North Central London Health and Care
Integrated Care System

NHS

Start Well Programme

Integrated Impact Assessment (IIA)

Decision Making Business Case - Maternity and neonatal services and Edgware Birth Centre proposals

March 2025

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Executive summary

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

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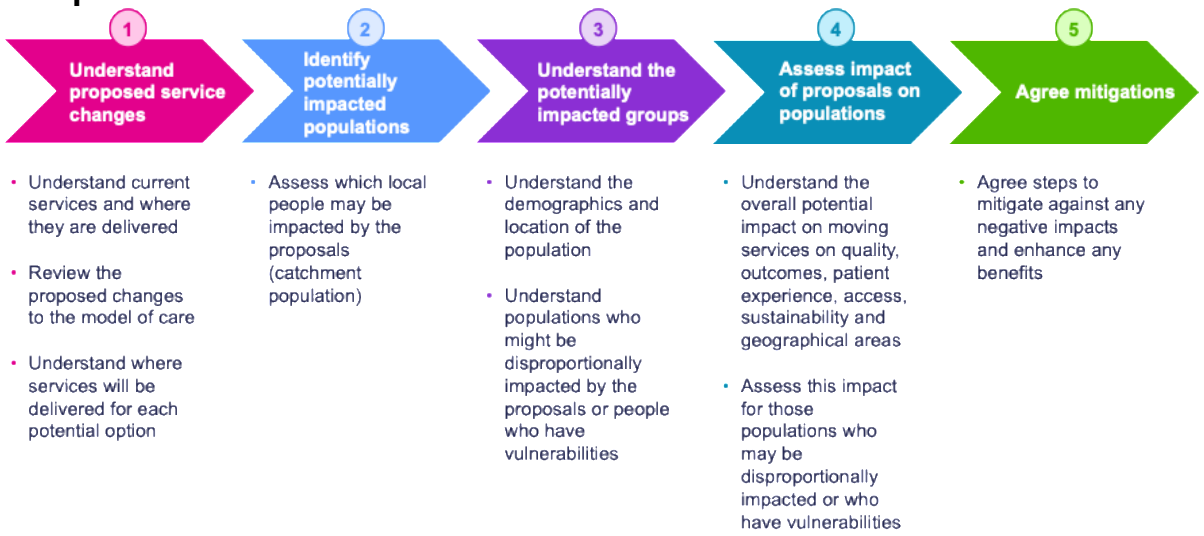
- We have developed proposals for maternity and neonatal services in NCL as part of the Start Well programme
- An interim integrated impact assessment (IIA) was completed in Summer 2023 and used to understand the potential impact of the proposals on local people
- Prior to consultation, we undertook engagement regarding our proposals which reached over 120 patients, residents and staff and contributed to a better understanding of the potential impact on service users
- Since the interim IIA was published, a public consultation was undertaken to gather further feedback on the proposals
- The consultation was robust, reaching thousands of people including those identified by the interim IIA as being potentially more impacted by the proposals such as the Orthodox Jewish community and those living in Core20 areas of deprivation
- This IIA is a refresh of the interim IIA to consider consultation feedback using updated data where available and the same robust approach, assessing our proposals for clinical, accessibility, sustainability and geographical impact
- During implementation, we would continue to engage with the public, staff and stakeholders to develop and implement mitigations

IIA process



Interim IIA engagement reach

- 38 engagement meetings facilitated
- 124 people, residents and staff have been involved
- 9 sessions with parents who have recent experience of neonatal care
- 5 meetings with specialist midwives supporting women with complex needs

Consultation reach

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

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

Maternity opportunities for improvement

Ensuring equality in maternity service provision and experience
- Stillbirth rate varies between boroughs, Haringey had the highest rate with 4.3 per 1,000 population
- Only 4.9% of pregnant women and people in NCL access perinatal mental health services

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

Supporting maternity workforce sustainability
- For many trusts, bank and agency are used to fill shifts to ensure compliance with this target due to vacancies
- Across the system there are currently 120 midwifery vacancies which would need to be filled to meet the BirthRate Plus required establishment

Neonatal opportunities for improvement

Matching neonatal care capacity and demand
- UCLH and GOSH NICU had occupancies higher than the maximum threshold
- Over stretched level 3 capacity in NCL resulted in 67 babies in 2023/24 needing to be transferred outside of NCL

Consider the sustainability of the RFH Special Care Unit
- The unit delivers 235 respiratory care days which is significantly below the 365 day BAPM upper threshold
- Low numbers of babies admitted creates a challenge for staff to maintain the required competencies

Minimising avoidable admissions to neonatal units
- The existing provision of neonatal community outreach programmes is not consistent between our boroughs

Addressing workforce vacancies and variation in provision and access to AHPs across neonatal units
- North Mid are unable to open their full establishment of cot spaces due to nursing vacancies
- NCL require an uplift in nursing establishment by 64.7 WTEs to meet the Dinning tool requirements

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

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

- We identified and consulted the public on two viable options, options A and B, to implement the proposed new model of care
- Option A (closing the consultant-led obstetric unit and co-located neonatal unit at the Royal Free) is the recommended option for implementation. However, the IIA supports decision-making so includes information on both options.

Further work has been done to consider the consultation feedback, which is reflected in this IIA (1/2)

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Feedback	IIA slides	DMBC section
During consultation, people fed back concerns around increased travel times and travel costs. In the questionnaire, ~16% of comments from individuals described concerns around increased travel distance, cost and decreased access. These themes were reiterated during in-person engagement, e.g., feedback that it is difficult to travel into central London with children with disabilities.	183-199- Detailed mitigations	Section 9.2- Feedback from consultation and assurance on the potential impact of the recommended option
During consultation, concerns around impact were raised regarding the following populations: • Residents from low socioeconomic backgrounds (areas of high deprivation) • Residents who do not speak English • People with disabilities who may not be able to drive • Orthodox Jewish community	183-199- Detailed mitigations	Section 9.2- Feedback from consultation and assurance on the potential impact of the recommended option
The Mayor's office recommended that we correct the language used in PCBC about IMD deciles.	Throughout	Section 9.2- Feedback from consultation and assurance on the potential impact of the recommended option

Further work has been done to consider the consultation feedback, which is reflected in this IIA (2/2)

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Feedback	IIA slides	DMBC section
The Mayor's office recommended that we add detail on environmental impact mitigations specifically for maternity and neonatal care.	Slide 191	Section 9.2- Feedback from consultation and assurance on the potential impact of the recommended option
The Mayor's office recommended that we quantify the proportion of NWL residents affected by our proposals and detail mitigations for longer travel times and costs for NWL residents.	Slide 62- NWL residents impacted Slides 193-194- mitigations	Section 9.2- Feedback from consultation and assurance on the potential impact of the recommended option
During consultation, it was suggested that women from some minority ethnic backgrounds could be disproportionately affected if option A is chosen, as they are statistically more likely to experience poorer maternal outcomes, especially those linked to other serious and long-term health conditions such as diabetes.	Slide 126- impact Slide 192- mitigations	Section 9.2- Feedback from consultation and assurance on the potential impact of the recommended option
Difficulties of travelling further and the negative impact of longer journey times, increased costs and reassurance on the additional parking facilities	183-199- Detailed mitigations	Section 10.4- Joint health overview and scrutiny committee (JHOSC) further assurance

The IIA has been updated to reflect feedback and refreshed data where available

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Based on feedback from the public consultation and updated data where available, this IIA has been refreshed since the interim IIA:

- Used 2024 travel time data to understand the impact on travel times of the proposed changes [interim IIA used 2022 travel times]
- Used 2023/24 activity data as the baseline which determines the catchment population that may be impacted by the proposed changes [interim IIA used 2021/22]
- March 2024 Trust workforce returns used [interim IIA used 2021]
- Pregnant women and people with complex (or pre-existing) health conditions included as a specific group to consider the impact of the proposed changes following feedback from the public consultation
- Iterated and strengthened mitigations for the potential impacts of the proposed service changes following feedback from the public consultation, including for the Orthodox Jewish community

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

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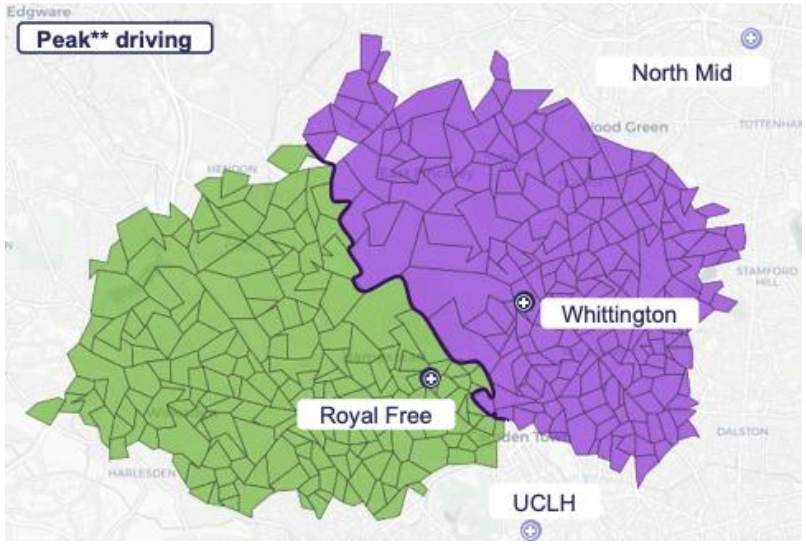
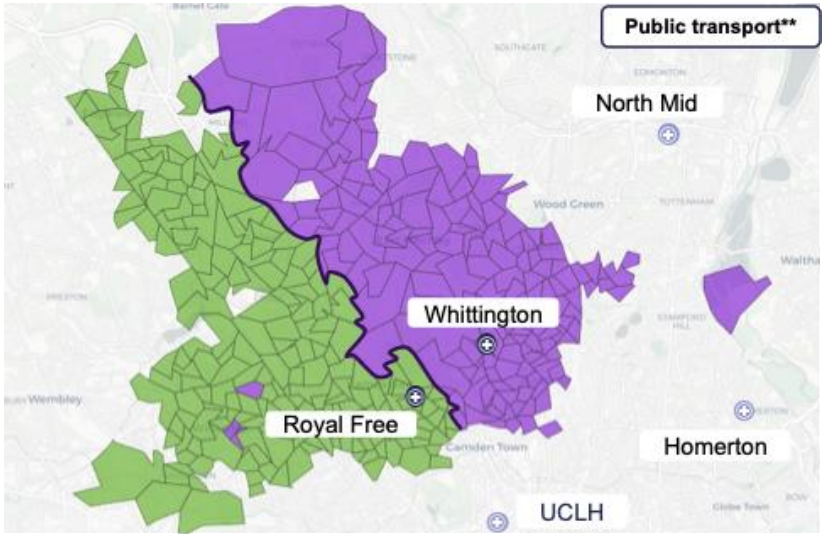
- We identified the people who may be impacted by the proposals (the ‘catchment population’) based on travel times. We identified the catchment population by identifying the geographies whose closest hospital based on travel time is currently Royal Free Hospital or Whittington Hospital.
- We looked at people who may be impacted by our proposals for maternity and neonatal units when driving (or being driven) at peak times. There is a slightly smaller population that could potentially be positively or negatively impacted for option A (~98,000 women of childbearing age) versus option B (~ 113,000 women of childbearing age).
- We also looked at people who may be impacted by our proposals when using public transport. There is a larger population that could potentially be impacted for option A (~91,000 women of childbearing age people) versus option B (~66,000 women of childbearing age people)
- We also looked at where people impacted by option A and option B would be likely to access care if their nearest unit (by travel time) were no longer available





