North Central London Integrated Care System

NHS

START WELL

Proposed changes to maternity, neonatal, and children's surgical services

Consultation document

11 December 2023 to 17 March 2024

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Section 1: Introduction

1 Who we are - about the North Central London Integrated Care System and Integrated Care Board

North Central London Integrated Care System (NCL ICS) brings together local health and care organisations, councils, and the voluntary, community and social enterprise sector to work in joined-up ways to improve health outcomes for residents of Barnet, Camden, Enfield, Haringey and Islington and tackle inequalities that currently exist.

Our ambition is to work with residents of all ages so they can have the best start in life, live more years in good physical and mental health in a sustainable environment, age within a connected and supportive community and have a dignified death. We also want to support those employed in health and social care to Work Well. We summarise this ambition as Start Well, Live Well, Work Well, Age Well. We want to achieve this ambition for everyone.

This document has been published by North Central London Integrated Care Board (ICB). The ICB is responsible for developing a plan to meet the health needs of the local population, managing the NHS budget for our Integrated Care System, and arranging for the provision of health services in this area.

As part of our statutory duties, we – North Central London Integrated Care Board – are consulting on proposals to change some maternity, neonatal, and children's emergency and planned surgical services on behalf of Integrated Care System partners.

Specialised services, for example neonatal care and some specialist surgery, are commissioned by NHS England's specialised commissioning team. Therefore, NHS England is jointly consulting with us on these proposals and has been closely involved in the work from the outset.

2 Get in touch

We hope you will get in touch and share your views. You can do this in several different ways including:

- Email: StartWellConsultation@ors.org.uk
- Phone: 0800 324 7005
- Post: FREEPOST SS1018, PO Box 530, Swansea, SA1 1ZL
- Website: nclhealthandcare.org.uk/start-well

If you would like this document in an alternative format, including Braille, audio, Easy Read, or translated into another language please get in touch with us.

*We want this document to be as inclusive of everyone's experiences of health care as possible and it therefore refers to 'pregnant women and people' when describing those who use maternity services to include individuals whose gender identity does not align with their sex at birth.

3 | Foreword

Thank you for taking the time to read our consultation document on proposed changes to services for maternity, neonatal (care of newborn babies), and children's emergency and planned surgery. We know how important these services are to pregnant women and people*, parents and carers, and their children. We understand how vital it is to make sure these services are as good as they can be so that we are able to provide the best possible care, with the best outcomes.

North Central London's Population Health and Integrated Care Strategy sets out an ambition to work with people of all ages 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 plays a central role in delivering this strategy, as we know that pregnancy and birth are the foundations of a good start in life.

We are pleased to present our proposals, and options for their implementation, to communities across North Central London, and beyond, to seek a wide range of views. These proposals have been developed by doctors, midwives, nurses, and other health professionals, working together with families with lived experience of maternity, neonatal, and children's emergency and planned surgical services. We have also worked with our colleagues at neighbouring integrated care boards.

We believe our proposed options for consultation would better help us to provide the quality of care and outcomes we aspire to deliver for all, in line with clinical evidence and national policy, guidance and standards.

We hope you will take the opportunity to share your views with us – there are many ways you can do this as described in section 4 of this document. Your opinion matters to us, and we are committed to carefully considering the feedback we receive from this consultation before making any decisions about changes to services.

We look forward to hearing from you.

Phill Wells, NCL ICB Chief Executive Officer
Dr Josephine Sauvage, NCL ICB Chief Medical Officer
Will Huxter, NHS England (London), Regional Director of Commissioning
Professor Simon Barton, NHS England (London), Regional Medical Director of Commissioning

"We believe that the case for change in maternity and neonatal services, and children's surgery, is compelling. The proposals presented in this document have had extensive clinical engagement, guided by best practice, and they represent an opportunity to improve care and outcomes.

"We encourage everyone to feedback on these proposals during the consultation. This feedback will allow us to work together to carefully consider next steps."

Chief Executives of Great Ormond Street Hospital for Children NHS Foundation Trust; North Middlesex University Hospital NHS Trust; Royal Free London NHS Foundation Trust, University College London Hospitals NHS Foundation Trust, and Whittington Health NHS Trust

4 | About this consultation document

This consultation document sets out our proposals for changes to maternity and neonatal services and to children's surgical services.

The remainder of this document is split into three sections:

- Section 2 covers our proposals for maternity and neonatal care and Edgware Birth Centre, and starts on page 15
- Section 3 covers our proposals for children's surgical services, and starts on page 41
- Section 4 explains how you can share your views with us, and starts on page 60.

You can choose to share your views on both the proposals for maternity and neonatal care and children's surgery, or on just one area. To find out more about how to share your views visit our website at **nclhealthandcare.org.uk/start-well**

These proposals are independent of each other but we are consulting on them at the same time.

5 | Background and context

North Central London covers five London boroughs: Barnet, Camden, Enfield, Haringey, and Islington, with a resident population of around 1.8 million people.

Working together as North Central London Integrated Care System, our ambition is to work with residents of all ages so they can have the best start in life, live more years in good physical and mental health in a sustainable environment, age within a connected and supportive community and have a dignified death. We also want to support those employed in health and social care to Work Well. We summarise this ambition as Start Well, Live Well, Work Well, Age Well. We want to achieve this ambition for everyone.

We know there are unacceptable variations in health across the population in North Central London, and that some groups – for example deprived communities and people from ethnic minority backgrounds – are more likely to live with poor health and have poorer health outcomes than others and may find it harder to access the right services at the right time. These differences in outcomes and access are referred to as health inequalities. We want to reduce these inequalities.

You can find out more about our wider work to improve the health and wellbeing of the population in North Central London (known as our 'population health strategy) at **nclhealthandcare.org.uk/our-working-areas/population-health**.

5.1 | About the Start Well programme

The 'Start Well' element of our Integrated Care System ambition recognises that the foundations of lifelong health are built during pregnancy, at birth and in childhood. We want to make sure that patients and service users receive the best care and outcomes possible when using maternity, neonatal, children and young people's services.

The collective ambition of our Integrated Care System is that we provide services that support the best start in life, both for our residents and for people from neighbouring boroughs and beyond who choose to use our services.

That's why, in November 2021, the partner organisations which make up North Central London's Integrated Care System formally launched a long-term programme to review and improve maternity, neonatal, children and young people's services. A key aim of the programme is to help address the health inequalities we see between the communities in our area.

This strand of work supports our wider Start Well ambition. It brings together people from across the NHS in North Central London working in partnership with NHS staff and patients to think about how we could improve these services. Through this Start Well programme, we want to make sure the NHS in this area is:

- delivering quality services to meet the needs of pregnant women and people, babies, children, young people, and their families
- doing all we can to reduce differences in health outcomes and experience
- positively influencing life chances through improving health outcomes at the start of life
- learning from the pandemic and responding to national policy and independent reviews that set clinical standards for the best way to design and deliver services.

The areas of focus for the programme are planned and emergency services for children and young people, and maternity and neonatal services currently provided at:

- North Middlesex University Hospital NHS Trust (North Mid)
- Royal Free London NHS Foundation Trust which covers: Barnet Hospital, Royal Free Hospital, Chase Farm Hospital and Edgware Birth Centre
- University College London Hospitals NHS Foundation Trust (UCLH)
- Whittington Health NHS Trust (Whittington Health).

The proposals developed by the programme would see Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) play a greater role in providing emergency and complex planned surgery for children living in North Central London. The programme also touches on surgical services for children provided by other specialist providers, including, Royal National Orthopaedic Hospital NHS Trust (RNOH) and Moorfields Eye Hospital NHS Foundation Trust (Moorfields). The links between the local hospitals and specialist hospitals, particularly GOSH, have been considered as part of our review.

Community, mental health, and primary care services are not being reviewed as part of this particular Start Well programme. However, the overlap between them and this programme is being carefully considered, and there are a number of other pieces of work ongoing to improve these services. You can find out more about this on our website at **nclhealthandcare.org.uk/get-involved/strategic-reviews-of-community-and-mental-health-services/**

5.2 Local health and care needs: maternity, neonatal, children and young people

Understanding the different characteristics and underlying health needs of the communities that use our services, and where there are differences between them, is critical in ensuring we plan and deliver services to meet the needs of local people. It is also important for us to understand the health inequalities that exist between different communities so that we ensure we target our resources where they are most needed. Health inequalities are unfair and avoidable differences in health across the population, and between different groups of people.

We have identified key themes regarding the health and care needs of our population that are particularly important to consider when we think about what maternity and neonatal services we need, and what surgical services we need for children and young people. This includes:

The number of women and people living in North Central London giving birth has been declining. Over a quarter of our population is currently women of childbearing age, defined as those aged 14-49. Between April 2021 and March 2022 around 20,000 babies were born. This is around 1,000 fewer births a year compared to 2018. The number of births vary between the different areas.

There are **more children being born in the more deprived areas** of North Central London. Between 2018 and 2020, there were more than **three times as many births in the most deprived areas**, compared to the least deprived areas.

Although the number of births has been declining for people living in our part of London, we do know there are **a number of pregnant women and people who don't live in our boroughs but choose to give birth here.** When planning for our local services, this needs to be reviewed against the declining birth rate in the North Central London population.

Fig 1: maternity, neonatal, and children and young people's care needs in North Central London

There are **differences in the number of pregnant women and people who have long-term conditions.** For example, within our five boroughs **pregnant women and people who are Asian are more than twice as likely to have diabetes in pregnancy,** compared to pregnant women and people who are white (21% vs. 9%). Similar differences are seen for other long-term conditions during pregnancy.

The number of children and young people living in North Central London is projected to decline. Around 21% of our 1.8 million residents are children and young people, defined as those aged 0-18. By 2041, the population is projected to decline by 10%.

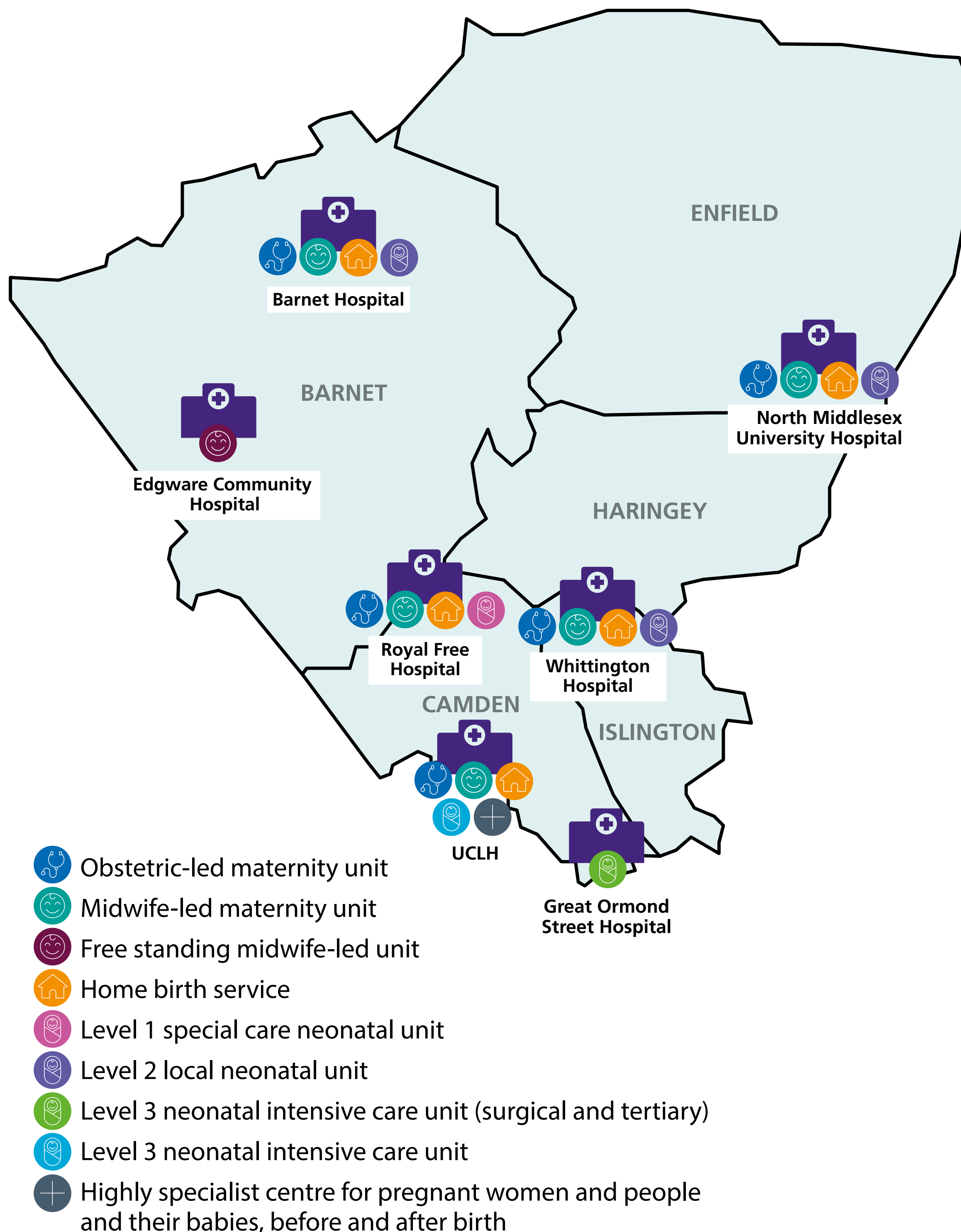
Children and young people living in North Central London are particularly diverse. Just over a quarter of children and young people in this area identify as White British, a quarter as White Other and 10% as Black African. **More than 150 languages are spoken by children in North Central London and 20% do not speak English as their first home language.**

An estimated **one in five children and young people under the age of 16 years live in poverty.** There is a link between income deprivation and ethnicity in North Central London, with children from some ethnicities being more deprived on average than others. **Children and young people of Black ethnicity are generally more deprived than other communities**, with over 80% of Black African and Black Caribbean children living in deprived areas in North Central London.

