# NCL Start Well – actions to improve maternity, neonatal, children and young people's services and proposed next steps for the programme

**Executive summary**

This ICB Board paper seeks to update on progress of the Start Well Programme following the report brought to the Board on 27 September 2022.

In September, the Board received an update on the work undertaken as part of the first phase of the Start Well programme and recommendations on the next steps. This included undertaking more detailed work on opportunities that may require the system to consider a change in which services are available in NCL and where these are located.

In exploring these opportunities, the Start Well Programme have developed best practice care models which have been created through two half day workshops, the Clinical Reference Group (CRG) and nine dedicated task and finish groups. These care models set out the aspiration of how care could be delivered in NCL in the future and cover:

- Maternity
- Neonatal
- Children and young people: emergency and planned surgery
- Children and young people: emergency medical
- Children and young people: planned medical
- Children and young people: long term condition

Delivering the proposed care models for children and young people's emergency medical, planned medical and long terms condition would require a change in how services are delivered on existing sites. Adopting these may require actions owned at either a local level or require system collaboration.

For maternity, neonatal and children and young people's emergency and planned surgery, delivering these proposed care models may require service change which would involve site-specific changes in terms of services that can be accessed and where these are located. Any service change implications would require an options appraisal process to be undertaken. This paper sets out the proposed next steps and recommendations for taking this work forward.

**Proposed neonatal care model**

Neonatal care is currently delivered across three types of units – Special Care Unit (SCU, level 1), Local Neonatal Unit (LNU, level 2) and Neonatal Intensive Care Unit (NICU, level 3). The presence of a SCU (level 1) is unusual in urban areas and currently provides an inequity in initial care if a baby is born unexpectedly premature or unwell in a hospital with a unit of this type. The current SCU (level 1) in NCL has activity volumes significantly below the upper limit of activity that a SCU (level 1) should admit, as outlined by the British Association of Perinatal Medicine (BAPM), which can make it difficult for our staff to maintain the required skills and competencies.

The proposed neonatal care model outlines that all neonatal care would be delivered in either a LNU (level 2) or NICU (level 3). To meet minimum activity and workforce

requirements, NCL would be able to safely sustain a maximum of four neonatal units of which all would be either designated a LNU (level 2) or NICU (level 3). There are currently five neonatal units in NCL (excluding the specialist NICU (level 3) at GOSH) which means there would be one fewer neonatal unit in the future. The ICB would need to undertake an options appraisals process which considers this proposed service change against the status quo.

**Proposed maternity care model**

In NCL pregnant women and people can currently choose to deliver in four different types of birth settings – obstetric led unit, alongside midwifery led unit, stand-alone midwifery unit or a home birth. There is different utilisation of these settings with our obstetric led services heavily utilised whilst the range of our midwifery led settings are underutilised. The current stand-alone unit had 45 deliveries in 2021/22 which is significantly below the minimum of 350 deliveries per year advised by the National Clinical Advisory Team (NCAT).

The proposed care model includes three birth settings – home birth, alongside midwifery led unit and obstetric led unit. It does not include a stand-alone midwifery unit as a birth setting. The clinical co-dependencies between neonatal and maternity services means that all obstetric led units would be co-located with either a LNU (level 2) or NICU (level 3).

Multiple factors were considered when determining whether a stand-alone midwifery unit would be included in the proposed care model and whether increasing activity to a sustainable volume was feasible. Factors considered included the declining birth rates in NCL, patient feedback on important factors in deciding a birth setting, the future workforce requirements and findings from the Ockenden review. Given these, it was agreed by the Start Well Programme Board that the proposed future models would not include a stand-alone midwifery unit.

In NCL there is currently one stand-alone midwifery unit and five obstetric led units. For a stand-alone midwifery unit to not be part of the future care model and for there to be one fewer obstetric led unit (in line with the proposed number of neonatal units), the ICB would need to undertake an options appraisal which considers these service changes against the status quo.

**Proposed children and young people's surgical services care model**

Across NCL, paediatric planned and emergency surgical care is delivered either locally or at a specialist hospital. Currently there is variation in whether a child is treated on site or transferred to a more specialist hospital for emergency surgical care. The low volumes of elective surgery for some specialties at non-specialist Trusts makes it challenging for surgical, nursing and anaesthetic staff to maintain the necessary skills and confidence in treating children.

The proposed surgical care models propose the creation of a centre of expertise that would consolidate some planned and emergency surgical activity. This unit would deliver paediatric surgery for low volume specialities and very young children. Any child under the age of 1 years requiring emergency surgery would be transferred

through a fast-track pathway with clear protocols to a dedicated unit(s). The ICB would need to undertake an options appraisal which considers this proposed service change against the status quo.

**Recommendations and next steps**

The work the Programme has undertaken since September sets out how care could be delivered in the future and has explored any potential service changes that would be required if these models were to be implemented. Considering these implications, a set of recommendations have been developed which outline the proposed next steps for the Start Well Programme.

The ICB Board is asked to:

1) Agree the proposed children and young people's care models for long-term conditions, emergency medical care model and planned medical requirements and commence planning for their adoption.

2) Agree to proceed to an options appraisal in respect to the implementation of the proposed maternity and neonatal care models. This options appraisal would:
   a) Set out all possible site-specific options for having four obstetric led birthing units co-located with four neonatal units (three of which will be level 2 and one will be level 3), instead of the current five (excluding the specialist level 3 at GOSH)
   b) Additionally, set out the option of no longer having a stand-alone midwifery unit. For all options identified in 2a, there would be two permutations – one with and one without the stand-alone midwifery unit.
   c) Set out the appraisal of these options, compared to the status quo against a set of criteria to be agreed by the Start Well Programme Board, but which would include at a minimum an assessment of the impact of the option on quality, access, workforce, and finances (including recurrent affordability, capital and cash availability) at both an organisational and system-level over an agreed time-horizon

3. Agree to proceed to an options appraisal in respect to the implementation of the proposed emergency and planned surgical children and young people's care models. This options appraisal would:
   a) Set out all possible site-specific options for the creation of a centre of expertise for the delivery of paediatric surgery for low volume specialities and very young children
   b) Additionally, set out the options of emergency care for under ones fast-tracking to dedicated unit(s). For all options identified in 3a there would be two permutations – with and without this fast-track pathway.
   c) Set out the appraisal of these options, compared to the status quo against a set of criteria to be agreed by the Start Well Programme Board, but which would include at a minimum an assessment of the impact of the option on quality, access, workforce, and finances

(including recurrent affordability, capital and cash availability) at both an organisational and system-level over an agreed time-horizon

4. Note that the ICB will undertake further public engagement and/or consultation when the outputs of the options appraisal are known and before any decisions as to service changes are taken.

5. Note that the options appraisal will be undertaken from December 2022 with the ambition to have a draft PCBC in April 2023 with the next update to the Board in March 2023.

Any options appraisal would need to be undertaken in line with best practice guidance and requirements for service reconfiguration. If an options appraisal process is recommended it would be undertaken from December 2022 with the ambition to have a draft pre-consultation business case (PCBC) by the beginning of April 2023. As part of this process any interdependencies with other services will be considered as well as the potential impact of the proposed service changes on protected population groups.

The outputs of the options appraisal process would be described in a PCBC which would set out the benefits and limitation of the options. The ICB may then need to formally consult the public on any proposed service changes, and this must be completed before any decisions are made on adopting the care models.

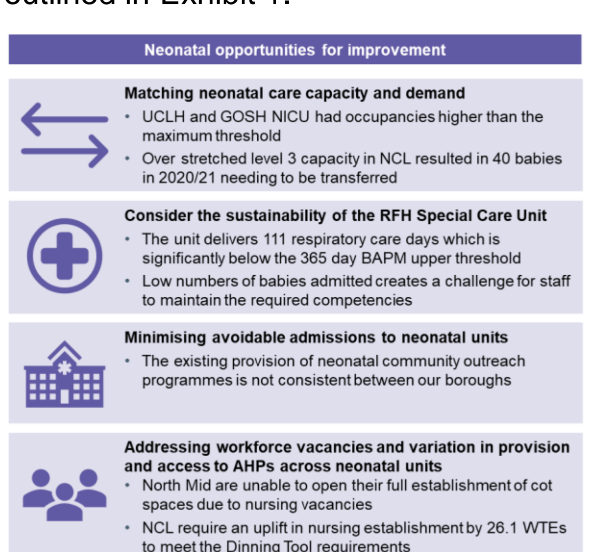
## Section 1: Introduction

The Start Well Programme (“Start Well”) was initiated in November 2021 and was set up to ensure that hospital-based maternity, neonatal and children and young people’s services in NCL are fully meeting the needs of those that use them.

There were several drivers for starting the programme which included:

- The coming together as an ICS and wanting to give babies, children, and young people the opportunity to have the best possible start in life and to deliver the ICS priority action to start well
- The clear calls to action set out in the NHS Long Term Plan and the initial Ockenden Report
- The learnings from the temporary changes to local children and young people’s services in NCL during the COVID-19 pandemic
- External reviews of services by the CQC, and NHS England and NHS Improvement
- The health inequalities further highlighted through the pandemic and the urgent need to address them
- The opportunity to build on existing partnership working as we moved into becoming a formal integrated care system
- Wanting to ensure there is a resilient and sustainable maternity, neonatal and paediatric workforce

Following a period of significant clinical engagement, quantitative data analysis, review of best practice standards and a review of qualitative views of patients and residents, a case for change was published in June 2022. The document highlighted the current challenges and set out a number of opportunities for improvement. An overview of the opportunities for improvement identified are outlined in Exhibit 1.



**Children and young people's opportunities for improvement**

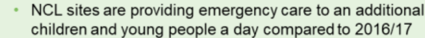
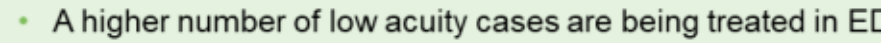
**Reducing long waits for elective care**
- In NCL, 1 in 46 (32,000) children and young people are currently waiting for treatment
- For admitted care there are currently c.4,300 children and young people waiting for treatment at NCL sites

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

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

**Meet national recommendations for the environment for paediatric surgical care**
- Currently not all sites provide dedicated paediatric theatres or child-friendly environments
- The impact of the current estate and organisation means that some sites are struggling to manage their activity

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

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

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

*Exhibit 1: Start Well case for change opportunities for improvement*

After publishing the document, a ten-week engagement period was undertaken from 4 July 2022 to 9 September 2022. The engagement sought to understand if the findings and opportunities for improvement set out in the case for change resonated with patients and the public, staff and wider stakeholders and what factors were important in providing high quality services and excellent care. The engagement themes were published and reported to the ICB Board on 27 September 2022, and a summary of these findings are detailed in appendix A.

Alongside the engagement themes, the paper that was taken to the September ICB Board meeting outlined the next steps for the programme in response to the findings from the case for change. These next steps included the establishment of a new governance structure for the Start Well programme, further exploration of areas based on feedback on the case for change and work to finalise care models which were being developed to set out how care could be delivered in the future.

