would be for people living furthest away from the centres of expertise.

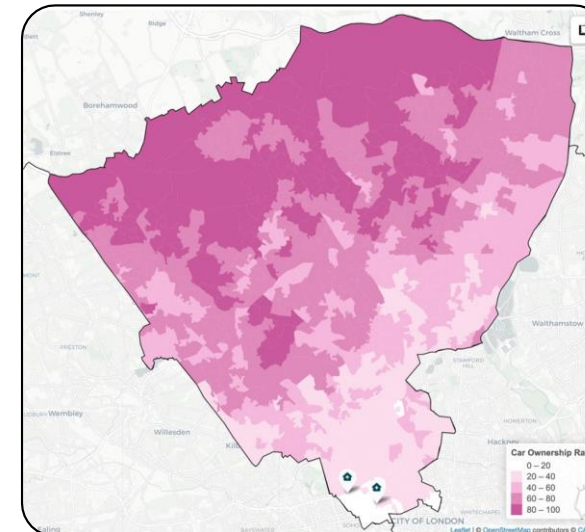
## Taxi costs

Taxi cost (£) from UCLH (day cases) and GOSH (planned inpatient care)



## Car ownership

Car ownership rate (2021) by LSOA

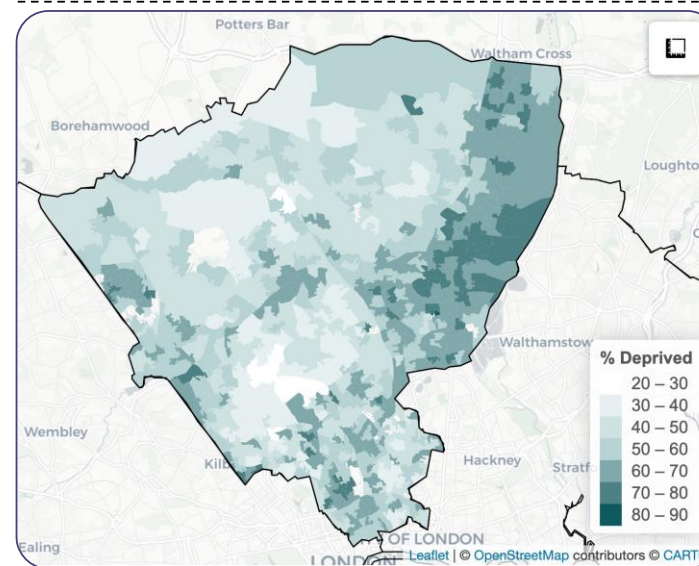


- There would be an **average additional taxi cost of around £22** per journey for both Centres of expertise. People furthest away from GOSH and UCLH may have to pay an additional £40.
- There is a **similar, high, level of digital access** within the catchment population for planned care
- People have similar **access to cars**, with over 50% of the catchment for planned care having access to a car. Car ownership varies, with people with disabilities substantially less likely to own cars
- Engagement found people may have **issues with travel times**, but it was important to receive **treatment from experienced staff**

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

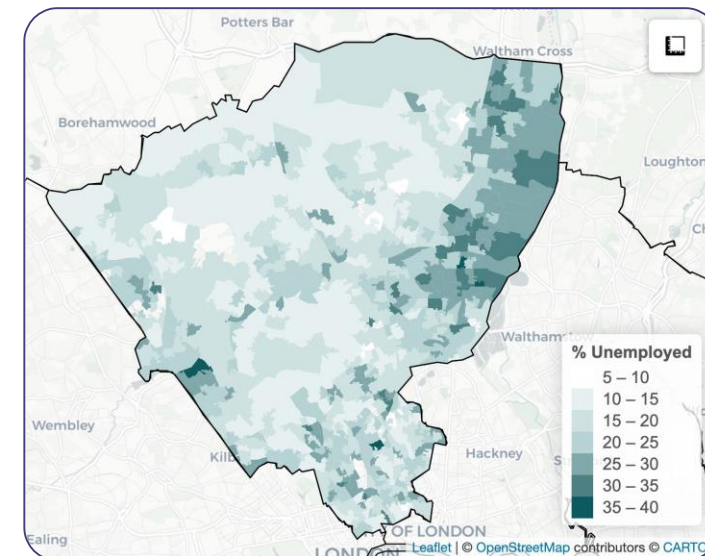
- **Children and young people living in areas of deprivation** are concentrated in the eastern and western parts of the planned care catchment. The biggest concentration of people living in areas of deprivation are situated to the north-east of the planned care catchment, close to the North Mid
- The largest concentration of **children and young people from economically inactive households** in the planned care catchment is around the north-east
- The largest proportion of **children and young people from ethnic minority groups** in the planned care catchment are situated towards the north-east of the planned care catchment

Deprived population  
Rate (%) of IMD deprived population per LSOA



See slides 117 - 121 for information on the potentially impacted population for paediatric emergency surgical care

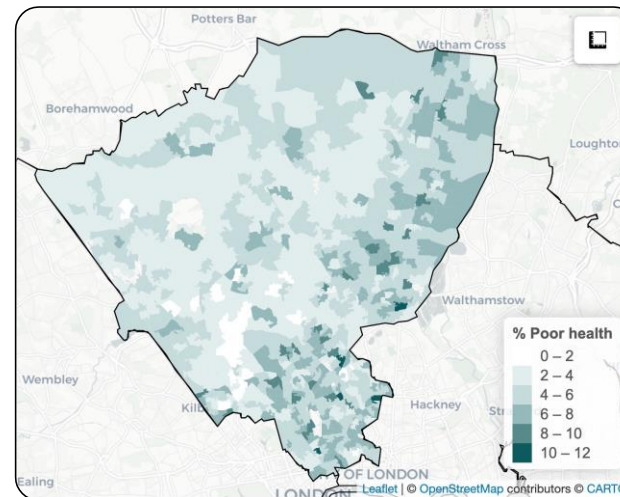
Economically inactive population  
Rate (%) of economically inactive population per LSOA



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

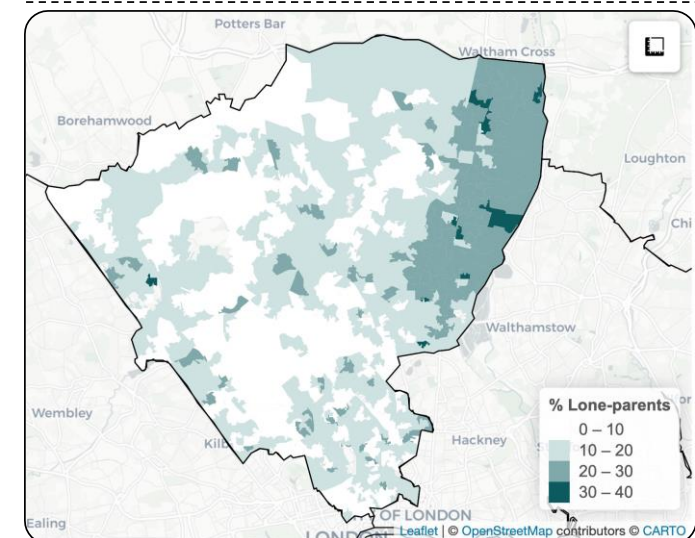
- The largest concentration of people with **poor English proficiency (including literacy)** is in the east of the planned care catchment, close to the North Middlesex hospital
- Children and young people with **poor health** are concentrated in the north and west of the planned care catchment
- The populations with the largest number of children from **single parent households** are concentrated around the north-east of the planned care catchment, around the North Middlesex hospital
- The largest concentration of **people with disabilities** is between the Royal Free hospital and the Whittington hospital, with an above-average concentration of disabled people around the Whittington

**Population with poor health**  
Rate (%) of population with poor health per LSOA



See slide 118 for information on the potentially impacted population for paediatric emergency surgical care

**Population of children from single parent household**  
Rate (%) of children that are from single parent households



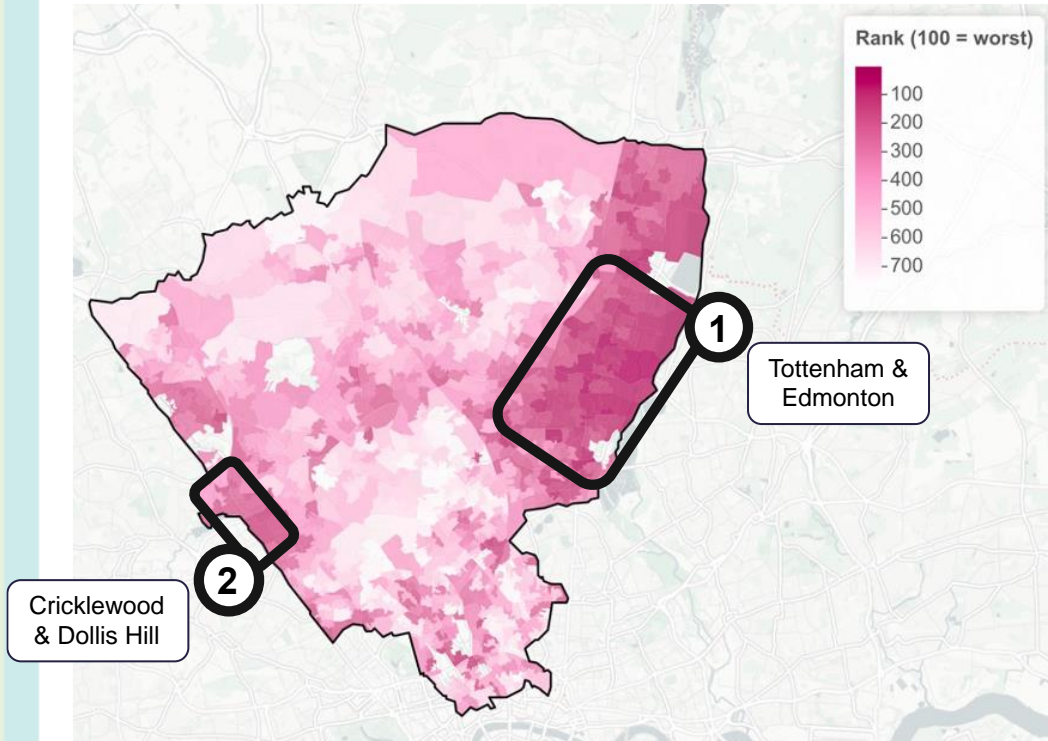


## There is an impact on some groups that would need to be mitigated because of our proposals for planned care

- The potential impact of our proposals for planned care on **people with protected characteristics and people who have vulnerabilities** has been reviewed and is **similar** to the potential impact on the general catchment population
- There is an impact on some groups that would **need to be mitigated** because of the proposals for planned care, as shown in the table below
- **Further details of mitigations** that have been developed for our proposals are shown later in this executive summary

		Potential impacts of the proposals for planned care that may require mitigations
Protected characteristic	Race	<ul style="list-style-type: none"> <li>• Language barriers may need to be addressed if people not proficient in English need to access an unfamiliar unit</li> </ul>
	People with disabilities	<ul style="list-style-type: none"> <li>• Support may be required for children and young people with disabilities (including special educational needs and disabilities) who need to access services on an unfamiliar site or have to undertake a long journey to access services</li> </ul>
Other	People living in areas of deprivation	<ul style="list-style-type: none"> <li>• Potential overlap with race, other inclusion groups and disabilities</li> <li>• The cost of travelling further, particularly by taxi, would need to be addressed</li> </ul>
	Other inclusion health groups	<ul style="list-style-type: none"> <li>• Potential overlap with race, deprivation and disabilities</li> <li>• Support may be required for single parent families who need childcare for other children whilst accessing care that is further away</li> <li>• The cost of travelling further, particularly by taxi, would need to be addressed</li> </ul>

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



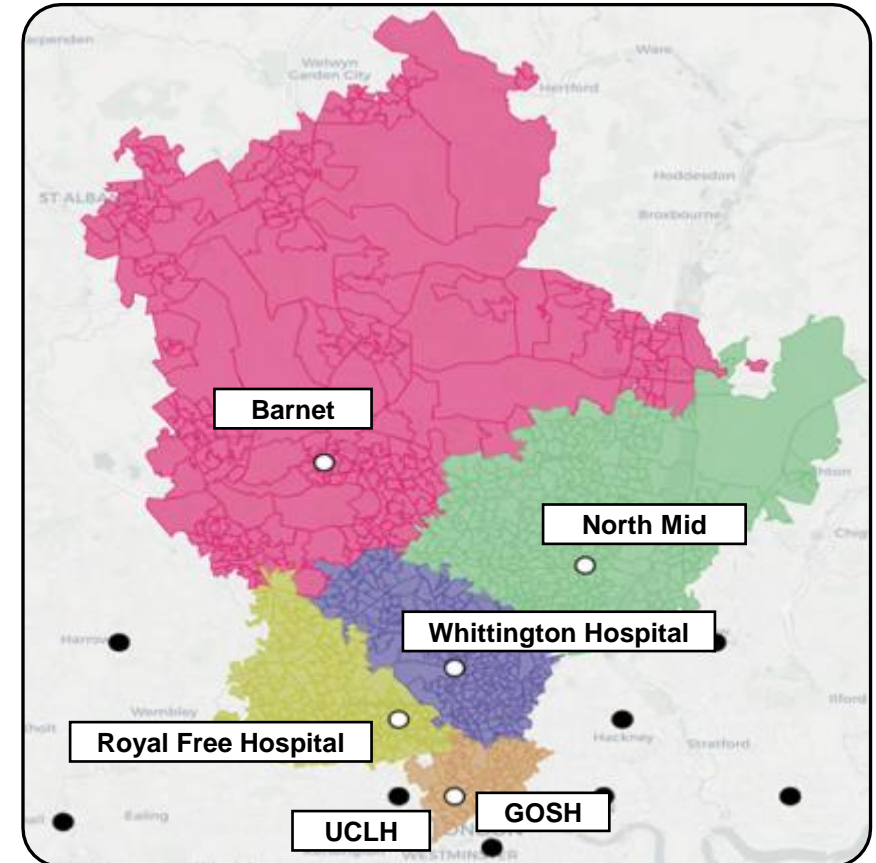
To identify populations who may be more vulnerable to the impact of our proposals, we ranked all LSOAs from highest to lowest against a range of metrics including ethnic minorities, deprivation and poor health outcomes where 1 = worst, 400 = best. A weighted average was then developed for each LSOA and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

- **Two geographical areas** were identified as having residents who may be more vulnerable to the impact of our proposals for planned care due to facing barriers to accessing services as they live in areas of deprivation and have high levels of children and young people with poor health
- As a result of the proposals, people in **Tottenham and Edmonton (1)** and **Cricklewood and Dollis Hill (2)** may need additional support to:
  - **Access the hospital site for planned care** if the children and young people or the families and carers have disabilities/are in poor health or are not proficient in English (including literacy)
  - **Access services at an unfamiliar hospital** as the location where planned surgical care for some children and young people takes place may change
  - **Travel to hospital by taxi for planned care**, if required, as it will cost on average an additional £20 for people living in Tottenham and Edmonton
  - **Access planned care services online** as the families and carers of young children and people may have low digital proficiency
  - **Care for other family members whilst accessing planned care** as they may be a single parent

## We reviewed the potential impact of the proposals for paediatric emergency surgical care

- Children and young people would continue to access emergency care at their local emergency department (ED)
- A small number of the sickest children (around 1,200 per year), who require highly expert care, would be transferred by ambulance from their local hospital to the GOSH centre of expertise, where specialist staff and equipment would be available to assess and treat them
- This means there would be no change to where children and young people access emergency paediatric surgical care and people would continue to access care at their nearest local ED
- However, there may be impact for families and carers visiting children and young people who have been transferred to the centre of expertise at GOSH from a local hospital, although many of these children will currently be transferring out of NCL
- Parents and carers of children and young people who have transferred to GOSH may need to travel up to 31 minutes (at peak travelling time) longer compared to travelling to their local hospital

### Emergency catchment





## There is an impact on some parent and carers that would require mitigations

- The potential impact of our proposals for emergency care on **the parents and carers with protected characteristics and people who have vulnerabilities** has been reviewed and is **similar** to the potential impact on the general catchment population
- There may be an impact on some parents and carers that would **need to be mitigated** because of the proposals for emergency care, as shown in the table below, although many of these parents would have to travel out of NCL under the current model of care
- **Further details of mitigations** that have been developed for our proposals are shown later in this executive summary

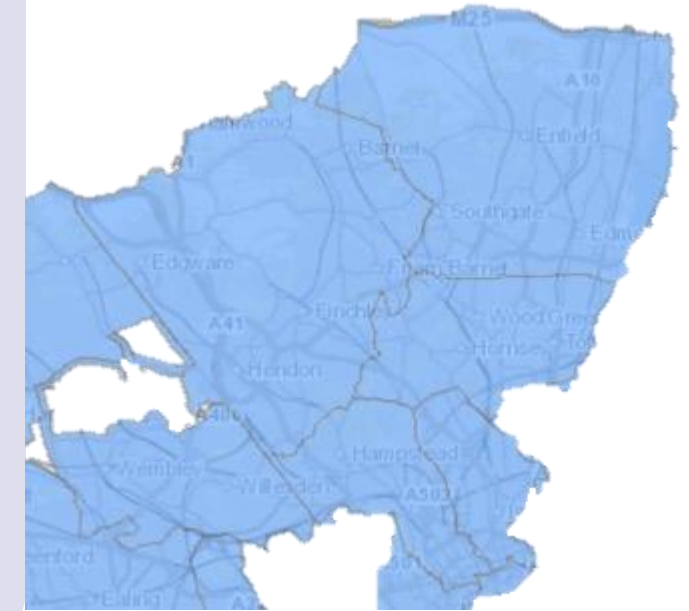
		Potential impacts that may require mitigations
Protected characteristic	Race	• Language barriers would need to be addressed if people not proficient in English need to access an unfamiliar unit
	Age	• Age is not relevant because the impacted population are all young children
	Sex	• Being male or female is not relevant for paediatric planned and emergency surgery
	People with disabilities	• Support may be required for children and young people with a disability (including SEND) who need to access services on an unfamiliar site or undertake a long journey to access services
	Being pregnant or on maternity leave	• The proposed changes impact young children therefore being pregnant is not relevant
	Gender reassignment	• The proposed changes impact young children therefore gender reassignment is not relevant
	Religion of belief	• Being of a certain religion is not relevant for paediatric planned and emergency surgery
	Sexual orientation	• The proposed changes impact young children therefore sexual orientation is not relevant
	Being married or in a civil partnership	• Being married or in a civil partnership are not directly impacted by our proposals as children are unable to be married/enter civil partnerships, and there is no differential impact for parents who are or are not of this status
Other	People living in areas of deprivation	<ul style="list-style-type: none"> <li>• Potential overlap with race, other inclusion groups and disabilities</li> <li>• The cost of travelling further, particularly by taxi, would need to be addressed</li> </ul>
	Other inclusion health groups	<ul style="list-style-type: none"> <li>• Potential overlap with race, other inclusion groups and disabilities</li> <li>• Support may be required for single parent families who need childcare for other children whilst accessing care that is further away</li> <li>• The cost of travelling further, particularly by taxi, would need to be addressed</li> </ul>



## 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, similar travel carbon impact** due to the small increase in travel distances as people access services at UCLH (day case) and GOSH (planned inpatient care) and increased vehicular emissions may need to be mitigated as UCLH and GOSH are within air quality management areas (AQMAs). Emissions for emergency care are unlikely to increase as many children are currently transferred outside of NCL.
- It should be noted that only very small numbers of children and young people would be impacted by these proposals and therefore the overall additional number of journeys would be very small
- **Refurbishment carbon emissions** for GOSH would be mitigated as part of their net zero strategy
- The number of patients that are impacted by the proposals are so small that there would be **no impact on organisations as anchor institution**

### AQMAs associated with the catchment



Centre of expertise	Total distance to closest provider (all journeys)	Total distance to Centre of expertise (all journeys)	Additional distance travelled	Increase in CO2 emission	Percentage increase in CO2 emissions per journey
<b>UCLH: day case</b>	419 miles	580 miles	+161 miles	+298kg	39%
<b>GOSH: planned inpatient</b>	411 miles	588 miles	+177 miles	+327kg	43%

# The potential impact of the proposals for paediatric surgical planned care

Population	Quality	Access	Populations with protected characteristics and people who have vulnerabilities	Sustainability
<ul style="list-style-type: none"> <li>Around 300 children and young people per year would travel to the UCLH centre of expertise for day case surgery and 300 children and young people per year would travel to the GOSH centre of expertise for planned inpatient surgery</li> </ul>	<p>The proposed service change to deliver centres of expertise at UCLH and GOSH would deliver positive clinical impact:</p> <ul style="list-style-type: none"> <li>Paediatric surgical care would be delivered in the appropriate setting</li> <li>Consolidating low volume specialties and ensuring staff maintain competencies</li> <li>Ensure all children receive care in a child friendly environment</li> <li>Providing clarity on surgical pathways</li> <li>Make best use of paediatric surgeons and consultant paediatric anaesthetists</li> </ul>	<p>Average increase in costs (peak)</p> <ul style="list-style-type: none"> <li>UCLH (day case): £22.13 by taxi, £2.10 driving</li> <li>GOSH (planned inpatient): £22.08 by taxi, £2.08 driving</li> </ul> <p>Average increase in travel times (peak)</p> <ul style="list-style-type: none"> <li>UCLH (day case): +27 mins by car/taxi (peak), +24 mins by car/taxi/ambulance (off peak) +13 mins by public transport</li> <li>GOSH (planned inpatient): +31 mins by car/taxi, +24 mins by car/taxi/ambulance (off peak) +18 mins by public transport</li> </ul>	<ul style="list-style-type: none"> <li>Language barriers may need to be addressed if people not proficient in English need to access an unfamiliar unit</li> <li>Support may be required for children and young people with a disability (including special educational needs and disabilities) who need to access services on an unfamiliar site or undertake a long journey to access services</li> <li>The cost of travelling further, particularly by taxi, may need to be addressed for people living in areas of deprivation and inclusion health groups</li> <li>Support may be required for single parent families who need childcare for other children whilst accessing care that is further away</li> <li>Tottenham &amp; Edmonton and Cricklewood &amp; Dollis Hill were identified as geographies that could be particularly vulnerable to the proposed service changes, with high levels of deprivation, a high proportion of ethnic minorities and high unemployment. An impact of the proposed changes on these population is the large increase in travel times and an increase in taxi prices as a result of increased travel times This may need to be explored further in consultation.</li> </ul>	<ul style="list-style-type: none"> <li>There is a 39% increase in carbon emissions per average journey for this very small group of patients as a result of the increased travel times to UCLH</li> <li>There is a 43% increase in carbon emissions per average journey for this very small group of patients as a result of the increased travel times to GOSH</li> </ul>

# The potential impact of the proposals for paediatric surgical emergency care

Population	Quality	Access	Populations with protected characteristics and people who have vulnerabilities	Sustainability
<p>Around 1,200 children and young people per year would access their local ED, as of now, and then be transferred to the GOSH Centre of expertise for emergency surgery</p>	<p>The proposed service change to deliver Centres of expertise at UCLH and GOSH would deliver positive clinical impact:</p> <ul style="list-style-type: none"> <li>• Paediatric surgical care would be delivered in the appropriate setting</li> <li>• Consolidating low volume specialties and ensuring staff maintain competencies</li> <li>• Ensure all children receive care in a child friendly environment</li> <li>• Providing clarity on surgical pathways</li> <li>• Make best use of paediatric surgeons and consultant paediatric anaesthetists</li> </ul>	<p>Parents and carers of children who have had emergency surgery at GOSH:</p> <ul style="list-style-type: none"> <li>• +33 minutes average travel time for people travelling from the north of the catchment</li> <li>• +63 minutes maximum travel time for people travelling from the north of the emergency care catchment population</li> </ul>	<ul style="list-style-type: none"> <li>• Language barriers may need to be addressed if parent and carers not proficient in English need to access an unfamiliar unit</li> <li>• Support may be required for the parents and carers of children and young people with a disability (including special educational needs and disabilities) who need to visit their children on an unfamiliar site or undertake a long journey to reach the site</li> <li>• Support may be required for the parents and carers of children and young people who are pregnant who need to visit their children by undertaking a long journey to reach the site</li> <li>• The cost of travelling further, particularly by taxi, may need to be addressed for people living in areas of deprivation and inclusion health groups</li> <li>• Support may be required for single parent families who need childcare for other children whilst visiting children who are further away</li> </ul>	<ul style="list-style-type: none"> <li>• Refurbishment carbon emissions for GOSH would be mitigated as part of their net zero strategy</li> <li>• Emissions for emergency care are unlikely to increase as many children are currently transferred outside of NCL</li> </ul>

## Several mitigations have been identified to address potential impacts of our proposals

Mitigations have been developed which address impacts identified both through the in-depth interim IIA analysis and the engagement with service users

- 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
- Supporting sustainability
- Supporting people who may be more vulnerable to the impacts of our proposals

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 (PPEG) supported development of mitigations at two of their meetings

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.