5.3 Our current services

We need to understand whether the services we currently have are able to meet the needs of those who use them, now and in the future.

Maternity and neonatal services in North Central London



Children and young people's hospital services in North Central London

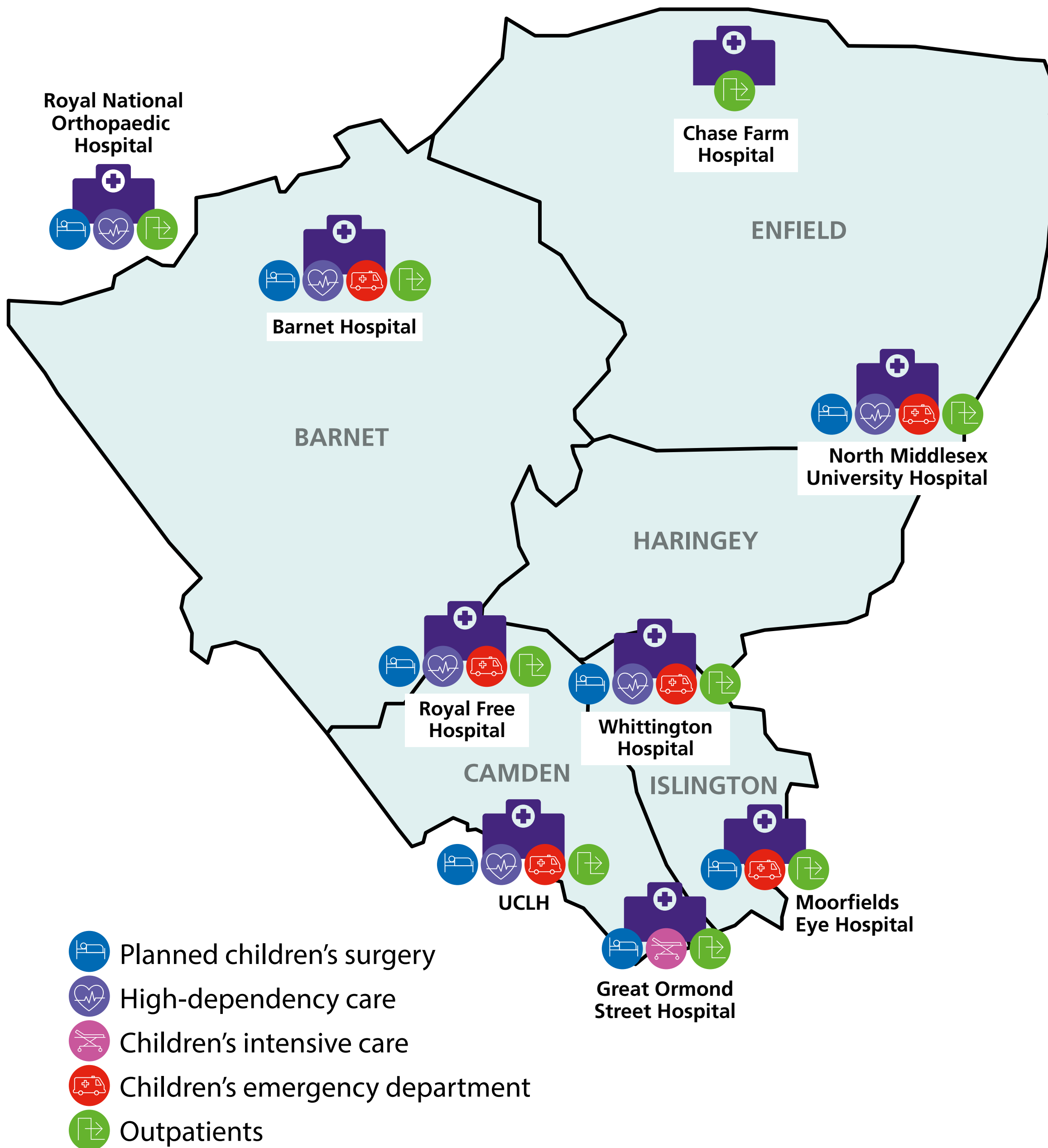


Fig 2: map of maternity, neonatal, and children and young people's hospital services in North Central London

Our current services	Description
Five obstetric-led birth units	A labour ward where care is delivered by obstetricians (specialist doctors trained to provide care during pregnancy and labour) and midwives. Anyone can give birth at these units and some pregnant women and people who are at higher risk of complications may be advised to give birth in an obstetric-led unit.
Five alongside midwife-led birth units	A birth unit where care is delivered by a team of midwives. The unit is located in the same hospital as a neonatal unit and an obstetric-led birth unit but has a more homely, less medicalised feel, often offering the opportunity to use birth pools. Pregnant women and people can easily be transferred to the obstetric-led unit during labour if they need additional support with pain relief or delivering their baby.
One standalone midwife-led birth unit	A birth unit where care is delivered by a team of midwives, that is not located with an obstetric-led birth unit or neonatal unit. The unit has a more homely, less medicalised feel, often offering the opportunity to use birth pools. Pregnant women and people can be transferred to an obstetric-led unit by ambulance during labour if they need additional support whilst delivering their baby. This could be for pain relief while delivering their baby, if there are complications delivering their baby, or if the baby or person in labour need specialist support during or after birth.
North Central London-wide home birth services	Pregnant women and people give birth at home, supported by midwives. Pregnant women and people can be transferred to an obstetric-led unit by ambulance during labour if they need additional support with pain relief whilst delivering their baby, there are complications delivering their baby or if the baby or person in labour need specialist support during or after birth.
One special care neonatal unit (level 1)	Typically care for newborn babies born after 32 weeks of pregnancy, with the least complex conditions. The level 1 neonatal unit at the Royal Free Hospital cares for babies born after 34 weeks.
Three local neonatal units (level 2)	The next step up in care: Babies born between 27 and 31 weeks of pregnancy who need a higher level of medical and nursing support.
One neonatal intensive care unit (level 3)	Care for the most premature or unwell babies, often born before 28 weeks of pregnancy who have the greatest need for specialist support from highly trained staff.

Service	Description
One specialist neonatal intensive care unit (level 3)	Even though it does not provide maternity services, Great Ormond Street Hospital (GOSH) does have a specialist level 3 neonatal unit. This is because GOSH carries out complex, highly specialist surgery and provides care for seriously unwell babies from across the UK with very complex care needs. We are not proposing any changes to the neonatal unit at GOSH and they are outside of the scope of the programme of work.
Five hospitals providing paediatric services, each with a co-located emergency department	Hospital based health care (including emergency care) for babies and children. Usually these hospitals provide care for people in the local area. We are not proposing any changes to paediatric emergency departments, which will remain as they are now.
Three clinical specialty hospitals providing services for children and young people	Hospital based health care focused on a particular clinical specialty (for example eye care at Moorfields, orthopaedic services at the Royal National Orthopaedic Hospital and specialist children's services at Great Ormond Street Hospital) for more complex or rare conditions for babies, children and young people. Usually, these hospitals provide services to people across a large geographical area.

Table 1: the different types of maternity, neonatal and children's services in North Central London

The questions we are asking you

As you read through this document, you may find it helpful to consider the key questions we are asking for this consultation. These questions apply to both our proposals on neonatal and maternity care and children's surgical services.

The questions are:

- Do you agree that the NHS needs to make changes to respond to challenges in these services?
- To what extent do you agree or disagree with the proposals we describe?
- What do you think are the main disadvantages and what can we do to address them?
- Are there any other options we should consider before making a decision?

The proposals for change set out in this consultation will help us achieve our Start Well ambition, but there are lots of other areas of work taking place to help babies, children and young people get the best start in life. You can find out more about this on our website at **nclhealthandcare.org.uk/start-well**

Section 2: maternity and neonatal care

This section of the consultation document focuses on our proposals for changes to maternity and neonatal services in North Central London. It sets out:

- why we think services need to change and the opportunities we have for improvement
- our proposed new 'model of care' to address our case for change
- how we developed our proposed options for implementing the proposed model of care that we are consulting on
- what our proposed options are and what they could mean for you and your family.

The information set out here is a summary of a technical document called the 'pre-consultation business case'. The pre-consultation business case sets out much more detail about the proposals and how they were developed. You can find it on our website at **nclhealthandcare.org.uk/start-well**.

1 The opportunities for improvement: Our case for change

We believe we have a compelling case for our proposed changes to services. We published a detailed case for change in June 2022 setting out the findings from our review of how maternity and neonatal services are currently delivered. This section of the consultation document is based on the case for change and updates it using the latest information and evidence we have about our services.

There were some opportunities identified in the case for change which aren't covered by this consultation. There is information on our website at **nclhealthandcare.org.uk/start-well** which explains more about the progress we are already making on these areas. You can read a more detailed summary and the full version of the case for change on our website at **nclhealthandcare.org.uk/start-well**

It is important to acknowledge that there are many areas of excellent care across North Central London, and we know our staff work incredibly hard and are committed to achieving the best possible outcomes for patients. However, we are facing challenges in maternity and neonatal services. There are opportunities for us to improve the quality of services, improve outcomes for local people, address areas of difference, and provide a better experience for our patients, their families, carers, and our staff.

1.1 The needs of local people are changing and our services need to adapt to meet those needs

We have done an extensive piece of work to better understand both the services we provide and the people who use our services.

The needs of local people have changed over recent years and our services are not always designed to meet those needs. Two of the key changes we need to consider are:

- the number of babies born in North Central London is falling
- pregnancies are getting more complex, with more pregnant women and people having conditions like diabetes and obesity in pregnancy. This can mean they need more support during pregnancy and birth, and their babies can need extra support when they are born.

1.2 Our services are not currently set up to meet the needs of everyone that uses them, and this can sometimes impact on their quality

We currently have five hospitals providing maternity and neonatal care. Because of the falling birth rate and the location of our maternity units, we have two units that currently provide care for a relatively small number of pregnant women and people.

Because of increasingly complex pregnancies, pregnant women and people in North Central London are more likely to choose, or be advised, to give birth in an obstetric (specialist doctor) led birth unit, rather than a midwife-led birth unit. This means that the use of obstetric-led units is very high, while on average, midwife-led units, either standalone or alongside, are used to only around 30% of their possible capacity.

The low use of midwife-led care is particularly stark at Edgware Birth Centre, the only standalone midwife-led birth unit, which is located on a site without services that may be needed in an emergency. On average fewer than 50 women and pregnant people (less than one a week) gave birth there over each of the last three years. Between April 2021 and March 2022, there were just 45 babies born at the birth centre out of a total of around 20,000 births across North Central London. This makes Edgware one of the standalone birth units with the lowest number of births in the country, and the smallest of the three units in London.

At Royal Free Hospital, we have a level 1 neonatal unit which provides the lowest level of care for newborn babies (see figure 3 below for an explanation of the different levels of neonatal care).

The use of this unit has been declining (in line with the number of births at the hospital), and over half of the cots are not used on any given day. Special arrangements are currently in place to help staff maintain their skills in looking after unwell babies. However, in the long term the unit cannot continue in it's current form, and we need to plan for what happens in the future.

In contrast, our neonatal units at UCLH and GOSH that care for the most premature and unwell babies are often full, which means that babies who need the highest level of care are sometimes transferred further away from home to other hospitals.