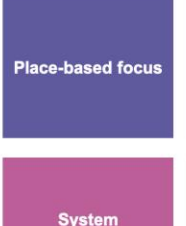
Having undertaken the work outlined in the September update to the ICB Board, the purpose of this paper is to:

- Update the ICB Board on how the Start Well programme has progressed since the last update in September 2022
- Share the proposed care models and potential implications on service change as recommended by the Start Well Programme Board
- Seek endorsement from the ICB Board on the principles of the proposed care models for maternity, neonatal and children and young people's services
- Seek the ICB Board's recommendation to undertake an options appraisal which considers the service changes

# Section 2: Responding to the case for change

## 2.1 ICS response to the case for change

Since the publication of the case for change and over summer 2022, the Start Well programme has been exploring how to address the opportunities identified in the case for change. Given the breadth of the case for change and the services in scope, responding to the opportunities for improvement requires action from different parts of the system. The programme has categorised potential responses into three action types: place-based focus, system collaboration and some opportunities which may require us to consider whether a service change is needed. A definition of each of the action type and examples are detailed in Exhibit 2.




- Opportunities and actions owned at a local level which would not involve change to the provision of services at sites.
- Actions that may need to be co-created at a local level (e.g., involving a Trust or borough partnership)
- Examples include local Trusts work to improve the quality of their maternity minimum data sets, an audit of stillbirths in Haringey and local Trusts working with clinical teams to understand challenges around communication and how this can be improved

- Action that is needed at a system level and requires work between multiple partners within the ICS to achieve but does not involve change to the provision of services at any site.
- For most areas this involves building upon an existing programme of work or working in a more collaborative way and the Start Well programme has provided further impetus to accelerate this existing work
- Examples include further expansion of continuity of carer across NCL in a consistent way led by the LMNS and improvements and expansion to the availability of perinatal mental health services through the mental health programme board

- Opportunities that may require the system to consider a service change I terms of which services can be accessed and where these services are located
- These potential service change will the focus of the Start Well Programme moving forward

*Exhibit 2: Categories of actions identified in the case for change*

In the update to the ICB Board in September 2022, we highlighted some emerging actions in order to make improvements to services. Since then, we have taken time to reflect on the engagement outcomes and reviewed these emerging outcomes against the feedback received. The engagement has helped to identify some additional opportunities, such as a focus on communication between clinical teams and services users, as well as amplifying the importance of some opportunities that had already been noted as being important to take forward.

## 2.2 Governance for actions to be taken forward at place level or through system collaboration

Many of the actions identified with either a place-based focus or through system-collaboration fall within the scope of existing programmes of work. These actions will be taken forward through these existing programmes and progress against them will be monitored through the NCL children, young people, maternity and neonatal (CYPMN) board. This board has membership from the Joint SROs for the Start Well programme: Sarah Mansuralli, Chief Development and Population Health Officer for the ICB and Dr Emma Whicher, ICS lead for children, young people, maternity and neonates; with the latter taking on the role of chair.

Other members include the ICB Chief Medical Officer, Dr Jo Sauvage, and ICB Chief Nursing Officer, Chris Caldwell; with the latter taking overall executive leadership for children, young people, maternity and neonatal services in NCL.

The CYPMN board has broad representation from across the ICS and covers programmes which span beyond the scope of Start Well, including children and young people's community and mental health commissioning, the Local Maternity and Neonatal System (LMNS) and the CYP regional improvement programme. Each of these programmes has a role in contributing to the ICS response to the opportunities identified through Start Well. Bringing programmes together in this way provides a place for there to be a bridge between the longer-term strategic work that Start Well and the two strategic reviews around mental health and community services are delivering alongside the more business as usual elements being delivered through other ICS programmes of work.

A detailed action plan has been put together in conjunction with all the work areas that cover children, young people, maternity and neonates, with key deliverables and timeframes set out. A summary of this action plan can be found at appendix B.

The CYPMN board at their November meeting agreed the approach to monitoring progress and delivery of the action plan. ICS programme teams will be invited to update on specific actions at key intervals. This will ensure there remains an important momentum and focus on actions that fall at either a place or system level to implement, that the linkages between different programmes are made, and there is senior level oversight of these actions through the executive level membership of the CYPMN board.

## Section 3: Best practice care models

A number of the opportunities identified in the case for change suggest a need to consider how services are currently organised, specifically:

- Better utilisation of maternity capacity offered in NCL
- Alignment of neonatal capacity and demand
- The sustainability of the Royal Free Hospital Special Care Unit (Level 1)
- Having the right maternity and neonatal facilities
- Organisation of paediatric surgical care
- Reducing long waits for elective care
- Meeting national recommendations for paediatric surgical care environment

In responding to challenges and opportunities outlined, the Start Well programme has developed future care models for maternity, neonatal, children and young people's services. These care models set out how care could be delivered in the future, considering best practice, national guidance, the opportunities for improvement and feedback from the engagement. These care models are aspirational and do not set out how care is currently delivered in NCL.

We have developed proposed best practice care models for:

- Maternity
- Neonates

- Children and young people: emergency and planned surgery
- Children and young people: emergency medical
- Children and young people: planned medical
- Children and young people: long term conditions

Developing the care models has been a collaborative exercise undertaken with a wide range of input from a number of system partners. The future care model development has been overseen by the Clinical Reference Group (CRG) which has membership from across all organisations as well as local system partners. We have engaged with over 100 individuals through two half day clinical workshops and nine dedicated task and finish groups. These focused task and finish groups explored areas such as the transition to adult services, training and education, maternal medicine and paediatric surgical care. Themes from the case for change engagement were fed through to the groups to ensure this feedback informed the care model development.

The care models have been shared at several system groups including the Network Oversight Group which bring together all surgical clinical networks, Primary Care Operations Group and one-to-one meetings with the clinical chairs of the six NCL surgical networks. A full list of the forums the care models have been tested at can be found in appendix C.

We have also sought patient and public feedback through two meetings of the Patient and Public Engagement Group (PPEG) and a youth summit session which captured the views on the emerging children and young people's care models from around twenty young people who are residents of NCL and were specifically recruited to be part of the engagement on Start Well. Relevant themes from these events have been shared with the CRG and task and finish groups to ensure that patient voice is at the centre of the care model development.

We aligned on a set of principles that have underpinned the design process of the care models which includes placing those using the services and their families at the centre, ensuring equity and consistent standards of care and making best use of our resources, people, places and money.

The care models have been reviewed and the principle of these care models have been recommended by the Start Well Programme Board, which includes senior specialised commissioning representatives. Where there was not a consensus by the CRG, such as the inclusion of a stand-alone midwifery unit in the maternity care model, the Start Well Programme Board reviewed the evidence and feedback and came to a view.

In this section we outline those care models that if delivered may require site specific changes in services to implement them with those care models that do not require a service change to deliver them set out in appendix D.

### 3.1 Neonatal care model

#### 3.1.1 Current neonatal care model

Currently neonatal care is delivered across three types of units – Special Care Unit (SCU, level 1), Local Neonatal Unit (LNU, level 2) and Neonatal Intensive Care Unit (NICU level 3). The presence of a SCU (level 1) is unusual in urban areas and currently provides an inequity in initial care if a baby is born unexpectedly premature or unwell in a hospital with a unit of this type. It is acknowledged by clinicians on the CRG that SCUs (level 1) are more effective in a rural setting where travel times are much longer than in urban settings. In rural areas, these units provide a setting where babies can be transferred to as they become more well, which is closer to home.

The current SCU (level 1) in NCL has activity volumes significantly below the upper limit of activity that a SCU should admit. In 2021/22, 111 respiratory care days were delivered in the unit, which is significantly below the 365 upper limit of respiratory care days per year set out by British Association of Perinatal Medicine (BAPM). The low volume of activity impacts on the ability for clinicians to maintain the required skills and competencies to provide high-quality care for babies that need respiratory support. There were also 58 babies who were transferred from Royal Free Hospital to another unit as a result of needing more intensive care and therefore separated from the person who has just given birth, who must stay in the unit in which they have just delivered their baby in. We know this doesn't provide the best experience at an already stressful time.

Babies requiring onward support can be looked after in the community, however the provision of this support is variable between the boroughs. This means that some babies can access treatment in a community setting, for instance phototherapy for jaundice, whilst other babies have to stay in hospital for the same treatment.

### 3.1.2 Future neonatal care model

The elements of our future neonatal care model is outlined in Exhibit 3.

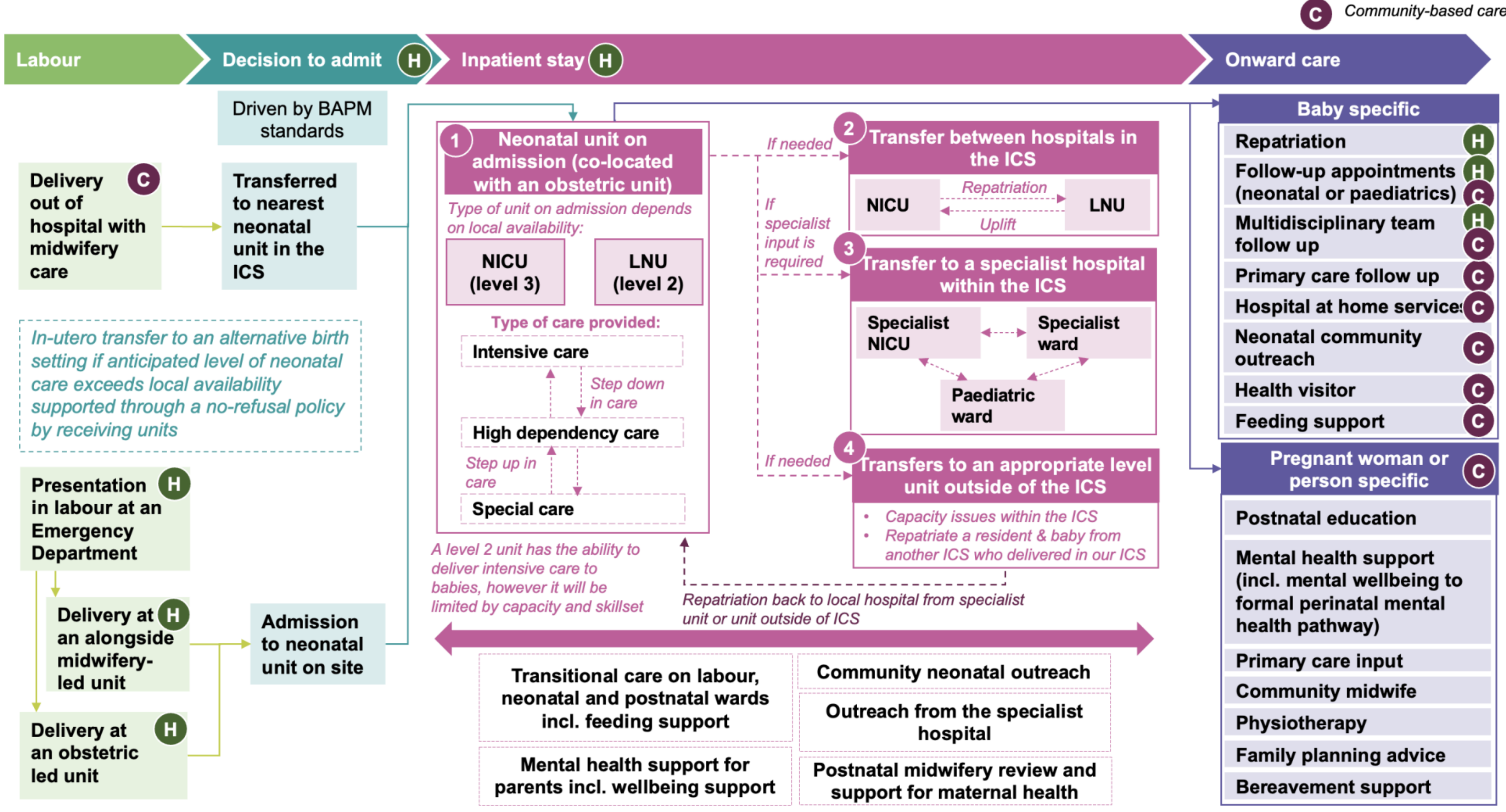



*Exhibit 33: Proposed neonatal care model*

In the proposed future care model, all hospital based neonatal care would be delivered in either a LNU (level 2) or NICU (level 3). Babies admitted to these units may require special care, high dependency care and/or intensive care and both of these types of units can deliver these three levels of care although intensive care in an LNU (level 2) would be provided on a short term basis. These neonatal units would mean that the highest quality of initial care is provided to all babies born in NCL no matter which unit they are born in.