# Background to the interim Integrated Impact Assessment (IIA)

# Summary: background to the interim integrated impact assessment

- We have developed proposals for paediatric surgical 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 explores the impact of our proposals on people sharing protected characteristics and vulnerable groups
- 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 about our proposals which have contributed to a better understanding of the impact of our proposals on service users

# We have developed proposals for paediatric surgical services in NCL as part of the Start Well programme

## 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 was published in September 2022
- Following the case for change, **new care models were developed** with a wide range of clinicians from organisations across the ICS as well as external stakeholders
- 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 further **public engagement and/or consultation** before any decisions as to service change are taken, prior to the development of a decision-making business case (DMBC)

### Purpose

- NCL Start Well is undertaking this **interim Integrated Impact Assessment (IIA)** to assess and understand the potential impact of the options 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

## Purpose of the interim 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

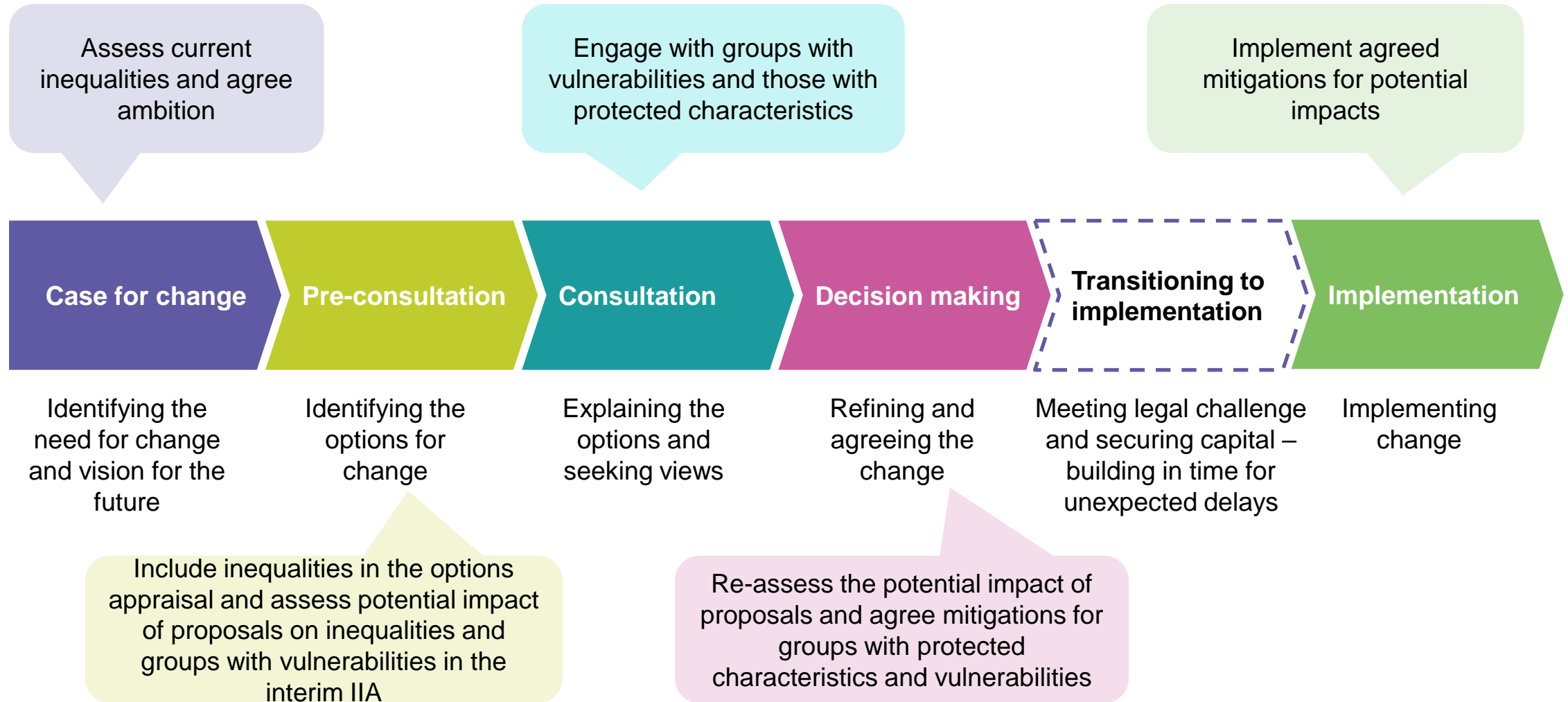
## Compliance with Public Sector Equality Duty (PSED)

- 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 who are vulnerable

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

- 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 have vulnerabilities)

### 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

# We have engaged with parents, carers and children and young people on our paediatric surgery proposals

## Engagement reach



Views on paediatric surgery were captured as part of our **engagement on the case for change** – through both **group discussions** and **questions in our survey**



An engagement session with **Great Ormond Street's Young People's Forum** where **18 children and young people** with **experience of care at GOSH** inputted into proposals and possible impact of implementing them.



Proposals were reviewed and the **impacts of implementing** them were discussed on **three occasions** by the **NCL Start Well patient participation and engagement (PPEG) group**



We held **three youth summits** with **60 young people** to identify impacted groups and **develop mitigations** to **reduce negative impacts** of implementing our proposals

**In total we spoke to 89 young people, parents, carers and residents**



# Proposed service change

## Summary: proposed service changes

- The Start Well case for change highlighted opportunities for improvement for paediatric surgical services in NCL
- We have developed a new model of care for paediatric surgical services that address these opportunities for improvement
- The paediatric surgery care model proposes different types of units: local, specialist and centre of expertise
- We have one preferred option for consultation for the location of a centre of expertise: day case and a centre of expertise: emergency and planned inpatient, which has been tested against the status quo.

# The Start Well case for change identified opportunities for improvement for paediatric surgical services in NCL

## Children and young people's opportunities for improvement



### Reducing long waits for elective care

- In NCL, 1 in 46 (32,000) children and young people are currently waiting for treatment
- For admitted care there are currently c.4,300 children and young people waiting for treatment at NCL sites



### Increasing demand for emergency care

- NCL sites are providing emergency care to an additional 73 children and young people a day compared to 2016/17
- A higher number of low acuity cases are being treated in ED



### Improving transition to adult services

- Across NCL there is a challenge in providing consistent care across transition into adult services
- There is no consistent definition across NCL around the age cut off for children's and young people's services



### Improving long-term conditions management

- Some children and young people do not get enough support to manage their health and wellbeing, and this can lead to unplanned time in hospital
- Children and young people with long term conditions who live in the most deprived areas are more likely to be admitted to hospital



### Recruitment and retention of the paediatric workforce

- Vacancy rates are particularly high in paediatric nursing, ranging from 13%-36% across NCL sites
- Often our own staff are having to work to provide cover for shifts



### Organisation of paediatric surgical care

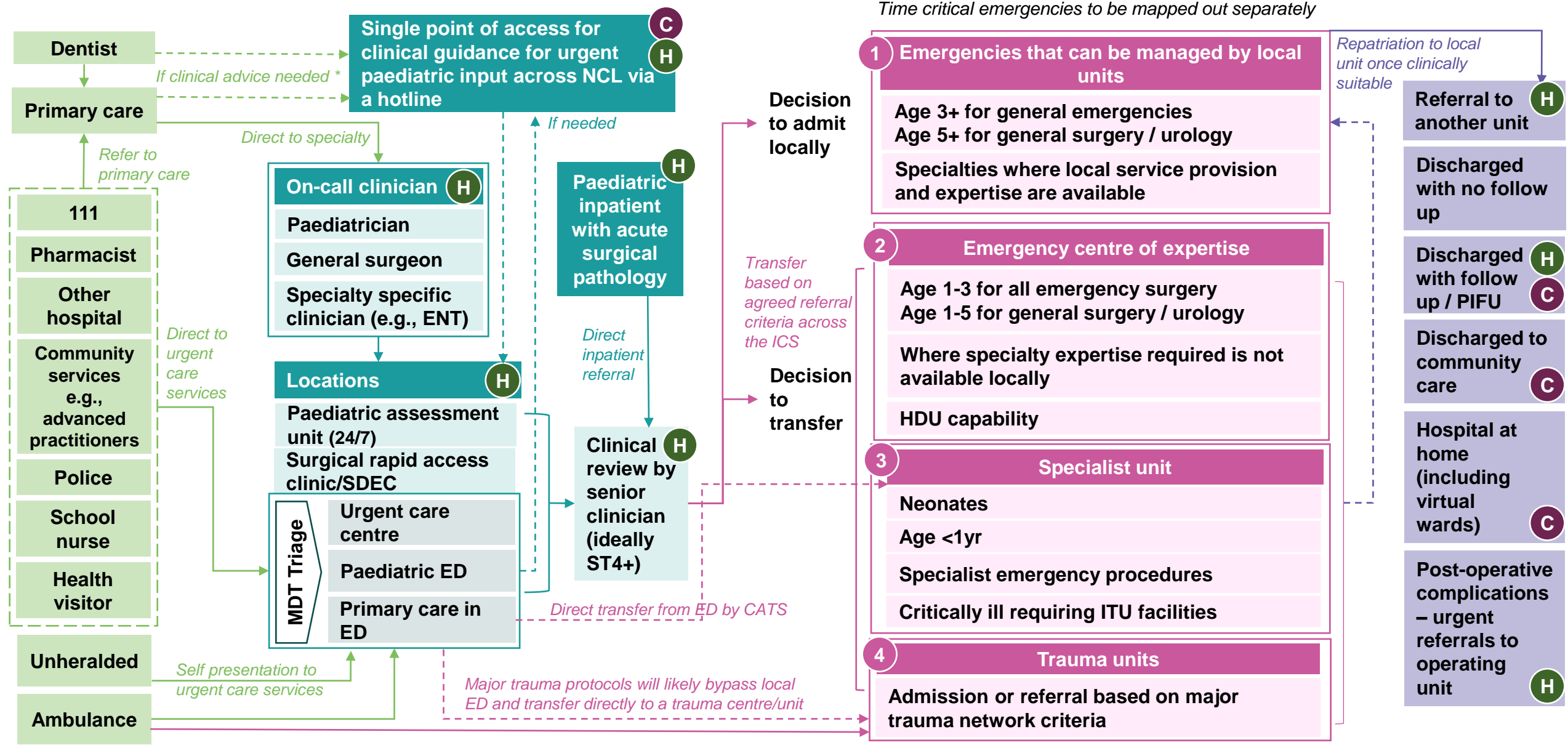
- There is variation between and within hospitals on whether a child can be treated on site, depending on the confidence and skills of adult surgeons and anaesthetists covering the emergency rota
- Children with lower complexity emergency cases are being transferred to specialist hospitals, causing treatment delays for some children.



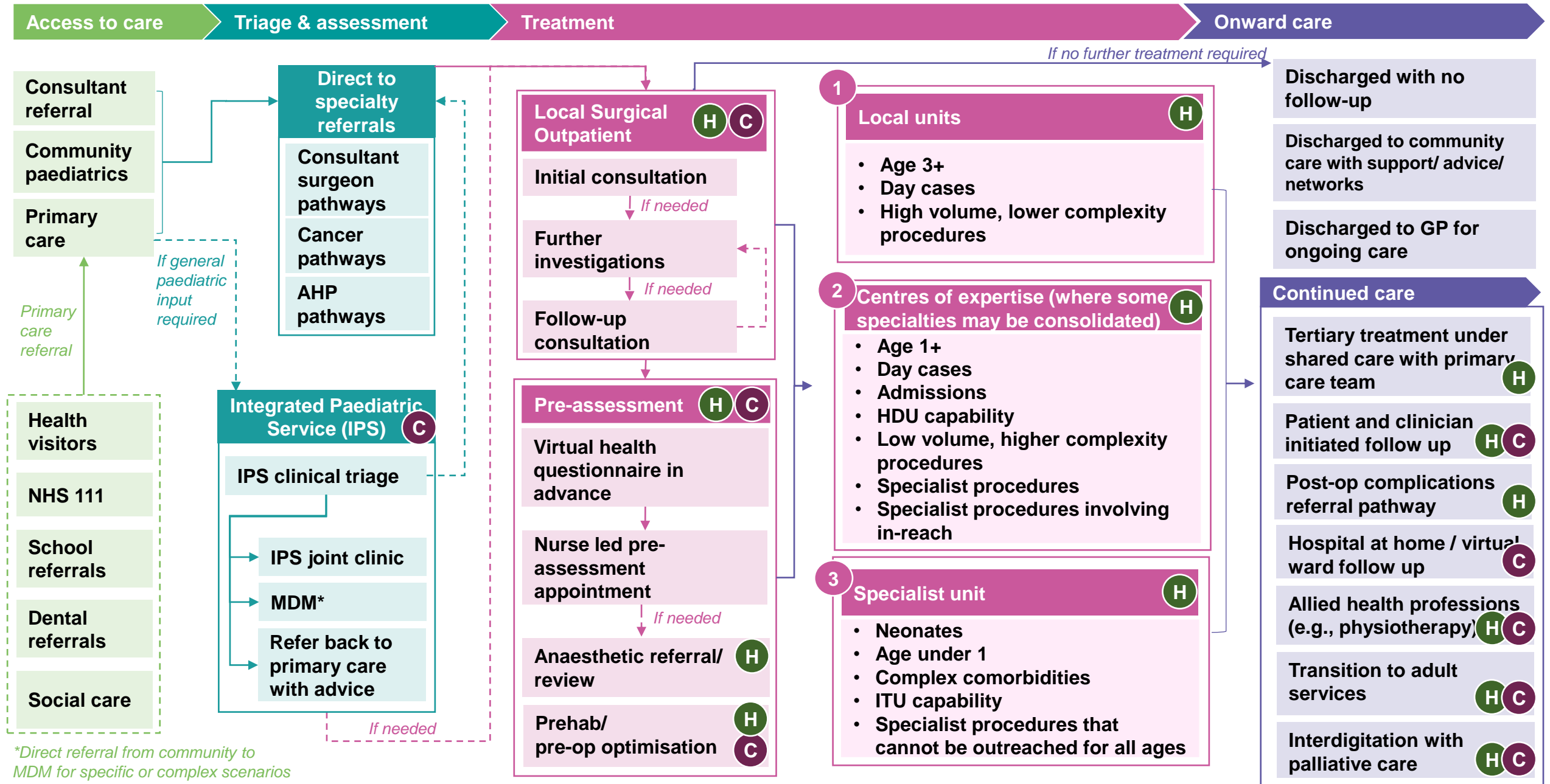
### Meet national recommendations for the environment for paediatric surgical care

- Currently not all sites provide dedicated paediatric theatres or child-friendly environments
- The impact of the current estate and organisation means that some sites are struggling to manage their activity

# We have developed a new model of care for emergency paediatric surgery



# We also developed a new model of care for planned paediatric surgery



# The paediatric surgery care model proposes different types of units: local, specialist and centre of expertise



Local unit

- Delivers **emergency surgery** for most children aged 3+
- Children under 5 may be **transferred to the centre of expertise:** emergency and planned inpatient
- Provides **day case and planned overnight-stay surgery** in ENT and dentistry for age 3+



Centre of expertise:  
emergency & planned inpatient

- Has a **24/7 paediatric surgical assessment unit**
- Delivers majority of **emergency surgery** for children under 3 and for some age 4-5
- Provides **low-volume inpatient planned surgery** for children aged 1+
- **Dedicated specialist paediatric workforce**



Centre of expertise:  
Day case

- Delivers **all day case surgery** for children aged 1-2
- Provides **low-volume day case surgery** for children aged 3+
- Provides **dedicated staff and spaces** for children
- **Dedicated specialist paediatric workforce**



Specialist unit

- Provides **highly specialist** emergency and planned surgery
- Delivers **across age groups**
- Supported by **highly specialist workforce**

## We have one preferred option for consultation for the location of a centre of expertise: day case and a centre of expertise: emergency and planned inpatient

### Centre of expertise: emergency & planned inpatient

**GOSH**

Delivers the majority of surgical care for children under 3 years and under 5 years (general surgery and urology). Provides planned inpatient surgery for children age 1 years and over for low volume specialties.

### Centre of expertise: day case

**UCLH**

Delivers all day case surgery for children age 1 and 2 years. Provides day case activity for all children age 3 years and over for low volume specialties.

- Through the options appraisal process it was recommended that one preferred option be taken forward for the location of the two centres of expertise
- It is recommended that GOSH would be the centre of expertise: emergency and inpatient
- It is recommended that UCLH would be the centre of expertise: day case
- This option has been tested against the status quo

# Potential impact of proposals on quality and patient experience



## Summary: potential impact of proposals on quality and patient experience

- 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

# Our proposals would improve quality and patient experience for paediatric surgical care

## Paediatric surgery care model benefits



### Access

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



### Workforce

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



### Sustainable services

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



### Environment

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



### Surgical pathways

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

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

Category	Benefit description	Outcome
<b>Surgical care delivered in the right setting</b>	<ul style="list-style-type: none"> <li>Children and young people access the surgical care that is aligned to their needs as quickly as possible. This may be in a local unit or in a more specialist setting.</li> <li>Development of an emergency surgical assessment unit allows children to be seen and assessed without delay by the specialist workforce who have the competencies and experience to make a decision</li> </ul>	<ul style="list-style-type: none"> <li>Reduced emergency admissions</li> <li>Increased day case rate at GOSH</li> </ul>
<b>Clear emergency surgical pathways</b>	<ul style="list-style-type: none"> <li>Clear emergency pathways with clear pathways for children and young people, dependent on the age and specialty. Clarity of pathways will mean less time is spent by staff in local units finding a bed.</li> <li>Reduce the number and the time it takes to transfer children and young people</li> </ul>	<ul style="list-style-type: none"> <li>Reduced the number of transfers and time taken for transfers</li> <li>Reduced transfers to units outside NCL, keeping care as close to home</li> <li>Improved staff productivity through less time spent organising transfers</li> </ul>
<b>Workforce</b>	<ul style="list-style-type: none"> <li>Delivering care at fewer sites means that the best use is made of the scarce specialist paediatric surgeon and consultant paediatric anaesthetist workforce</li> <li>Making sure that people who are anaesthetising children under the age of 3 see sufficient cases to maintain their skills and experience</li> </ul>	<ul style="list-style-type: none"> <li>Improved staff experience</li> <li>Improved recruitment and retention through training and development opportunities across NCL</li> </ul>
<b>Sustainable volumes of surgical activity</b>	<ul style="list-style-type: none"> <li>Anaesthetists, junior doctors, specialist nurses and consultants within paediatric services can learn and practice the necessary skills to undertake paediatric surgery and maintain their competencies</li> <li>All children and young people are seen by specialist staff with access to specialist equipment by consolidating low volume day case activity into a centre of expertise</li> </ul>	<ul style="list-style-type: none"> <li>Children and young people are seen by specialist staff</li> <li>Improved patient experience</li> <li>Staff deliver enough activity to maintain their skills and competencies</li> </ul>
<b>Child friendly environment</b>	<ul style="list-style-type: none"> <li>Children are operated on in a child friendly environments and dedicated paediatric surgical lists</li> </ul>	<ul style="list-style-type: none"> <li>Improved patient, family and carer experience</li> </ul>

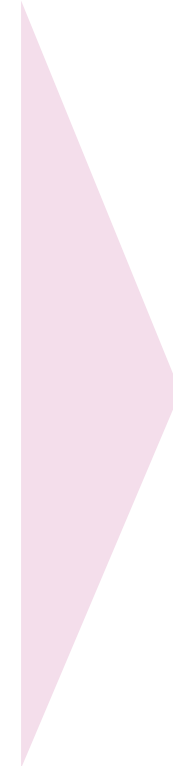
# Understanding the potentially impacted population

## Summary: understanding the potentially impacted population

- We engaged extensively with several groups of people to understand who may be impacted by our proposals
- Our case for change identified vulnerable groups that may be impacted by the proposals, 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
- The interim IIA is therefore focused on people who may be disproportionately impacted by our proposals

