Start Well Pre-Consultation Business Case – Paediatric Surgery

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Foreword

North Central London Health and Care Partnership has committed to improving population health outcomes and reducing inequalities. Our Population Health and Integrated Care Strategy which has at its heart an ambition to work with residents of all ages in North Central London so they can

have the best start in life, live more years in good physical and mental health and in a sustainable environment.

The Start Well programme is a key aspect of delivering this strategy as paediatric surgery provides life-changing surgery to babies, infants and children and has potentially transformative results. Starting well in life has a big influence on life chances and supports reducing inequalities. We want to ensure that our paediatric surgical services are organised to ensure pathways are clear, that children and young people receive care in the right setting and by the right workforce. Whilst only a small number of babies and young children may require surgery, it is important that everyone has access to the specialist workforce in NCL no matter where they live.

The development of the proposals has been clinically led and informed by the current experience of children, young people and their families. The proposed changes seek to fundamentally improve access, experience and quality of care, which formalise and enhance existing arrangements that are in place to support the care of young children and babies and will make getting the right care at the right time by skilled specialists easier.

We recognise that achieving this vision is not solely about creating centres of expertise; it necessitates a broader collaborative effort. To successfully implement these improvements, it is imperative that we extend our focus beyond the boundaries of our proposed centres of expertise. Training and development at local hospital sites are integral components of the proposals. It is through collective commitment, sharing knowledge and skills, and a more joined up approach that we can ensure paediatric surgical care is not only accessible but also consistently of the highest quality.

Consultation provides us with an opportunity to hear your views on the proposals and will help to inform our next steps towards improved paediatric surgical care services across North Central London.

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

Specialised commissioning

We are pleased to be jointly presenting the proposals outlined in this pre-consultation business case. The work that has gone into considering the best possible solutions to address the case for change in NCL has been robust and the proposals recognise the complex interconnectivity between services across the capital. The Region, as the commissioner of specialist children's surgery, fully supports the proposals put forward, and will continue to work with NCL through the next steps of this important programme of work.

Hannah Witty
Regional Director of Finance, NHSE London Region

1. Executive Summary

1.1 Introduction

North Central London (NCL) Integrated Care System (ICS) has developed a pre-consultation business case (PCBC) for the Start Well programme for maternity and neonatal services, in partnership with NHSE Specialised Commissioning (the commissioner of specialised paediatric surgery). This sits alongside a separate PCBC on our proposed changes to maternity and neonates, which have also been developed as part of the Start Well programme.

We have brought together a range of stakeholders and system partners from across North Central London (NCL) to help understand the opportunities for improvement in paediatric surgery and develop an approach to address these. The Start Well programme has been a truly collaborative programme of work that has meaningfully engaged ICS partner organisations and clinical leaders from across NCL, demonstrating system working. In addition to scope and purpose of the PCBC this section also sets out the context of the Start Well programme, the relevant population who may be impacted by the proposals, the main drivers for the programme and the overarching governance.

1.2 Case for change

Clinicians have looked at our current services and there is consensus that currently paediatric surgery services are not always delivering the best clinical care possible and are not providing a positive patient experience for everyone who uses them. Although hospital staff across the units in NCL deliver the best possible care within the current service models, there are real opportunities to improve outcomes and experience for our children, young people and their families. This includes:

- **Reducing long waits for elective care:** as of September 2023, there were around 5,000 children and young people in NCL waiting for a planned operation with over 500 children and young people waiting over a year for surgery. The waiting list is growing, and the current situation doesn't meet NHS targets and has a significant impact on the wellbeing of the children, young people and families waiting.
- **Meeting national recommendations for the environment for paediatric surgical care:** within NCL not all sites are able to meet the recommendations. Not all sites are able to provide dedicated paediatric theatres or age-appropriate environments. The impact of the current estate and organisation means that some sites are struggling to manage their activity or are having to manage activity in a way that does not meet best practice guidance. There are also productivity implications for Trusts; dedicated paediatric lists provide opportunities to improve efficiency of planned surgery.
- **Organisation of paediatric surgical care:** NCL lacks consistent system-wide protocols for many common pathways of emergency care that requires surgical review of treatment and for the management of surgical transfers between providers, particularly for children aged 3-5 years. Treatment at local hospitals can be dependent on the experience and skills of both surgeons and anaesthetists covering the emergency rota to manage the care of children. The variation in workforce between local units and lack of clarity on the emergency surgical pathways and defined ages for emergency surgery at local units, means that for very young

children under 5 years, there is no clear pathway in NCL to transfer for treatment. This can lead to clinicians at local hospital sites spending a significant amount of time seeking surgical review for children who attend emergency departments.

- **Improving transition to adult services:** in NCL the cut off age for paediatric services varies between the different sites in NCL which means that some young people move to adult services at 16, whilst others move at their 19th birthday.

This PCBC focuses on the proposed changes to improve the organisation of paediatric surgical care and meeting the national recommendations for the environment of paediatric care. Other opportunities for improvement identified are being addressed through other workstreams, overseen by the Children, Young people, Maternity and Neonatal (CYPMN) Board. A paper which outlines how these opportunities are being taken forward can be found here.

1.3 Vision and care models

Our vision is to ensure that any child or young person requiring planned, or emergency surgery is treated by the right teams, at the right place and in a timely way. If an emergency operation is needed, for example to manage appendicitis, children and young people, their families and carers should be confident that they are receiving the best possible care. We want to ensure that all children and young people have access to the same experience and quality of care wherever they may access it.

For emergency and planned inpatient surgery for under 3s or under 5s (general surgery and urology), our proposal is that this surgical activity would be delivered at a single centre of expertise: emergency and planned inpatient. This centre would have access to a 24/7 specialist paediatric surgical and paediatric anaesthetic workforce as well as the wider clinical staff who regularly look after very young children. This unit would have a paediatric ED or surgical assessment unit (SAU) which can assess children who may need a surgical procedure. Local units would transfer children from local EDs to the SAU or paediatric ED. Local units would continue to deliver emergency and planned inpatient surgical activity where there is a single overnight stay in ENT and dentistry (where currently doing so) for children over the age of 3 or 5 years (general surgery and urology).

For day case procedures in low volume specialties and for children aged 1-2 years, our proposal is that this activity would be consolidated in a single centre of expertise: day case. This unit would have access to the specialist consultant paediatric anaesthetic workforce. Specialist paediatric surgical workforce from GOSH would be in reach as needed. The centre of expertise: day case would have a child-friendly environment and deliver activity on dedicated paediatric theatre lists.

Highly specialist surgical activity would continue to be delivered at specialist units in NCL, and this may be delivered on a networked basis. This includes surgery in babies under 1 years which would continue to be delivered at Great Ormond Street Hospital (GOSH).

1.4 Options appraisal

We have followed a detailed process by which we identified and assessed options for the location of the centres of excellence for public consultation. We have followed a robust governance process throughout to maintain continuity with the case for change and care model.

We undertook a two-stage evaluation process to assess options for the location of the centres of expertise.

- Step 1: centre of expertise: emergency paediatric surgery and inpatient planned surgery (for children aged under 3 or under 5 depending on surgery required)
- Step 2: centre of expertise: day case (for children aged 1-2 years)

Clinicians agreed that the centre of expertise for emergency paediatric surgery and inpatient planned surgery should be located at GOSH. This is because for any location in NCL other than GOSH, an additional paediatric surgical rota would need to be established. This would not be possible due to national workforce shortages, and it would not be an efficient use of resources. The majority of emergency surgery for under 3s (under 5 for urology and general surgery) and planned inpatient care for children currently takes place at GOSH.

Clinicians also agreed that Barnet Hospital (Barnet), North Middlesex University Hospital (North Mid), Royal Free Hospital, University College London Hospitals (UCLH) and Whittington Hospital should continue to deliver emergency surgery for children aged 5+ (plus orthopaedic, ENT and maxillo-facial for children aged 3-4 where applicable) and ENT and dentistry day case surgery for child aged 3+ (plus those who require a single overnight stay) where they do now as they currently deliver enough activity to maintain skills. In some cases, this surgery is provided, and would continue to be provided, on a networked basis. Services delivered by specialist units such as plastic surgery at the Royal Free Hospital would continue to be delivered there.

Clinicians agreed that GOSH should not be the centre of expertise: day case as it is recommended as the single viable option for the centre of expertise: emergency and planned inpatient. GOSH is a physically constrained site and it is important to retain this space for only those children who are best treated there, many of whom come from other parts of London, the UK and internationally. Delivering day case activity on a separate site to emergency would also reduce the risk of cancelling planned work to accommodate emergency activity and improve productivity.

Based on the clinical recommendation that the centre of expertise: day case should be on a different site to the centre of expertise: emergency and planned inpatient, we evaluated five options for the location of the centre of expertise: day case:

A. Barnet
B. North Mid
C. Royal Free Hospital
D. UCLH
E. Whittington Hospital

We undertook a robust evaluation process that reviewed each of the options for quality of care, workforce, access to care and affordability and value for money. As a result of this process, we concluded that Option D, UCLH, is the only viable option for the centre of expertise: day case. This is because it is the only option with sufficient clinical infrastructure (including consultant paediatric anaesthetists who can provide care for children over the age of 1) to be able to deliver the proposed model of care. UCLH also currently deliver two thirds of this day case activity. It is therefore recommended by the Start Well Programme Board that only this option is taken forward for consultation.

1.5 Option for consultation

Our proposal is to develop a centre of expertise for emergency and planned inpatient care at GOSH and a centre of expertise for day case at UCLH:

- A centre of expertise: emergency and planned inpatient for children under 3 (under 5 for urology and general surgery) including a surgical assessment unit at GOSH. GOSH have 24/7 access to the specialist paediatric surgical and paediatric consultant anaesthetists workforce that is needed to deliver this surgical activity.
- A centre of expertise: day case at UCLH to deliver low volume day case activity and day case activity for children aged 1-2 years. UCLH have the specialist consultant paediatric anaesthetist workforce on site to deliver care. The unit is also able to deliver a child friendly environment including a dedicated paediatric recovery area which is important in delivering a better patient experience.
- Barnet, North Mid, Royal Free Hospital, UCLH and Whittington Hospital would continue to deliver emergency surgery for children aged 5+ (plus orthopaedic, ENT and maxillo-facial for children aged 3-4) and ENT and dentistry day case surgery for child aged 3+ (plus those requiring a single overnight stay) where they do now.
- Surgical activity delivered at specialist units, such as orthopaedics, ophthalmology and plastics would continue to be delivered in line with the current pathways

This would mean:

- Specialist workforce would remain at the units they currently work at. The in-reach service provided by GOSH (via their Specialist Neonatal and Paediatric Surgery team) would be enhanced to support the centre of expertise: day case at UCLH as needed
- For people travelling to GOSH for planned inpatient surgery an increase in travel times for car/taxi (peak) by 31 minutes, by 24 minutes (off-peak) and public transport by 18 minutes and an increase in taxi costs of £22 per average journey.
- For people travelling to UCLH for planned day case surgery an increase travel times for car/taxi (peak) by 27 minutes, by 24 minutes (off-peak), public transport by 13 minutes and an increase in taxi costs of £22 per average journey
- Mitigations have been developed to support children and their families to access surgical care that they need given this increase in journey time and cost, including: support for people who may find it more difficult to access a different hospital site, as well as sharing information about how people can claim for the cost of transport to hospital where appropriate
- There would be a similar impact on travel times for vulnerable populations. People further away from the centres of expertise may need to pay up to an additional £56 per taxi journey. Specific consideration would also need to be given to other access needs for vulnerable populations including digital access, access to cars, physical on-site access and cultural and language barriers.
- A capital investment of c.£3.7m to deliver the additional capacity requirements at UCLH and GOSH. Additional annual workforce revenue costs of c.£3m would also be required to staff the additional capacity at the centre of expertise: emergency and planned inpatient. This would be further refined if the programme progresses to a DMBC.

The status quo (leaving services as they are) has been reviewed but is not being recommended by the Programme as an option for public consultation. That is because an option of maintaining the status quo would mean:

- A paediatric surgical care model that does not deliver the best practice and achieve the clinical standards as set out by professional bodies such as Getting It Right First Time (GIRFT)[1].
- The opportunities for improvement of paediatric surgery would not be realised. This would mean that surgical services would remain fragmented, and surgical care for children aged under 3 or 5 years would continue to be delivered at local units where the expertise required to deliver the best quality care is not readily available. For surgical staff at local units, it would continue to be difficult to maintain and develop the skills and capabilities to deliver this service locally.
- Staff at local units would continue to spend time trying to find a suitable bed for young children requiring surgical assessment and treatment. This may mean being transferred multiple times and to units outside of NCL.
- Access to care would remain the same with no changes in the travel or driving times but children and young people having to sometimes travel outside of NCL to access care

1.6 Implementation and enablers

In order to deliver these proposals, we would need to invest in enablers:

- **Workforce:** training and skills development of local unit adult surgical workforce to ensure there are the skills and capabilities in place to provide surgical and anaesthetic care for children aged 5 years and older
- **Finance:** delivering the required capacity and estate requirements are critical at both UCLH and GOSH. The capital investment would be funded within the ICB Capital Departmental Expenditure Limit Envelope (CDEL) and through the organisations.
- **Communication and engagement:** to communicate the changes and engage with local population and providers on these and the new pathways

We have developed a high-level timeline for implementation for our proposals and identified a number of enabling programmes, such as workforce development that would need to be undertaken to support the implementation of the proposed changes.

1.7 Benefits

We expect a range of benefits from the implementation of the vision and paediatric surgery care model. Implementing the care model would ensure that surgical care is delivered in the right setting, deliver clear emergency surgical pathways, make best use of the scare specialist paediatric surgical workforce, enable sustainable volumes of surgical activity, deliver surgical activity in child friendly environment and reduce in waiting times. These benefits would be felt and experienced by everyone including patients, families, carers, staff and local communities. The benefits outlined demonstrate how our proposals would address a number of the opportunities for improvement in our case for change.

[1] https://gettingitrightfirsttime.co.uk/

1.8 Stakeholder engagement

We have undertaken detailed and robust engagement to develop our proposals for paediatric surgery. Inclusiveness has underpinned our approach to engagement, and we have focused on ensuring that a wide range of perspectives have been captured in line with our commitments to local populations and our legal responsibilities.

Our thinking on the proposals and work undertaken has been tested with clinical patient groups, providers, local authorities through a series of events, meetings, youth summits and online surveys. In addition, all MPs have been offered briefings on the Programme and its progress to date. In promoting an inclusive approach to engagement, we have utilised a range of engagement techniques including traditional engagement methods, virtual sessions, online platforms and communicating via social media. Feedback from engagement showed that people are willing to travel beyond their local hospital to see a specialist if their child needs specialist care and this feedback has helped to shape the proposals.

1.9 Quality assurance

We have undertaken a robust quality assurance process which underpins the programme and gives assurance to this PCBC. The process undertaken by the programme has been assured by NHS England (NHSE) and going to public consultation was dependent on this assurance being received. Our proposals have been independently reviewed by the London Clinical Senate who provided us with feedback on the proposed changes. This has been acted upon and built into this business case.

NHSE has stated that the programme has met the five tests for reconfiguration set out by the Secretary of State:

- **TEST #1**: The proposed change can demonstrate strong public and patient engagement.
    - We have had early involvement with patients and the public via our communications and engagement workstream and patient and public engagement group (PPEG). Our materials have been tailored to meet the needs of the audience and ensure participation.
- **TEST #2**: The proposed change is consistent with current and prospective need for patient choice
    - We have ensured that our proposals maintain choice as per the NHS Choice Framework
- **TEST #3**: The proposed change is underpinned by a clear, clinical evidence base.
    - We developed a set of clinical design principles through the Paediatric Surgery Clinical Reference Group (CRG) to reflect best practice clinical care. The care model development has been clinically-led and underpinned by best practice and professional body guidance.
- **TEST #4**: The proposed change to service is owned and led by the commissioners.
    - We have led the development of the PCBC and the Start Well programme has been progressed through the NCL ICB Board and NHSE London Region Specialised Commissioning governance arrangements, in accordance with the organisations' constitutions and supporting documents

- **TEST #5**: Proposals including significantly reducing hospital bed numbers will have to meet one of the following three conditions:
    - Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
    - How that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
    - Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the getting it right first time programme).

The proposed service change will not reduce hospital bed numbers and therefore the conditions set out by this test do not apply.

In addition, assurance has been received from engagement with potentially impacted populations through the case for change engagement period.

In line with the programme governance set, the approvals process for the PCBC was:

- Paediatric Surgery Clinical Reference Group (CRG), Finance and Analytics Group, PPEG and Integrated Impact Assessment (IIA) Steering Group ratified the information that has formed part of this document before being submitted to the Start Well Programme Board
- The Start Well Programme Board reviewed this document and submitted to NHSE for assurance
- Documentation has been shared with the Joint Health Overview and Scrutiny Committee (JHOSC)
- London Joint Committee for specialised services reviewed and supported the proposals set out in this PCBC and to initiate public consultation. The decision has been ratified by the London Executive team.
- After assurance, a decision to proceed to consultation has been made by a meeting in public of the NCL ICB Board on 5 December 2023

1.10 Plans for consultation

We have developed a comprehensive approach to public consultation. This plan sets out the approach that we will use for consultation and the activities and channels that we will use to ensure we inform and actively engage with a diverse range of audiences and stakeholders.

The overall management and delivery of the consultation will be undertaken by the ICB internal communications and engagement team[2]. It will be undertaken in line with the legal duty on NHS organisations to involve patients, staff, and the public. The consultation exercise will be undertaken over a 14-week period in line with best practice standards.

The purpose of the consultation is:

- To ensure people in NCL and surrounding areas are aware of the public consultation and how to participate

[2] On behalf of NHSE London Region specialised Commissioning

- To present the case for change and the proposed options, by providing clear, simple, and accessible information in a variety of formats
- To provide a variety of methods and mechanisms to give and receive information appropriate to different audiences, with a focus on groups with protected characteristics and those who may be more impacted by the proposed changes
- To enable and encourage people to feed in their views on the proposed changes and the potential impacts
- To understand the views relating to our proposals for maternity and neonatal services and what concerns and mitigations we should consider in relation to any future implementation
- To ensure responses received are independently evaluated and the results published
- To ensure decision-makers receive detailed outputs and feedback from the consultation exercise so that they are as well-informed as possible before any decisions are made

Our plan builds on extensive engagement with staff, stakeholders, patients, carers and local communities during the pre-consultation period. To support the consultation, we have developed accessible materials including a consultation document and questionnaire that explains why change is needed, what the proposed changes are and the benefits we feel the proposals would bring. We have developed a communication and engagement plan which encompasses online and offline activity to maximise the opportunities for public, patient and staff to participate. We will focus efforts to engage with groups identified as potentially impacted through our interim IIA who may be less likely to give their feedback as well as impacted groups identified who reside outside of NCL.

Throughout the consultation period we will monitor responses to identify any demographic or other trends which may indicate a need to adapt our approach regarding consultation activity or refocus efforts to engage a specific group or locality. In line with best practice, we will commission an independent organisation to analyse responses and produce a non-biased objective report summarising all feedback.

1.11 Next steps and approvals

This has been recommended by the Start Well Programme Board to the NCL ICB Board and London Region Joint Specialised Commissioning Committee. NCL ICB plan to consult on the proposals for the location of maternity and neonatal services in NCL. Following consultation, all the consultation responses will be collated and taken into consideration. The business case will be updated into a full Decision-Making Business Case (DMBC) before any final decisions are made. There will also be an independent report compiled on the consultation responses which will be considered before a decision is made. We expect a decision on service change to be made 6-9 months following the consultation end. Timelines are dependent on the outcome of public consultation.

2. Introduction and context

This PCBC provides information on our proposal to reconfigure paediatric surgery services in NCL. NCL ICB, as part of the wider ICS, is a statutory organisation which holds responsibility for planning NHS services. NHSE London Region Specialised Commissioning is the statutory organisation responsible for commissioning neonatal services. Given the interdependency between

maternity and neonatal services, NCL ICB and NHSE London Region Specialised Commissioning will jointly give approval for this PCBC and plans to consult. The proposals have been developed with a wide range of stakeholders, including NCL ICB, provider organisations, neighbouring ICSs and local stakeholders, alongside the public, patients and staff.

2.1 Purpose and scope of pre-consultation business case (PCBC)

2.1.1 Purpose and aims of the PCBC

This document is a PCBC setting out the proposed changes to paediatric surgical services in NCL.

The aims of this document are:

1. To describe the **health needs of our population** and outline the **case for change**, which describes the clinical environment and infrastructure needed to support the delivery of the programme. The intent is to deliver the best care for our patients and provide a positive working environment for all staff. The case for change describes the **key challenges facing us**, opportunities for improvement and explains why change is necessary.
2. To describe the **decision-making process** we have followed and the **governance arrangements** required to support the proposed changes. This PCBC describes the process we have followed to ensure any decision-making is supported by clinical best practice, underlying evidence and has the support of local stakeholders.
3. To describe the **vision and care model** that was developed by local clinicians describing how patients' needs will be met, recognising co-dependencies and aspiring to positive impacts on both patients and staff. The **benefits section** describes the benefits of the proposed clinical model and how it will meet the needs of our local population.
4. To set out the **options appraisal process** and show how we evaluated the longlist of options against a set of evaluation criteria to determine the short-list of options, subsequently evaluating these options to identify our options for consultation. The options appraisal process describes the approach we have taken to understand the possible options to address the opportunities for improvement as set out in our case for change and delivery of the model of care.
5. To outline the **key enablers** needed for our model of care including workforce and estates.
6. To outline the **public and stakeholder engagement** that has been carried out at each stage of the programme, and how we plan to consult if a decision is made to proceed to consultation. The stakeholder engagement plan describes how key stakeholders have been engaged with, and involved in, our process.
7. To demonstrate the **planning and proposed implementation** if, following public consultation and due regard to the responses has been considered, a decision is made to move forward with the changes. The **governance section** describes the role of the assurance bodies and scrutiny committees around decision-making.

The PCBC outlines a commissioner-led review of the potential service delivery models and service options. The intent is to then seek opinion from the public through a formal public consultation. The

PCBC also demonstrates how we have met the five tests of assurance in line with regulatory requirements by NHSE[3]. The five tests for assurance are:

- **TEST #1**: The proposed change can demonstrate strong public and patient engagement.
- **TEST #2**: The proposed change is consistent with current and prospective need for patient choice.
- **TEST #3**: The proposed change is underpinned by a clear, clinical evidence base.
- **TEST #4**: The proposed change to service is owned and led by the commissioners.
- **TEST #5**: Proposals including significantly reducing hospital bed numbers will have to meet one of the following three conditions:
    - Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
    - How that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
    - Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time[4] programme).

This PCBC is a technical and analytical document intended to provide sufficient information to enable the NCL ICB Board and NHSE London Region Specialised Commissioning (as the current commissioner of specialised paediatric surgical care) to agree options for a service change to be part of a public consultation to agree options for a service change to be part of a public consultation. The PCBC is prepared in accordance with the NHSE guidance on planning for major service change and reconfiguration[5], and aligns with guidance in His Majesty's (HM) Treasury Green Book[6].

2.2 NCL Integrated Care System (ICS)

On 1 July 2022, NCL formalised working as an ICS. The ICS covers five boroughs: Barnet, Camden, Enfield, Haringey and Islington (see Figure 1).

[3] NHS England. 2018. https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

[4] https://gettingitrightfirsttime.co.uk/

[5] https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

[6] Gov.UK, 2022. The Green Book. https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent/the-green-book-2020

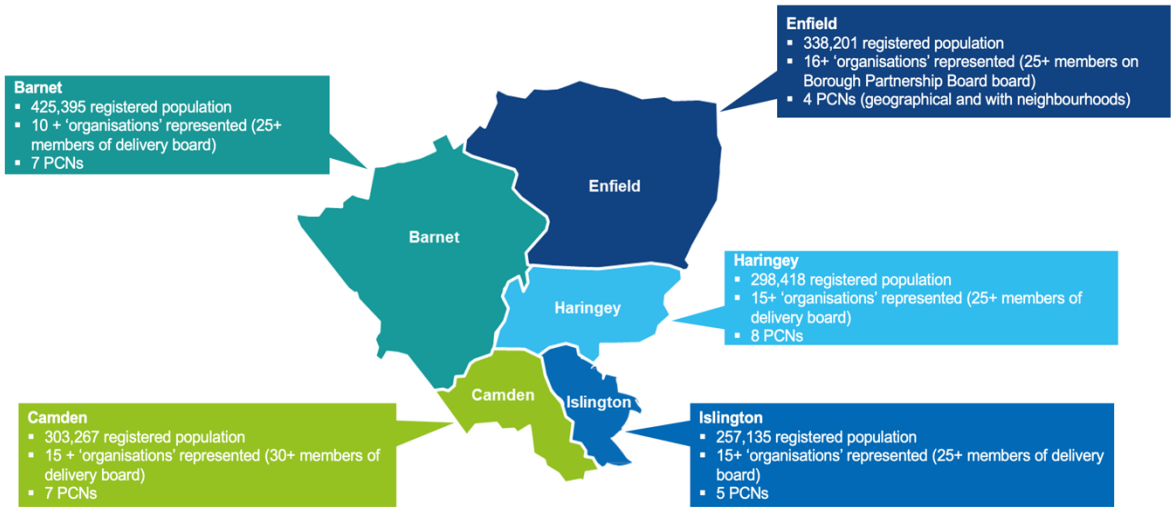


Figure 1: NCL geography

The principles informing the work of the NCL ICB are drawn from the Population Health and Integrated Care Strategy[7]:

- **Trust the strengths of individuals and our communities:** we will listen to our communities and develop care models that are strengths-based and focused on what communities need, not just what services have always delivered.
- **Break down barriers and make brave decisions that demonstrate our collective accountability for population health:** we understand each other's viewpoints and take shared responsibility for achieving our ICS outcomes and our role as anchor institutions.
- **Build from insights:** we create digital partnerships and use integrated qualitative and quantitative data to understand need.
- **Strengthen our Borough Partnerships:** we build a system approach for local decision making and accountability to support local action on physical and mental health inequalities and wider determinants.
- **Mobilise our system's world class improvement and academic expertise for innovation and learning:** we build the evidence base for population health improvements and innovative approaches to improve integrated working.
- **Break new ground in system finance for population health and inequalities:** we shift our investment toward prevention and proactive care models and create payment models based on outcomes.
- **Build 'one workforce' to deliver sustainable, integrated health and care service:** we maximise our workforce skills, efficiencies and capabilities across the system.
- **Support hyper-local delivery to tackle health inequalities and address wider determinants:** we make care more sustainable by creating local integrated teams that coordinate care around the communities they serve.

[7] https://nclhealthandcare.org.uk/wp-content/uploads/2023/05/PH-IC-Strategy-V.Final-long-version.pdf

- **Relentlessly focus on communities with the greatest needs:** we embed Core20PLUS5 in all our programmes, with a particular focus on inclusion health to make sure no-one is left behind.
- **Deliver more environmentally sustainable health and care services:** we prioritise activity which impacts our communities' health and environment, such as transport.

2.3 NCL vision

Our vision in NCL is that we want our population to live better, healthier and longer, fulfilling their full potential over the course of their entire life. Our vision, as set out in Figure 2 is that people in NCL:

- **Start Well:** every child has the best start in life and all children, adolescents and young people improve their mental health and emotional resilience
- **Live Well:** better prevention and management of long-term conditions, reduced unemployment levels and parity of importance between physical and mental health
- **Age Well:** people over 65 are independent and live in the community for longer, feel less isolated and more socially connected

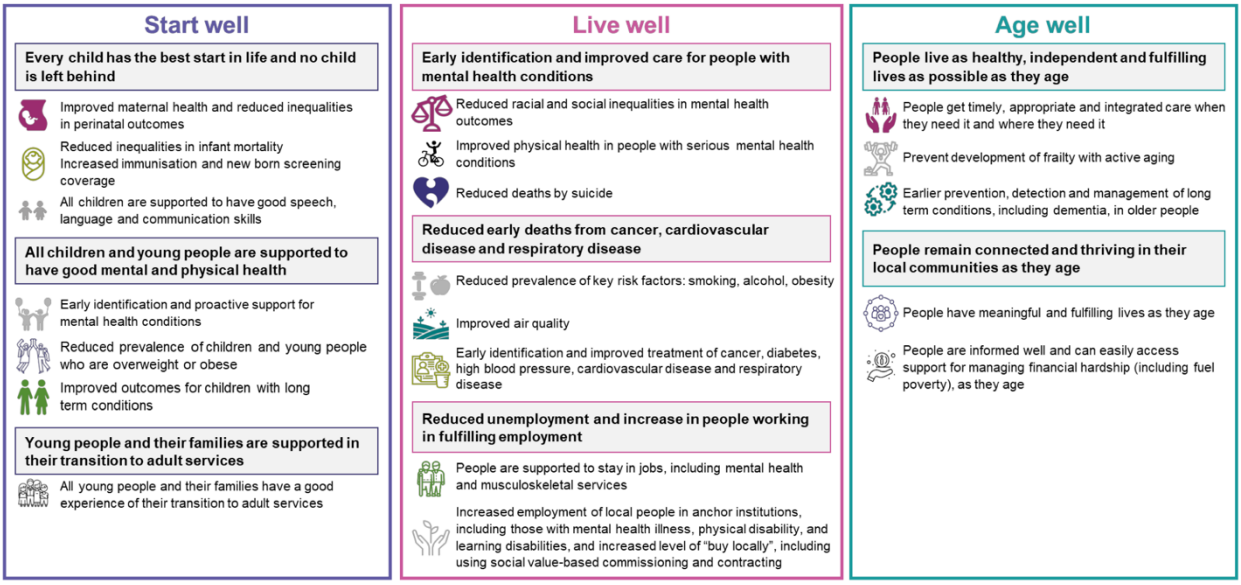


Figure 2: NCL ICB priorities

To start life well is one of the core aims of NCL's ICS; the way we deliver services for pregnant women and people, babies, children and young people can have a lasting impact on the rest of their lives both in the immediate future and for years to come. The Start Well Programme has provided an early opportunity to collaborate as an ICS and work in a way that is true to the ICB's principles. This programme has been shaped by clinical and operational leaders in our partner organisations, as well as people who use our services.

2.4 Start Well Programme overview

In November 2021, partner organisations in NCL ICS formally launched Start Well, a long-term programme looking at maternity, neonatal, children and young people's services. The aim of the Start Well Programme is to ensure we are delivering the best care to meet the needs of pregnant women and people, babies, children, young people and their families. A number of drivers were identified for the Programme including the urgent need to address health inequalities identified through the pandemic, external reviews of services and learning from the temporary changes to local paediatric services during the pandemic. Taking a population health approach, examining services and outcomes through an equalities lens, particularly in understanding the impact of deprivation and ethnicity, has underpinned the work to date.

2.5 Overview of Start Well Programme timeline

The Start Well programme commenced in November 2021, with implementation, subject to consultation, not anticipated to start until at least Summer 2025 onwards. The steps of the programme are as follows:

- **Confirm case for change** (November 2021 to September 2022): including mobilising the Start Well programme, publishing the case for change and undertaking engagement on the findings
- **Development of clinical models and options** (July 2022 to December 2023): including designing and agreeing the clinical model for paediatric surgery, identifying options for public consultation, developing the PCBC and ongoing stakeholder engagement
- **Public consultation** (planned December 2023 to March 2024): consultation on the proposals with the public, including extensive engagement across the impacted populations
- **Decision-making** (estimated 6-9 months, subject to consultation feedback): consideration of the feedback from consultation and the decision making on the option to implement following engagement and consultation
- **Outline business case (OBC) and full business case (FBC):** provider-led business case development to secure capital requirements (12 months)
- **Transition to implementation**

The indicative timeline for the programme is shown in Figure 3. Timeline following public consultation is dependent on outcome of consultation.

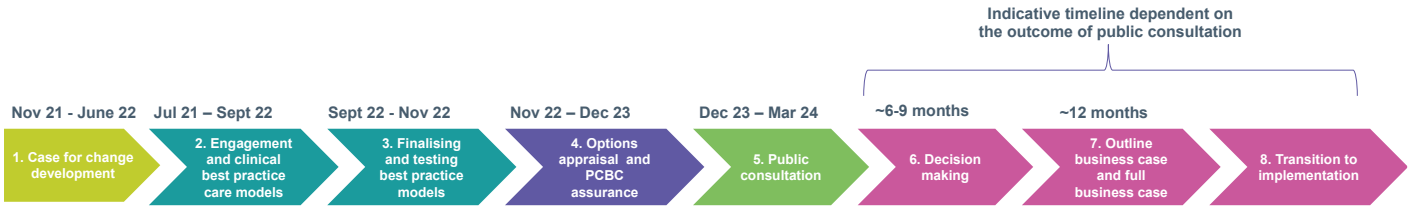


Figure 3: Indicative Programme timeline

2.6 Governance arrangements

NCL ICB Board and NHSE London Region Specialised Commissioning will make the final decisions on proposals covered by the consultation. The board comprises independent members, including our Chair, Executives from NCL ICB and members from partner organisations, including trusts and local authorities.

The **Start Well Programme Board** reports to the ICB's Board of Members and makes recommendations on proposed changes to children and young people's services in NCL. The Programme Board provides oversight and steer for the Start Well programme. It is comprised of executive representatives from each provider in NCL, plus patient and local authority representatives, NHSE Specialised Commissioning and representatives from the neighbouring ICSs of NEL, NWL, Hertfordshire and West Essex.

The Programme Board is chaired by the ICB's Chief Medical Officer. The governance structure of the Programme is set out in Figure 4. The Programme Board has agreed a set of principles to underpin the work, which includes taking a population-based approach, bringing a system-wide perspective, and using evidence and best practice to inform the work.

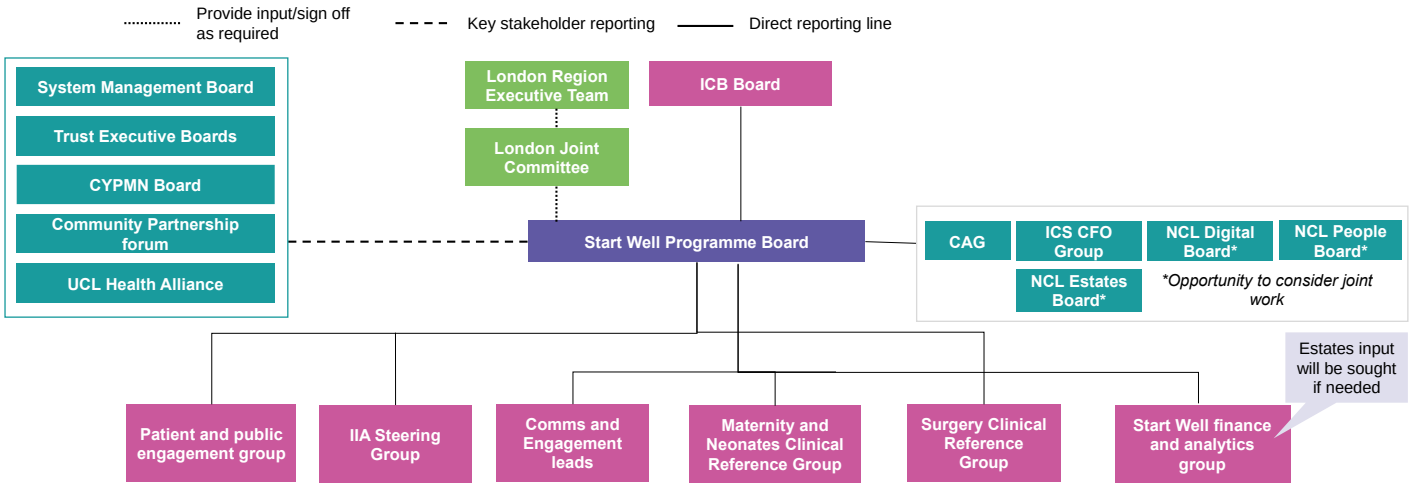


Figure 4: Start Well programme governance structure

There are several groups reporting to the Start Well Programme Board who are undertaking more detailed work as part of the development of these proposals. These are:

- **Surgical Clinical Reference Group (CRG):** the Start Well Programme Board is advised by the surgical CRG which provides clinical leadership and input into the Programme. It was established in November 2022 and the group comprises of members from provider organisations and across the different professional groups. This includes paediatricians, paediatric surgeons, anaesthetists, allied health professionals (AHPs), NHE London Region Specialised Commissioning, NHSE Workforce, Training and Education directorate and North Thames Paediatric Network (NTPN).
- **Finance and Analytics Group:** leads on the financial aspects of the programme and has supported the work to understand the affordability and value for money of the proposals. The group supported the development of the case for change. The membership was

refreshed in November 2022 to support the next phase of work and comprises members from each provider organisation and the ICB.