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

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- We engaged extensively and undertook a public health-led literature review to identify people who may be impacted by our proposals to develop the interim IIA
- Our case for change identified vulnerable groups that may be disproportionally impacted by the proposals, we undertook a supplementary evidence review examining inequalities in maternal and neonatal outcomes in the UK, we considered potentially impacted groups using the national CORE20PLUS5 framework and there are nine protected groups that we must consider to fulfil our legal duties
- The public consultation sought feedback on how the proposed changes to maternity and neonatal services may disproportionately impact certain populations and this IIA responds to the feedback received
- Our IIA is therefore focused on people who may be disproportionately impacted by our proposals

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

Potentially impacted populations	How we identified potentially impacted populations					Quantitative analysis possible?
	Protected characteristic	CORE20	Engagement	Case for change	Public consultation	
People living in Core20 areas*		✓	✓	✓	✓	Y
People who are economically inactive					✓	Y
People from minority ethnic groups	✓	✓	✓	✓	✓	Y
People who have poor English proficiency			✓		✓	Y
People with poor health		✓			✓	Y
Inclusion health groups		✓	✓	✓	✓	
People who are LGBTQ+	✓		✓	✓	✓	
People who are transgender	✓				✓	
Religion (particularly Orthodox Jewish community)	✓		✓		✓	Y
Women and people of childbearing age (sex)	✓		✓		✓	Y
Younger pregnant women and people	✓			✓	✓	
Older pregnant women and people	✓		✓	✓	✓	
Pregnant women and people with complex (or pre-existing) health conditions					✓	
Single pregnant women and people					✓	Y
People with disabilities	✓		✓	✓	✓	Y
People with learning disabilities		✓	✓		✓	
People with serious mental illness		✓			✓	

***Note:** Core20 areas refers to people living in the 20% most deprived areas nationally*

We considered where people that may be impacted by our proposals are concentrated in the catchment (1/2)

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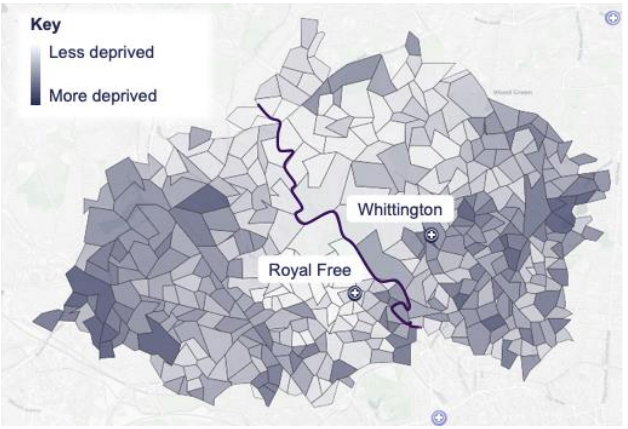
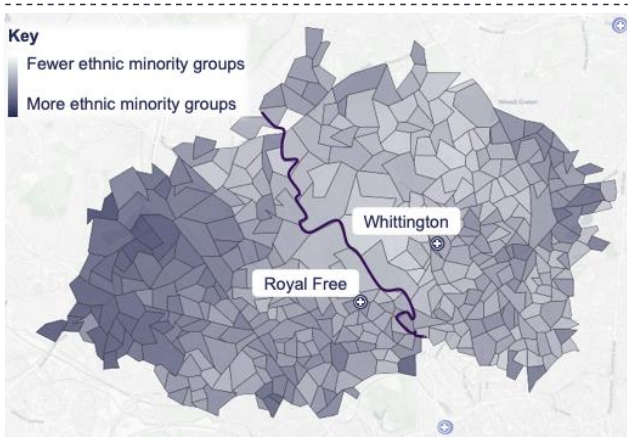
- The most **people living in Core20 areas of deprivation** are concentrated on the western part of the catchment for option A and the eastern part of the catchment for option B. The populations with the fewest people living in areas of deprivation lie around Hampstead and Highgate. Whilst the people living in areas of deprivation around Whittington Hospital are relatively close to the hospital site. The people living in areas of deprivation for Royal Free Hospital are further away.
- There is a concentration of people who are **economically inactive** in the west of the catchment (in the catchment for option A) and around the Whittington Hospital in Islington (the catchment for option B).
- The largest proportion of people from **minority ethnic groups** who could be impacted by potential changes are concentrated in the west around the Royal Free Hospital in Kilburn, Harlesden and Willesden.
- The largest concentrations of people who have **poor English proficiency (including literacy)** are in the west, closer to the Royal Free Hospital (catchment for option A). There is also a large concentration of non-English speakers around Wood Green close to the Whittington Hospital (catchment for option B).
- People with **poor health** are concentrated to the south of the Whittington Hospital and to the east of the Royal Free Hospital. There are also some pockets of people with poor health in the west of the catchment (potentially impacted under option A) in Harlesden and Willesden.

People living in areas of deprivation
Deprivation decile of each LSOA, from 1-10



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



We considered where people that may be impacted by our proposals are concentrated in the catchment (2/2)

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- The percentage of **women and people of childbearing age** is distributed across the catchment population for the Royal Free Hospital whilst there is a concentration of women and people of childbearing age east of the Whittington Hospital (potentially impacted under option B)
- There are pockets **single pregnant women and people** across the catchment population for both options A and B
- The largest concentration of **people with disabilities** are between the Royal Free Hospital and the Whittington Hospital, with an above-average concentration of people with disabilities around the Whittington Hospital
- The largest concentration of **Jewish people, as a proxy for the Orthodox Jewish community,** are to the north west of the Royal Free and Whittington
- **An additional eight groups** were explored using engagement, public consultation and qualitative assessments only: transgender populations, pregnant women and people with complex (or pre-existing) health conditions, people who are LGBTQ+, younger pregnant women and people, older pregnant women and people, people with serious mental illness, people with learning disabilities and inclusion health groups

Single parent household populations
Rate (%) of households containing a single parent with dependent children

People with disabilities
Rate (%) of people with disabilities

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

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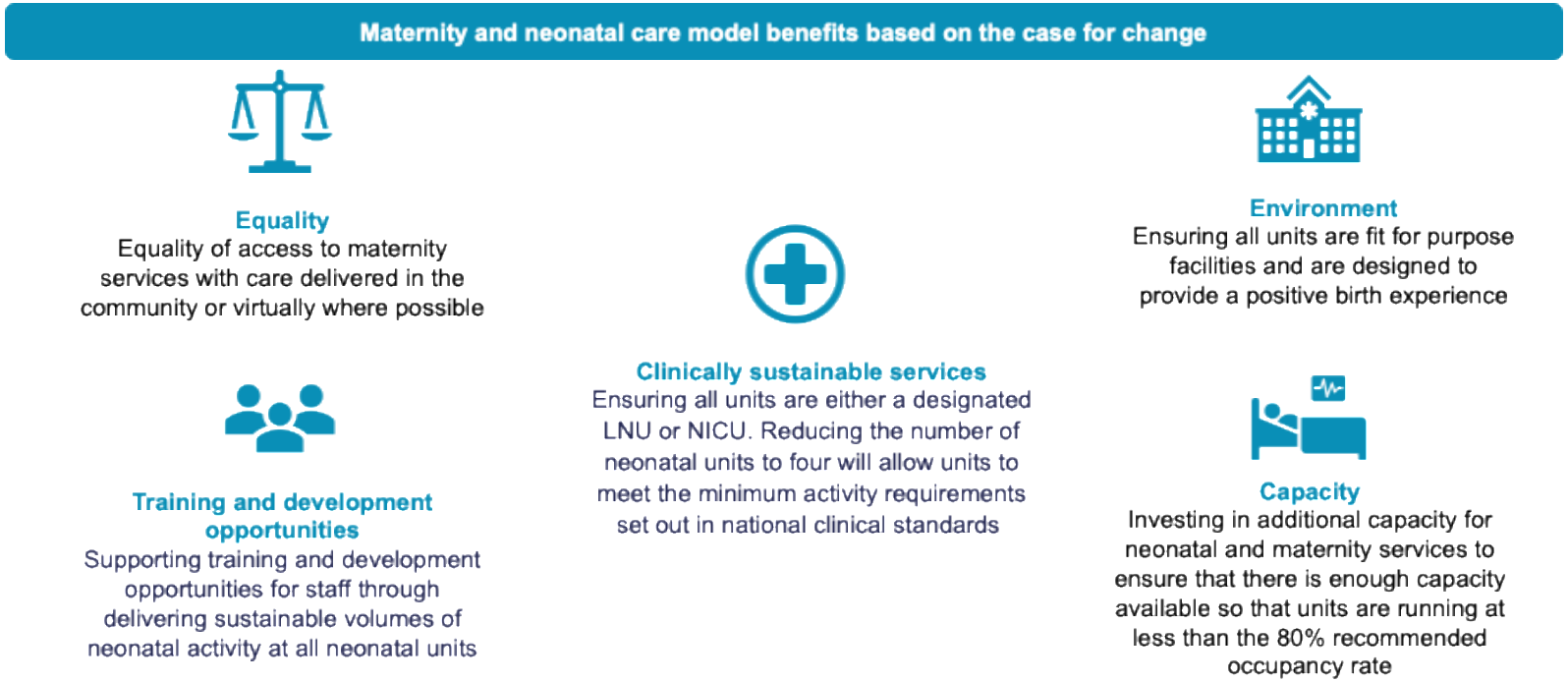
- The proposed new care model would improve quality and experience for service users and staff, and would be delivered under options A and B
- The benefits of the care model and metrics to track them have been developed from, and align to, the opportunities for improvement highlighted in the case for change
- Benefits include improved quality and outcomes, improved recruitment, retention and enhanced staff experience



Metrics have been identified to help understand the potential impact of the proposals on access in each option

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- Following engagement, four access statistics and five impact metrics were identified to review the potential impact of the proposals on access across different demographic groups
- During public consultation, we heard that some key concerns were the additional travel times and associated costs of the proposed changes and the ability to access an unfamiliar unit via public transport or if there was insufficient parking available. No additional statistics or metrics were identified following public consultation.
- We reviewed four access statistics (digital access, public transport accessibility, car ownership and parking spaces) and five impact metrics (travel time (peak/public transport), travel time (peak taxi/private car), travel time (off-peak taxi/private car/ambulance, taxi costs and driving costs) to assess the potential impact of our proposals on access