# We engaged extensively with several groups of people to understand who may be impacted by our proposals

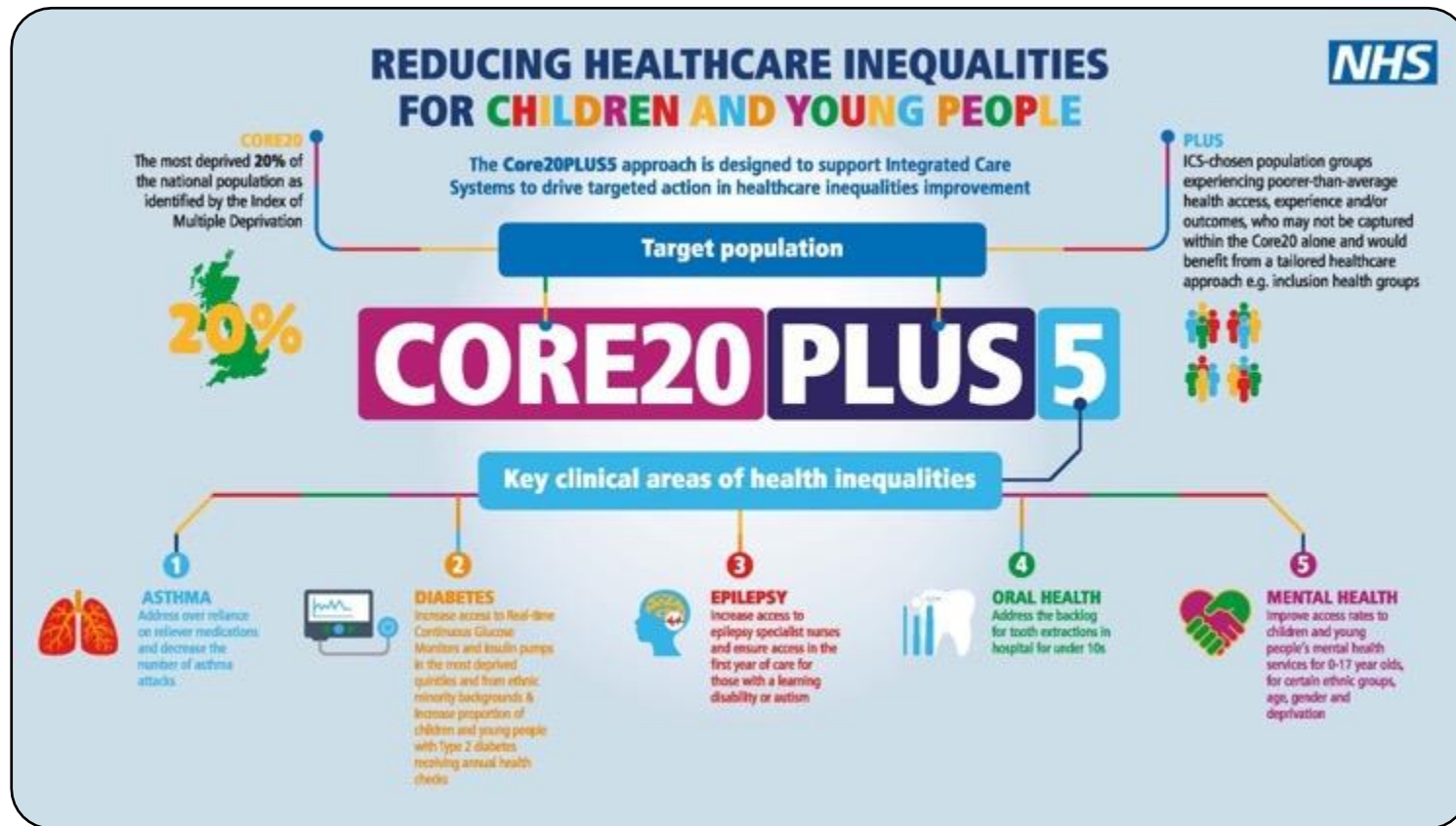
- A 10-week case for change engagement period took place in summer 2022 to identify whether the themes highlighted from the case for change resonated with patients, residents, staff and wider stakeholders
- The engagement established what was important in planning good care and worked in partnership 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
- Diverse communities and groups with specific insights were targeted to ensure a wide range of views were captured



People that may be vulnerable or disproportionately impacted by our proposals were identified through the case for change and engagement:

- Different ethnic groups
- Deprived communities
- Single parent households
- Children and young people with specific religions or faiths
- Children and young people with disabilities

# 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’ children and young people populations refers to population groups identified by NCL as having poorer-than-average health access and outcomes outside of the CORE20 group. In NCL these groups have been identified as:

- Children with special educational needs and disabilities (SEND)
- Looked after children (LAC) and care leavers
- Children and young people from select Black, Asian and Minority Ethnic (BAME) groups

“5” is five national clinical areas of focus which are asthma, diabetes, epilepsy, oral health and mental health

# Our case for change identified vulnerable groups that may be disproportionately impacted by the proposals

Children and young people with **physical and learning disabilities** because:

- Those with disabilities may experience **inequitable access** to care
- They are also more likely to require surgical care due to their conditions
- Children or young people with disabilities and learning disabilities have a **higher prevalence of long-term conditions** and a **lower life expectancy**

**People living in areas of deprivation** because:

- Children and young people from deprived communities generally **have poorer health and a higher prevalence of long-term conditions.**
- They are also **more likely to attend the emergency department (ED) and have higher admissions rates for asthma**
- **Specific ethnic communities** because:
  - Black, Asian and mixed ethnic communities have **higher rates of long-term conditions** in children and young people including asthma, epilepsy, learning disabilities and sickle cell anaemia
  - Children and young people from Black communities have **higher rates of emergency attendances/admissions**

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

- Children and young people who are **homeless** tend to be admitted to hospital with more minor illnesses and are more likely to re-attend emergency departments following discharge
- Children and young people who are **migrants** tend to **have varied health needs**. They are more likely to have complex health needs and are at a higher risk of developing a mental health condition. These populations are also known to experience barriers to healthcare access.



# There are also 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.

Due to the nature of the proposed service changes **some of the protected characteristics are not relevant for the impacted populations** and are therefore not being assessed further:

- **Age** is not relevant because the impacted population are all children
- Being **male or female** is not relevant for paediatric planned and emergency surgery
- The proposed changes impact young children and therefore **sexual orientation, gender reassignment and being pregnant** is not relevant for these individuals. Being pregnant may be relevant for parents and carers
- Being **married or in a civil partnership** are not directly impacted by our proposals as children are unable to be married / enter civil partnerships, and there is no differential impact for parents who are or are not of this status
- Being of a certain **religion** is not relevant for planned paediatric surgery

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

Potentially impacted population	How we identified the potentially impacted population				Quantitative analysis possible?
	Protected characteristic	CORE20	Engagement	Case for change	
Children and young people living in areas of deprivation		✓	✓	✓	Y
Children and young people from economically inactive households					Y
Children from ethnic minority groups	✓	✓	✓	✓	Y
Children and young people who have poor English proficiency (or their parents)					Y
Children with poor general health		✓			Y
Children and young people from inclusion health groups		✓		✓	
Children and young people with disabilities	✓			✓	Y
Children from single parent households					Y
Children with special educational needs and disabilities (SEND)		✓			
Looked after children and care leavers		✓			

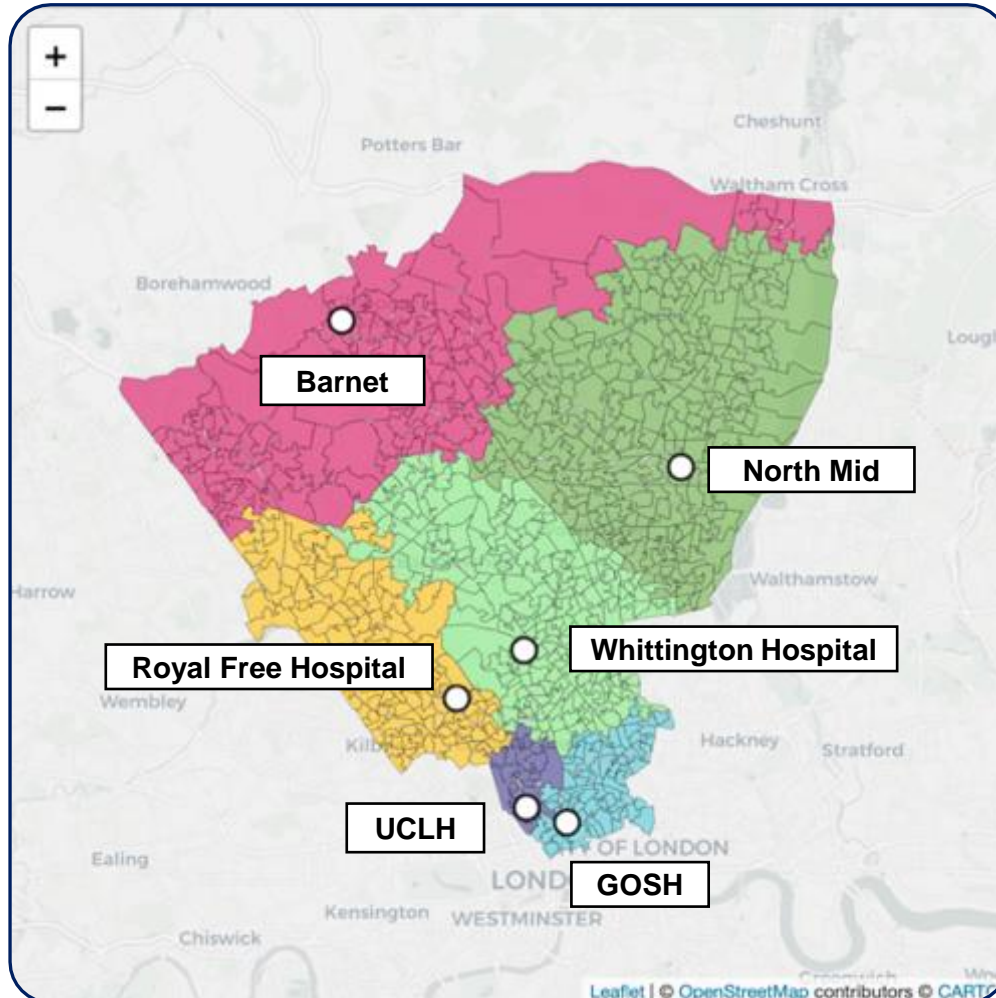
The protected characteristics of age, sex, sexual orientation, gender reassignment, being married or in a civil partnership, being pregnant and religion have been assessed as not relevant for children and young people under these proposals.

# Identifying people who may be impacted by our proposals for planned care

# Summary: Identifying people who may be impacted by our proposals for planned care

- We looked at people who might be impacted by our proposals for changes to paediatric day case, planned inpatient and emergency surgical services (the catchment population)
- We found different catchment populations for:
  1. **Planned care:** day case (going to UCLH) and planned inpatient care (going to GOSH)
  2. **Emergency care** (going to GOSH) because children and young people having day case and planned inpatient care will travel direct to UCLH or GOSH for their procedure whilst, in an emergency, children and young people will go to their local hospital first (as they do now) before being transferred to GOSH, if required. Further information on the potential impact of the proposals can be found on slides 117 to 121
- The catchment for day case (UCLH) and planned inpatient care (GOSH) surgical activity is all LSOAs within NCL
- We identified the people who may be impacted by the proposals for planned care using travel times and several assumptions have been used to generate these travel times

## The catchment for day case (UCLH) and planned inpatient care (GOSH) surgical activity is all LSOAs within NCL



### Method

- NCL boundaries have been used as the “**planned care catchment**” for both day case (UCLH) and planned inpatient care (GOSH)
- This assumes that all planned paediatric surgical care within NCL would go to an NCL provider (day case to UCLH and planned inpatient care to GOSH).
- This is because GP and outpatient referrals can be **directed to NCL providers**. Whilst GPs can make referrals to non-NCL providers, it is expected the majority would be made to NCL providers because pre- and post-surgical care, as well as wider pathways, are usually provided within GP, local authority and/or NCL boundaries
- The planned care catchment has been split into **current hospital catchments** based on the peak travel time by car to the closest unit

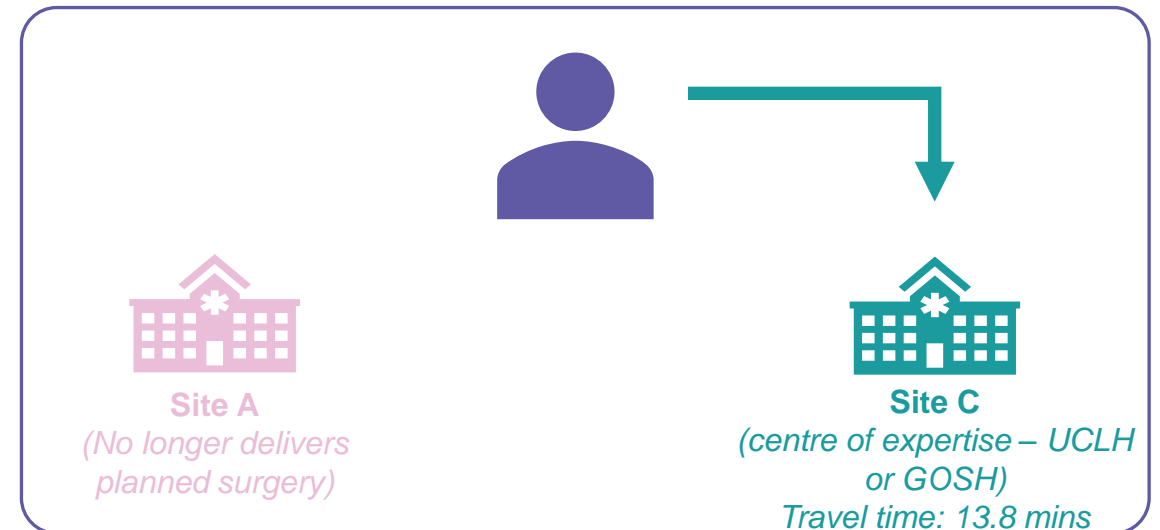
# We identified the people who may be impacted by the proposals for planned care using travel times

- For day cases, (ULCH) we looked at where people currently live and identified people in the planned care catchment whose closest hospital is not UCLH.
- For planned inpatient care (GOSH), we looked at where people currently live and identified people in the planned care catchment whose closest hospital is not GOSH.
- The potentially impacted populations for the proposed service change for planned care is defined as the LSOAs in NCL minus the current catchment area either UCLH (day case) or GOSH (planned inpatient care)
- For the potentially impacted populations, we looked at what the travel time would likely be to UCLH (day case) or UCLH (planned inpatient care) and assessed what the travel impact would be for off-peak driving time (car, taxi and ambulance), peak driving time (car and taxi) and public transport

Currently: where people go now (the closest)



Future: Flow if site A no longer delivered the required planned care



# 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 very 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 was also used as a proxy for ambulance 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**

# Potential impact of proposals on accessibility for planned care



# Summary: potential impact of the proposals on accessibility for planned care (1/2)

- **Engagement** was undertaken to identify the potential impact of the proposals on access for planned care
- 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 for the day case catchment population of UCLH is an **increase in average travel times** for peak, off-peak and public transport of:
  - 27 minutes at peak driving time
  - 24 minutes at off-peak driving time
  - 13 minutes by public transport
- There may also be an **average increase in taxi costs of £22** and a **maximum increase of £40** for the day case catchment population of UCLH
- A potential impact of the proposals for the planned inpatient care catchment population of GOSH is an **increase in average travel times** for peak, off-peak and public transport for:
  - 31 minutes at peak driving time
  - 24 minutes at off-peak driving time
  - 18 minutes for public transport
- There may also be an **average increase in taxi costs of £22** and a **maximum increase of £40**
- Engagement found people may have **issues with increased travel times**, but it was important to receive **treatment from experienced staff**

## Summary: potential impact of the proposals on accessibility for planned care (2/2)

- There is a small number of **car parking spaces** available at UCLH (day cases) and no car parking spaces available at GOSH (planned inpatient care)
- **Public transport accessibility** is similar at UCLH (day cases) and GOSH (planned inpatient care). People have better public transport accessibility closer to the centre of London.
- **Average additional driving costs would be around £2 per journey for both GOSH (planned inpatient care) and UCLH (day cases)**. The largest increase (~£3) in driving costs would be for people living furthest away from the Centres of expertise
- There would be **average additional taxi cost of around £22** per journey for both centres of expertise. People furthest away from GOSH and UCLH may have to pay an additional £56.
- There is a **similar, high, level of digital access** within the catchment population for planned care
- People have similar **access to cars**, with over 50% of the catchment for planned care having access to a car. Car ownership varies, with people with disabilities substantially less likely to own cars.
- Engagement found people may have **issues with travel times**, but it was important to receive **treatment from experienced staff**

# Engagement was undertaken to identify the potential impact of our proposals on access to planned care

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.

**1**  
**Digital access**

Poor digital access might create barriers for accessing care if people cannot access equipment or data

**2**  
**Public transport accessibility**

Lack of public transport accessibility may make it difficult for people without access to a car to access services

**3**  
**Car ownership**

Lack of car access may mean people find it difficult to access services, particularly if public transport is not good

**4**  
**Parking spaces**

Lack of parking might make accessing sites difficult, particularly for vulnerable populations (such as the disabled)

**1**  
**Public transport travel time**

Additional public time to travel to sites can be difficult and might dissuade people who rely on public transport

**2**  
**Peak travel time**

Additional time to travel to sites can be difficult for people and might dissuade them from attending

**3**  
**Off-peak travel time**

Additional time to travel to sites can be difficult for people and might dissuade them from attending

**4**  
**Taxi costs**

People without access to a car may need to catch a taxi and high taxi costs may be unaffordable

**5**  
**Driving costs**

Long / expensive journeys might place financial strain on some households

# A potential impact of the proposals is an increase in average travel times and taxi costs

## Catchment population

*Access statistics for catchment population*

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>Day case: UCLH</b>	95.8%	14.88	55.9%	105
<b>GOSH: planned inpatient</b>	95.8%	12.95	58.0%	0

## Impact on catchment population

*Average impact across catchment population*

Centre of expertise		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>Day case: UCLH</b>	<i>Current</i>	22.85	15.64	12.86	£13.55	£1.27
	<i>Future</i>	+12.7	+26.88	+23.99	+£22.13	+£2.10
<b>GOSH: planned inpatient</b>	<i>Current</i>	22.90	15.74	12.85	£13.85	£1.30
	<i>Future</i>	+17.67	+30.80	+23.71	+£22.08	+£2.08

## Impact of the proposals compared to now

- A potential impact of the proposals is to increase average travel time by car/taxi by 27 mins (peak), by 24 minutes (off-peak) and by public transport by 13 mins for day case at UCLH
- A potential impact of the proposals is to increase average travel time by car/taxi by 31 mins (peak), by 24 minutes (off-peak) and by public transport by 18 mins for planned inpatient care at GOSH
- A potential impact would be an increase in average taxi costs of around £22 for both day case and planned inpatient care

# There would be an increase in average travel times for peak, off-peak and public transport for planned care

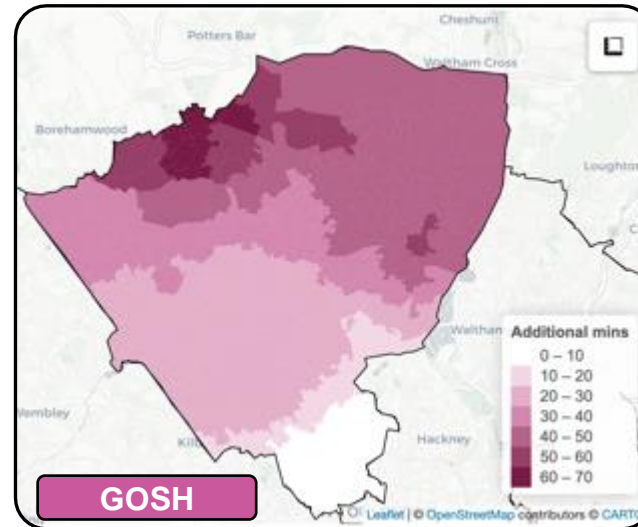
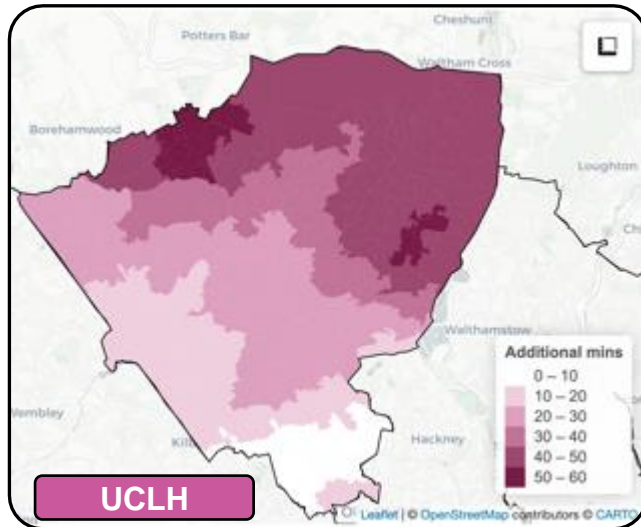
High
  Mid
  Low

Centre of expertise	Transport method	Average travel time to current closest unit (mins)	Average travel time to centre of expertise (mins)	Difference for average (mins)	Maximum travel time to current closest unit (mins)	Maximum travel time to centre of expertise (mins)	Difference for maximum (mins)
Day case: UCLH	Off-peak	12.86	36.85	23.99	28.9	59.6	30.7
	Peak	15.64	42.52	26.88	29.9	78.5	48.6
	Public transport	22.85	35.50	12.65	48.4	61.3	12.9
GOSH: planned inpatient	Off-peak	12.85	36.56	23.71	28.9	62.4	33.5
	Peak	15.74	46.54	30.80	29.9	79.3	49.4
	Public transport	22.90	40.57	17.67	48.4	66.4	18.0

# The average travel time to both UCLH and GOSH would increase by around 30 minutes during peak travel times

## Additional travel time

Additional travel time (mins) for peak driving per centre of expertise



## Additional travel time

Average & max time (mins): peak driving

	Day case: UCLH	Planned inpatient: GOSH
Current average travel time (min)	15.64	15.74
Average travel time after proposed changes (min)	42.52	46.54
Difference in average travel time (min)	26.88	30.80
Current maximum travel time (min)	29.9	29.9
Maximum travel time after proposed changes (min)	78.5	79.3
Difference in maximum travel time (min)	48.6	49.4



## There is limited car parking at GOSH and UCLH

### Available parking spaces per provider site

*Total available parking spaces by centre of expertise*

Centre of expertise	Total parking spaces
Day case: <i>UCLH</i>	105
Planned inpatient: <i>GOSH</i>	0

### Available parking spaces per option

*Available parking spaces by centre of expertise*

Centre of expertise	Total parking spaces
Day case: <i>UCLH</i>	105
Planned inpatient: <i>GOSH</i>	0

- *This data includes the total parking spaces available across all sites*
- *Despite GOSH not having any specific on-site parking, they do offer permits in partnership with Camden council for families to park*



# Public transport accessibility is similar at UCLH and GOSH

## Public transport accessibility

*Mean public transport accessibility within catchment area*

Centre of expertise	Public transport accessibility
UCLH (day case)	14.88
GOSH (emergency & inpatient)	12.95

The catchment population for each centre of expertise has a similar public transport accessibility, with UCLH being slightly better connected due to the location of mainline stations 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 adequately captured. A 45-minute regular bus journey is very different from an irregular 30-minute bus journey from a bus stop.