These units would be staffed in line with the BAPM guidance which would include specialist medical workforce as well as the nursing and allied healthcare professional (AHP) support. Workforce would be available 24/7 so babies would have access to specialist care at all times of the day and all days of the week.

If a baby's care needs are beyond the capabilities of the neonatal unit at their place of birth, they may require a transfer to another unit within or outside the ICS or to a specialist hospital. This would typically mean moving from a LNU (level 2) to a NICU (level 3). Subject to cot capacity, the ICS aspires to operate a 'say yes' policy whereby no admission would be refused. Similarly, if a baby has an anticipated high level of care pre-delivery that exceeds the local neonatal unit's capabilities, effort should be made to arrange an in-utero transfer to minimise postnatal transfers.

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

Through our engagement, patients and public have highlighted how important it is that neonatal care is delivered by staff who often care for sick or unwell babies. In the proposed future care model, all neonatal units would be staffed with a specialist workforce, who are seeing volumes of activity that enables them to maintain the required skills and competencies.

For babies that require onward care, community neonatal care provision would also be standardised across the different boroughs. This means that babies would be able to be treated closer to home, reduce the time spent in hospital and prevent further admissions.

Underpinning the neonatal care model would be ongoing communication where parents and carers are kept fully informed and actively involved in any decisions.

### 3.2 Maternity care model

#### 3.2.1 Our current maternity care model

Maternity care is provided across all sites within NCL and currently pregnant women and people can choose to deliver in four different types of birth settings – obstetric led unit, alongside midwifery led unit, stand-alone midwifery unit or a home birth. There is different utilisation of these settings with many pregnant women or people choosing to deliver, or being recommended to deliver, in an obstetric led setting. This means that

often our obstetric led services are heavily utilised whilst the range of our midwifery led settings are underutilised.

Currently not all pregnant women and people have access to the same services and experience the same quality of care. For example, the current provision and delivery of continuity of carer in NCL is variable. There are also different models of continuity of carer implemented across the system, with some sites providing continuity pre- and postnatally, but not during labour, and others providing full continuity throughout the pathway.

Where a pregnant woman or person gives birth is just one element of the maternity pathway and a pregnant woman or person's experience of maternity services. A range of antenatal and postnatal services are provided in NCL, although many women and people have reflected that access to information and guidance is not always easy, especially for those whose first language is not English.

### 3.2.2 Our proposed care model

We want to deliver a care model in the future that ensures equality of access to services. This means all pregnant women and people can access the range of services that suits their needs. We also want to ensure that pregnant women and people are provided with information and guidance that enables them to make an informed choice on where to give birth and that the choice of birth settings are aligned to our population needs.

The future care model considers the full pregnancy pathway and is set out in Exhibit 4.

H – *Hospital-based care*
C – *Community-based care*

## Pre-conception

### Pre-conception counselling
- General advice (C)
- Specialist advice (H) (C)
- Perinatal mental health support (H) (C)

## Access to care

*Woman or person confirms pregnancy:*

| Self-referral (online) | Primary care referral |
|---|---|
| Institutional referral | Hospital referral |

### Central booking system for preference selection* (C)
**Helpline available*

### Booking appointment (H) (C)
- Risk stratification
- Personalised care plan
- Social support advice
- Mental health support

*If needed*

### Emergency care access (H)

| 111 and 999 | A&E |
|---|---|
| Maternity hotline | Maternity triage |
| Early pregnant unit | |

## Antenatal care

### Routine care
- Advice and education (obesity, smoking, alcohol) (C)
- Routine appointments, investigations & scanning (H) (C)
- Immunisation hub (C)
- Health visitor (C)

*Additional services if required*
- Community / peer support networks (C)
- Antenatal screening +/- referral to fetal medicine (H) (C)
- Mental health support (C)

### Additional care / specialist input (H) (C)
- Maternal medicine pathway
- Fetal medicine pathway (incl. counselling and other specialist clinics)
- Safeguarding pathways
- Perinatal mental health specialist / MDT

## Birth and treatment

*Care may be transferred to an alternative unit (patient choice or clinical indication) during the antenatal or birthing period*

### Birthing
**Labour triage to assess suitability of birthing location:**
- Home birth (C) – *If needed* → Alongside midwife led unit (H)
- Obstetric led unit (H)

*Transfer to alongside midwife unit or obstetric unit if needed*

*If needed* → Planned / emergency operative delivery (H)

**Birthing supported by:** NCL maternal medicine network in-reach service

*If needed*

### Complications (H)
**Pregnant woman or person**
- Maternity HDU
- Adult ICU

**Baby – enhanced ward-based care**
- Transitional care

**Baby – neonatal care**
- Neonatal outreach
- Neonatal unit (LNU / NICU) co-located with an obstetric led unit

Access to mental health support / risk assessment if needed

## Postnatal care

### Parent and baby
- Postnatal ward / readmissions (H)
- Home visits (C)
- Health visitor (C)
- Feeding support (C)
- Neonatal community outreach (C)
- Specialist neonatal referral (H) (C)
- Paediatric referral (H) (C)
- Mother and baby MH unit (H)

### Post partum woman or person specific (C)
- Primary care support
- Mental health support
- Physiotherapy
- Community midwife
- Family planning
- Bereavement support (across whole maternity pathway)
- Postnatal education

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

*Exhibit 4: Proposed maternity care model*

**Antenatal support**

A wide range of support would be available including:

- Advice and education (such as weight management, smoking cessation and alcohol advice)
- Routine appointments, investigations and scans including maternal blood borne virus
- Health visitor and immunisation hub in the community
- Antenatal screening (and referral to fetal medicine where necessary)
- Community and peer support networks
- Mental health support
- Safeguarding input throughout the maternity care journey

These services would be offered as a mixture of face-to-face or virtual appointments, enabling choice for the woman or pregnant person. Where safe to do so, services would be available in the community and as close to home as possible. Pregnant women or people would be made aware of services that are only accessible in specific locations or face-to-face to allow planning and minimise disruption to their routine, supporting freedom of choice and flexibility. This includes maternal and fetal medicine services for those who may require specialist input.

If there are complications during the pregnancy, pregnant women and people would be able to access care via a maternity helpline, early pregnancy unit (<20 weeks), maternity triage (>20 weeks) or emergency department and antenatal ward.

**Birth and treatment**

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

- **Home birth:** these women and people, typically low risk would have the support of a midwife at home. When deciding on a home birth the woman or person would be fully informed of the transfer times to a consultant led obstetric unit if it were to be required.
- **Alongside midwifery led unit:** low risk pregnant women and people would be advised to give birth in an alongside midwifery led unit. From speaking with women and people, we understand that the environment of a midwifery unit can influence and promote health and wellbeing of the pregnant women or person, their families and staff.
- **Obstetric led unit:** pregnant women and people with high levels of complexity would be advised to give birth at an obstetric led unit that can provide sufficient care for all of their needs. All obstetric led units would be co-located with a neonatal unit, either a LNU (level 2) or NICU (level 3). This would help to minimise transfers and avoid separation after birth.

The future maternity care model does not include a stand-alone midwifery unit as a birth setting. Current activity at the stand-alone midwifery unit is very low with just 45

deliveries in 2021/22. This is the lowest in London and has been declining over the last five years. Pregnant women and people would still have the choice to deliver in an alongside midwifery led unit or at home if clinically suitable and they prefer a setting outside of a hospital. Low volumes of activity at a stand-alone midwifery unit can pose safety and sustainability challenges within the service.

Across all birth settings, mental health support and access to liaison psychiatry would be made available, especially for pregnant women and people with pre-existing mental health conditions that could be exacerbated during labour.

**Postnatal care**

It is important that all women and people are provided with support after they have given birth. Postnatal services available would include:

- Midwife and health visitor home visits to provide physical review, feeding support, contraception education, advice and guidance
- Postnatal education including counselling on subsequent pregnancies and methods to reduce risk factors
- Postnatal admission guidance for those who need to seek medical attention in the postnatal period
- Specialist neonatal referrals
- Paediatric referral for babies with ongoing needs
- Mental health support including formal mental health services referral
- Specialist services follow up for those who required it during their pregnancy
- Bereavement support

To address health inequalities and outcomes for those populations most at risk and those groups identified in the Core20PLUS5, they would be targeted for continuity of carer. Receiving care from the same midwife throughout the pregnancy pathway enables pregnant women and people to build a relationship with their midwife and reduce the need to repeat medical information or traumatic experiences.

### 3.3 Emergency and planned children and young people's surgical care model

#### 3.3.1 Our current surgical care model

Across NCL paediatric planned and emergency surgical care is delivered either locally or at a specialist unit. The majority of planned surgical care is delivered at a specialist unit whilst the majority of emergency surgical care is undertaken at local units.

For emergency surgical care, those with complex medical conditions or those undergoing specialist procedures, such as cardiothoracic and neurosurgery, are usually treated in a specialist children's unit which is at Great Ormond Street Hospital (GOSH). Currently there is variation in whether a child is treated on site or transferred to a more specialist hospital for other emergency surgical care. There are no consistent system-wide protocols for emergency care pathways for the management of transfers. Treatment at local hospitals can be dependent on the confidence and skills of both the surgeons and anaesthetists covering the emergency rota to manage

the care of children. From April 2020 to March 2021, 144 children and young people were transferred from an NCL provider to other hospitals for an emergency surgical procedure.

Complex planned paediatric surgery is delivered by specialist paediatric surgeons at GOSH, with some GOSH consultants also operating at other local units. Planned paediatric surgery is also undertaken at local units in NCL although this tends to be procedures that are less complex. The low volumes of elective surgery for some specialties at non-specialist Trusts makes it challenging for surgical, nursing and anaesthetic staff to maintain the necessary skills and confidence in treating children.

### 3.3.2 Our proposed surgical care model

For children and young people requiring surgery, we want to ensure that they are treated by a specialist workforce who are regularly assessing and treating children and young people and delivering sufficient volumes of activity to be able to do this.

The proposed paediatric emergency and planned surgical care model is summarised in Exhibit 5.