- **Patient and Public Engagement Group (PPEG):** is comprised of patient representatives, Maternity Voices Partnership (MVP) representatives, voluntary and community sector representatives and provider engagement teams. The group leads on the access to care aspects of the programme as well as providing input and feedback on the Programme. This group is chaired by the Start Well Programme Board patient representative and includes members who live locally in NCL and have experienced paediatric, maternity and neonatal services.
- **Integrated Impact Assessment (IIA) Steering Group:** has provided insight and expertise on the interim IIA. The group is co-chaired by a Director of Public Health and the Start Well Programme Senior Responsible Officer (SRO) with perspectives from the local authority, clinicians and public health teams.
- **Communications and Engagement Group:** ensures that communications and engagement is coordinated across all provider organisations in NCL and are taking place as required. It comprises of communication and engagement leads from each organisation represented on the Programme Board and is led by the ICB.

The work of the Start Well Programme Board is also supported by wider ICS groups to ensure there is coherence with other workstreams within NCL. These include:

- **System Management Board (SMB):** SMB is responsible for providing strategic oversight to reduce inequalities, reviewing system wide transformation programmes, investment and disinvestment decisions, and ensuring their alignment with medium- and longer-term ICS priorities. The group will provide assurance to the ICS Steering Committee about key programmes of work. SMB is chaired by the NCL ICB Chief Executive and has membership from all NCL Trust CEOs, as well as other ICB Executives and system leaders including local authority and primary care. SMB have had regular updates on the Programme at key intervals.
- **Children and Young People Maternity and Neonatal Board (CYPMN Board):** the CYPMN board has broad representation from across the ICS and covers programmes which span beyond the scope of Start Well, including children and young people's community and mental health commissioning, the local maternity and neonatal system (LMNS) and the children and young people (CYP) regional improvement programme. Each of these programmes has a role in contributing to the ICS response to the opportunities identified through Start Well. Bringing programmes together in this way provides a bridge between the longer-term strategic work that Start Well and the two strategic reviews around mental health and community services are delivering, and the more business-as-usual elements of work being delivered through other ICS programmes of work.
- **UCL Health Alliance:** is a provider collaborative covering all sectors of NHS care within North Central London. It brings together 14 member organisations across acute, mental health, community, specialist, and primary care sectors alongside a world leading university partner to be the delivery vehicle for cross-provider innovation in North Central London. The UCL Health Alliance has received updates at key intervals of the Programme.
- **Clinical Advisory Group (CAG):** CAG is co-chaired by the ICB Chief Nursing and Chief Medical Officer of the ICB. It reports into SMB in an advisory capacity, rather than making decisions on behalf of statutory organisation. The CAG membership is drawn from senior

clinical leaders from across NCL organisations. The role of the CAG is to provide clinical oversight of pan-NCL service change and new service developments and new ways of working. The CAG has received updates at key intervals of the programme and provided their clinical endorsement of updates.

- **GP Provider Alliance:** The GP Provider Alliance brings together General Practice with a unified provider voice to strategically lead, influence and enable Primary Care provision at the North Central London level. They are a key partner in the Integrated Care System and ensure that primary care provides the best possible services for our communities, optimises health gains and reduce inequalities.
- **ICS Chief Finance Officer Group (CFO):** This is a group of the NCL Directors of Finance which meet on a regular basis. This is an informal, non-decision-making group which brings together the Directors of Finance from across providers in NCL.

There are other groups that are not part of the ICS but have a role in the Programme.

- **North Central London Joint Health Overview and Scrutiny Committee:** The Joint Health Overview and Scrutiny Committee (JHOSC) is made up of the Chairs of the Health Overview and Scrutiny Committees from five London boroughs: Barnet, Haringey, Camden, Islington and Enfield.

2.6.1 Working with NHSE London Region Specialised Commissioning

NHSE London Region Specialised Commissioning is the current commissioner of specialist paediatric surgical care. This means that they have a significant role in the programme and will continue to do so as it moves forward. They are represented on the Programme Board and have clinical representation at the CRG.

Nationally, the commissioning of some specialised services is due to be delegated to ICBs. To support planning until delegation formally takes place (anticipated in April 2025), joint working arrangements have been put in place between NHSE and ICSs through a statutory joint committee. In London, a Joint Committee has been established consisting of representatives from all ICBs and selected provider representatives as well as representatives from other regions outside of London to join up decision making across boundaries. The Joint Committee reports into the London Regional Executive which includes the five ICB accountable officers and the London region executive team. Regular reports on Start Well have been made to the Joint Committee.

Into these structures, NCL is linking our existing work on population health, the Start Well programme and other strategies to ensure that outcome improvements are achieved for the services being delegated along with existing services and that we continue to ensure the long term sustainability of services for our own population and for those who access our specialist services.

Given their continued role as the commissioner of neonatal services and the joint working that is taking place between the ICB and NHSE, approval has been sought to commence consultation from both the ICB Board and the London Joint Committee for specialised services. The London Joint Committee for specialised services met and supported the proposals set out in the PCBC and the move to public consultation. The decision has been ratified by the London Regional Executive.

2.7 Geography and demography of North Central London

2.7.1 Population and demographics

NCL is made up of five boroughs (Barnet, Camden, Enfield, Haringey and Islington) and has a population size of around 1.8 million. The population is younger than average and is set to increase by 5% by 2030, with the largest increase in 65+ year olds[8].

There are high levels of deprivation in some areas and NCL is the second most deprived ICS in London. More than 1 in 5 people in NCL live in deprivation with particular concentrations of deprivation in the east of the system. The population living in NCL is also ethnically diverse, Barnet and Camden have larger Asian communities whereas Haringey and Enfield have larger Black communities. The Marmot Review highlighted that deprivation and racial discrimination are strongly associated with health inequalities, which impacts on all areas of people's lives, and health outcomes, from conception through to death[9]. The direct and indirect impacts of COVID-19 have starkly highlighted this[10]. The diversity of our local communities and their different cultures means that they may have different health needs and may want to access services differently.

Across NCL there is a high level of population health needs and inequality which has been explored in detail as part of the NCL population health strategy[11]. In recent years life expectancy and healthy life expectancy (average number of years that a person can expect to live in "full health") have declined following the pandemic. Life expectancy ranges between the different boroughs. Residents in Barnet and Camden have a higher life expectancy than the London average whilst Islington residents have lower life expectancies. Between the most and least affluent areas in NCL, there is nearly a 20 year variation in healthy life expectancy[12].

Around 18% of NCL's 1.8m residents are children and young people, defined as those aged 0-18 (316,900)[13]. By 2041, the population is projected to decline by 10%[14].

Children and young people in NCL are diverse; just over a quarter identify as white British, a quarter as white other and 10% as black African[15]. One in five children do not speak English as their first language at home[16] and an estimated 62,000 children and young people under 16 years in NCL are living in poverty[17]. The eastern border of NCL, in Enfield, Haringey and Islington, generally has a

[8] North Central London Population Health and Integrated Care Strategy, 2023 https://nclhealthandcare.org.uk/wp-content/uploads/2023/05/PH-IC-Strategy-V.Final-long-version.pdf

[9] The Marmot Review: Fair Society, Healthy Lives. 2010. https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf (Accessed June 2023)

[10] Marmot M. Build Back Fairer: The COVID-19 Marmot Review. 2020. https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review (Accessed June 2023)

[11] North Central London Population Health and Integrated Care Strategy, 2023 [https://nclhealthandcare.org.uk/wp-content/uploads/2023/05/PH-IC-Strategy-V.Final-long-version.pdf]

[12] North Central London Population Health and Integrated Care Strategy, 2023 [https://nclhealthandcare.org.uk/wp-content/uploads/2023/05/PH-IC-Strategy-V.Final-long-version.pdf]

[13] ONS. Population projections.

[14] GLA Housing-led projections. 2020.

[15] Local GP data flows, GPDPR and SUS data. 2021.

[16] ONS (2011 Census). 2009-2018.

[17] NCL ICB data

high level of deprivation, with the western areas of Barnet and Camden generally being the least deprived[18].

Islington has the highest percentage of children living in poverty in London, with around 1 in 4 children living in poverty. Within certain pockets of Islington and Haringey, nearly half of the children live in an area that is income deprived. In Barnet, Camden and Enfield, there are small areas with nearly 40% of children living in poverty. Although Haringey and Islington have areas which have the highest proportion of children that are living in poverty, Enfield has greatest absolute number of children under 16 that live in a deprived area in NCL. The borough averages, however, mask the fact that in all NCL boroughs, there are areas where children and young people are growing up in poverty as shown in Figure 5, which will have substantial implications for their life chances and their health.

1= most deprived, 10=least deprived

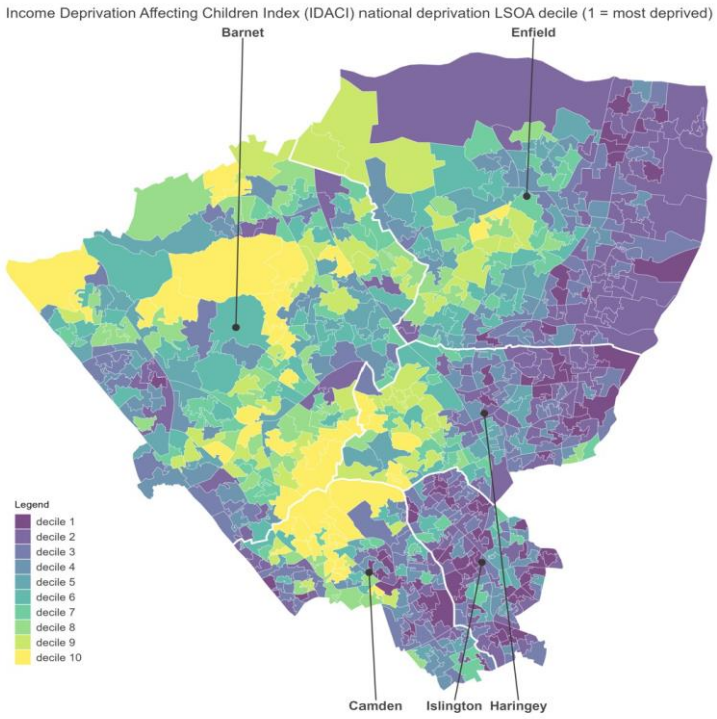


Figure 5: NCL deprivation map by IDACI decile

2.8 Background to paediatric surgery

2.8.1 Emergency paediatric surgery

Emergency surgical pathways for children and young people are those where a child or young person (usually up until their 18th birthday) needs an emergency operation or procedure, which could be as a result of an accident (such as a broken bone or serious cut that needs repairing), or to treat a medical condition (such as appendicitis or an abscess that needs to be drained).

[18] *Ministry of Housing, Communities & Local Government 2019, ONS geospatial data, CF analysis (2011 LSOA boundaries)*

2.8.2 Planned paediatric surgery

Planned surgical pathways are where a child or young person's procedure is planned. Planned surgery may be undertaken as a day case or as inpatient. Day case surgery takes place on the same day as the patient arriving and leaving the unit whereas inpatient planned surgery requires an overnight stay of one night or more[19].

Planned low complexity surgery can be delivered in the following ways:

- **Centralised:** child and family travel to the specialist hospital for surgery
- **Hub and spoke (network):** specialist paediatric surgeon travels to a local hospital (spoke) to deliver planned surgical care. This model is often used when there is a challenge in recruiting a surgeon with the required expertise.
- **Local care:** surgeon with paediatric interest delivers surgery at the local hospital

Examples of low complexity planned care include an operation to take out a child's tonsils or to correct a squint. These need to be carried out in a timely way, but they are not urgent in the same way that an operation needed for appendicitis is required.

Planned surgery which is higher in complexity would typically take place in a specialist unit. These larger, specialist centres have access to the expertise and facilities to deliver this activity[20].

2.8.3 Paediatric surgical workforce

Many clinicians are involved in the delivery of paediatric surgery, including[21]:

- **Specialist paediatric surgeons:** are mainly employed by specialist trusts. Specialist paediatric general surgeons undertake a six-year dedicated training programme in paediatric surgery. Specialist paediatric urologists are specialist paediatric surgeons with expertise in treatment of paediatric genitourinary conditions.
- **Adult surgeons (across a number of specialties):** mostly deliver emergency, low complexity paediatric care. Some adult surgeons may have a specialist interest in paediatric surgery and may be involved in delivery of planned low-complexity surgery.
- **Adult urologists:** deliver a significant proportion of general paediatric surgery in local units. All urologists are expected to have the skillset to deliver some paediatric urology.
- **Paediatric anaesthetists:** paediatric anaesthesia is a subspecialty of anaesthesia. Paediatric anaesthetists have received specialist training that gives them expertise in the peri-operative care of babies and children.
- **General anaesthetists:** all general anaesthetists are expected to deliver anaesthesia in children over three years of age. Most of the planned and emergency anaesthesia in children in local units is delivered by general anaesthetists.
- **Children's nurses:** are registered nurses who have had an undergraduate training in the nursing care of babies, children and young people

[19] https://www.rcseng.ac.uk/patient-care/having-surgery/types-of-surgery/

[20] https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/02/PaediatricReport-Mar30v-Embargoed.pdf

[21] https://gettingitrightfirsttime.co.uk/wp-content/uploads/2022/09/PaediatricSurgeryReport-Sept21w.pdf

- **Specialist children's nurses in paediatric surgery:** are registered nurses who hold specialist knowledge, skills, competencies and experience in paediatric surgery.

2.9 Current organisation of paediatric surgery services in NCL

In NCL, paediatric surgery is provided by seven hospital trusts across ten sites:

- **Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH)** is a specialist tertiary and quaternary centre providing local, regional, national, and international care for babies (including neonates), children, and young people. The hospital provides planned care and takes planned emergency transfers within its areas of specialism. It does not have a maternity unit, emergency department (ED), or ambulatory care unit. GOSH has a 17-bedded, level three paediatric intensive care unit, which serves not only NCL, but London and the rest of the country. GOSH only see children up until the age of 16 years or 18 years for specific commissioned specialised services. GOSH has a 10-cot specialist NICU (level 3).

  Specialist regional, national and international services at GOSH, for example specialist cardiology, neurology and neurosurgery, are not within scope of the Start Well programme, and neither are cancer services.

- **North Middlesex University Hospital NHS Trust (North Mid)** is the busiest emergency healthcare provider for children and young people in NCL. Its ambulatory care unit is a nine bedded short stay ward adjacent to the paediatric emergency department, looking after children for up to 48 hours. Within the ambulatory care unit, the North Mid also run a paediatric assessment unit (PAU), which is a 24/7 facility for the assessment and treatment of children who require care from home or need to stay longer after an emergency department visit. There is one longer-stay children's ward with 16 beds. The hospital has no commissioned dedicated high dependency unit (HDU) beds; however, provision can be made if required to provide high dependency care nursing levels on the ward. Due to the high emergency flows within the Trust, it offers only a small number of planned surgical pathways, although it does carry out a larger number of emergency operations. Many children and young people in the North Middlesex catchment area will be referred to other hospitals, such as UCLH or Barnet, for planned surgery.

- **Moorfields Eye Hospital NHS Foundation Trust (Moorfields)** is a leading provider of eye health services nationally, regionally and locally, for both children and adults. It is an international centre for ophthalmic research, education and advanced clinical practice. The Richard Desmond Children's Eye Hospital at Moorfields Eye Hospital, based at the main Moorfields site on City Road in Islington, offers care for children and young people up to the age of 16, providing outpatient consulting rooms, a day care ward and a children's emergency department (open weekdays 9am to 4pm). Out of hours children and young people are seen in a dedicated area of the main emergency department on the City Road site.

  There are close working relationships between Moorfields and GOSH ophthalmology teams, with some shared or joint appointments between the two organisations for several ophthalmology pathways. All of Moorfields' surgery takes place on a day-case basis, meaning that the hospital has no beds for children and young people to stay overnight. Children requiring a planned overnight stay prior to surgery will normally be admitted overnight at

GOSH and then be transferred to have their surgery at Moorfields, although this pathway is rarely used. If a child needs an unplanned stay post-operatively, a bed will be secured in liaison with neighbouring trusts and a transfer will be arranged.

- **Royal Free London NHS Foundation Trust (Royal Free)** provides paediatric surgical services from three sites within NCL: Barnet Hospital, Chase Farm Hospital and the Royal Free Hospital. Chase Farm Hospital provides planned paediatric medical and surgical outpatient services, predominately to residents of Barnet and Enfield and outpatient services for young people over 16 years which are out of scope of these proposals.

    - **Barnet Hospital** operates as a predominantly emergency hospital for both adults and children. It has one paediatric ward with 20 medical and surgical beds. An ambulatory care unit, open from 9am to 10pm, and linked to the paediatric emergency department provides assessment and treatment of children who need to stay longer after an emergency department visit for observation or medications. The hospital has no dedicated paediatric high dependency beds; provision can be opened if required to provide high dependency care nursing levels on the paediatric ward. Due to the high emergency flows, Barnet does not offer many planned surgical pathways. The exception to this is ear nose and throat (ENT) and oral maxillofacial surgery in children, where Barnet Hospital is a major provider within NCL. Barnet offers a range of paediatric medical specialities, with the highest volume clinics being general paediatrics and allergy, as well as offering medical specialities such as diabetes.

    - **The Royal Free Hospital (Royal Free Hospital)** provides general and specialised paediatric medical and surgical services in both outpatient and inpatient settings. It has a dedicated, recently refurbished paediatric emergency department offering a range of different services. There is an ambulatory or short stay unit with 10 beds, however this is for planned care only and it does not take admissions directly from the paediatric emergency department. There is also a longer stay inpatient ward of 20 beds. The hospital has no dedicated high dependency unit beds; provision can be opened if required to provide high dependency care nursing levels on the main paediatric ward. A particular area of specialism within the hospital is plastic or reconstructive surgery, for which the Royal Free is the specialist centre for both adults and children in NCL. Children requiring plastic or reconstructive surgery, for example repairing a lip laceration, will be referred to the Royal Free from other hospitals in NCL and beyond. This is often an emergency pathway, with a child or young person treated for their immediate injury at their local hospital's paediatric emergency department and then asked to attend for surgery at the Royal Free Hospital the next day, often via the ambulatory care unit. If the injury requires immediate surgery, the child or young person will be admitted to the main paediatric ward, via the Royal Free paediatric emergency department.

- **Royal National Hospital Orthopaedic Hospital NHS Trust (RNOH)** is a highly specialist orthopaedic hospital providing neuro-musculoskeletal care to both children and adults. It is recognised as a national centre of excellence for the treatment of acute and chronic neuro-musculoskeletal conditions in children and young people. The Trust provides planned care, in both medical and surgical services and does not have an emergency department or

ambulatory care unit. Specialist regional, national, and international services such as paediatric spinal surgery and limb lengthening are out of scope of the Start Well programme. The RNOH provides a permanent level two paediatric high dependency unit to support its specialist work. The Trust has several shared pathways and joint appointment to support its specialist work; with UCLH around cancer pathways and with GOSH around specialist orthopaedic pathways of care. Although RNOH predominantly provides highly specialised care, some local pathways are in place for more routine orthopaedic care for children and young people in NCL.

- **University College London Hospitals NHS Foundation Trust (UCLH)** provides local, regional and national acute and specialist services based across several hospitals. Compared to overall activity, UCLH has a relatively small paediatric emergency department and a six bedded, 24 hour 7 days a week, same day emergency care unit (SDEC) co-located on the ward, which allows timely treatment and investigation of short stay emergency presentations and speciality referrals. This protects flow through the emergency pathway, reduces admissions and length of hospital stay and minimises infection risk to staff and patients. Children and young people are admitted for both planned and emergency care to three wards in the main hospital tower with 41 beds.

  The hospital provides a range of specialist and general services for children and young people, covering all ages, with a particular specialism in caring for teenagers and young adults. The trust has one of the largest adolescent services in the country, with a team of specially trained staff; as a result, it takes referrals not just from NCL boroughs, but from London and beyond. The close geographical proximity with GOSH means that there is very close working between the two organisations, with many joint or shared appointments; for several pathways – including oncology, endocrinology and rheumatology – GOSH will manage children up to 13 and they will then transition into the specialist teenage and adolescent services at UCLH. UCLH also provides a range of specialist paediatric surgery for ear nose and throat, dentistry, urology and gynaecology. Established level 2 paediatric high dependency unit care is available to support the teenage and young adult practice (over 13 years old). The hospital currently has no dedicated HDU beds for children under 13 years of age, however provision can be opened if required to provide high dependency care nursing levels.

- **Whittington Health NHS Trust (Whittington Hospital):** provides integrated hospital and community care services to people living in Islington and Haringey, including services for children and young people and some community services to other boroughs, including Barnet, Enfield, and Hackney. The children's emergency department is supported by an ambulatory care unit which aims to avoid unnecessary admissions by allowing children and young people to be observed for longer periods of time than is possible in the emergency department. It enables children to come back in a planned way for IV antibiotics, rather than waiting in hospital or being admitted. For longer stay admissions, children and young people are admitted to the main 21-bedded children and young people's ward and 2 HDU beds. Whittington Health are a provider of community dental services across sites in North London. This service specialises in the dental treatment of children who cannot be treated in general dental services.

2.10 Current planned and emergency paediatric surgical activity in NCL

Across sites in NCL the volume of paediatric surgery in 2021/22 was 21,691 procedures. This includes children and young people who live outside of NCL but access services at our sites. Of these procedures, GOSH delivered 13,478 (62%) of which 1,710 were for NCL residents. UCLH is the second largest provider of paediatric surgery in NCL with 1,885 procedures delivered. North Mid delivered the lowest volume of paediatric surgery in 2021/22 with less than two per day.

2.10.1 Planned paediatric surgical activity

In 2021/22, very small volumes of planned inpatient surgical activity were undertaken at local NCL units. Barnet and North Mid deliver low volumes of planned surgery, with North Mid delivering less than one procedure per day (Figure 6). NCL sites do not currently deliver surgical care for all specialties and the specialties delivered varies between the providers.

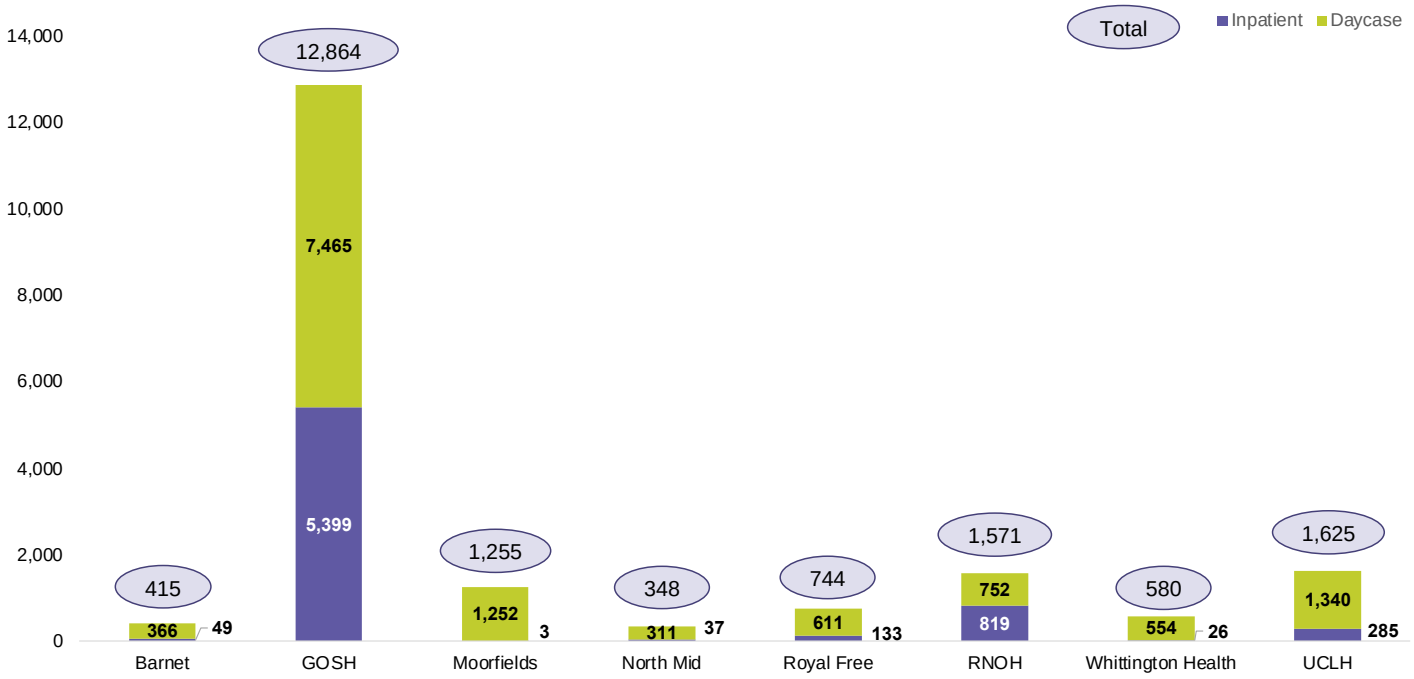


Figure 6: Total volume of planned paediatric surgery at NCL sites in 2021/22

Across all NCL sites, the population with the greatest volume of planned surgical activity is in children aged 5 and over (Figure 7). The majority of paediatric surgical activity delivered at local units is in children over the age of 5 years. Planned activity in very young children (under 5 years) is predominantly delivered at GOSH.

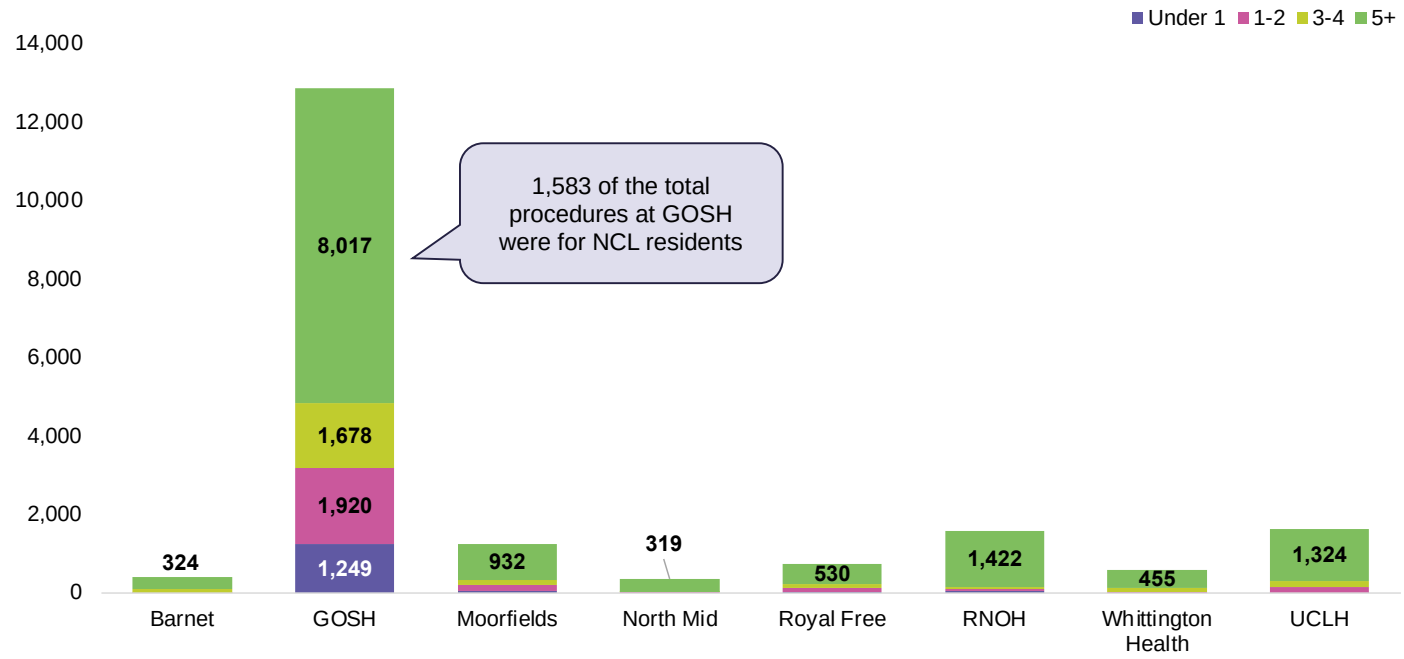


Figure 7: Planned surgical procedures at NCL sites in 2021/22 split by age band

2.10.2 Emergency paediatric surgical activity

As with planned surgery, small volumes of paediatric emergency surgical procedures took place in 2021/22 across sites in NCL (Figure 8), with Barnet and Royal Free being the only local sites that delivered more than one emergency surgical procedure per day.

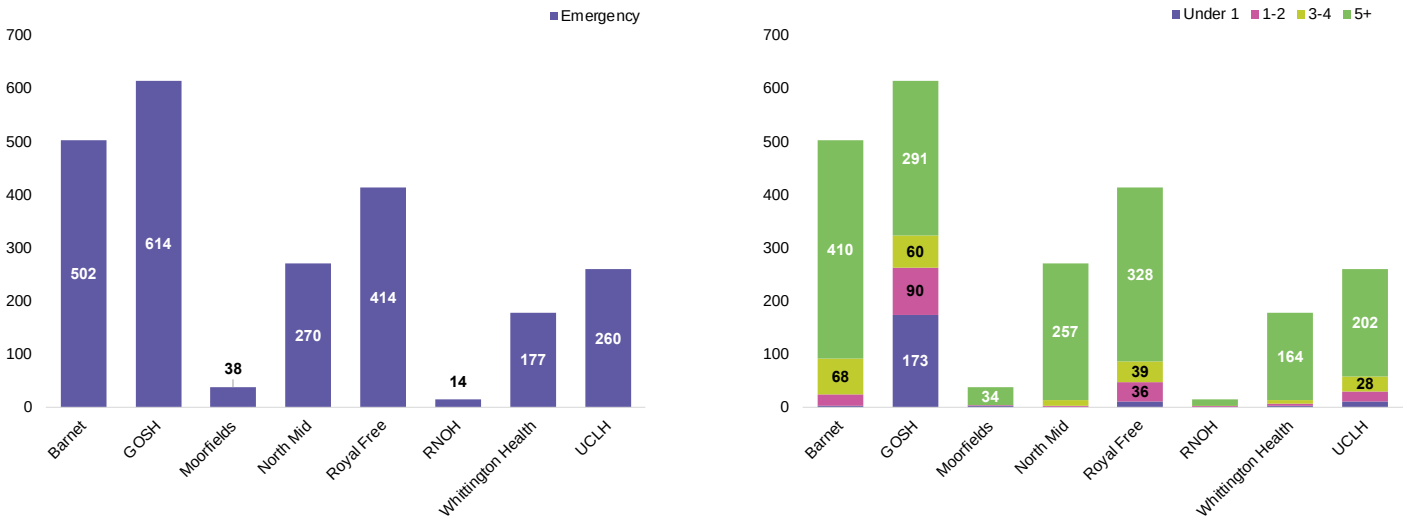


Figure 8: Total volume of emergency surgical procedures at NCL sites in 2021/22 and split by age band

Across all sites in NCL the largest volume of emergency surgery took place in children and young people aged 5 years and over, with less than 30 procedures taking place in children under the age of 1 in all sites combined (excluding GOSH).

3. Case for change

The development of the Start Well case for change was clinically led with involvement from patients, provider organisations and wider system partners. It was published in June 2022 and sets out a range of opportunities for improvement for children and young people's services. Opportunities for improvement that sit outside paediatric surgery are being overseen by Children Young People and Maternity and Neonatal (CYPMN) Board.

This section sets out the key elements of the paediatric surgery case for change and the opportunities for improvement for these services. The Start Well Case for Change is available here.

3.1 Opportunities for improvement

We know that across NCL there are a number of opportunities for improvement for children and young people's services as outlined in Figure 9.

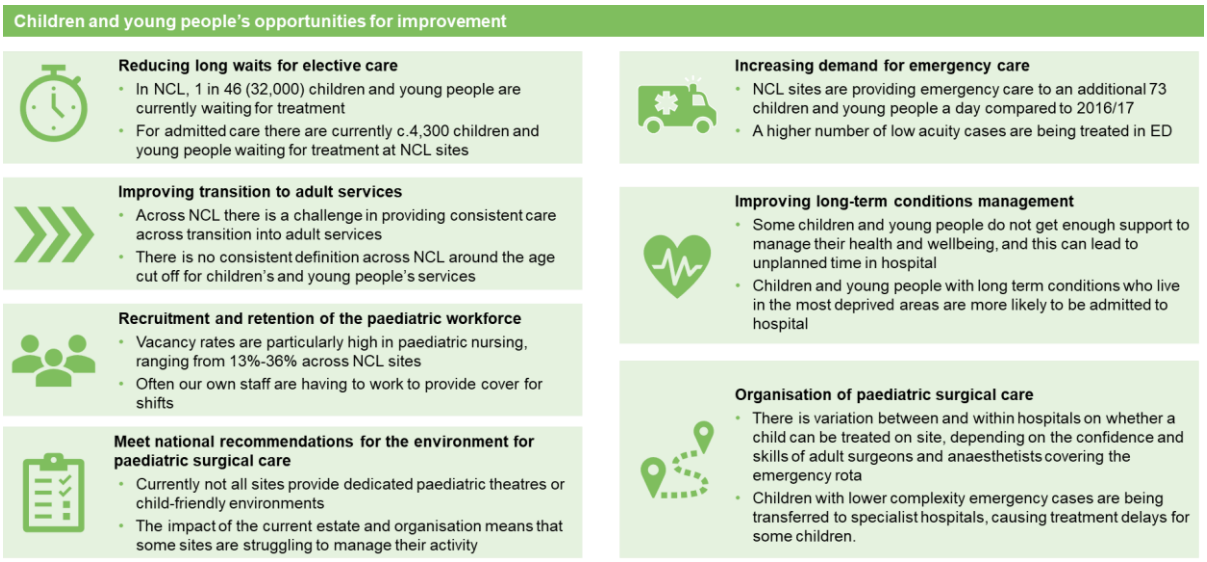


Figure 9: Opportunities for improvement for children and young people's services

Across NCL sites our emergency departments provide emergency care for over 160,000 children and young people a year. Staff have also reflected that the complexity of those accessing emergency services are changing. Data shows that there are increasing numbers of children and young people attending who could have potentially been treated in a more appropriate care setting. Whilst some do require hospital treatment, many children and young people could be better looked after in the community. To ensure children and young people are accessing emergency care in the right place, more could be done to focus on joined up services between hospitals, GPs and community services.