For that, the analysis used the **2015 PTAL** (Public Transport Accessibility Levels) score in order to gain an idea. Ranked from 0 to 100 (**where 0 is the worst and 100 is the best**) it measures:

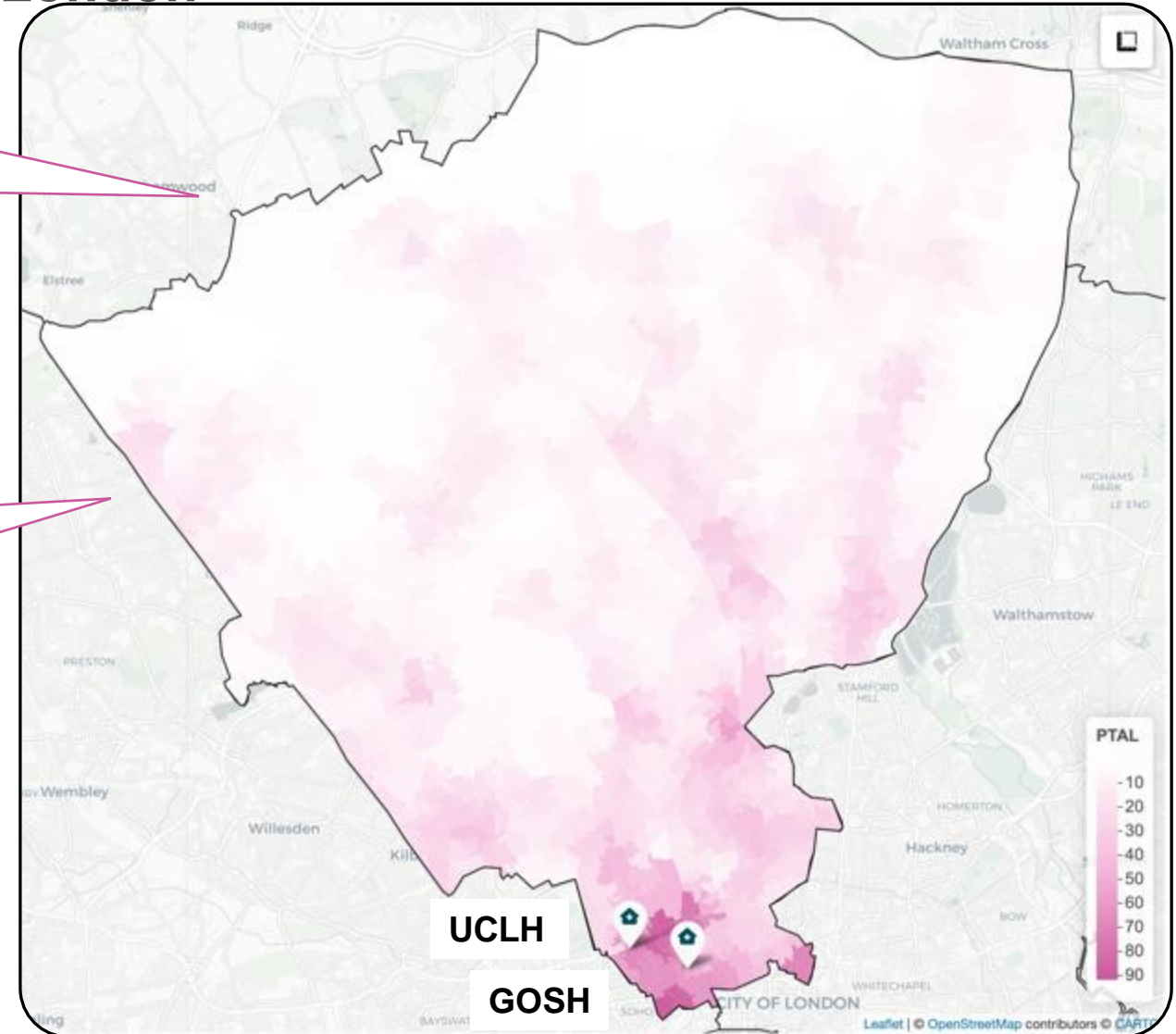
- Walking time from the point-of interest to the public transport access points;
- The reliability of the service modes available;
- The number of services available within the catchment; and
- The level of service at the public transport access points

The analysis then examined how **well-connected the catchment areas are**, providing an overview of an additional layer of potential impact on patients in each options.

# 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 to UCLH and GOSH would be around £2 per journey

### Driving costs

Additional driving costs (£) for each centre of expertise

Centre of expertise	Average additional cost per journey (£)
Day case: UCLH	£2.10
Planned inpatient: GOSH	£2.08

### 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 for each catchment population**.
- The result is the **average additional cost of driving (£) per LSOA**.
- There is a further potential impact related to the **congestion charge if parents and carers do drive to GOSH** which is within the congestion charge zone. The cost of entering the congestion zone is £15 per day.
- Driving costs may also be impacted by the **ULEZ charge** which is £12.50 per day
- **However, the impact would be minimal due to the low volume of activity** that is moving to GOSH and will only impact on those currently living outside the congestion charge zone

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

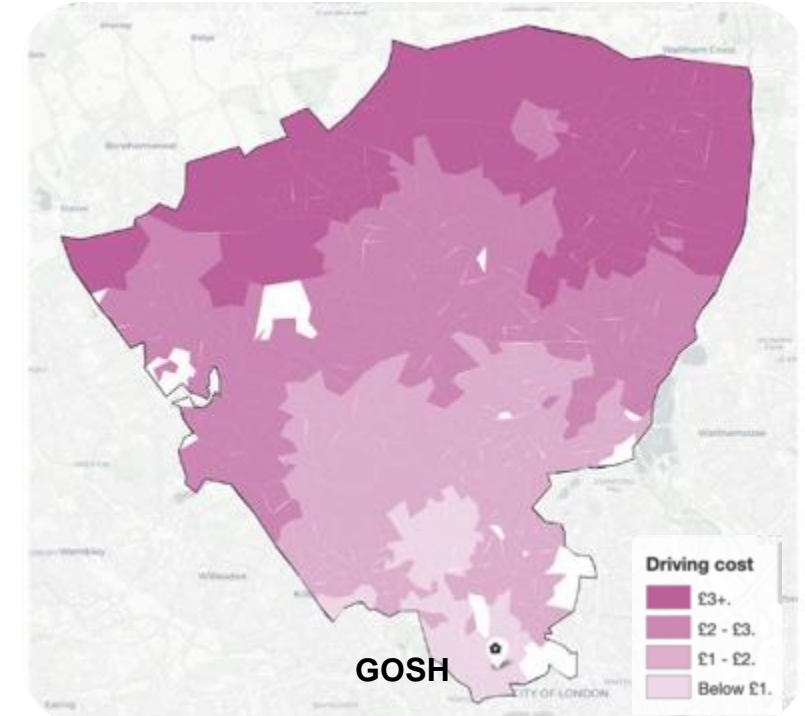
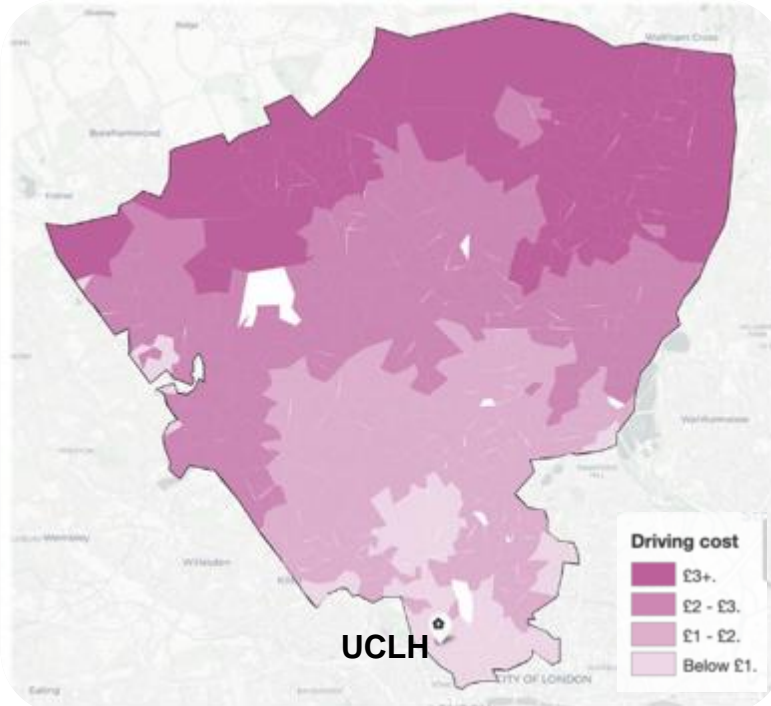


Average additional  
distance of travel  
(mile)

## The largest increase (~£3) in driving costs would be for people living furthest from the centres of expertise

### Driving costs

*Driving cost (£) per centre of expertise*



- For both centres of expertise, there may be a small increase in driving costs, both being around a £2 increase per average journey
- GOSH is located within the congestion zone and therefore for some families travelling from outside the congestion zone to GOSH, additional costs would be required. The number of families potentially impacted by this would be very small, however these additional costs should be considered, particularly for people who have vulnerabilities.



## There would be average additional taxi cost of around £22 per journey for both centres of expertise

### Taxi costs

Additional taxi costs (£) for each centre of expertise

Centre of expertise	Average additional cost (£)
Day case: UCLH	£22.13
Planned inpatient: GOSH	£22.08

### 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 for each catchment population**.

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  
running a taxi per mile  
(£5 per mile)

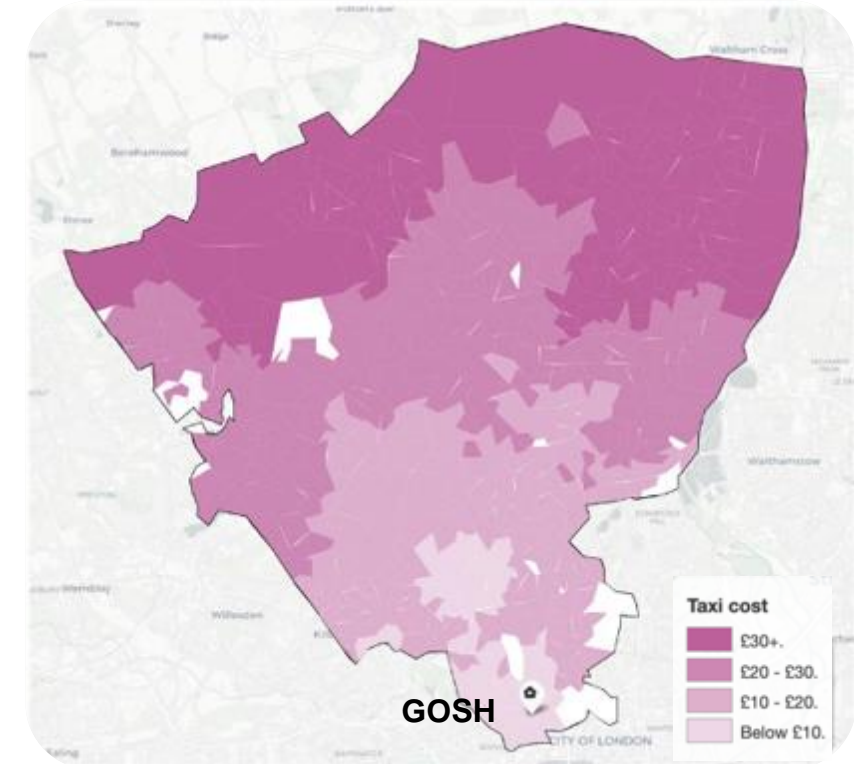
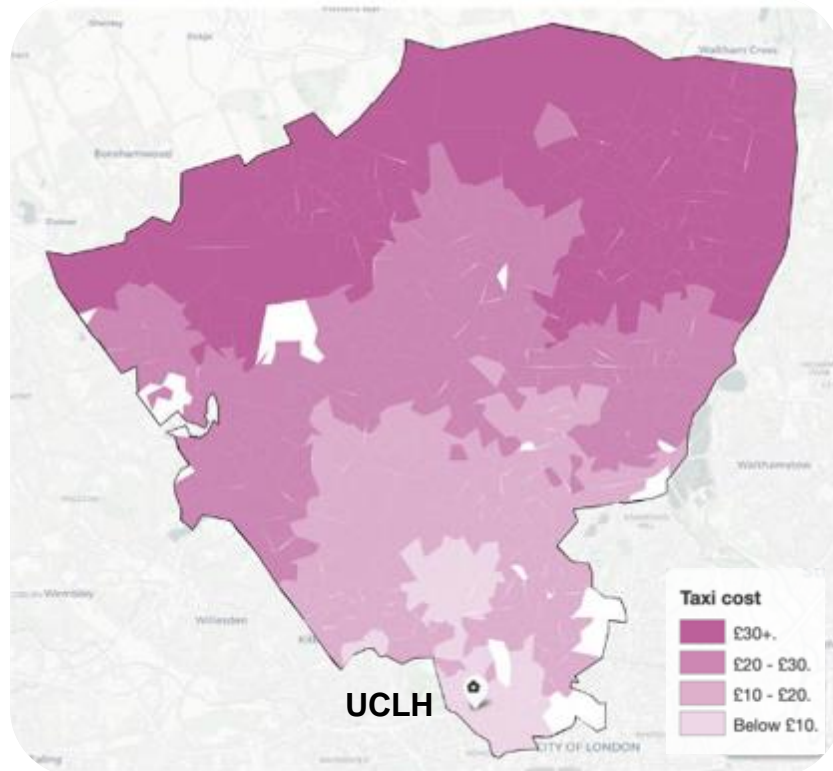


Average additional  
distance of travel (mile)





## People furthest away from the Centres of expertise may need to pay up to an additional £40 per taxi journey



- The average increase in taxi costs is:
  - **Day case (UCLH):** £22.13
  - **Planned inpatient (GOSH):** £22.08
- People furthest away from the Centre of expertise may need to pay up to an additional £40 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 planned care

### Digital access

Mean digital propensity scores for each centre of expertise

Centre of expertise	DPI of impacted population
<b>Day case: UCLH</b>	95.8%
<b>Planned inpatient : GOSH</b>	95.8%

### 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 impacted 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, with over 50% of the catchment for planned care having access to a car

### Car ownership

Mean rates (%) of car access per impacted LSOA (2023)

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### Car ownership

Centre of expertise	Car access rates (%)
<b>Day case: UCLH</b>	55.9%
<b>Planned inpatient: GOSH</b>	58.0%

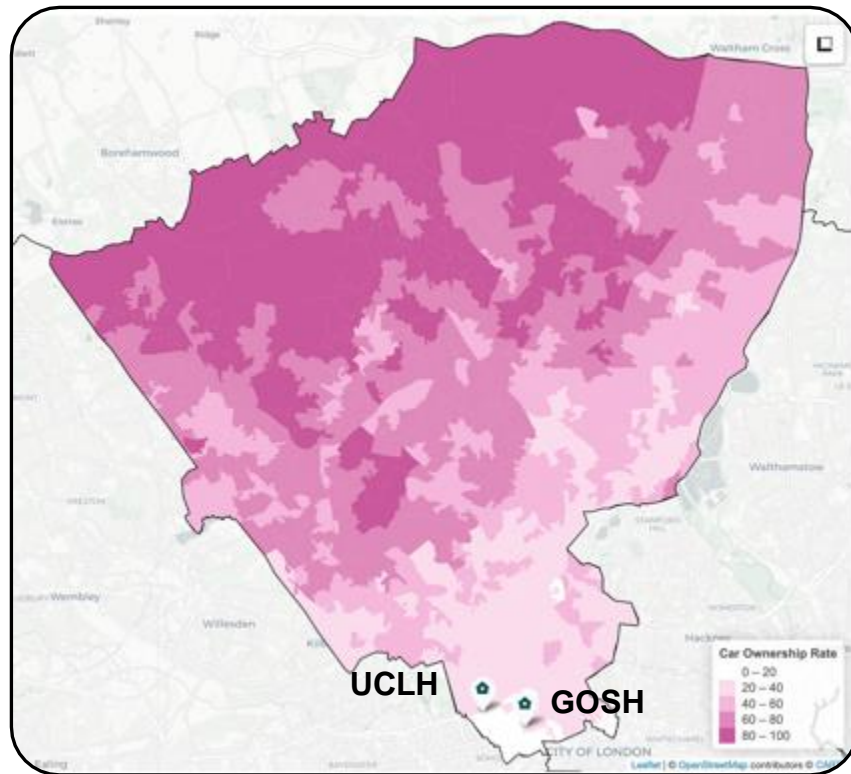
The ONS measures rates of vehicle access (defined as any household that owns any number of vehicles) per LSOA, with estimates taken from the 2021 census.

*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, it does not take into account a household with only one car and a person who uses it for work in terms of access to healthcare during working hours.*

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

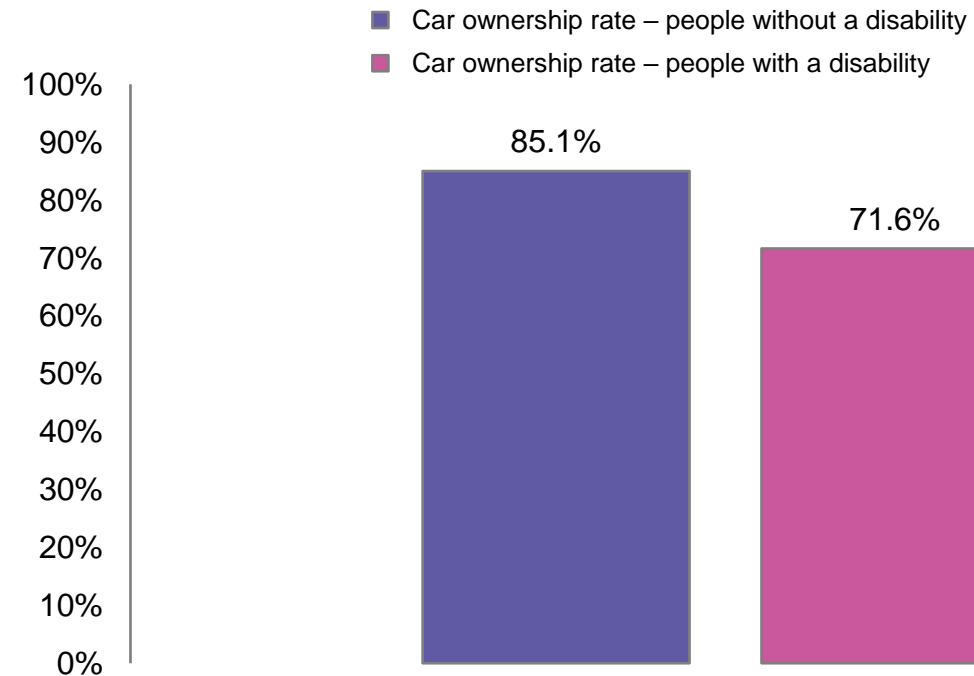
## Car ownership

Car ownership rate (2021) by LSOA



## Car ownership (people with disabilities)

Car ownership rates (2021) for people with disabilities under equality act



# Engagement found people may have issues with travel times, but it was important to receive treatment from experienced staff

## Getting to and leaving hospital

- Generally, people felt it is important that a child or young person receives treatment from experienced specialists who routinely undertake operations, even if this requires them to be transferred to a different hospital site
- There was some concern around transfer time between providers, should a child require time critical intervention
- Continuity of care is important and having to travel to the centre of expertise for pre and post operative care could be difficult
- People felt that journeys could be more complicated (for example with multiple changes or modes of travel) with an impact on those who may travel with a buggy or who have other children
- Change could result in travel times being longer and journeys more expensive – this may be difficult for certain groups to manage and afford and make it difficult for families to visit
- On discharge following an operation or anaesthetic, it is likely a private transport or a taxi as would be required potentially increasing cost

## Access to services

- Ensuring the wider needs of children can be met at the centre of expertise – such as those with learning disabilities, mental health conditions is important and the wider support structures need to be in place
- Those who have additional needs such as physical and learning disabilities should be considered
- Concerns raised that waiting times could be longer if everyone is treated in one location
- There needs to be clear post-discharge guidance about where to get help should it be needed

Engagement on the paediatric surgery proposals was undertaken with 80 people during 2023

# **Potential impact of proposals for planned care on protected characteristics and people with vulnerabilities**

# Summary: potential impact of the proposals for planned care on protected characteristics and people with vulnerabilities (1/3)

- We undertook analysis with quantitative data, where available, alongside engagement and qualitative assessment to understand the potential impact on the planned care catchment population:
  - People **living in areas of deprivation** are concentrated in the eastern and western parts of the planned care catchment. The biggest concentration of deprived populations are situated to the north-east of the planned care catchment, close to North Mid
  - The largest concentration of **economically inactive people** in the planned care catchment is around the north-east
  - The largest proportion of **people from ethnic minority groups** in the planned care catchment are situated towards the north-east of the planned care catchment
  - The largest concentration of people with **poor English proficiency (including literacy)** is in the east of the planned care catchment, close to North Mid
  - People with **poor health** are concentrated in the north and west of the planned care catchment
  - The populations with the largest number of **single parent households** are concentrated around the north-east of the planned care catchment, around the North Mid
  - The largest concentration of **people with disabilities** is between the Royal Free Hospital and the Whittington Hospital, with an above-average concentration of disabled people around the Whittington Hospital
- See slide 117 – 121 for information on the potentially impacted population for emergency care

# Summary: potential impact of the proposals for planned care on protected characteristics and people with vulnerabilities (2/3)

The potential impact of our proposals for planned care on people with protected characteristics and people who have vulnerabilities has been reviewed

## UCLH: day cases

- **Race:** there is an average increase in taxi costs of almost £23 for people from ethnic minority groups
- **Not proficient in English:** there is an average increase in taxi costs of around £22 for people not proficient in English (including literacy)
- **Children and young people (and parents and carers) with disabilities:** there is an average increase in taxi costs of almost £20 for disabled populations, whose parents/carer have lower car access. Children and young people (and parents and carers) with disabilities may need additional support to access care where service location changes.
- **Children and young people living in areas of deprivation:** the main impact on access for people living in areas of deprivation, people who are economically inactive and people with poor health is an average increase in taxi costs of between £19 - £22 with lower car ownership for the parents and carers. There are barriers for cost of transport and digital exclusion.
- **Other inclusion health groups:** groups such as homelessness and children from single parent households have been considered. There is an average increase in taxi costs of almost £20 for single parent households. There may be barriers for cost of transport, digital exclusion and language for the parents and carer for these groups.