1 Digital access	Poor digital access might create barriers for accessing care if people cannot access equipment or data
2 Public transport accessibility	Lack of public transport accessibility may make it difficult for people without access to a car to access services
3 Car ownership	Lack of car access may mean people find it difficult to access services, particularly if public transport is not good
4 Parking spaces	Lack of parking might make accessing sites difficult, particularly for vulnerable populations (such as the disabled)

1 Public transport travel time	Additional public time to travel to sites can be difficult and might dissuade people who rely on public transport
2 Peak travel time	Additional time to travel to sites can be difficult for people and might dissuade them from attending
3 Off-peak travel time	Additional time to travel to sites can be difficult for people and might dissuade them from attending
4 Taxi costs	People without access to a car may need to catch a taxi and high taxi costs may be unaffordable
5 Driving costs	Long / expensive journeys might place financial strain on some households

Impact on catchment population
Average impact across catchment population

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
A	Current	32.2	14.2	11.1	£17.59	£2.01
	Future	+ 4.5	+ 5.4	+ 3.8	+ £5.54	+ £0.63
B	Current	27.0	13.4	10.1	£13.52	£1.54
	Future	+ 8.1	+ 6.5	+ 4.9	+ £4.38	+ £0.50

- A potential impact of the proposals on access for the catchment population would be an **average increase in taxi costs of around £5 in either option**
- There would be a **limited increase in average travel times** for peak, off-peak and public transport for options A and B. People in the catchment population would be able to access services, on average:
  - within 20 minutes at peak driving time
  - within 15 minutes at off-peak driving time for options A and B
  - with limited impact on public transport travel times for options A and B, with a maximum average increase of ~8 additional minutes

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

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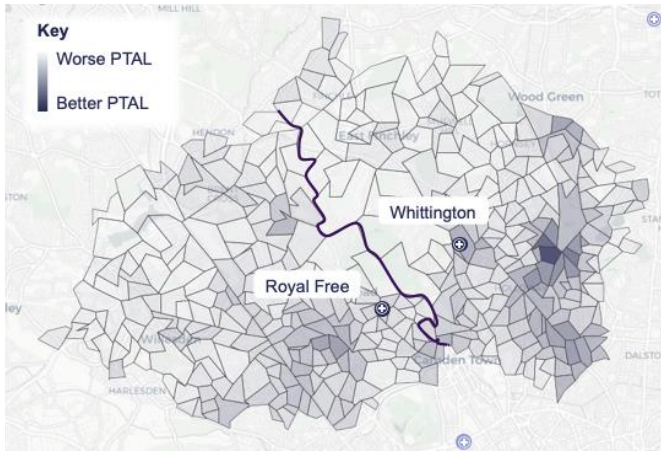
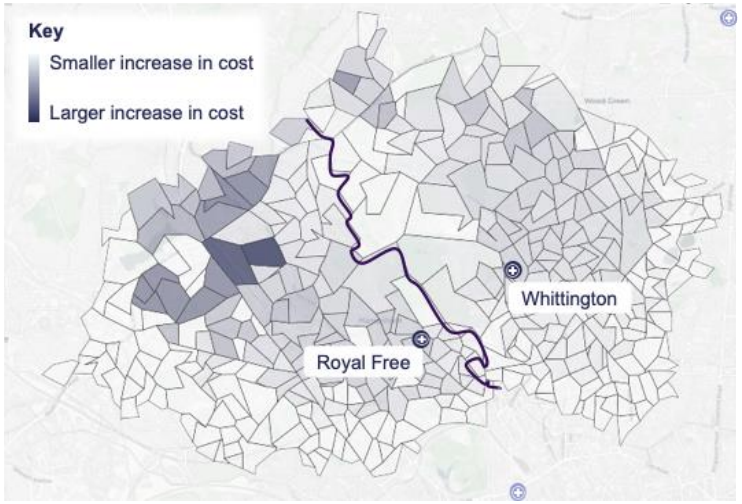
- There would be a similar number of on-site car parking spaces retained for options A and B compared to the status quo
- The catchment population for options A and B have a similar level of public transport accessibility. People generally have better public transport accessibility closer to the centre of London.
- Average additional driving costs would be minimal, and similar for options A and B, with a maximum increase of around £3. The largest increase in driving costs would be for people who live closest to the potentially closing maternity and neonatal unit.

Public transport availability
Public transport availability by option, peak catchment



Increase in taxi costs
Average increase in taxi cost by option



- Average additional taxi costs would be similar for options A and B and around £5 more. People closest to each of the potentially closing sites may need to pay up to an additional £28 per taxi journey as their current taxi costs are very low.
- People have similar access to cars for options A and B, with just under 50% of local people having access to a car. Car ownership varies, with people with disabilities substantially less likely to own a car and a slightly higher number of people with disabilities are potentially impacted in option A.
- Mitigations for these impacts can be found in slides 183-194

Our proposals may impact on people with protected characteristics and people who have vulnerabilities

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- The impact of the proposals on groups who share protected characteristics and people who have vulnerabilities has been reviewed, in line with legal duties, and it is similar to the potential impact on the general catchment population
- We identified that there is a potential impact on some groups that may need to be mitigated
- Further details of mitigations that have been developed are shown later in the executive summary (slides 24-29) and the detailed mitigations can be found in IIA slides 183-199

		Potential impacts that may require mitigations
Protected characteristic	Race	• Impact on the Orthodox Jewish community has been considered as a set of bespoke analysis as they share both the race and religion protected characteristic • No difference between the options for other groups that share this protected characteristic • Language barriers would need to be addressed if people not proficient in English need to access an unfamiliar unit to ensure that they understand the changes and seek the care that they need • The Somali communities in Harlesden and Willesden and Finsbury Park may need to travel further or switch hospital compared to now
	Age	• No difference between the options • Older and younger women of childbearing age may need to attend more appointments throughout their pregnancy due to increased complexity and therefore could be impacted if the appointments were further away compared to now
	Sex	• No difference between the options • No specific impacts of the proposals that require mitigations
	People with disabilities	• No difference between the options • People with a disability may have difficulty accessing services on an unfamiliar site compared to now particularly those who may be less likely to drive or be able to afford any additional travel costs
	Being pregnant or on maternity leave	• No difference between options • The proposals are to change services for pregnant women and people and this IIA considers barriers they may face in accessing services when pregnant, in labour or with a newborn baby
	Gender reassignment	• No difference between the options • No specific impacts of the proposals that require mitigation, but improved education of staff and healthcare processes would be considered
	Religion of belief	• Impact on the Orthodox Jewish community has been considered as a set of bespoke analysis as they share both the race and religion protected characteristic • No specific impacts of the proposals that require mitigations for any other religion
	Sexual orientation	• No difference between the options • No specific impacts of the proposals that require mitigations but improved education of staff and healthcare processes across the system should be considered
	Being married or in a civil partnership	• No difference between the options • No specific mitigations required
Other	Orthodox Jewish community	• Greater impact on the Orthodox Jewish community under option A • People from this community who cannot drive or use public transport on Shabbat or on Jewish festivals may have difficulties in accessing services at a different unit to the Royal Free • Initial mitigations have been developed and will be iterated with this community
	People living in Core20 areas	• There is a greater impact on people living in Core20 areas in option B • Potential overlap with race, other inclusion groups and disabilities that should be considered • People living in Core20 areas may have difficulties with cost of transport, digital exclusion and barriers for people who already have children compared to now as a result of the additional travel time
	People in poor health	• No difference between the options • People in poor health may have more complex pregnancies that require additional antenatal appointments during pregnancy which will therefore cause a greater travel time and cost impact of accessing services at an alternative unit
	Pregnant women and people with complex (or pre-existing) health conditions	• No difference between the options (potential overlap with deprivation and disabilities) • People with complex health conditions affecting pregnancy may need to access their specialist care at a different site to their obstetric care
	Other inclusion health groups	• No difference between the options (potential overlap with race, deprivation and disabilities) • People in other inclusion groups may have difficulties with cost of transport, digital exclusion and language barriers compared to now

Two specific geographical areas were identified as being potentially impacted by our proposals

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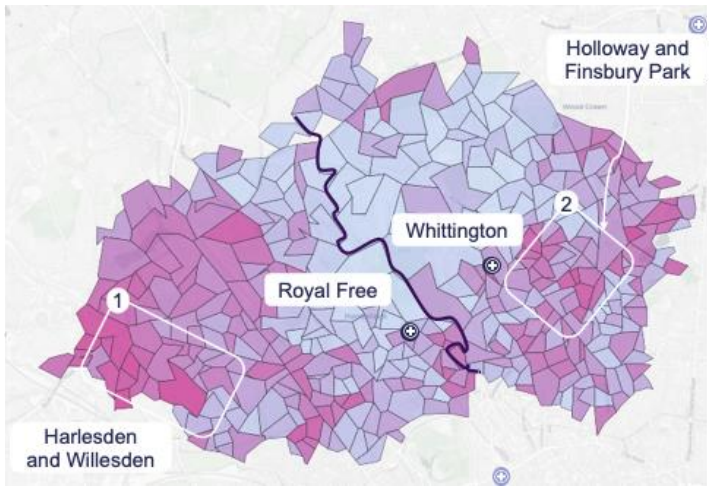
Vulnerability index
Weighted vulnerability rank by LSOA



Weighted vulnerability rank scale

400 = Best

1 = Worst

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

- Two geographical areas were identified as potentially being more vulnerable to the impact of our proposals because residents may face barriers to accessing services as they live in areas of deprivation and have high levels of poor general health. These are: Harlesden and Willesden (option A) and Holloway and Finsbury (option B). This is because:
  - There are Black and Caribbean populations concentrated in these geographies, which are also areas of deprivation, and there is evidence this population have poorer maternity outcomes and poor general health
  - Harlesden has a large proportion of Bangladeshi and Pakistani populations, who also live in areas of deprivation, who have poor general health and are more likely to have worse maternal health outcomes
- As a result of the proposals, people in this Harlesden and Willesden (option A), and Holloway and Finsbury (option B) may need additional support to:
  - Access the hospital site if they have a disability/in poor health or are not proficient in English
  - Travel to hospital by taxi, if required, as it would cost an additional £4-5
  - Access services online as they may have low digital proficiency
  - Care for other family members as they may be a single parent
- Residents living in these areas targeted as part of the public consultation with 12 events and activities in Harlesden and Willesden and 8 events and activities in Holloway and Finsbury Park
- Mitigations have since been developed based on the feedback that was received during the consultation regarding increases in travel times and associated costs