Planned care should be delivered within 18 weeks and across NCL we are not meeting this standard of care. As of September 2023, there were around 5,000 children and young people in

NCL waiting for a planned operation with over 500 children and young people waiting over a year for surgery. The current waiting list is growing and currently providers in NCL do not meet NHS targets. At best, the waiting time for treatment for children, young people and their families is stressful and frustrating, and at worst it can impact children and young people's health and their wider lives.

Across NCL there is an opportunity for us to improve the organisation of both planned and emergency paediatric surgery. In line with national guidance, our local hospitals should be able to provide low complexity paediatric surgical care for children over the age of three, but we know this is not currently always happening. For emergency surgical care from April 2020 to March 2021, 144 children and young people were transferred from an NCL provider to other hospitals for an emergency surgical procedure, with almost 30 of these children moved to hospitals outside NCL. For patients and their families, this can cause added stress at an already stressful time. From speaking with staff, we know that some children and young people in NCL are being transferred for some treatments which should be managed locally. There is a gap in paediatric consultant anaesthetist provision at local sites and the low volumes of activity delivered at local units make it difficult for general anaesthetists and general surgeons to maintain skills to feel confident in delivering surgical care on children aged 3-5 years.

This PCBC focuses only on those opportunities that relate to paediatric surgery. This section describes in further detail the opportunities to improve the organisation of paediatric surgical care, improve access to specialist surgical workforce and meet the national recommendations for the environment. Other opportunities identified are being picked up through other workstreams within the ICB.

3.2 Emergency paediatric surgery

Emergency paediatric surgery in NCL is currently delivered at all local sites however from speaking with staff and reviewing the data we know that there are challenges in respect to:

- A lack of consistent and clearly defined emergency surgical pathways meaning that clinicians have to make multiple enquires to secure the right pathway for individual children who present to emergency departments
- Multiple emergency surgical transfers can be required to find babies or children a bed in the right setting
- Lack of clarity on the role of GOSH in caring for local NCL children and young people requiring surgery, alongside its tertiary and quaternary work
- Access to workforce to deliver surgical activity in children under 3 years or under 5 years (general surgery and urology)

These challenges mean that some children and young people are being transferred multiple times, sometimes to units outside of NCL to receive emergency surgical care. For staff at local units, the fragmentation and lack of clarity on the emergency surgical pathway can mean lots of time is spent trying to locate a bed and therefore delays in accessing the right care.

3.2.1 Lack of consistent and clearly defined emergency surgical pathways

In NCL there are very few consistent system-wide protocols on pathways for emergency surgical care or for the management of transfers, particularly for children aged 3-5 years. From speaking with staff, treatment at local hospitals can be dependent on the expertise and skills of both the general surgeons and anaesthetists covering the emergency rota on a particular day to manage the care of children. Children under the age of 3 or under the age of 5 for general surgery and urology require more specialist paediatric surgical and anaesthetist input. However, this expertise is not always available at local units, and often our staff at these units do not deliver sufficient volumes of this activity to maintain the skills.

The variation in workforce between local units and a lack of clarity on the emergency surgical pathways and defined ages for emergency surgery at local units, means that for those very young children under 5 years, there is not clear pathways in NCL to transfer for treatment.

Whilst transfers may be necessary for complex cases or where there is a need for a paediatric surgeon where the child is aged under 5 years, there are instances where treatment, particularly low-complexity surgery, could have been undertaken at the local non-specialist hospital. Transferring a child or young person risks delaying treatment and may result in being treated further away from home. For families and carers, this means further to travel and can create additional stress in an already stressful circumstance.

3.2.2 Access to specialist paediatric workforce

For young children, particularly those aged under 3 years or under 5 years (general surgery and urology) specialist paediatric and anaesthetic surgical specialists are required to provide surgical care. In NCL, there is variation in the access to this workforce, with only GOSH, as a specialist unit, with paediatric surgeons (surgeons who have completed a Certificate of Completion of Training in paediatric surgery) in post, as set out in

Figure 10.

Site	Current number of paediatric surgeons* in post (WTE)	Current number of consultant paediatric anaesthetist in post (WTE)	Notes
Barnet	0	2	• Only anaesthetise paediatric elective cases 3 years and above
GOSH	6.6	48	
North Mid	0	0	
Royal Free	0	2	• 2 WTE competent to anaesthetise under 3s if needed
UCLH	0	4	• Additional 3.5 WTE are competent to anaesthetise from 12 months but work on mixed paeds and adult rota • GOSH paediatric surgeons currently support some elective work at UCLH

Whittington	0	0	• 4 WTE regularly anaesthetising children on paeds dental lists over the age of 3

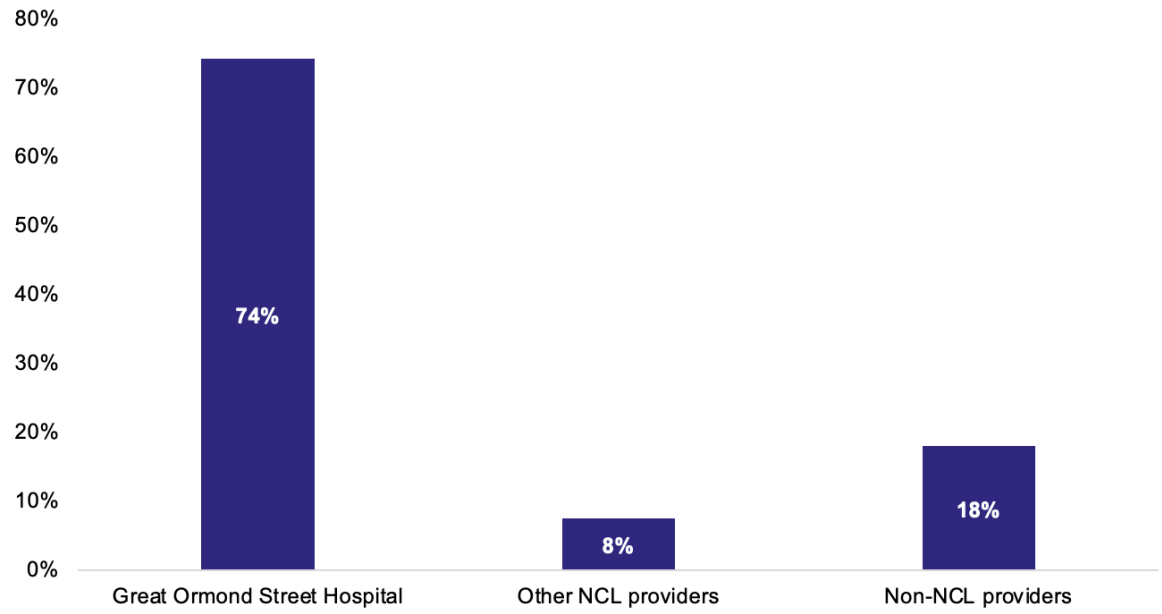
Figure 10: Current number of paediatric surgeons and consultant paediatric anaesthetist in post (WTE) by site

The variation and access to specialist workforce across units and lack of a defined emergency surgical pathway means that a number of children and young people are being transferred multiple times which may delay treatment. This can be stressful, for both the patient and their families and can also increase the risk of adverse outcomes[22]. Emergency department staff have also reflected that arranging a transfer can be stressful and time consuming for the team, who need to make sure the child or young person gets the treatment they need in a timely manner and now it can often take multiple phone calls to secure a transfer which in many instances is to a unit outside NCL.

From April 2020 to March 2021, 144 children and young people out of 1,401 procedures were transferred from an NCL provider to other hospitals for an emergency surgical procedure; 18% of these transfers were to hospitals outside of NCL. In some instances, individuals were transferred up to three times before receiving emergency treatment.

3.2.3 Role of Great Ormond Street (GOSH)

GOSH provide excellent emergency care for children and young people requiring complex treatment and the pathway for this works well across NCL. However, staff feedback has highlighted that the role of GOSH within some non-specialist emergency care pathways is not fully defined or agreed across the system. Currently of those transferred for emergency treatment, almost 75% were transferred to GOSH (Figure 11).



Source: SUS data, CF analysis

[22] Are we there yet? A review of organisational and clinical aspects of children's surgery. In: p 55, National Confidential Enquiry Into Perioperative Death, editor. London2011 https://www.ncepod.org.uk/2011sic.html

Figure 11: Emergency surgical transfers from NCL providers

Challenges with maintenance of surgical and anaesthetic skills at local units means that often children over the age of 5 years are being transferred or referred to GOSH for emergency surgery. Whilst in some instances, such as if a child is medically complex, this is clinically required, often this activity could have been delivered locally. This ambiguity can be difficult to manage on a day-to-day basis and can result in inappropriate cases being transferred.

As a specialist provider, GOSH has a role as a national and international centre and needs to accept referrals and treat babies and children from a much wider geographical area. Whilst some cases do require specialist care, we need to ensure that the role of GOSH is fully defined for our clinicians, ensuring we are utilising this scarce and specialist resource in the most effective way.

GOSH does not have a receiving point for children and young people presenting as an emergency attendance, neither an ED nor ambulatory care unit, so emergency cases need to be planned and admitted directly to a ward. Having no assessment facility or ED can make it challenging for a rapid surgical assessment to take place. For GOSH this risks children and young people being admitted where it may not be needed. This can add extra pressure to an already constrained specialist resource.

3.3 Planned paediatric surgery

The most complex planned paediatric surgery is delivered by specialist paediatric surgeons at specialist trusts; in NCL this is predominantly provided by GOSH, with some GOSH consultants also operating at UCLH via an in-reach service. Less complex, planned paediatric surgery in NCL is currently delivered at a number of sites (specialty dependent). However, from speaking with staff and reviewing the data, we know that there are challenges in respect to:

- Low volumes of some planned surgery being delivered at some local units
- Access to specialist paediatric workforce to deliver planned surgery in children aged 1-2 years

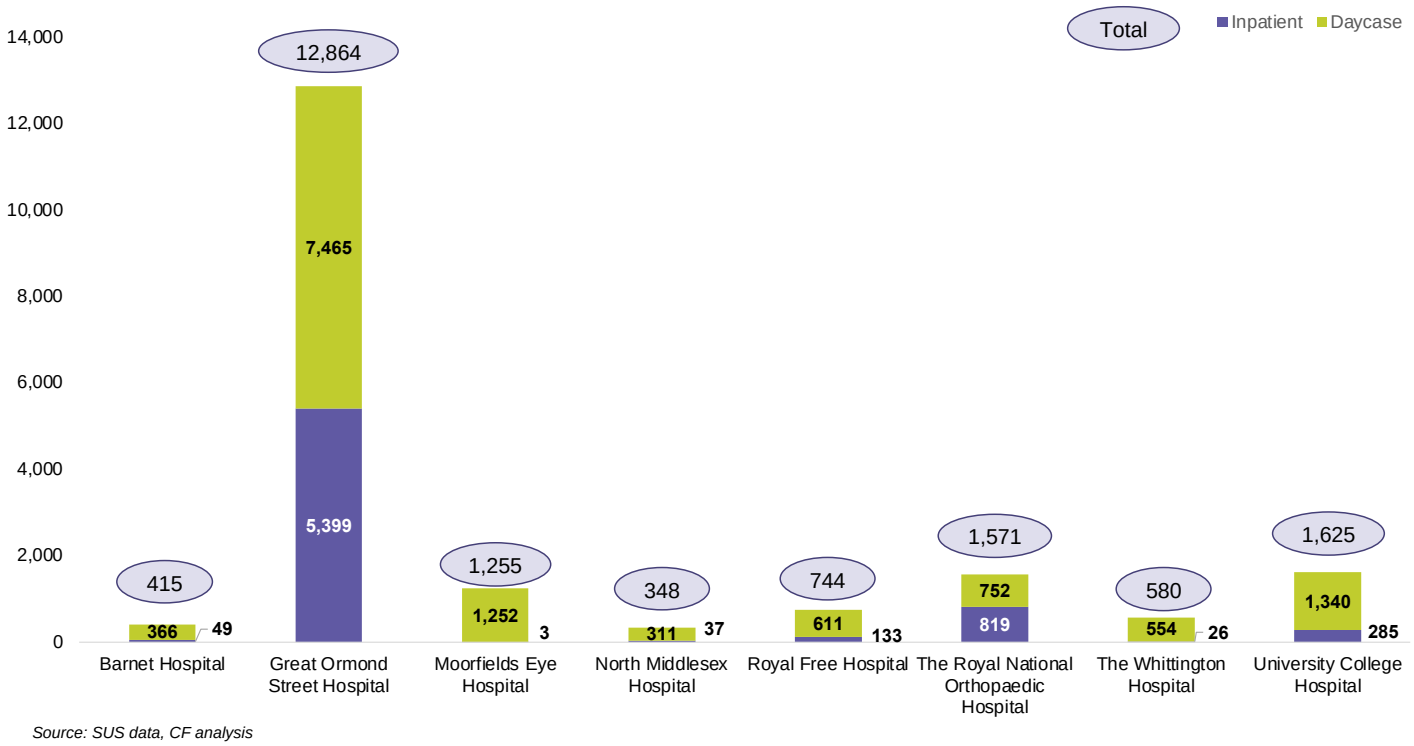
The GIRFT review of paediatric surgery states that most low-complexity cases can be treated as day cases at local units[23]. However, in some specialities, there is fragmentation and an opportunity to consolidate planned surgery for low volume specialties and for planned surgery in children aged 1-2 years where more specialist input may be required.

3.3.1 Low volumes planned paediatric surgery

Nationally, increasing volumes of planned paediatric surgery are being undertaken at specialist Trusts and decreasing volumes are being delivered at local units. Specialist services that deliver excellent patient outcomes are built through high-volume delivery of care to patients within that specialism.

[23] https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/02/PaediatricReport-Mar30v-Embargoed.pdf

Whilst across NCL there is excellent planned care being delivered across specialisms, there are services which currently do not have a sustainable volume of cases in order for staff to maintain skills and competencies. As shown in Figure 12, North Mid deliver the lowest volume of planned procedures with just 348 delivered in 2021/22. UCLH deliver the highest of the local units at 1,625 per year. GOSH in its role as a specialist unit delivers the majority activity. Of the 12,864 planned procedures delivered in 2021/22 at GOSH, 1,271 (10%) were for NCL residents.



Source: SUS data, CF analysis

Figure 12: Volumes of planned surgery at NCL sites in 2021/22

The low volume of planned surgery at local units means there is reduced exposure to paediatric surgery and paediatric anaesthesia for staff. This can make it challenging for staff, particularly anaesthetists, junior doctors, specialist nurses and consultants within paediatric services to learn and practice the necessary skills and maintain their competencies. As highlighted in section 3.2 this also impacts on the ability of hospitals to deal with emergency paediatric surgery, as there is a risk that staff may become deskilled if they are not seeing a sufficient volume of cases on a planned basis.

3.3.2 Access to paediatric consultant anaesthetist workforce

Throughout engagement, the provision of paediatric anaesthetics has been noted as a significant barrier to delivering surgical care across multiple specialties. Paediatric anaesthetists have had additional training in paediatric anaesthesia and are required to anaesthetise children under the age of 3 years. As set out in

Figure 13 the number of paediatric consultant anaesthetists varies local sites. UCLH, Barnet, Royal Free Hospital and Whittington Hospital have paediatric consultant anaesthetists, whilst the low

volumes of paediatric planned surgery at North Mid means it has not been feasible to recruit to this role.

Site	Current number of consultant paediatric anaesthetists in post that can anaesthetise children 1-2 (WTE)	Current number of consultant paediatric anaesthetists in post that can only anaesthetise children 3+ (WTE)	Notes
Barnet	0	2	• Only anaesthetise paediatric elective cases 3 years and above
North Mid	0	0	
Royal Free	0	2	• 2 WTE competent to anaesthetise under 3s if needed
UCLH	4	7.5	• Additional 7.5 WTE are competent to anaesthetise from 12 months but work on mixed paeds and adult rota
Whittington	0	4	• 4 WTE regularly anaesthetising children on paeds dental lists over the age of 3

Figure 13: Paediatric consultant anaesthetist competency by NCL site

The variation and availability of paediatric consultant anaesthetic workforce means that not all local units have on-site access to the workforce required to deliver the surgical activity in children aged 3 years and under. Whilst surgical activity in children under the age of 1 years is predominantly delivered by GOSH there is an opportunity for NCL to think about consolidating planned surgical activity in children aged 1 – 2 years to where consultant paediatric anaesthetists are available.

There is also an opportunity for NCL to think about how collaboration around anaesthetic provision could help anaesthetists to maintain their skills for younger patients. There may also be innovative ways in which the system can consider workforce solutions or further training opportunities.

3.4 Meeting national recommendations for the environment for paediatric surgical care

A positive and safe experience of healthcare can have a long-term impact on children and young people. The environment in which care is delivered is critical and recognised in national guidance. The Royal College of Surgeons standards[24] for paediatric surgery outlines that the environment in which children and young people are treated in should be:

- Safe
- Suitably staffed and equipped
- Child and family friendly

The environment and infrastructure can have an impact on the care delivered and the experience of children, young people, their families, and carers.

[24] Royal College of Surgeons: Standards for Children's surgery, 2013

When it comes to delivering paediatric surgery, we know that the environment of some sites is not providing the best experience for children and young people. National guidance recommends that children should be separated and not managed directly alongside adults[25]. Children, where possible, should also be operated on in child-friendly theatres, have separate recovery rooms and should be on a dedicated children's list if possible[26]. All theatre staff should also have child-specific training to ensuring the best possible experience for children and young people is provided[5].

Through a series of bespoke Start Well youth forums, young people from across NCL have shared their views on how services could better meet their needs. In terms of improving the hospital environment and experience of care, young people told us it was important to have dedicated spaces for children and young people that are separate from adults, including in waiting rooms. They suggested ways in which the environment could be enhanced including spaces for families, colourful spaces, artwork, peaceful music, mood lighting and toys.

However, within NCL not all sites are able to meet the recommendations. As set out in Figure 14 only UCLH and GOSH provide dedicated paediatric lists, dedicated paediatric theatres and paediatric recovery areas. Barnet, North Mid, Royal Free Hospital and Whittington Hospital do not have dedicated paediatric theatres or recovery areas which is in part driven by the low volumes of planned activity and the need to manage adult surgery.

Hospital	Dedicated paediatric surgical lists	Dedicated paediatric surgical theatres	Dedicated paediatric recovery areas
Barnet Hospital	✓	✗	✗
Great Ormond Street Hospital (GOSH)	✓	✓	✓
North Middlesex University Hospital (North Mid)	✓	✗	✗
Royal Free Hospital	✓	✗	✗
University College London Hospital (UCLH)	✓	✓	✓
Whittington Hospital	✓	✗	✗

Figure 14: Organisation of surgical services at NCL Trusts

The impact of the current estate and organisation of care means that some sites are struggling to manage their activity or are having to manage activity in a way that does not meet best practice guidance. There are also productivity implications for Trusts; dedicated paediatric lists provide

[25] https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/02/PaediatricReport-Mar30v-Embargoed.pdf

[26] Royal College of Surgeons: Standards for Children's surgery, 2013

opportunities to improve efficiencies of elective surgery and reduce waiting times for surgical procedures.

Improving and optimising the current facilities is important in ensuring a positive experience, as patients' families have reflected on the importance of facilities and the environment in how they experience care.

4. Vision and care models

The vision for paediatric surgical services is to deliver high quality services and ensure that any child or young person requiring planned or emergency surgery is seen by the right people, at the right place and in the right setting.

4.1 Responding to full paediatric case for change and wider care model implementation

This PCBC is focused on the treatment element of the emergency and planned paediatric surgery care model. The full case for change (published June 2022) outlined a number of opportunities outside of surgical treatment to improve care for children and young people in NCL. Many of these opportunities, and wider elements of the developed care models are already being taken forward through other programmes of work in the ICB, as they do not require a change in service in order to deliver. The key areas of work and how these are being taken forward are outlined in

Figure 16.

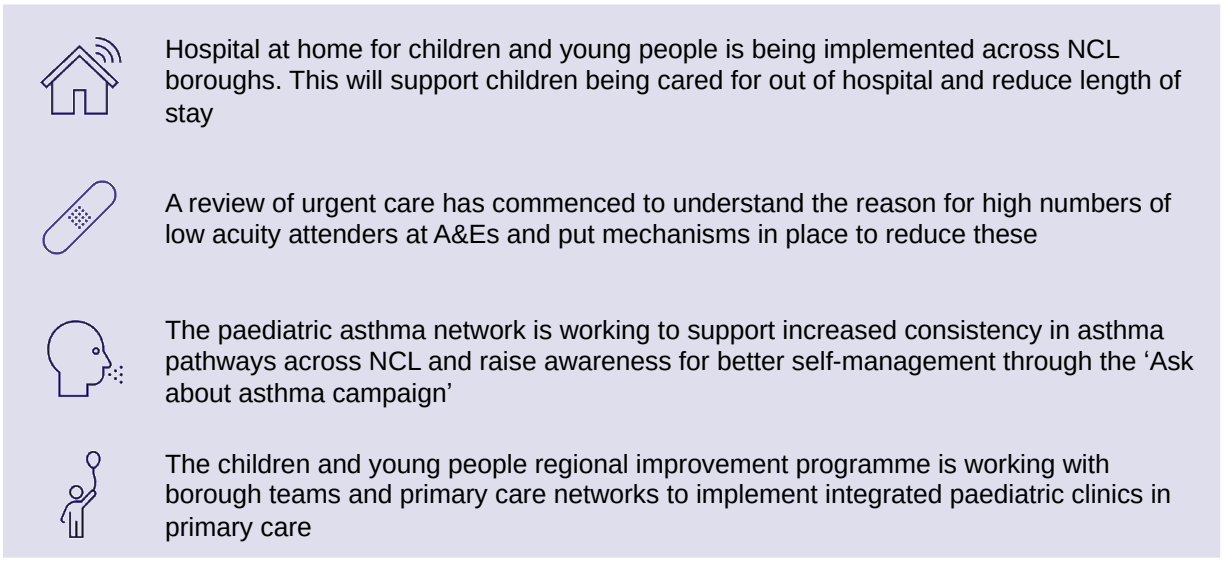


Figure 15: Work ongoing to address the opportunities in the case for change outside the proposed surgical care model

4.2 Vision for paediatric surgery services

For paediatric surgery, our vision is to ensure that any child or young person requiring planned or emergency surgery is seen by the right people, at the right place and in the right setting. If an emergency operation is needed, for example to manage appendicitis, children and young people, their families and carers should be confident that they are receiving the best possible care without

delay. We want to ensure that all children and young people have the same experience and quality of care.

If a child or young person needs more specialist care at another hospital, transfer needs to be timely and smooth, within defined pathways to prevent any delays to treatment. For our staff, the surgical pathways should be clear, and staff providing surgical care should be doing this regularly and have the skills to provide this. To deliver our vision, our new care model would:

- Ensure that, where possible, children and young people receive emergency care in NCL and outflows to sites outside of NCL are reduced to minimise travel and uncertainty at a time of stress
- Ensure that, where a child or young person requires an emergency surgical transfer, this is undertaken as soon as possible and to the right setting the first time
- Make sure workforce at local units is delivering sufficient volumes of surgical activity to maintain skills and competencies
- Provide access in NCL to specialist surgical and anaesthetist workforce on-site 24 hours a day, 7 days a week to provide the specialist care required for very young children (those under 3 or under 5 requiring general surgery or urology)
- Consolidate emergency and planned surgical care for very young children to ensure they are able to access the specialist skills required
- Deliver improved quality of care, patient experience and patient outcomes
- Deliver surgical care in a child or young adult friendly environment and on dedicated paediatric theatre lists
- Provide enhanced training opportunities for our staff and post graduate doctors in training

4.3 The role of the North Thames Paediatric Network (NTPN)

The North Thames Paediatric Network is an NHS-funded group of operational delivery networks (ODN) and strategic workstreams that focuses on improving and streamlining children and young people's services and pathways. The Network is hosted by GOSH and represents 25 hospitals across the North London area – from NEL, through NCL and into NWL – and includes all NCL organisations.

The Network has representation from across all organisations and has a clear vision to function as a virtual children's hospital, so that every child in any hospital gets access to the best high-level care possible. It currently covers a range of specialities including surgery, gastroenterology, dentistry, respiratory, cardiac, oncology and a focus on transition across all specialities.

NCL is looking to work closely with the NTPN given their role around the development of surgical services through their surgical ODN. Given the changes to specialised commissioning and future devolvement of responsibility for specialist services to ICSs, NCL and the NTPN are looking to ensure that collaboration continues, and that the ODN continues to support NCL at a local level. There are aspects of the care model described in this section which will require close working with the NTPN in order to implement them and some of these aspects are described in section 7.3.1.

4.4 Approach to developing our care model

Developing the paediatric care model between July and November 2022 was a collaborative exercise undertaken with a wide range of input from a wider range of health and care stakeholders. More detail on development and who has been engaged is set out in section 9.3.3. The paediatric surgical care model has been shared at several system groups including the Network Oversight Group (NOG) which bring together all surgical clinical networks, Primary Care Operations Group and one-to-one meetings with the clinical chairs of the six NCL surgical networks. A full list of the forums that the care model has been tested at can be found in Appendix A.

We have also sought patient and public feedback through two meetings of the PPEG and a workshop with a group of young people which captured the views on the emerging children and young people's care models from around twenty young people who are residents of NCL.

The guiding principles underpinning the care model design process, including placing those using the services and their families at the centre, ensuring equity and consistent standards of care and making best use of our resources, people, places and money.

The care models were reviewed and recommended by the Start Well Programme Board, which includes senior specialised commissioning representatives alongside senior clinical leaders. The proposals for the paediatric surgery care model were formally signed off by the NCL ICB Board in November 2022, with representatives for NHSE London Region Specialised Commissioning in attendance.

Implementation of the paediatric surgery care model would be contingent on adoption of the proposed option in this PCBC following public consultation.

4.5 Paediatric surgical care model

We want paediatric surgical care to be delivered as locally as possible and by specialist staff who regularly deliver this type of care.

Our planned and emergency paediatric surgical care model can each be split into four elements, with an overview of the model for emergency paediatric surgery outlined in
Figure 16 and planned paediatric surgery in Figure 17:

- **Access to care:** delivered in a variety of settings in the community with onward referrals directed through standardised pathways
- **Triage and assessment:** supporting appropriate assessment and referrals so that children and young people receive the right care they need first time
- **Treatment:** diagnostics, consultations and treatment delivered in the most appropriate setting with access to specialist input as needed. Ensuring there are the supporting services and environment to deliver the best possible experience for patients, families and carers.
- **Onward care:** follow up care delivered in the most appropriate setting, in a setting as close to home as possible and delivering the best possible outcomes.

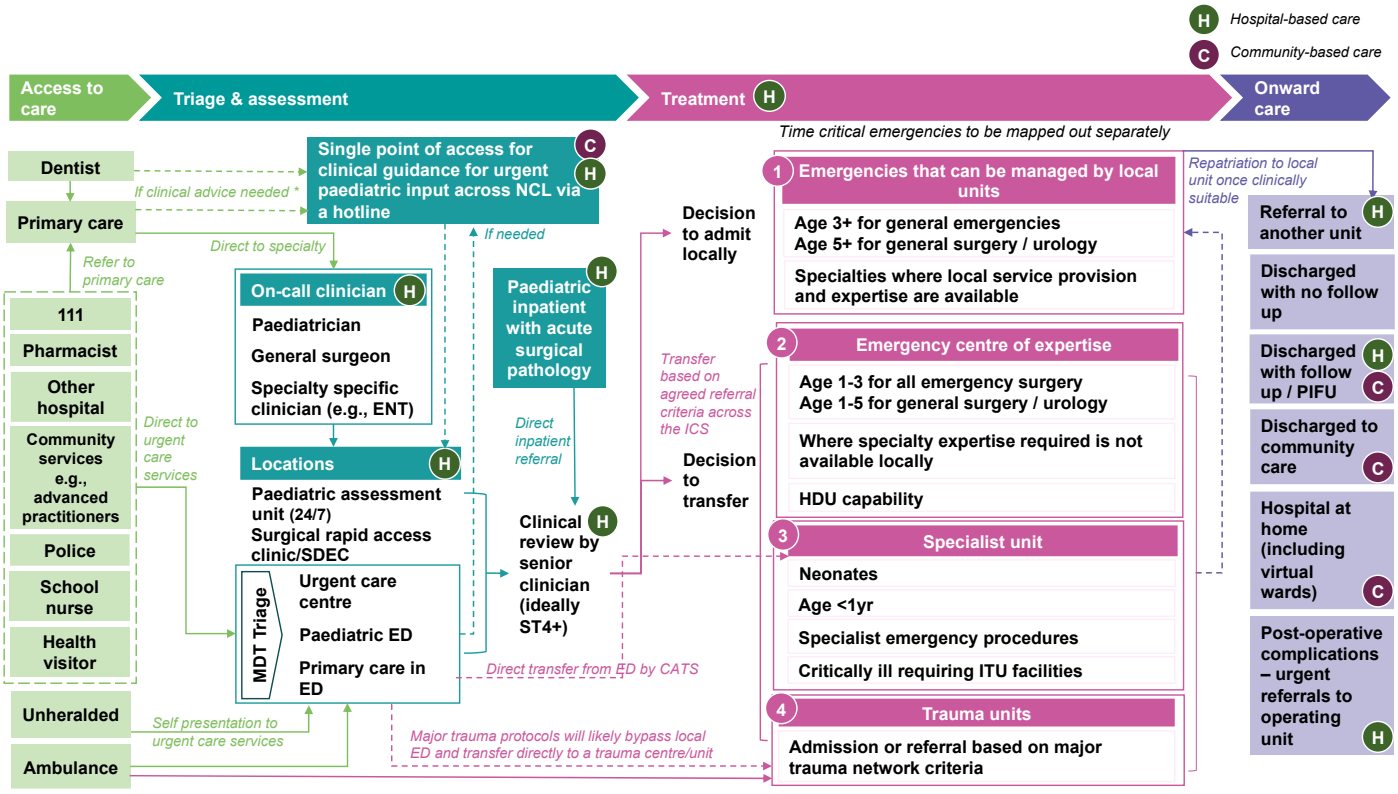


Figure 16: Paediatric emergency surgery care model

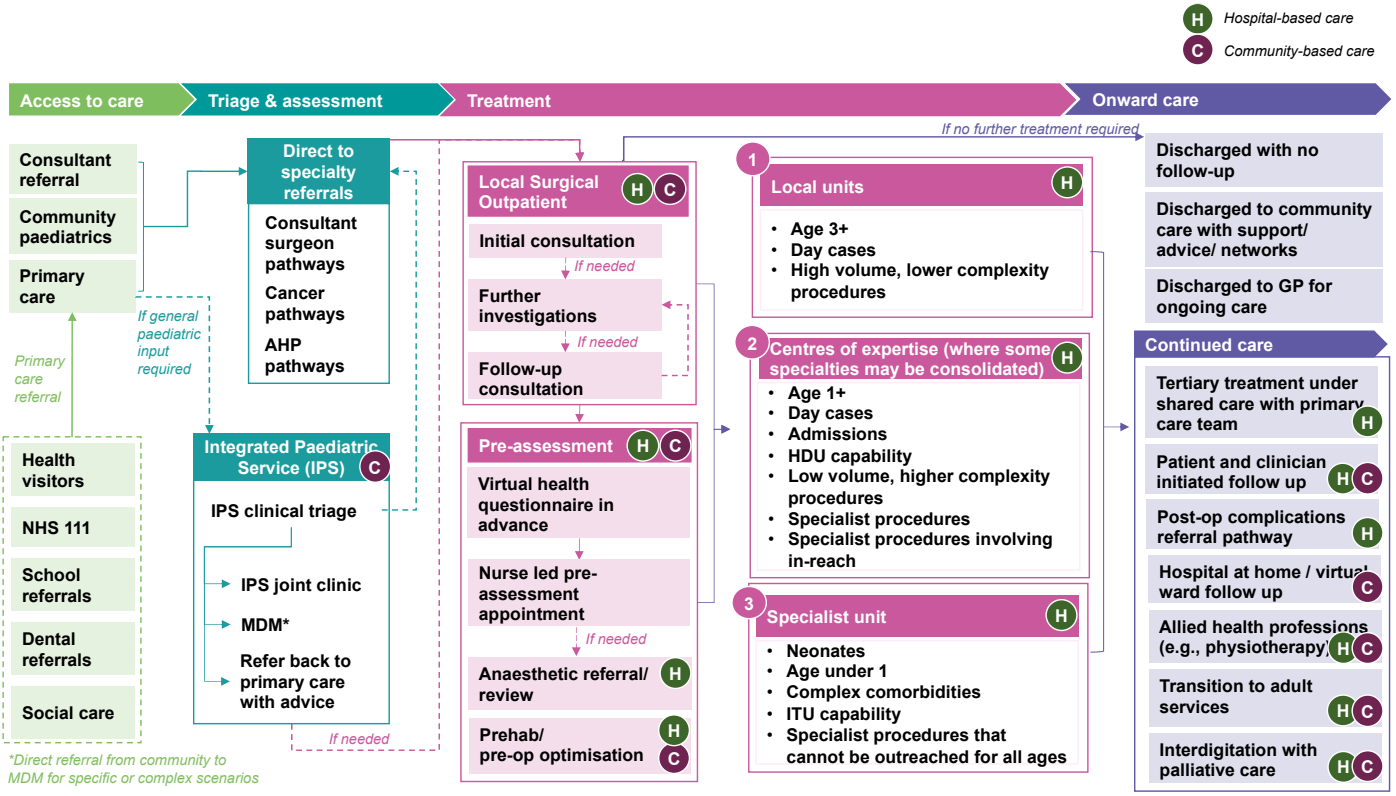


Figure 17: Paediatric planned surgery care model

Currently in NCL, emergency and planned paediatric surgery is delivered either at a local unit or a specialist unit. Under the proposed care model, paediatric surgery in NCL surgical activity would continue to be provided at these units. However, as set out in the case for change (section 3), there are opportunities to improve surgical services through consolidating some emergency and planned surgery to reduce the fragmentation and ensure the specialist workforce and equipment are on site to deliver the best quality of care and outcomes for children and young people. To support this there would need to be training support for teams at local units to ensure there is the confidence to appropriately manage cases locally where appropriate.

This section sets out under the proposed care model what type of activity would be delivered at each unit type and the rationale for this.

4.5.1 Paediatric surgical activity that will not change sites

It is important that, where possible and safe to do so, that emergency and planned surgical care is delivered as locally as possible. Under the proposed care model, the majority of paediatric surgical activity (emergency and planned) would remain where it is currently delivered. This may be at a local unit or at a specialist unit depending on the type of activity and age of the child. Some children may also require care that is best delivered at a unit outside of NCL where there are London wide pathways, for example major trauma, and this would also remain the same. To support this, there will need to be clarity about the pathways and support to local sites. This would be a focus when planning for implementation.