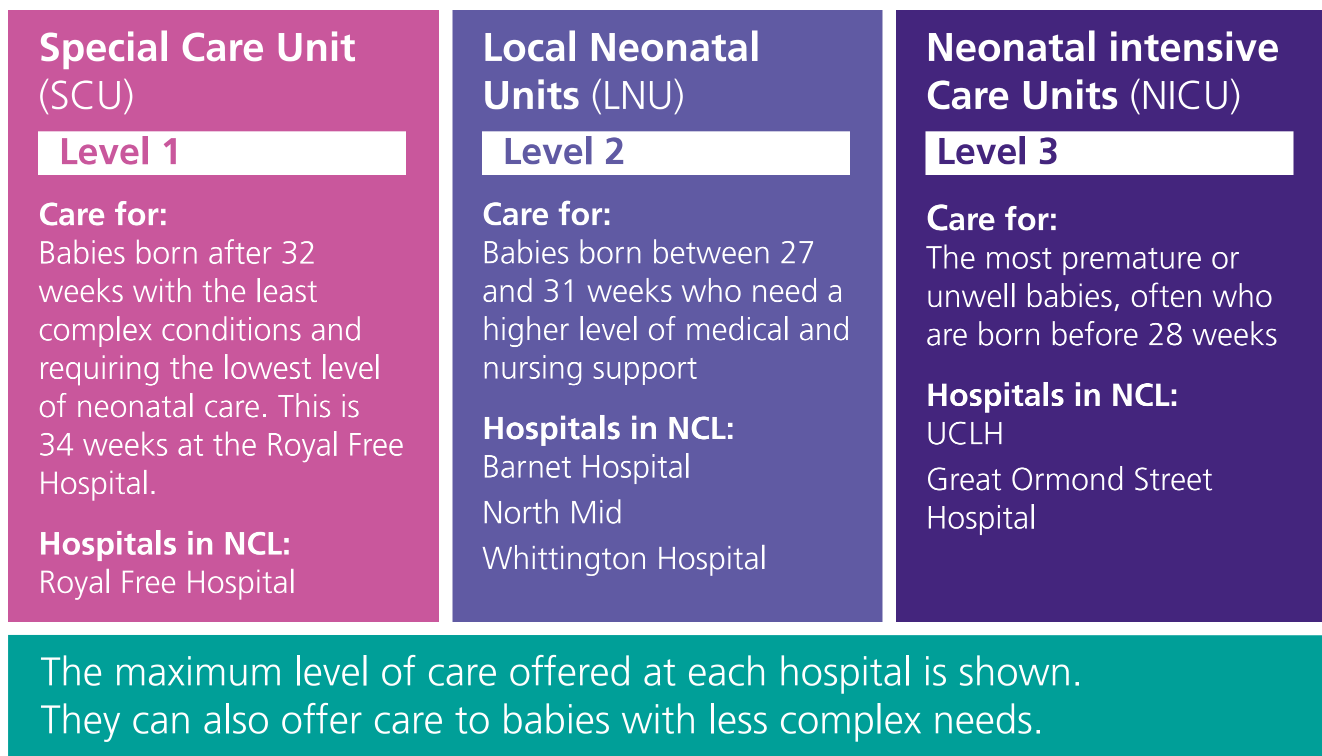


Fig 3: the different levels of neonatal care provided by different types of units

1.3 We need to address staffing challenges in midwifery, neonatal nursing, and other health professions

The fact we have five units means our staff are spread thinly, and this sometimes limits our ability to provide a full range of birth settings when the units are busy. Often, midwife-led care is forced to close to enable staff to support higher risk births in obstetric-led units.

Additional neonatal nursing posts are needed across North Central London units and there are also significant gaps in allied health professional roles to support babies, such as speech and language therapists whose skills help identify and support babies at risk of feeding difficulties.

To address staffing gaps, staff in maternity and neonatal care work under pressure, and this is leading to staff burnout.

There are opportunities for organisations across North Central London to work together to develop innovative solutions and address these challenges.

1.4 Not all our hospital buildings meet modern standards, and this can impact on patient experience

Hospital facilities should be designed for modern-day healthcare and provide privacy and dignity. For example, we want to be able to offer all pregnant women and people labour rooms with en-suite bathrooms and space for a birth partner to be there for deliveries when possible. We also want our neonatal units to have enough space around cots to meet best practice standards for infection control, and to allow parents to be supported by staff to provide care to their baby. Some hospitals have modern facilities that offer all of this; however, the quality of some of the buildings, most notably the facilities at the Whittington Hospital, do not currently meet modern standards for maternity or neonatal units. Staff currently work hard to ensure this does not impact on patient care or experience.

1.5 What people told us about the opportunities for improvement

Between July and September 2022, we asked people across our five boroughs to share their views on our case for change and the opportunities to make improvements we have identified. Thousands of people visited our web pages and social media channels to find out more and we heard views from hundreds of people in response.

In summary, most people who responded to and joined our conversation agreed with the opportunities for improvement.

The headline findings about what people told us are important to them were:

- Maternity care: safe and compassionate care and good communications
- Neonatal care: the best possible services delivered by specialists and good communications.

You can read the detailed report on the engagement activity we carried out on our website at **nclhealthandcare.org.uk/start-well**

1.6 Our response to addressing the case for change

Following the public conversation on the case for change, we carefully considered the feedback we received alongside the evidence we had gathered to determine how best to address the opportunities we had identified.

Many of the opportunities to improve maternity and neonatal care are already being addressed through initiatives that do not require significant changes to where or how services are provided, and you can read about them on our website at **nclhealthandcare.org.uk/start-well**

However, based on all the evidence and feedback on the case for change, it is our carefully considered view that we must make more significant changes to maternity and neonatal care. The changes we are proposing would help to address the challenges we face, make the most of the opportunities we have for improvement, and make services fit for the future.

We think that making changes to services will help us to ensure:

- all our hospitals can offer the same minimum level of neonatal care so that everyone has equal access to services
- units are staffed in line with best practice, making them less likely to need short term, unplanned closures and ensuring that we can consistently offer pregnant women and people a choice of birth setting
- we can meet demand and the changing needs of local people, and reduce the need to transfer babies to other hospitals outside of North Central London
- our hospital environments provide a positive birthing experience and a suitable space for neonatal care.

2 Developing a new model of care for maternity and neonatal services

What is a model of care?

A model of care sets out how services should be provided for a particular clinical area (for example, maternity care). It describes the different types of services that should be available at each stage of a patient's journey from their first interaction with the NHS (for example their GP) through to triage and assessment, treatment and then onward care following treatment. Models of care are based on best practice standards and evidence-based guidelines and take into account the needs of the local population.

The first step in designing new ways of working in maternity and neonatal care was to develop best practice, evidence-based models of care to help address the opportunities for improvement set out in the case for change. The models of care were developed with significant input from clinicians and managers who run services across North Central London and from surrounding areas.

In order to do this, we have developed a model of care that:

- reduces the number of maternity and neonatal units overall: this will increase birth numbers and neonatal care days at all units within North Central London making them more sustainable in terms of staffing and births, when considering the further declining birth rate
- ensures that all neonatal units are at least level 2, with one level 3 NICU so that all sites have the specialist staff to care for the needs of premature or unwell newborn babies. This would reduce the need for emergency transfers to another hospital which can sometimes mean separating babies from their parent
- proposes investment in our hospital buildings to enhance birth experiences and improve the maternity and neonatal care environment
- will help us to facilitate and support birth choices more consistently and enhances midwife-led care alongside obstetric-led care on all sites.

This section describes the model of care in more detail.

2.1 Neonatal model of care

As is the case now, our new neonatal model of care would ensure that there would be comprehensive support available for babies who need additional care after birth.

As described in section 1.3 on page 18, there are currently three different levels of neonatal care provided in North Central London. Under our new proposed model of care, there would be changes to the levels and number of neonatal units.

Level 1 special care units

Level 1 special care units provide the lowest level of care to newborns. At present we have one level 1 unit in North Central London at the Royal Free Hospital. Under the proposed model of care there would be no level 1 special care units. The main reason for this is that the current unit is under-used as it is not suitable to provide care for the most premature and unwell babies.

This under-use makes it harder for staff to maintain their competencies and skills. Best practice standards say that special care units should provide up to 365 days of respiratory care to newborn babies each year. The special care unit at the Royal Free Hospital provided the equivalent of 211 days of respiratory care in 2021/22. Our other neonatal units are often very busy or full, and the Royal Free Hospital is not able to support as it is not the right level to provide care for very premature or unwell babies.

It is important to note that the proposed new model of care, if implemented, would not necessarily mean that the neonatal services at the Royal Free Hospital would close. However, they would need to be significantly enhanced in order become a level 2 unit. One of our options for consultation (see Section 4/page 28) includes a proposal to upgrade the current unit at the Royal Free Hospital to a Level 2 unit.

Level 2 local neonatal units and Level 3 neonatal intensive care units

Level 2 local neonatal units provide the next step up in care for newborns and Level 3 neonatal intensive care units offer the highest level of care for the most premature or unwell babies.

To ensure staff on level 2 and 3 units can maintain their specialist skills and expertise, best practice guidance sets out the minimum number of very low birth weight babies (babies that are less than 1.5kg or 3.3 pounds) that should be admitted to each unit per year. These are:

- Level 3 neonatal intensive care units: at least 100 very low birth weight babies per year
- Level 2 local neonatal units: at least 25 very low birth weight babies per year.

In 2021/22 neonatal units in North Central London admitted 215 very low birth weight babies. This means that, in theory, there are just enough babies born or cared for in our part of London to have five neonatal units providing level 2 or 3 care. However, due to a national shortage of health professionals, we would struggle to recruit enough specialist doctors, nurses, and allied health professionals to run the units in line with best practice standards for staffing numbers. Therefore, our new model of care proposes we would have four neonatal units in total. One of these would be a level 3 unit, with three further level 2 units. These units would also be able to take care of babies with less complex needs. Each neonatal unit would be located alongside an obstetric-led birth unit.

Just as now, our model of care would mean that, where possible, babies likely to need neonatal care are identified during pregnancy or labour so that pregnant women or people give birth in a hospital with the required level of neonatal unit. If babies needing additional care are not identified during pregnancy or labour, our new model of care means that all birth units would be located with at least a level 2 neonatal unit. This means that it would be possible to care for all but the most unwell newborns at the hospital where they are born, reducing the number of babies who need to be transferred to a different hospital after birth and women and people being separated from their baby.

Our model of care does not propose any changes to the neonatal unit at Great Ormond Street Hospital because it is a specialist unit, serving the whole country.

The new model of care would also continue to provide a wide range of ongoing support to babies and families, such as neonatal or paediatric follow up care at home or in hospital, postnatal care for the woman or person who gave birth, feeding support, health visitor services and bereavement support services.

You can find the full model of care for neonatal services on our website at **nclhealthandcare.org.uk/start-well**

2.2 | Maternity model of care

Currently in North Central London, we have five obstetric-led maternity units each with a co-located 'alongside' midwife-led unit, one 'standalone' midwife-led unit (located on a different site to any obstetric-led maternity care) and home birth services.

Our main proposed change to the model of care for maternity services is around the number and type of birth units we have. Under the proposed new model of care women and pregnant people would have the choice of three birth settings: home birth, obstetric-led or alongside midwife-led birth unit. The choice of birth setting would be made in discussion with maternity service professionals, based on an individual's clinical need.

Obstetric-led and alongside midwife-led units

The new model of care proposes that there would be four, rather than five, obstetric-led birth units, each with an alongside midwife-led unit. The reason for this is to ensure that all birth units can also be located alongside a level 2 or 3 neonatal care unit. This is important to avoid newborn babies being transferred to different hospitals after birth, and women and people being separated from their baby.

Standalone midwife-led unit

Our proposed new model of care does not feature a standalone midwife-led maternity unit with birth suites. The main reason for this is that, as outlined in the opportunities in the case for change, there is very low usage of our standalone unit, Edgware Birth Centre. The number of babies being born at the unit has been declining for several years, and in 2021/22 just 45 babies were born there. Senior clinicians involved in the Start Well programme agree that the number of births at the unit are too low and the way the unit currently operates means it is not clinically sustainable. Evidence from the National Institute for Health and Care Research says that a standalone midwife-led birth unit should deliver at least 350 babies each year to be financially viable.

Evidence from the National Institute for Health and Care Excellence (NICE) shows that standalone birth units are safest for women and people whose pregnancy is assessed as low-risk. A review of all the births in North Central London in 2021/22 indicates that around 70% of births in North Central London are assessed as being moderate to high-risk. This means that the group of pregnant women and people considered suitable to give birth at Edgware, should they choose to do so, is relatively small. Of this proportion of eligible pregnant women and people, an even smaller number would be within close travelling distance of the unit.

Due to a combination of a falling birth rate and a higher likelihood of complications during pregnancy and childbirth, it is unlikely that there will be an increase in the number of low-risk women and pregnant people who would be eligible to give birth at Edgware Birth Centre.

When we asked people what they based their choices of maternity care on, it was recommendation, proximity to home, familiarity with the hospital and having medical support on hand if required. Based on this, it seems likely that it would be difficult to significantly increase the number of eligible people choosing to use Edgware Birth Centre given the location of other hospital-based midwife-led birth units.

There are not always enough midwives to staff the unit which means Edgware Birth Centre is sometimes closed and pregnant women and people have to go elsewhere at short notice to give birth. National and local midwife shortages mean it is unlikely we would be able to recruit enough midwives to reliably ensure Edgware Birth Centre is always available for deliveries.

We would continue to use Edgware Birth Centre for antenatal and postnatal care.

Home birth services

We recognise that it is very important to offer pregnant women and people the choice to give birth at home. We are committed to facilitating this choice so that everyone who wishes to give birth at home has the option to do so.

Under our proposed new model of care, dedicated home birth teams would continue to be available in all North Central London boroughs, enabling pregnant women and people to give birth in familiar surroundings with the support of two midwives.

Midwives and doctors would support pregnant women and people during their antenatal care to decide whether home birth is right for them based on the individual risk of their pregnancy.

If there is a complication during a home birth, pregnant women and people would be transferred by ambulance to the nearest obstetric-led birth unit.

Antenatal and postnatal care

As is the case now, women and pregnant people would continue to have access to a wide range of routine and, where needed, specialist care and support while trying for a baby, during pregnancy and after giving birth. This would include routine midwife-led antenatal and postnatal care, scans and antenatal screening, access to metal health support before, during and after pregnancy as well as specialist services such as maternal and fetal medicine.

We want to provide antenatal and postnatal care as close to home as possible, making use of virtual appointments where appropriate. If the proposed model of care is implemented then as is the case now, a significant proportion of antenatal and postnatal care would be provided out of hospitals, at community and family centres and in community hospitals, for example antenatal and postnatal care would continue to be provided at Edgware Community Hospital.