There would be an increase in emissions within air quality management areas

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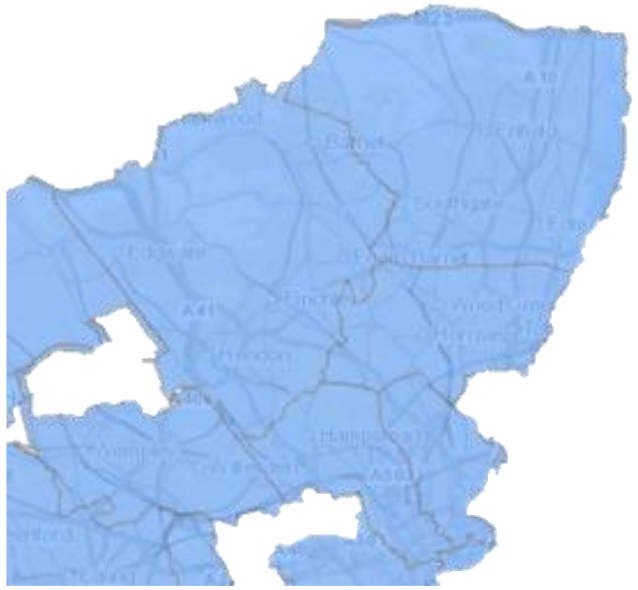
- Following engagement, we identified four sustainability metrics to explore the potential sustainability impact: travel carbon impact, building carbon impact, protected air quality and anchor institutions. No further metrics were suggested during the public consultation.
- There may be a small, similar travel carbon impact for options A and B due to the small increase in travel distances and increased vehicular emissions may need to be mitigated as options A and B are within air quality management areas (AQMAs)
- Refurbishment carbon emissions for the Whittington Hospital and Royal Free Hospital would be mitigated as part of their net zero strategy for their wider refurbishment programme
- In options A and B, there would be little impact on the hospitals in their wider role as anchor institutions compared to now as the services represent a small percentage of the hospitals' overall workforce
- Mitigations for the environmental impact for accessing maternity and neonatal care have been developed including expanding neonatal community care provision through hospital at home and where appropriate delivering virtual maternity outpatient appointments to reduce travel emissions for accessing care

Air Quality Management Areas across the the catchment are shaded in blue



Total impact on the workforce

Current workforce by funded establishment WTE that may be moved as a % of the total clinical workforce (2023/24)

Option	Total workforce moved (clinical staff only)	Percentage of total workforce
Option A	214.2	5.6%
Option B	290.2	8.4%

Summary of the potential impacts of option A (1/2)

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	Option A
Population	• There is a slightly smaller population that could potentially be impacted for option A when driving (~98,000 people) compared to option B (~113,000 people) but there would be a larger impacted population for public transport in option A (~91,000 people) compared to option B (~66,000 people) • There is a larger proportion of people from minority ethnic groups and the Orthodox Jewish community that may be impacted in option A compared to option B
Quality	Option A and B would deliver the proposed maternity and neonates care model, and would therefore deliver many benefits: • Care that ensures equity of provision and experience • Services which are clinically sustainable • Capacity to meet projected demand • Up to date estate and buildings which are fit for purpose • Training and development opportunities • Provide choice for pregnant women and people
Access	• Average increase in taxi costs would be ~£5.54 and the average increase in driving costs per journey would be ~£0.63 compared to now, with 48% car ownership in the local population. • Average travel times would increase by ~5.4 mins by car and ~4.5 mins by public transport compared to now. People in the catchment population would be able to access services within ~30 mins at peak driving time and within ~23 mins at off-peak.
Sustainability	• There would be an increase in carbon emissions of ~251g per average journey as a result of slightly increased travel times • There would be environmental gains to be made in making buildings more energy efficient compared to now • ~214 WTE of staff may move between sites, with the estate being retained and repurposed so there would be likely to be little impact on hospitals as anchor institutions

Summary of the potential impacts of option A (2/2)

North Central London Health and Care
Integrated Care System

Option A	
Populations with protected characteristics and people who have vulnerabilities	• Greater impact on the Orthodox Jewish community compared to option B due to the ties with the Royal Free Hospital built up over time, the religiously and culturally sensitive care provided there and the proximity of the hospital, particularly impacting visitors arriving on foot on religious festivals and Shabbat. • People from minority ethnic groups may face language barriers when travelling to, and accessing, a different site • Somali community in Kilburn may face difficulties travelling to, and accessing, their closest hospital which would change from the Royal Free Hospital to Northwick Park Hospital or St Mary's Hospital • People with disabilities may have difficulties changing service location, especially without access to a car, compared to now • People from single parent households may have difficulties travelling further if they already have children compared to now • People living in areas of deprivation and those that are economically inactive may face difficulties with cost of transport, digital exclusion and already having children • People in poor health may have more complex pregnancies that require additional antenatal appointments during pregnancy which will therefore cause a greater travel time and cost impact of accessing services at an alternative unit • Some pregnant women and people with complex (or pre-existing) health conditions who attend Royal Free Hospital would need to access their obstetric care at a different site to their specialist care in the future, which would mean accessing an unfamiliar unit. In either option, this may result in less joined up care • Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language • The Bangladeshi and Pakistani population in Chalk Farm are close to a maternity unit that may move in option A, and therefore would be more impacted in terms of travel times compared to option B
Geographical populations	• Harlesden and Willesden was identified as a geography that could be particularly vulnerable to the proposed changes in Option A compared to now, with poor health outcomes, poor digital access, and poor English proficiency. This population also a high number of Black African and Black Caribbean people in it alongside Bangladeshi and Pakistani people • This population, by public transport, are already able to access Northwick Park Hospital and St Mary's Hospital more quickly than the Royal Free Hospital. Therefore, they may not be significantly impacted by increased transport costs compared to now. • This population may face barriers to attending an unfamiliar site

Summary of the potential impacts of option B (1/2)

North Central London Health and Care
Integrated Care System

	Option B
Population	• There is a larger population that could potentially be impacted for Option B when driving (~113,000 people) compared to Option A (~98,000 people). There are fewer people impacted for Option B via public transport in Option B (~66,000 people) compared to Option A ~91,000 people) • There is a larger proportion of people that may be impacted that live in areas of deprivation in option B compared to option A
Quality	Option A and B would deliver the proposed maternity and neonates care model, and would therefore deliver positive clinical impact: • Care that ensures equity of provision and experience • Services which are clinically sustainable • Capacity to meet projected demand • Up to date estate and buildings which are fit for purpose • Training and development opportunities • Provide choice for pregnant women and people
Access	• Average increase in taxi costs would be ~£4.38 and the average increase in driving costs would be ~£0.50 per journey compared to now, with ~45% car ownership. • Average travel times would increase by ~6.5 mins by car and ~8.1 mins by public transport compared to now. People in the catchment population would be able to access services within ~28 mins at peak driving time and within ~21 mins at off-peak compared to now.
Sustainability	• There would be an increase in carbon emissions of ~181g per average journey as a result of slightly increased travel times. • There would be environmental gains to be made in making buildings more energy efficient • ~290 WTE of staff may move between sites, with the estate being retained and repurposed so there would be likely to be little impact on hospitals as anchor institutions

Summary of the potential impacts of option B (2/2)

North Central London Health and Care
Integrated Care System

	Option B
Populations with protected characteristics and people who have vulnerabilities	• People from minority ethnic groups may face language barriers when travelling to, and accessing, a different hospital site • The Somali community in Finsbury Park would access services at the Royal Free rather than the Whittington Hospital. Given their proximity to the Whittington Hospital, they may be impacted by the relatively higher increases in taxi costs to an alternative maternity unit compared to now. • People living in areas of deprivation in option B are nearer to the maternity unit that may move, so the impact may be more significant for this population compared to option A (people may pay up to ~£11 more to travel by taxi). These people and those that are economically inactive may face difficulties with cost of transport, digital exclusion and already having children when travelling further or to a new site • People from single parent households may have difficulties travelling further if they already have children compared to now • People with disabilities may have difficulties changing service location, especially without access to a car, compared to now • People in poor health may have more complex pregnancies that require additional antenatal appointments during pregnancy which will therefore cause a greater travel time and cost impact of accessing services at an alternative unit • Some pregnant women and people with complex (or pre-existing) health conditions who attend Whittigton Hospital would need to access their obstetric care at a different site to their specialist care in the future, which would mean accessing an unfamiliar unit. In either option, this may result in less joined up care • Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language when travelling further or to a new site
Geographical populations	• Holloway and Finsbury Park was identified as a geography that could be particularly vulnerable to the changes in Option B, with poor health outcomes, poor digital access, and poor English proficiency - this population has a high number of Black African and Caribbean in it • This population is located close to the maternity unit that may move, and are therefore likely to be more impacted by increased travel time and cost compared to now, although public transport accessibility in this area is better than for Option A • This population may face barriers to attending an unfamiliar site compared to now

We are considering several potential impacts that may require mitigations

North Central London Health and Care
Integrated Care System

As the programme progresses, we need to **continue to understand the impact of proposals** through **further engagement** with potentially impacted groups. It is particularly important to ensure we **hear from groups that are less likely to engage**, or **where there are barriers** for them to do so. (See slide 183)

Should a decision be taken to implement changes, the **changes need to be well communicated and accessible to residents**. Mitigations will need to be put in place to ensure that **all groups are informed of changes**, and they **understand their choices for maternity care**. **Clear information needs to be available** to support both **choice of maternity unit** and **birth setting** to meet the needs of expectant parents. (See slide 184)

There are some service users for whom **changes may mean attending a different hospital than they are used to**. This change may be more **difficult** for some service users, and they would need **extra support to manage this and consider accessibility to this site.** (See slides 185-186)

Should a decision be taken to implement any changes, it may result in service users going to a different hospital they are unfamiliar with. This may lead to **changes to journeys to hospital that people are used to**. Mitigations would be needed to ensure that people have **information to plan their journeys to hospital.** (See slides 187)

There may be an impact on the **cost of travel** should changes be implemented – **particularly for people who travel by taxi**. There will be some service users who are more impacted by this than others, and it is important that patients **understand what is available to support them with cost of travel to hospital** and that any **additional travel costs do not create a barrier to accessing care.** (See slide 189)

Access to parking spaces is variable across NCL sites. **Parking** has been raised as a particular consideration for parents who have a baby **admitted to a neonatal unit** given their need to visit their child on an ongoing basis and in some instances over an extended period. Mitigations may be needed around **parking to ensure that families can easily visit their child by car.** (See slide 190)

Women and people with complex (or pre-existing) health conditions are currently looked after under networked arrangements with input from both obstetric physicians and other specialists. Mitigations would be needed to ensure that pregnant women and people with complex (or pre-existing) health conditions could continue to access the specialist and obstetric care they need. (See slide 192)

More detailed mitigations have been developed for the potential impacts of the recommended option (1/6)