## GOSH: planned inpatient care (continues overleaf)

- **Race:** there is an average increase in taxi costs of almost £23 for people from ethnic minority groups. Barriers identified for people from ethnic minority groups include language and cultural barriers.
- **Not proficient in English:** there is an average increase in taxi costs of almost £23 for people not proficient in English (including literacy)



# Summary: potential impact of the proposals for planned care on protected characteristics and people with vulnerabilities (3/3)

## GOSH: planned inpatient care (continued)

- **Children and young people (and parents and carers) with disabilities:** there is an average increase in taxi costs of almost £20 for disabled populations. Children and young people (and parents and carers) with disabilities may need additional support to access care where service location changes.
- **Children and young people living in areas of deprivation:** the main impact on access for people living in deprived areas is an average increase cost of almost £20. For economically inactive and poor general health there is an average increase in taxi costs of around £21. For parents and carers living in deprived areas there are barriers for cost of transport and digital exclusion.
- **Other inclusion groups:** groups such as homelessness and children from single parent households have been considered (slide 80). There is an average increase in taxi costs of almost £23 for single carers. There may be barriers for cost of transport, digital exclusion and language for the parents and carer for these groups.

## Other children and young people with vulnerabilities

- There are fewer than 2,000 looked after children in NCL and the new care model will have positive impacts
- Inclusion health groups such as homeless, refugees, domestic abuse and travellers may need support to access services that move further away
- Children who have special educational needs and disabilities may need support to access services where there is a change in location or long journey

# 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 data available, we used this to review the impact on groups with protected characteristics and people who have vulnerabilities (there may be some overlap between the groups, for example, people who have poor English proficiency (including literacy) are likely to overlap with people from ethnic minority groups, and we have assessed where this may be the case.) We have also used engagement and qualitative assessment.
- Due to the nature of the proposed service changes some of the protected characteristics are not relevant for the impacted populations and are therefore not being assessed further. See slide 80 for further detail.
- There is an impact on some groups that would need to be mitigated because of the proposals for planned care

# Seven populations were analysed with quantitative data, alongside engagement and qualitative assessment

Seven populations were analysed using quantitative data alongside stakeholder engagement to assess whether they may be impacted by the proposals

**1 Children and young people living in areas of deprivation**

Deprived children and young people have worse outcomes. They also face barriers to accessing healthcare (e.g. due to cost of travel)

**5 Children and young people with poor health**

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

**2 Children and young people from economically inactive households**

Children and young people in economically inactive households may face barriers to accessing healthcare (e.g. due to cost of travel)

**6 Children and young people with disabilities**

Disabled populations may have difficulty in accessing services and sites. They may have health conditions that increase their complexity when receiving care

**3 Children and young people from ethnic minority groups**

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

**7 Children and young people from single parent household**

Children and young people from single-parent households might find accessing healthcare difficult due to childcare requirements for their siblings

**4 Children and young people in families not proficient in English (including literacy)**

Children and young people in families who are not proficient in English may have difficulty travelling to, and accessing health services



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

Impact	Children and young people living in areas of deprivation	Children and young people form economically inactive households	Children and young people from ethnic minority groups	Children and young people with poor English proficiency (including literacy)	Children and young people with poor health	Children and young people with disabilities	Children from single parent household
Day case: UCLH	53.7%	19.5%	31.4%	4.7%	4.8%	14.1%	14.2%
Planned inpatient: GOSH	54.0%	19.5%	32.8%	4.8%	4.7%	13.9%	14.3%

- These seven demographic metrics are intended to provide an overview of the characteristics of the impacted population for each catchment population to better understand the populations the analysis is working with
- There are 1.37m potentially impacted individuals (total population) in the day case catchment area
- There are 1.49m potentially impacted individuals (total population) in the planned inpatient catchment area

# There is an impact on some groups that would need to be mitigated because of the proposals for planned care

		Potential impacts of the proposals for planned care that may require mitigations
Protected characteristic	Race	<ul style="list-style-type: none"> <li>Language barriers may need to be addressed if people not proficient in English need to access an unfamiliar unit</li> </ul>
	Age	<ul style="list-style-type: none"> <li>Age is not relevant because the impacted population are all young children</li> </ul>
	Sex	<ul style="list-style-type: none"> <li>Being male or female is not relevant for paediatric planned and emergency surgery</li> </ul>
	People with disabilities	<ul style="list-style-type: none"> <li>Support may be required for children and young people with a disability (including special educational needs and disabilities) who need to access services on an unfamiliar site or or undertake a long journey to access services</li> </ul>
	Being pregnant or on maternity leave	<ul style="list-style-type: none"> <li>The proposed changes for planned care impact very young children and therefore being pregnant is not relevant for these individuals</li> </ul>
	Gender reassignment	<ul style="list-style-type: none"> <li>The proposed changes for planned care impact very young children and therefore gender reassignment is not relevant for these individuals</li> </ul>
	Religion of belief	<ul style="list-style-type: none"> <li>Being of a certain religion is not relevant for planned paediatric surgery</li> </ul>
	Sexual orientation	<ul style="list-style-type: none"> <li>The proposed changes for planned care impact very young children and therefore sexual orientation is not relevant for these individuals</li> </ul>
	Being married or in a civil partnership	<ul style="list-style-type: none"> <li>Being married or in a civil partnership are not directly impacted by our proposals as children are unable to be married / enter civil partnerships, and there is no differential impact for parents who are or are not of this status</li> </ul>
Other	People living in areas of deprivation	<ul style="list-style-type: none"> <li>Potential overlap with race, other inclusion groups and disabilities</li> <li>The cost of travelling further, particularly by taxi, would need to be addressed</li> </ul>
	Other inclusion health groups	<ul style="list-style-type: none"> <li>Potential overlap with race, deprivation and disabilities</li> <li>Support may be required for single parent families who need childcare for other children whilst accessing care that is further away</li> <li>The cost of travelling further, particularly by taxi, would need to be addressed</li> </ul>

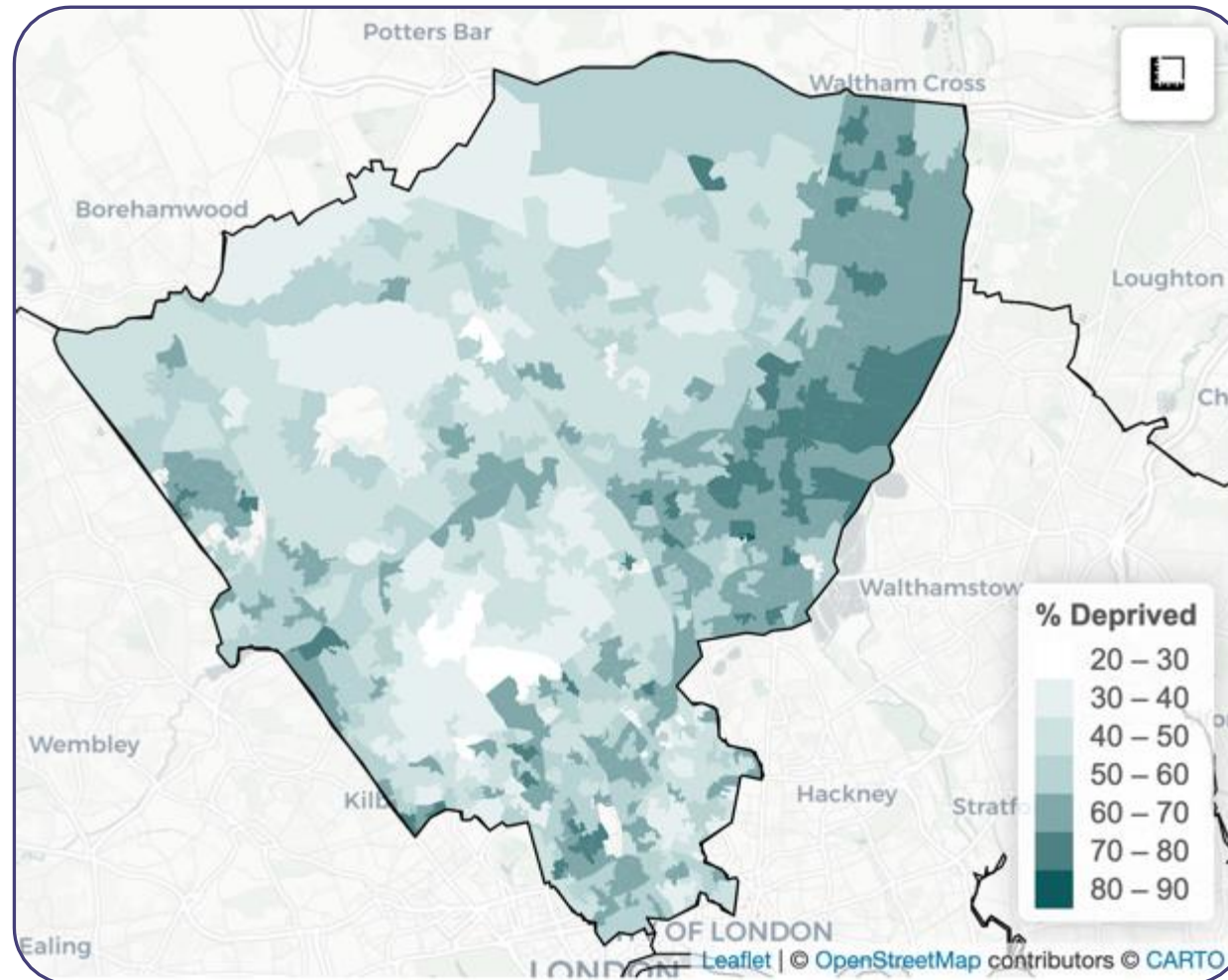
# Population demographics



# Demographics: Children and young people living in areas of deprivation

## Children and young people living in areas of deprivation

Rate (%) of IMD deprived population per LSOA



### Definition

Deprivation is defined as any population that is in the top four most deprived deciles in the Indices of Multiple Deprivation (IMD)

### Observations

People living in areas of deprivation are concentrated in the eastern and western parts of the planned care catchment. The biggest concentration of deprived populations are situated to the north-east of the planned care catchment, close to the North Mid. There are also pockets of deprivation in populations spread across the southern part of the catchment. The least deprived populations are around Hampstead and Highgate.

The most children and young people living in areas of deprivation in the catchment also tend to have the highest proportion of people from ethnic minority groups

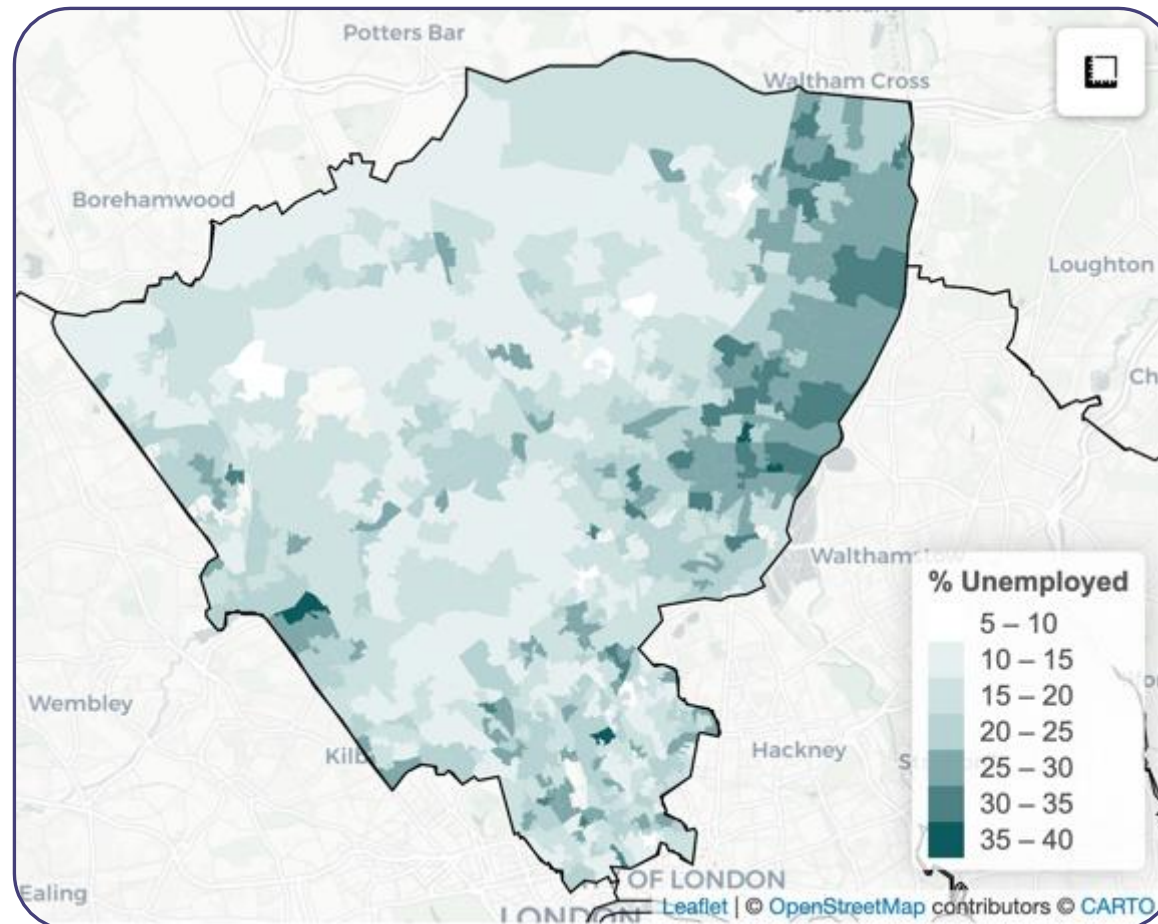




# Demographics: Children and young people from economically inactive households

## Children and young people from economically inactive households

Rate (%) of economically inactive population per LSOA



### Definition

Economically inactive is defined as people aged 16 years and over who did not have a job and had not looked for work in the preceding month or could not start work within two weeks.

### Observations

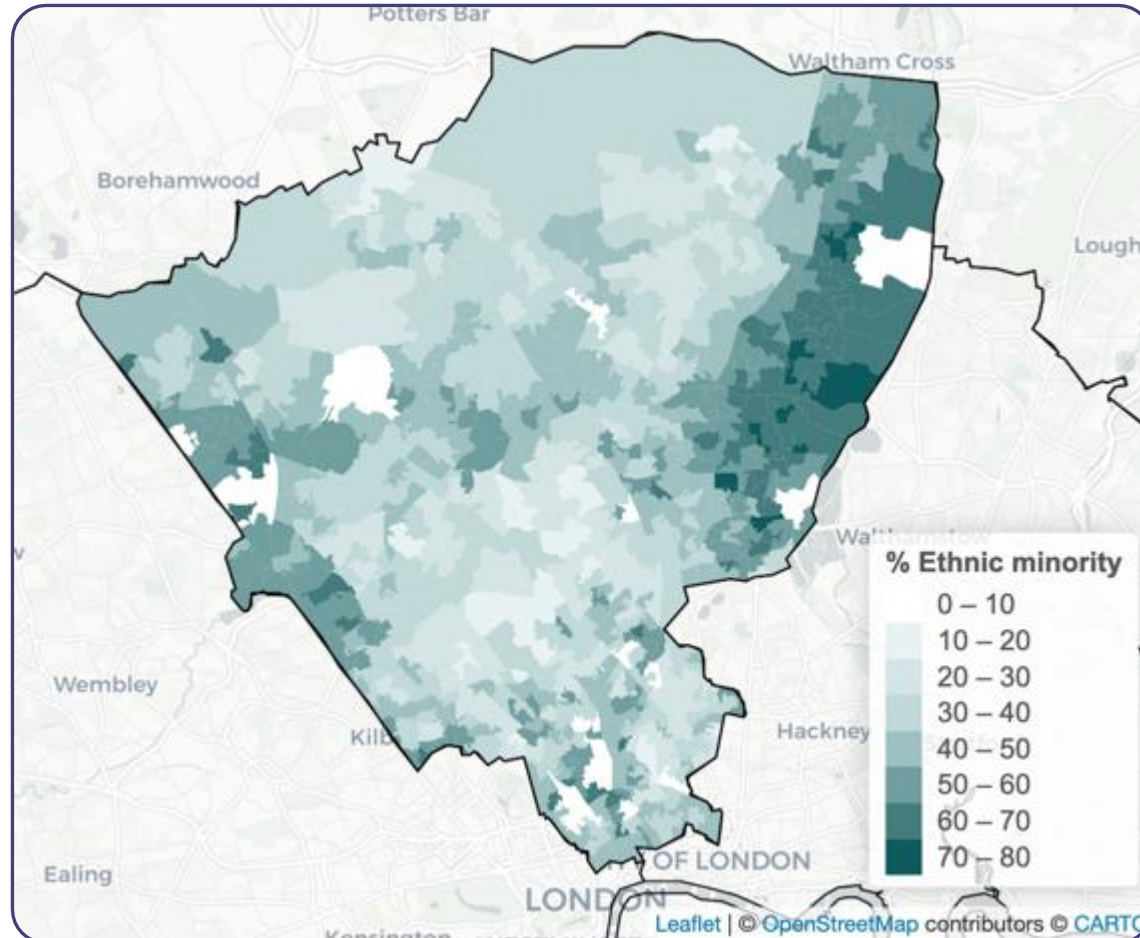
The largest concentration of economically inactive people in the planned care catchment is around the north-east

There are other areas of high levels of unemployment dotted across the catchment.

# Demographics: Children and young people from ethnic minority groups

## Children and young people from ethnic minority groups

Rate (%) of children and young people from ethnic minority groups per LSOA



### Definition

Ethnic minority refers to any individual except those who identify as white British

### Observations

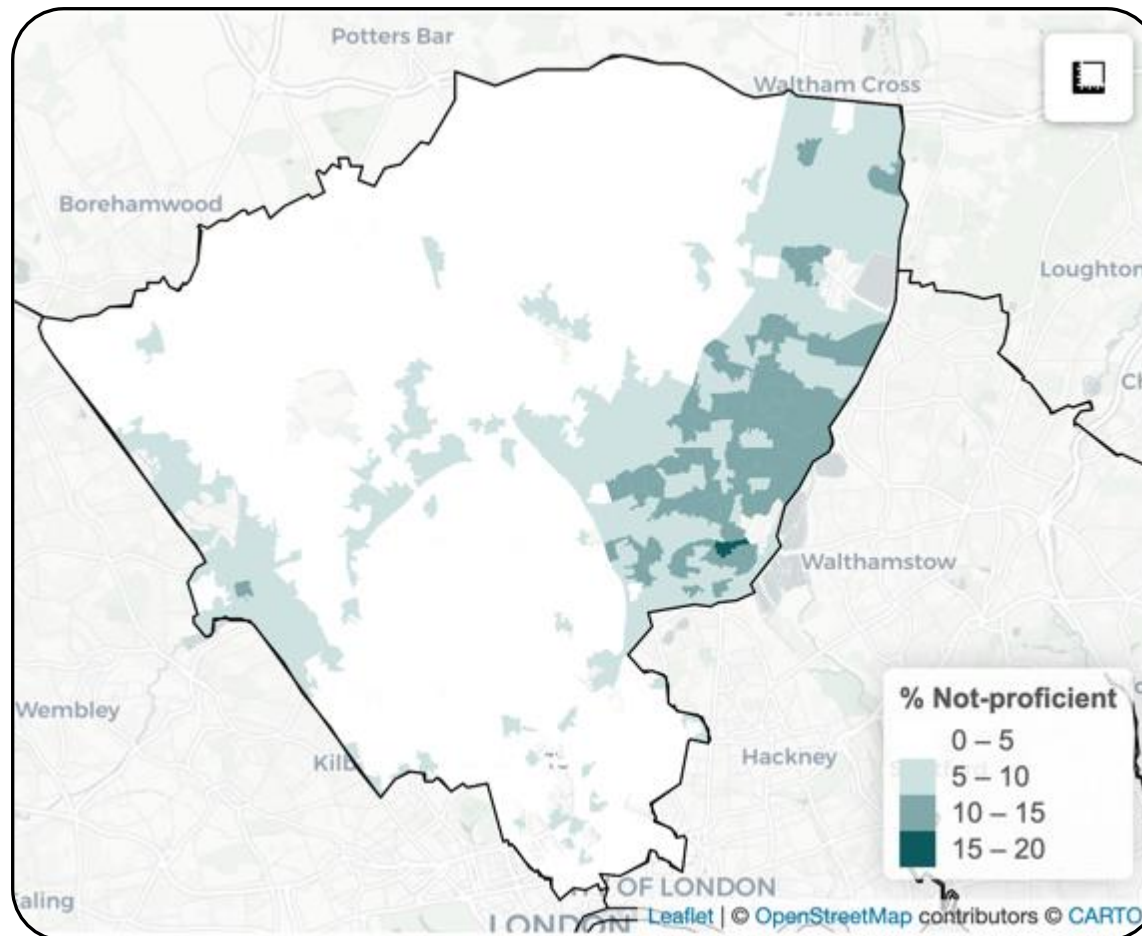
The largest proportion of ethnic minorities in the planned care catchment are situated towards the north-east of the planned care catchment

There are other areas that have high proportions of ethnic minority residents dotted across the catchment

# Demographics: Children and young people from households not proficient in English

## Children and young people from households not proficient in English

Rate (%) of population not proficient in English per LSOA



### Definition

English proficiency is defined as the ability of an individual to speak English when their main language is not English. This metric measures the proportion of individuals in an LSOA that have poor or no English proficiency.