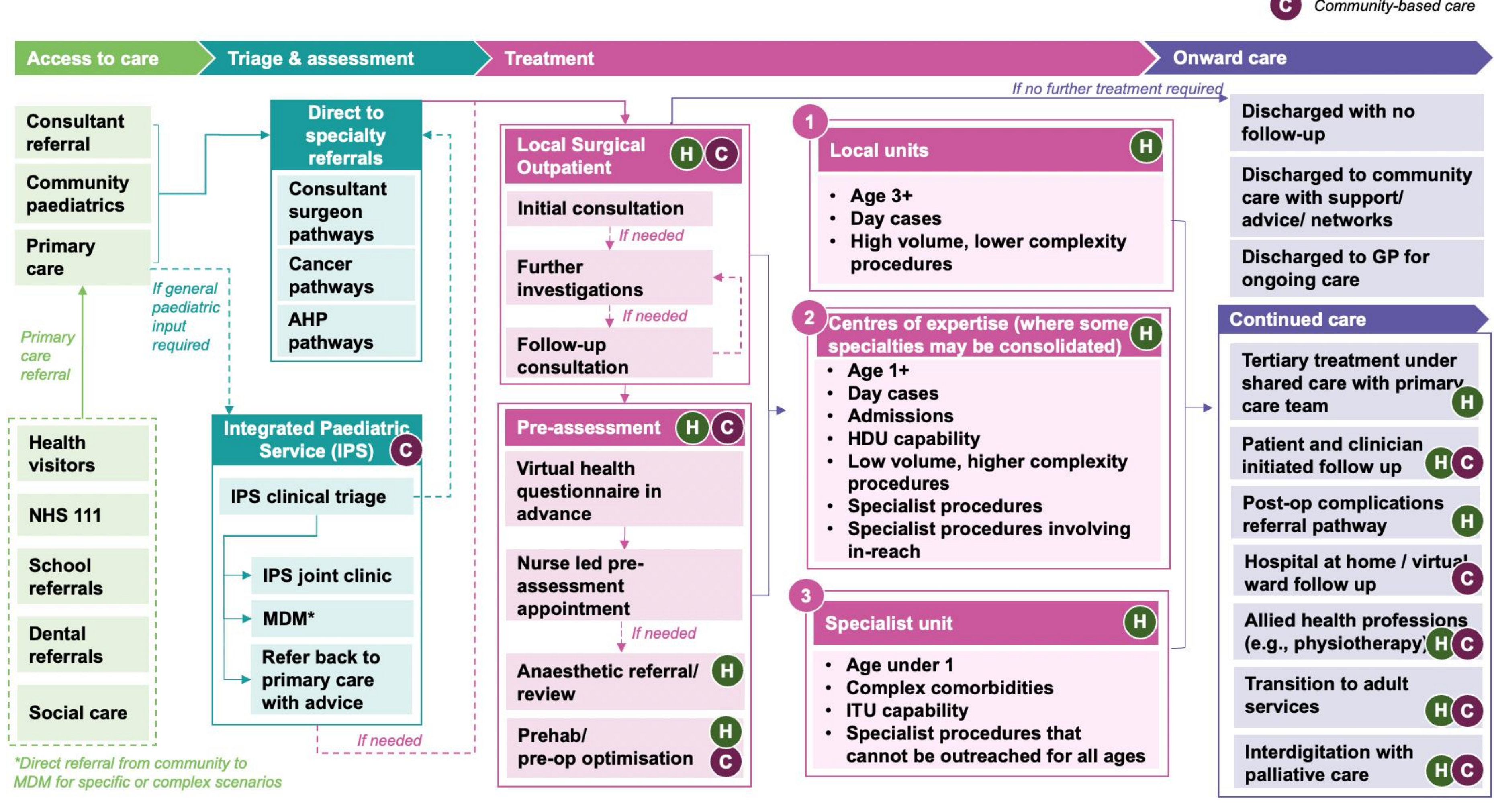



*Exhibit 5a4: Proposed planned surgical care model*

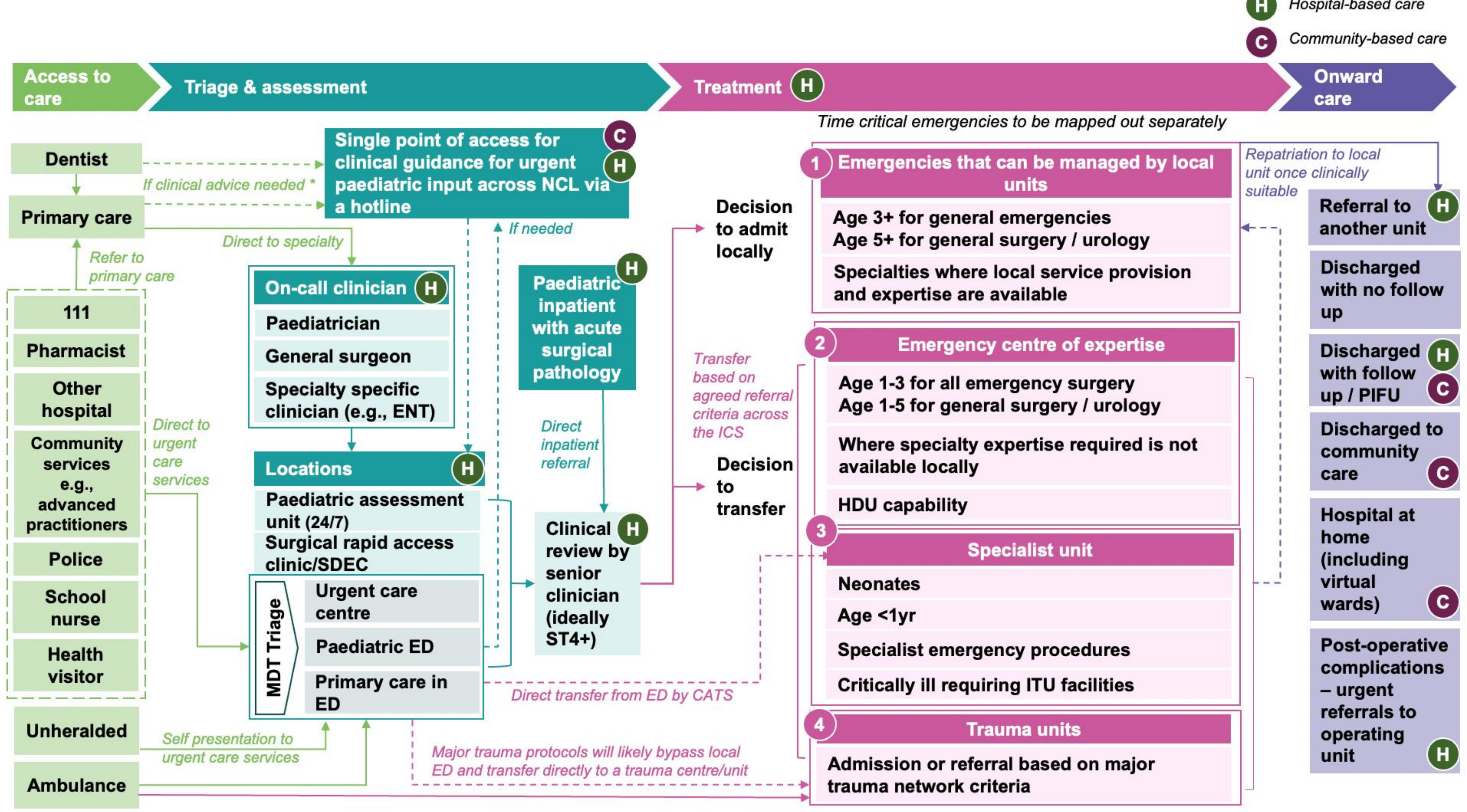



*Exhibit 5b5: Proposed emergency surgical care model*

To reduce fragmentation, surgical care would be delivered at either a local unit, centre of expertise or specialist unit. These units would deliver surgical care aligned to a set of inclusion criteria to ensure children and young people are treated in a setting that best supports their needs. The type of surgical treatment that would be delivered at each unit would be:

**Local unit**

- **Emergency surgical care:** emergency day case surgical procedures in children and young people over the age of 3 (or over the age of 5 for general surgery or urology) which does not require any specialist surgical input or HDU capability. These procedures would typically be lower complexity.
- **Planned surgical care:** day case planned surgical procedures for children and young people over the age of 3 for high volume, low complexity procedures. An example would be ENT and dentistry specialties.

**Centre of Expertise**

- **Emergency surgical care:** emergency surgical procedures for the local catchment population of the unit and all surgical procedures for children aged 1-3 (and up to age 5 for general surgery and urology) and any procedure that requires post-operative admission or HDU capability.
- **Planned surgical care:** all inpatient planned surgical procedures, all planned surgical procedures for lower volume specialties and for children aged 1-3 years.

To support the management of transfers there would be standardised clear admissions or referral protocols for all Trusts. To ensure that young children can be managed at all times of the day, the centre of expertise would have a 24/7 paediatric anaesthetist workforce.

There may be some exceptions for some specialties being included in the centre of expertise where existing arrangements and partnerships exist with other specialist units.

Consolidating surgical procedures would support the concentration of specialist nursing and allied healthcare professional in one location. This would enable the delivery of consistent and high-quality perioperative support to children and young people in their care pathway and provide opportunities for enhanced training and education in a multidisciplinary approach.

**Specialist unit:**

- **Emergency surgical care:** for children under the age of 1, children or young people with complex co-morbidities, any procedures requiring ICU perioperatively and any complex surgical procedures that cannot be managed locally or at a centre of expertise.
- **Planned surgical care:** planned surgical care for children under the age of 1, children and young people with complex co-morbidities, complex surgical procedures that cannot be outreached or those that require ICU capability.

Underpinning this model would be joint working between the local units, centre of expertise and specialist unit. This may include collaborative workforce approaches including joint appointments, rotations for continuing professional development or partnership agreements.

## Section 4: Implications of the proposed care models on services

Delivering these care models may require service changes in terms of which service can be accessed and where these are located in NCL. These service change implications have been explored and are set out in this section.

### 4.1 Neonatal services

The proposed neonatal care model outlines that all neonatal care would be delivered in either a LNU (level 2) or NICU (level 3) and that this would be delivered across four neonatal units in NCL.

To provide a high-quality, clinically sustainable service where staff can maintain their skills and competencies, neonatal units would need to deliver minimum activity volumes. NICUs (level 3) at a minimum must admit 100 very low birth weight babies and LNUs (level 2) must admit at least 25 very low birth weight. In 2021/22 there were 215 very low birth weight admissions in NCL. There may be just enough activity volumes to sustain the thresholds required for up to five neonatal units, one of which would be a NICU (level 3) and the remaining would be LNUs (level 2).

Under the future care model, neonatal units would also be staffed by a 24/7 specialist workforce. Each unit would have at least seven neonatal paediatrician/neonatology consultants and at least eight middle grade medical clinicians. Considering the current workforce in NCL and the minimum workforce requirements for five neonatal units, NCL would need to recruit at least an additional six neonatal paediatricians/neonatology consultants and eight middle grade clinicians. This is against a backdrop of existing workforce shortages and recruitment challenges. It is therefore not feasible to staff five neonatal units.

Therefore, in the future NCL, would be able to safely sustain a maximum of four neonatal units of which all would be either designated a LNU (level 2) or NICU (level 3).