North Central London Health and Care
Integrated Care System

Impacts	Mitigations	What we think
Average increase in taxi costs would be £5.54 and the average increase in driving costs per journey is £0.63, with 48% car ownership compared to now.	• Ensure that patients understand what is available to help with the cost of travel to hospital such as a discussion at time of booking and providing information on Trust-level arrangements. • Ensure that any additional travel costs do not create a barrier to accessing care including supporting patients with travel costs through Healthcare Travel Costs Scheme and working with charitable partners and the voluntary sector	• We believe that the mitigations would reduce the potential impact, especially as the additional driving costs are small
Average travel times would increase by 5.4 mins by car and 4.5 mins by public transport compared to now. People in the catchment population would be able to access services within 30 mins at peak driving time and within 23 mins at off-peak.	• Aim to deliver as much care as close to home as possible as part of the proposed care model including utilising family hubs and children's centres to minimise travel times. • Where possible, provide more virtual appointments when clinically recommended as part of the proposed maternity care model	• We believe that the mitigations would reduce the potential impact especially as the additional travel times are small
There is an increase in carbon emissions of 251g per average journey as a result of slightly increased travel times	• Appropriate appointments would be provided in community settings or online which reduce the need to travel to a hospital site and would support a reduction in the overall number of journeys taken to access maternity care. • Expansion of neonatal community care through hospital at home as part of the proposed neonatal care model would reduce the need for families to travel to hospital therefore reducing carbon emissions • Through the refurbishment that would be undertaken, buildings would increase in their energy efficiency which would offset some impact of increasing emissions	• We believe that the mitigations would reduce the potential impact
214 WTE of staff moved between sites, with the estate being retained and repurposed so there is likely to be little impact on hospitals as anchor institutions	• Whilst some workforce would be moved, the overall impact as a proportion of the total available workforce, meaning the impact on the resources available to local communities, would be likely to be relatively small. • We believe no mitigations are necessary as the number is so small it would not impact the local community	• We believe no mitigations are necessary

More detailed mitigations have been developed for the potential impacts of the recommended option (2/6)

North Central London Health and Care
Integrated Care System

Impacts	Mitigations	What we think
People with disabilities may have difficulties changing service location, especially without access to a car, compared to now	• When scheduling appointments, steps would be taken to ensure service users with a disability, or those with a family member with a disability, particularly children, are offered appointments at the most suitable time to allow them to travel into central London when it is most convenient	• We believe that the mitigations would remove/reduce the potential impact
People from single parent households may have difficulties travelling further if they already have children compared to now	• When scheduling appointments, steps would be taken to ensure single parents who already have children are offered appointments at the most suitable time to allow them to travel into central London when it is most convenient	• We believe that the mitigations would remove/reduce the potential impact
People living in areas of deprivation and those that are economically inactive may face difficulties with cost of transport, digital exclusion and already having children	• Ensure that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care • We would ensure appointments are at the most appropriate times for service users • We would ensure there is accessible information about choices of maternity care available in non-digital formats for those who are less able to access the internet	• We believe that the mitigations would remove/reduce the potential impact
People in poor health may have more complex pregnancies that require additional antenatal appointments during pregnancy which will therefore cause a greater travel time and cost impact of accessing services at an alternative unit	• Aim to deliver as much care as close to home as possible to minimise travel times and where possible, provide virtual appointments when clinically recommended • Ensure that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care	• We believe that the mitigations would reduce the potential impact

More detailed mitigations have been developed for the potential impacts of the recommended option (3/6)

North Central London Health and Care
Integrated Care System

Impacts	Mitigations	What we think
People from minority ethnic groups may face language barriers when travelling to, and accessing, a different site as they are less familiar with the journey, which may also be more complex, and therefore this population may need support to travel elsewhere	• Clear information would be provided to service users about travel and transport options to all maternity units. • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted	• We believe that the mitigations would reduce the potential impact
Somali community in Kilburn may face difficulties travelling to, and accessing, their closest hospital which would change from the Royal Free Hospital to Northwick Park Hospital or St Mary's Hospital. Additional difficulties may arise from English not being their first language so may need additional support in travelling to one of these alternative units	• Patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments • We would offer detailed information about how to navigate to the right area of the hospital where appointments or admissions are scheduled, as part of communication with service users • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted	• We believe that the mitigations would reduce the potential impact
The Bangladeshi and Pakistani population in Chalk Farm are close to a maternity unit that may move in Option A, and therefore may be more impacted in terms of travel times compared to other groups	• Aim to deliver as much care as close to home as possible to minimise travel times and where possible, provide virtual appointments when clinically recommended • Ensure that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care	• We believe that the mitigations would reduce the potential impact

More detailed mitigations have been developed for the potential impacts of the recommended option (4/6)

North Central London Health and Care
Integrated Care System

Impacts	Mitigations	What we think
Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language	• Ensure that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care • We would ensure there is accessible information about choices of maternity care available in non-digital formats for those who are less able to access the internet • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted	• We believe that the mitigations would reduce the potential impact
Harlesden and Willesden was identified as a geography that could be particularly vulnerable to the proposed changes in Option A compared to now, with poor health outcomes, poor digital access, and poor English proficiency. This population also a high number of Black African and Black Caribbean people in it alongside Bangladeshi and Pakistani people. This population may face barriers to attending an unfamiliar site.	• Some specific mitigations that would be taken forward for this population are around the communication of changes being available in accessible formats and in different languages, supporting continuity of carer in the community to deliver care as close to home as possible, supporting populations with the cost of travel • Working with NWL partners we would continue to engage with residents of Harlesden and Willesden during implementation to understand any unanticipated impacts and develop further mitigations if necessary	• We believe that the mitigations would reduce the potential impact

More detailed mitigations have been developed for the potential impacts of the recommended option (5/6)

North Central London Health and Care
Integrated Care System

Impacts	Mitigations	What we think
• Pregnant women and people with the most complex (or pre-existing) health conditions who attend Royal Free Hospital would need to access their obstetric care at a different site to their specialist care in the future, which would mean accessing an unfamiliar unit. In either option, this may result in less joined up care • Some of these pregnant women and people may need to access obstetric care at a unit that is not their next closest, because of their needs, which means they would need to travel further than the general population • Some minority ethnic groups and people living in areas of deprivation associated with poorer maternity outcomes are likely to be disproportionately represented amongst those with the most complex (or pre-existing) health conditions, although these are very small numbers	• Support clinicians to work together to deliver care within current networked arrangements, utilising technology and virtual appointments where appropriate to link in all relevant clinicians, to minimise the impact on pregnant women and people with complex (or pre-existing) health conditions that may need to access specialist and obstetric care at different sites and ensure care remains joined up. • Provide clear information to service users about travel and transport options to all alternative units where they may need to access specialist or obstetric care to meet their specific needs. Ensuring that information is available in different languages that meets the needs of the population and is in accessible formats including non-digital to support those with poor digital access • We would offer women and pregnant people opportunities to visit unfamiliar sites outside of planned appointments or birth to familiarise themselves with the unit and patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments • Raise awareness of schemes to support patients with travel costs, as well as how to make a claim. Ensure that all information is available in different languages and formats to suit needs of service users. Including: - Healthcare Travel Costs Scheme - financial assistance for patients, who do not have a medical need for ambulance transport, and their carers but who require assistance with their travel - ULEZ and Congestion Charge reimbursement schemes where applicable - Blue badge schemes - support key groups with travel and increasingly being made available to those with a mental health conditions	• We believe that the mitigations would reduce the potential impact

More detailed mitigations have been developed for the potential impacts of the recommended option (6/6)

North Central London Health and Care
Integrated Care System

Impacts	Mitigations	What we think
Greater impact on the Orthodox Jewish community compared to option B due to the ties with the Royal Free Hospital built up over time, the religiously and culturally sensitive care provided there and the proximity of the hospital, particularly impacting visitors arriving on foot on religious festivals and Shabbat.	• Remaining units would work with the community to develop Trust-level action plan to build on existing provision of culturally and religiously sensitive care • Action plans may cover areas such as staff training, Kosher food, communication, religious requirements around the observance of Shabbat including families remaining in hospital and working relationships between the population and NCL hospitals • Following a decision, the proposed mitigations would be further tested with the Orthodox Jewish community and its leaders throughout implementation to ensure key concerns are captured and mitigated against. Agreed mitigations would be monitored and evaluated by a working group which would include members of Orthodox Jewish community	• We believe impacts related to the provision of religiously and culturally sensitive care can be fully mitigated at alternative units in NCL through the measures identified and careful close working with the Orthodox Jewish community • We believe the impact regarding the religious requirements of the observance of Shabbat for families staying in hospital can be fully mitigated through the measures identified and careful close working with the Orthodox Jewish community • Members of the Orthodox Jewish community currently access maternity care, and other forms of care, from other hospital sites within NCL, so we know that it is possible to mitigate these impacts, and we need to learn from and build on these experiences • However, we acknowledge that for those who wish to visit someone in hospital on Shabbat or visitors who need to leave hospital on Shabbat, there may be impacts that cannot be mitigated. Specifically, those walking to and from the hospital are likely to have to walk further, as overall travel times will be greater. Further, Royal Free Hospital is in an eruv (enabling some relaxation of the prohibition of carrying items outside the house on Shabbat), whereas other hospitals are not. • We will continue to work with the community to mitigate the impact of these issues as far as possible, including by scheduling procedures around Shabbat wherever possible, but they cannot be completely eliminated.