Some antenatal care, such as scans and screening tests, would continue to be provided at each of the four hospitals with obstetric and midwife-led birth units. This means there would be four hospital locations providing antenatal and postnatal care in the future, compared to five currently.

You can find the full model of care for maternity services on our website at **nclhealthandcare.org.uk/start-well**

How did local people and health professionals contribute to the model of care?

We have engaged with local people, doctors, nurses, midwives and managers who run our services to ensure a wide range of views have informed the development of the proposed model of care. This has included:

- using the feedback we heard during the engagement on the case for change
- establishing a Patient and Public Engagement Group (PPEG) to review and input into the model of care
- holding workshops on the model of care attended by almost 90 people from across the NHS and local councils
- involving over 75 NHS staff in a range of groups tasked with developing specific elements of the model of care.

2.3 Summary

In summary our new model of care proposes:

- four neonatal care units – one level 3 neonatal unit and three level 2 neonatal units – each located alongside an obstetric-led and a midwife-led birth unit
- four obstetric-led birth units and four alongside midwife-led birth units
- home birth services available across North Central London.

3 Developing our proposals for neonatal care and maternity services

This section of our consultation document explains more about the process we followed to develop our proposed options we are presenting for consultation.

Our proposed new model of care helped us to identify the types of services we need for local people, and the number of each different type of unit. We then looked at how we might implement them in North Central London and considered where services could be located.

To do this we carried out an options appraisal process. This process was led by health professionals, including senior doctors, midwives, nurses, and allied health professionals. It also included patients and patient representatives. We carefully considered all the feedback we had heard from our engagement and conversations on the case for change, and feedback from other sources.

The options appraisal process involved identifying all possible options for implementing our model of care and 'filtering' them using increasingly refined criteria to identify options most likely to deliver the best care for patients.

You can find out a lot more detail about the options development process on our website at **nclhealthandcare.org.uk/start-well**

3.1 Developing our proposed options

To develop the options for neonatal care and maternity services, we first considered that our current level 3 neonatal unit, providing the highest level of care for the sickest babies, is based at UCLH. It would be very difficult to move this unit because it is located with other specialist services needed to support the care of very premature and sick babies, and because of the arrangements in place to provide care to babies outside of North Central London. Therefore we concluded that all options should include a level 3 unit at UCLH. We then looked at the different possible combinations of options for the location of the remaining three neonatal and birth units. This gave us four possible options for how future services could be provided for further consideration.

As a result of going from five to four maternity and neonatal units, the maternity and neonatal services at one hospital would close under each potential option.

Option 1	Option 2	Option 3	Option 4
North Mid Obstetric-led birth unit Midwife-led birth unit Level 2 local neonatal unit Home birth service	**Barnet Hospital** Obstetric-led birth unit Midwife-led birth unit Level 2 local neonatal unit Home birth service	**Barnet Hospital** Obstetric-led birth unit Midwife-led birth unit Level 2 local neonatal unit Home birth service	**Barnet Hospital** Obstetric-led birth unit Midwife-led birth unit Level 2 local neonatal unit Home birth service
Royal Free Hospital Obstetric-led birth unit Midwife-led birth unit Level 2 local neonatal unit Home birth service	**Royal Free Hospital** Obstetric-led birth unit Midwife-led birth unit Level 2 local neonatal unit Home birth service	**North Mid** Obstetric-led birth unit Midwife-led birth unit Level 2 local neonatal unit Home birth service	**North Mid** Obstetric-led birth unit Midwife-led birth unit Level 2 local neonatal unit Home birth service
Whittington Hospital Obstetric-led birth unit Midwife-led birth unit Level 2 local neonatal unit Home birth service	**Whittington Hospital** Obstetric-led birth unit Midwife-led birth unit Level 2 local neonatal unit Home birth service	**Whittington Hospital** Obstetric-led birth unit Midwife-led birth unit Level 2 local neonatal unit Home birth service	**Royal Free Hospital** Obstetric-led birth unit Midwife-led birth unit Level 2 local neonatal unit Home birth service
UCLH Obstetric-led birth unit Midwife-led birth unit Level 3 neonatal intensive care unit Home birth service	**UCLH** Obstetric-led birth unit Midwife-led birth unit Level 3 neonatal intensive care unit Home birth service	**UCLH** Obstetric-led birth unit Midwife-led birth unit Level 3 neonatal intensive care unit Home birth service	**UCLH** Obstetric-led birth unit Midwife-led birth unit Level 3 neonatal intensive care unit Home birth service
Barnet Hospital Closure of maternity and neonatal services	**North Mid** Closure of maternity and neonatal services	**Royal Free Hospital** Closure of maternity and neonatal services	**Whittington Hospital** Closure of maternity and neonatal services

Fig 4: the four options for the future for evaluation

We used the following criteria to evaluate the strengths and weaknesses of each option:

- **Quality of care:** would there be significant numbers of pregnant women and people going to hospitals outside of North Central London to give birth? Under the quality of care criteria we also looked at how many more patients may need to go to hospitals outside of North Central London for their care because this impacts on the funding hospitals receive which in turn can impact on the quality of care and on patients' experience of care. The evaluation of the impact each option would have on quality was led by a group of senior doctors, nurses and other health professionals.
- **Workforce:** How easy is it to implement the proposed model of care? This included looking at how many additional neonatal consultants are required, how many doctors would need to move units and how many additional midwives are required. We also considered how well the option would support training opportunities for our staff. The evaluation of the impact each option would have on workforce was led by a group of senior doctors, nurses and other health professionals.
- **Access to care:** what would the impact be on patients', families', and carers' journey times to services? Is there a particular impact for people living in areas of deprivation? Would journeys to hospital become more complex or less accessible? The evaluation of the impact each option would have on access to care was led by our Patient and Public Engagement Group, which is made up of people with lived experience of maternity and neonatal services and people who represent them.
- **Affordability and value for money:** what is the capital investment required? Would the cost of the option outweigh the potential benefits for patients? The evaluation of the impact each option would have on finance was led by a group of senior finance professionals from NHS organisations in North Central London.

Is keeping things the same an option for consultation?

As part of our options appraisal process, we evaluated the way our services are currently set up to see if we could address the challenges we face and make the most of the opportunities for improvement, even if we don't make any changes. We consider that keeping things the same is not a viable option because:

- our current model of care does not meet best practice guidelines and clinical standards, so this means we would not be able to achieve our ambitions for maternity and neonatal care if we leave things as they are
- as described above, the neonatal unit at the Royal Free Hospital does not treat enough babies each year for staff to maintain their specialist skills and competencies. The safety measures we have put in place to reduce the risks associated with this cost over £750,000 a year and are not a good use of resources
- there are lots of staff vacancies, particularly in neonatal care, and because of a national shortage of health professionals, we cannot recruit enough staff to fill these jobs across five hospitals.

As a result of this process, we concluded that options 1 and 2 were not viable and should be excluded because of the high numbers of people who would have to go to neighbouring areas to give birth (Hertfordshire and West Essex if maternity and neonatal services at Barnet Hospital closed, and North East London if North Mid services closed). The neighbouring hospitals that would be impacted by options 1 and 2 have confirmed they would not have enough capacity for the likely additional numbers of patients under these options. These options were also evaluated less well for access to care, with longer journey times and poorer accessibility for local residents.

As both options 3 and 4 were both assessed as being viable, they are being taken forward for public consultation.

Going forward in this document, option 3 will be referred to as option A and option 4 will be referred to as option B.

4 | The proposals for consultation: maternity and neonatal care

We are consulting on two proposed options for implementing the proposed model of care. In each option a different hospital would no longer provide any maternity and neonatal care. The options we are consulting on are summarised below.

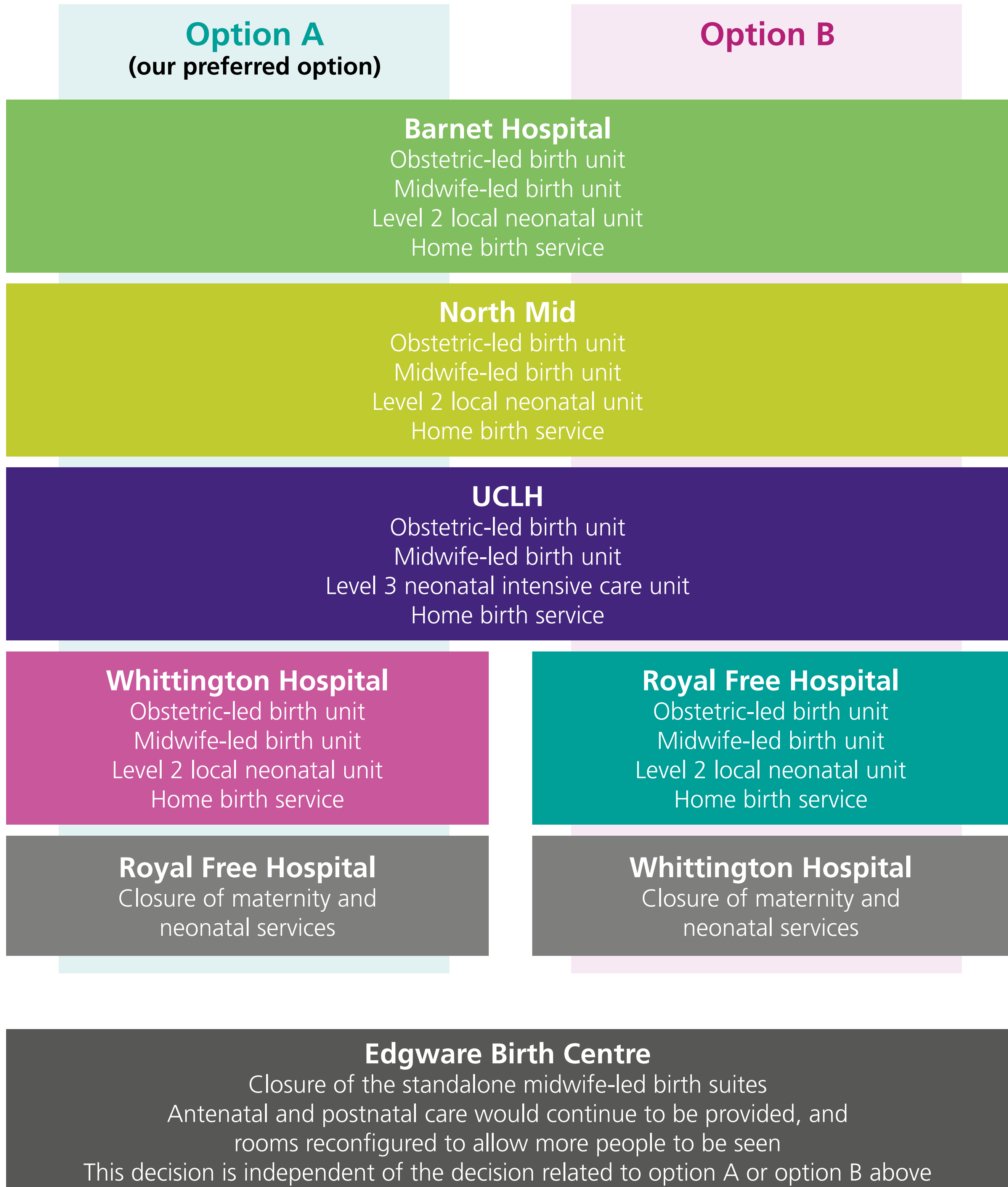


Fig 5: the maternity and neonatal proposals for consultation

While both options are implementable, option A is our preferred option because, we think that on balance it has more advantages than option B.

In summary, option A is our preferred option because:

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

The table on page 30 describes the advantages and disadvantages of our proposed options in more detail, setting out the similarities and differences between them.

Why are you proposing to close the birthing suites at Edgware Birth Centre?

Because our model of care does not include standalone birth units, our proposals also include the closure of the Edgware Birth Centre at Edgware Community Hospital. This would mean fewer than 50 pregnant women and people a year would no longer be able to give birth there. Antenatal and postnatal care would still be provided at Edgware Community Hospital and the rooms that make up the birth centre would be reconfigured so that more people could be seen there.

A key consideration in this proposed closure was the very low number of women and pregnant people choosing to give birth there each year, balanced against the NHS resources needed to keep the centre running. Having a centre that is delivering less than one baby a week, and birth suites that are each used once a month, does not represent a good use of resources.

We would continue to offer the choice of midwife-led care through high quality alongside midwife-led units and home birth services.

The decision about the closure of Edgware Birth Centre is independent of the decision about our other proposals for hospital-based maternity and neonatal care.

Both options

Under **both option A and B** we would:

- provide antenatal and postnatal care as close to home as possible, ensuring everyone has access to the same services and information
- continue to offer the choice of home birth
- have obstetric-led and midwife-led birth units at UCLH, Barnet Hospital and North Mid
- provide an environment that would ensure privacy and dignity for pregnant women and people giving birth
- have equitable access to neonatal care out of hospital by implementing a 'virtual ward' service allowing treatment of babies in their own home
- have a level 3 neonatal intensive care unit at UCLH, which can meet demand
- provide high quality level 2 local neonatal units at Barnet Hospital and North Mid
- carefully consider how to reduce the impact of changes to services on vulnerable populations, especially around access to digital technology and cars, ease of accessing hospital sites and cultural and language barriers.