4.5.1.1 Local units

We want emergency surgical care to be delivered as locally as possible and we also want to ensure that our local units maintain their skills and competencies in delivering paediatric surgical care and ensure that families do not have to travel long distances to visit their child should they need an admission. In the paediatric surgery care model, local units would continue to deliver emergency paediatric surgery as follows:

- **Emergency surgical care delivered at local units:** emergency surgical procedures for children and young people over the age of 3 (and over the age of 5 for general surgery or urology) which does not require any specialist surgical input or intensive care. These procedures would typically be lower complexity and more commonly occurring.

In order to deliver the surgical activity that is designated to stay locally, there will need to be a significant focus through implementation to upskill local teams. All units in NCL would also continue to operate a paediatric ED and therefore would continue to be required to assess and stabilise children under the age of 3 in emergency situations. Working closely with the NTPN to ensure our staff at local units maintain their skills and competencies to safely deliver care in emergency situations, we would also:

- establish agreed paediatric anaesthetics continuing professional development (CPD) arrangements across all NCL sites, delivered in partnership across providers and utilising training and skills maintenance opportunities at the specialist providers,

- provide rotational paediatric anaesthetic appointments capitalising on the expertise across the system
- provide overall surgical clinical leadership in NCL through the appointment of a paediatric surgical lead to support implementation of the proposed model
- standardise pathways and develop standard operating procedures (SOPs) for these pathways

Local units would also continue to deliver planned paediatric surgery where there were sufficient volumes to deliver this. For planned surgery local units would deliver:

- **Planned surgical care:** day case and planned overnight stay surgery in ENT and dentistry for children and young people aged 3 years and over.

This activity is currently high volume and is delivered in well-established units currently. Delivering planned care in this way ensures our staff can maintain the skills needed to support local emergency care. This includes surgical skills, as well as ensuring local staff have exposure to paediatric anaesthetics.

4.5.1.2 Specialist units

In NCL there are units that deliver specialised care. These units include the tertiary centres (GOSH, RNOH, Moorfields) as well as local units that deliver highlight specialist work. For example, plastic surgery at the Royal Free Hospital. These pathways for emergency and planned surgical treatment currently work well, and this activity would continue to be delivered at these units as follows:

For **emergency surgical care** specialist units would continue to deliver:

- **Emergency surgical care:** for children under the age of 1, children or young people with complex co-morbidities, procedures requiring ICU perioperatively, existing complex pathways such as neurosurgery, cardiac surgery and any complex surgical procedures that cannot be managed locally or at a centre of expertise. This is currently delivered at GOSH and would continue to do so. It is out of scope of this work and therefore not part of the options appraisal process
- **Existing pan-London emergency pathways:** including major trauma would continue to be delivered at St Mary's Hospital or The Royal London Hospital and care for children with significant burns would continue to be provided at Chelsea and Westminster Hospital

For **planned surgical services** specialist units would continue to deliver:

- Planned surgical care for children under the age of 1, children and young people with complex co-morbidities, complex surgical procedures or those that require ICU would continue to be delivered at GOSH
- Planned surgical care for highly specialist ophthalmology would continue to be delivered in partnership between GOSH and Moorfields
- Planned surgical care for highly specialist orthopaedics would continue to be delivered in partnership between GOSH and the RNOH

- Planned plastic surgery would continue to be delivered at the Royal Free Hospital, working with GOSH to ensure that the needs of very young children requiring specialist anaesthetics are met

Detailed view of the specialist unit activity by hospital site is set out in Appendix D.

4.5.2 Paediatric surgery to be consolidated

There are some planned and emergency services (dependent on age and specialty) which need to be consolidated to allow access to specialist paediatric workforce and equipment. Based on current activity this equates to less than 10% of paediatric surgical activity. Where planned or emergency services need to be consolidated in order to have access to specialist paediatric workforce, we have termed the unit a centre of expertise.

Where emergency and planned inpatient services need to be consolidated into a centre of expertise, it was agreed that emergency activity and inpatient planned procedures be co-located on the same site because of workforce co-dependencies. It was agreed that while planned inpatient surgery could theoretically be delivered with paediatric surgeons in reaching to a site from a specialist centre, in practice the requirements for after and post-operative review from a scarce workforce make this unworkable in practice.

For day case surgery that doesn't require an overnight stay clinicians agreed that there would be benefits to delivering this activity at a different centre of expertise to the emergency and planned inpatient activity as it would preserve capacity (theatres and workforce) for day case work, reduce cancellations and improve productivity.

Therefore, based on this, the proposed care model sets out the creation of two centre of expertise as follows:

- Centre of expertise: emergency and planned inpatient
- Centre of expertise: day case

These units would be located at an existing specialist unit or an existing local unit in NCL.

4.5.2.1 Centre of expertise: emergency and planned inpatient

Emergency and planned inpatient surgical activity would be consolidated onto a single unit and delivered at a centre of expertise: emergency and planned inpatient. The activity that would be consolidated is as follows and outlined in Figure 18:

- **Emergency surgery** for all children under 3 (excluding neonates), and those under 5 requiring general surgery or urology
- **Planned inpatient surgery:** for children 0-1 for ENT and dentistry (excluding single overnight stay in ENT and dentistry for children over 1 years where surgical follow-up is not required the following day) and for children age over 1 for all other specialties.

	Centre of Expertise: emergency and planned inpatient surgical activity

	Emergency surgical pathways	Planned inpatient surgical pathways
ENT	0-3 years	0-1 years inpatients
Dentistry	0-3 years	0 -1 years inpatients
Oral and maxillofacial surgery	0-3 years	Inpatient 1+ night length of stay
Plastics	0-3 years	0-3 years inpatient
Urology	0-5 years	Inpatient 1+ night length of stay up to adolescent
Ophthalmology	n/a	All ages inpatients
Orthopaedics	0-3 years	-
General surgery	0-5 years	Inpatient 1+ night length of stay up to adolescent
Endoscopy	0-14 years	Inpatient 1+ length of stay
Gynaecology	Pre-pubertal covered through urology and general surgery	

Figure 18: Surgical activity consolidated at the centre of expertise: emergency and planned inpatient

The centre of expertise: emergency and planned inpatient would require either a paediatric ED or a surgical assessment unit (SAU) which would receive emergency transfers as needed from local units. The unit (either paediatric ED or SAU) would assess any children with a suspected surgical need. Depending on the outcome of the assessment the young child may be admitted for a surgical procedure, admitted with a medical need, or may be transferred back to a local unit if safe to do so. The pathway for the emergency surgical assessment is outlined in Figure 19.

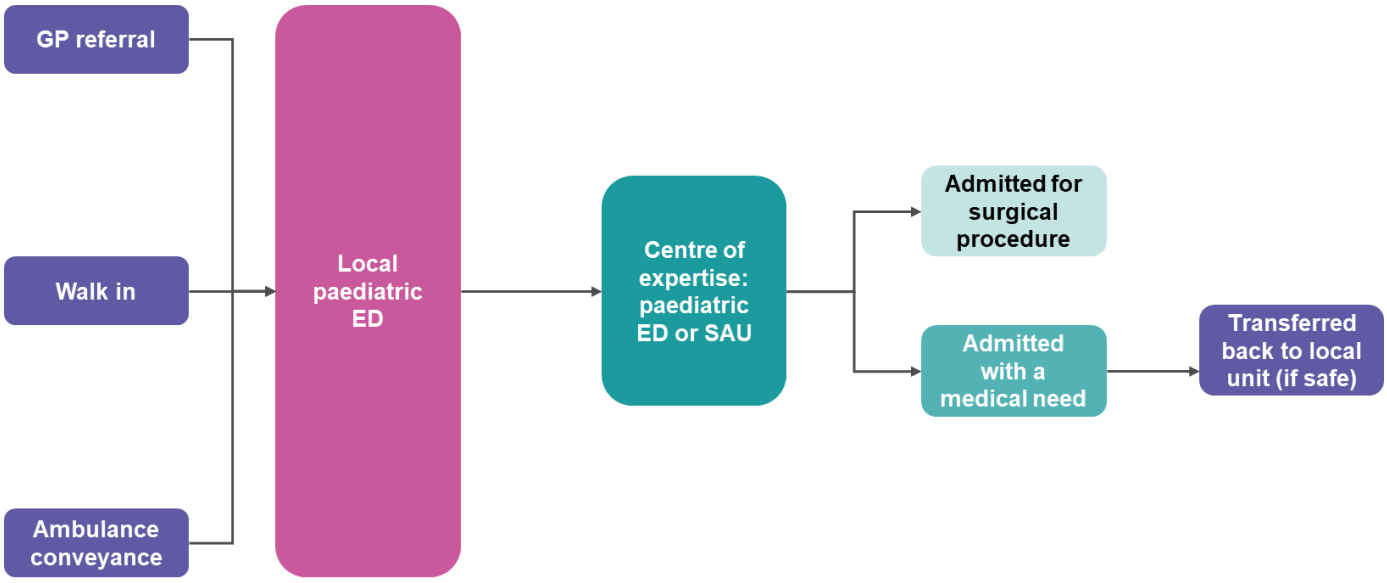


Figure 19: Emergency surgical pathway for children under 3 or under 5 (general surgery and urology)

To support the management of transfers to the SAU or paediatric ED there would be standardised clear admissions or referral protocols for all Trusts. This would be considered on a speciality-by-

speciality basis. More detail on this is set out in section 7.3.5. The unit would accept the referral from a local paediatric ED by the most senior clinician available at the local ED/unit. For some specialities a specialist surgical opinion would be required.

The local paediatric ED or SAU would be accessible for NCL sites (this would include NCL and non-NCL residents who use these sites). It is estimated that approximately 1,200 children or young people per year would be transferred to the centre of expertise: emergency and planned inpatient requiring a surgical assessment. The centre would be responsible for finding a bed from the point that they accept the referral.

To deliver this surgical activity the centre of expertise: emergency and planned inpatient would have a 24/7 on-call specialist paediatric surgical rota and an 24/7 on-call paediatric consultant anaesthetist rota. This would ensure that the specialist workforce required to deliver this type of surgical activity is available 24 hours a day 7 days a week. For planned inpatient activity, the workforce would be available the following day to ensure continuity of care.

Surgical care would be delivered in a child-friendly environment as set out in the Royal College of Surgeons[27]. This includes dedicated paediatric theatres, paediatric recovery areas and assessment areas.

The unit would have level 2 (HDU) facilities which would either be dedicated or flexed from current bed base. Any child or young person who requires paediatric intensive care (PICU) would be transferred to the local specialist hospital as per current transfer protocols.

For staff at our local units, having a clear dedicated unit to transfer patients would ensure that this is undertaken in a timely manner, activity is delivered at a unit within NCL and that there is the specialist staff available 24 hours a day 7 days a week.

4.5.2.2 Centre of expertise: day case

Where day case activity is low volume, this would be consolidated into a centre of expertise day case which would deliver:

- **Day case surgery** in low-volume specialties (i.e., excluding ENT and dentistry for age 3+ because this is high volume in local sites)
- **Day case surgery** for all specialties for children aged 1-2 years

A specialty view of the day case surgical activity being consolidated at the centre of expertise: day case is set out in Figure 20.

	Centre of expertise: daycase surgical activity
ENT	1-3 years day cases and single overnight stay
Dentistry	1-3 years day cases and single overnight stay
Oral and maxillofacial surgery	1-3 years day cases and single overnight stay

[27] Standards for children's surgery, 2013

Urology	1+ years day case and single overnight stay
General surgery	1+ years day case and single overnight stay (via SNAPS in reach)

Figure 20: Centre of expertise: day case surgical activity

The centre of expertise: day case would have a paediatric consultant anaesthetist cover who would have the skills and capabilities to provide care for children aged 1-2 years. For day case procedures, specialist paediatric surgeons would in-reach of the centre as needed, building on existing pathways in place in NCL.

To support delivering care as locally as possible, outpatient appointments and follow ups would be delivered through a hub and spoke model.

There is an ambition that a child or young person requiring a day case procedure at the centre of expertise: day case would be offered outpatient or follow up appointments at a more local unit. This would be either a North or South of NCL base, with volumes too low to feasibly offer outpatient appointments at all local units. The centre of expertise: day case would also provide pre-operative assessments as much as possible virtually, as it is important that this is undertaken by a member of the team who would be supporting the procedure. There would be a triage process in place so that any child or young person with difficult airways or learning disabilities for example, would be offered a fact to face pre-operative assessment.

The paediatric surgical care model would mean that surgical care would be delivered in four types of units as outlined in **Error! Reference source not found.**. The next section (section 5) sets out the site-specific location of the centre of expertise: emergency and planned inpatient and centre of expertise: day case.

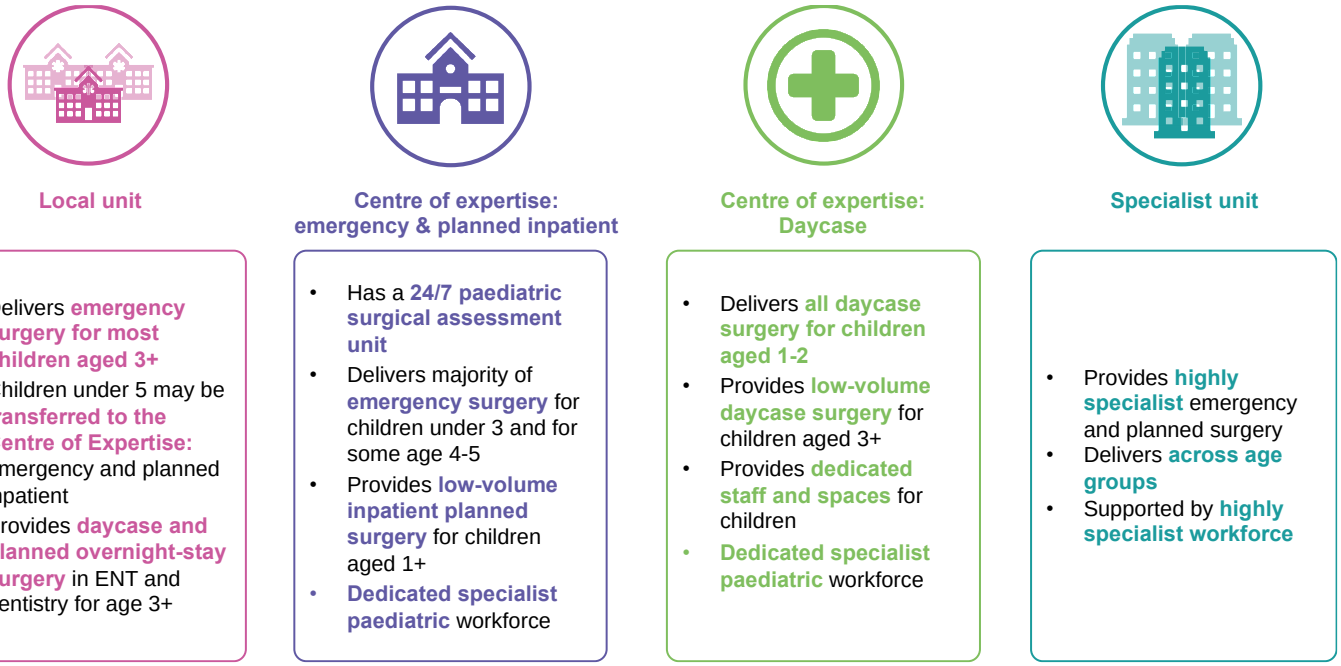


Figure 21 Paediatric surgery care model unit types

5. Options appraisal

5.1 Introduction

We are focused on addressing the specific challenges facing paediatric surgical services in NCL. To address these challenges, we propose changes which will facilitate high quality and accessible care for local residents.

In the case for change, we identified opportunities to:

- **Improve the organisation of paediatric surgery:** there is currently variation between and within hospitals on whether a child or young person can be treated on site. This often is dependent on the capabilities of adult surgeons and anaesthetists covering the emergency rota on any given day

- **Meet national recommendation on 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.

Our new model of care (see section 4), responds directly to our case for change, establishing a centre of expertise: emergency and planned inpatient and centre of expertise: day case which would:

- Ensure clearly defined emergency surgical pathway for children under 3 years or under 5 years (general surgery and urology)
- Provide access to specialist paediatric surgical and consultant paediatric anaesthetists for the surgical activity that requires this expertise
- Ensure that emergency and planned activity is delivered on dedicated paediatric theatre lists
- Deliver planned inpatient surgery in children under 3 years and day case activity in children age 1-2 years and in low volume specialties in dedicated paediatric theatres with dedicated recovery areas.

We have developed and evaluated a set of options for the delivery of the paediatric surgery care model. A structured approach to identifying and filtering a broad range of options has been undertaken and further detail on this approach is set out in section 9.3.4. The Start Well Programme Board then evaluated the options, with clinical input, during a half day evaluation workshop. This process is shown in
Figure 22**.**

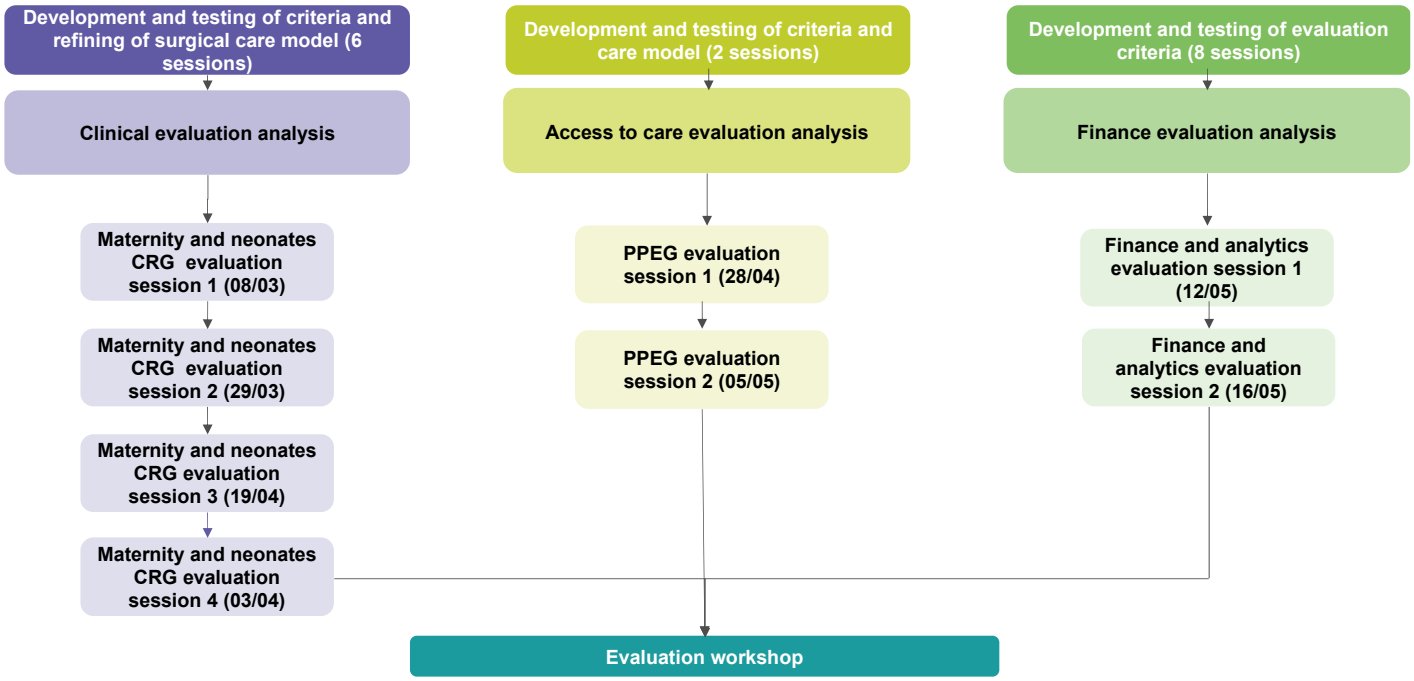


Figure 22: Options evaluation process

5.2 Our approach to appraising the options

An options evaluation process was designed that enabled us to move through a filter 'funnel' from an initial possibility of a significant number of options down to a small number of options to undergo further analysis, before agreeing the options that would go to consultation. Figure 23 summarises how initial inputs are used to develop a longlist which we then refined in subsequent phases of the options appraisal.

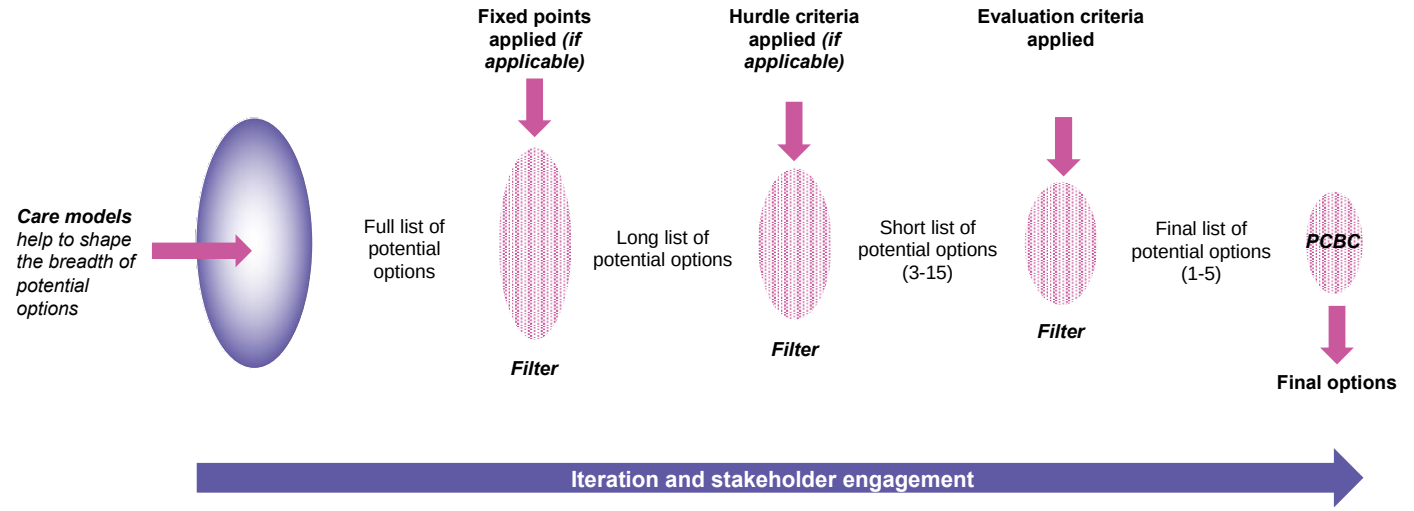


Figure 23: Options appraisal process

We undertook an extensive process to consider an exhaustive list of options. Our starting point was to understand the case for change (section 3) and the care model that could meet these needs (section 4). We then considered where services might best be located to meet the needs of residents and resolve the issues in the case for change. We have looked at all permutations of the locations of the centres of expertise in NCL.

5.3 Reviewing the status quo

The status quo has been considered but is not being recommended by the Programme as an option for public consultation. This is because an option of maintaining the status quo would mean:

- The current paediatric surgical care model would not deliver the best practice and achieve the clinical standards as set out by professional bodies Getting It Right First Time (GIRFT).
- The opportunities for improvement of paediatric surgery would not be addressed. This would mean that surgical services would remain fragmented, and there would continue to be lack of clarity on where children aged under 3 or 5 years would be treated. For surgical staff at local units, it would continue to be difficult to maintain and develop the skills and capabilities to deliver this locally.
- Staff at local units would continue to spend time trying to find a suitable bed for young children requiring surgical assessment and treatment. This may mean being transferred multiple times and to units outside of NCL.
- Access to care would remain the same with no changes in the travel or driving times and people having to sometimes travel outside of NCL to access care

5.4 Number of centres of expertise

The care model (as detailed in section 4) proposes that the following paediatric surgery be consolidated into centres of expertise:

- **Emergency surgery**: all emergency surgery for under 3s, and for under 5s in general surgery and urology
- **Planned inpatient surgery**: for all specialities excluding single overnight stay in ENT and dentistry
- **Day case surgery:** in low-volume specialties (i.e., excluding ENT and dentistry for age 3+)
- **Day case surgery:** for children aged 1-2 years who require access to paediatric anaesthetists

5.5 Options for appraisal

It was recommended by clinicians in the CRG and subsequently agreed by the Programme Board that the emergency and planned inpatient surgery should be delivered at a different site to the day case surgery. This is to ensure that this capacity can be preserved for day case activity and reduce the risk of cancellations due to emergency surgery pressures. The options appraisal process has looked at the permutations of location for the centre of expertise: emergency and planned inpatient

and for the centre of expertise: day case. This was undertaken through a two-step process. We first considered all locations for the centre of expertise: emergency and planned inpatient and then all locations for the centre of expertise: day case.

5.6 Options for appraisal for centre of expertise: emergency and planned inpatient

We considered six locations for the centre of expertise: emergency and planned inpatient as follows:

1. Barnet
2. Great Ormond Street Hospital (GOSH)
3. North Mid
4. Royal Free
5. UCLH
6. Whittington

For any option for the centre for expertise: emergency and planned inpatient other than GOSH, an additional paediatric surgical rota and consultant paediatric anaesthetist rota would need to be established. As set out in Figure 24 only GOSH currently has a dedicated paediatric surgical rota and dedicated consultant paediatric anaesthetist rota.

Emergency activity	Current number of dedicated paediatric surgical rotas across NCL	Future number of rotas required	Current number of dedicated consultant paediatric anaesthetist rotas across NCL (general only)	Future number of rotas required
Option 1: Barnet	1	2	1	2
Option 2: GOSH	1	1	1	1
Option 3: North Mid	1	2	1	2
Option 4: Royal Free	1	2	1	2
Option 5: UCLH	1	2	1	2
Option 6: Whittington	1	2	1	2

Figure 24: Future number of dedicated paediatric surgical and dedicated consultant paediatric anaesthetist rota across NCL by option

All other local units do not have the required workforce and therefore on call rotas, any option other than GOSH would require an additional paediatric surgical rota to be established. This would not be possible due to national workforce shortages, and it would not be an efficient use of resources.

In addition to the specialist surgical workforce, the majority of emergency surgery for under 3s (under 5 for urology and general surgery) and planned inpatient care for children currently takes place at GOSH as set out in Figure 25.

Site	Current volume of emergency surgery (under 5s)	Current volume of planned inpatient (age 1-3)	Current volume of planned inpatient (age 3+)
Option 1: Barnet	19	0	18
Option 2: GOSH	46	98	201
Option 3: North Mid	5	0	12
Option 4: Royal Free	18	3	3
Option 5: UCLH	21	44	34
Option 6: Whittington	5	1	8

Figure 25: Volumes of emergency and planned inpatient by age and site in NCL in 2021/22

Considering the specialist workforce requirements and where the emergency and planned inpatient activity is being delivered currently, the surgical CRG recommended that:

- GOSH be the centre of expertise: emergency and planned inpatient with the inclusion of an urgent surgical assessment facility to improve the pathway (see section **Error! Reference source not found.** for a description of this pathway)
- Barnet, North Mid, Royal Free Hospital, UCLH and the Whittington Hospital continue to deliver emergency surgery for children aged 5+ (plus orthopaedic, ENT and maxillo-facial for children aged 3-4) and ENT and dentistry day case surgery for child aged 3+ (plus children requiring a single overnight stay) where this is already being delivered
- Services delivered by specialist units should continue to be delivered as now

Detail on the surgical pathways is set out in Appendix D.

To deliver this additional activity would require additional capacity at GOSH. To provide the assessment capacity a four-bedded assessment unit would be required. To support the inpatient activity an additional six inpatient beds would be required. To deliver this would require a capital invest of c.£3.7m.

The creation of a centre of expertise: emergency and planned inpatient would not change the way in which the local population access local EDs. The number of EDs would remain the same in NCL and not be impacted by the proposed changes.

5.7 Options for appraisal for centre of expertise: day case

The surgical CRG recommended that GOSH should not be the centre of expertise: day case as it is recommended as the single viable option for the centre of expertise: emergency and planned inpatient. GOSH is a physically constrained site and it is important to retain this space for only those children who are best treated there. There are also advantages in delivering the day case activity on a different site to emergency activity, as this would preserve capacity (theatres and workforce) for day case work, reduce cancellations and improve productivity:

- Getting It Right First Time (GIRFT)[28] recommends establishing surgical hubs as part of their high-volume low complexity programme to improve efficiency, productivity, and patient safety
- Studies have evidenced a relationship between volumes and improved outcomes for specialist surgery[29].

Based on the agreement by the Programme Board that the centre of expertise: emergency and planned inpatient and that the centre of expertise: day case should be on different sites we shortlisted and evaluated five options for the location of the centre of expertise: day case as follows:

A. Barnet
B. North Mid
C. Royal Free
D. UCLH
E. Whittington

5.7.1 Evaluation criteria

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

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

Each option was rated against the evaluation criteria as ++, +, /, -, - - based on the evidence presented.

5.8 Quality of care

The proposed paediatric surgery care model would improve quality and experience for all those who use our services. To differentiate between options, the CRG considered two evaluation questions to assess the difference between options with regard to quality of care:

[28] Getting It Right First Time: High volume low complexity programme
[29] For example Chowdhury, M. M., Dagash, H., & Pierro, A. (2007). A systematic review of the impact of volume of surgery and specialization on patient outcome. Journal of British Surgery, 94(2), 145-161

- Are there other specialist paediatric services on site?
- What activity would be delivered at the site, in addition to current activity?

5.8.1 Are there other co-dependent services on site?

Clinicians considered whether there are other co-dependent services on site. This is because having other paediatric services on site allows for specialists to more easily give an opinion on other cases whilst on site doing their day case work.

This analysis as outlined in Figure 26 showed that only option D had co-dependent services on site. Four co-dependent services were identified including the fetal/maternal medicine centre, Gastroenterology, cancer and specialist adolescent services. It was acknowledged that option A, C and E had other paediatric surgical services however these were not co-dependent with the paediatric surgery day case activity that the centre of expertise: day case would be providing.

Site	Number	Co-dependent services	Other paediatric surgical services
Option A: Barnet	0		ENT Max fax
Option B: North Mid	0		
Option C: Royal Free	0		Plastics
Option D: UCLH	4	• Obstetrics & gynaecology including the fetal/maternal medicine centre • Gastroenterology • Cancer, • >16s	
Option E: Whittington	0		Dentistry

Figure 26: Number of co-dependent services on site

On this basis, the CRG rated option D '++' as four co-dependent services are on site. Options A, B, C and E have been evaluated '/' as no co-dependent services are on site. This evaluation is shown in
Figure 27.

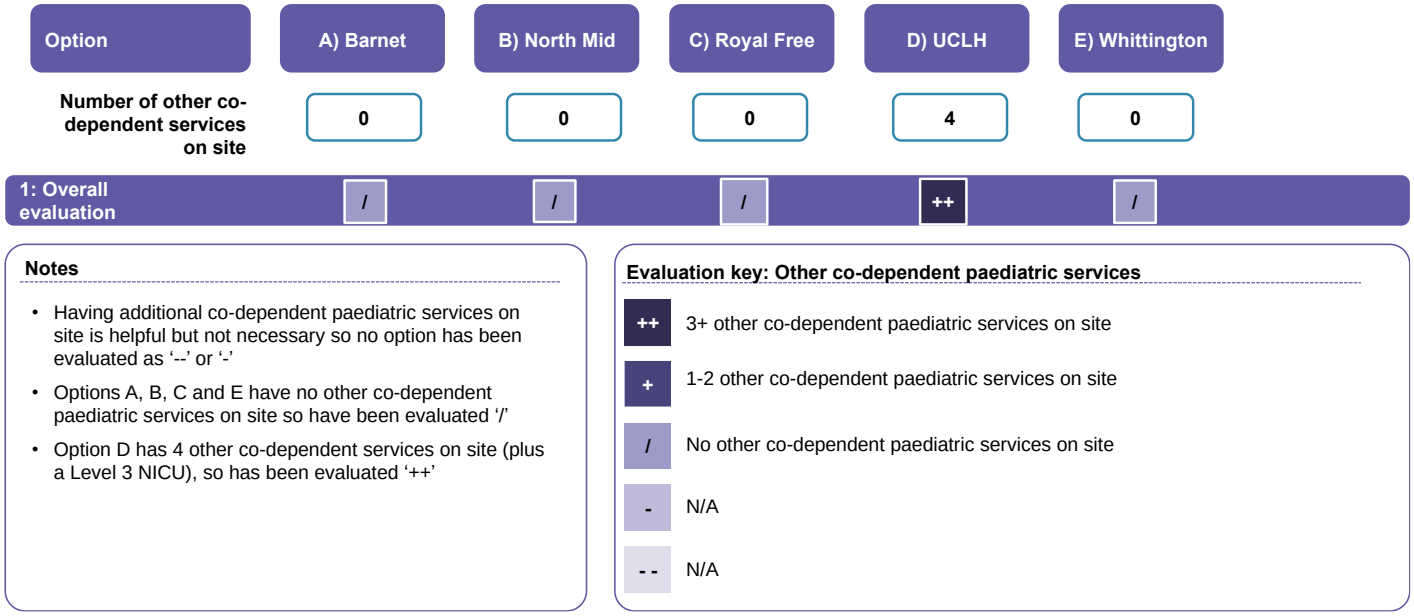


Figure 27: Evaluation of options for co-dependent services

5.8.2 What activity would be delivered at the site, in addition to current activity?

The CRG considered the difference between total current day case activity and projected future activity as the centre of expertise: day case. This was because it would be easier to implement the centre of expertise: day case if there are higher amounts of day case activity already being delivered at the site. The additional day case surgical activity that each site would have to deliver at the centre of expertise: day case as compared to what is currently delivered is shown in

Hospital	Planned daycase activity currently delivered which would be consolidated into the Centre of Expertise: daycase	Total additional activity required to deliver in site role as Centre of expertise: daycase	Additional planned daycase activity delivered (2031/32) based on current activity delivered	Projected total daycase surgical activity to be delivered
Barnet	5	+303	289	597
North Mid	34	+274	206	514
Royal Free	15	+293	445	752
UCLH	205	+103	1,326	1,634
Whittington	49	+259	326	634

Figure 28.

Hospital	Planned daycase activity currently delivered which would be consolidated into the Centre of Expertise: daycase	Total additional activity required to deliver in site role as Centre of expertise: daycase	Additional planned daycase activity delivered (2031/32) based on current activity delivered	Projected total daycase surgical activity to be delivered
Barnet	5	+303	289	597
North Mid	34	+274	206	514
Royal Free	15	+293	445	752
UCLH	205	+103	1,326	1,634
Whittington	49	+259	326	634

Figure 28: Additional day case surgical activity by site

All options would be required to deliver additional day case activity. Options A, B, C and E have a greater stretch to deliver the activity as the centre of expertise. The additional activity for these options range from 250 to 400 additional procedures and the options have been evaluated a '/'. Option D has the smallest stretch but the additional procedures to deliver is over 100 so has been evaluated a '+'. The evaluation is shown in Figure 29.