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

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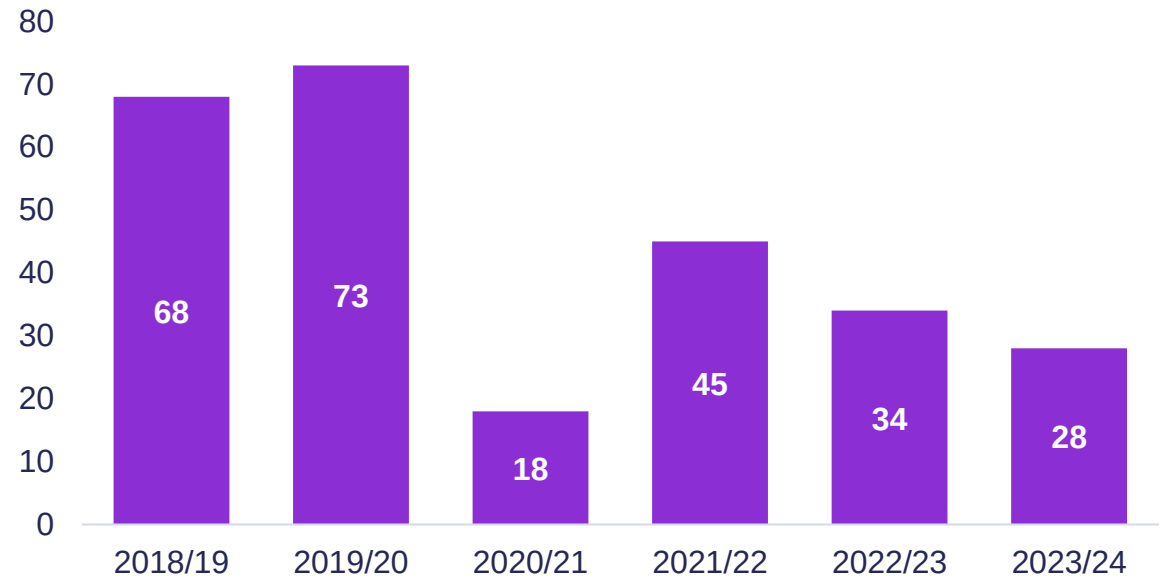
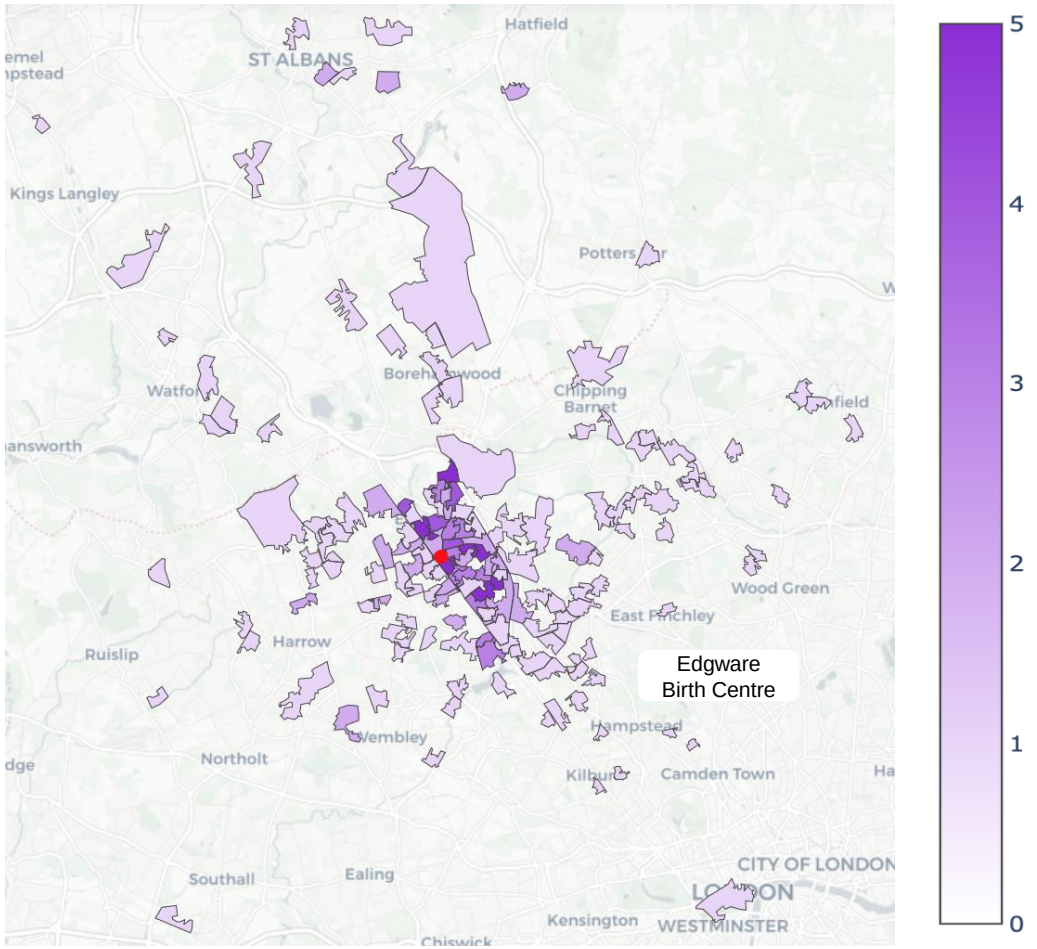
- The Start Well programme also consulted on proposals to close the birthing suites at Edgware Birth Centre (EBC)
- Our proposals for EBC would impact on people who might have wanted to give birth at the unit. This is anticipated to be a very small number given only 28 pregnant women and people gave birth there in 2023/24.
- The population who give birth at EBC are also extremely geographically dispersed.
- The number of births are so small and the geographical spread so wide, it is hard to say whether any group might be disproportionally impacted.

Number of deliveries at Edgware*, *2018/19 – 2023/24*



*Numbers of births in 2020/21 impacted by the birth centre being temporarily closed for some periods due to the COVID-19 pandemic

LSOAs that have delivered at Edgware between 18/19 and 23/24



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

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		Potential impacts that may require mitigations
Protected characteristic	Race	• No evidence to suggest there would be a differential impact. This is because of the low number of women and people who use the unit.
	Age	• Women and pregnant people are more likely to use a standalone birthing centre for a second or subsequent birth, so while the closure of the birthing suites reduces choice for all service users, this may have a disproportionate impact on older service users.
	Sex	• No evidence to suggest there would be a differential impact
	People with disabilities	• People with some disabilities may find a non-hospitalised environment less stressful so may be disproportionately impacted by the closure of the birth suites.
	Being pregnant or on maternity leave	• No evidence to suggest there would be a differential impact
	Gender reassignment	• No evidence to suggest there would be a differential impact
	Religion of belief	• No evidence to suggest there would be a differential impact
	Sexual orientation	• No evidence to suggest there would be a differential impact
	Being married or in a civil partnership	• No evidence to suggest there would be a differential impact
Other	Pregnant women and people with complex (or pre-existing) health conditions	• No evidence to suggest there would be a differential impact as pregnant women and people with complex (or pre-existing) health conditions do not have the clinical profile to use a standalone midwife led unit
	People living in areas of deprivation	• No evidence to suggest there would be a differential impact
	Other inclusion health groups	• People who have undergone some types of trauma may be more comfortable in a non-hospitalised environment

Mitigations have been developed for the potential impacts of the Edgware proposals

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Impacts	Mitigations	What we think
Women and pregnant people are more likely to use a standalone birthing centre for a second or subsequent birth, so while the closure of the birthing suites reduces choice for all service users, this may have a disproportionate impact on older service users.	• Investing in co-located midwife-led units and making sure that the environment is set up in a way that facilitates the best outcomes for pregnant women and people who choose them • Home birthing would remain a choice for pregnant women and people, and we would ensure that this is consistently available for those that would prefer a birth that is physically separated from a hospital site • Ensure that women for whom this is a preference can retain access to high-quality consistently available midwifery-led care	• We believe that the mitigations will remove/reduce the potential impact
People with some disabilities may find a non-hospitalised environment less stressful so may be disproportionately impacted by the closure of the birth suites.	• Investing in co-located midwife-led units and making sure that the environment is set up in a way that facilitates the best outcomes for pregnant women and people who choose them • Home birthing would remain a choice for pregnant women and people, and we would ensure that this is consistently available for those that would prefer a birth that is physically separated from a hospital site • Ensure that women for whom this is a preference can retain access to high-quality consistently available midwifery-led care	• We believe that the mitigations will remove/reduce the potential impact
People who have undergone some types of trauma may be more comfortable in a non-hospitalised environment	• Investing in co-located midwife-led units and making sure that the environment is set up in a way that facilitates the best outcomes for pregnant women and people who choose them • Home birthing would remain a choice for pregnant women and people, and we would ensure that this is consistently available for those that would prefer a birth that is physically separated from a hospital site • ensure that women for whom this is a preference can retain access to high-quality consistently available midwifery-led care	• We believe that the mitigations will remove/reduce the potential impact

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Background to the Integrated Impact Assessment (IIA)

Summary: background to the Integrated Impact Assessment (IIA)

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- We have developed proposals for maternity and neonatal services in NCL as part of the Start Well programme
- An interim integrated impact assessment (IIA) was completed in Summer 2023 and used to understand the potential impact of the proposals on local people
- Prior to consultation, we undertook engagement regarding our proposals which reached over 120 patients, residents and staff and contributed to a better understanding of the potential impact on service users
- Since the interim IIA was published, a public consultation was undertaken to gather further feedback on the proposals
- The consultation was robust, reaching thousands of people including those identified by the interim IIA as being potentially more impacted by the proposals such as the Orthodox Jewish community and those living in Core20 areas of deprivation
- This IIA is a refresh of the interim IIA to consider consultation feedback using updated data where available and the same robust approach, assessing our proposals for clinical, accessibility, sustainability and geographical impact
- During implementation, we would continue to engage with the public, staff and stakeholders to develop and implement mitigations

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

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Background to Start Well Programme

- In November 2021, the partner organisations who make up NCL's Integrated Care System (ICS) formally launched a long-term programme looking at maternity, neonatal, children and young people's services, called the Start Well programme.
- There were several drivers for starting this work:
  - The calls to action set out in the NHS Long Term Plan and the initial Ockenden Report
  - The learning from the temporary changes to local children and young people's services in NCL during the COVID-19 pandemic
  - External reviews of services across NCL sites by the Care Quality Commission (CQC) and NHS England (NHSE) 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 during the transition to a formal integrated care system
- A **case for change** was published in June 2022 which set out how services are currently delivered and highlighted some **opportunities for the future**
- **Engagement on the case for change** took place over Summer 2022 and a report summarising this was published in September 2022
- An **options appraisal**, which is a formal process that considers **all viable options against the status quo** (how services are currently delivered) and their feasibility, was undertaken and options for consultation were identified
- The ICB undertook a **14-week public consultation from 11 December 2023 to 17 March 2024** seeking feedback on proposals which will inform subsequent decision making
- A Decision-Making Business Case (DMBC) has been developed to agree the option for implementation

Purpose of the IIA

- NCL Start Well developed **an interim Integrated Impact Assessment (IIA)** to assess and understand the potential impact of options A and B for consultation and identified **high level mitigations** to any potential negative impacts
- This updated IIA contains newer data and travel times, to support consideration of the DMBC and considers any additional potential impacts raised during the public consultation and more detailed mitigations

We have used the IIA to explore the potential impact of our proposals on local people

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Purpose of the Integrated Impact Assessment (IIA)

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

Compliance with Public Sector Equality Duty (PSED)

- Have due regard to:
  - Eliminate unlawful discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Equality Act 2010
  - Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
  - Foster good relations between people who share a relevant protected characteristic and those who do not share it

Health and Care Act 2022

- NHSE, ICBs and NHS Trusts and Foundation Trusts are subject to the 'triple aim' duty in section 14Z43 of the National Health Service Act 2006 (as amended by the Health and Care Act 2022) which requires these bodies to have regard to 'all likely effects' of their decision in relation to:
  1. Health and wellbeing of people (including inequalities)
  2. The quality of health services provided to people (including inequalities in benefits from those services)
  3. Efficiency and sustainability in relation to the use of resources
- Each integrated care board must, in the exercise of its functions, have regard to the need to:
  a. reduce inequalities between persons with respect to their ability to access health services, and
  b. reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services (including the outcomes described in section 14Z43(3))

Source: https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted, Section 149 of the Equality Act 2010

In particular, the IIA tests whether the proposals directly or indirectly discriminate