Option A

Under **option A** we would:

- have obstetric-led and midwife-led birth units at Whittington Hospital
- close the obstetric-led and midwife-led birth units at the Royal Free Hospital
- have a level 2 local neonatal unit at Whittington Hospital
- close the level 1 special care neonatal unit at the Royal Free Hospital.

This would mean:

- clinical staff working at the Royal Free Hospital would be supported to move to other hospitals in North Central London, where there are vacancies
- an increase in average travel times to hospital by car, ambulance and taxi of around four to five minutes
- an increase in average travel times by public transport of around six minutes
- an average increase in taxi costs of £5 per journey and a maximum increase of up to £11
- around 385 more patients a year would go to St Mary's Hospital in Paddington and around 465 to Northwick Park Hospital in Harrow, instead of a hospital in North Central London
- an additional investment of around £42.4m in our hospital buildings, in particular to modernise the Victorian buildings at the Whittington Hospital.

Option B

Under **option B** we would:

- have obstetric-led and midwife-led birth units at the Royal Free Hospital
- close the obstetric-led and midwife-led birthing units at Whittington Hospital
- upgrade the level 1 unit at the Royal Free Hospital to a level 2 local neonatal unit
- close the level 2 local neonatal unit at Whittington Hospital.

This would mean:

- more clinical staff working at Whittington Hospital would be supported to move to other hospitals in North Central London, where there are vacancies
- an increase in average travel times to hospital by car, ambulance and taxi of around five to six minutes
- an increase in average travel times by public transport of around seven minutes
- an average increase in taxi costs of £4.50 per journey and a maximum increase of up to £11
- around 322 more patients a year would go to Homerton Hospital in Hackney instead of a hospital in North Central London
- an additional investment of around £39.4m in our hospital buildings to improve the environment for pregnant women and people, babies and families.

Table 2: similarities and differences between our proposed options for maternity and neonatal care

4.1 Things to consider when responding to the consultation proposals for maternity and neonatal care

This section of this document looks in more detail at some of the differences between the two options we are consulting on for **maternity and neonatal care**, what they might mean for you and your family, the impact these options would have on travel and access, on people who have vulnerabilities, the environment and on our finances. We hope this information, along with the description of our proposed options on the previous page, will help you to form your response to the consultation.

How we considered the impact of our proposals

To help us understand the impact of our proposals on local communities an interim 'integrated impact assessment' was carried out in partnership with an independent organisation with the Start Well programme. The interim integrated impact assessment looked at the impact of the proposed options on:

- clinical care/outcomes
- accessibility
- sustainability and the environment
- people who have vulnerabilities and populations in different geographical areas
- finances.

Some of the findings from the interim integrated impact assessment are included in this section, and the full report is available to see at **nclhealthandcare.org.uk/start-well**

Both proposed options for implementing our proposals are expected to improve care and experience overall for everyone by enabling us to:

- provide the same level of neonatal care no matter which unit babies are born in
- offer more personalised and individual care where people are supported and get information that best suits their own needs
- increase capacity in our neonatal units, reducing the number of babies that need to be transferred outside of North Central London for care
- make better use of our existing doctors, midwives, and neonatal care nurses so that all our units would be staffed in line with best practice guidelines
- offer our staff better training and development opportunities, helping them to maintain and build skills and expertise, and make North Central London a more attractive place to work
- invest in our buildings to bring them up to modern standards so that we can create units and spaces that promote a positive environment for giving birth and a positive working environment for our staff.

How we considered the impact of the proposed closure of the birth suites a Edgware Birth Centre

We have carefully considered the impact of the proposed closure of birth suites at Edgware Birth Centre.

Because a very small number of women and pregnant people give birth at the centre each year, and because they would have the choice to have a home birth instead, the proposals are very unlikely to impact on access or inequalities.

Evidence shows that there are no significant differences in outcomes for babies who are born in an alongside or standalone midwife-led unit. By continuing to offer the choice of an alongside midwife-led unit, women and pregnant people would still have access to the benefits of midwife-led care.

We recognise that some people will not agree with the proposed closure of the birth suites at Edgware Birth Centre, and we are keen to hear through the consultation about the potential impact of this proposal, ways to reduce any negative impact and potential solutions or opportunities that you think we may not have considered.

The decision about the closure of the birth suites at Edgware Birth Centre is independent of the decision about our proposals for hospital-based maternity and neonatal care.

Impact on travel times and access

We know that travel times and access to services is likely to a be an important issue for people when considering their response to this consultation.

Under both the options we are consulting on, there are proposed changes that would have an impact on some access and travel times by private car or public transport for both patients and visitors.

We have calculated these travel times using data based on actual travel routes, rather than 'as the crow flies' distances and using accurate data about public transport. We calculated travel times for:

- peak time car travel: based on weekday morning average journey times
- off-peak car travel: based on weekday lunchtime average journey times. We also use off-peak as a reasonable indicator of average ambulance journey times.
- public transport travel: based on weekday morning public transport average journey times.

	Average travel times and costs					
	Option	Public transport travel time	Peak car/taxi travel time	Off peak car/ taxi travel time	Taxi cost per journey	Driving cost per journey
A	Current	22.3 minutes	14.4 minutes	12.4 minutes	£17.55	£1.65
	Future	28.6 minutes	19.7 minutes	19.1 minutes	£22.46	£2.11
B	Current	18.9 minutes	14.1 minutes	12.1 minutes	£16.10	£1.51
	Future	25.9 minutes	19.9 minutes	17.5 minutes	£20.53	£1.93

Table 3: the potential impact of each option for maternity and neonatal care on average travel times and cost

	Maximum travel times and costs					
	Option	Public transport travel time	Peak car/taxi travel time	Off peak car/ taxi travel time	Maximum increase in taxi cost per journey	Maximum increase in driving cost per journey
A	Current	66.2 minutes	26.9 minutes	23 minutes	+£10.56	+£0.99
	Future	69.6 minutes	29.5 minutes	24.7 minutes		
B	Current	36.8 minutes	25.9 minutes	22.2 minutes	+£10.03	+£0.94
	Future	38.3 minutes	28.3 minutes	23.4 minutes		

Table 4: the potential impact of each option for maternity and neonatal care on maximum travel times and cost

We have undertaken travel time and cost analysis for groups of people protected by the Equality Act, people from deprived communities, and people who are more vulnerable to the impact of our proposals. Through this, we have identified that there would not be more of an increase in travel time or cost for either option as compared to the general population. Despite this, people who may be more vulnerable to the impact of our proposals may be particularly impacted by increased taxi costs, although our analysis shows access to public transport is higher for these population groups. In addition, some people from vulnerable populations may have more access needs on our hospital sites in terms of finding their way around and communicating with staff and managing steps or stairs, particularly if they haven't used that site previously.

Impact on protected groups, deprived communities and people who may be more vulnerable to the impact of our proposals

We looked carefully at the potential impact of our proposals on different groups of people, including groups of people protected by the Equality Act. We identified the following priority groups and possible impacts. The needs of each of these groups would require careful consideration. The potential impacts are different for each of our proposed options and vary depending on where people live:

- **Race:** Somali pregnant women and people tend to have more serious complications in pregnancy and birth compared to other groups in the population. Under our proposals, they may need to travel further or switch hospitals. For other ethnic minority groups, there is little difference between the impact of options A and B. We will need to consider language and cultural barriers when explaining changes and supporting access to our services.
- **Age:** younger and older pregnant women and people may need to attend more appointments throughout their pregnancy and could be impacted by our proposals if services move further away.
- **People with disabilities:** people with disabilities may need additional support to access services at an unfamiliar hospital. Some people may find it more difficult to go to a hospital that is further away, or on a different site, on a more frequent basis due to an underlying health condition that impacts on the complexity of their pregnancy.
- **Religion:** the Orthodox Jewish community have specific requirements such as Kosher food, observance of Shabbat and lack of access to online or digital materials. Option A would have a greater impact on this community than Option B because they live near to the maternity and neonatal services that may close in this option. During the consultation we want to work closely with the Orthodox Jewish community to understand how we could minimise any negative impact of our proposals.
- **People living in areas of deprivation:** the main impact on of our proposals for people living in deprived areas, people who are economically inactive and people with poor health is the potential increase in travel times or distance to reach services. For example, both option A and B would mean an average increase in taxi costs of around £5.
- **Other inclusion health groups:** we have considered the impact of our proposals on groups such as homeless people, refugees, victims of domestic abuse and travellers. There is little difference between the impact of options A and B for these groups, but they may find it difficult to travel further or go to a different hospital due the increased cost of transport. We will also need to consider ease of access to online or digital materials and of language barriers when explaining changes and supporting access to our services.

People living in particular geographic areas who are more vulnerable to the impact of our proposals: Communities from two specific areas were identified as being more vulnerable to the impact of our proposals because they live in areas of deprivation and have high levels of poor health. These are: Harlesden and Willesden (option A) and Holloway and Finsbury (option B). This is because:

- there are more Black and Caribbean people in these areas, which are also areas of deprivation, and there is evidence that they tend to have more serious complications in pregnancy and birth and poorer general health
- Harlesden has a large proportion of Bangladeshi and Pakistani people, who also live in areas of deprivation, who have poorer general health and tend to have more serious complications in pregnancy and birth.

The above is not an exhaustive list and we have considered other potentially impacted groups which are outlined in our interim integrated impact assessment (available on our website) whose views we are seeking to hear during the consultation.

Impact on sustainability and the environment

We looked at the potential impact of our proposed options on sustainability and the environment. We considered the impact on carbon emissions and air quality from increased journey times and building works that might need to be carried out. We also considered the impact of making changes to hospitals which positively contribute to local communities and areas in many ways beyond providing health and care – known as 'anchor institutions'. The sustainability and environmental impact is summarised in the table below:

	Carbon and air quality impact from travel	Carbon impact from building works	Anchor institution impact
Option A	Total increase of 216g per average journey. This may need to be offset as North Central London is in an air quality management area	Any impact would be offset by making buildings more energy efficient in line with net zero strategies	Although staff would move from Royal Free Hospital, the hospital space would be re-used so there is likely to be minimal impact on the hospital as an anchor institution.
Option B	Total increase of 195g per average journey. This may need to be offset as North Central London is in an air quality management area	As above, any impact would be offset by making buildings more energy efficient.	Although full time staff would move from Whittington, the hospital space would be re-used so there is likely to be minimal impact on the hospital as an anchor institution.

Table 5: the potential impact of our proposed options on sustainability and the environment

Impact on finances

Both sites would require financial investment. The investment would allow us to deliver services in line with best practice standards of care, which would in turn improve outcomes and experience of care for pregnant women and people, babies and their families and carers.

Most of this investment would be used to fund the refurbishment of existing buildings to ensure that our maternity and neonatal wards are in line with national quality standards. This is in addition to the business as usual requirements to maintain existing estate and equipment. We would also need a smaller amount on an ongoing basis to fund IT systems, equipment and to maintain buildings.

The cost for each option is shown in the table below. These figures show the total investment needed over 30 years, although most of the investment would be spent over an initial four-year implementation phase on building costs.

Option A	Option B
£42.4m	£39.4m

We considered that in the long term both options would be good value for money because they would help us to work more efficiently and make best use of the staff and other resources we have.

4.2 Example patient stories: maternity and neonatal care

We have developed some patient stories to help illustrate how things could be different in the future under each option. These are not real patients, but scenarios to explain the changes we are proposing.

Home birth

Rachel has chosen to give birth to her second child in the familiar surroundings of her own home, with the support of midwives from her local dedicated home birth team.

Having a home birth is very important to Rachel. She feels she will be more relaxed at home, and it makes plans for her other child to be cared for much easier to organise.

Rachel discusses the benefits and potential risks of a home birth with midwives at her antenatal appointments. As her pregnancy is straightforward and both Rachel and her baby are well, the chance of any potential risk to herself or her baby is low and midwives support Rachel to write a care plan for a delivery at home.

While this is not anticipated, midwives explain that Rachel and her baby can be transferred to an obstetric (doctor)-led unit by ambulance during or after labour if any additional support is needed.

Rachel goes into labour at 40 weeks and three days and is supported throughout at home by two midwives that she has got to know during her antenatal appointments at her local GP practice.

There are no complications during labour, and Rachel gives birth to a healthy baby at home.

Midwives stay and support Rachel in the immediate period after the birth to feed and care for her baby and to ensure she is recovering well.

Rachel and her baby are offered the same support and examinations following the birth, that would be offered in a midwife-led birth unit or obstetric-led birth unit in a hospital. Rachel's older child is able to meet the new baby in calm and familiar surroundings which is very important to the family.

Alongside midwife-led birth unit

Amara has chosen to give birth to her baby in a midwife-led birth unit. Amara chooses the alongside midwife-led unit at her local hospital as it is closest to where she lives and is familiar as friends and family have received care there.

Amara likes that the midwife-led unit feels less medical and more like a 'home from home'. She is pleased there is the opportunity to use a birth pool and the room is spacious and has a double bed.

Amara's pregnancy is straightforward, but she is reassured there is an obstetric-led unit (where care is provided by specialist doctors called obstetricians and midwives) on the same hospital site as the alongside midwife-led birth unit.

This means Amara can be easily transferred during labour if she needs additional pain relief such as an epidural or extra support delivering her baby.