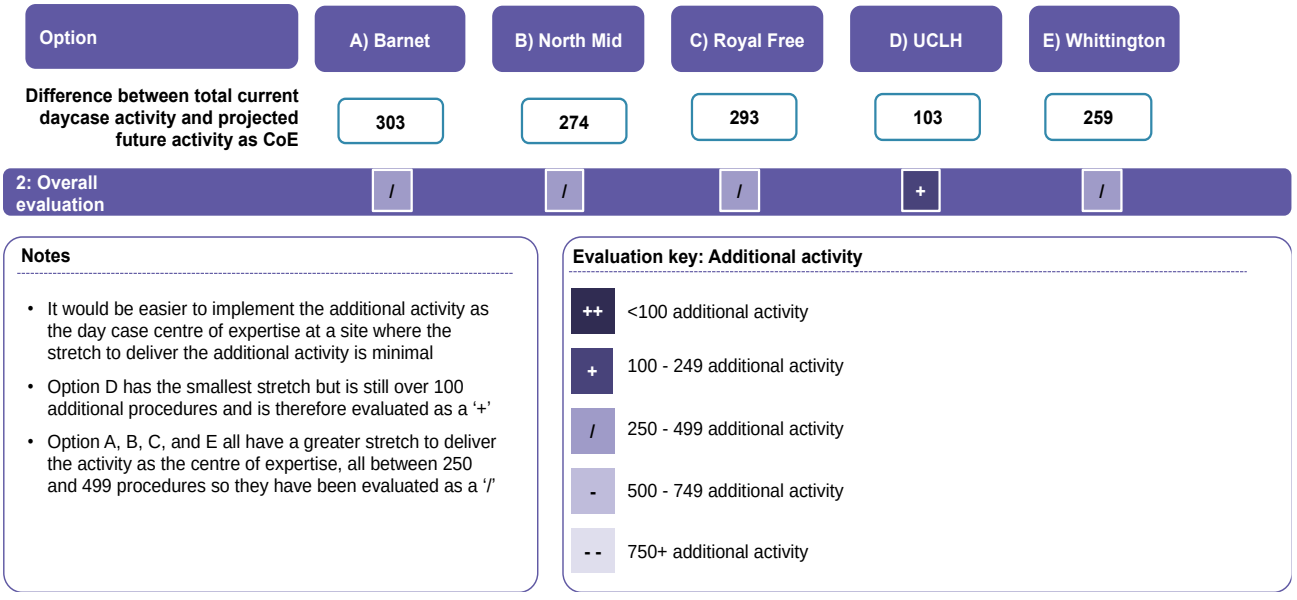


Figure 29: Evaluation of stretch to deliver day case surgical activity

5.9 Workforce

5.9.1 Is there sufficient activity to sustain a paediatric day case anaesthetic rota?

Clinicians considered the total on-site paediatric consultant anaesthetists able to anaesthetise children over the age of 1. This is because although paediatric consultant anaesthetists can be in-reached, it is more straightforward to organise rotas if they are already on the site doing other work.

The model of care aspires to ensure that the specialist workforce including paediatric consultant anaesthetists deliver care for very young children (age 1-2). Only option D has 4 WTE paediatric consultant anaesthetists on-site able to deliver care on children age 1-2 years and a further 7.5 WTE who can care for children over the age of 3 years and has been evaluated a '++'. Option E has 4 WTE paediatric consultant anaesthetists on-site who can deliver care for children over the age of 3 and has been evaluated a '/'. Options A and C each have 2 WTE paediatric consultant anaesthetists on-site who can deliver care for children over the age of 3 and have been evaluated a '-'. Option B has no paediatric consultant anaesthetists on site and has been evaluated a '- -'. This evaluation is shown in Figure 30.

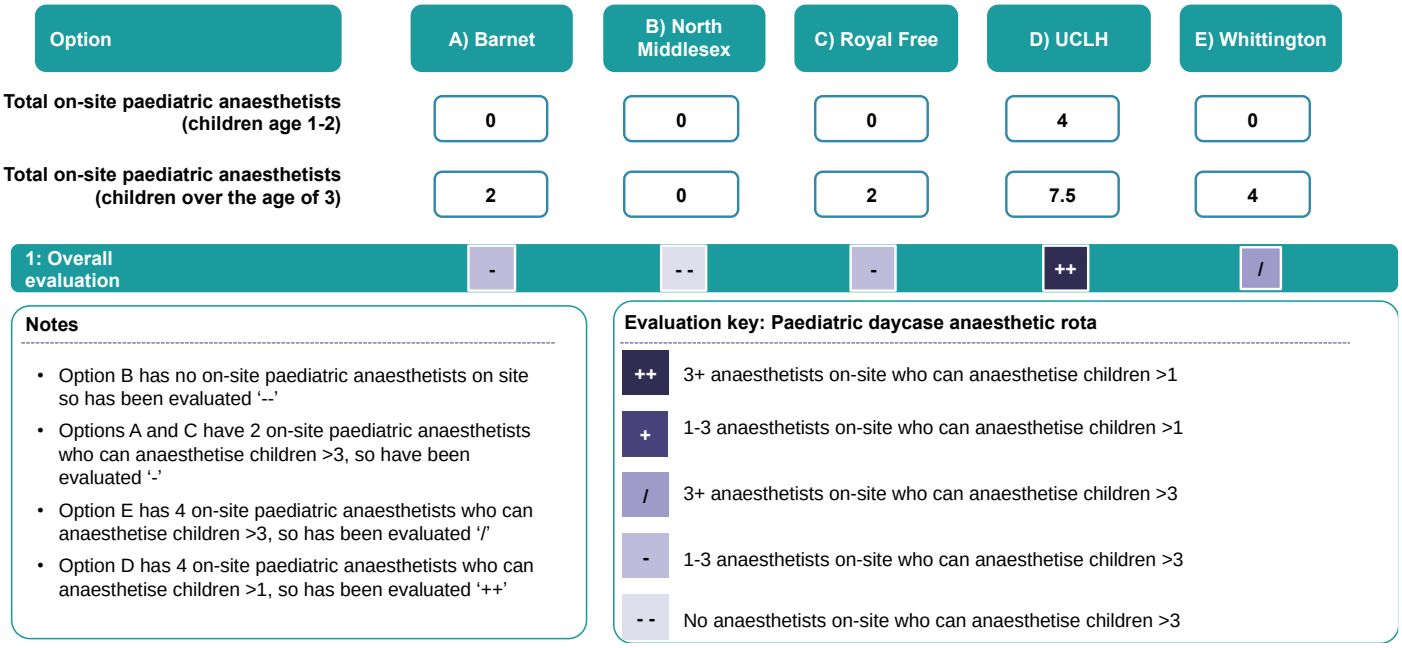


Figure 30: Evaluation of paediatric anaesthetic provision

5.10 Access to care

The PPEG considered metrics to evaluate access to care. The PPEG and feedback from pre-consultant engagement highlighted that people were willing to travel further for planned care if it was being delivered by specialists.

The PPEG also agreed that, although the length of time it takes to travel to access services is important, there are other factors such as the cost of travel, and access to services once on site (which might include physical factors such as availability of parking, wayfinding, and cultural/environmental factors such as neuro-divergent friendly environments and English as a second language). However, the PPEG recognised that implementing the paediatric surgery care

model would mean that most of the cultural/environmental factors would not be differentiating between options. Instead, these factors have been considered as part of the impact of the options in section 6. The PPEG therefore evaluated options in terms of travel to services as these are differentiating between options.

5.10.1 How long would it take populations to travel to the centre of expertise for planned surgery?

The PPEG considered the evaluation question “How long would it take populations to travel to the centre of expertise for planned surgery?”. This is because it is important to understand how much further people may need to travel to access services and the impact on people who use the service who would have to travel the furthest (maximum travel times). The PPEG reviewed average and maximum travel times as compared to current travel times for people currently accessing these services. The group evaluated the average increase in travel times, looking at journeys by off-peak driving/taxi/ambulance, peak driving/taxi and public transport. Further information of how the travel time analysis was undertaken can be found in section 6.2.3.

5.10.1.1 Average and maximum travel time for off-peak, peak and public transport

The PPEG considered the maximum and average travel time for off-peak journeys (which include journeys by private car and taxi) for people for whom the sites under consideration (Barnet, North Mid, Royal Free Hospital, UCLH, Whittington Hospital) are the closest by driving as shown in

Figure 31. Journeys by ambulance are equivalent to off-peak journeys. As we are looking at planned surgery, we have used NCL boundaries as the study area as it is assumed that all planned activity within NCL would go to a NCL provider (there would be no outflows for these services).

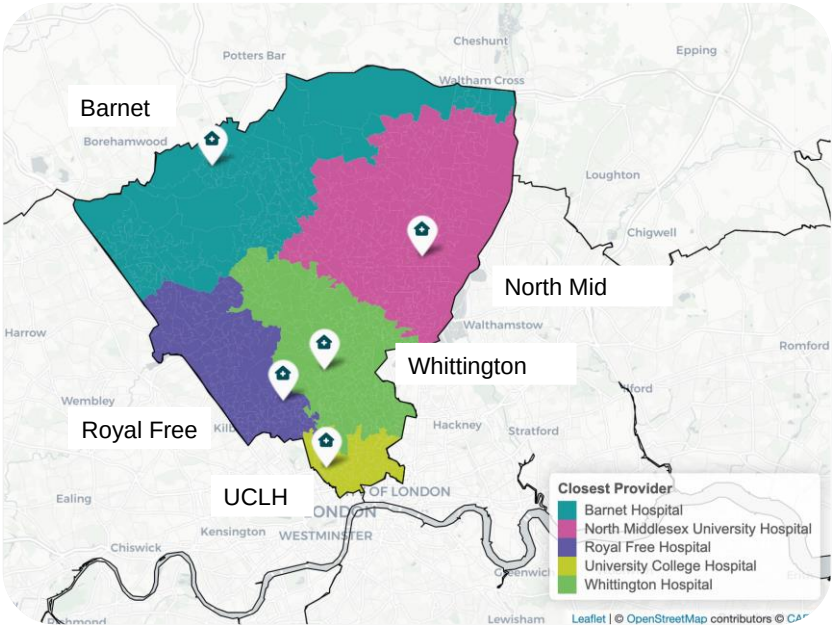


Figure 31: Travel time catchment population

The average and maximum additional travel time for this population is shown in **Error! Reference source not found.**.

High Mid Low

Option	Transport method	Average travel time to closest unit (mins)	Average travel time to selected unit only (mins)	Difference for average (mins)	Maximum travel time to closest unit (mins)	Maximum travel time to selected unit only (mins)	Difference for maximum (mins)
Option A: Barnet	Off-peak	16.5	34.2	17.7	25.1	64	38.9
	Peak	19.6	40.1	20.5	30.3	75.6	45.3
	Public transport	25.3	43.9	18.6	48.4	77.2	28.8
Option B: North Mid	Off-peak	15	26.3	11.3	25.6	56.1	30.5
	Peak	17.7	31	13.2	30.3	64.9	34.6
	Public transport	26.1	40.3	14.1	45.5	79.3	33.8
Option C: Royal Free	Off-peak	11.1	24.6	13.5	22.6	50.1	27.6
	Peak	12.6	29.1	16.5	26.4	60.7	34.3
	Public transport	20.8	37.5	16.7	39.2	70.7	31.5
Option D: UCLH	Off-peak	12.9	36.6	24.0	13.5	66.7	53.2
	Peak	15.6	42.5	26.9	17.3	77.3	60
	Public transport	22.9	35.5	12.7	38.7	61.3	22.6

Option E: Whittington	Off-peak	12	22.8	10.9	22.2	48.1	25.9
	Peak	14.1	26.6	12.5	27.6	57.6	30.9
	Public transport	19.4	33.9	14.5	36.8	68.7	31.9

Figure 32: Average and maximum travel times by option

For peak travel times, all options would result in an increase in average and maximum travel times and therefore no option has been evaluated a '++' or a '+'. Options B and E would result in an increase in average travel times of less than 15 minutes for peak journeys and have been rated a '/' whilst option A and C would result in an increase of average travel times for peak journeys of between 15 minutes and 25 minutes and have therefore been evaluated '-'. Option D would result in the greatest increase in average travel time and has been evaluated '- -'. This evaluation is shown in Figure 33.

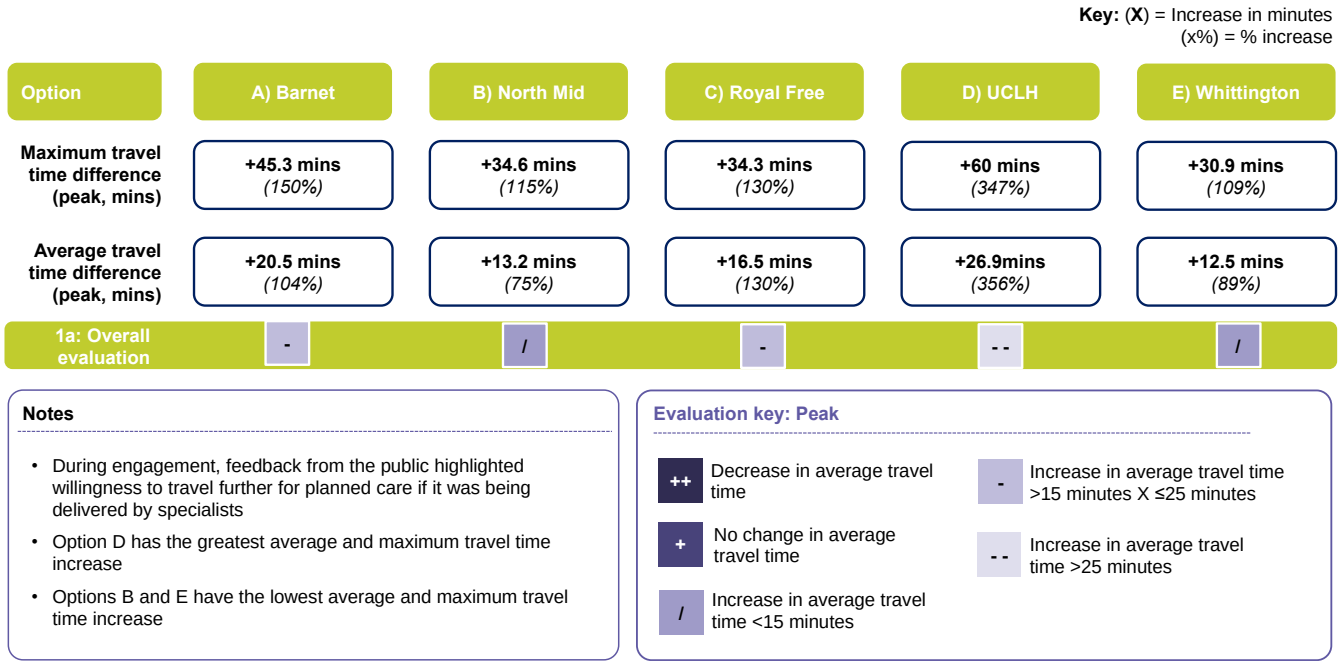


Figure 33: Maximum and average travel time (peak) difference option evaluation

All options would result in an increase in average and maximum travel times and therefore no option has been evaluated a '++' or a '+'. Options B, C and E would result in an increase in average travel times of less than 15 minutes for off-peak journeys and have been rated a '/' whilst option A would result in an increase of average travel times for off-peak journeys of between 15 and 20 minutes and has therefore been evaluated a '-'. Option D would result in the greatest average travel time increase. The average increase is more than 20 minutes and has been evaluated a '- -'. This evaluation is shown in Figure 34.

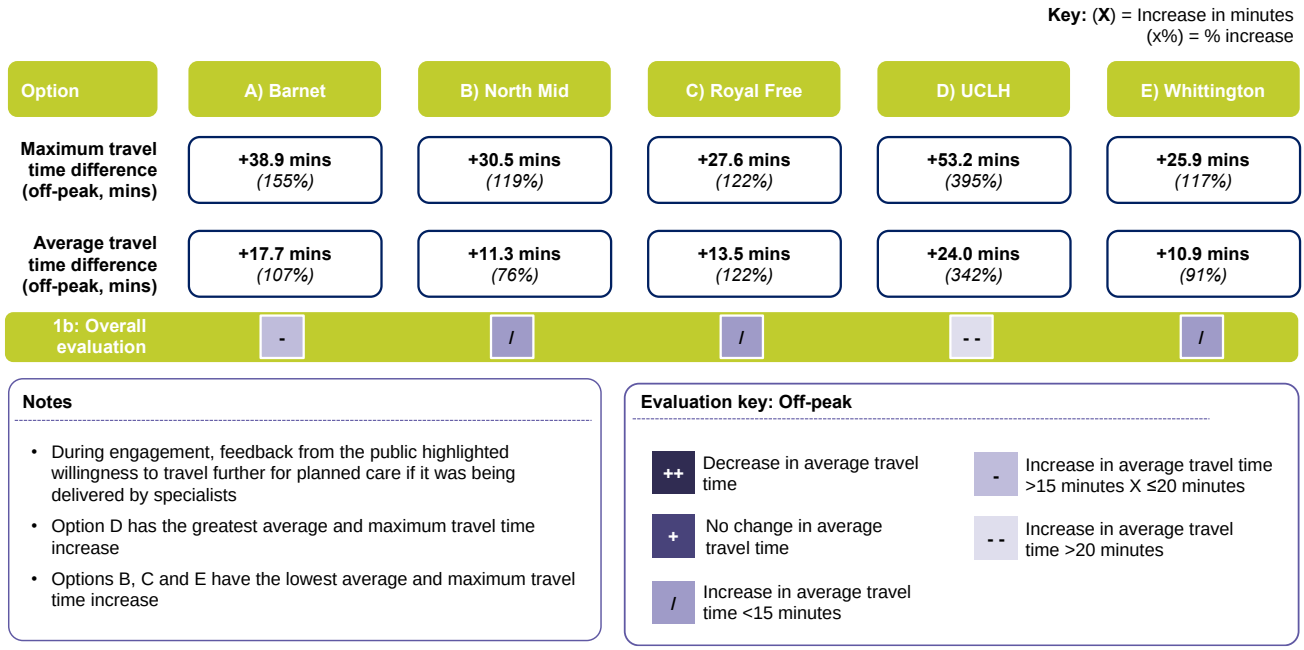


Figure 34: Maximum and average travel time (off-peak) difference option evaluation

All options would result in an increase in average and maximum travel times and therefore no option has been evaluated a '++' or a '+'. Options B and E would result in an increase in average travel times of less than 15 minutes for public transport journeys and have been rated a '/' whilst option A, C and D would result in an increase of average travel times for public transport journeys of between 15 and 25 minutes and have been evaluated a '-'. This evaluation is shown in Figure 35.

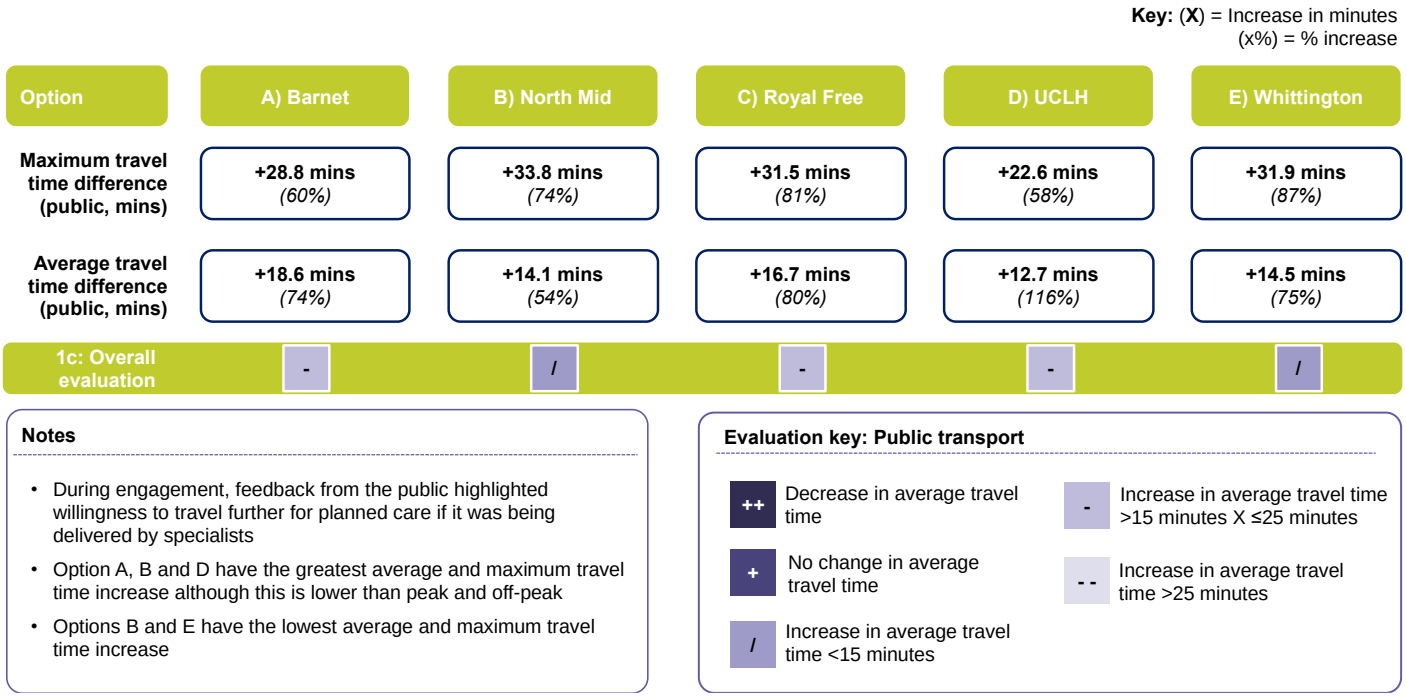


Figure 35: Maximum and average travel time (public transport) difference option evaluation

5.10.1.2 Overall evaluation: How long does it take people to travel to the centre of expertise: day case?

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

- Option A was rated '-' overall because it saw a higher increase in travel times on average for off-peak, peak and public transport journeys of 15 to 25 minutes
- Option B was rated '/' overall because it saw a slightly lower increase in travel times of less than 15 minutes on average for off-peak, peak and public transport journeys
- Option C was rated '/' overall because it saw a slightly lower increase in travel times of less than 15 minutes on average for off-peak and public transport journeys and a slightly higher increase in peak transport journey of 15 to 25
- Option D was rated '- -' overall because it saw the greatest increase in travel times of greater than 25 minutes on average for off-peak and peak journeys and 15 to 25 minutes for average travel times by public transport
- Option E was rated '/' overall because it saw a slightly lower increase in travel times of less than 15 minutes on average for off-peak, peak and public transport journeys

The overall evaluation is shown in Figure 36.

	Barnet	North Mid	Royal Free	UCLH	Whittington
1a) Average and maximum travel time (peak, taxi/ private car journey	-	/	/	- -	/
1b) Average and maximum travel time (off-peak, taxi / ambulance private car)	-	/	/	- -	/
1c) Average and maximum travel time (public transport journey)	-	/	/	-	/
1) Overall evaluation	-	/	/	- -	/
	Option A was rated '-' overall because it saw a higher increase in travel times of average travel times for off-peak, peak and public transport journeys of 15 to 25 minutes	Option B was rated '/' overall because it saw a slightly lower increase in travel times of less than 15 minutes for average travel times for off-peak, peak and public transport journeys	Option C was rated '/' overall because it saw a slightly lower increase in travel times of less than 15 minutes for average travel times for off-peak and public transport journeys and a slightly higher increase in peak transport journey of 15 to 25	Option D was rated '- -' overall because it saw the greatest increase in travel times of greater than 25 minutes for average times for off-peak and peak journeys and 15 to 25 minutes for average travel times by public transport	Option E was rated '/' overall because it saw a slightly lower increase in travel times of less than 15 minutes for average travel times for off-peak, peak and public transport journeys

Figure 36: Overall evaluation

5.10.2 Are more deprived populations having to travel further for planned surgery?

The PPEG considered the evaluation question "Are more deprived populations having to travel further for planned surgery?". This is because it is important to understand how much further people living in areas of deprivation may need to travel to access services and the impact on people from deprived populations who would have to travel the furthest (maximum travel times). The PPEG reviewed the proposed average travel times compared to current travel times for people

who currently use the service, to assess the increase in travel time of journeys taken by people from deprived populations using off-peak car/taxi/ambulance, peak car/taxi and public transport. The deprived population is defined as the 20% most deprived households, as shown in Figure 37.

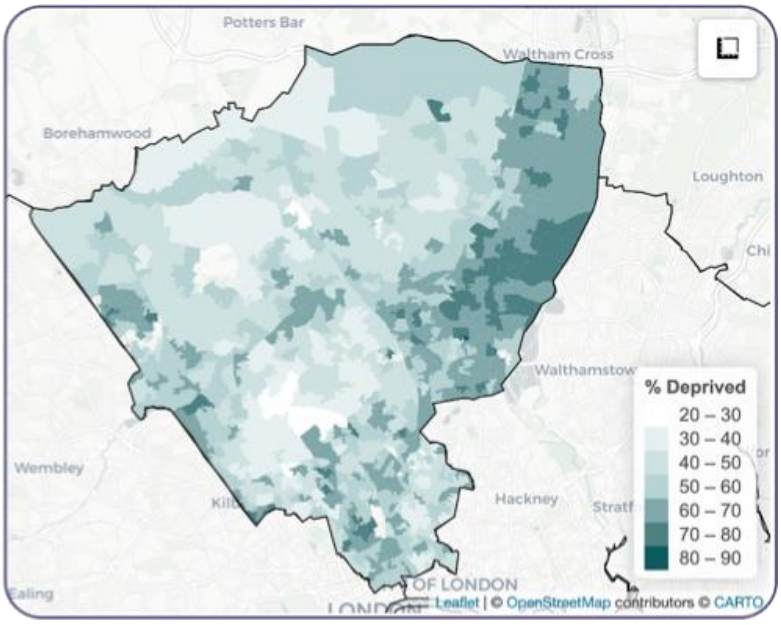


Figure 37: NCL deprivation map

The average additional travel time for people living in areas of deprivation is shown in Figure 38.

High Mid Low

Option	Transport method	Current Core20 population average travel time (mins)	Core20 population average travel time in the option (mins)	Difference to BAU Core20 population (mins)
Option 1: Barnet	Off-peak	16.76	34.73	17.97
	Peak	19.85	40.78	20.92
	Public transport	25.02	44.6	19.58
Option 2: GOSH	Off-peak	11.48	36.93	25.45
	Peak	13.47	43.86	30.39
	Public transport	16.75	38.08	21.33
Option 3: North Mid	Off-peak	14.67	25.8	11.12
	Peak	17.3	30.32	13.02
	Public transport	25.61	39.32	13.71
Option 4: Royal Free	Off-peak	11.22	24.96	13.74
	Peak	12.86	29.57	16.72
	Public transport	20.85	37.59	16.74
Option 5: UCLH	Off-peak	8.6	35.73	27.13
	Peak	8.96	40.29	31.33
	Public transport	16.69	33.64	16.95
Option 6: Whittington	Off-peak	11.91	22.97	11.06

	Peak	14.05	26.81	12.75
	Public transport	19.05	33.97	14.92

Figure 38: Average travel time for deprived populations by option

All options would result in an increase in average travel times and therefore no option has been evaluated a '++' or a '+'. Options B and E would result in an increase in average travel time of less than 15 minutes for any journey and have been rated a '/' whilst option A and C would result in an increase of average travel time of more than one journey type of between 15 and 20 minutes and have therefore been rated a '-'. Option D would result in an increase in average travel time of more than 20 minutes for more than one journey type and has been evaluated a '- -'. This evaluation is shown in Figure 39.

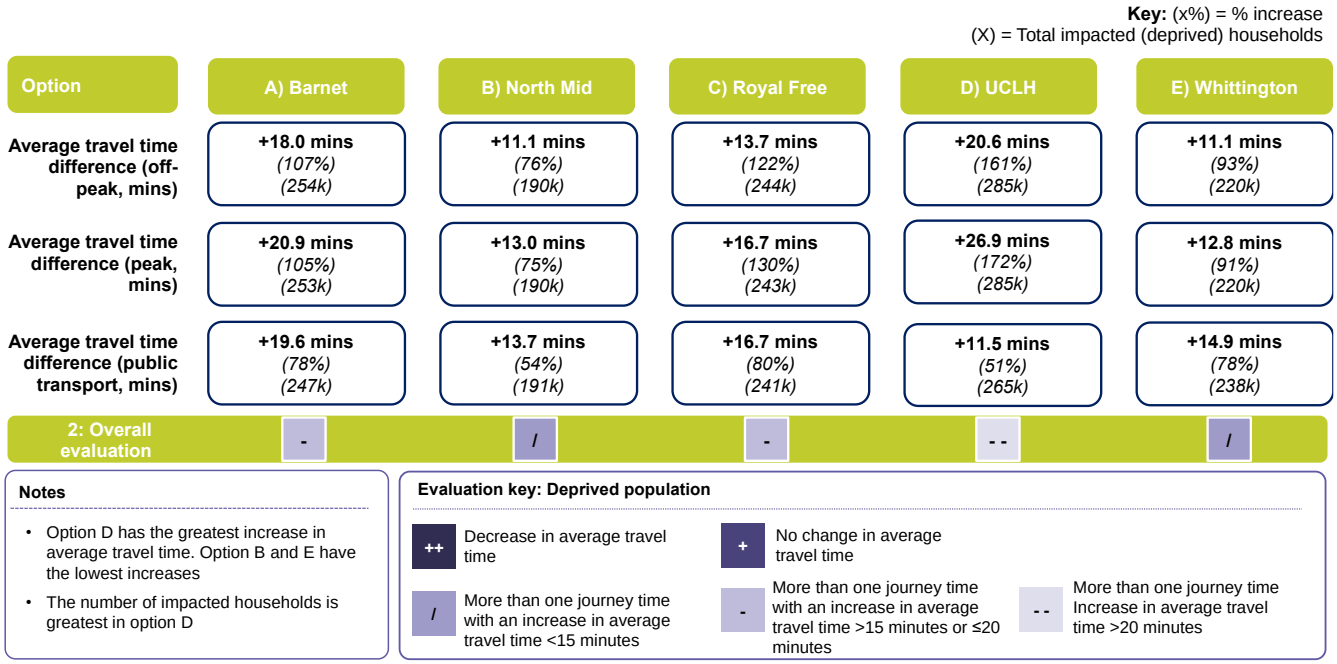


Figure 39: Deprived population average travel time difference option evaluation

5.11 Affordability and value for money

The Finance and Analytics Group considered three evaluation questions to assess the difference between the options with regards to workforce:

- What is the capital investment required for each option?
- What is the impact on system finances for each option?

It was agreed by the group that 'What are the transition costs for each option'. Therefore, these evaluation criteria have not been considered as part of the options appraisal.

5.11.1 What is the capital investment required for each option?

The Finance and Analytics Group considered the evaluation question "What is the capital investment required for each option?". This is because it is important to understand the capital

implications of the proposed service change to ensure that it is affordable and therefore able to be consulted on.

5.11.1.1 Capital investment required

The Finance and Analytics Group considered the capital investment required for each option, based on the additional capacity required to deliver the additional day case surgical activity. All options have similar, low, capital investment and have therefore all been evaluated a '/'. This evaluation is shown in Figure 40

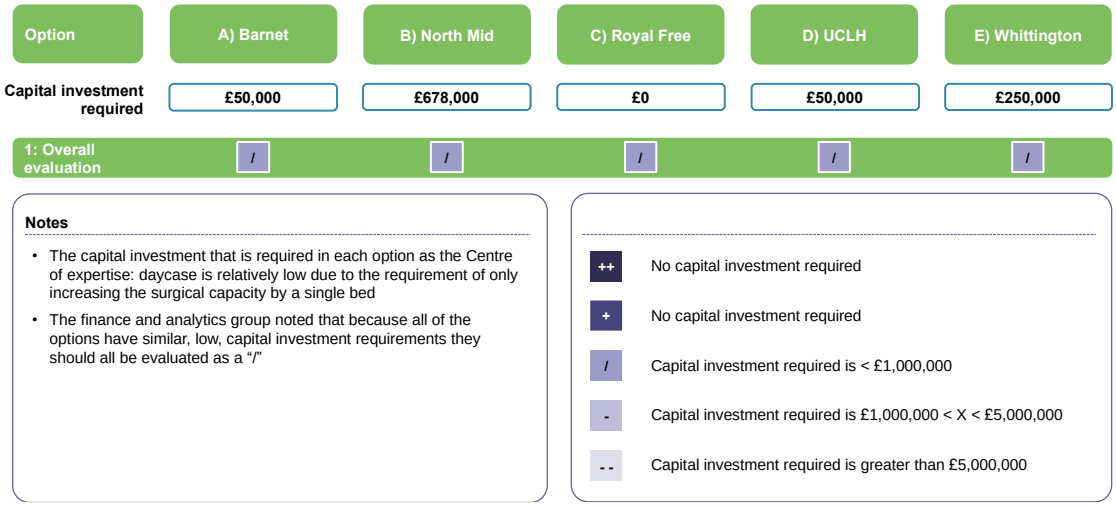


Figure 40: Capital investment required option evaluation

5.11.2 What is the impact on system finances for each option?

The Finance and Analytics Group considered the evaluation question "What is the impact on system finances for each option?". This is used to understand how each of the options will impact on the revenue that is produced within the system.

5.11.2.1 System revenue impact

The system revenue in each of the option varies depending on the market forces factor (MFF) of the provider that would deliver the paediatric day case surgical care in each of the options. The revenue benefit has been included in each of the options as a result of the new care model but is not included in the baseline.

All options (excluding the status quo) would result in a revenue benefit as compared to the baseline of more than £0 but less than £50,000, therefore all options have been evaluated as a '/'. This evaluation is shown in

Figure 41.

Option	A) Barnet	B) North Mid	C) Royal Free	D) UCLH	E) Whittington
Revenue benefit compared to the baseline	£28,408	£23,953	£28,408	£48,336	£28,846
2: Overall evaluation	/	/	/	/	/

Notes

- The evaluation criteria considers the revenue benefit of each option compared to the baseline
- Income has been considered based on the activity projections and the activity that would be delivered at the centre of expertise
- The income is compared to the relative costs of delivering the activity in the new care model for each option
- The costs in each option differ from the baseline due to the cost saving benefits that are associated with the future paediatric daycase surgery care model

Evaluation key: System revenue

++	Revenue benefit compared to the baseline >£100,000
+	Revenue benefit compared to the baseline is >£100,000 X ≤£50,000
/	Revenue benefit compared to the baseline is >£0 X ≤£50,000
-	Loss of revenue compared to the baseline that is ≤£50,000 X >£0
- -	Loss of revenue >£50,000 compared to the baseline

Figure 41: System revenue impact option evaluation

5.12 Option for consultation

The overall evaluation is shown in Figure 42.

	1) UCLH, North Mid, Royal Free, Whittington	2) UCLH, Barnet, Royal Free, Whittington	3) UCLH, Barnet, North Mid, Whittington	4) UCLH, Barnet, North Mid, Royal Free
1) Quality of care	- -	- -	/	/
2) Workforce – implementation and delivery	- -	- -	+	-
2) Workforce – training opportunities	-	- -	/	- -
3) Access to care: Average and maximum travel time	- -	- -	-	-
3) Access to care: Core20 Average and maximum travel time	- -	- -	-	-
3) Access to care: General accessibility	- -	-	/	/
Evaluation outcome	X	X	✓	✓

Figure 42: Paediatric surgery overall evaluation

As a result of the evaluation, we concluded that:

- Options A, B, C and E are not implementable given there are no consultant paediatric anaesthetists on-site that would be able to provide care for children aged 1-2 years. Therefore, these options should not be taken forward for consultation.
- Only Option D has consultant paediatric anaesthetist workforce in place that could deliver care for children aged 1 - 2 years. On this basis, it is recommended that only option D be taken forward to public consultation. All other options would not be deliverable given the consultant paediatric anaesthetic workforce constraints. The challenges for access were highlighted and it was agreed that access to care be explored and to develop a set of mitigations for issues identified. This should be picked up through the interim integrated impact assessment (IIA).