### 4.2 Maternity services

NCL currently has one stand-alone midwifery unit, and the proposed maternity care model does not include a stand-alone midwifery unit as a birth setting.

A number of factors were considered in determining whether there should be a stand-alone midwifery unit in the future care model. The current stand-alone midwifery unit is underutilised. In 2019/20, there were just 73 deliveries at this unit and most recently in 2021/22, only 45 pregnant women and people delivered babies at this unit. Those using the unit are from across the spectrum of deprivation and were either from close geographical proximity or to the north of the unit. This suggests that there isn't one specific cohort of our population using the service. The

current volume of deliveries accounts for less than 1% of all deliveries in NCL and is the lowest volume of deliveries at any care setting across London and is significantly lower than the other two stand-alone midwifery units in the capital.

The low utilisation of the stand-alone midwifery unit poses sustainability questions. The National Clinical Advisory Team (NCAT) advises that there should be a minimum of 350 deliveries per year at a stand-alone midwifery unit[1]. These volumes of deliveries ensure that staff are able to maintain their skills and competencies and that pregnant women and people receive high-quality care.

Increasing activity to bring it in line with national recommendations would also mean ensuring the unit is open and staffed 24/7. Currently the stand-alone midwifery unit is opened on a case-by-case basis and staffed by midwives who support home birthing services. Opening the unit 24/7 in order for the unit to meet the scale of activity increase would require additional dedicated staffing model. Workforce recruitment and retention is a challenge in NCL, as well as nationally, so having to recruit additional midwives would be difficult.

To deliver the minimum number of deliveries recommended by NCAT would require an eight-fold increase in deliveries at the stand-alone midwifery unit. A number of factors suggest that increasing the activity to these levels would be challenging, even if it was opened as a sector wide resource:

- The age and complexity of pregnant women and people is increasing across NCL. Along with a declining birth rate, the cohort of pregnant women and people who are eligible to give birth in this setting is likely to decline in the future.
- Speaking with those who use maternity services through the engagement on the case for change has highlighted some of the factors that are considered important when choosing where to give birth. Recommendations from friends and family, proximity to the hospital and familiarity with the hospital were the three most important factors. Individuals also highlighted that having access to neonatal services in case of complications is an important consideration in deciding on a birth setting.
- To provide a service that can deliver the increased activity would require the unit to be open and staffed 24/7and would require an additional dedicated staffing model. Workforce recruitment and retention is a challenge in NCL, as well as nationally, so having to recruit additional midwives would prove difficult.

It is important that NCL continue to offer an out of hospital choice. In the proposed care model, home birth services would continue to be offered and we would improve the extent to which alongside midwifery led units are able to provide an experience which is closer to an out of hospital setting.

It was agreed by the CRG and maternity task and finish group that the unit was not sustainable in its current form and the benefits and challenges of increasing the

[1] https://www.ncbi.nlm.nih.gov/books/NBK280133/#s4-7

activity was shared. The Start Well Programme Board considered the data and recommended that a stand-alone midwifery unit would not be included in the care model.

In NCL there is currently one stand-alone midwifery unit. For a stand-alone midwifery unit not to be part of the future care model, the ICB would need to undertake an options appraisal comparing the future care model that does not include a stand-alone midwifery unit, against the status quo.

The maternity care model also proposes that obstetric led units be co-located with neonatal units. The neonatal care model has four neonatal units which would therefore mean four obstetric led units in NCL. For there to be one fewer obstetric led unit, the ICB would need to undertake an options appraisal which considers the service change against the status quo.

### 4.3 Children and young people's surgical services

The future surgical care models propose the creation of a centre of expertise that would consolidate planned and emergency surgical activity. This would be surgical activity that requires the greatest skills and would consist of:

- Planned day case for low volume specialties
- All inpatient planned procedures (all ages)
- All planned procedures for children aged 1-3 years
- Emergency procedures for children and young people aged 1-3 years
- Emergency procedures on children aged 1-5 years for general surgery and urology
- All emergency procedures requiring an admission

The creation of a centre of expertise would require specialist workforce which would include a 24/7 paediatric anaesthetic rota. To sustain a 1 in 10 paediatric on-call rota would require a centre of expertise to deliver c.6,700, of which around 80% would be planned surgical procedures and 20% would be emergency surgical procedures. In 2021/22, there were c.8,300 surgical procedures (planned and emergency). These activity volumes suggest that NCL would have sufficient activity to sustain one centre of expertise.

Any child under the age of 1 year requiring emergency surgery would be transferred through a fast-track pathway with clear protocols to a dedicated unit(s).

The proposed care model consolidates some surgical activity into a centre of expertise. The ICB would need to undertake an options appraisal which considers this service change against the status quo.

## Section 5: Summary and next steps

Any options appraisal would need to be undertaken in line with best practice guidance and requirements for service reconfiguration.

If an options appraisal process is recommended to consider the proposed service changes outlined in this document, it would need to follow best practice and requirements on service reconfiguration. This would be undertaken from December

2022 with the ambition to have a draft pre-consultation business case by the beginning of April 2023. An indicative process is outlined in Exhibit 6.

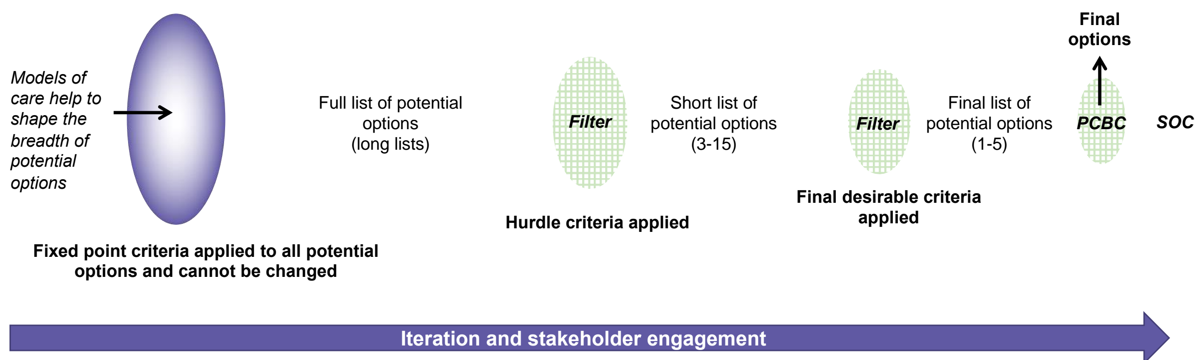



*Exhibit 66: Indicative options appraisal process*

As part of this process, any interdependencies with other services will be considered as well as potential impact of the proposed service changes on protected population groups. The outputs of the options appraisal process would be described in a pre-consultation business case (PCBC). Any proposed service change would subject to an assurance process, part of which would review the proposals against the five tests which include considerations around patient choice.

The ICB may then need to formally consult the public on any proposed service changes, and this must be completed before any decisions are made on adopting the care models. Any decision to consult would require formal approval of the ICB Board, who would consider in public the PCBC.

## Section 6: Recommendations

The ICB Board is asked to:

1. Agree the proposed children and young people's care models for long-term conditions, emergency medical care model and planned medical requirements and commence planning for their adoption.

2. Agree to proceed to an options appraisal in respect to the implementation of the proposed maternity and neonatal care models. This options appraisal would:
    a. Set out all possible site-specific options for having four obstetric led birthing units co-located with four neonatal units (three of which will be level 2 and one will be level 3), instead of the current five (excluding the specialist NICU at GOSH)
    b. Additionally, set out the option of no longer having a stand-alone midwifery unit. For all options identified in 2a, there would be two permutations – one with and one without the stand-alone midwifery unit.
    c. Set out the appraisal of these options, compared to the status quo against a set of criteria to be agreed by the Start Well Programme Board, but which would include at a minimum an assessment of the

impact of the option on quality, access, workforce, and finances (including recurrent affordability, capital and cash availability) at both an organisational and system-level over an agreed time-horizon

3. Agree to proceed to an options appraisal in respect to the implementation of the proposed emergency and planned surgical children and young people's care models. This options appraisal would:
    a) Set out all possible site-specific options for the creation of a centre of expertise for the delivery of paediatric surgery for low volume specialities and very young children
    b) Additionally, set out the options of emergency care for under ones fast-tracking to dedicated unit(s). For all options identified in 3a there would be two permutations – with and without this fast-track pathway.
    c) Set out the appraisal of these options, compared to the status quo against a set of criteria to be agreed by the Start Well Programme Board, but which would include at a minimum an assessment of the impact of the option on quality, access, workforce, and finances (including recurrent affordability, capital and cash availability) at both an organisational and system-level over an agreed time-horizon

4) Note that the ICB will undertake a further public engagement and/or consultation when the outputs of the options appraisal are known and before any decisions as to service changes are taken.

5) Note that the options appraisal will be undertaken from December 2022 with the ambition to have a draft PCBC in April 2023 with the next update to the Board in March 2023.

# Appendices

### Appendix A: Case for change engagement summary

**How engagement was undertaken and reach of engagement**
A formal report was written to evaluate the responses received during this engagement. A link to the full report is here: https://nclhealthandcare.org.uk/wp-content/uploads/2022/09/Start-Well-engagement-report-September-2022.pdf.

Following approval by the NCL CCG Governing Body (as the precursor organisation to the NCL ICB) on 30 June 2022, a 10-week programme of engagement commenced on 4 July 2022. The engagement aimed to:

- identify whether the themes highlighted in the case for change resonated with patients, residents, staff and stakeholders
- capture the views of patients, residents, staff and stakeholders on the opportunities to improve care in NCL

During this period there was a wide-range of engagement including patients and residents of NCL, staff who work in maternity, neonatal and children and young people's services and other key stakeholders including local authority partners, neighbouring Integrated Care Systems (ICSs) and the voluntary sector.

A range of materials were developed to support the engagement process:

- An information leaflet and case for change summary were made available which described the background to Start Well as well as highlighting opportunities to improve
- The information leaflet was translated into six of the most spoken community languages in NCL, as well as into an Easy Read format for those with learning disabilities
- A survey was also developed which could be completed online or on paper for staff, service users or other stakeholders to complete

In addition to the survey, there were a number of ways individuals or organisations could give their views:

- Giving feedback verbally, during face-to-face engagement events
- Taking part in focus groups and discussions, both online and face-to-face
- Participating in staff meetings and giving views during the discussions
- Participating in workshops and other interactive opportunities (such as a Youth Summit)
- Filling in an online survey or requesting a printed version
- Writing to the programme either via the post or via email
- Telephoning a publicised number to give verbal feedback

During the engagement period, face-to-face and online feedback opportunities were put in place to capture views on the case for change. At each event participants either

gave direct feedback to the Start Well Team or were encouraged to complete and submit an online or paper questionnaire depending on the circumstances of the event. Stakeholders were also able to submit direct feedback via a programme email address. All the information captured and submitted was analysed as part of the report.

During the engagement period a total **43** engagement events took place, reaching a total of **518** residents, **207** of which conversations were in-depth, with people sharing their views and experiences. In total **389** people completed the survey by answering at least one of the questions.