### Observations

The largest concentration of families with poor English proficiency (including literacy) is in the east of the planned care catchment, close to the North Middlesex hospital

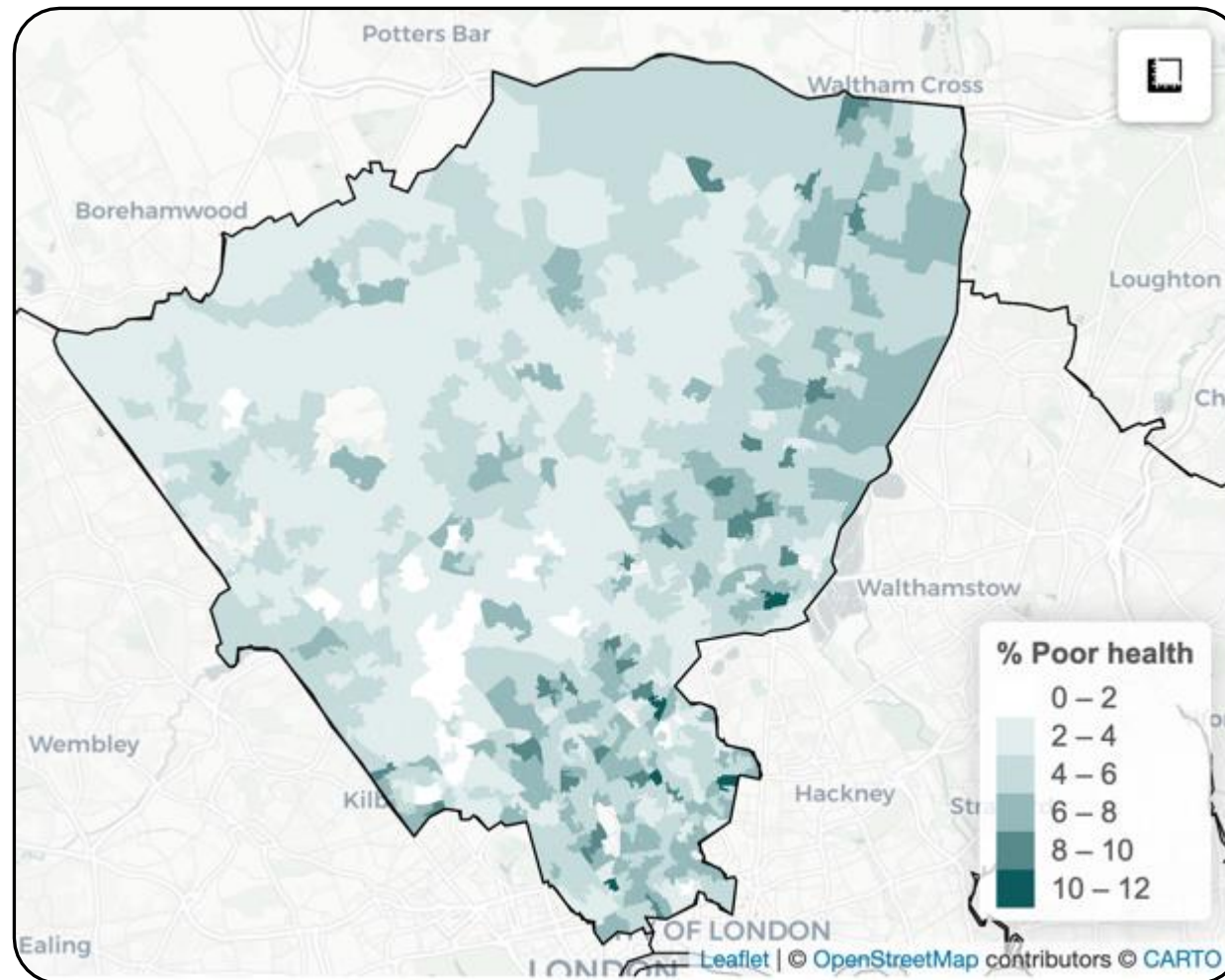
There is also a population to the west of the catchment with a slightly higher proportion of residents who are not proficient in English



# Demographics: Children and young people with poor health

## Children and young people with poor health

*Rate (%) of population with children and young people with poor health per LSOA*



### Definition

This metric examines the proportion of the population in any LSOA that self-reports “Bad” or “Very Bad” general health

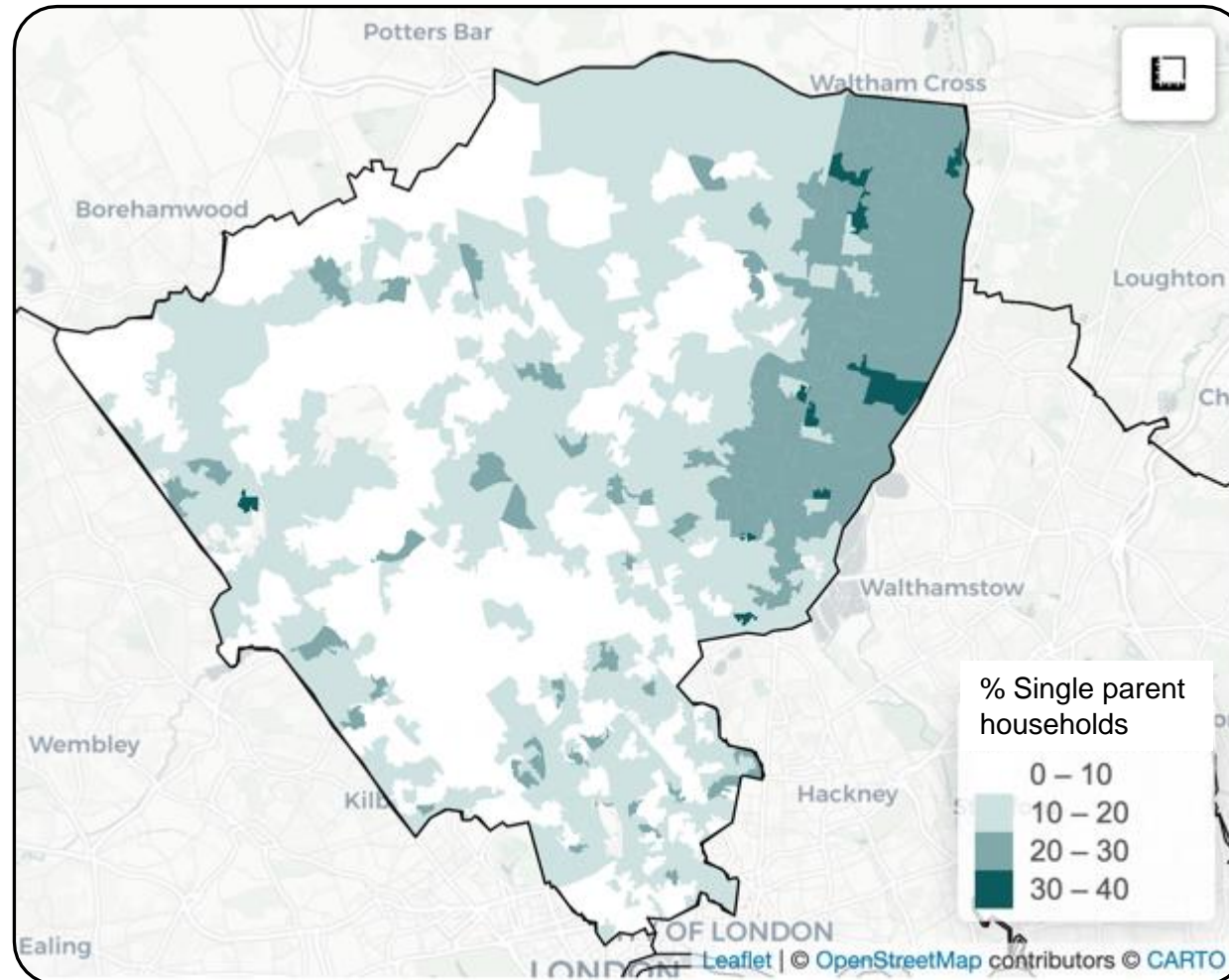
### Observations

People with poor general health are concentrated in the north and west of the planned care catchment

The populations with the lowest proportion of residents with poor health are mostly in the north and west of the patch

# Demographics: Children and young people from single parent household

**Population of children and young people from single parent household**  
*Rate (%) of children from single parent households*



## Definition

The proportion of single parents in an LSOA is defined as the proportion of households where a single parent lives with a dependent or non-dependent child

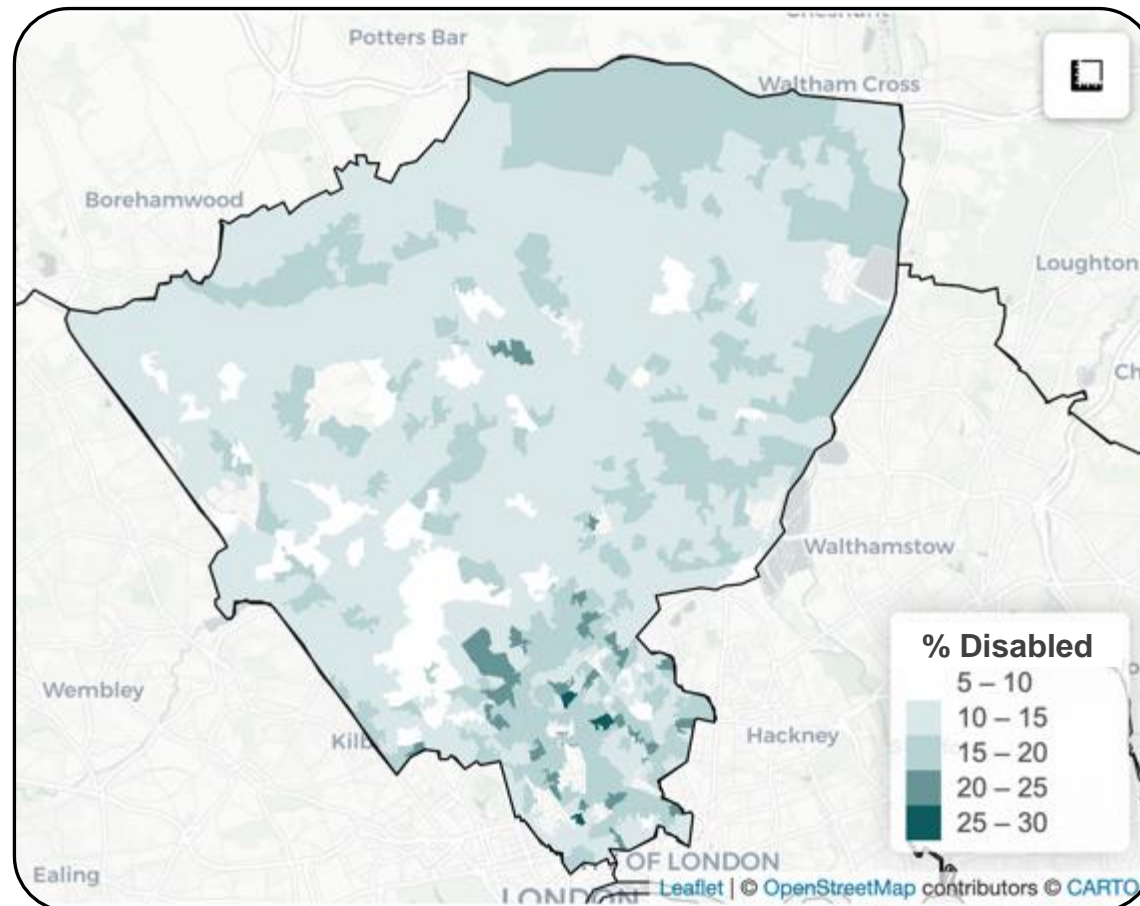
## Observations

The populations with the largest number of single parent households are concentrated around the north-east of the planned care catchment, around the North Mid

# Demographics: Children and young people with disabilities

## Children and young people with disabilities

Rate (%) of children and young people with disabilities per LSOA



### Definition

People who assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses were considered disabled by ONS. This is in line with the Government Statistical Service harmonised standard for measuring disability. This is also aligned with the Equality Act (2010), which requires that a person has a physical or mental impairment, and that the impairment has a substantial and long-term adverse impact on a person's ability to carry out day-to-day activities.

### Observations

The largest concentration of children and young people with disabilities is between the Royal Free hospital and the Whittington hospital, with an above-average concentration of disabled people around the Whittington

Otherwise, the number of children and young people with disabilities is relatively evenly distributed

# Centre of expertise: day case at UCLH



## There would be an average increase in car/taxi travel times of 29 mins for children and young people from ethnic minorities for day cases

### Children and young people from ethnic minority groups

#### Access statistics

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>UCLH</b>	95.8%	14.99	54.8%	105

### Impact on children and young people from ethnic minority groups

#### Average impact

Centre of expertise		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>UCLH</b>	Current	22.47	15.51	12.48	£13.65	£1.28
	Future	+12.63	+29.09	+19.59	+£23.09	+£2.17

### Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi (peak) by 29 minutes, by 20 minutes (off-peak) and by public transport by 12 minutes for children from ethnic minorities for day cases
- There would be an average increase in taxi costs of around £23 for day cases, with car ownership being slightly lower than for the day case catchment population (55.9%)
- Public transport accessibility is slightly higher for children and young people from ethnic minorities than for the day case catchment population (14.88)

## There would be an average increase in car/taxi travel time of 30 mins for people with poor English proficiency for day cases

### Children and young people from households not proficient in English (including literacy)

#### Access statistics

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>UCLH</b>	95.8%	15.18	52.6%	105

### Children and young people from households not proficient in English (including literacy)

#### Average impact

Centre of expertise		Public transport travel times	Peak car/taxi travel times	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>UCLH</b>	Current	23.15	16.19	12.80	£13.46	£1.27
	Future	+12.19	+29.85	+21.56	+£22.90	+£2.15

### Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi (peak) by 29 minutes, by 22 minutes (off-peak) and by public transport by 12 minutes for day cases
- There would be an average increase in taxi costs of almost £23 for day cases, and car ownership for populations not proficient in English (52.6%) is lower than for the day case catchment population (55.9%)
- Public transport accessibility is slightly higher for those not proficient in English than for the day case catchment population (14.88)
- Language barriers may need to be addressed if people not proficient in English need to access an unfamiliar unit



# People with disabilities would have an average increase in travel time by car/taxi of 25 minutes for day cases

## Children and young people with disabilities

### Access statistics

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>UCLH</b>	95.7%	16.18	52.5%	105

## Impact on children and young people with disabilities

### Average impact

Centre of expertise		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>UCLH</b>	Current	21.83	15.36	12.73	£21.45	£1.17
	Future	+11.22	+25.82	+20.17	+£20.45	+£1.92

## Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time for children and young people (and parents and carers) with disabilities by car/taxi (peak) by over 25 minutes, by 20 minutes (off-peak) and by public transport by over 11 minutes for day cases
- There would be an increase in average taxi costs of around £20 for day cases, and car ownership is lower than for the general day case catchment population (55.9%)
- Public transport accessibility is higher for children and young people (and parents and carers) with disabilities than for the general day case catchment population (14.88)
- Support may be required for children and young people (and parents and carers) with a disability who need to access services on an unfamiliar site



## There would be an average increase in car/taxi travel times of 26 minutes for people with poor health for day cases

### Populations with poor health *Access statistics*

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>UCLH</b>	95.6%	16.47	51.3%	105

### Impact on people with poor health *Average impact*

Centre of expertise		Public transport travel times	Peak car/taxi travel times	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>UCLH</b>	<i>Current</i>	21.83	15.33	12.63	£12.33	£1.16
	<i>Future</i>	+11.19	+26.10	+20.14	+£20.53	+£1.93

### Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi (peak) by 26 minutes, by 20 minutes (off-peak) and by public transport by 11 minutes for day cases
- There would be an increase in average taxi costs by around £20 for day cases, with car ownership being lower than for the general day case catchment population (55.9%)
- Public transport accessibility is higher for people with poor general health than for the general day case catchment population (14.88)



## There would be an average increase in travel times by car/taxi of 27 minutes for children and young people from economically inactive households for day cases

### Children and young people from economically inactive households

#### Access statistics

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>UCLH</b>	95.8%	15.72	52.6%	105

### Impact on children and young people from economically inactive households

#### Average impact

Centre of expertise		Public transport travel times	Peak car/taxi travel times	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>UCLH</b>	Current	22.32	15.61	12.67	£12.72	£1.20
	Future	+11.44	+26.95	+20.36	+£21.17	+£1.99

### Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi (peak) by 26 minutes, by 20 minutes (off-peak) and by public transport by 11 minutes for children and young people whose parents/carers are economically inactive for day cases
- There would be an increase in average taxi costs by around £21 for day cases which may cause financial hardship, and car ownership is lower than for the general day case catchment population (55.9%)
- Public transport accessibility is slightly higher for children and young people whose families are economically inactive compared to the general day case catchment population (14.88)



## There would be an average increase in car/taxi travel times of 27 minutes for people living in areas of deprivation for day cases

### Children and young people living in areas of deprivation

#### Access statistics

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>UCLH</b>	95.8%	15.69	53.1%	105

### Impact on children and young people living in areas of deprivation

#### Average impact

Centre of expertise		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ambulance travel times (mins)	Taxi costs	Driving costs
<b>UCLH</b>	Current	22.34	15.65	12.82	£12.82	£1.20
	Future	+11.49	+26.90	+20.59	+£19.37	+£1.82

### Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi (peak) by 27 minutes, by 21 minutes (off-peak) and by public transport by over 11 minutes for day cases
- There would be an increase in average taxi costs of £19.37 per journey for day cases which may cause financial hardship and car ownership is lower than for the general day case catchment population (55.9%)
- Public transport accessibility is slightly higher for deprived populations (15.69) than for the general day case catchment population (14.88)

## There would be an average increase in car/taxi travel time of 29 minutes for children and young people from single parent households for day cases

### Children and young people from single parent household

#### Access statistics

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>UCLH</b>	95.7%	14.74	53.5%	105

### Impact on children and young people from single parent household

#### Average impact

Centre of expertise		Public transport travel times	Peak car/taxi travel times	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>UCLH</b>	Current	22.96	16.07	12.97	£13.20	£1.24
	Future	+11.98	+28.80	+21.73	+£20.07	+£1.89

### Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi by 28 minutes (peak), by 21 minutes (off-peak) and by public transport by 11 minutes for children that live in single parent households for day cases
- There would be an increase in average taxi costs of around £20 for day cases, and car ownership is lower than for the general day case catchment population (55.9%)
- Public transport accessibility is similar for children from single parent households than for the general day case catchment population (14.88)
- Support may be required for single parent families who need childcare for other children whilst accessing care that is further away



# Accessibility summary: potential impact of the proposals across the quantitative analysis (day case at UCLH)



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
UCLH	Catchment population	95.8%	14.88	+12.7	22.85	+26.88	15.64	+23.99	12.86	55.9%	+£22.13	£13.55	+£2.10	£1.27	105
	Children and young people living in areas of deprivation	95.8%	15.69	+11.49	22.34	+26.90	15.65	+20.59	12.82	53.1%	+£19.37	£12.82	+£1.82	£1.20	
	Children and young people with disabilities	95.7%	16.18	+11.22	21.83	+25.82	15.36	+20.17	12.73	52.5%	+£20.45	£21.45	+£1.92	£1.17	
	Children and young people from economically inactive households	95.8%	15.72	+11.44	22.32	+26.95	15.61	+20.36	12.67	52.6%	+£21.17	£12.72	+£1.99	£1.20	
	Children and young people from ethnic minority groups	95.8%	14.99	+12.63	22.47	+29.09	15.51	+19.59	12.48	54.8%	+£23.09	£13.65	+£2.17	£1.28	
	Children and young people in poor health	95.6%	16.47	+11.19	21.83	+26.10	15.33	+20.14	12.63	51.3%	+£20.53	£12.33	+£1.93	£1.16	
	Children from single parent households	95.7%	14.74	+11.98	22.96	+28.80	16.07	+21.73	12.97	53.5%	+£20.07	£13.20	+£1.89	£1.24	
	Children and young people with poor English proficiency	95.8%	15.18	+12.19	23.15	+29.85	16.19	+21.56	12.80	52.6%	+£22.90	£13.46	+£2.15	£1.27	

# Centre of expertise: planned inpatient at GOSH



## There would be an average increase in car/taxi travel times of 32 mins for children and young people from ethnic minority groups for planned inpatient care

### Children and young people from ethnic minority groups

#### Access statistics

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>GOSH</b>	95.8%	13.37	56.0%	0

### Impact on children and young people from ethnic minority groups

#### Average impact

Centre of expertise		Public transport travel times	Peak car/taxi travel times	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>GOSH</b>	Current	22.80	15.73	12.78	£13.97	£1.31
	Future	+18.14	+32.09	+22.37	+£22.98	+£2.16

### Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi (peak) by 32 minutes, by 22 minutes (off-peak) and by public transport by 18 minutes for children and young people of ethnic minorities for planned inpatient care
- There would be an increase in average taxi costs of almost £23 for planned inpatient care for the parents/carers of children and young people from these populations, with car ownership being lower than for the general planned inpatient catchment population (58%)
- Public transport accessibility is slightly higher for children and young people from ethnic minority groups than for the general planned inpatient catchment population (12.95)



## There would be an average increase in car/taxi travel time of 32 mins for people with poor English proficiency for planned inpatient care

### Children and young people from households not proficient in English (including literacy)

#### Access statistics

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>GOSH</b>	95.8%	13.95	53.8%	0

### Children and young people from households not proficient in English (including literacy)

#### Average impact

Centre of expertise		Public transport travel times	Peak car/taxi travel times	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>GOSH</b>	Current	23.41	16.29	12.79	£13.90	£1.31
	Future	+17.35	+32.21	+22.98	+£22.96	+£2.16

### Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi (peak) by 32 minutes, by 23 minutes (off-peak) and by public transport by 17 minutes for planned inpatient care
- There would be an increase in average taxi costs of almost £23 for planned inpatient care for parents/carers, and car ownership is lower than for the general planned inpatient care catchment population
- Public transport accessibility is slightly higher for those not proficient in English than for the general planned inpatient care catchment population
- Language barriers may need to be addressed if people not proficient in English need to access an unfamiliar unit

# People with disabilities would have an average increase in travel time by car/taxi of 30 minutes for planned inpatient care

## Children and young people with disabilities *Access statistics*

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>GOSH</b>	95.8%	14.01	54.9%	0

## Impact on children and young people with disabilities *Average impact*

Centre of expertise		Public transport travel times	Peak car/taxi travel times	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>GOSH</b>	Current	22.23	15.43	12.72	£26.47	£1.24
	Future	+17.16	+29.88	+21.92	+£20.42	+£1.92

## Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi (peak) by 30 minutes, by 22 minutes (off-peak) and by public transport by 18 minutes for children and young (and parents and carers) with disabilities for planned inpatient care
- There would be an increase in average taxi costs of around £20 for planned inpatient care, and car ownership for disabled populations is lower (54.9%) than for the general planned inpatient care catchment population (58.0%)
- Public accessibility is slightly higher for children and young people (and parents and carers) with disabilities (14.01) than for the general planned inpatient care catchment population (12.95)
- Support may be required for children and young people (and parents and carers) with a disability who need to access services on an unfamiliar site

## There would be an average increase in car/taxi travel times of 30 minutes for people with poor health for planned inpatient care