It is therefore recommended that option D is taken forward for consultation.

6. Option for consultation

We are proposing GOSH as the centre of expertise: emergency and planned inpatient and UCLH as the centre of expertise: day case be taken to public consultation, as shown in

Local Unit (Barnet, North Mid, Royal Free and Whittington)	Centre of expertise: emergency & planned inpatient (GOSH)	Centre of expertise: Daycase (UCLH)	Specialist unit (GOSH, Moorfields and RNHOH)
• Delivers **emergency surgery for most children aged 3+** • Children under 5 may be **transferred to the Centre of Expertise:** emergency and planned inpatient • Provides **daycase and planned overnight-stay surgery** in ENT and dentistry for age 3+	• 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	• Delivers **all daycase surgery for children aged 1-2** • Provides **low-volume daycase surgery** for children aged 3+ • Provides **dedicated staff and spaces** for children • **Dedicated specialist paediatric** workforce	• Provides **highly specialist** emergency and planned surgery • Delivers **across age groups** • Supported by **highly specialist workforce**

Figure 43.

Local Unit (Barnet, North Mid, Royal Free and Whittington)	Centre of expertise: emergency & planned inpatient (GOSH)	Centre of expertise: Daycase (UCLH)	Specialist unit (GOSH, Moorfields and RNHOH)
• Delivers **emergency surgery for most children aged 3+** • Children under 5 may be **transferred to the Centre of Expertise:** emergency and planned inpatient • Provides **daycase and planned overnight-stay surgery** in ENT and dentistry for age 3+	• 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	• Delivers **all daycase surgery for children aged 1-2** • Provides **low-volume daycase surgery** for children aged 3+ • Provides **dedicated staff and spaces** for children • **Dedicated specialist paediatric** workforce	• Provides **highly specialist** emergency and planned surgery • Delivers **across age groups** • Supported by **highly specialist workforce**

Figure 43: Paediatric surgery units in NCL

6.1.1 Integrated model of care

Our proposals would see the implementation of our new care model and changes to the paediatric surgery pathways. This includes:

- consolidation of emergency surgery for children under 3, and some aged 4-5 alongside low volume planned inpatient surgery for children aged 1+ at a dedicated centre of expertise: emergency and planned inpatient centre at GOSH. This includes the development of a surgical assessment unit at GOSH and would support access for babies and children to the expertise at GOSH.

- consolidation of all day case surgery for children aged 1 to 2 and all low-volume surgery for children aged 3+ at UCLH, allowing access to specialist skills and experience
- delivery of emergency surgery for most children aged 3+ at local units (5+ for urology and general surgery)
- delivery of surgical activity at existing specialist units such as plastic surgery in children over the age of 3 years at the Royal Free Hospital and adolescent planned surgery at UCLH
- provision of paediatric surgical outpatients at local units, or virtually to ensure access to services close to home, where possible
- continuing provision of specialist emergency care at specialist units including emergency surgery for under 1s at GOSH and emergency eye surgery at Moorfields Eye Hospital

6.2 Interim Integrated Impact Assessment (IIA)

An interim Integrated Impact Assessment (IIA) was undertaken to assess the impact of each of the options. This interim IIA was undertaken by NCL ICB and NHSE London Region Specialised Commissioning to support evaluation of the options and to discharge their duties under the Equality Act 2010. The interim IIA is an iterative process, and the assessment has been updated throughout the planning process to ensure rigor and provide impartiality in relation to the proposed service change options. The interim IIA is used to understand the potential impact of the proposals on residents.

The full interim IIA can be found here. The interim IIA has been developed through in-depth analysis looking at areas such as travel time and demographics, patient engagement, and public health analysis.

6.2.1 Clinical considerations

Our proposals would deliver the proposed paediatric surgery care model and therefore would deliver positive clinical impact. Clinicians, through the paediatric surgery CRG, have outlined the following clinical impacts:

1. **Surgical care delivered in the right setting**
    - Our proposed care model has been designed to ensure children and young people access the surgical care that is aligned to their needs as quickly as possible. This includes ensuring that children over the age of 3 (or 5 for general surgery and urology) can usually be treated at their local hospital. Currently many of these children in NCL are having to travel further to specialist hospitals, which may be outside of NCL. In the event of an emergency, or for more serious cases, children under the age of 3 or 5 years (general surgery and urology) are transferred straight to a more specialist setting
    - The development of an emergency surgical assessment unit at GOSH, so that very young children can be seen by specialist staff without delay in the event of an emergency, and reducing the need for children to be admitted to hospital for assessment

2. **Clear emergency surgical pathways**
    - We would have standardised, clear emergency 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
    - We would reduce the number of transfers and the time it takes to transfer children and young people, reducing stress and decreasing the risk of adverse outcomes

3. **Workforce**
    - We would 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, making sure that people who are anesthetising children under the age of 3 see sufficient cases to maintain their skills and experience

4. **Sustainable volumes of surgical activity**
    - We would ensure that 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
    - We would make sure that all children and young people are seen by specialist staff with access to specialist equipment by consolidating low volume day case activity into a single centre of expertise

5. **Child friendly environment**
    - We would make sure that children, where possible, are operated on in child-friendly theatres and have separate recovery space, with theatre staff who have child-specific training to ensuring the best possible experience for children and young people is provided
    - We would make sure that children are seen as part of a children's list rather than tacked on to an adult surgical list.

6.2.2 Exploring the demographics of service users who may be impacted

We engaged extensively to explore the demographics of people who may be impacted by our proposals. Our case for change identified vulnerable groups that may be disproportionately impacted by the proposals, we considered potentially impacted groups using the national Core20PLUS5 framework and there are also nine protected groups that we must consider to fulfil our legal duties. Our integrated impact assessment is therefore focused on people who may be impacted by our proposals, as shown in

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.

Figure 44.

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.

Figure 44: Interim IIA focus populations

We looked at people who might be impacted by our proposals for changes to paediatric daycase, planned inpatient and emergency surgical services (the catchment population). We found different catchment populations for 1. **planned care** – daycase (going to UCLH) and planned inpatient care (going to GOSH) and 2. **emergency care** (going to GOSH). This is because children and young people having daycase and planned inpatient care would 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 on access for paediatric emergency surgical care can be found in section 6.2.8.

6.2.3 Travel time analysis

To assess the travel time, Travel Time API has been used which accurately calculates distance and time based on actual travel routes, rather than using a straight-line estimate, making it an accurate platform to use for this analysis.

- Peak travel times: weekday morning average travel time was used as an estimate for peak.
- Off-peak travel times: weekday lunchtime was used as an estimate for off-peak. Off-peak is used as a proxy for ambulance times, as this most closely aligns with actual ambulance journey times.
- Public transport travel times: weekday morning public transport travel times were used for public transport.

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

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

This has been used to understand how well-connected the catchment areas are for GOSH and ULCH.

6.2.4 Accessibility for planned paediatric surgical care

Following extensive engagement, 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/ambulance), travel time (off-peak taxi/private car/ambulance), taxi costs and driving costs) to assess the potential impact of our proposals on accessibility.

We also reviewed the demographics of people in the potentially impacted population for the proposed changes to inpatient services. Our analysis showed that:

- **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
- 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 Hospital

The impact on disadvantaged, deprived and minority groups was considered throughout, and mitigations have been identified for any dis-benefits. These are outlined in section 6.6.

6.2.5 Impact of the proposals on accessibility for planned inpatient services

The impact of the proposals on accessibility for planned inpatient paediatric surgery is shown in Figure 45:

- The biggest impact on accessibility for the general population would be an increase in average taxi costs of £22. People closest to a site that would no longer provide the service may need to pay up to an additional £40 per taxi journey.
- The proposals would increase average travel time by car/taxi by 31 minutes (peak), by 23 minutes (off-peak) and by public transport by 18 minutes for the general catchment population.
- People would be able to access services within 64 minutes at peak driving time
- Average additional driving costs are minimal with an average increase of around £2
- People may also be affected by the proposals because of physical or cultural barriers whilst accessing services on site, such as wayfinding.

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

Figure 45: Impact on accessibility for planned inpatient paediatric surgery

Vulnerable people would be particularly impacted by higher taxi costs and may also be impacted by on-site access

- There would be an average increase in taxi costs of £22 - £23 for people who have vulnerabilities although public transport accessibility is generally higher than for the general catchment population
- The impacted population has lower car ownership but has better public transport accessibility
- People who have vulnerabilities may also be other issues whilst accessing services:
    - Language barriers may need to be addressed if people not proficient in English need to access an unfamiliar unit
    - 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 there is a long journey to the service
    - The cost of travelling further, particularly by taxi, may need to be addressed for people living in areas of deprivation and inclusion health groups
    - Support may be required for single parent families who need childcare for other

Mitigations for this can be found in section 6.46.

6.2.6 Impact of the proposals on accessibility for day case paediatric surgery

The impact of the proposals on accessibility for day case paediatric surgery is similar for both options, as shown in Figure 46:

- The biggest impact on accessibility for the general catchment population would be an increase in average taxi costs of £22. People closest to each of the potentially closing sites may need to pay up to an additional £40 per taxi journey.
- The proposals would increase average travel time by car/taxi by 27 minutes (peak), by 24 minutes (off-peak) and by public transport by 12 minutes for the general catchment population
- People would be able to access services within 55 minutes at peak driving time for either option
- Average additional driving costs would be minimal with an average increase of £2
- The general catchment population may also be impacted by other issues whilst accessing services on site, such as wayfinding.

Centre of expertise		Public transport travel times	Peak car/taxi travel times	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
UCLH	*Current*	*22.80*	*15.64*	*12.86*	*£13.55*	*£1.27*
	Future	+12.7	+26.88	+23.99	+£22.13	+£2.10

Figure 46: Impact on accessibility for day case paediatric surgery

People who have vulnerabilities would be particularly impacted by higher taxi costs and may also be impacted by on-site access

- There would be an average increase in taxi costs of £20 - £23 for people who have vulnerabilities, although public transport accessibility is generally higher for these groups than for the general catchment population.
- The impacted population has lower car ownership but has better public transport accessibility
- People who have vulnerabilities may also be impacted by other issues whilst accessing services:
    - Language barriers may need to be addressed if people not proficient in English need to access an unfamiliar unit
    - 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 undertake a long journey to access the site
    - The cost of travelling further, particularly by taxi, may need to be addressed for people living in areas of deprivation and inclusion health groups
    - Support may be required for single parent families who need childcare for other children whilst accessing care that is further away

6.2.7 Specific geographies more vulnerable to the impact of our proposals

We looked at populations who may be more vulnerable to the impact of our proposals and identified two areas for further consideration due to facing barriers to accessing services because they live in areas of deprivation and have high levels of children and young people with poor health, Tottenham & Edmonton and Cricklewood & Dollis Hill, as shown in Figure 47.

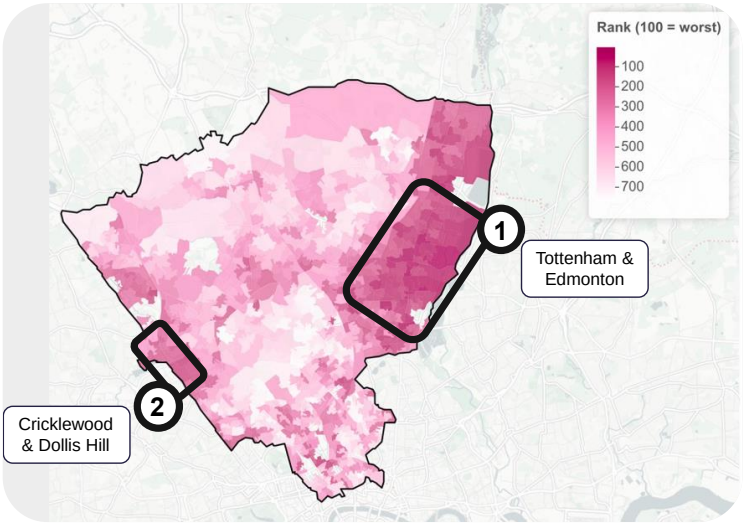


Figure 47: Vulnerable populations

As a result of the proposals at GOSH and UCLH, people in **Tottenham and Edmonton (1)** and **Cricklewood and Dollis Hill (2)** may need additional support to:

- Access the hospital site 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

The population has a high proportion of African and Caribbean children that tend to have poorer outcomes.

6.2.8 Accessibility for emergency surgical care

The impact of the proposals on accessibility for emergency paediatric surgery should be minimal as children would still access services through their local hospital. They would only be transferred to the centre of expertise: emergency and planned inpatient if clinically necessary, and by ambulance. This means there would be no change to where children and young people normally 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.

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 Figure 47, 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 in section 6.4.

		Potential impacts of the proposals for emergency care on parents and carers that may require mitigations
Protected characteristic	Race	• 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
	Age	• Age is not relevant because parents and carers are likely to be a similar age
	Sex	• Being male or female is not relevant as parents are male and female
	People with disabilities	• 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
	Being pregnant or on maternity leave	• 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
	Gender reassignment	• Gender reassignment is not relevant for parents and carers visiting children
	Religion of belief	• Being of a certain religion is not relevant for parents and carers visiting children
	Sexual orientation	• Sexual orientation is not relevant for parents and carers visiting children
	Being married or in a civil partnership	• Being married or in a civil partnership is not relevant for parents and carers visiting children
Other	People living in areas of deprivation	• Potential overlap with race, other inclusion groups and disabilities • 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
	Other inclusion health groups	• Potential overlap with race, deprivation and disabilities • Support may be required for single parent families who need childcare for other children whilst visiting children who are further away • 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

Figure 48: Vulnerable populations

6.2.9 Sustainability

Four sustainability impact metrics have been reviewed to explore the potential sustainability impact:

- **Travel carbon impact:** additional distance travelled might result in higher carbon emissions which needs to be examined from a net-zero standpoint.
- **Protected air quality:** the carbon impact from different options may have an adverse impact on air quality

- **Building carbon impact:** building and refurbishing buildings causes carbon emissions which are harmful to the environment
- **Anchor institutions:** local hospitals are anchor institutions that support local communities and removal of services may impact adversely on local communities

6.2.10 Impact of the proposals on sustainability at GOSH

These metrics provide an understanding of the impact on sustainability on the centre of expertise: emergency and planned care at GOSH. For GOSH the impact on sustainability is as follows:

- **Carbon impact and protected air quality:** there is a small increase in carbon emissions. An additional 327kg in total carbon emissions, as a result of increased travel times for planned care. This may need to be mitigated as the option is within air quality management areas (AQMAs) for NO2 emissions and vehicular particulates.
- **Building carbon impact:** refurbishment carbon emissions for GOSH would be mitigated as part of their net zero strategy

6.2.11 Impact of the proposals on sustainability on UCLH

These metrics provide an understanding of the impact on sustainability on the centre of expertise: day cases at UCLH. For UCLH the impact on sustainability is as follows:

- **Carbon impact and protected air quality:** there is a small increase in carbon emissions. An additional 298kg of carbon emissions, as a result of increased travel times for planned care. This may need to be mitigated as the option is within air quality management areas (AQMAs) for NO2 emissions and vehicular particulates.

6.3 Financial impact and implementation timelines

The key financial test set out by NHSE is that any proposal is affordable in terms of capital and revenue. It is also important that the proposals deliver value for money (VfM) for the taxpayer, although the proposal set out for paediatric surgical services are quality driven.

The financial analysis undertaken at the PCBC stage outlines the capital and revenue requirements for both GOSH and UCLH. This has been assured by the NCL finance team and by the regional finance team at the level appropriate for this stage in the process.

The approach to determine total capital requirements has been worked on by each Trust using a standard template. Assumptions in relation to inflation, fees, contingency and optimism bias have been agreed and tested through the Finance and Analytics working group as follows:

- Optimism bias of 20%
- Trust contingency of 10%
- Inclusion of design and commissioning fees in the cost per m^2
- Inflation assumption of 12.9%

Trust capital costs have been tested through check and challenge sessions with the NCL ICB Chief Finance Officer.

Delivering the required capacity and estate requirements are critical for options for the centres of expertise. There would be a capital investment requirement of c.£3.7m to deliver the additional inpatient and surgical assessment bed capacity at GOSH and UCLH.

6.4 Potential mitigations for disbenefits

There are a number of high level mitigations which have been identified to address some of the potential disbenefits which have been identified by the impact assessment across the areas of accessibility, sustainability and for specific vulnerable groups (Figure 49). Mitigations have been co-created with a number of stakeholders, including members of our PPEG as well as through a Youth Summit with a group of young people. The below figure summarises the mitigations that may be required should changes be implemented. For the full list of all mitigations that have been suggested, refer to Appendix B.

Paediatric surgery mitigations	
Theme	**Mitigations required**
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 surgical pathways	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.
Mitigations for those who may need extra support to access an unfamiliar hospital	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.
Information about how to travel to a hospital site	Should a decision be taken to implement any changes be made in future, it may result in service users going to a different hospital they are unfamiliar with. This may lead to changes to journeys to hospital that people are used to. Mitigations would be needed to ensure that people have information to plan their journeys to hospital.
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 should be considered to reduce the overall number of journeys to hospital, such as continuing as much outpatient care locally.

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
Supporting sustainability	The impact assessment identifies a small impact on carbon dioxide emissions as a result of changes to journey times as well as an impact of refurbishment of estate to deliver the capacity needed. Mitigations needed to address the impacts identified fall within the wider green agenda for the ICS and sites that are impacted. The NHS has a target to reach net zero by 2040 and the ICS and each individual Trust has their own plans to deliver on this.
Supporting populations who may be particularly vulnerable	The populations residing in Tottenham, Edmonton, Cricklewood and Dollis Hill have been identified as a vulnerable who may need additional mitigations in order to support them accessing the care they need. Some specific mitigations that would need 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

Figure 49: Summary of mitigations for disbenefits

7. Implementing the proposals

We have developed high level implementation plans for our proposed options for consultation. Subject to the outcome of the public consultation and decision-making process, we expect that implementation of these proposals will commence from summer 2025. We have developed a high level implementation timeline and set out the key enablers to delivering the proposal. This includes finance, workforce training, digital, standard operating procedure (SOP) development and communication and engagement of pathways. Any high-level risks and mitigations have also been considered.

7.1 Introduction

Oversight of the implementation process would be the responsibility of the relevant governance groups within the NCL ICB.

The Start Well Programme Board, established in 2022, would oversee the implementation of the new care model. Throughout the implementation process, it would meet monthly to provide direction, ensure central co-ordination, manage risks and interdependencies. As the Programme moves into implementation we would review and refresh the current membership as needed.

A Senior Responsible Officer, with support from the Start Well Programme team, has been supporting the Start Well work and would take accountability for the implementation. They would be responsible for ensuring effective working relationships across NCL, and neighbouring ICSs, as needed, in planning and implementing the changes. A number of workstreams would be established to lead on both the planning and development required to support changes to service provision. Governance arrangements would have clear links with the ICB arrangements to ensure that implementation plans across the system are aligned.

The implementation plans for changes to individual sites would be developed at site level. We would review the composition of the Start Well Programme Board ahead of implementation and seek to refresh it if required.

7.2 Timelines for implementation

Pre-consultation activities and the next stages of the business case process (i.e., decision making business case, outline business case and full business case) would be dependent on the outcome of public consultation. Indicative timelines would mean a decision is made 6-9 months following the end of public consultation, with completion of the OBC and FBC following a decision.

Following a final decision by the NCL ICB Board and NHSE London Region Specialised Commissioning, more detailed and organisation specific implementation plans would need to be developed. In order for GOSH to accommodate the additional activity outlined in this document, they need to reconfigure their capacity which is linked to changes they are making to their site for a new cancer centre. This is a co-dependency for this Programme and the changes would need to be implemented in line with the new cancer centre. A high-level implementation plan is outlined in Figure 50.

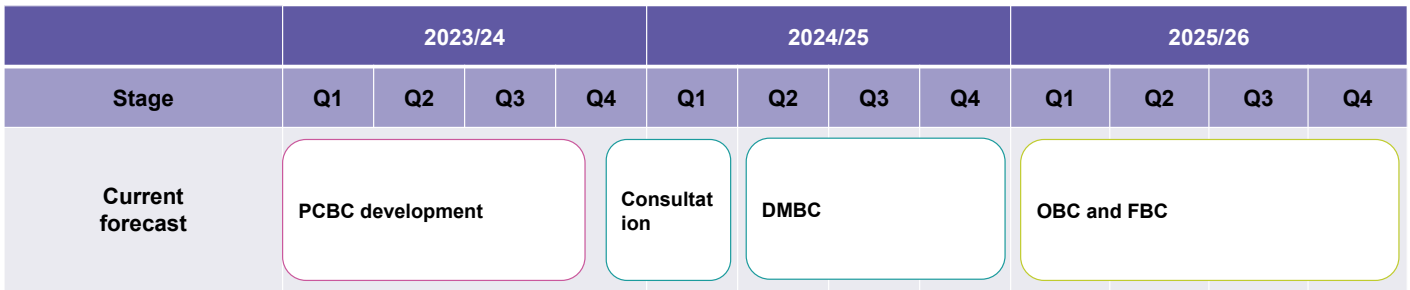


Figure 50: Indicative high level implementation plan

7.3 Key enablers for implementation

7.3.1 Working with the North Thames Paediatric Network

As outlined in section 4.3, the NTPN will be a key partner for NCL to deliver the new care model. Given future devolvement of some services from specialised commissioning to ICBs, ICSs and the Network are currently working to establish how they will work together in the future. However, we envisage the Network playing a key role in terms of implementation in training and development and supporting surgical clinical leadership.

7.3.1.1 Training and development

The NTPN already have a significant role around the training and development of workforce in NCL to have the skills to care for children and young people. For example, they run courses to support the upskilling of nurses in areas such as: pre-assessment, recovery, caring for post-operative surgical patients and for acutely unwell children. They are also currently supporting an initiative with the NHSE Training and Workforce Directorate to support the enhancement of skills in paediatric anaesthesia through rotational posts in paediatric emergency departments.

As part of implementing any proposals, NCL would continue to work with the NTPN, making use of the resources and expertise that the Network has in training and development to put in place a highly localised offer for NCL staff. This will ensure that the appropriate skills and competencies are in place for staff to confidently care for children who are having surgery, at both specialist centres and local sites.

7.3.1.2 Clinical leadership

Skills to care for young children having paediatric surgery are scarce. As has been outlined, given the scarcity of these skills, there are some surgical pathways which are delivered across a number of ICSs in London. Surgery for all North London is overseen by the surgical ODN which is hosted by the NTPN. In order to implement proposals, we will need the support and expertise of the ODN in order to develop and implement new patient pathways which are clear for all clinical teams.

In conjunction with the ODN and NTPN, we would look to put in place NCL-level surgical clinical leadership to support with the implementation of our proposals, and to also play a role in advocating for surgery in children across the ICS in areas such as elective recovery.

7.3.2 Supporting training and educational opportunities

Through implementing our proposals, we anticipate that we will be able to enhance training opportunities for all disciplines. Through ensuring that children are treated in the right setting for their clinical need and ensuring sustainable volumes, means that staff who want to gain expertise in paediatric will be exposed to the number of cases that are needed to do this.

7.3.2.1 Nursing and Allied Health Professional (AHP) workforce

It is anticipated that the staffing of the surgical assessment unit will be nurse-led through Advanced Nurse Practitioner roles. This represents an innovative model of care that provides NCL with the opportunity to train and develop roles for the future and that could eventually go on to work in other settings across NCL. In addition to this, the model will support the development of AHPs with skills to support children recovering from paediatric surgery.

7.3.2.2 Postgraduate doctors in training

The paediatric surgical care model provides us with an opportunity to improve and enhance our training offer, particularly for Postgraduate Doctors in Training (PGDiT). There is a collective ambition in NCL to keep PGDiT at units within NCL, ensuring that we can keep this expertise at local units and improve future recruitment opportunities. The NHSE - Workforce, Training and Education directorate and Heads of School have been briefed on the Programme and involved from the start so that forward planning can take place.

PGDiT rotate between posts and as such posts can be moved at suitable rotation times to whichever unit has suitable activity and learning opportunities. Using the experience from the pandemic, the care model would be an opportunity to enhance the transferability of PGDiT (and other healthcare professionals) between organisations in NCL which could have the potential to recruit and retain staff using the breadth of the educational opportunities. The development of shared onboarding arrangements, honorary contracts and employment passports would facilitate this. We would look to continue to engage educational leaders as part of our ongoing work on the programme.

7.3.2.3 Anaesthetic postgraduate doctors in training

Given the fragmentation of paediatric surgical care in NCL, it has been identified that there can be challenges with ensuring the postgraduate anaesthetic trainees treat enough cases in order to train effectively. This can mean that some trainees within NCL need to have placements outside of the area in order to obtain these skills. This means that implementation of these changes is seen as a positive thing for anaesthetic training in NCL as it ensures that there are increased activity numbers at UCLH through being the day case centre of expertise. There are also opportunities to explore more innovative posts - such as rotations between UCLH and GOSH as part of implementation and ensuring that training can be enhanced.

7.3.3 Local unit workforce training

Critical to delivering the proposed changes to paediatric surgery, is ensuring local units deliver surgical care in children over the age of 3 years and over the age of 5 years for general surgery and urology. Should local units not deliver this activity, there is a risk of overburdening the capacity at the centre of expertise: emergency and planned inpatient. For some of our local units, this activity is not currently being delivered and under the proposed care model, these units would need to have the workforce available 24/7 to deliver this surgical activity confidently.

To support our staff to have the skills, competencies and confidence to deliver this activity a training and development plan would be put in place. This needs to include the whole workforce involved in delivering this care: surgeons, anaesthetists, nurses, ODPs, AHPs etc. This would include training and rotational opportunities. More detailed plans to address any current skills and capabilities gaps at local units would need to involve adult surgical workforce across NCL and would be worked through with the NTPN.

It is also important that our anaesthetic staff continue to have the confidence to manage emergency paediatric admissions who may require emergency intubation. Under our proposals, the majority of care will remain at local sites however there may be small impact on the overall number of paediatric anaesthetic cases anaesthetists are exposed to as a result. Emergency airway management is integral to the safe functioning of paediatric emergency departments, therefore consistent CPD arrangements will also be put in place to ensure that these skills are maintained across all sites.

To further support the delivery of this surgical activity locally, we would ensure clear protocols and pathways are in place and communicated extensively with staff at local units.

7.3.4 Supporting staff and organisational development (OD) through the changes

The continued engagement of our workforce is key to delivering these proposals. Part of the rationale for undertaking this work is to ensure that staff have the opportunity to work in environments that are set up to enable them to deliver high quality patient care and we want to ensure that they continue to feel valued as the programme progresses.

The programme has already made efforts to ensure this is the case through careful management with staff. This has included:

- Executive level leadership from each of the impacted Trusts on the programme to ensure all Trusts are represented
- Coordinated staff briefings across sites at key programme intervals
- Consistent written updates published on staff intranets
- Involvement of senior clinical, finance and analytics teams in the programme through membership of the CRG and finance group
- An organisational development programme during the case for change development through which some senior clinical staff received 1:1 coaching, specialty specific action learning sets were undertaken, and wider workshops were held

As the programme moves into consultation, it will be integral to continue with this level of consistency and engagement with staff to ensure that they understand the proposals being put forward, are clear how they can provide their feedback and understand that at this stage, no decisions have been taken to implement any changes. During the consultation period we will do this through:

- Coordinated, consistent staff briefings around the commencement of the consultation
- Offering multiple mechanisms for staff to provide feedback
- Providing information to staff about where they can seek support from
- Being clear about the potential timeline following consultation and decision making for implementation and what support would be in place for staff should any proposals be implemented

Should there be any agreement to implement proposals, we would need to continue to support staff to work under the new arrangements. This may include through specific organisational development work between staff across organisations. There may be particular work needed at GOSH given the changes to working practices that these changes represent.

7.3.5 Workforce development, recruitment and retention

We want services in NCL at both centres of expertise and local sites to be dynamic, interesting places to work where staff are supported to develop. We also know that there are vacancies within services which can sometimes have an impact on service delivery, as well as the retention of staff working in them. Through implementing changes, we would want to use the opportunity to improve staff experience as well as reduce vacancies. NCL recently published a People Strategy[30] which outlines the ambition for 'one workforce' for NCL which will allow staff to have meaningful work and multiple careers within the ICS. In implementing the proposals, we would use the three pillars outlined in the strategy to improve recruitment, retention and wellbeing of staff: workforce supply, workforce development and workforce transformation. As implementation plans progress, we will also ensure to make the most of opportunities and new roles identified in the NHS Long Term Workforce Plan[31]. This will mean the following:

- Working closely with education providers to provide routes into careers in paediatrics
- Making sure that career opportunities are made available to our local populations. This may be done through considering further provision of apprenticeship placements, as well as placements for T-Levels[32]
- Provide the infrastructure to support staff to work across sites to maximise training opportunities and sharing of specialist knowledge
- Maximise the breadth of training opportunities in NCL through joint training, development and Continuing Professional Development between providers supported by the NTPN
- Continue to engage with the NHSE - Workforce, Training and Education directorate who have been a key member of our clinical reference group to ensure that continuity of training is maintained through implementation and that the model of care maximises the opportunity to improve training and education for all levels of staff
- Make use of new workforce models such as the development of roles such as Advanced Clinical Practitioners, which may support staffing of the SAU. GOSH in partnership with Alder Hay Children's Hospital and education providers have recently been designated as a training site for a masters in paediatric advanced practice
- Supporting inclusion and diversity of our workforce
- Adopting new ways of working including through making best use of digital advancements
- Further develop and expand existing initiatives around recruitment and retention such as the NCL Capital Nurse international recruitment[33]

7.3.6 Standard Operating Procedures (SOPs)

Clear standard operating procedures (SOPs) and pathways would be defined and fully understood and communicated across all sites in NCL. Having these pathways clearly defined would be critical in ensuring that children and young people are sent to the right setting for their needs as quickly as

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

[31] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

[32] https://www.tlevels.gov.uk/

[33] https://www.capitalnurselondon.co.uk/about-us/

possible and that NCL is using the resource at the centre of expertise: emergency and planned inpatient and centre of expertise: day case most effectively. With scare paediatric specialist resource available, it important that this resource is used on surgical activity that only they can deliver.

7.3.7 Holistic care for a child or young person

In addition to the surgical assessment and treatment of children, it is important that through implementation we consider their wider needs. During implementation we would look to ensure that standards for the care of children are considered. This would need to include:

- Age appropriate environment and separation of care from adults
- The availability of wider workforce that support care for children, such as play specialists and allied health professionals
- Access to education where children may be admitted to hospital for an extended period
- Arrangements in place that can ensure the child can be visited by their family

7.3.8 Finance

The capital investment required at GOSH and ULCH would be funded within the NCL ICB Capital Departmental Expenditure Budget envelope (CDEL). More information on the fiancé can be found in Appendix E.

The impact of the proposal has been modelled to show that the changes are affordable. As changes are made, there are expected to be some costs associated with transition:

- Programme team of £500,00 to support decision making and implementation of the programme over 18 months
- Communication and engagement of £200,000 to communicate the proposed changes to the public and the workforce

7.3.9 Digital

We have considered the digital requirements to deliver the proposals, including the need to share information across providers and transfer patient records. Sharing of information and data is already in place and improving this flow of data could be included as part of the ongoing work on the London Care Record (LCR). This would be explored further following consultation.

7.3.10 Stakeholder engagement

The Start Well Programme will continue to actively engage stakeholders in the detailed planning for, and during, implementation. These proposed changes would impact a very small number of children, all of whom for emergency care would attend their local hospital first, as they do now. The proposed changes of the paediatric surgery care model (see section 4.5) would impact around 2,000 children and young people each year, given that much of this activity is already being delivered at either UCLH or GOSH. This includes around 1,200 children and young people who may be transferred to GOSH for an emergency surgical assessment. Our approach to

communications and engagement will be inclusive and co-ordinated and will include the following groups:

- **Patients and public:** to ensure that patients are well informed about what changes are proposed and how it will impact on them, and can contribute to co-design of the implementation plans as appropriate
- **Providers:** will be taking a lead in the planning and implementation of service change, particularly to support service change impacts that need to be implemented smoothly across multiple trusts
- **NHS staff:** to actively engage with affected staff to build awareness of the proposals and to consider and promote their central role in making these changes happen so they can contribute to co-design of the implementation plans as appropriate
- **Clinicians:** will need to be actively involved in the planning and implementation of service change to ensure patient safety is not compromised as changes are made. They would also need to contribute to the co-design of the implementation plans as appropriate.

7.4 Implementation risks and dependencies

Effective risk management is imperative not only to provide a safe environment and improved quality of care for patients and staff, but also for the management and planning of publicly accountable health services. The consolidation of clinical services across organisations brings risks which will need to be carefully managed throughout implementation and beyond.

The risk management process involves the identification, evaluation, and mitigation of risk as part of continuous practice aimed at reducing the incidence and impact of risks, which may include risks related to patients, people, performance, and partnerships. Risk management is therefore a fundamental part of both the operational and strategic thinking of every part of service delivery.

The timelines outlined are indicative, however from experience, once a decision has been taken on changes to services, any sites impacted by the proposals are likely to be affected as follows:

- Ensuring staff maintain skills and competencies at local units, in particular staff at local units are able to manage emergency activity in children under 3 or under 5 (general surgery and urology) before individuals are transferred
- Ensuring sufficient volumes of paediatric surgical activity is still delivered at local units
- Supporting general surgeons and anaesthetists to deliver the surgical activity in children 3 years and older or 5 years and older (general surgery and urology)

These potential risks have been recognised and discussed by surgical CRG. As part of the implementation planning, consideration of mitigations against risks have been developed as outlined in Figure 51.

Risk	Mitigations discussed

Upskilling of those involved in surgical care at local sites is required to fulfil the model of care. This includes surgeons, anaesthetists, nurses and ODPs. This will involve a range of surgical specialties and a number of staff.	• Plan to support upskilling to be developed in conjunction with the NTPN as well as the NCL surgical networks to ensure a robust approach is in place to support implementation of the model • Paediatric surgical leadership to have oversight of the implementation of this plan, escalating risks to delivery as needed
Skills of anaesthetists at local sites will need to be maintained to care for young children who may require emergency intubation.	• The majority of surgical care for children will be maintained at local sites. Many of the cases that are proposed to be consolidated are not being undertaken at local sites under the current arrangements therefore the impact on anaesthetic competencies is anticipated to be small • However, to support the maintenance of skills, consistent CPD arrangements will be developed to ensure that anaesthetists continue to have the skills to look after young children in an emergency situations
The establishment of a surgical assessment unit at GOSH is a new way of working for the organisation.	• Early engagement with GOSH clinical teams to ensure they are aware of proposals and consider the impact of the surgical assessment unit on ways of working • Drawing on models of surgical assessment units in other organisations to ensure that this is established in a way that will facilitate the best possible pathway for children
GOSH is a physically constrained site and there will be a need to manage their capacity effectively so that children who require care there both from NCL and from the broader catchment that they serve are able to continue to do so.	• As well as the surgical assessment unit, we have identified additional inpatient bed capacity at GOSH to support the implementation of the new care model • At times when capacity is constrained, a clinical prioritisation will take place to ensure that children who are most in need of treatment are able to access this
For staff working at GOSH this represents a change in working arrangements. Surgical trainees are not currently resident overnight on call and to ensure maximum exposure to learning opportunities there is an ambition for this to continue.	• The number of cases anticipated to be consolidated at GOSH under these arrangements is small, and across a number of different presenting specialties which means the impact on an individuals on call is not anticipated to be significant • Further detailed work to take place with GOSH following consultation around the staffing model required for the surgical assessment unit
The model requires transfer of patients between organisations which could involve LAS or CATs. Ensuring that they have capacity and can support the model effectively at times of high demand is important.	• Early engagement with LAS and CATs as part of implementation planning • Consider the use of alternative modes of transport where appropriate for patients presenting with less serious conditions

There is potential that patients misunderstand the new arrangements and think that this means an emergency department is being established at GOSH, and present at the site as opposed to accessing their local emergency department.	• A communication plan will be put together which is proportionate to the changes that are being proposed. This will focus on ensuring that families know how to access the right care in the right place for their clinical need, as opposed to the arrangements specifically to surgical care

Figure 51: Risks and mitigations

The Start Well Programme Board meets monthly and regularly reviews the risks to the Programme and there is a clear process in place to ensure that risk registers are connected both within the ICB, and with provider organisations. If the programme progresses to an implementation phase, we would keep our process for managing risks under review.