**Summary of feedback received during the engagement period**

*The case for change*

The questionnaire asked for views on the case for change and the opportunity to comment on the document. The results showed that of those who responded, there was broad agreement with the opportunities to improve services identified. 79% of all respondents either strongly agreed or agreed with opportunities identified in the case for change to improve maternity and neonatal services and 77% of all respondents either strongly agreed or agreed with opportunities to improve children and young people's services. This provided the Start Well programme with a clear mandate and platform to continue to explore how the opportunities identified in the case for change could be improved upon.

*Qualitative analysis themes*

The feedback received through specific engagement events was recorded and analysed as part of the report, and the themes identified are summarised below:

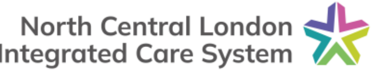
| Theme | Key points |
|---|---|
| **Communication in delivery of clinical care** | • The importance of communication in the delivery of clinical care was highlighted throughout the engagement period by respondents across all care settings. This included both communication between patients and staff, as well between healthcare professionals working within and between organisations<br>• Examples given included ensuring information is communicated using accessible language, use of interpreters and receiving consistent information from healthcare professionals |
| **Maternity care** | • Feedback from residents and patients said that safe and compassionate care were paramount in maternity care<br>• Analysis showed that people commonly chose maternity care based on recommendations from family and friends, proximity to home and familiarity with a hospital<br>• Consistency of care in maternity was also highlighted – patients and residents felt it was important where possible that pregnant women and people saw the same midwife and team |
| **Neonatal care** | • Responses showed that people wanted babies in need of neonatal care to be given the best possible service by specialists. It was important to people that neonatal services were co-located with maternity services so that there was seamless care before and after a baby was born, and so that babies did not have to be moved to other hospitals for neonatal care. |
| **Emergency care for children and young people** | • Patients and residents valued having emergency care for children and young people close to home. They said that having specialist paediatric emergency departments available was important because |

| | |
|---|---|
| | they felt that their children would get care from staff experienced in dealing with children and young people, which was reassuring for parents and children alike.<br>• Participants in the Youth Summit said that good and compassionate communication was important. They felt that clinicians should look at the whole person and should take them and their concerns seriously. They would like to have clarity on what they could expect from their care. |
| **Planned care for children and young people** | • Generally, people were willing to travel further than their local hospital to have specialist care for children and young people. There could be long waits for appointments, and between different types of appointment, so consolidating appointments would be welcomed to reduce waiting times in clinics and between appointments<br>• The participants of the Youth Summit raised that long waits for care had a significant impact on patients and their families. |

# Appendix B: Emerging Start Well action plan

## Emerging draft action plan

| Area | Action | Theme from engagement? | Delivery owner |
|---|---|---|---|
| Addressing difference in outcomes for maternity services | Undertake an audit of stillbirths in Haringey 2018-2020 to determine route cause, and any difference in care would have lead to a different outcome. Learning to be shared across the LMNS | | NCL LMNS |
| | Improve the quality of and access to maternity data in NCL through improving the underlying MDSs | | NCL LMNS with ICB Digital team |
| | Creation of a ICS maternity dashboard that allows for benchmarking and review of key outcomes metrics | | NCL LMNS with ICB Digital team |
| | Further implementation of maternity continuity of carer to ensure NCL will meed the CORE20PLUS5 target by March 2024, ensuring those at highest risk of poor outcome are prioritised to receive it | ✓ | NCL LMNS |
| | Implementation for health inequalities project manager role within the LMNS | | NCL LMNS |
| | Cultural competency and unconscious bias training - how is this being rolled out and targetted? | ✓ | NCL LMNS |
| | Outputs from the pre-term birth NCL network group - determining causal factors and themes in those that give birth pre-term | | NCL LMNS |
| Managing complex pregnancies | Implementation of the pan-London IUT guidance | ✓ | NCL LMNS |
| | NCL compliance with the 85% target for babies to be born in a unit with a NICU when born under 27 weeks | | NCL LMNS |
| | Development and agreement of the maternal medicine pathways to further support pregnant women and people who have complex pregnancies | | NCL LMNS with the maternal medicine |
| Improving communication and supporting choice in maternity care | Improving the provision of the provision and access to translation and interpretation services across maternity services in NCL | ✓ | NCL LMNS |
| | Implementation of the Personalised Care and Support Plan across NCL maternity services | ✓ | NCL LMNS |
| Improving pre and post natal support to families | Implementation of the NCL infant feeding strategy, and bid for Start for Life funding to enahnce breasfeeding support across NCL | ✓ | NCL LMNS |
| | Actions in place to support improvement in the pre and post natal care - **TO BE AGREED** | ✓ | NCL LMNS |
| Supporting safe staffing of maternity units | Implementation of the OPEL Framework for maternity services across NCL | | NCL LMNS |
| Perinatal mental health | Further roll out of the Maple perinatal mental health service to Barnet | ✓ | Mental Health Programme Team |
| | Increasing the take up of perinatal mental health services across NCL to be closer to the LTP target | ✓ | Mental Health Programme Team |
| | Progress of collaborative around mother and baby units | | Mental Health Programme Team |
| Community paediatric care | Implementation of hospital at home services across NCL covering both CYP and neonates | ✓ | Community programme team |
| | Additional CYP community nursing for asthma in Barnet and Haringey | | Community programme team |
| CYP mental health | Growing and/or establishing new community, crisis, disordered eating and intensive home treatment CYP mental health services in NCL including enhancing early intervention with the aim of supporting more children to stay out of hospital | | Community programme team |
| | Evaluation of CYP community mental health crisis hubs | | Community programme team |
| | Improving multi-agency partnership working around risk support to ensure CYP with mental illnesses are supported in the right settings | | Community programme team |
| | Roll out of dynamic support registers for complex CYP cases presenting with co-morbid mental health and learning disability or autism | | Community programme team |
| CYP UEC access | Understanding reasons behind increasing low acuity attendances and supporting the implmentation of models / schemes which would reduce this, directing families to the most appropriate place for their needs | | Flow Operational Group |
| CYP LTC mangement | Increasing the consistency in diabetes pathways and care for children in NCL | | Regional improvement programme |
| CYP Surgery | Appointment of a paediatric surgery clinical lead for NCL | | Start Well team |
| | Development of a paediatric surgery clinical network in NCL to support paediatric surgical pathways and provide a governance structure over surgical activity within the region | | Start Well team |
| | Targetted waiting list backlog reduction work and demand smoothing for paediatric wait times across the sector | | Start Well team |
| Transition | Improving the transition between paediatric and adult services for CYP and ensuring this is consistent with regional and national guidelines | | |
| Communication | Improving the communication between clinical teams and patients, carers and families | | Individual Trust teams |
| Supporting those with additional needs | Additional support is provided to those with learning difficulties such as advocacy, passporting, specialist LD nursing to support at appointments/inpatient stay, and extra help and information to support new mums with the baby such as breast feeding and first aid. | ✓ | Individual Trust teams |
| Information about accessing care and overall wellbeing for families in NCL | Developing a family wellbeing strategy for NCL - supporting a better understanding of services available, where and when to access them | ✓ | |




## Appendix C: Care model development and testing meetings

| Meeting | Meeting focus | Date | Number of attendees |
|---|---|---|---|
| **Care model development workshop #1** | A workshop with a range of attendees from both NHS and local authority invited commence work on best practice models. | 14/07/2022 | 49 |
| **Start Well Clinical Reference Group** | The first meeting of the CRG split the group into two breakouts: one covering maternity and neonates and the other covering paediatrics and asked for their feedback on the developing models of care | 31/08/2022 | 20 |
| **Youth Summit #1** | A group of young people were asked to think about elements of the care models including alternatives to ED and surgery | 01/09/2022 | c.15-20 |
| **Care model development workshop #2** | The second large workshop where attendees reviewed updated best practice care models and provided feedback on them. | 08/09/2022 | 40 |
| **Start Well Clinical Reference Group** | The CRG were asked to review the proposed task and finish groups and then split into two group to consider some specific questions on the care models as well as starting to look at co-dependencies | 14/09/2022 | 19 |
| **Start Well Clinical Reference Group** | The CRG were presented the emerging themes from the engagement period and reviewed the proposed membership for task and finish groups | 28/09/2022 | 14 |

| | | | |
|---|---|---|---|
| **Task and finish group: maternity #1** | A group which included obstetric and midwifery leads were invited to explore elements of the maternity care model | 12/10/2022 | 12 |
| **Task and finish group: surgery #1** | A group consisting of surgeons, anaesthetists, AHPs and nurses were invited to explore surgical pathways for CYP | 20/10/2022 | 16 |
| **Task and finish group: maternity #2** | A group which obstetric and midwifery leads were invited to further explore elements of the maternity care model | 21/10/2022 | 4 |
| **Start Well Patient Participation and Engagement Group** | The group were shown the emerging neonatal care model and asked for their feedback on it | 21/10/2022 | 7 |
| **Youth Summit #2** | A group of young people explored the advantages and disadvantages of two possible models for surgical care and the age cut off for CYP and adult services | 27/10/2022 | c.15 |
| **Task and finish group: maternal medicine** | Obstetric and maternal medicine leads as well as lead midwives explored the NCL maternal medicine pathways | 28/10/2022 | 6 |
| **Task and finish group: HEE** | Heads of School for paediatrics, anaesthetics, general practice and obstetrics and gynaecology invited to comment on the potential impact of the care models on training | 31/10/2022 | 4 |
| **NCL Network Oversight Group** | Emerging surgical models of care were shared with the attendees of the NCL Network Oversight Group which includes clinical and operational leads from NCL surgical networks (urology, gynae, | 01/11/2022 | 10 |

| | | | |
|---|---|---|---|
| | orthopaedics, general surgery, ENT) | | |
| **Task and finish group: transition between paediatric and adult services** | A group including paediatricians, transition leads from Trusts and community nursing explored the differential age cut off between some paediatric and adult services and how transfer between services takes place | 02/11/2022 | 7 |
| **Task and finish group: surgery #2** | A group consisting of surgeons, anaesthetists, AHPs and nurses were invited to explore surgical pathways for CYP | 03/11/2022 | 15 |
| **Task and finish group: community settings** | Colleagues from across the five local authorities, ICB Directors of Integration and primary care were invited to feedback on emerging care models. The emerging work on family hubs in local authorities was also explored relating to the care models | 04/11/2022 | 17 |
| **Start Well Clinical Reference Group** | The CRG reviewed the updated best practice models for neonates, maternity CYP planned and emergency care | 09/11/2022 | 19 |
| **Task and finish group: surgery #3** | A group consisting of surgeons, anaesthetists, AHPs and nurses were invited to explore surgical pathways for CYP | 10/11/2022 | 12 |
| **Start Well Patient Participation Group** | The maternity and paediatric surgery care models were shown and feedback invited from the group | 11/11/2022 | 7 |

| | | | |
|---|---|---|---|
| **Briefing with NCL General Surgery Network leadership** | The surgical care models were shared and feedback invited as well as a specific discussion around age ranges for surgical services | 11/11/2022 | 2 |
| **Briefing with NCL Orthopaedic Network leadership** | The surgical care models were shared and feedback invited as well as a specific discussion around age ranges for surgical services | 11/11/2022 | 2 |
| **Briefing with RFL lead for plastic surgery** | The surgical care models were shared and feedback invited as well as a specific discussion around age ranges for surgical services | 11/11/2022 | 1 |
| **Briefing with the NCL Urology Network leadership** | The surgical care models were shared and feedback invited as well as a specific discussion around age ranges for surgical services | 14/11/2022 | 2 |
| **Briefing with the NCL ENT Network leadership** | The surgical care models were shared and feedback invited as well as a specific discussion around age ranges for surgical services | 15/11/2022 | 3 |
| **Briefing with Chair of the NCL ophthalmology Network** | The surgical care models were shared and feedback invited as well as a specific discussion around age ranges for surgical services | 15/11/2022 | 2 |
| **Primary Care Silver Group** | The care models were shared with the group and feedback invited, with a specific focus on primary care elements of the pathways | 17/11/2022 | 50 |

**Appendix D: Additional care models**

The care models described here are not expected to require site-specific service change if delivered.