Amara goes into labour at 38 weeks. At the alongside midwife-led birth unit, Amara plays music on a speaker system in the room and uses the birthing pool and to help manage her pain. There is a birthing ball which helps in the earlier stage of labour. She has her partner with her throughout her labour and also other family and friends are able to come and support her. Entonox (gas and air) is available within the room and Amara is supported to use it as needed.

With the support of the midwife team, Amara gives birth to a healthy baby.

Amara and her baby are ready to go home within six hours of delivering her baby. They are visited by the community midwife team at home in the following days.

Obstetric-led birth unit

Aysha has chosen to give birth to her baby in an obstetric-led unit, where care is provided by specialist doctors called obstetricians and midwives, after discussing options with her obstetric and midwifery team.

Aysha is expecting her second baby. She has high blood pressure which means that she and her baby are at a higher risk of problems during labour or immediately after birth. Aysha also wanted to give birth at a hospital with a neonatal unit that can care for her baby after birth if needed.

Complications mean it's necessary for Aysha to deliver her baby at 31 weeks by caesarean section (a surgical procedure). Aysha's baby is born with a low birth weight and needs extra support to establish their breathing and feeding.

Alongside the obstetric-led birth unit, there is a local neonatal unit where Aysha's baby receives immediate care within the high dependency area of the unit.

Locating the local neonatal unit at the same hospital as the obstetric-led unit where Aysha gave birth avoids the need to for the baby to be transferred to another hospital where Aysha may not be able to immediately go to as she recovers from the caesarean.

It also reduces stress and upset for Aysha's partner who does not need to travel between different hospitals to provide care and support to mum and baby, at an already difficult time.

After five weeks in the local neonatal unit, Aysha's baby has made good progress and is well enough to go home with care from community neonatal nurses and appropriate neonatal and paediatric follow up care in place.

Thank you for reading our proposals on maternity and neonatal care. You can respond to our consultation questionnaire on our website at **nclhealthandcare.org.uk/start-well** or see page 60 for more information about how to respond to our consultation and what will happen when the consultation closes.

The next section of this document sets out our proposals for children's surgical services. These proposals are independent from our proposals on maternity and neonatal services.

PLEASE MIND THE
STEP!!!

Section 3: Children's surgical services

This section of the consultation document focuses on our proposals for changes to children's surgical services in North Central London. It sets out:

- why we think services need to change and the opportunities we have for improvement,
- our proposed new 'model of care'
- how we developed our proposed option that we are consulting on
- what our proposed option is and what they could mean for you and your family.

The proposals for children's surgery are independent of the proposals for maternity and neonatal services.

The information set out here is a summary of a technical document called the 'pre-consultation business case'. The pre-consultation business case sets out much more detail about the proposals and how they were developed. You can find it on our website at **nclhealthandcare.org.uk/start-well**

1 The opportunities for improvement: Our case for change

We believe we have a compelling case for our proposed changes to services. We published a detailed case for change in June 2022 setting out the findings from our review of how children and young people's services are currently delivered and the opportunities for improvement. You can read a summary and the full version of the case for change on our website at **nclhealthandcare.org.uk/start-well**

The majority of the opportunities for improvements to children and young people's services that were identified in the case for change are being addressed without making significant changes to how or where services are delivered. There is more information on our website at **nclhealthandcare.org.uk/start-well** which explains more about the progress we are already making on these areas. This section of the consultation document gives a summary of the opportunities for improvement that relate only to the proposals for consultation set out in this document.

It is important to acknowledge that there are many areas of excellent care across North Central London, and we know our staff work incredibly hard and are committed to achieving the best possible outcomes for patients. However, the care for young children and babies requiring surgical care is not always consistent or timely and there is inequitable access to these services across North Central London. There are opportunities for us to improve the quality of services, improve the outcomes for local people, address areas of difference, and provide a better experience for our patients, their families, carers, and our staff.

1.1 Opportunities for improvement in emergency surgery

We have several opportunities for improvement in children's emergency surgery:

The treatment pathways for emergency surgery are inconsistent and unclear

Hospital staff often need to seek specialist advice from a specially trained children's surgeon on whether a child can be treated at their local hospital or if and where they should be transferred to for care. Staff often spend a lot of time contacting different hospitals to find somewhere that can carry out the surgical assessment and potentially the surgery the child needs. Sometimes babies and children, especially those who are very young, are transferred multiple times before getting to the right place, and around one in five of these very young children needing care has to go to a hospital outside of North Central London. This is potentially distressing for children and their families and can sometimes lead to worse outcomes because of delays in getting treatment.

There are particular challenges in arranging emergency surgery for very young children under five years

We don't have the same types and number of specialists able to operate on very young children at each of our hospitals. Often decisions about where these children have their operation are based on the expertise of the staff available on the day. At the moment a high proportion of very young children are transferred to hospitals outside of North Central London to get specialist care, despite GOSH being in our local area. This is partly because GOSH does not currently have a suitable surgical assessment unit to receive children who may need emergency surgery. It is also the case that some older children, who currently are transferred to other units, could be seen in local hospitals if a team with the right surgical or anaesthetic skills were available.

We need to make the best use of the specialist services at Great Ormond Street Hospital (GOSH)

We have found that children and young people over the age of five are being transferred to Great Ormond Street Hospital (GOSH) for surgery that could have been carried at their local hospital. This puts additional pressure on the services at GOSH and we need to make sure that we are using the scarce and highly specialist resources in the right way. GOSH is not currently set up to easily receive children transferred from other hospitals in North Central London for emergency admissions. GOSH also provides specialist services for the rest of London and country.

1.2 Opportunities for improvement in planned surgery

We need to reduce waiting times for planned surgery

As of September 2023, there were around 5,000 children and young people in North Central London waiting for a planned operation and the waiting list is growing. The current situation doesn't meet NHS targets and has a significant impact on the wellbeing of the children, young people and families waiting.

In September 2023, over 500 children and young people had been waiting over a year for surgery. Some types of surgery, such as for significant dental problems, have longer waits than others.

Some hospitals don't see enough patients for staff to maintain their skills and competencies

Some hospitals see very small numbers of children and young people for certain surgical specialties. This makes it difficult for staff to learn and practice the specialist skills needed to provide children and young people's surgery. This could impact on the quality of care we can provide.

Bringing surgical services together at fewer hospitals would mean our highly skilled staff would see more children needing specialist care. This would help staff to maintain and build their skills and competencies, in turn improving outcomes for patients.

Bringing services for some types of planned operations together at fewer hospital sites would also help us to make better use of our limited number of staff, including staff with specialist skills such as anaesthetic care for very young children.

1.3 What people told us about the opportunities for improvement

Between July and September 2022, we asked people across our five boroughs to share their views on our case for change and the opportunities to make improvements we have identified. Thousands of people visited our web pages and social media channels to find out more and we heard views from hundreds of people in response.

In summary, most people who responded to and joined our conversation about this agreed with the opportunities for improvement in children and young people's services.

The headline findings about what people told us are important to them were:

- Emergency care for children and young people: care close to home, being seen quickly and good communications
- Planned care for children and young people: having the best care even if it is further from home and good communications.

You can read the detailed report on the engagement activity we carried out on our website at **nclhealthandcare.org.uk/start-well**

2 | Developing a new model of care for children and young people's emergency and planned care services

The first step in designing new ways of working children and young people's surgical services was to develop best practice, evidence-based 'models of care'.

What is a model of care?

A model of care sets out how services should be provided for a particular clinical area (for example, children and young people's planned surgery). It describes the different types of services that should be available at each stage of the patient's journey from their first interaction with NHS services (for example, via GPs or their nearest emergency department) through to triage and assessment, treatment and then onward care following treatment. Models of care are based on best practice standards and evidence-based guidelines and take into account the needs of the local population.

2.1 | Children and young people's surgery

At the moment, most children and young people's surgery is provided at our local hospitals, with some provided in specialist units (such as at Great Ormond Street Hospital – GOSH).

In our proposed new model of care, we want to develop two new 'centres of expertise', one to provide day case surgery and the other to provide both emergency surgery for younger children and planned inpatient surgery.

This would not change how children access these services, but would mean there are agreed plans in place to ensure that children receive care in the most appropriate place, more quickly.

Both centres of expertise would be specially designed to meet the needs of children's surgery and would have dedicated specialist staff, helping to reduce cancellations and improve productivity.

A detailed table of where a child would have surgery in the proposed model of care is available on our website at **nclhealthandcare.org.uk/start-well**

Centre of expertise: day case surgery

This centre of expertise would provide all day case surgery for babies aged one to two years. It would also provide day case surgery for more complex or less common operations in children aged three and over. Consolidating day case surgery onto one site would mean that our staff treat a higher number of very young children, helping them to maintain their skills and competencies. It would also help us to manage our waiting lists.

Centre of expertise: emergency surgery and planned inpatient surgery

It is proposed that the centre of expertise would provide:

Children aged:	Type of surgery provided
Emergency surgery	
0 to 3 years	Ear, nose and throat (ENT), dentistry, plastic surgery (reconstructing or repairing facial or body skin and tissue) and orthopaedics (bones)
0 to 5 years	'General surgery' (see box below for explanation) and urology surgery
Planned inpatient surgery	
0 to 1 years	Ear, nose and throat, and dentistry
All children 1 and over	Less common types of planned inpatient surgery

Bringing emergency surgery and more complex types of inpatient surgery onto one site would help us to establish much clearer treatment pathways, making it easier for our staff to know where a child should be transferred to and speeding up access to emergency care. It would also help us to make the best use of limited specialist staff.

What is 'general surgery'?

In children and young people, the term 'general surgery' typically covers surgery on the abdomen (tummy) and urology surgery, which is for conditions affecting the bladder, kidneys and, for boys, the genitals. Common operations in children that come under general surgery and urology include:

Planned operations:

- hernia repair
- hydrocoele repair (collection of fluid around the testicle)
- correction of undescended testicle
- circumcision
- belly button hernia repair.

Emergency operations:

- appendix removal
- correction of testicular torsion (twisted testicles)
- correcting narrowing of the opening between stomach and intestine (pyloric stenosis).

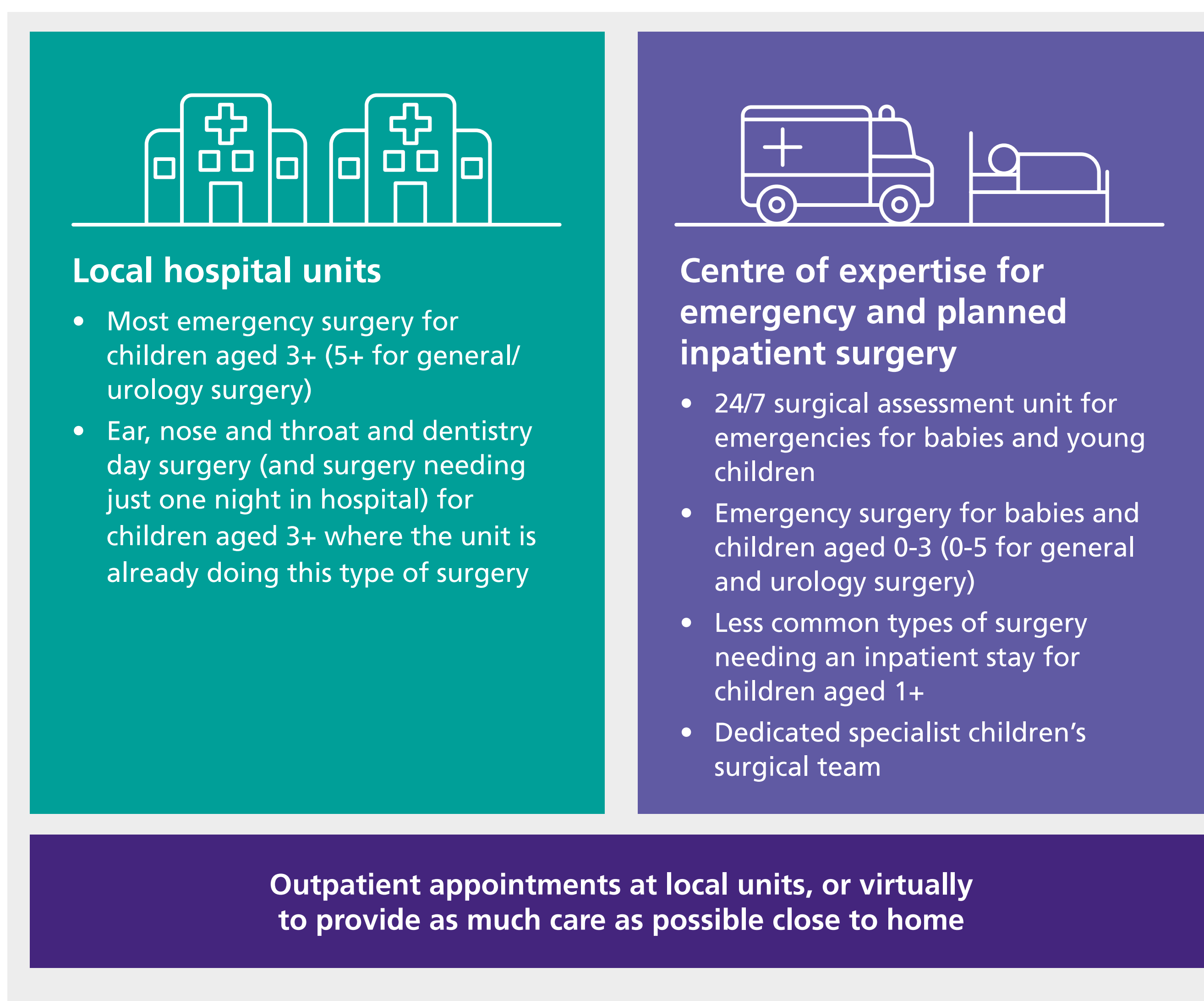
Local hospitals

In addition to the centres of expertise, all our current hospitals would continue to provide:

- common types of day surgery as they do now for children over the age of three
- emergency ear nose and throat surgery, dentistry, plastic surgery, and orthopaedic surgery for children over three years where the unit is delivering this type of surgery
- emergency urology and 'general surgery' for children over five years.