7.5 Decision-making process

Decision making on these proposals will be preceded and informed by:

- The outputs of early engagement
- The options consideration process
- Independent review by the Clinical Senate of the care model
- Assurance by NHSE of this PCBC
- An interim IIA with mitigations
- Formal public consultation.

Following assurance and consultation, a DMBC will be developed to review the outcomes and set out final recommendations for change. As set out in the NHS guidance 'planning, assuring, and delivering service change for patients'[34], the DMBC will ensure that:

- The final proposal is clinically, economically and financially sustainable
- The proposal can be delivered within the planned envelope for capital spend
- A full account is given of how views were captured during consultation.

The DMBC may be assured by NHSE before final decision making. Implementation of our proposals is therefore dependent on the outcomes of public consultation and decisions taken as part of the DMBC.

8. Benefits

Delivering our vision will change the way in which paediatric surgery is organised and delivered. The proposed care model is expected to deliver a range of positive benefits. These benefits will be felt by those who use our services, their families, our staff and the local populations we serve. Consolidating some surgical activity and providing improved training opportunities will help us realise our ambition of delivering high quality care.

[34] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

The expected benefits outlined demonstrate how our proposals for services address a number of the opportunities for improvement highlighted in the case for change. We expect these proposals would deliver positive impacts in terms of clinical benefits, economic, workforce and environment.

8.1 Benefits framework

The benefits framework enables the quantification and monitoring of the successful delivery of benefits from the changes that are implemented. It is important to translate the proposals into specific benefits, so the public can have a better understanding of what would be achieved and so improvements from the Start Well Programme can be measured. The benefits framework align to the opportunities for improvement outlined in the case for change:

- Organisation of paediatric surgery
- Meeting national recommendations for the environment for paediatric surgical care

Setting out the benefits framework demonstrates that clear benefits can be realised through the implementation of the proposed model of care and consolidation of services set out in these proposals, and that consideration has been given to how this would be achieved. The benefits set out have been informed and tested with clinicians through the CRG, and the Finance and analytics group (where the benefits are cash-releasing).

8.2 High level benefits

Our care model (see section 4) would deliver a number of benefits for children and young people who use our services, their families, carers and our staff. The proposals set out impact a very small number of babies and children but would have a significant impact on the quality of care and experience for the individuals. High level benefits for the proposals is set out in section 6.2.1.

8.3 Detailed benefits

Benefits can be a combination of cash-releasing, quantifiable but not cash-releasing, and qualitative. Cash-releasing benefits identify where money can be reallocated or the cost of delivering a service is reduced. Non-cash-releasing benefits are efficiency savings such as staff time saved, but the cost of delivering the services may stay the same[35].The high level benefits for our proposals are set out in Figure 52.

Category	Benefit description	Outcome
Surgical care delivered in	• 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.	• Reduced emergency admissions

[35] https://digital.nhs.uk/services/personal-health-records-adoption-service/personal-health-records-adoption-toolkit/benefits-of-personal-health-records/financial-benefits-of-personal-health-records#:~:text=cash%2d%20Releasing%20benefits%20are%20there,release%20money%20back%20to%20%20budgets

the right setting	• Development of an emergency surgical assessment unit (SAU) allows children to be seen and assessed without delay by the specialist workforce who have the competencies and experience to make a decision • 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.	• Increased daycase rate at GOSH • Reduced inpatient admissions at GOSH for assessments • Reduced transfers from local hospitals to GOSH
Clear emergency surgical pathways	• 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. • Reduce the number of transfers and the time it takes to transfer children and young people	• Reduce the number of transfers and time take for transfers • Reduced transfers to units outside of NCL, keeping care as close to home • Improved staff productivity through less time spend organising transfers
Workforce	• Delivering care at fewer sites means that that best use is made of the scarce specialist paediatric surgeon and consultant paediatric anaesthetists workforce • Making sure that people who are anesthetising children under the age of 3 see sufficient cases to maintain their skills and experience	• Improved staff experience • Improved recruitment and retention through training and development opportunities across NCL
Sustainable volumes of surgical activity	• 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 • 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	• Children and young people are seen by specialist staff Improved patient experience • Staff deliver enough activity to maintain their skills and competencies
Child friendly environment	• Children are operated in child friendly environments and dedicated paediatric surgical lists	• Improved patient, family and carer experience

Figure 52: Expected benefits

8.4 Patient experience and outcomes benefits

We anticipate that patient experience and outcomes will improve as a result of implementing our new model of care. We would also want to work with service users to determine if there are patient benefits that they would place priority on as part of implementation. Following implementation, we will seek to track both patient and family experience as well as outcomes from surgery. From a patient experience perspective, we would look to use the following:

- The Friends and Family Test
- The CQC children and young people's survey
- Developing a surgery-specific patient / family experience survey for children who are operated on as part of our model of care

In terms of clinical outcomes, it will be important to use metrics as developed by GIRFT in order to track improvements to clinical outcomes. Areas that we may look at as part of this are:

- Day case rates for certain procedures
- Readmission rates
- Infection rates
- Long term health outcomes

8.5 Benefits realisation

It is important to make sure that the benefits are delivered, and, after consultation, the benefits framework will be extended to describe the benefits realisation of the proposals.

Benefits realisation needs careful management and close measurement. Benefits measures should focus on and record both outputs (e.g., reduced surgical transfers) and expected outcomes to demonstrate the success of delivery. A realistic list of measurable performance indicators will sit alongside the benefits outlined in the benefits framework. It is recognised that there can sometimes be a 'dip' in performance during implementation and that some changes will not always be viewed positively by individual patients or staff. However, patient safety remains paramount.

Benefits tracking is firmly embedded within performance management arrangements under business-as-usual. There will be strong clinical leadership of benefits realisation to support successful delivery of the programme. Wherever possible, existing mechanisms and systems will be used to monitor the realisation of benefits, rather than creating an additional data burden.

8.6 When benefits can expect to be realised

High level implementation plans have been included in this PCBC (see section 7.2) and are part of the public consultation process. Whilst different elements of the proposals have differing associated timescales, changes to services will start as soon as possible, and realisation of benefits will follow. However, all benefits are likely to be maximised after the plans are fully implemented.

It is sometimes difficult to isolate benefits from specific changes but measuring benefits alongside implementation plans will help. Some improvements may be attributable to several factors but also not seeing improvements against a particular measure may not necessarily mean that the changes have been unsuccessful. Other factors may have arisen which means improvements are not seen but the benefits framework will allow investigation and rectification, if required.

8.7 Monitoring of benefits realisation

Clear benefits realisation will be part of implementation, with:

- Clinically led, clear and comprehensive implementation plans
- A pragmatic benefits realisation framework, with associated governance arrangements and processes to:
    - Formally track progress of benefits realisation
    - Identify actions in response to any benefits not being realised
    - Define reporting requirements visible to all organisations involved, patients and the public.

Further work to develop the approach to benefits realisation will be done prior to the DMBC. This will include finalising metrics to be used to support benefits realisation and will focus on the final set of proposals being developed by the programme.

9. Stakeholder engagement

9.1 Communications and engagement context

Effective communication and engagement with staff, stakeholders, patients, and residents has been key and has informed the direction of the programme from the beginning. An early communications and engagement plan was approved by the Start Well Programme Board and has been regularly updated as we move into different phases of the programme.

The Children, Young People, Maternity and Neonatal Board members all agreed to adopt specific communications and engagement principles for the Start Well programme in December 2021. We committed to:

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

- Tell staff, families and children and young people (CYP) how their feedback has helped to shape the programme and informed decision-making

Following feedback from stakeholders, including partners from our council children's services teams, the Programme Board also made a commitment to engage with children and young people throughout the life of this programme. We have worked to ensure that their voices are heard, and their views have informed the development of this programme.

The programme team understood that it was very important to have extensive input from a wide range of stakeholders including clinicians, officers from council public health and children's services teams, educators including HEE, NTPN, NHSE London Region Specialised Commissioning, and representatives from neighbouring ICSs. All these groups are represented on the Start Well Programme Board and have been involved in the development of the case for change, care models and options appraisal.

9.2 Approaches taken to stakeholder engagement

The Start Well programme has been a true piece of ICS system working, delivered through collaborative engagement between organisations and with clinical leaders from across NCL.

9.2.1 Staff communications and engagement

We have worked collaboratively with communications leads in the NHS trusts delivering services in scope of Start Well – UCLH, GOSH, Royal Free London, North Mid and Whittington Health. We established the Comms and Engagement Leads Group as an advisory group formed to provide expert input and insights to the Start Well Programme Board.

All staff have received regular and consistent information about the progress of the programme and have been provided ongoing opportunities to give broad feedback, ask questions and raise concerns. Additionally, staff update sessions were offered by Trusts, delivered by their executive lead for the programme. These offered opportunities for two-way dialogue, for the programme to give information to staff and the staff to provide feedback to the programme. These were supported by regular internal staff communications and an online feedback form was promoted on Trust intranets, and in regular communications and e-bulletins.

9.2.2 Identifying programme stakeholders

We carried out a series of actions to identify all key Start Well stakeholders. This included:

- Desktop research and a review of existing reports and papers on paediatric services locally and nationally
- A stakeholder mapping and prioritisation exercise to establish which stakeholders we would want to communicate and engage with
- A number of briefings to partners and forums such as Health and Wellbeing Boards where we asked for suggested groups and communities that we should include in our stakeholder lists

- Developing a stakeholder database with over 200 partners and voluntary and communities sector organisations, with a particular focus on communities who experience poorer health outcomes and greater health inequalities
- To support our engagement, we created an engagement log which records details of all briefings, meetings and engagement activity.

9.2.3 Clinical workstreams and reference group

Key to the progress of the programme has been the input from clinical leaders from across NCL organisations and the wider NHS. At all stages we have had an engaged group of multi-disciplinary clinical professionals who have contributed to the programme. This has been done through:

- Clinical workstreams that have focussed on different elements of the programme - for example during development of the Case for Change, we had three workstreams: emergency paediatrics, planned paediatrics and maternity and neonatal care. These were all lead by the Executive Leads from each of the Trusts who are themselves clinicians
- System-wide workshops at key points in the programme that have engaged broader clinical teams from across NCL
- Clinical reference groups were established to support the options appraisal. There was one group with a focus on maternity and neonates and another to support the paediatric surgery options appraisal

These groups have involved: medical, nursing and allied health leadership from across NCL, as well as representation from community clinicians and general practice. The intention of this has been to ensure that the programme benefits from the range of knowledge and expertise that staff with these different perspectives bring to the programme.

9.2.4 Youth Summits and mentoring

The establishment of youth summits and a mentoring scheme for clinical leads was agreed to ensure that the voices of young people are at the centre of the programme.

In partnership with a specialist youth engagement agency, Participation People, starting in summer 2022, a group of young people from across NCL took part in a series of ‘Youth Summits’. The input of these young people has been sought at key milestones in the programme, with summits planned to coincide with school holidays to maximise participation. The youth summits have focused on reflecting on the opportunities for improvement listed in the case for change, the areas that young people feel are important when planning for these services, the development of care models and access to services.

In addition to the summits, several young people act as ‘Youth Mentors’ to the programme to ensure that clinical leaders are given the opportunity to listen to the views of young service users and are challenged in some of their perceptions about what is important to children and young people.

9.2.5 Patient and Public Engagement Group (PPEG)

The PPEG is an advisory group that has been formed to provide expert input and insights to the Start Well Programme Board. The group provides feedback and oversight of planning and delivery in relation to communication and engagement with patients and the public, and members are able to influence and inform the development of the care models and options appraisal.

In carrying out its responsibilities, the PPEG has committed to:

- Pay particular attention to the duties of public sector organisations relating to groups with protected characteristics set out in the Equality Act 2010 and in the NHS Act 2006.
- Provide challenge to the programme on behalf of patients and residents of NCL.
- Provide information or expertise to the PPEG to support effective communications and engagement activity to aid well-informed decision-making.
- Respect differing views, experiences and be conscious of biases in discussions.
- Ensure that the process and outputs of the programme are led by population health needs rather than those of individual organisations.
- Champion the interest of the public, patients, carers and staff

9.2.6 Working with VCSE organisations and partners

As we developed our stakeholder database, we have forged relationships with VCSE partners who have existing trusted relationships with some of the groups and communities who experience poorer health outcomes and greater health inequalities. We have worked collaboratively with our VCSE partners, such as Manor Gardens, Umoja, Interlink, and with the patient experience teams within the NHS trusts, to run engagement activities.

9.3 Engagement objectives and methodologies

Broadly, our engagement objectives have been to:

- Ensure all staff in relevant service areas had opportunities to respond, feedback and identify any additional themes or areas to explore when considering these services
- Maximise opportunities for local patients, residents and wider stakeholders to share their views, experiences and what they feel is important when planning for these services
- Ensure the range of voices heard from during engagement reflected the diversity of NCL's communities, including those who are most at risk of health inequalities, deprivation, ill health or have barriers to accessing services
- Employ a broad range of engagement techniques to gain feedback from patients and residents, providing opportunities for all who wish to contribute, whilst focussing on gaining deeper feedback from those identified in our stakeholder prioritisation exercise
- Work in partnership with local authority, voluntary and community sector (VCS) partners and established patient groups and networks and to establish new relationships where necessary

9.3.1 Phase 1: case for change development

In the development of the Case for Change document, a range of approaches were used to ensure a variety of views and insights were captured from across the system, as follows:

- **Staff interviews**: close to sixty clinical leaders from across NCL took part in one-to-one interviews with the Start Well programme team. The interviews were an opportunity to explore the needs of NCL's population and to identify both strengths and challenges in how services are currently delivered.
- **Clinical workstream reference groups**: bringing together clinical and operational expertise, the clinical reference groups met to provide feedback and insights on the data analysis, identify interdependencies with other services and review best practice standards
- **Wider clinical workshops:** two half-day workshops, with approximately one hundred participants, were held to explore current patient care pathways in more depth and reflect on themes that had emerged through the workstreams, interviews and data analysis.
- **Surgical deep dives**: five focused sessions with surgical colleagues from NCL providers were undertaken to understand the current surgical services, pathways and areas of strengths and challenges.
- **Broader stakeholder engagement** – we wrote and offered briefings to ICS stakeholders on the establishment of the programme, a number of face to face briefings were held with local MPs and lead members for health and children's services. We also attended meetings to present on the aims and scope of the programme including, Health and Wellbeing Boards, Children's Partnership Boards, meetings with the Directors of Public Health and Directors of Children's Services and NCL Social Partnership Forum
- **Patient and public representation**: an online patient panel was recruited in February 2022, with the aim of establishing a group of local representatives interested in, and with experience of, using services for children and young people, maternity and neonatal services in NCL. In May 2022, eight individuals from the online panel were involved in smaller focus group where they have shared their experiences.
- **Patient representative groups**: we provided briefings to patient representative organisations and our five local Healthwatches
- **Targeted public engagement:** A number of priority groups were invited to take part in conversations with the Start Well programme team to ensure that the voices of those who may not normally participate or who may be disproportionately disadvantaged (as outlined in our population analysis) have been captured. Due to the vulnerability or communication barriers of some groups, community and voluntary sector organisations were asked to undertake engagement on our behalf and insight was captured using a structured interview format. Examples include a group of young people who were previously in care, women with experience of domestic violence and an Asian women's group.

9.3.2 Phase 2: engagement on the case for change

A ten-week programme of engagement on the Case for Change ran between 4 July 2022 and 9 September 2022. The engagement aimed to establish whether the opportunities for improvement set out in the Case for Change reflected the views and experiences of staff, stakeholders, patients and residents. We also asked participants to tell us what they felt were the important factors to be considered when planning for these services.

We developed materials to support this engagement including a summary of the case for change, also available in EasyRead and six community languages (Arabic, Bengali, Farsi, Polish, Somali, Turkish), a questionnaire which was available both online and in paper form and a discussion guide for use at engagement meetings and focus groups. The Case for Change Summary and Questionnaire were tested by a patient reader panel and their feedback was incorporated to ensure the materials were as clear and accessible as possible.

A range of engagement activities were carried out including 43 events with patients and the public, including a youth summit, resulting in over 200 in-depth conversations. A survey was available online which was advertised via contacting 188 VCS organisations as well as being promoted through Trust communications. In total, 389 surveys were completed. Methods of engagement also included presentations and feedback sessions at community meetings, online discussion and focus groups, attendance at hospital outpatient and antenatal clinics, targeted social media advertising, attendance at community groups for parents and carers and via community newsletters and networks.

We heard from:

- **Staff and Clinicians**: we sought staff feedback via staff meetings and briefings, information cascades through managers, internal intranets and newsletters. All staff were encouraged to feedback via the online survey
- **Patients and the public**: we worked with voluntary and community organisations to involve NCL's diverse communities and focus on those who might have specific insights including:
    - Early years services
    - Baby and child loss organisations
    - Women's and family centres
    - Youth justice
    - Carers
    - Parents with young children
    - Children and young people
    - People with LD and Autism
    - Children with mental health illness and long term conditions
- **Stakeholders**: feedback was sought from a wide range of local and national stakeholders who were identified as potentially impacted by or interested in the case for change. Key stakeholders included: local MPs, elected members, professional bodies, educators, neighbouring ICS areas, the London Clinical Senate and Clinical Senate Patient Representation Group.

From the completed surveys we heard from current or recent service users (42%), staff (28%) and most people were resident in Barnet, Camden, Enfield, Haringey or Islington (90%). Qualitative and quantitative data was produced during the engagement, which was independently evaluated, and a report was published which is available on NCL Integrated Care System's website.

The headline findings from the engagement on the Case for Change are that the following were considered important factors:

- **Emergency care for children and young people**: care close to home, being seen quickly and having good communications

- **Planned care for children and young people**: having the best care even if it is further from home and good communications

9.3.3 Phase 3: care model development

In response to the Case for Change, new care models were developed which aim to address the opportunities for improvement that were identified. Developing the care models was a collaborative exercise undertaken with a wide range of input from a number of system partners. The future care model development was overseen by the Paediatric Surgery Clinical Reference Group (CRG) which had membership from across all organisations as well as local system partners.

Other clinical engagement, outlined in Figure 53, included 100 individuals through two half day clinical workshops and nine dedicated task and finish groups. These focused task and finish groups explored areas such as the transition to adult services, training and education and paediatric surgical care.

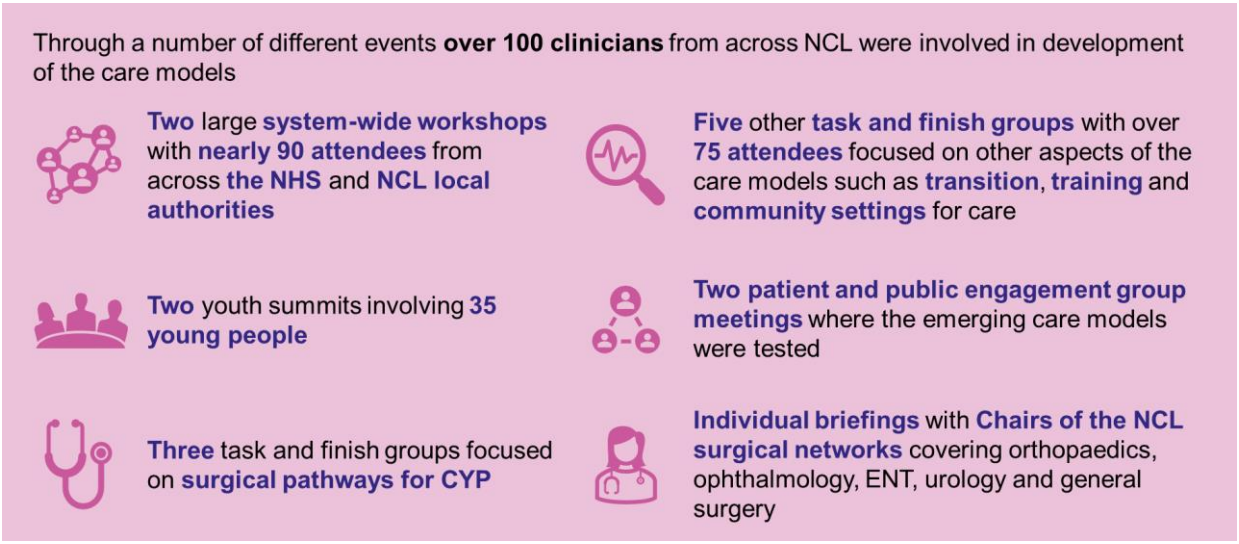


Figure 53: Care model clinical engagement

Themes from the case for change engagement were fed through to the task and finish groups to ensure this feedback informed the care model development. The care models were shared at several system groups including the Network Oversight Group (which brings together all surgical clinical networks) Primary Care Operations Group and one-to-one meetings with the clinical chairs of the six NCL surgical networks. A full list of the forums the care models have been tested at can be found in Appendix A.

We also sought patient and public feedback through two meetings of the PPEG and a youth summit session which captured the views on the emerging children and young people's care models from around twenty young people who are residents of NCL. Relevant themes from these events were shared with the CRG and task and finish groups to ensure that patient voices are at the centre of the care model development.

A set of principles underpinned the design process of the care models which included placing those using the services and their families at the centre, ensuring equity and consistent standards of care, and making best use of our resources, people, places and money.

The care models were reviewed and approved by both the Start Well Programme Board and the NCL Integrated Care Board. The paper that was taken through the ICB Board and can be found here.

How patient feedback has influenced the care models
The care models were shaped through the clinical feedback we received during this phase of the programme. It was however also crucially important that patients were engaged regarding the care models. Some of the areas that were included as a direct result of PPEG feedback is highlighted below:

- For paediatric surgery care model, they highlighted the importance of pathways being clear on how appropriate support post discharge support would be provided
- To ensure that support for children and young people with learning disabilities, autism and mental health conditions had been considered.

9.3.4 Phase 4: options development

In November 2022, the NCL ICB Board approved the programme to commence an options appraisal to explore the implementation of the paediatric surgery care model. Since then, the programme has been engaging with a number of different groups in order to deliver this work. The groups involved have been:

- Paediatric surgery CRG
- Finance and analytics group
- PPEG

The engagement of these groups has been key to the progress of the options appraisal, influencing both the criteria that were used in the options appraisal and an initial evaluation against these criteria. The role of these groups during the process has been outlined below:

- **Paediatric surgery Clinical Reference group (CRG):** The CRG was focussed on the quality and workforce evaluation criteria. They met a total of eight times in order to support the options appraisal process. This included six meetings to develop the criteria that were used for the evaluation, and then a further two meetings in order to undertake the evaluation.
- **Finance and analytics groups:** This group were focussed on the affordability and value for money criteria. The group met on 14 occasions following the November NCL ICB Board approval to commence the options appraisal.
- **Patient and Public Engagement Group (PPEG):** The PPEG were focussed on the access criteria for the options appraisal. They were responsible for both developing the criteria used and an evaluation against these criteria. The group met a total of seven times to undertake this work, which included four sessions to develop the criteria and three to undertake the evaluation.

The role of the Start Well Programme Board in the options appraisal
The Programme Board has been responsible for overseeing the options appraisal. It has met at key intervals throughout the progress of the work and signed off on recommendations made through other groups involved in the process.

The Programme Board came together for a full day workshop in order to review the work undertaken through the CRG, Finance and Analytics Group and PPEG. The purpose of this workshop was to undertake a calibration of the initial evaluation conducted by the groups and review the different options in the round considering all criteria to understand if any option(s) would not be implementable.

The workshop had all members or representatives of the Programme Board in attendance, as well as some additional system partners whose organisations may be impacted by possible changes, namely: NEL, NWL and Hertfordshire and West Essex ICBs.

How the options appraisal was conducted
The options evaluation workshop was set up to ensure that all criteria were reviewed, with input from the representatives of the relevant groups. Members of the CRG and finance group attended the workshop at intervals throughout the day to ensure they could answer questions about the criteria used or the initial evaluation that was undertaken. The Programme Board then discussed each of the criteria to understand if there were any moderations to be made to the evaluation. This ensured that all criteria were reviewed in a systematic way, and that rationale for the initial evaluation by the groups inputting into the process could be shared. Section 5 of this document describes in more detail the options which were considered and how they have been taken forward.

9.3.5 Phase 5: Interim IIA engagement
The work on the interim IIA has been overseen by a steering group which has provided multi-disciplinary oversight of the work related to the impact assessment.

In order to inform the interim IIA and mitigations needed to support the delivery of changes to paediatric surgical care, we engaged with a number of service users. The aim of this engagement was to identify who may be more impacted by changes, what the impact would be on them and what effective mitigations may be put in place that would address any negative impacts. Through a number of different mechanisms, our engagement reached 89 young people, parents, carers and residents:

- Views on paediatric surgery captured as part of engagement on the case for change - both in discussion groups and through our questionnaire
- An engagement event at 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 on three occasions by PPEG
- Three youth summits with 60 young people in attendance were held which supported identification of groups that may be impacted by proposals

The feedback from this engagement has been around the following themes:

- **Travel and transport:** impact of changes on journey time and cost and how these could be mitigated
- **Access to care:** the importance of children to be cared for by teams who are experienced in delivering this care and ensuring that wider needs of a child are considered alongside their surgical presentation
- **Environment:** going to an unfamiliar hospital can cause anxiety for both child and family and there may need to be particular consideration given to those who are neurodivergent
- **Communication:** ensuring the administration of care is effective and ensuring appropriate follow up is in place

10. Quality assurance

We have undertaken a robust quality assurance process which underpins the programme and gives assurance to this PCBC. Clinicians have been at the heart of setting out the case for change and designing the care model and proposal set out in this document. Our proposals have been independently reviewed by the London Clinical Senate who provided us with feedback, which we have acted upon and built into this business case. The proposals will be scrutinised by the JHOSC. The proposals have also been assured by NHSE and going to public consultation was dependent on this assurance being received. The programme has met the four tests for reconfiguration set out by the Secretary of State, plus the fifth bed test set out by NHSE (five tests). The Start Well programme complies with NHSE guidance on the business case process major service change[36] and HM Treasury's Green Book requirements for significant capital investments[37], where applicable.

10.1 Approvals process for the programme recommendations

In line with the Programme governance set out in section 2.6, the approval process for this document is:

- The paediatric surgery CRG, Finance and Analytics Group, PPEG have ratified the information that they were responsible for evaluating which has formed part of this document before being submitted to the Start Well Programme Board
- The Start Well Programme Board have reviewed this document and submitted it to NHSE for assurance
- A recommendation was made to each of the provider trust boards for discussion, assurance, and support
- The London Joint Committee for specialised services met and supported the proposals set out in the PCBC and the move to public consultation. The decision has been ratified by the London Regional Executive.
- A decision on whether to proceed to consultation has been made on the basis of this PCBC by a meeting in public of the NCL ICB Board of Members.

10.2 Engagement and review with the London Clinical Senate

[36] NHS England, 2018. Planning, assuring and delivering service change for patients. https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

[37] Gov.uk, 2022. The Green Book. https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent/the-green-book-2020

The proposals and new care model have undergone a review by the London Clinical Senate. Clinical Senates are a source of independent and objective clinical advice and guidance to local health and care systems, to assist them to make the best decisions about healthcare for the populations they represent. A formal review of the of the proposal and care model was undertaken on 12 July 2023. A link to the Senate's report on our proposals can be found here. Prior to the review session, a set of supporting materials were submitted to the senate panel. Queries generated were shared back with the programme team to enable a full and informed discussion on the day.

The London Clinical Senate are supportive of the proposals as outlined in the PCBC. The panel agreed the case for change is underpinned by evidence and best practice guidance and that our ambition to improve was informed by national policy.

The London Clinical Senate provided some recommendations to strengthen the work we have done to date. Some of these have been directly addressed through further work on this document, whilst others will be addressed within the DMBC. The detailed recommendations, and how these have been addressed or plan to be addressed, can be found in Appendix C. At a high level, recommendations focus in the following areas:

- Further work to describe mitigations around capacity pressures that GOSH may face given their wider role as a specialist provider
- Further detail around implementation planning to ensure that skills at local sites are maintained
- How educational opportunities can be maximised under the proposals
- An understanding of how these proposals fit within the wider context of improving services for children and young people
- Continued engagement with service users and wider stakeholders

10.3 Joint Health overview and scrutiny committee (JHOSC) engagement

Throughout the Programme we have engaged with the JHOSC with regards to the Start Well Programme. This includes updates on progress and the proposed changes. Further detail on the engagement can be found in section 11.

10.4 Assurance by NHS England (NHSE)

NHSE has the responsibility of overseeing that ICBs and NHSE Specialised Commissioning meet their statutory duties and other responsibilities under the *NHS Oversight Framework*[38]. It has a role to both support and assure the development of proposals for service change. NHSE supports commissioners and local partners to produce evidence-based proposals for service change, and to undertake assurance to ensure they can progress, with due consideration for the government's four tests of service change and the test for any proposed bed closures (five tests).

Prior to public consultation, NHSE considers the proposal in terms of both capital and revenue and its financial sustainability. This ensures any option submitted for public consultation is:

[38] https://www.england.nhs.uk/publication/nhs-oversight-framework-22-23/

- Sustainable in service and revenue and capital affordability terms
- Proportionate in terms of scheme size
- Capable of meeting applicable value for money and return on investment criteria.

NHSE operates a two-stage assurance process prior to public consultation, and the outcome of this process is shown in section **Error! Reference source not found.**.

10.4.1 NHS reconfiguration five tests

There are five "reconfiguration tests" for the NHS that must be applied to all significant service change proposals, as specified in national policy and guidance. NHSE guidance on service change is intended to support commissioners and partner organisations in navigating a clear path from inception to implementation. It aims to assist organisations in taking forward their proposals, enabling them to reach robust decisions on change in the best interests of patients. National guidance is set out in 'Planning, assuring, and delivering service change for patients' and the addendum added in May 2022.[39,40]

These tests are designed to demonstrate that there has been a consistent approach to managing change, and therefore build confidence within the service, and with patients and the public. This section demonstrates how we meet the governments four tests for service reconfiguration and change, and how the final test set out by NHSE isn't applicable. These tests are:

- **TEST #1**: The proposed change can demonstrate strong public and patient engagement.
- **TEST #2**: The proposed change is consistent with current and prospective need for patient choice.
- **TEST #3**: The proposed change is underpinned by a clear, clinical evidence base.
- **TEST #4**: The proposed change to service is owned and led by the commissioners.
- **TEST #5**: Proposals including significantly reducing hospital bed numbers will have to meet one of the following three conditions:

    - Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
    - How that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
    - Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the getting it right first time programme).

NHSE assured the proposed services changes prior to the launch of public consultation. The five tests have been applied throughout the pre-consultation phases of the Start Well programme. The following section demonstrates how we met each of the tests of service change and assurance.

[39] NHS England, 2018. 'Planning, assuring and delivering services change for patients'. https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

[40] NHS England, 2022. 'Addendum to Planning, assuring and delivering service change for patients (March 2018)'. https://www.england.nhs.uk/wp-content/uploads/2018/03/B0595_addendum-to-planning-assuring-and-delivering-service-change-for-patients_may-2022.pdf

10.4.2 Test 1 – The proposed change can demonstrate strong public and patient engagement

This test evaluates how service users, and the public are involved in the development of the proposals for change, and how their views and insights are considered throughout each stage of the programme.

Patients and the public have been involved throughout the development, planning and decision making of the proposed service change. We have been able to involve diverse communities through both our engagement on the case for change and the subsequent pre-consultation engagement for the interim IIA. Through both these periods of engagement we have used connections with the local voluntary sector and local authorities to ensure we engaged with a range of diverse service users. We have also had engagement on an ongoing basis with a group of patients through our PPEG, who were represented by their Chair at our options appraisal evaluation workshop in May 2023.

We have had early involvement with patients and the public through multiple communication streams to ensure an ongoing dialogue could take place in the stages of proposal development. The communications and engagement workstream have set out a communications and engagement plan to set out objectives and methods to monitor engagement and to provide assurance. We had made sure that our methods and materials have been tailored to meet specific audiences, provided opportunities for vulnerable and seldom heard groups to participate, and offered accessible forms of documentation. The principles we have used to define our approach to demonstrate strong public and patient engagement can be found in the stakeholder engagement section 11.2 and plan for consultation section 11.

10.4.3 Test 2 – The proposed change is consistent with current and prospective need for patient choice

This test looks at whether any proposed redevelopment and/or changes to services would maintain the availability of service user choice. Patient choice in this context refers to the statutory requirements set out in the *NHS Choice Framework*[41] which sets out patients' rights around choice of provider for planned care and maternity services (as well as choice of GP and some other services out of scope for this programme of work).

The proposals set out would ensure that children and young people still have choice on where to have planned surgery in NCL. It is also important to note that the patient choice test does not extend to the specific location of the provider. Moving the location of a particular service from one part of a geography to another still maintains patient choice of provider in this context.

The *NHS Choice Framework*[41] sets out statutory requirements for choice, of which the most relevant are outlined below.

[41] NHS Choice Framework (Department of Health and Social Care, 2020)

Statutory requirement for choice	Your choices as a patient
Choosing where to go for your first appointment as an outpatient	If you need to be referred as an outpatient to see a consultant or specialist, you may choose the organisation that provides your NHS care and treatment (an outpatient appointment means you will not be admitted to a ward). You may choose whenever you are referred for the first time for an appointment for a physical or mental health condition. You may choose any organisation that provides clinically appropriate care for your condition that has been appointed by the NHS to provide that service. You may also choose which clinical team will oversee your treatment within your chosen organisation.
Asking to change hospital if you must wait longer than the maximum waiting times	Maximum waiting time is usually 18 weeks, or 2 weeks to see a specialist for cancer. You can ask to be referred to a different hospital if: • you must wait more than 18 weeks before starting treatment for a physical or mental health condition, if your treatment is not urgent • you must wait more than 2 weeks before seeing a specialist for suspected cancer Waiting times can vary between hospitals and you have the right to be referred to another hospital that may be able to start your treatment sooner. Waiting times start from the day the hospital receives the referral letter, or when you book your first appointment through the NHS e-Referral Service.