**Children and young people: Planned medical care model**

**Current planned care model:**

Long waits for planned care are a national challenge which has been worsened by the COVID-19 pandemic. In NCL, the waiting list has increased by 8.5% since May 2021 and waiting for care can impact wider aspect of a child or young person's life such as their development, ability to access education and lead active lives.

As of February 2022, there were around 4,000 children and young people waiting for non-admitted care in NCL who are typically waiting for an outpatient appointment and the number of children and young people waiting over 18 weeks had increased by almost 40%.

Across a range of specialties, staff have reflected the increasing volume of duplicate referrals, often with more than one GP referring to the same outpatient specialty. One in 20 individuals referred to the paediatric allergy service have had more than one GP referral. There is an opportunity to consider innovative ways to manage outpatient waiting lists through efficient triaging, delivering appointments virtually or in the community and patient or clinician-initiated follow-up.

**Future planned care model:**

In the future, we want to deliver a service where children and young people are seen by the right person at the right place, the first time. The care model facilitates a streamlined approach to triage with early paediatrician input to reduce the potential number of encounters a child or young person may experience before being seen by the right team and thereby improving their experience of care overall. Children and young people would be put in the right waiting list for further assessment or treatment the first time, which would reduce how long a child or young person has to wait to be seen.

**Access and triage:**

For non-urgent concerns, children and young people can access their GP or community services such as community paediatric teams, NHS 111, health visitors, dentists, school nurses or social care services. For those who require onward referral for further assessment or input, GPs, community paediatricians or other hospital consultants can refer directly to specialty through existing referral pathways.

For children or young people who require general paediatric input, they can be referred by GPs to the Integrated Paediatric Service (IPS). IPS is a collaborative

model that joins together GPs with paediatricians and other allied healthcare professionals in a multi-disciplinary team. A GP referral will be reviewed by a paediatrician in IPS and can have a range of outcomes:

- Referral back to the GP with advice and guidance
- Re-direction to another specialty that is more suitable
- Discussion at the IPS multidisciplinary team meeting (MDM). Community teams such as schools, health visitors and social services would also directly refer to the IPS MDM.
- Outpatient review in a joint clinic (GP and paediatrician) could take place in a community hub where possible

Outcomes from the IPS joint clinic or IPS MDM will be communicated back to the GP for further care.

IPS would be able to help identify the most suitable place for children and young people to be seen, in turn reducing the number of encounters they may have with a healthcare professional before being seen by the right team. This would also reduce the potential backlog and waiting times for outpatient clinics.

**Assessment and treatment:**

Once a referral has a been accepted by the required specialty, children or young people may need assessment or diagnostics and this would take place in community settings where possible to reduce the burden of travel on children, young people and their families.

Outpatient clinics would take place in a community setting where possible where assessments and treatment could be initiated. The types of clinics include:

- Surgical
- Medical
- Specialised paediatric
- Community paediatric

**Onward care:**

Following assessment and treatment, children and young people may not require any further treatment and would be discharged with advice and guidance or discharged to community teams with advice or support networks.

Children and young people who require ongoing care may receive different levels of input from different services, which include:

- Ongoing care through primary care
- Referral for tertiary / specialist input under shared care with their GP
- Hospital at home / virtual ward follow up for those who require additional monitoring or treatment that can be delivered in the community

- Follow up with current team through patient initiated or clinician initiated follow up to reduce unnecessary appointments. Children and young people would be given clear guidance on when to seek or initiate follow up to prevent avoidable delays to clinical review
- Allied healthcare professionals and community or specialist nurses
- Transition to adult services input where needed
- Referral to other services including palliative care where needed

See Exhibit 7 for the proposed future planned care model.

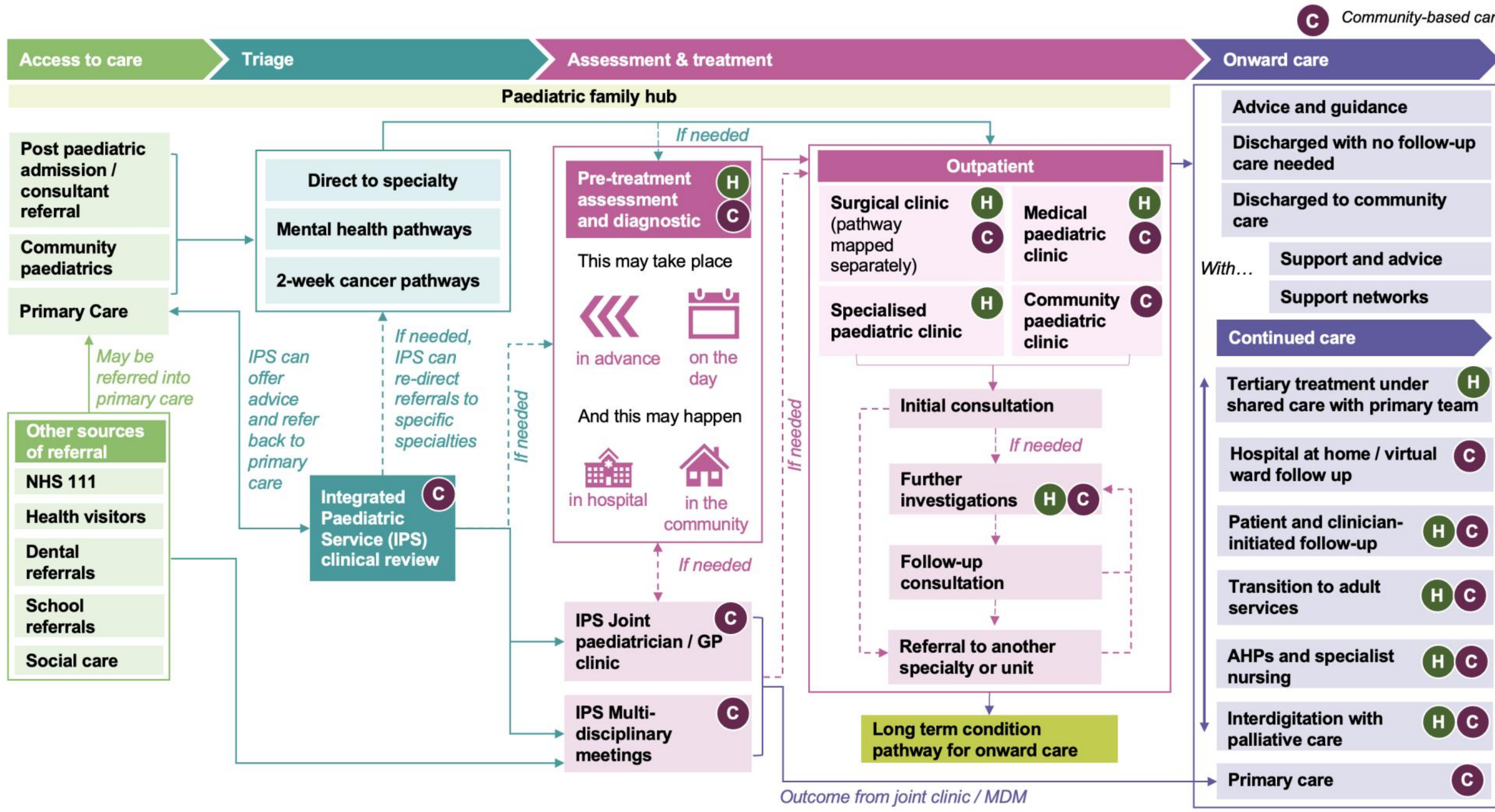



*Exhibit 77: Proposed planned care model*

**Children and young people: Long-term condition care model**

**Current care model:**

The management of long-term conditions is crucial early in life to support better outcomes in adulthood. Often, children and young people do not get enough support to manage their health and wellbeing, which can lead to unplanned time in hospital.

Those living in the most deprived areas with long-term conditions are more likely to be admitted. Over one in 10 children have asthma, making it the most prevalent long-term condition. However, there is an unequal burden with significantly higher prevalence in the 40% most deprived areas. This trend is also seen in other long-term conditions such as diabetes and epilepsy.

Addressing the variance in the management and support of long-term conditions will require a system approach across NCL and with the right support, it should be possible to help children, young people and their families manage their long-term condition better day-to-day at home and reduce the requirement for hospital services.

**Future care model:**

Children and young people with long-term conditions need to have care that is well coordinated that also empowers them to take ownership of their condition and manage it in the community as much as possible. Having access to a named specialist nurse or consultant would reduce potential delays in accessing care or guidance. This also establishes a collaborative approach with primary care that encourages shared decision making and ongoing care.

How children and young people access non-urgent care would remain as described in the planned care model.

The majority of long-term conditions are diagnosed and managed in primary care without the need for secondary or tertiary care intervention. Where clinical advice or care escalation is required, GPs would refer directly to the specialty. GPs would also identify high-risk cohorts based on wider determinants of health and inequalities to initiate a proactive management approach of long-term conditions. This would encourage empowerment of children and young people on their long-term condition and aim to keep their condition manageable in primary care and reduce hospital-based encounters.

Once a child or young person would be referred for specialist review, they may require diagnostics prior to the appointment, which would take place in the community where possible. Once a long-term condition has been confirmed or diagnosed by the specialist, the child or young person would have named consultant or specialist nurse for ongoing care and care co-ordination.

When children and young people need to access non-urgent advice on their long-term condition, they would contact their GP or named consultant or specialist nurse. Direct access to the named consultant or specialist nurse would be made available to the child or young person and their GP through a dedicated helpline.

If children and young people need emergency care related to their long-term condition, they would access the pathways as described in the emergency care model. Following urgent / emergency care assessment and treatment, the healthcare professional would seek advice from the child or young person's named consultant or specialist nurse where possible and inform them of the acute presentation or admission. If unable to do so (e.g., out of hours), the healthcare professional would seek advice from local specialist for immediate management advice or guidance and inform the named consultant or specialist nurse as soon as possible.

**Onward care:**

Children and young people have a wide range of services that they can access for their ongoing care, which includes:

- General advice and guidance on the management of their long-term condition through their GP or specialist
- Ongoing self-management and education of their condition
- Referral to community nurses or school nurses where available (e.g., Asthma Friendly School Nurse)
- Routine follow up with their specialist through patient initiated or clinician initiated follow up. Children and young people would have clear guidance on when to seek or initiate follow up to minimise risk of potential delays to advice or treatment
- Tertiary unit referral and input through shared care with their main care delivery team (which would be the child or young person's GP or secondary care specialist)
- Transition to adult services would be introduced at the earliest possible opportunity to enable a gradual transition process, opportunity to learn about their condition in more detail, meet the adult services team through joint appointments where possible and preparation for practical steps such as requesting and collecting prescriptions
- Referral to allied healthcare professionals and specialist nurses that can support the long-term management of their condition
- Hospital at home / virtual wards if the child or young person requires additional monitoring or treatment that would take place in the community safely and can reduce the time spent in hospital
- Signpost to community support networks, peers or charities relevant to their long-term condition
- Access to mental health support that ranges from mental wellbeing to formal mental health support where needed, for both the child and young person and their families

See Exhibit 8 for the proposed future long-term condition care model.