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- The refreshed IIA tests whether the proposed changes to maternity and neonatal services would disadvantage anyone sharing a protected characteristic or anyone that is part of a specific population that has been identified during the programme as a group that could potentially be impacted by the proposals
- In particular the IIA tests for:
  - **Direct discrimination** occurs where a service provider treats a person less favourably than they treat or would treat others because of a protected characteristic. (Section 13, Equality Act 2010)
  - **Indirect discrimination** occurs where a service provider applies a provision, criterion or practice (PCP) that puts persons sharing a protected characteristic at a particular disadvantage compared to those without that characteristic unless justified as a proportionate means of achieving a legitimate aim (Section 19, Equality Act 2010).
- Our view is that our maternity and neonatal proposals would not amount to either direct or indirect discrimination

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

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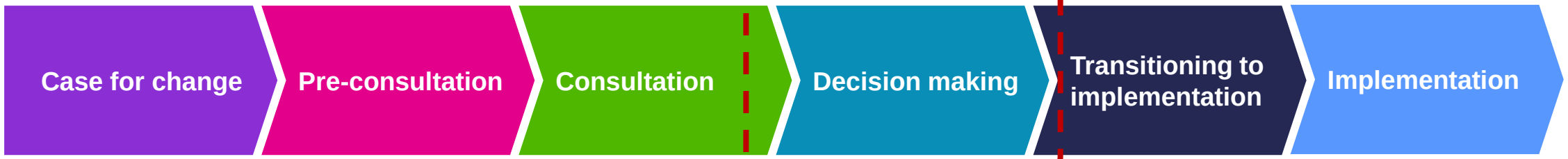
Integrated Care System

Assess current inequalities and agree ambition

Engage with groups with vulnerabilities and those with protected characteristics

Implement agreed mitigations for potential impacts which will continue to be reviewed to meet the continuing duty

Current stage



Identifying the need for change and vision for the future

Identifying the options for change

Explaining the options and seeking views

Refining and agreeing the change

Meeting legal challenge and securing capital – building in time for unexpected delays

Implementing change

Include inequalities in options appraisal and assess potential impact of proposals on inequalities and groups with vulnerabilities in the IIA

Re-assess potential impact of proposals and agree mitigations for groups with protected characteristics and vulnerabilities

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

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1 Understand proposed service changes

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

2 Identify potentially impacted populations

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

3 Understand the potentially impacted groups

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

4 Assess impact of proposals on populations

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

5 Agree mitigations

- Agree steps to mitigate against any negative impacts and enhance any benefits or consider whether any negative impacts which cannot be mitigated can be justified as a proportionate means of achieving a legitimate aim

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

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

Clinical

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

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

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

Accessibility

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

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

Sustainability

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

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

Geographic

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

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

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

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Groups scoped into Start Well maternity and neonatal IIA engagement

'Older' women (35+)	Women with physical disabilities	Asian women	Jewish women	People living in areas of deprivation
Parents who are carers	Women with long-term health conditions	Muslim women	Families who have experienced bereavement	People with poor literacy
Women with learning disabilities	Inclusion health groups (e.g., asylum, homelessness)	Parents with experience of neonatal care	Gypsy, Roma and Traveller communities	No further groups were identified as part of the public consultation completed in early 2024
Black women	People who are LGBTQ+ parents	Women who have given birth at Edgware	Eastern European women	

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

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

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

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

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Interim IIA engagement reach

38 engagement meetings facilitated

124 people, residents and staff have been involved

9 sessions with parents who have recent experience of neonatal care

5 meetings with specialist midwives supporting women with complex needs

People reached through engagement:

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

Engagement on the programme did not stop at this stage. We engaged with groups not reached through initial interim IIA engagement, as well as other groups, during consultation.

Since the interim IIA was published, a public consultation was undertaken to gather feedback on the proposals

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The Start Well programme set out to **deliver a 14-week public consultation** in line with best practice that complies with legal requirements and duties. The aim was to:

- Provide clear and accessible information about proposals and how they have been developed
- Allow time and opportunities for feedback from staff, residents, and stakeholders
- Ensure diverse voices are heard
- Seek alternative proposals or new evidence
- Understand the pros, cons and unintended consequences of the proposals
- Explore mitigations for any disadvantages
- Find out what matters most to patients and how this might affect implementation
- Ensure feedback was recorded and could be analysed to support thoughtful decision-making

We achieved this through:

- Developing a range of materials that explained the consultation proposals in an accessible way
- Ensuring feedback could be shared several ways: questionnaire, telephone, written response, at a focus group and through attending a public drop-in session
- Focussing resources and working with the voluntary sector to reach population groups identified as potentially more impacted through our impact assessments
- Widely promoting the opportunity to take part in the consultation through social media and other promotional opportunities
- Engaging with staff working across services and in the wider NHS
- Identifying local political and other stakeholders to seek their feedback on the proposals

The consultation had a wide reach and included various activities

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Programme team attendance at **199** different meetings or events, reaching just under **3,400 people**, of which:

- **32** were in depth staff feedback sessions with **over 470 participants**
- **26** were promotional drop ins at local hospital sites reaching nearly **600 people**
- **46** were sessions targeted at communities who have protected characteristics or face health inequalities reaching **503 people**

Example communities reached:
Orthodox Jewish community, Black and Asian women's groups, families with learning disabilities, women over the age of 35, women with experience of maternal medicine services, women living in areas of deprivation, people with experience of mental health problems, women and people with poor English proficiency

- **34** were in target geographies as identified by the interim integrated impact assessments reaching **582 residents**
- **8** were local GP meetings reaching **279 GP staff** across NCL as well as Brent and Harrow
- **9** were targeted close the Edgware Birth Centre, reaching **81 staff and residents**

79 written submissions and emails of which:

- **32** came from members of the public
- **47** came from NHS staff, stakeholder organisations and officials

Social media promotion leading to over **720,000** impressions and over **3,670 clicks** through to the consultation website

Video content totalling **1,310 views**

Print adverts placed in **13 local papers** or circulars

Over **40 items of news coverage** in local and national press

Nearly **7,000 letters sent** to households in target geographies

Nearly **9,000 website** views, of which **6,335 were individual users**

3,112 questionnaire responses, of which:

- **2,031** came from members of the public
- **1,060** came from NHS staff
- **21** came from organisations

Feedback was gathered during consultation to understand the potential impact of the proposals

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A questionnaire was developed which was designed to gather feedback on the proposals. The questionnaire had separate questions covering each of the three aspects of the proposals and these questions were then used as a framework for focus groups and meetings that were undertaken to gather feedback. At a high level, these questions covered:

- The **characteristics / demographics** of the person or organisation responding (e.g. gender, age, place of residence, capacity in which they were responding)
- Whether the **challenges described were recognised**, and the extent to which there was agreement that changes are needed
- The **level of support for the proposal described**, and which of the options for maternity and neonatal services was preferred
- Any **alternative solutions** that could address the identified challenges
- Any **equalities impacts** of the proposed changes

There were also a number of other feedback mechanisms made available, including written submission, attendance at meetings / focus groups and drop-in feedback sessions which aimed to capture the same information as the questionnaire.

Further work has been done to consider the consultation feedback, which is reflected in this IIA (1/2)

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Feedback	IIA slides	DMBC section
During consultation, people fed back concerns around increased travel times and travel costs. In the questionnaire, ~16% of comments from individuals described concerns around increased travel distance, cost and decreased access. These themes were reiterated during in-person engagement, e.g., feedback that it is difficult to travel into central London with children with disabilities.	183-199- Detailed mitigations	Section 9.2- Feedback from consultation and assurance on the potential impact of the recommended option
During consultation, concerns around impact were raised regarding the following populations: • Residents from low socioeconomic backgrounds (areas of high deprivation) • Residents who do not speak English • People with disabilities who may not be able to drive • Orthodox Jewish community	183-199- Detailed mitigations	Section 9.2- Feedback from consultation and assurance on the potential impact of the recommended option
The Mayor's office recommended that we correct the language used in PCBC about IMD deciles.	Throughout	Section 9.2- Feedback from consultation and assurance on the potential impact of the recommended option

Further work has been done to consider the consultation feedback, which is reflected in this IIA (2/2)

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Feedback	IIA slides	DMBC section
The Mayor's office recommended that we add detail on environmental impact mitigations specifically for maternity and neonatal care.	Slide 191	Section 9.2- Feedback from consultation and assurance on the potential impact of the recommended option
The Mayor's office recommended that we quantify the proportion of NWL residents affected by our proposals and detail mitigations for longer travel times and costs for NWL residents.	Slide 62- NWL residents impacted Slides 193-194- mitigations	Section 9.2- Feedback from consultation and assurance on the potential impact of the recommended option
During consultation, it was suggested that women from some minority ethnic backgrounds could be disproportionately affected if option A is chosen, as they are statistically more likely to experience poorer maternal outcomes, especially those linked to other serious and long-term health conditions such as diabetes.	Slide 126- impact Slide 192- mitigations	Section 9.2- Feedback from consultation and assurance on the potential impact of the recommended option
Difficulties of travelling further and the negative impact of longer journey times, increased costs and reassurance on the additional parking facilities	183-199- Detailed mitigations	Section 10.4- Joint health overview and scrutiny committee (JHOSC) further assurance

The IIA has been updated to reflect feedback and refreshed data where available

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Based on feedback from the public consultation and updated data where available, this IIA has been refreshed since the interim IIA:

- Used 2024 travel time data to understand the impact on travel times of the proposed changes [interim IIA used 2022 travel times]
- Used 2023/24 activity data as the baseline which determines the catchment population that may be impacted by the proposed changes [interim IIA used 2021/22]
- March 2024 Trust workforce returns used [interim IIA used 2021]
- Pregnant women and people with complex (or pre-existing) health conditions included as a specific group to consider the impact of the proposed changes following feedback from the public consultation
- Iterated and strengthened mitigations for the potential impacts of the proposed service changes following feedback from the public consultation, including for the Orthodox Jewish community

During implementation, we would continue to engage with the public, staff and stakeholders to develop and implement mitigations

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Current stage

Mitigations review
- Post-consultation, reviewing mitigations identified in the interim IIA engagement and consultation discussions

Case for change development
- Review of existing patient experience insights data from 11 different sources
- Establishment of a youth mentoring scheme and youth summits
- Targeted engagement with a small number of patient groups

Care model development
- Establishment of the Patient and Public Engagement Group (PPEG) to review and input into care models
- Feedback from case for change engagement informed their development
- Two youth summits involving 35 young people

Interim IIA Engagement
- 11-week targeted engagement period focussing on those with protected characteristics and at risk of poorer outcomes
- 38 sessions held, reaching 124 patients

Winter 2022 | *Summer 2022* | *Spring / summer 2023* | *Winter 2023 / 2024* | *Winter 2024*

Case for change engagement
- A 10-week engagement programme
- 43 engagement events
- 207 in-depth conversations
- 389 questionnaires completed

Options appraisal
- PPEG responsible for development and initial evaluation of access criteria
- PPEG Chair a member of the programme board and participated in the programme board workshop for the options appraisal