### Populations with poor health *Access statistics*

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>GOSH</b>	95.7%	14.11	53.8%	0

### Impact on people with poor health *Average impact*

Centre of expertise		Public transport travel times	Peak car/taxi travel times	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
		<b>GOSH</b>	Current	22.30	15.42	12.64
	Future	+17.17	+30.09	+21.74	+£20.64	+£1.94

### Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi (peak) by 30 minutes, by almost 22 minutes (off-peak) and by public transport by 17 minutes for planned inpatient care
- There would be an increase in average taxi costs of around £20 for planned inpatient care for parents/carers, and car ownership is lower than for the general planned inpatient care catchment population (58%)
- Public transport accessibility is higher for people with poor health than for the general planned inpatient care catchment population (12.95)

## There would be an average increase in travel times by car/taxi of 27 minutes children and young people from economically inactive households

### Children and young people from economically inactive households

#### Access statistics

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>GOSH</b>	95.8%	13.81	54.6%	0

### Impact on children and young people from economically inactive households

#### Average impact

Centre of expertise		Public transport travel times	Peak car/taxi travel times	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>GOSH</b>	Current	22.68	15.67	12.65	£13.43	£1.26
	Future	+17.29	+30.67	+22.06	+£21.12	+£1.99

### Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi (peak) by 31 minutes, by 22 minutes (off-peak) and by public transport by 17 minutes for planned inpatient care
- There would be an increase in average taxi costs of around £21 for planned inpatient care for the parents/carers which may cause financial hardship, and car ownership for economically inactive parents/carers is lower (54.6%) than for the general planned inpatient care catchment population (58%)
- Public accessibility is slightly higher for economically inactive populations (13.81) than for the general planned inpatient care catchment population (12.95)



## There would be an average increase in car/taxi travel times of 31 minutes for people living in areas of deprivation for planned inpatient care

### Children and young people living in areas of deprivation

#### Access statistics

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>GOSH</b>	95.8%	13.87	58.0%	0

### Impact on children and young people living in areas of deprivation

#### Average impact

Centre of expertise		Public transport travel times	Peak car/taxi travel times	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>GOSH</b>	Current	22.69	15.72	12.78	£13.49	£1.27
	Future	+17.25	+30.40	+22.37	+£19.64	+£1.85

### Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi (peak) by 30 minutes, by 22 minutes (off-peak) and by public transport by around 17 minutes for deprived children and young people for planned inpatient care
- There would be increase of around £20 for planned inpatient care for the parents/carers on average which may cause financial hardship although car ownership is similar to the general planned inpatient care catchment population (58%)
- Public transport accessibility is slightly higher for deprived populations than for the general planned inpatient care catchment population (12.95)

## There would be an average increase in car/taxi travel time of 32 minutes for children from single parent households for planned inpatient care

### Children and young people from single parent household

#### Access statistics

Centre of expertise	Digital access	Public transport accessibility	Car ownership	Parking spaces
<b>GOSH</b>	95.8%	13.11	55.4%	0

### Impact on children and young people from single parent household

#### Average impact

Centre of expertise		Public transport travel times	Peak car/taxi travel times	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
<b>GOSH</b>	Current	23.30	16.09	12.96	£13.90	£1.31
	Future	+17.67	+32.16	+23.36	+£20.20	+£1.90

### Impact of the proposals compared to the status quo

- An impact of the proposals would be to increase average travel time by car/taxi (peak) by 33 minutes, by 23 minutes (off-peak) and by public transport by 18 minutes for planned inpatient care
- There would be an increase in average taxi costs of around £20 for planned inpatient care for parents/carers, and car ownership is lower than for the general planned inpatient care catchment population (58%)
- Public transport accessibility is slightly higher for single parents than for the general planned inpatient care catchment population
- Support may be required for single parent families who need childcare for other children whilst accessing care that is further away

# Accessibility summary: potential impact of the proposals across the quantitative analysis (planned inpatient at GOSH)

Demographics		Digital 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
GOSH	Catchment population	95.8%	12.95	+17.67	22.90	+30.80	15.74	+23.71	12.85	58.0%	£22.08	£13.85	+£2.08	£1.30	
	Children and young people living in areas of deprivation	95.8%	13.87	+17.25	22.69	+30.40	15.72	+22.37	12.78	58.0%	£19.64	£13.49	+£1.85	£1.27	
	Children and young people with disabilities	95.8%	14.01	+17.16	22.23	+29.88	15.43	+21.92	12.72	54.9%	£20.42	£26.47	+£1.92	£1.24	
	Children and young people from economically inactive households	95.8%	13.81	+17.29	22.68	+30.67	15.67	+22.06	12.65	54.6%	£21.12	£13.43	+£1.99	£1.26	0
	Children and young people from ethnic minority groups	95.8%	13.37	+18.14	22.80	+32.09	15.73	+22.37	12.78	56.0%	£22.98	£13.97	+£2.16	£1.31	
	Children and young people in poor health	95.7%	14.11	+17.17	22.30	+30.09	15.42	+21.74	12.64	53.8%	£20.64	£13.19	+£1.94	£1.24	
	Children from single parent households	95.8%	13.11	+17.67	23.30	+32.16	16.09	+23.36	12.96	55.4%	£20.20	£13.90	+£1.90	£1.31	
	Children and young people with poor English proficiency	95.8%	13.95	+17.35	23.41	+32.21	16.29	+22.98	12.79	53.8%	£22.96	£13.90	+£2.16	£1.31	

# **Other children and young people who have vulnerabilities**

# There are fewer than 2,000 looked after children in NCL and the new care model will have positive impacts

## Looked after children and care leavers

### Service provision and outcomes

- As of 31 March 2022, there were almost 1,700 looked after children across the NCL boroughs
- Camden had the lowest number of children who were being looked after at just under 200, whereas all other boroughs had between 330 and 390 children and young people in this population
- This population are more likely to have greater physical, mental and emotional health needs than the planned care catchment population as they are likely to have had experiences which put them more at risk of poor outcomes compared to their peers
- Looked after children have high levels of mental health needs which may cause difficulties in accessing care and a negative experience of receiving care

### Other considerations

- The new care model will ensure that effective channels of communication between the local authority and health staff are developed to ensure these vulnerable children receive the care they require promptly
- Sufficient resources and specialist guidance should be available for health care professionals to ensure this population receive care that is aligned to their heightened needs

### Potential impacts that may require mitigation

- From work to date, there appears to be **no differential impact on looked after children or specific impacts that require mitigation**. We will continue to engage with this group during consultation and beyond.



## Inclusion health groups such as homeless, refugees, domestic abuse and travellers may need support to access services that move further away

### Inclusion health groups

#### Service provision and outcomes

- There are a variety of different inclusion groups which will have local populations including homeless people, refugees, children and young people from a lone parent household, Gypsy and Roma traveller communities and those that misuse substances
- These populations of children and young people tend to be very small and dispersed
- Many parents in these populations find it difficult to access care consistently, which has an impact on their children's health outcomes and healthcare experience
- Evidence suggest that these communities consistently have poorer health outcomes

#### Potential impacts that may require mitigation

- From work to date, it will be **important to ensure that these population can access services which may be further away than currently**. We will continue to engage with this group during consultation and beyond.

# Children who have special educational needs and disabilities may need support to access services where there is a change in location or long journey

## Children with special educational needs and disabilities

### Service provision and outcome

- Across all schools in NCL in 2022/23 there were around 28,000 children and young people that received support for special educational needs and disabilities (SEND)
- This equates to 12.3% of the total population, compared to the national average of 13%
- Islington had the highest proportion of children receiving SEND support at 16%, with Barnet being the lowest at 10.8%
- Nationally, children with SEND are more likely to be eligible for a free school meal than the general catchment population which suggests an intersection between children with SEND and deprivation
- Children with SEND are more likely to experience poorer physical and mental health outcomes than their peers
- There is a complex relationship between special educational needs and disabilities and poor mental health. Children and young people with SEND can be at higher risk of mental health difficulties than the general catchment population

### Other considerations

- This population of children and young people will receive additional support when accessing paediatric surgical care if required to ensure that all children and young people in the catchment population have equitable access to the care they need

### Potential impacts that may require mitigation

- From work to date, it will be **important to ensure that these children and young people can access services where there is a change in location or long journey.** We will continue to engage with this group during consultation and beyond.

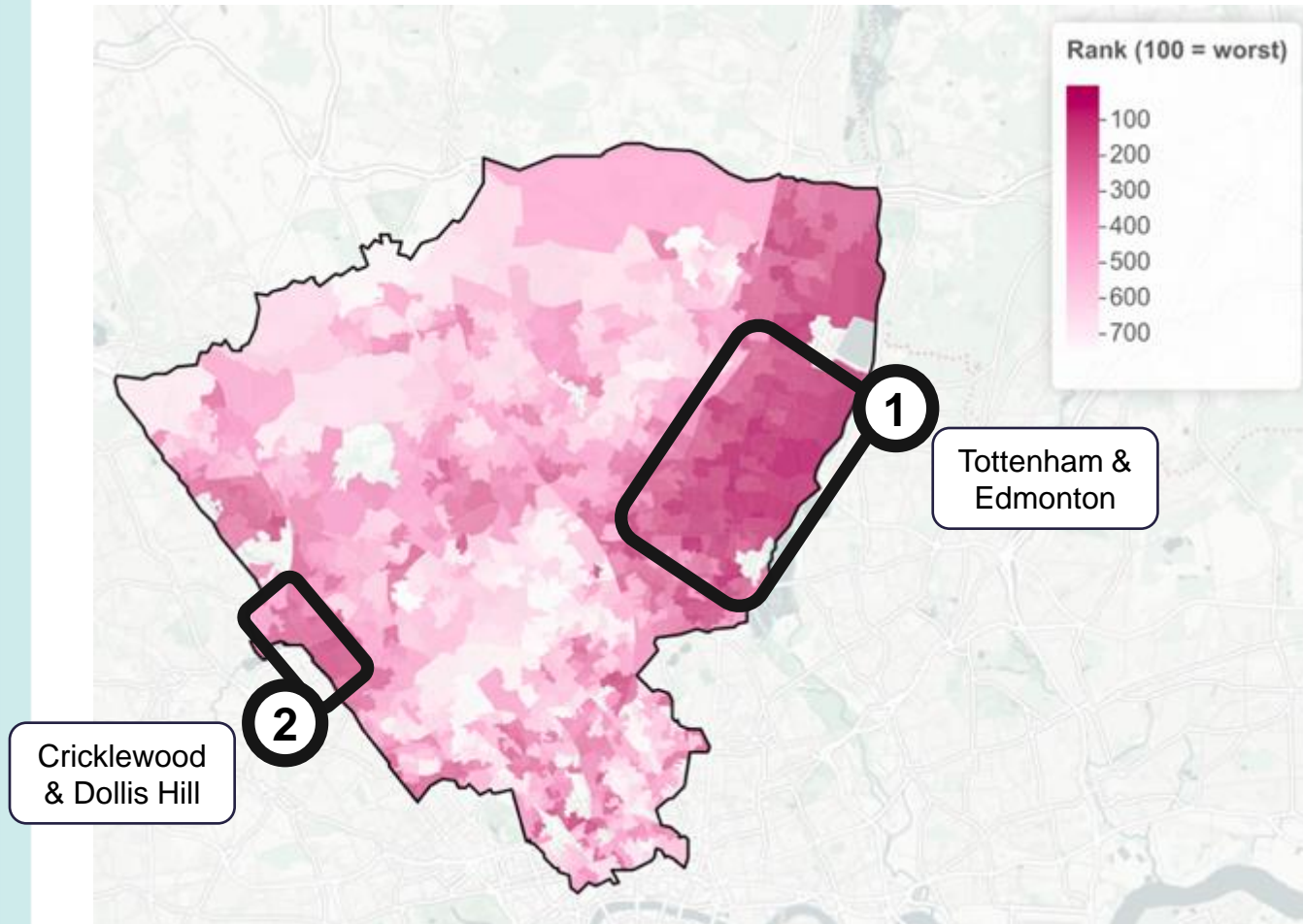


# **Potential impact on areas that may be more vulnerable to the impact of our proposals for planned care**

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

- Two geographical areas were identified as having residents who may be more vulnerable to the impact of our proposals as they face barriers to accessing services because they live in areas of deprivation and have high levels of poor health
- As a result of the proposals, people in Tottenham and Edmonton, and Cricklewood and Dollis Hill, may need additional support to:
  - Access the hospital site for planned care if the children and young people or the families and carers have disabilities/in poor health or are not proficient in English (including literacy)
  - Accessing services at an unfamiliar hospital as the location where planned surgical care for some children and young people takes place may change
  - Travel to hospital by taxi for planned care, if required, as it will cost on average an additional £20 for population living in Tottenham and Edmonton
  - Access planned care services online as the families and carers of young children and people may have low digital proficiency
  - Care for other family members whilst accessing planned care as they may be a single parent

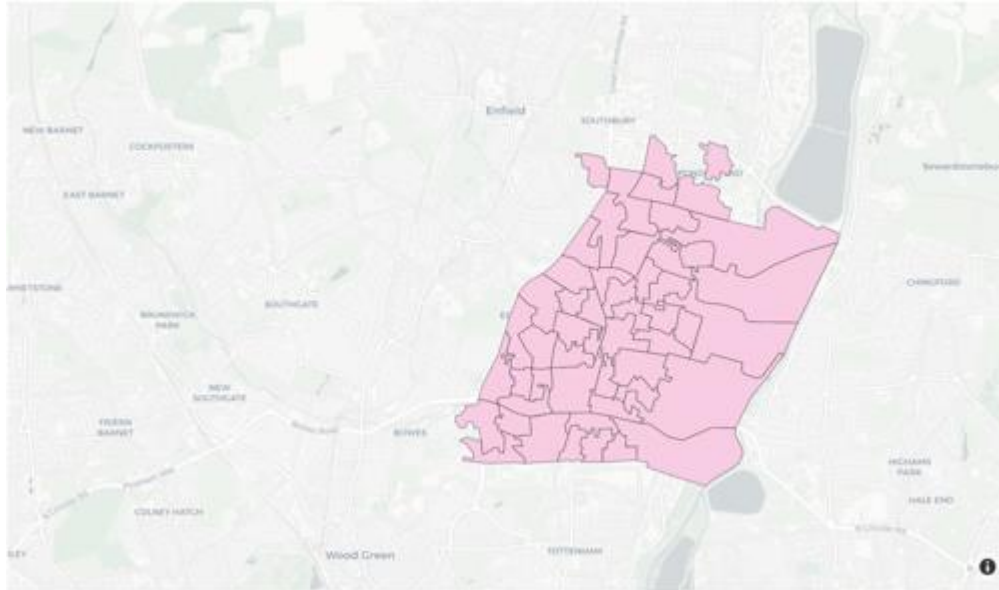
After considering both qualitative data and engagement outputs, areas were identified that may be more vulnerable to our proposals for planned care



- This map uses weightings to better visualise the demographic outputs
  - The index is an equally weighted average of all LSOAs ranked by the percentage of ethnic minorities, the most deprived and those with poor health outcomes
  - The scales from 1-800 with 1= worst and 800 = best
1. **Tottenham and Edmonton** have been identified as a geographic populations that may be more vulnerable to our proposed changes for planned care
  2. **Cricklewood and Dollis Hill** has also been identified as a geographic populations that may be more vulnerable to our proposed changes for planned care



## Tottenham and Edmonton was identified as a vulnerable geography that face barriers to accessing services



### Impact on transport to the hospital

For most of this population, their current closest hospital is North Mid

- **Public transport:** On average, this population would have to travel an additional 21 minutes to UCLH and 25 minutes to GOSH
- **Private transport:** Travelling by car would take on average an additional 46-47 minutes to both units. Taxi costs would increase by around £20 per journey to both units.

### Population characteristics

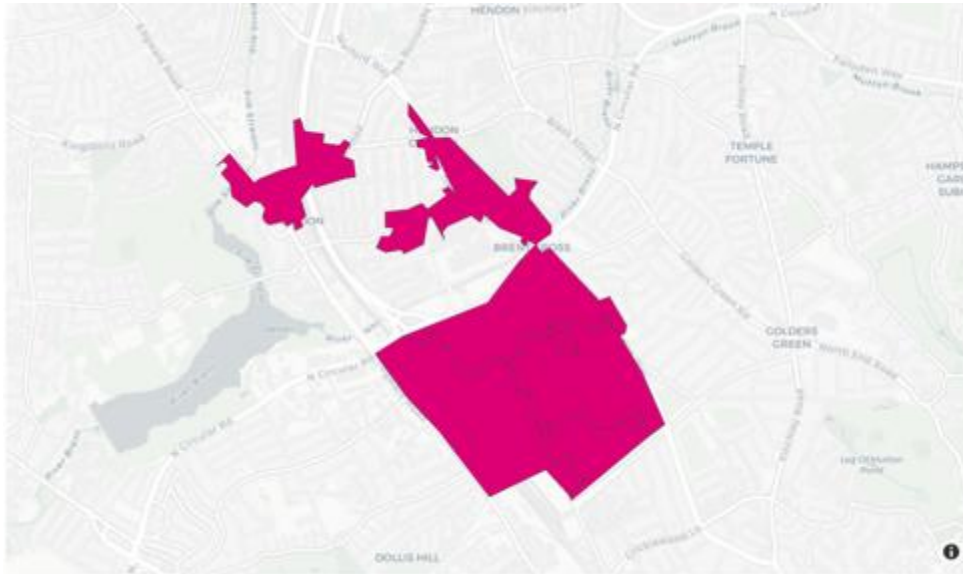
- 14% of the population in this area are disabled with 6% reporting to be in poor general health
- 9% of this population are not proficient in English
- 67% of this population live areas of deprivation and 27% are from economically inactive households
- 24% of children live in single parent households
- 62% of parents and carers have access to a car
- 55% of this population are from ethnic minority groups

### As a result of the proposals parents/carers of children and young people in Tottenham and Edmonton may need additional support to:

- Access the hospital site if they are disabled/in poor health or are not proficient in English
- Access services at an unfamiliar hospital as the location where planned surgical care for some children and young people takes place may change from North Mid to UCLH or GOSH
- Take their child to hospital by taxi, if required, as it will cost an additional £20 per journey
- Access services online as they may have low digital proficiency
- Care for other family members as they may be a lone parent



## Cricklewood and Dollis Hill was identified as a vulnerable geography that face barriers to accessing services



### Impact on transport to the hospital

For most of this population, their current closest hospital is Royal Free

- **Public transport:** On average, this population would have to travel an additional 8 minutes to UCLH and 14 minutes to GOSH
- **Private transport:** Travelling by car would take on average an additional 17 minutes to UCLH and 25.5 minutes to GOSH. Taxi costs would increase by around £7 per journey to both units.

### Population characteristics

- 14% of the population in this area are disabled with 5% reporting to be in poor general health
- 7% of this population are not proficient in English (including literacy)
- 62% of this population live in a deprived population and 26% are economically inactive
- 17% of children and young people live in single parent households
- 60% of parents and carers have access to a car
- 52% of this population are people from ethnic minority groups

### As a result of the proposals parents/carers of children and young people in Cricklewood and Dollis Hill may need additional support to:

- Access the hospital site if they are disabled/in poor health or are not proficient in English
- Access services at an unfamiliar hospital as the location where planned surgical care for some children and young people takes place may change from the Royal Free to UCLH or GOSH
- Take their child to hospital by taxi, if required, as it will cost an additional £7 per journey
- Access services online as they may have low digital proficiency
- Care for other family members as they may be a lone parent

# Potential impact of proposals on accessibility for emergency care



# Summary: Potential impact of proposals on accessibility for emergency care

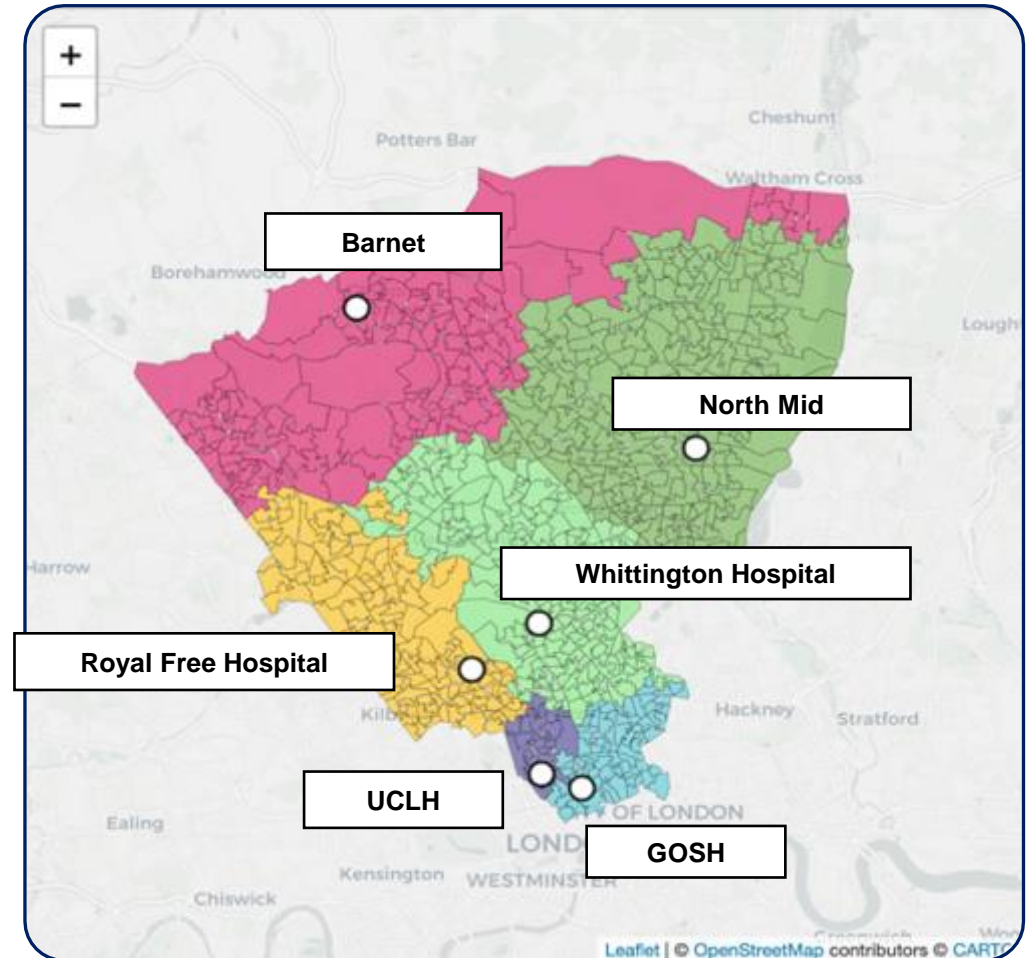
- Children and young people would continue to access emergency care at their local emergency department (ED)
- A small number of the sickest children (around 1,200 per year), who require highly expert care, would be transferred by ambulance from their local hospital to the GOSH Centre of expertise, where specialist staff and equipment would be available to treat them
- This means there would be no change to where children and young people access emergency paediatric surgical care and people would continue to access care at their nearest local ED
- However, there may be impact for families and carers visiting children and young people who have been transferred to the Centre of expertise at GOSH from local hospital, although many of these children will currently be transferring out of NCL
- Parents and carers of children and young people who have transferred to GOSH may need to travel up to 34 minutes longer compared to travelling to their local hospital
- The potential impact of our proposals for emergency care on the parents and carers with protected characteristics and people who have vulnerabilities has been reviewed and is similar to the potential impact on the general catchment population
- There may be an impact on some groups that would need to be mitigated because of the proposals for emergency care, although many of these parents would have to travel out of NCL under the current model of care
- Further details of mitigations that have been developed for our proposals are shown on slide 133 - 140