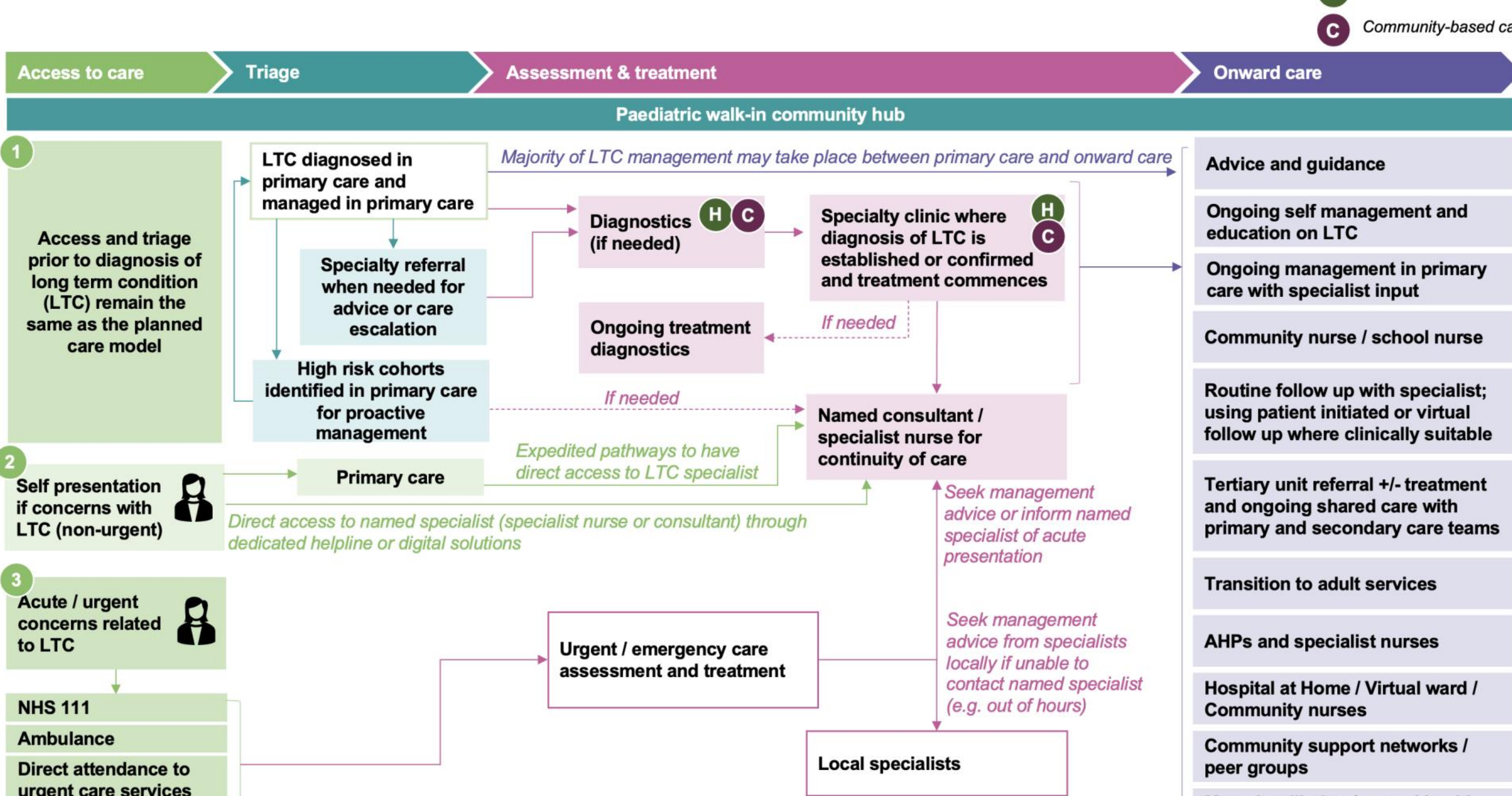



*Exhibit 8: Proposed long term condition care model*

**Children and young people: Emergency medical care model**

**Current emergency care model**

As 2020/21, our sites deliver emergency care for 160,000 children and young people a year with the highest rate of attendance in the 0-4 age group. The demand for emergency care has been increasing across NCL which has meant that children and young people are having to wait more than four hours to be seen and, in some cases, more than ten hours. Being treated quickly in the Emergency Department (ED) is important for both the experience and outcomes of children and young people.

As well as the changes in demand, we know that there is a change in the complexity of our patients, with more attendances with lower acuity cases. Whilst some of these low acuity attendances require acute emergency care, a large proportion of cases could be treated in the community or primary care.

**Future emergency care model**

In the future, urgent and emergency care would be fully integrated, to ensure that children and young people are seen by the right people, in the right setting at first time. Pressure on our EDs are increasing and it is important that children, young people and their families are able to access care and guidance in the community and through primary care.

**Access to care:**

Children, young people and their families would be able to access emergency care through primary care and numerous community services including NHS 111, dentists, pharmacists, other hospitals, and community services, police, school nurse or health visitor.

Following assessment in primary care, an individual would be referred directly to an on-call clinician or specific pathways such as Child and Adolescent Mental Health triage. Where there is clinical uncertainty, a single point of access for clinical advice would be available to clinicians, and individuals may be directed to an appropriate urgent care setting based on their clinical needs.

Children and young people would access emergency care directly by attending an urgent care service and would be triaged by a member of the multidisciplinary team to determine the most suitable and safest place the child or young person would be seen to prevent them from attending multiple departments and being triaged multiple times. Locations include:

- Urgent care centre (may not be 24/7 service)
- Paediatric ED (24/7 service)
- Primary care physician in ED (may not be 24/7 service)
- Paediatric assessment unit (24/7 service)
- Surgical same day emergency care (SDEC)

**Treatment**

Following assessment at the urgent care setting, the child or young person may be discharged or admitted. A child or young person may be admitted for:

- Ambulatory care for further monitoring or treatment that does not require overnight admission
- Day admission if treatment requires several hours during the day and ambulatory care is not appropriate
- Admission for medical or surgical conditions

Children or young people who may require inpatient specialist input would be transferred to a centre of expertise or the specialist unit.

All interactions with emergency care services are an opportunity to educate the child or young person and their parent or carer on alternative methods to accessing care in the community. This would help to ensure that children and young people would be seen in the best possible setting for their needs as soon as possible.

**Onwards care**

Following treatment, a child or young person would be discharged either with or without follow up. Onward care services that the child or young person may be discharged to would include:

- **Community services** such as youth workers, social prescribers, specialist nurses and safeguarding pathways
- **Referral for further assessment**
- **Hospital at home** where treatment and monitoring would be undertaken at home and virtually
- **Discharged to GP** where they would continue with treatment outlined in a discharge plan.

See exhibit 9 for the emergency care model.

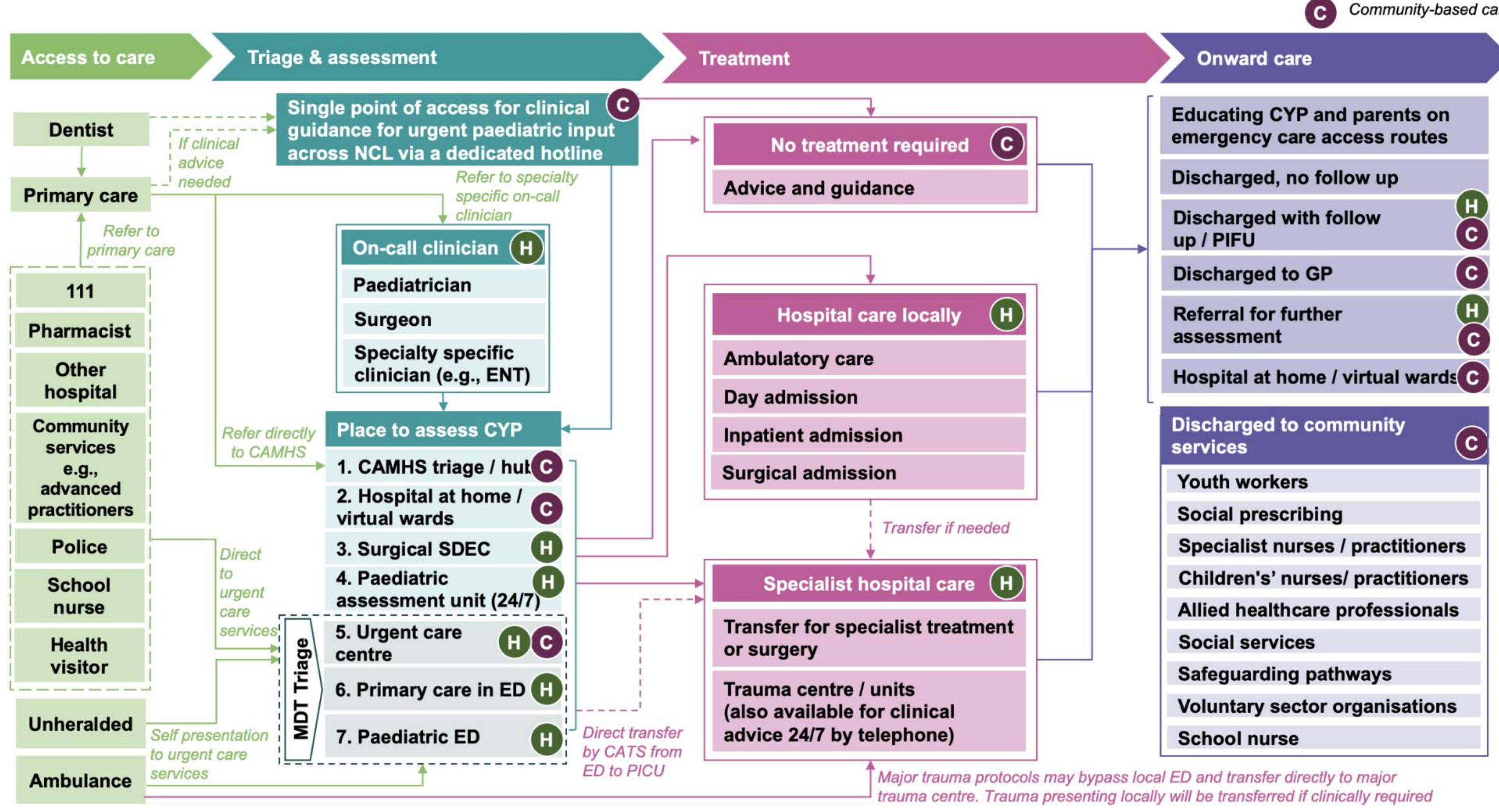



*Exhibit 99: Proposed emergency care model*