Just as now, the new proposed model of care would include pre-hospital (for example GP care or ambulance services), outpatient and follow-up care. Services would be organised so that outpatient appointments would take place at local hospitals, regardless of where the operation was being performed.

Fig 6: proposed approach to providing children and young people's surgical services



Very specialist surgery

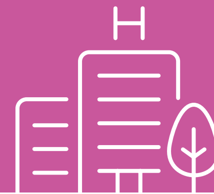
No changes are proposed to very specialist surgery for very young babies, and for very complex operations. As is the case now this care would be provided at specialist units across London, including:

- emergency and planned surgery for babies under the age of one and surgery for children and young people with complex medical needs would continue to be delivered at GOSH
- planned eye operations would continue to be delivered in partnership between GOSH and Moorfields Hospital
- planned plastic surgery continue to be delivered by the Royal Free Hospital
- planned orthopaedic inpatient surgery would be provided at the Royal National Orthopaedic Hospital and GOSH
- trauma care for serious multiple injuries would continue to be provided at dedicated trauma centres such as St Mary's Hospital in Paddington, and The Royal London Hospital in Whitechapel.

The diagram below gives a summary of which surgical services would be provided at each type of unit or centre.

Centre of expertise for day case surgery

- All day surgery for children aged 1-2
- Less common types of day surgery for children aged 3+
- Designed to meet the specific needs of children
- Dedicated specialist children's surgical unit



Specialist units

- Highly specialist surgery and surgery for children with complex medical needs at GOSH
- Emergency eye surgery at Moorfields
- Planned inpatient orthopaedic surgery at RNOH
- Plastic surgery for children aged 3+ at Royal Free Hospital
- Trauma units at St Mary's and The Royal London

Outpatient appointments at local units, or virtually to provide as much care as possible close to home

You can find the full model of care for children and young people's surgical services on our website at **nclhealthandcare.org.uk/start-well**

How did local people and health professionals contribute to the model of care?

We have engaged with local people and staff from across North Central London to ensure a wide range of views have informed the development of the model of care. This has included:

- using the feedback we heard during the engagement on the case for change
- establishing a Patient and Public Engagement Group (PPEG) to review and input into the model of care
- holding two youth summits with young people to seek their views
- holding workshops on the model of care attended by almost 90 people from across the NHS and local councils
- involving over 75 NHS staff in a range of groups tasked with developing specific elements of the model of care.

3 Developing our proposals

This section of our consultation document explains more about the process we followed to develop the option we are presenting for consultation.

Our proposed new models of care helped us to identify the types of services we need for local people, and the number of each different type of unit. We then looked at how we might implement them and considered where services could be located.

To do this we carried out an options appraisal process. This process was led by health professionals, including senior doctors and nurses. It also included patients and patient representatives. We also carefully considered all the feedback we had heard from our engagement and conversations on the case for change, and feedback from other sources.

The options appraisal process involved identifying possible options for implementing our model of care and 'filtering' them using increasingly refined criteria to identify options most likely to deliver the best care for patients.

You can find out a lot more detail about the options development process on our website at **nclhealthandcare.org.uk/start-well**

3.1 Developing our proposed option for children's surgery

We carried out a two-stage evaluation process to assess options for the location of the proposed centres of expertise for children's surgery.

- **Step 1:** Centre of expertise: emergency surgery and planned inpatient (overnight stay) surgery
- **Step 2:** Centre of expertise: day case surgery

We concluded that the proposed centre of expertise: emergency surgery and planned inpatient surgery, if implemented, should be located at Great Ormond Street Hospital (GOSH). This is because if it was in any other location, we would need to recruit a large number of additional specialist surgical staff to run the centre. This would be very difficult to do because of national shortages of specialist staff, and would not be a good use of resources. Currently, most emergency surgery for children under three and most planned inpatient surgery already takes place at GOSH.

The evaluation process identified that it would not be possible to locate the centre of expertise for day case surgery at GOSH because:

- it is the only suitable location for the centre of expertise for emergency and planned inpatient surgery
- it would not be easy to expand the GOSH site to include another centre of expertise, so it is important to use this space for children whose age, and/or complexity of surgery, means they are best treated there

As a result, we looked at five options for the location of the centre of expertise for day case surgery:

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

We used the following criteria to evaluate the strengths and weaknesses of each option:

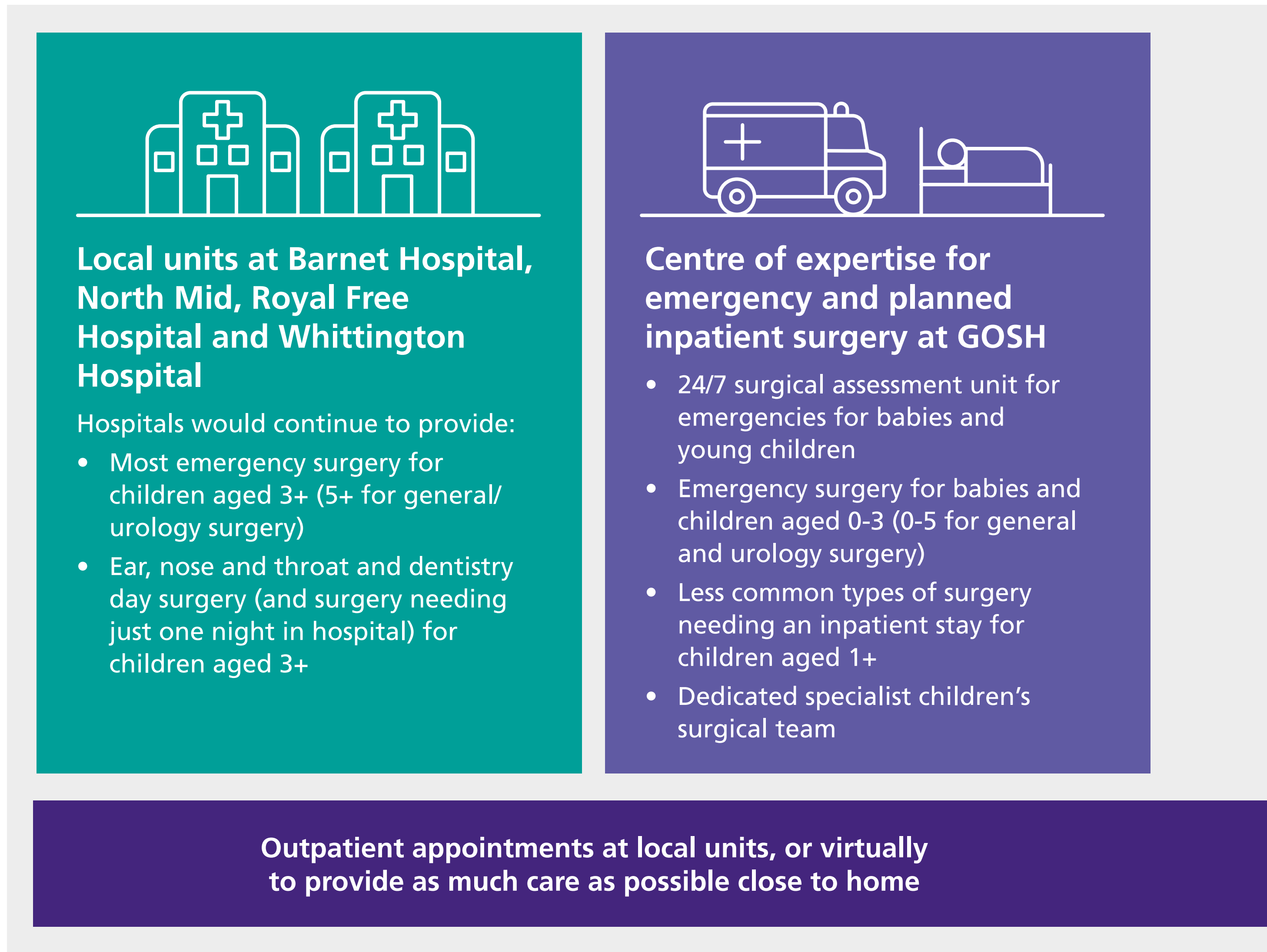
- Quality of care
- Workforce
- Access to care
- Affordability and value for money.

After applying all the evaluation criteria, we concluded that Option D, UCLH, is the only viable location for the propsed centre of expertise for day case surgery. This is because it is the only hospital, other than GOSH, that currently has the consultant paediatric anaesthetist workforce based on-site who can provide care for children aged one to two years. In addition, UCLH already provides around two thirds of the current children and young people's day case operations in North Central London. However, this option did not evaluate as well for 'access to care' compared to the other criteria for children age one to two, so further work would be needed to look at how we can minimise the impact on people who would need to travel further or for longer to access care at UCLH. The next section looks at this in more detail.

4 Our proposed option for consultation: children's surgery

We are consulting on one proposed option for children and young people's surgery, which is shown below.

Fig 7: the children and young people's surgery option for consultation

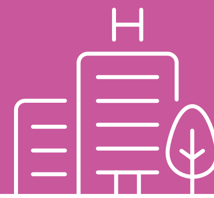


On our website you can find detailed tables showing where different types of surgery would be provided for emergency, planned inpatient and day case surgery. You may find it helpful to review these as well as the information in this document when responding to the consultation.

While there is only one option that we think is viable, we still want to hear your views on it. What would the benefits of this option be? And what would be the downsides? How could we reduce any negative impacts this proposal may have?

Centre of expertise for day case surgery at UCLH

- All day surgery for children aged 1-2
- Less common types of day case surgery for children aged 3+
- Designed to meet the specific needs of children
- Dedicated specialist children's surgical team



Specialist units

- Highly specialist surgery and surgery for children with complex medical needs at GOSH
- Emergency eye surgery at Moorfields
- Planned inpatient orthopaedic surgery at the RNOH
- Plastic surgery for children aged 3+ at Royal Free
- Trauma units at St Mary's and The Royal London

Outpatient appointments at local units, or virtually to provide as much care as possible close to home

4.1 Things to consider when responding to the consultation

This section of this document looks in more detail at the proposed option for children and young people's surgery, what it might mean for you and your family, the impact on travel and access, on people who have vulnerabilities, the environment and on our finances. We hope this information, along with the description of our proposed option on the previous page, will help you to form your response to the consultation.

How we considered the impact of our proposals

To help us understand the impact of our proposals on local communities we carried out with a partner organisation an interim 'integrated impact assessment' on behalf of the Start Well programme. The interim integrated impact assessment looked at the impact of the proposed options on:

- clinical care/outcomes
- accessibility
- sustainability and the environment
- vulnerable groups and populations in different geographical areas.

Some of the findings from the integrated impact assessment are included in this section, and the full report is available on our website at **nclhealthandcare.org.uk/start-well**

When considering the impact of our proposed option, it is important to remember it is expected to improve care and experience overall for everyone by enabling us to:

- ensure children and young people get the surgery they need as quickly as possible
- provide most emergency surgery for children over the age of five at their local hospital
- treat younger children and more complex cases in centres of expertise with dedicated children's surgical and anaesthetic teams
- provide a dedicated centre of expertise for day case surgery helping us to protect day case surgery capacity and reduce cancellations
- have agreed systems and processes for emergency surgery so all staff know where children should be seen, speeding up care and reducing need for staff to find an available bed at short notice
- reduce the number of children that are transferred to different units and the time it takes to transfer them when needed, helping to reduce stress for staff, patients and parents and reduce the risk of children becoming more unwell
- Make the best use of the expertise of specialist children's surgical teams by consolidating some surgery on to fewer sites, making care more efficient and ensuring children are seen by experienced specialists, especially for less common planned surgical procedures

- help our staff learn, build, and maintain their skills by seeing more patients because of services being consolidated onto fewer sites
- treat children in specially designed environments including in child-friendly operating theatres and recovery spaces, by staff with specific training in caring for children, helping to improve their experience of care.

It is also important to remember that the proposed changes would impact a very small proportion of the total surgical care we provide each year. Under our proposals less than 10% of children's surgical services would move, many of which already get transferred to other hospitals.