# Children and young people would continue to access emergency care at their local emergency department

## Method

- LSOAs where an NCL hospital with an emergency department is the nearest hospital by travel time have been used as the “**emergency care catchment**”)
- Children and young people would continue to access the emergency department (ED) their local hospital for emergency paediatric surgery and the majority would continue to be treated locally
- A small number of the sickest children (around 1,200 per year), who require highly expert care, would be transferred by ambulance from their local hospital to the GOSH centre of expertise, where specialist staff and equipment would be available to treat them
- This means there would be no change to where children and young people access emergency paediatric surgical care and people would continue to access care at their nearest local ED
- However, there may be impact for families and carers visiting children and young people who have been transferred to the centre of expertise at GOSH from local hospitals, although many of these children will currently be transferring out of NCL



## Parents and carers of children and young people who have transferred to GOSH may need to travel up to 34 minutes longer

	Average (off-peak)			Maximum (off-peak)		
	Current travel time (mins)	Future travel time (mins)	Difference (mins)	Current travel time (mins)	Future travel time (mins)	Difference (mins)
<b>UCLH</b>	8.0	11.2	+3.3	13.6	17.5	+3.8
<b>Whittington Hospital</b>	11.2	26.1	+ 14.9	19.7	39.8	+20.0
<b>Royal Free Hospital</b>	10.8	28.3	+17.5	22.0	36.2	+14.3
<b>North Mid</b>	13.4	43.4	+30.0	22.5	56.3	+33.8
<b>Barnet</b>	15.9	48.0	+32.2	28.9	62.4	+33.5

- An impact of the proposals could be to increase average travel time by car/taxi by up to 33 minutes for parent and carers of children and young people, for people travelling from the north of the emergency care catchment population, although many of these parents and carers would have to travel out of NCL under the current model of care
- An impact of the proposals could be to increase the maximum travel time by car/taxi to 63 minutes for parent and carers of children and young people travelling from the north of the emergency care catchment population, although many of these parents and carers would have to travel out of NCL under the current model of care

# The impact of the proposals for emergency care would be similar across protected groups and people with vulnerabilities

	General catchment population	Children and young people with disabilities	Children and young people from ethnic minority groups	Children and young people with poor English proficiency	Children and young people from economically inactive households	Children and young people in poor health	Children and young people living in areas of deprivation	Children from single parent households
<b>UCLH</b>	8 (+3.3 mins)	8.1 (+3.2 mins)	8 (+3.3 mins)	8 (+3.2 mins)	8.1 (+3.2 mins)	8.1 (+3.1 mins)	8 (+3.2 mins)	8.1 (+3.1 mins)
<b>Whittington Hospital</b>	11.2 (+14.9 mins)	10.9 (+14.3 mins)	11.6 (+14.2 mins)	12.5 (+13.9 mins)	11.2 (+14.1 mins)	10.9 (+14 mins)	11.2 (+14.3 mins)	11.2 (+14.1 mins)
<b>Royal Free Hospital</b>	10.8 (+17.5 mins)	10.7 (+17.2 mins)	11.4 (+17.3 mins)	12.5 (+17.1 mins)	11.3 (+17.2 mins)	11 (+17.1 mins)	11.3 (+17.2 mins)	11.6 (+16.8 mins)
<b>North Mid</b>	13.4 (+30 mins)	13.6 (+29.7 mins)	13 (+29.3 mins)	12.6 (+29.2 mins)	13.2 (+29.8 mins)	13.5 (+29.6 mins)	13.3 (+29.8 mins)	13.3 (+30.1 mins)
<b>Barnet</b>	15.9 (+32.2 mins)	15.8 (+32.5 mins)	15.3 (+30.9 mins)	15.4 (+30.8 mins)	15.7 (+32 mins)	15.7 (+32.4 mins)	15.8 (+32.2 mins)	15.8 (+32.2 mins)

- The impact on parents and carers of children and young people who have been transferred to GOSH for emergency surgical care is similar across protected groups and people with vulnerabilities
- An increase in travel time may cause difficulties or financial hardship, particularly for people with a disability, people who are from deprived populations, people who are pregnant and single parent families, although many of these parents and carers would have to travel out of NCL under the current model of care
- GOSH is in the congestion zone so for some families there may be a daily charge of £15 when visiting
- There may also be costs from the ULEZ charge of £12 per day

# There is an impact on some groups that would need to be mitigated because of the proposals for emergency care

		Potential impacts of the proposals for emergency care on parents and carers that may require mitigations
Protected characteristic	Race	<ul style="list-style-type: none"> <li>Language barriers may need to be addressed if parent and carers and/or the child is not proficient in English need to access an unfamiliar unit</li> </ul>
	Age	<ul style="list-style-type: none"> <li>Age is not relevant because parents and carers are likely to be a similar age</li> </ul>
	Sex	<ul style="list-style-type: none"> <li>Being male or female is not relevant as parents are male and female</li> </ul>
	People with disabilities	<ul style="list-style-type: none"> <li>Support may be required for the disabled child, disabled parent/care and parent/care of disabled child (including special educational needs and disabilities) where a long journey may need to be undertaken</li> </ul>
	Being pregnant or on maternity leave	<ul style="list-style-type: none"> <li>Support may be required for the parents and carers of children and young people who are pregnant who need to visit their child where there is a long journey to the service, , although many of these parents and carers would have to travel out of NCL under the current model of care</li> </ul>
	Gender reassignment	<ul style="list-style-type: none"> <li>Gender reassignment is not relevant for parents and carers visiting children</li> </ul>
	Religion of belief	<ul style="list-style-type: none"> <li>Being of a certain religion is not relevant for parents and carers visiting children</li> </ul>
	Sexual orientation	<ul style="list-style-type: none"> <li>Sexual orientation is not relevant for parents and carers visiting children</li> </ul>
	Being married or in a civil partnership	<ul style="list-style-type: none"> <li>Being married or in a civil partnership is not relevant for parents and carers visiting children</li> </ul>
Other	People living in areas of deprivation	<ul style="list-style-type: none"> <li>Potential overlap with race, other inclusion groups and disabilities</li> <li>The cost of travelling further, particularly by taxi, would need to be addressed, although many of these parents and carers would have to travel out of NCL under the current model of care</li> </ul>
	Other inclusion health groups	<ul style="list-style-type: none"> <li>Potential overlap with race, deprivation and disabilities</li> <li>Support may be required for single parent families who need childcare for other children whilst visiting children who are further away</li> <li>The cost of travelling further to visit children, particularly by taxi, would need to be addressed, although many of these parents and carers would have to travel out of NCL under the current model of care</li> </ul>

# Potential impact of proposals on sustainability

## Summary: potential impact of the proposals on sustainability

- 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, similar travel carbon impact due to the small increase in travel distances as people access services at UCLH (day case) and GOSH (planned inpatient care) and increased vehicular emissions may need to be mitigated as UCLH and GOSH are within air quality management areas (AQMAS). Emissions for emergency care are unlikely to increase as many children are currently transferred outside of NCL.
- It should be noted that the case numbers moving under these proposals are very small and therefore the overall additional number of journeys would be very small
- Refurbishment carbon emissions for GOSH would be mitigated as part of their net zero strategy
- The number of patients that are impacted by the proposals are so small that there would be no impact on organisations as anchor institutions



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



Centre of expertise	Travel carbon impact (planned care only)	Protected air quality	Building carbon impact
Day case: UCLH	+298kg	AQMA: NO2 and vehicular particulates	None
Emergency and planned inpatient: GOSH	+327kg	AQMA: NO2 and vehicular particulates	Minimal

These metrics provide an understanding of the impact on sustainability:

- For both the day case and planned inpatient care, there would be a small carbon impact due to increase in travel distances. Mitigations would need to be explored as both UCLH and GOSH are within air quality management areas (AQMA) for NO2 emissions and vehicular particulates. This means the sites are located in an area where air pollution level have exceeded the national air quality objectives.
- Emissions for emergency care are unlikely to increase as many children are currently transferred outside of NCL
- There may be some carbon impact due to refurbishing buildings at GOSH but there are substantial environmental gains to be made in making the building more energy efficient, in line with government policy

## Four sustainability metrics were identified to explore the potential sustainability impact

Metric	Rationale	Methodology	Source
Travel carbon impact	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 the planned care proposals	Travel time API (2023), EPA.gov (2018)
Protected air quality	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)
Building carbon impact	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 would be undertaken	NA
Anchor institutions	Local hospitals are anchor institutions that support local communities and removal of services may impact adversely on local communities	The number of patients that are impacted by the proposals are so small that there would be no impact on organisations as anchor institutions	NA

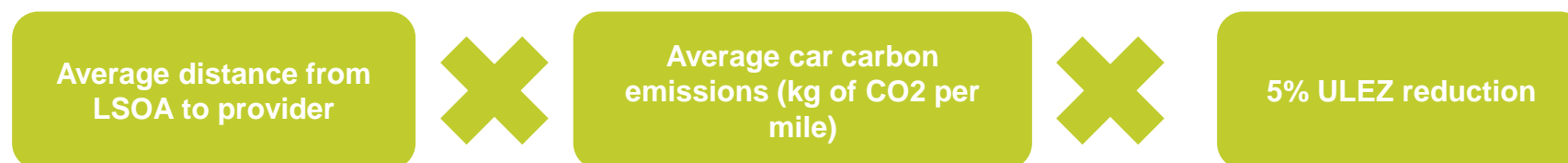
*Note: whilst quantitative data was examined where available, engagement was additionally undertaken with staff and relevant stakeholders to better identify the impact of the proposals*

# The increased travel time for planned care\* increases the CO2 emissions

## Distances and CO2 cost per journey

*Total distance to current closest and Centre of expertise and % impact on CO2 cost per journey (planned care)*

Centre of expertise	Total distance to closest provider (all planned care journeys)	Total distance to Centre of expertise (all planned care journeys)	Additional distance travelled	Increase in CO2 emission (kg)	Percentage increase in CO2 emissions per journey (%)
<b>Day case: UCLH</b>	419 miles	580 miles	+161 miles	+298	39%
<b>Emergency and planned inpatient: GOSH</b>	411 miles	588 miles	+177 miles	+327	43%



*The calculations were made by assuming each mile travelled by car is associated with a fixed carbon cost based on assumptions of average car emissions and a reduction due to the impact of ULEZ, this gives us an average figure that shows the per capita impact of each Centre of expertise.*

*\*Emissions for emergency care are unlikely to increase as many children are currently transferred outside of NCL*



## Increased vehicular emissions may need to be mitigated as both centres of Expertise are within AQMAs

### AQMAs (Air Quality Management Areas)

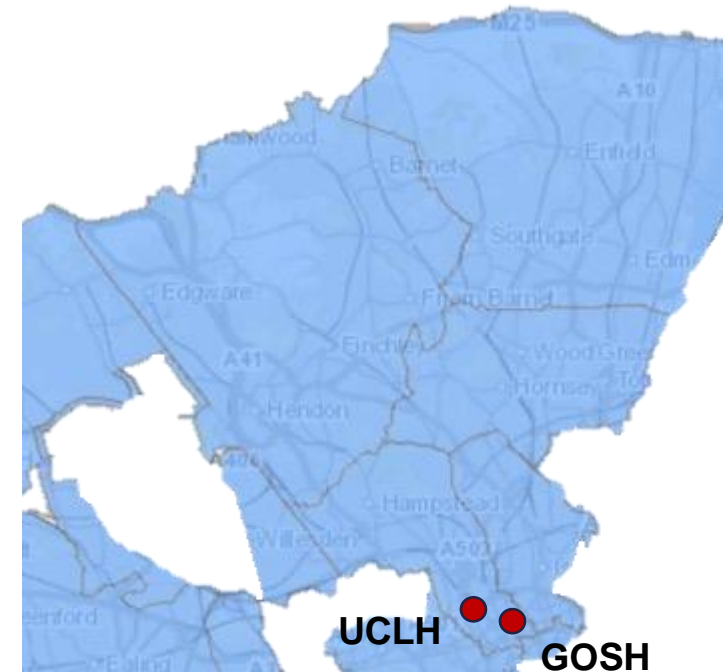
*“Since December 1997, each local authority in the UK has been carrying out a review and assessment of air quality in their area. This involves measuring air pollution and trying to predict how it will change in the next few years. The aim of the review is to make sure that the national air quality objectives 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 139.

# Potential impact of proposals: overall summary

# The potential impact of the proposals for paediatric surgical planned care

Population	Quality	Access	Populations with protected characteristics and people who have vulnerabilities	Sustainability
<ul style="list-style-type: none"> <li>Around 300 children and young people per year would travel to the UCLH centre of expertise for day case surgery and 300 children and young people per year would travel to the GOSH centre of expertise for planned inpatient surgery</li> </ul>	<p>The proposed service change to deliver centres of expertise at UCLH and GOSH would deliver positive clinical impact:</p> <ul style="list-style-type: none"> <li>Paediatric surgical care would be delivered in the appropriate setting</li> <li>Consolidating low volume specialties and ensuring staff maintain competencies</li> <li>Ensure all children receive care in a child friendly environment</li> <li>Providing clarity on surgical pathways</li> <li>Make best use of paediatric surgeons and consultant paediatric anaesthetists</li> </ul>	<p>Average increase in costs (peak)</p> <ul style="list-style-type: none"> <li>UCLH (day case): £22.13 by taxi, £2.10 driving</li> <li>GOSH (planned inpatient): £22.08 by taxi, £2.08 driving</li> </ul> <p>Average increase in travel times (peak)</p> <ul style="list-style-type: none"> <li>UCLH (day case): +27 mins by car/taxi (peak), +24 mins by car/taxi/ambulance (off peak) +12 mins by public transport</li> <li>GOSH (planned inpatient): +31 mins by car/taxi, +24 mins by car/taxi/ambulance (off peak) +18 mins by public transport</li> </ul>	<ul style="list-style-type: none"> <li>Language barriers may need to be addressed if people not proficient in English need to access an unfamiliar unit</li> <li>Support may be required for children and young people with a disability (including special educational needs and disabilities) who need to access services on an unfamiliar site or undertake a long journey to access services</li> <li>The cost of travelling further, particularly by taxi, may need to be addressed for people living in areas of deprivation and inclusion health groups</li> <li>Support may be required for single parent families who need childcare for other children whilst accessing care that is further away</li> <li>Tottenham &amp; Edmonton and Cricklewood &amp; Dollis Hill were identified as geographies that could be particularly vulnerable to the proposed service changes, with high levels of deprivation, a high proportion of ethnic minorities and high unemployment. An impact of the proposed changes on these population is the large increase in travel times and an increase in taxi prices as a result of increased travel times This may need to be explored further in consultation.</li> </ul>	<ul style="list-style-type: none"> <li>There is a 39% increase in carbon emissions per average journey for this very small group of patients as a result of the increased travel times to UCLH</li> <li>There is a 43% increase in carbon emissions per average journey for this very small group of patients as a result of the increased travel times to GOSH</li> </ul>

# The potential impact of the proposals for paediatric surgical emergency care

Population	Quality	Access	Populations with protected characteristics and people who have vulnerabilities	Sustainability
<p>Around 1,200 children and young people per year would access their local ED, as of now, and then be transferred to the GOSH Centre of expertise for emergency surgery</p>	<p>The proposed service change to deliver Centres of expertise at UCLH and GOSH would deliver positive clinical impact:</p> <ul style="list-style-type: none"> <li>• Paediatric surgical care will be delivered in the appropriate setting</li> <li>• Consolidating low volume specialties and ensuring staff maintain competencies</li> <li>• Ensure all children receive care in a child friendly environment</li> <li>• Providing clarity on surgical pathways</li> <li>• Make best use of paediatric surgeons and consultant paediatric anaesthetists</li> </ul>	<p>Parents and carers of children who have had emergency surgery at GOSH:</p> <ul style="list-style-type: none"> <li>• +33 minutes average travel time for people travelling from the north of the catchment</li> <li>• +63 minutes maximum travel time for people travelling from the north of the emergency care catchment population</li> </ul>	<ul style="list-style-type: none"> <li>• Language barriers may need to be addressed if parent and carers not proficient in English need to access an unfamiliar unit</li> <li>• Support may be required for the parents and carers of children and young people with a disability (including special educational needs and disabilities) who need to visit their children on an unfamiliar site or undertake a long journey to reach the site</li> <li>• Support may be required for the parents and carers of children and young people who are pregnant who need to visit their children by undertaking a long journey to reach the site</li> <li>• The cost of travelling further, particularly by taxi, may need to be addressed for people living in areas of deprivation and inclusion health groups</li> <li>• Support may be required for single parent families who need childcare for other children whilst visiting children who are further away</li> </ul>	<ul style="list-style-type: none"> <li>• Refurbishment carbon emissions for GOSH would be mitigated as part of their net zero strategy</li> <li>• Emissions for emergency care are unlikely to increase as many children are currently transferred outside of NCL</li> </ul>



# Mitigations

## Summary: mitigations

- There are several different impacts that may need mitigations
  - 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
  - Supporting sustainability
  - Supporting people who may be more vulnerable to the impacts of our proposals

# 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 languages locally, 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 potentially impacted service users identified through 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. 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 about implementation should changes be agreed



Should a decision be taken to implement any changes in the future, mitigations will be needed to ensure families understand pathways of care when they need to access surgical services for their children. The following mitigations may be needed to support this:

When a child is referred or transferred to centre of expertise for treatment in an emergency situation, there needs to be information given to families about this ensure they what is happening and how their child's care is being taken forward

For emergency care be clear in communication that there is no change to where children access immediate care

Engage with primary care to ensure pathways are clear from primary to secondary care if needed

For planned care, outpatient clinics should provide information to families when their child is listed for surgery as to where this surgery will take place

This information is needed in different formats to meet the communication needs of a range of service users including different languages, easy read, large print etc. This could include the provision of technology to support with interpretation or translation of webpages into an appropriate languages

Consideration to be given to the development of a webpage on the ICB website that can be linked to which can host information about surgical pathways, travel to different hospital sites and information about common surgical presentations

Consider use of visual tools and audio versions of information to support with understanding

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



There are some service users for whom attending a different hospital site may be more difficult. For example, people with learning disabilities and autism have reported that they find this more difficult and can cause anxiety and additional stress. Mitigations may need to be put in place at the point of implementation to support people who would find this difficult. This could be through:

Offering opportunities to visit the site outside of a planned appointment to familiarise people with the hospital

Providing access to videos or information about the hospital site in advance of appointments in order that people can better prepare

Detailed information about how to navigate to the right area of the hospital where appointments or admissions are scheduled

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

## 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 site. This may lead to changes to journeys that people are otherwise familiar with. Mitigations would be needed to ensure that people can plan their journeys to hospital

Provide clear information about transport options to hospital where care is being delivered

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

This information may be best hosted a webpage of the ICB website where it can be easily updated. Consideration will need to be given to those who cannot access information digitally through the ability to provide or print hard copies of information

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

## Providing as much care locally as possible



An important part of our care model is that for planned care, as much care as possible is delivered at a local hospital site. Mitigations that should be considered to reduce the overall number of journeys to hospital are:

Appointments at base-hospital sites (negating the need to travel to the centre of expertise on many occasions, or where a patient may only receive outpatient surgical care)

Ensuring information and support is available in the community about where to access the right treatment for a particular condition. This enables people to access the clinical input they need in a more timely way.

Offer of virtual appointments (including pre-operative assessment) where clinically appropriate

Implementation of hospital at home for paediatric care to ensure children can be discharged as early as possible, reducing the burden of travelling to visit a child when they are admitted



# Support with the costs of travel to hospital



Increased taxi costs have been identified as a significant impact. For some groups this may be up to £40 per journey. There will be some service users who are more impacted by this than others based on where they live, and it is important that patients understand what is available to support them with cost of travel to hospital

Raise awareness of schemes and eligibility for scheme to support patients with travel costs, 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
- Blue badge schemes - support key groups with travel and increasingly being made available to those with a mental health conditions

Include this information on all patient information and the proposed website

Include information about travel cost and reimbursement on paediatric surgery website. Ensure all information is translated and accessible in a number of different formats

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

Consider the use of volunteer staff to help patients with claiming reimbursement for travel costs – particularly for families who may find this more difficult – for example for those that don't speak English

Where a child may be admitted to centre of expertise for an extended period, consider the provision of a pre-paid travel card to enable visiting for families that may find this financially challenging – use of charity funds to support this

For transfers via tracked taxis or hospital transfers, consider the provision of appropriate care seats at the referring site to ensure this does not delay transfer

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



The interim IIA identifies an 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.

Providing appropriate appointments in local hospital sites settings or online which negate the need to travel to a hospital site will support a reduction in the overall number of journeys taken

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

# Supporting people who may be more vulnerable to the impacts of our proposals



The interim IIA identifies a population in Tottenham, Edmonton, Cricklewood and Dollis Hill which may need particular mitigations given their characteristics as well as distance from the identified centres of expertise.

The populations residing in Tottenham, Edmonton, Cricklewood and Dollis Hill have been identified as people who may need additional mitigations in order to support them accessing the care they need. Some specific mitigations that would need to be taken forward for these populations

- **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, targeted information sharing should be considered. This would need to factor in the most commonly spoken languages within this area
- **Working with the local hospitals:** we would look to work with the North Middlesex and Royal Free Hospital as the local hospitals of residents in this area to ensure that families who need to access surgical care at one of the centres of expertise are supported to do so with: consistent information about the pathway and support available to them
- **Cost of travel:** when travelling by taxi, increased costs have been identified. We would look to put in place to range of mitigations identified under the proposals more generally but in a targeted way and there are clear arrangements in place for: re-imbursement 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