10.4.4 Test 3 – The proposed change is underpinned by a clear, clinical evidence base

The proposed change in service is underpinned by a care model that has been clinically led in line with local guidance, national policy, and best practice. The care model was developed using clinical evidence and clinical best practice. There has been clinical leadership and engagement in development of the clinical model and implementation plans.

Developing the care model was a collaborative exercise undertaken with a wide range of input from a number of system partners. The future care model development was overseen by the Paediatric Surgery CRG which had membership from across all organisations as well as local system partners.

There was wider clinical engagement to develop the care models which included:

- Two half day workshops attended by nearly 90 individuals from both the NHS and local authorities
- Nine dedicated task and finish groups
- Engagement with Chairs of the surgical networks groups

The proposed changes have been taken to the London Clinical Senate as a source of independent, strategic advice and guidance to assist us in making the best decisions for the local population. A review of this process is seen in section 10.2. Section 3 addresses the case for change with a proposed paediatric surgical care model that is underpinned by a clear, clinical evidence base in more detail.

10.4.5 Test 4 – The proposed change to the service is owned and led by the commissioners

Commissioners (through the NCL ICB Board) and NHSE London Region Specialised Commissioning have led the development of the PCBC and the Start Well programme has been progressed through the NCL ICB Board governance arrangements, in accordance with the organisation's constitution and supporting documents. Workstream outputs from the Start Well Programme have been taken to the Start Well Programme Board (succeeded by the ICB Board) to ensure process rigor and quality of content.

The Start Well Programme has robust governance that covers how the programme is going to manage the inevitable complexity and interdependencies and bring the different aspects together. The NCL ICB is an integral member of the Start Well programme and is leading the proposed service changes. The Start Well Programme Board has representation from the ICB. The governance for the programme can be found in section 2.6.

10.4.6 Test 5 – Proposals including significantly reducing hospital bed numbers

The proposed service change would not reduce hospital bed numbers and therefore the conditions set out by this test do not apply.

11. Plans for consultation

The proposals to be considered during the consultation will set out the potential solutions for delivering high quality paediatric surgical services for the local population. We will aim to obtain a broad range of views from our local communities, service users and their representatives and partners on our proposals.

No decisions about any changes to services will be made until after a full public consultation has taken place and all the information, including the feedback from the consultation, has been considered by NCL Integrated Care Board and partners in line with Gunning principle 4[42].

The purpose of the consultation is:

- To ensure people in NCL and surrounding areas are aware of the public consultation and how to participate
- To present the case for change and the proposed options, by providing clear, simple and accessible information in a variety of formats

[42] https://www.local.gov.uk/sites/default/files/documents/The%20Gunning%20Principles.pdf

- To provide a variety of methods and mechanisms to give and receive information, appropriate to different audiences with a focus on groups with protected characteristics and those who may be more impacted by the proposed changes
- To enable and encourage people to feed in their views on the proposed changes and the potential impacts
- To understand the views relating to our proposals for paediatric surgical services and what concerns and mitigations we should consider in relation to any future implementation
- To ensure responses received are independently evaluated and the results published
- To ensure decision-makers receive detailed outputs and feedback from the consultation exercise so that they are as well-informed as possible before any decisions are made

The consideration of all feedback and additional evidence gathered during consultation will help the Integrated Care Board to make an informed decision on progressing the future shape of services. We will commission an independent partner to analyse all the consultation responses and outputs from all engagement methods.

On conclusion of the analysis the independent partner will produce a final written report which will be publicly available and shared with the Joint Health and Overview Scrutiny Committee. The report will be used to support deliberation and decision making by NCL ICB Board of Members on behalf of the partners of NCL Integrated Care System.

11.1 Delivering a consultation

Subject to approval of this PCBC we are committed to undertaking a full public consultation to seek views on the proposed options. Our consultation plan outlines our approach of how we intend to gather and respond to views from our local communities and partners. Our plan has been developed with input from our Public and Patient Engagement Group and the Start Well Programme Board. The plan will continue to be developed throughout the consultation period to ensure that we are meeting our consultation purpose and obtaining a diverse range of views from patients, public, staff and stakeholders.

Under Section 14Z2 and Section 13Q of the NHS Act 2006, the NHSE and ICB has a duty to ensure that people who use NHS services are involved in the development and consideration of proposals for change in the way that services are provided. We will also be complying with our duty to consult the local authority, under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, made under section 244 NHS Act 2006.

We will deliver a best practice consultation, based upon the Start Well communication and engagement principles and ensuring that all our statutory duties are met.

11.2 Consultation principles

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

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

11.3 Consultation oversight

For the purposes of this consultation, the proposals are being put forward by NCL ICB, on behalf of NCL ICS (comprising the boroughs of Barnet, Camden, Enfield, Haringey and Islington) and NHSE London Region Specialised Commissioning. The consultation will be overseen by the Start Well Programme Board.

We will also seek feedback on the consultation from local groups such as Healthwatch. These groups will support with:

- Commenting on consultation documentation and communications materials and their accessibility
- Ensuring we are facilitating involvement from a wide range of communities including all relevant groups identified in the interim IIA
- Commenting on methods to raise awareness of the consultation with NCL residents and stakeholders
- Particularly ensuring that we are engaging with children and young people in a meaningful way to allow them to participate in the consultation
- Champion the voices of patients and residents
- Ensure that the voices of children and young people are incorporated into the consultation

11.4 Co-designing the consultation plan

The approach and methods used for the consultation will be developed in line with best practice and with input and oversight from our partners. The plan is a working document and will iterate during the life of the consultation as we monitor responses and participation. In developing the draft plan, we have considered feedback from all our early engagement and interim IIA engagement activities.

11.5 Audiences

The consultation aims to engage as effectively as possible with the following groups across NCL and in neighbouring ICS areas, particularly NEL, NWL and Herts and West Essex:
To inform our decision-making, we are seeking views about the proposed change from:

- People who have experienced paediatric surgical care in the past, at one of the existing sites
- People who may need services in the future
- The families and carers of affected groups, including local residents and the public
- Children and young people who live in NCL or surrounding areas
- Community representatives, including the voluntary sector
- Staff in directly impacted services
- Staff and partners in health and social care in primary, secondary, community and social care
- Councillors and MPs
- Unions, and professional bodies including royal colleges and education providers
- Relevant councils
- Neighbouring Integrated Care Boards who commission similar services
- Local media

11.6 Consultation methods and materials

We will use a range of materials and methods to encourage a wide range of local people to take part in the consultation and talk to us about the proposals. Our methodology falls into two areas: giving information and getting information.

Our consultation document will clearly lay out the basis on which we are consulting, the background to the consultation, a summary of how the proposals have been developed and a clear, simple explanation of what the proposals are and what they will mean for patients and users of these services. We will signpost more detailed technical information and data where appropriate. Our consultation materials and methods will highlight the different ways in which people may choose to participate, allowing for different levels of engagement or interest. By using a mix of methods, we will support a wide range and breadth of feedback and enable the people to contribute in the way that best suits them.

We will seek to engage with patients, carers, their families, healthcare staff at NHS trusts and in the community, local people, families, carers and their representatives through a range of activities:

- Online engagement through our residents' health panel
- Using NCL public participation and engagement networks to reach local residents
- Stakeholder and community outreach activities such as voluntary sector facilitated groups and working with VCSE partners to convene discussion groups with particular communities
- Staff meetings and feedback facilitated through communication leads at each of the sites in NCL
- We also may commission external, independent experts to deliver some of the engagement activities and to analyse the responses for groups that may be particularly challenging to reach or where there may be barriers to their participation

A range of consultation materials will be developed to support the process including:

- A full consultation document which lays out proposals in a clear and easy to understand way. This will be available in a number of other formats (such as easy read) and languages
- Summary consultation document
- Posters promoting the consultation and encouraging participation
- Short film/animation explaining the proposals
- Presentation outlining the proposals to use in meetings
- A range of visual aids including maps, infographics, example patient pathways
- Quotes and talking heads from local clinicians
- Interim IIA

11.7 Handling responses

It is important that patients, the public, staff and other stakeholders feel that their feedback is valued and that they can give feedback easily. We have appointed an independent evaluation partner who will support with the consultation response and ensure that all responses are recorded, captured, and can subsequently be independently analysed. The mechanisms for response will include:

- Freepost address for return of the consultation questionnaire or other written responses
- Online questionnaire (echoing the paper version)
- Generic email address
- Freephone telephone number
- Verbal feedback captured through notes recorded at engagement events

11.8 Raising awareness of the consultation

We will aim to raise awareness of the consultation process, questions and timelines throughout the consultation period. We will achieve this through a dedicated marketing and communication plan. This plan will focus particularly on populations identified as potentially impacted through our interim IIA. Our plan will include a number of elements including:

- Media releases
- Social media activity with content, assets and engagement activity
- News stories and case studies for community newsletters
- Advertising
- Displays and info in public buildings – clinics, hospitals, libraries
- Newsletter
- Website pages
- QR Code

11.9 Consultation analysis and decision making

Once the formal consultation data input has taken place and the data analysed, all the feedback will be captured in an evaluation report, produced by an independent organisation, which specialises in consultation analysis. The report will capture all responses and highlight the following:

- Relevant to and/or having implications for the model of care and/or one or more of the options.
- Well-evidenced submissions that point to evidence for alternative options that may not have been considered.
- The impact of proposals on particular groups that have been highlighted through the integrated impact assessment.
- Suggestions for how implementation can be effectively managed and any mitigations that may need to be put in place for certain groups.

12. Next steps and approvals

Following approval of this PCBC, we plan to undertake a public consultation which will inform the development of the DMBC.

12.1 Regulatory assurance

We have been developing the proposal for this PCBC since November 2021, ensuring that there has been the time and engagement in making ensuring that the proposed changes are as robust as possible. It was submitted to NHS for stage two of the national assurance process for service change and reconfiguration on 9 November 2023 and they gave formal approval for us to proceed to consultation.

12.1.1 System assurance and the 'decision to consult'

The PCBC was reviewed and supported by the London Joint Committee for specialised services and has been ratified by the London Region Executive. A decision on whether to proceed to consultation has been made on the basis of this PCBC by a meeting in public of the NCL ICB Board of Members.

12.2 Next steps for stakeholder engagement

12.2.1 Moving to formal public consultation

Section **Error! Reference source not found.** sets out our approach and plans for consultation. We are planning to run the consultation for 14-weeks and we will continue to work with our stakeholders to refine our consultation plan.

12.2.2 Joint Health overview and scrutiny committee (JHOSC)

In addition to informing the approach to consultation, we will conduct a full public consultation on our proposals for change. We have consulted directly with local authorities on our proposals via the JHOSC. This is as per our Section 244 duty under the National Health Service (as amended by the Health and Social Care Act 2021) which requires NHS bodies to consult relevant local authority overview and scrutiny committees on any proposals for substantial variations or substantial developments of health services.

We will meet with NCL JHOSC members during the consultation period to hear members' views, answer questions, and update the committee on the progress of the public consultation. We will seek a further meeting at the end of the consultation period, once we have an independent report of the consultation findings to share with the committee. We will agree regular meetings to keep the committee updated through the next stage of our work and preparation of our DMBC, before the NCL ICB and NHSE London Region Specialised Commissioning makes a final decision on the proposals for change.

12.2.3 Post consultation

After the consultation closes, the responses received from members of the public, patients, staff, stakeholders, and partner organisations will be independently analysed, as per best practice. A report based on this analysis will be submitted to the ICB Board to help inform its decision-making, alongside all the other evidence and data gathered throughout the lifecycle of the programme, which together will be reflected in, and will help inform, a DMBC.

12.3 Developing a decision-making business case

The process to develop the DMBC will be supported formally through the established Start Well Programme governance. Additional workshop sessions will be undertaken to support Board members to consider consultation responses carefully and conscientiously. These sessions will happen as part of the preparation for their decision-making meeting and consideration of the DMBC in the round.

On approval of the DMBC by the NCL ICB Board and NHS London Region Specialised Commissioning, the OBC and FBC will be finalised for approval by Trust Boards and HMT, if required.

12.4 Next steps for the interim Integrated Impact Assessment (IIA)

The Start Well Programme commissioned an interim independent IIA in 2023 to assess the impact of the proposals. The interim IIA is used to understand the potential impact of the proposals on local residents and allows us to explore the impact of our proposals on inequalities and vulnerable groups. The interim IIA report sets out an assessment of the potential impacts which may be experienced as a result of the proposed changes to paediatric surgical services across NCL and, in line with commissioners' public sector equality duty, helps to ensure that genuine consideration is given to equality as part of the decision-making process.

The interim IIA will be revisited over the course of the public consultation process and beyond, as part of an iterative process. We will review and refresh the interim IIA considering the findings from public consultation.

13. Glossary

	Meaning
AHP	Allied Health Professionals (physiotherapy, occupational therapy, dietetics, speech and language therapy, psychologists and pharmacists)
AQMAs	Air quality management areas
CAG	Clinical Advisory Group
CATS	Children's Acute Transport Service
CDEL	Capital departmental expenditure limit
CEO	Chief executive officer
CFC	Case For Change
Core20PLUS5	National NHS England approach to inform action to reduce healthcare inequalities at both national and system level
CPD	Continuing professional development
CQC	Care Quality Commission
CRG	Clinical Reference Group
CYP	Children and Young People
CYPMN Board	Children, Young People, Maternity and Neonatal Board
DGH	District general hospital
DMBC	Decision-Making Business Case
DoF	Directors of Finance Group
ED	Emergency department
ENT	Ear nose and throat
FBC	Full business case
FFT	Family and Friends Test
GIRFT	Getting it Right First Time
GOSH	Great Ormond Street Hospital for Children NHS Foundation Trust
HDU	High dependency unit
HEE	Health Education England
HMT	His Majesty's Treasury
ICB	Integrated Care Board
ICS	Integrated Care System
IDACI	Income deprivation affecting children index
IIA	Integrated Impact Assessment
IPS	Integrated Paediatric Service
IV	Intravenous
JHOSC	Joint health and overview scrutiny committee, with representatives from each of the borough Health overview and Scrutiny Committees.
LAS	London Ambulance Service
LCR	London Care Record
LD	Learning Disability
MDM	Multi-disciplinary team meeting
MFF	Market forces factor
Moorfields	Moorfields Eye Hospital NHS Foundation Trust
MP	Member of Parliament
NCL	North Central London
NEL	North East London

NHS	National Health Service
NHSE	NHS England
NOG	Network Oversight Group
North Mid	North Middlesex University Hospital NHS Trust
NTPN	North Thames Paediatric Network
NWL	North West London
OBC	Outline business case
OD	Organisational development
ODN	Operational Delivery Network
PAU	Paediatric assessment unit
PCBC	Pre consultation business case
PGDiT	Postgraduate doctors in training
PICU	Paediatric intensive care
PIFU	Patient initiated follow-up
PPEG	Patient and public engagement group
PTAL	Public transport accessibility levels
RNOH	Royal National Hospital Orthopaedic Hospital NHS Trust
Royal Free	Royal Free London NHS Foundation Trust comprising of Barnet Hospital, Royal Free Hospital and Chase Farm Hospital
SAU	Surgical assessment unit
SDEC	Same day emergency care unit
SEND	Special educational needs and disabilities
SMB	System Management Board
SOP	Standard operating procedure
SRO	Senior responsible officer
UCLH	University College London Hospitals NHS Foundation Trust
ULEZ	Ultra-Low Emission Zone
VCSE	Voluntary, community and social enterprise
Whittington Health	Whittington Health NHS Trust
WTE	Whole time equivalent

14. Appendix

14.1 Appendix A: Care model development meetings

Meeting	Meeting Focus	Date	Number of Attendees
Care Model Development Workshop #1	A workshop with a range of attendees from both the NHS and Local Authorities were invited to commence work on best practice models of care.	14/07/22	49
Youth Summit #1	Introductory sessions with a group of young people were asked to think about key elements of emergency care that mattered to them including communication.	27/07/22	c20
Start Well Clinical Reference Group	The first meeting of the CRG split the group into two break outs; one covering maternity and neonates the other covering paediatrics and asked for their feedback on the developing models of care.	31/08/22	20
Youth Summit #2	A group of young people were asked to think about elements the care models including alternatives to ED and surgery.	01/09/22	16
Care Model Workshop #2	The second large workshop where attendees reviewed of the best practice models of care and provided feedback.	08/09/22	40
Start Well Clinical Reference Group	The CRG were asked review the proposed task and finish groups and then split into two groups to consider some specific questions on the care models as well as starting to look at co-dependencies	14/09/22	19
Start With Clinical Reference Group	The CRG were presented with the emerging themes from the engagement and reviewed the proposed membership of the task and finish groups.	28/09/22	14
Start Well Patient Participation Group	Initial meeting to discuss terms of reference and determine ways of working.	30/09/22	7
Task and Finish Group: Surgery #1	A group consisting of surgeons, anaesthetist AHPs and nurses were invited to explore the surgical pathways were for CYP	20/10/22	16
Youth Summit #3	A group of young people explored the advantages and disadvantages of two possible models for surgical care and the age cut off for CYP and adult services.	27/10/22	15
Task And Finish Group: HEE	Heads of the school for paediatrics, anaesthetics, general practice an obstetrics and gynaecology were invited to comment on the potential impact of the care modules on training.	31/10/22	4

NCL Network Oversight Group	Emerging surgical models of care were shared with the attendees of the NCL network oversight group which includes clinical and operational leads from NCL surgical networks including urology, gynaecology, orthopaedics, general surgery, and ENT.	01/11/22	10
Task and Finish Group: Transition between Paediatric and Adult Services	A group including paediatricians, transition leads from trusts and community nursing explored the different age cut offs between some paediatric and adult services and how to transfer between services takes place.	2/11/22	7
Task and Finish Group: Surgery #2	A group consisting of surgeons, anaesthetists, AHPs and nurses were invited to explore surgical pathways for CYP.	3/11/22	15
Task and Finish Group: Community Settings	Colleagues from across five local authorities, ICB Directors of Integration and primary care were invited to feedback on the emerging models of care. The emerging work on Family Hubs in local authorities was also explored in relation to the care models.	04/11/22	17
Start Well Clinical Reference Group	The CRG reviewed the updated best practice models for neonates, maternity CYP planned and emergency care.	9/11/22	19
Task And Finish Group: Surgery #3	A group consisting of surgeons and anaesthetists, AHPs and nurses were invited to explore surgical pathways for CYP.	10/11/22	12
Start Well Patient Participation Group	The maternity and paediatric surgical care models were shown, and feedback invited from the group.	11/11/22	7
Briefing with the NCL General Surgery Network leadership	The surgical care models were shared, and feedback invited as well as specific discussion on the age ranges for surgical services.	11/11/22	2
Briefing With the NCL Orthopaedic Network leadership	The surgical care models were shared, and feedback invited as well as specific discussion on the age ranges for surgical services.	11/11/22	2
Briefing with the NCL Plastic Surgery Network leadership	The surgical care models were shared, and feedback invited as well as specific discussion on the age ranges for surgical services.	11/11/22	1
Briefing with the NCL Urology Network Leadership	The surgical care models were shared, and feedback invited as well as specific discussion on the age ranges for surgical services.	14/11/22	2
Briefing with the NCL ENT Network leadership	The surgical care models were shared, and feedback invited as well as specific discussion on the age ranges for surgical services.	15/11/22	3
Briefing with the NCL Ophthalmology Network leadership	The surgical care models were shared, and feedback invited as well as specific discussion on the age ranges for surgical services.	15/11/22	2

Primary Care Silver Group	The care modules were shared with the group and feedback invited with a specific focus on primary care elements of pathways.	17/11/22	50

14.2 Appendix B: Interim IIA mitigations

Mitigations for paediatric surgery 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 in NCL, 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 for groups where response rates 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.
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.	• When a child is referred or transferred to the centre of expertise for treatment in an emergency situation, there needs to be information given to families about this to ensure they know 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 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
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	• 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

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.	• Consider innovative tools or technology to support wayfinding or giving directions within a hospital
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 on 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
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 should be considered to reduce the overall number of journeys to hospital	• 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 assessments) 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

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 to support patients with travel costs, as well as how to make a claim, including:
	  • Healthcare Travel Costs Scheme - financial assistance for patients, who do not have a medical need for ambulance transport, and their carers but who require assistance with their travel
	  • ULEZ and Congestion Charge reimbursement schemes where applicable
	  • Blue badge schemes - support key groups with travel and increasingly being made available to those with a mental health conditions
	  • Information about these schemes to be available in different languages and formats to suit needs of service users
	• 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 the 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 car 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 impact assessment identifies a small impact on carbon dioxide emissions as a result of changes to journey times as well as an impact of refurbishment of estate to deliver the capacity needed. Mitigations needed to address the impacts identified fall within the wider green agenda for the ICS and sites that are impacted. The NHS has a target to reach net zero by 2040 and the ICS and each individual Trust has their own plans to deliver on this.	• 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
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 a vulnerable who may need additional mitigations in order to support them accessing the care they need. Some specific mitigations that would need 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 a 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

14.3 Appendix C: London Clinical Senate recommendations

Area	Recommendation		Where this is reflected or being addressed
Case for change	**R1**	The Case for Change is clearly articulated; it could be strengthened further to emphasise why the status quo is likely to be unsustainable and to describe how the proposals provide greater opportunities for improvement.	This is outlined in section 5.3 of the PCBC.
	R2	Improvements to quality and safety are clear drivers of the case for change and would benefit from greater specificity; there may be opportunities to co-produce these with public and patients. It is important that they are regularly tracked and monitored, including being to alert to and facilitate the mitigation of unintended consequences.	Section 8 of the PCBC outlines the anticipated benefits and the opportunity to consider co-development of benefits with patients and public.
	R3	There are several quality and safety improvement projects that are in progress alongside the proposed service reconfiguration e.g., addressing variation in stillbirth rates and improving access to perinatal mental health care. Clearly referencing these as aligned but independent pieces of work would add clarity.	A paper has been written which outlines how opportunities to improve in a number of areas outside the scope of the reconfiguration are being taken forward. It can be here.
Outcomes & Equity	**R4**	The PCBC and discussion on the day emphasised that the proposed changes would improve service provision and outcomes for the whole population, with focussed improvement on the most vulnerable groups and communities. This could be articulated more fully in the PCBC and the DMBC: • Further describe how access will be improved for all populations e.g., more care and assessment being provided closer to home (community or virtual); integration with place-based services including primary care and pre-natal, post-natal and health visiting, pre-surgery, post-surgery. • Provide further specificity on how inequities and inequalities will be positively addressed for the most vulnerable populations e.g., prioritising continuity of care and local access.	Section 4 of the PCBC outlines our care model which indicates that as much care is retained locally as possible, both for emergency cases (all children over the age of 5) and for planned care through the provision of outpatient appointments locally. We recognise that the changes being proposed to paediatric surgical care will impact a small number of children each year. There are wider improvement programmes in place across the ICS in order to address the other opportunities raised in the case for change and have an impact on population health more generally. These can be found in the paper here.
	R5	Continue work on the Integrated Impact Assessment to ensure that where access to care is negatively impacted by the proposed changes, specific mitigating actions are clearly articulated. For example, timely presentation and transport issues and costs for the populations potentially most disadvantaged, particularly CORE20plus and those with protected characteristics.	Our interim IIA indicated a number of mitigations to ensure that proposals do not negatively impact on population groups. We will continue to work on this as proposals develop and following consultation.
Workforce	**R6**	There is potential to explore and describe further North Central London's role as an anchor institution with the possibility of	Given the changes proposed are very minor, there is not anticipated to be a significant impact of proposals on the organisations' role as anchor institutions.

		recruiting, developing, and educating people from local communities.	
	R7	Organisational development (OD) work during the consultation and implementation phase can help to ensure that staff contribute to and strengthen plans throughout the change process, that their wellbeing is supported, and the risk of attrition is reduced. Illustrating links to the NCL people plan, and associated OD is likely to support this.	Section 7.3 outlines the workforce enablers for implementation, including reference to the People Plan and the requirement to support staff through changes with organisational development.
	R8	Further describe how continued liaison with education providers and staff while the changes are implemented will maintain continuity of training and optimise opportunities to further improve skills and experience.	Section 7.3 outlines the importance of maintaining and enhancing training as part of the proposals. This includes continued liaison with educational leaders as it progresses.
	R9	Continue to develop thinking on workforce: opportunities exist aligned to the Long Term Workforce Plan (2023), new roles, new ways of working, and lead employer contracts. Ensure effective dovetailing between funding recently made available to meet standards as well as investment aligned specifically to Start Well.	Section 7.3.5 outlines our approach to workforce development recruitment and retention.
Estates & Environmental Sustainability	**R10**	The midwifery and neonatal integrated impact assessment includes sustainability. There is opportunity to build on this to specify how the proposals will further all NHS providers to improve environmental sustainability and net zero. This aligns to the role as an anchor institution, community models and digital opportunity.	NA - this relates to maternity and neonatal services.
Data & Digital	**R11**	Ensure that improving data quality in maternity and supporting digital alignment (e.g., integration with other information systems and move to a single records system) are prioritised. This should support the proposals and enable implementation of different care models and specialist outreach. It should also include mitigations for digitally excluded populations.	NA - this relates to maternity and neonatal services.
Patient & Public Engagement	**R12**	The PCBC is clear on the ambition to work with more disadvantaged and deprived populations. It is important that the communication plan demonstrates multi channelled and sustained communication on what might be different or is different, and why.	This is a key principle of our communication and engagement approach and is reflected in the materials that we have developed to support the consultation.
	R13	During implementation there should be opportunities for service users to co-design and influence the way services are delivered at Place and Neighbourhood level (with their linkages to Primary Care, Community Services, Schools, and Social Care). Some of the priorities are articulated in the Three-Year Delivery Plan for maternity and neonatal services.	NA - this relates to maternity and neonatal services.
Communication with clinicians	**R14**	Ensure that there is connectivity between risk registers held at ICS level and provider level,	Risk management is an important part of implementation. Some high level risks and

and wider stakeholders		which inform the proposals and monitor the transition and early years of implementation to provide assurance that ambitions are met, and unintended consequences are rapidly highlighted for mitigating action.	an approach to how these will be managed is outlined in section 7.4 of the PCBC.
	R15	A different provider configuration could disrupt established relationships with local authorities and their teams e.g., Health Visiting and Children and Young People's health. It would be helpful to reference plans for approach during implementation.	Both GOSH and UCLH have strong processes in place to work with local authority colleagues when needed, although this is not felt to be a significant impact of these changes, given the small volume of activity. We would look, as part of implementation, to explore if there are any further areas around discharges and links with local authorities that have not yet been considered.
Model and Pathway	**R29**	Describe any mitigations regarding capacity pressures on Great Ormond Street Hospital (GOSH) recognising the wider role GOSH provides as a specialist provider for all of London and surrounding areas. This should mitigate the potential unintended impact for other children relying on GOSH who live outside NCL.	This is indicated in section 7.4 of the PCBC. Mitigations include additional inpatient capacity in order to support the additional activity, as well as a clinical prioritisation taking place to ensure that children with the most urgent conditions are prioritised for treatment
	R30	Include greater specificity in patient pathways defining the conditions that would go to Great Ormond Street Hospital and University College London Hospital would be helpful.	This is outlined in Appendix D of the PCBC
Workforce	**R31**	Further detail on the processes and activity levels to ensure the expertise and experience of workforce in the district general hospital (DGH) areas is maintained, particularly around immediate airway management, and emergency and elective paediatric surgery (for older children).	Section 7.3.3 outlines our approach to local workforce training including both surgical care and emergency airway management of young children and this would be a significant focus of implementation planning after consultation.
	R32	Increasing specialisation and training may affect the future workforce competencies required to manage other surgical conditions in children in their local hospitals. Further detail would be helpful on how the plans will mitigate this risk and maintain and sustain sufficient paediatric surgical expertise on all hospital sites in the future.	The proposals outline that the majority of surgical care would continue at local sites. The work being considered for consolidation for the most part is already taking place outside of local units. Through these proposals we would be looking to upskill clinical teams at local sites and through implementation would develop a robust plan around this, encompassing the whole workforce who are involved in delivering this care.
	R33	Describe further the educational opportunities the planned changes can provide, recognising that the London region is a major training provider. Work with educators and trainees to secure the best training opportunities from the changes needs to continue.	Improving training is anticipated to be a key benefit of our proposals through ensuring there are volumes of activity for staff who want to gain specialist skills in paediatrics can achieve this.
	R34	Explore opportunities for common continuing professional development (CPD) and training arrangements across Trusts alongside	Our ambition to provide consistent CPD and rotational posts is outlined in section 4.5.1.1 and this would be a key focus of any

		consideration of rotations and joint appointments.	implementation planning that would follow public consultation.
	R35	Describe further how alternative options e.g., surgeons, anaesthetists, nurses, AHPs and other healthcare professionals rotating and upskilling at other centres has been explored to ensure that all opportunities have been considered and maximised.	In reach of surgeons was considered through the development of the options but this was not felt to be deliverable given the wider workload that there is at GOSH around their specialist work. There are existing models where surgeons operate on an outreach basis for planned care, and it is anticipated that this would continue and be built on should proposals be implemented.
Population impact and improvements	**R36**	Further describe how the North Central London Population and Integration Strategy underpins and interfaces with the proposed improved clinical outcomes of children's surgery. Indicate how clinical outcomes and the overall improvement for the system's child population will be tracked, measured, and monitored.	We recognise that the changes proposed to paediatric surgery are small, and in order to have a bigger impact on population health outcomes, wider changes are needed across paediatric services. In responding to the case for change, a number of programmes have work in place already. These are outlined in a paper found here. The changes are underpinned by the population health strategy in that it involves addressing unequal provision of surgical care where pathways of treatment can be unclear and fragmented
	R37	Include further detail on the communication strategy with NCL residents about the new model and pathway, particularly focussing on messaging and communications regarding babies and young children requiring the most complex care. There may be an inclination to try and bypass the DGH and go direct - for reasons of seeking direct access and costs of transport which would be counterproductive.	Our communication strategy would be proportionate to the changes that are being proposed and would focus on how families can access the right care in the right place at the right time for all conditions as opposed to relating specifically to surgical care. We would look to target communications around the new arrangements to ensure the impression was not created that GOSH had an emergency front door for all to attend.

14.4 Appendix D: Detailed surgical pathways

Emergency surgical pathways

	GOSH as specialist hospital	Centre of expertise: emergency and planned inpatient	Other site as specialist service	Local sites
ENT	Neonates Surgically and medically complex	0-3	3+ to UCLH and Barnet	
Dentistry	Neonates Surgically and medically complex	0-3	3+ to UCLH and Barnet	
OMFS	Neonates Surgically and medically complex	0-3	3+ to UCLH and Barnet	
Cardiothoracic	All 0-16		16+ to Barts	
Neurosurgery	All 0-16		16+ to NHNN RLH or St Marys for major trauma	
Plastics	Neonates Surgically and medically complex	0-3	3+ to Royal Free	
Urology	Neonates Surgically and medically complex	0-5		5+ Or along local pathways where agreed
Ophthalmology	All (in partnership with MEH)		16+ to MEH Major trauma with eye involvement to RLH or St Marys	
Orthopaedics	Neonates Surgically and medically complex	0-3	Major trauma to RLH or St Marys	3+
General surgery	Neonates Surgically and medically complex	0-5		5+
Endoscopy	Neonates Surgically and medically complex	0-14	14+ to UCLH	

Gynae	Pre-pubertal covered through urology and general surgery	Post-pubertal patients (including management of miscarriage) to UCLH	Ectopic pregnancies to be managed locally

Planned surgical pathways

	GOSH as specialist hospital	Centre of expertise: emergency and planned inpatient	Centre of expertise: daycase	Other site as specialist service	Local sites
ENT	Neonates 0-1 day cases Surgically and medically complex	0-1 inpatients	1-3 day cases and single overnight stay	1+ inpatients to UCLH	3+ day case or single overnight stay (UCLH, Barnet)
Dentistry	Neonates 0-1 day cases Surgically and medically complex	0-1 inpatients	1-3 day cases and single overnight stay	1+ inpatients to UCLH Whittington retain community dental service	3+ day case or single overnight stay (UCLH, Barnet, Whittington)
OMFS	Neonates 0-1 day cases Surgically and medically complex	Inpatient 1+ night length of stay	1-3 day cases and single overnight stay		3+ day case or single overnight stay (Predominately at Barnet and mainly dental work)
Cardiothoracic	All 0-16			16+ to Barts	
Neurosurgery	All 0-16			16+ to NHNN	
Plastics	Neonates 0-3 day cases Surgically and medically complex	0-3 inpatient		3+ inpatient and day case Royal Free Hospital	
Urology	Neonates 0-1 day cases Surgically and medically complex	Inpatient 1+ night length of stay up to adolescent	1+ day case and single overnight stay	UCLH adolescent urology service Adolescents seen through adult services where appropriate safeguarding in place	

Ophthalmology	0-1 day case Neonates Surgically and medically complex (in partnership with MEH)	0+ inpatients	*Further pathway work needed to determine most appropriate day case pathways*		
Orthopaedics	All (partnership between RNOH and GOSH) Spinal surgery also carried out at RNOH and GOSH Spinal surgery also delivered through this partnership			Activity carried out by RFL in partnership with RNOH	
General surgery	Neonates 0-1 day case Surgically and medically complex	Inpatient 1+ night length of stay up to adolescent	1+ day case and single overnight stay (via SNAPS in reach)		
Endoscopy	Neonates 0-1 day case Surgically and medically complex	Inpatient 1+ length of stay	*Further work needed to define appropriate pathway routine planned for paediatric endoscopy*	14+ to UCLH	
Gynae	Pre-pubertal covered through urology and general surgery			Post-pubertal patients to UCLH	Termination of pregnancy through local pathways

14.5 Appendix E: Finance information

The following information sets out the key figures for the centres of expertise at UCLH and GOSH for the proposals related to paediatric surgery services as well as the key information relating to financial aspects of the service reconfiguration process.

	Centre of expertise: day case (UCLH) and Centre of expertise: emergency and planned inpatient (GOSH)
Gross capital investment	£3.7m
ICS capital funding	£3.7m
Are capital costs affordable?	Yes
Are the revenue costs affordable for each Trust?	Yes
Asset life cycle	30 years
PUBSEC[1] index baseline	Q2 2022
RIBA[2] stage	• GOSH: Stage 0-1 • UCLH: Stage 0-1
Optimism bias assumption	• GOSH: 20% • UCLH: 20%
Inflation assumption	• GOSH: 20.1% • UCLH: 20.1%
Trust contingency value	10%
Fees (design and commissioning)	• UCLH: Fees included in the cost per m^2 • GOSH: 20%

1 - The Tender Price Index of Public Sector Building Non-Housing **(PUBSEC)** measure the movement of prices in tenders for building contracts in the public sector.

2- The RIBA Plan of Work organises the process of briefing, designing, constructing and operating building projects into eight stages. The RIBA Plan of Work eight stages can be found here.

Key financial information on the reconfiguration process

What is the role of finance in the option appraisal process?

The key financial test, as set out by NHS England in the 'Planning Assuring and Delivering Service Change for Patients 2018', is that any proposal is affordable in capital and revenue terms ahead of public consultation. Both options have been agreed by NHS England as affordable in terms of revenue and capital requirements.

The financial implications of the potential service changes have been fully considered as part of the development of the PCBC. The financial implications have been signed off through the Start Well Programme's governance and has been assured by NHSE London Region.

What about other costs that might be relevant?

Transition costs are short-term costs associated with the service change. This may include the costs of staff time or Programme team time that is needed to ensure that the service change is managed effectively.