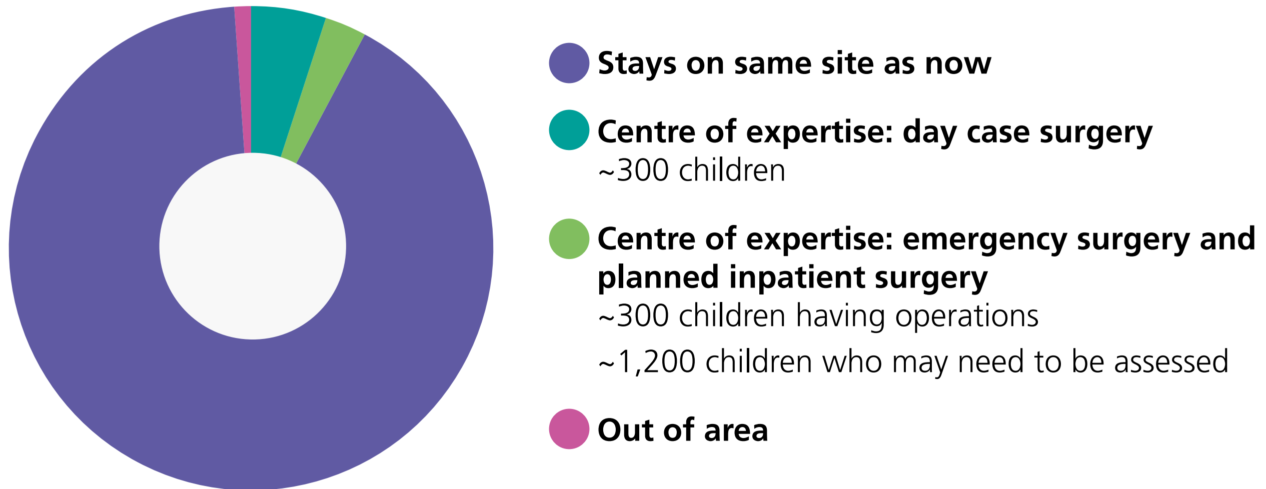


Fig 8: impact of proposals on location of surgery compared to now

Impact on travel times and access

We know that travel times and access to services is likely to a be an important issue for people when considering their response to this consultation.

With the proposed option we are consulting on, there are proposed changes that would have an impact on some access and travel times by private car or public transport for both patients and visitors.

It should be noted that a lot of this care is already taking place at the sites which have been proposed as the centres of expertise, therefore children are already travelling to access specialist care.

We have calculated these travel times using data based on actual travel routes, rather than 'as the crow flies' distances and using accurate data about public transport. We calculated travel times for:

- peak time car travel: based on weekday morning average journey times
- off-peak car travel: based on weekday lunchtime journey times. We also use off-peak as a reasonable indicator of ambulance journey times
- public transport travel: based on weekday morning public transport journey times.

Travel and access to emergency surgery

The impact of our proposals on access to **emergency surgery** would be minimal. Children would initially go to their local hospital emergency department, as they do now, and only be transferred by ambulance to the centre of expertise for emergency surgery if clinically necessary.

Travel and access to planned inpatient surgery

The impact of our proposal on the increase in average journey times and costs to access **planned inpatient surgery at the centre of expertise at Great Ormond Street Hospital** is shown in the table below.

	Average travel time and costs				
	Public transport travel time	Peak car/ taxi travel time	Off peak car/taxi travel time	Taxi cost per journey	Driving cost per journey
Current nearest planned inpatient surgery unit	22.9 minutes	15.7 minutes	12.9 minutes	£13.85	£1.30
Future (services at GOSH)	40.6 minutes	46.5 minutes	36.6 minutes	£35.93	£3.38

Table 6: average journey times and costs to access planned inpatient surgery

As planned inpatient surgery would be provided at GOSH, people in North Central London who live furthest away may need to pay up to an extra £56 per taxi journey to reach services. The maximum journey time would be around 80 minutes by car at peak times, compared to a maximum journey time of 28 minutes now to reach the nearest planned surgery inpatient unit.

The travel and access impact of our proposal on vulnerable populations is slightly greater than for the population as a whole. People from vulnerable populations would be particularly impacted by increased taxi costs with an average increase in taxi fares of between £22 and £23, although access to public transport amongst vulnerable populations is higher than for the population as a whole. People who may be more vulnerable to the impact of our proposals tend to have lower levels of car ownership but have better public transport access. In addition, people from vulnerable populations may have more access needs on our hospital sites in terms of finding their way around if they haven't visited the site before, communicating with staff and managing steps or stairs.

Day case surgery

The impact of our proposal on average journey times and costs to access day case surgery is shown in the table below.

	Average travel times and costs				
	Public transport travel time	Peak car/ taxi travel time	Off peak car/taxi travel time	Taxi cost per journey	Driving cost per journey
Current nearest planned day surgery unit	22.9 minutes	15.6 minutes	12.9 minutes	£13.55	£1.27
Future (services at UCLH)	35.5 minutes	42.5 minutes	36.9 minutes	£38.86	£3.37

Table 7: average journey times and costs to access planned day surgery

As day case surgery for younger children would be provided at UCLH, people in North Central London who live furthest away may need to pay up to an extra £40 per taxi journey to reach services. The maximum journey time would be around 49 minutes by car at peak times, compared to a maximum journey time of around 30 minutes currently.

The travel and access impact of our proposal on people who may be more vulnerable to the impact of our proposals is slightly greater than for the population as a whole. People from vulnerable populations would be particularly impacted by increased taxi costs with an average increase in taxi fares of between £8 and £10, although access to public transport is higher amongst people with vulnerabilities than for the population as a whole. People who may be more vulnerable to the impact of our proposals tend to have lower levels of car ownership but have better public transport access. In addition, people with vulnerabilities may have more access needs on our hospital sites that they haven't visited before, in terms of finding their way around and communicating with staff and managing steps or stairs.

Impact on people with vulnerabilities and populations

We looked carefully at the potential impact of our proposal on people with vulnerabilities, including people protected by the Equality Act and people from living in deprived areas.

We identified that, as a result of our proposals to relocate some surgical services to UCLH and GOSH, people in Tottenham and Edmonton and Cricklewood and Dollis Hill may need additional support to:

- access hospital sites if the children and young people or the families and carers are disabled, have poor health or do not speak or read English fluently
- travel to hospital by taxi as it would cost on average an additional £20 for people living in Tottenham and Edmonton
- access services online as some families and carers of young children and people may not have internet access or may not be used to using digital technology
- care for other family members as they may be a lone parent.

Impact on sustainability and the environment

We looked at the potential environmental and sustainability impact of consolidating planned inpatient and day case surgery for some patients onto single sites. We considered the impact on carbon emissions and air quality from increased journey times and building works that might need to be carried out. We also considered the impact of making changes to hospitals which play an important role in local communities – known as 'anchor institutions'. The sustainability and environmental impact is summarised in the table below:

	Carbon and air quality impact from travel	Carbon impact from building works	Anchor institution impact
Planned inpatient surgery	Total increase of 327kg in total as a result of increased travel times. This may need to be offset as North Central London is in an air quality management area	No anticipated impact	No anticipated impact
Planned day surgery	Total increase of 298kg in total as a result of increased travel times. This may need to be offset as North Central London is in an air quality management area	No anticipated impact	No anticipated impact

Table 8: the potential impact of our option for change on sustainability and the environment

Impact on finances

Developing the centres of expertise at UCLH and GOSH would require some additional financial investment. This investment would be used to increase capacity and bed numbers at both GOSH and UCLH.

The investment would allow us to deliver services in line with best practice standards of care, which would in turn improve outcomes and experience of care for children and their families and carers.

Site	Investment needed
GOSH and UCLH	£3.7m

4.2 | Example patient stories: surgery for babies and children

We have developed some patient stories to help illustrate how things could be different in the future under our proposed option for changes to children and young people's planned and emergency surgery. These are not real patients but scenarios we have developed to explain our proposed changes.

Emergency surgery

Lily is 18 months old and has not been eating or drinking for 48 hours. She has started vomiting and her stomach (abdomen) is painful when touched.

Lily's parents have brought her to the children's emergency department at the family's local hospital. The children's (paediatric) emergency doctor suspects Lily has an abdominal problem that may need surgery.

Lily's doctor phones the surgical assessment unit for emergencies at Great Ormond Street Hospital (GOSH) and asks for Lily to be assessed by specialist surgical staff.

Emergency surgery for younger children is now provided at a 'Centre of expertise for emergency surgery and planned inpatient surgery' at GOSH.

This means Lily's doctor does not need to call around multiple local paediatric surgical units in north London or beyond to find a bed for Lily.

GOSH accepts the care of Lily and she is transferred within six hours to the centre of expertise. Lily is assessed by specialist surgical staff and surgery is organised.

Lily's surgery is carried out by a specialist children's surgeon supported by a children's anaesthetist, in a child friendly operating theatre.

Lily recovers well on a ward designed to meet the needs of children and cared for by nursing staff trained to care for children and returns home with her parents two days later.

Lily's parents are told that if she needs any follow up appointments these will be back at her local hospital, closer to home.

Planned day surgery

Mohammed is two-and-a-half years old and has had severe tonsilitis with complications – an infection of the tonsils at the back of the throat – three times over the last six months.

Following discussion with Mohammed's parents, the family's GP refers Mohammed to the ear, nose, and throat (ENT) department at his local hospital.

Mohammed and his mum attend an outpatient appointment at his local hospital, where Mohammed is assessed by a children's doctor who specialises in ear, nose, and throat conditions.

Due to the severity, the risk of further complications, and number of times he has had an infection, the doctor recommends that Mohammed has an operation to remove his tonsils.

Because Mohammed is under three years old, the doctor arranges for Mohammed to have planned day surgery at the 'Centre of expertise: planned day case surgery' at UCLH where highly experienced, specialist surgical staff care for babies and very young children.

Mohammed and his parents will only need to travel to the centre of expertise at UCLH once for the surgery – all outpatient appointments will take place at his local hospital. Day surgery means he is highly likely to go home on the same day as his operation.

On the day of his surgery, Mohammed is operated on by the specialist surgical team in a child friendly operating theatre. He spends four hours recovering on a ward designed for children with his parents and with nursing staff trained to care for children, before being well enough to go home.

Four weeks later, Mohammed has an outpatient appointment at this local hospital where the children's doctor who specialises in ear, nose and throat conditions finds he has recovered well from the surgery.

Section 4: Responding to the consultation

1 How to share your views

We would like to know what you think about our proposals to help us decide how to proceed. Our consultation runs for 14 weeks from 11 December 2023 until midnight on 17 March 2024.

It is vitally important to our decision-making process that we are fully aware of the views of people in North Central London and neighbouring areas, that we have heard about potential alternative options that people would like us to consider, and that we understand any concerns and people's ideas on how we could address these.

Over the course of the consultation there will be many ways you can find out more about our proposals and share your views with us.

If you cannot access the website or require additional support to share your views, please phone the consultation team on 0800 324 7005.

1.1 Read our more detailed documents

There is lots more detailed information about our proposals for both maternity and neonatal care, and children's surgery on our website at **nclhealthandcare.org.uk/start-well** These are technical documents with more clinical and financial language, but if you do want to know more, we would encourage you to look at them.

You can also find supporting factsheets, frequently asked questions and information about the background to the Start Well programme on our website.

1.2 Complete the questionnaire or write a letter

Once you have read or heard enough information to give your opinion you can formally respond to the consultation questionnaire or send a letter or email. We welcome responses from individuals and from organisations.

- Complete the consultation questionnaire on our website: **nclhealthandcare.org.uk/start-well**
- Return a paper copy of the questionnaire to our freepost address
- Email StartWellConsultation@ors.org.uk
- Post a letter to Opinion Research Services, FREEPOST SS1018, PO Box 530, Swansea, SA1 1ZL

1.3 Call the consultation team

If you cannot complete the questionnaire or send an email or letter, we can offer a telephone survey to collect your views. Please call the consultation team on 0800 324 7005 to arrange this. You can use this option if you cannot access the internet or send a written response.

1.4 Invite us to your group

If you run or are involved in a group for people that might be impacted by our proposals, we would be happy to come and speak to you about them in more detail and hear feedback. We can attend groups in person or virtually to talk about our plans. Please contact the consultation team as soon as possible on 0800 324 7005 or by emailing StartWellConsultation@ors.org.uk

1.5 Online, in the news and in your community

Read regular updates on our website, Facebook, X (formerly Twitter) and in the local media. Printed information will also be available at GP surgeries, hospitals and community centres in local communities.

2 Next steps

After the consultation closes on 17 March 2024 all the feedback we have received will be analysed by an independent research organisation. They will prepare a report for the us setting out what people think about the proposals. Alongside colleagues from NHS England specialised commissioning, we will then consider the feedback from the consultation, along with a wide range of other information such as what the medical evidence tells us will deliver the greatest improvements to care, how we can safely staff services for the long term, and which proposals offer us the best value for money. We will use all the feedback, evidence, and information to decide how to proceed. We will continue to share information about our work, including publishing the consultation report and key papers that will inform the decision-making, with staff, patients, local people, and wider stakeholders. The final decision-making meeting will be held in public to allow those who are interested to hear the discussion and how the decision is made.

3 What will happen to my information

North Central London Integrated Care Board has commissioned Opinion Research Services (ORS) to help manage aspects of the consultation, including analysing and reporting feedback. ORS will produce a full report of the consultation in which the views of individual members of the public acting in a personal capacity will be anonymous. However, where feedback is from representatives of organisations or someone acting in an official capacity, it may be attributed. Information will only be used to inform this consultation and any personal information that could identify you will be kept by ORS for no more than one year after any decisions have been finalised. For further information please see **nclhealthandcare.org.uk/privacy-notices** or **www.ors.org.uk/privacy**

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