Public Consultation
- Widely promoted high volume engagement with all staff, stakeholders and residents
- Ongoing local authority consultation
- In-depth conversations with targeted groups
- A formal part of our statutory duties around substantial service change and ongoing involvement of people and communities

Implementation engagement
- Further engagement with impacted groups and involvement in implementation to ensure robust mitigations are in place

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Proposed service changes

Summary: proposed service changes

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- Our case for change highlighted opportunities for improvement in maternity and neonatal services in NCL
- We developed a new model of care for maternity and neonatal services that address these opportunities
- We developed and appraised options for the location of maternity and neonatal units in NCL
- We identified and consulted the public on two viable options, options A and B, to implement the proposed new model of care
- Option A is the recommended option but the IIA considers the impact of both options to support decision-making

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

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Maternity opportunities for improvement

Ensuring equality in maternity service provision and experience

- Stillbirth rate varies between boroughs, Haringey had the highest rate with 4.3 per 1,000 population
- Only 4.9% of pregnant women and people in NCL access perinatal mental health services

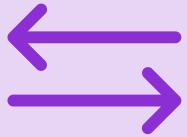
Better utilisation of maternity capacity offered in NCL

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

Supporting maternity workforce sustainability

- For many trusts, bank and agency are used to fill shifts to ensure compliance with this target due to vacancies
- Across the system there are currently 120 midwifery vacancies which would need to be filled to meet the BirthRate Plus required establishment

Neonatal opportunities for improvement



Matching neonatal care capacity and demand

- UCLH and GOSH NICU had occupancies higher than the maximum threshold
- Over stretched level 3 capacity in NCL resulted in 67 babies in 2023/24 needing to be transferred outside of NCL

Consider the sustainability of the RFH Special Care Unit

- The unit delivers 235 respiratory care days which is significantly below the 365 day BAPM upper threshold
- Low numbers of babies admitted creates a challenge for staff to maintain the required competencies

Minimising avoidable admissions to neonatal units

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

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

- North Mid are unable to open their full establishment of cot spaces due to nursing vacancies
- NCL require an uplift in nursing establishment by 64.7 WTEs to meet the Dinning tool requirements

We developed a new model of care for maternity services

H Hospital-based care
C Community-based care

Pre-conception | **Access to care** | **Antenatal care** | **Birth and treatment** | **Postnatal care**

Pre-conception counselling

- General advice C
- Specialist advice H C
- Perinatal mental health support H C

Woman or person confirms pregnancy:

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

If needed

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

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

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
- Alongside midwifery 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

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

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

We developed a new model of care for neonatal services

H Hospital-based care
C Community-based care

Labour | **Decision to admit** H | **Inpatient stay** H | **Onward care**

Driven by BAPM standards

Delivery out of hospital with midwifery care C → **Transferred to nearest neonatal unit in the ICS**

In-utero transfer to an alternative birth setting if anticipated level of neonatal care exceeds local availability supported through a no-refusal policy by receiving units

Presentation in labour H

- **Delivery at an alongside midwifery led unit** H
- **Delivery at an obstetric led unit** H

→ **Admission to neonatal unit on site**

1 Neonatal unit on admission (co-located with an obstetric unit)

Type of unit on admission depends on local availability:

- **NICU (level 3)**
- **LNU (level 2)**

Type of care provided:

- **Intensive care**
- *Step down in care*
- **High dependency care**
- *Step up in care*
- **Special care**

A level 2 unit has the ability to deliver intensive care to babies, however it will be limited by capacity and skillset

If needed / *If specialist input is required* / *If needed*

2 Transfer between hospitals in the ICS

NICU ⇄ *Repatriation* / *Uplift* ⇄ **LNU**

3 Transfer to a specialist hospital within the ICS

Specialist NICU ⇄ **Specialist ward**

Paediatric ward

4 Transfers to an appropriate level unit outside of the ICS

- *Capacity issues within the ICS*
- *Repatriate a resident & baby from another ICS who delivered in our ICS*

Repatriation back to local hospital from specialist unit or unit outside of ICS

Transitional care on labour, neonatal and postnatal wards incl. feeding support

Mental health support for parents incl. wellbeing support

Community neonatal outreach

Outreach from the specialist hospital

Postnatal midwifery review and support for maternal health

Baby specific

- **Repatriation** H
- **Follow-up appointments (neonatal or paediatrics)** H C
- **Multidisciplinary team follow up** H C
- **Primary care follow up** C
- **Hospital at home service** C
- **Neonatal community outreach** C
- **Health visitor** C
- **Feeding support** C

Pregnant woman or person specific C

- **Postnatal education**
- **Mental health support (incl. mental wellbeing to formal perinatal mental health pathway)**
- **Primary care input**
- **Community midwife**
- **Physiotherapy**
- **Family planning advice**
- **Bereavement support**

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

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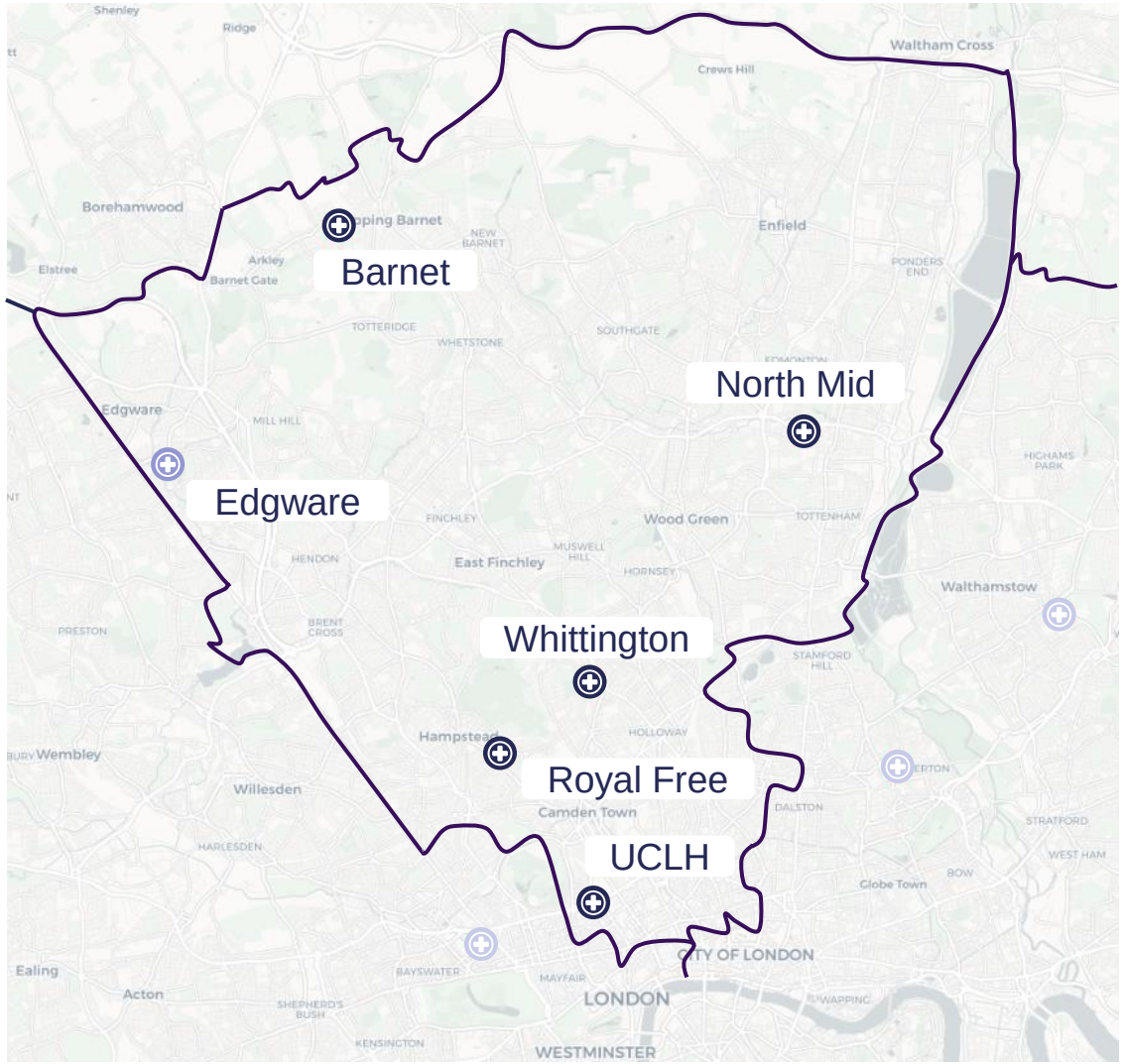

We undertook a process to develop options for consultation on the location of maternity and neonatal units in NCL:

- Currently there are five obstetric-led maternity units and alongside midwife led units with co-located neonatal units at **Barnet, North Mid, Royal Free Hospital, UCLH and Whittington Hospital**. There is one standalone midwife-led unit at **Edgware Birth Centre.**
- It is proposed that there would be four obstetric-led maternity units and alongside midwife led units co-located with four neonatal units in the future
- Closing the birthing suites (standalone midwife-led unit) at Edgware Birth Centre is also proposed. This is being considered as a separate proposal. The potential impact of these proposals can be found on slides 215-217.

We identified and consulted on two viable options, options A and B, to implement the proposed new model of care

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

- The difference between the options is that the Whittington Hospital retains its consultant-led obstetric unit with co-located local neonatal unit (level 2) in Option A and the Royal Free Hospital becomes a consultant-led obstetric unit with co-located Level 2 neonatal intensive care unit in Option B (the Royal Free Hospital currently has an obstetric and midwifery-led unit with co-located special care (level 1) neonatal unit)
- We developed two proposals for maternity and neonatal services. These proposals were independent from each other. We developed and appraised options for the location of maternity and neonatal units in NCL, for which there were two proposed options for consultation (options A and B). We also developed a proposal to close the birthing suites at Edgware Birth Centre (see slide 214). This IIA assesses the potential impact of both proposals.
- There are also proposed changes in location of tongue-tie, out of hours interventional radiology, neonatal retinopathy of prematurity screening services, ED, LAS emergency transfer protocols, gynaecology, early pregnancy unit and maternal medicine services. We have considered the potential impact of these changes on the catchment population for the recommended option.

Option A is the recommended option but the IIA considers the impact of both options to support decision-making

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- The Programme consulted on two options with option A (unit at Royal Free Hospital closes) as the preferred option because it was considered to be easier to implement from a workforce perspective and because the potential outflow of some patients to units outside NCL would be easier to manage and provide more benefits for those patients.
- Considering the new evidence, including latest data and the consultation feedback, the Programme Board reviewed the refreshed evaluation for option A and option B.
- This IIA supports the decision-making process and therefore considered the potential impact of both options on their catchment population
- **It has been recommended by the Programme Board that option A is taken forward for implementation**. This is particularly because:
  - It would still be significantly less complex to implement option A than option B from a workforce perspective because the Royal Free Hospital currently has a SCU (level 1) neonatal unit whilst the Whittington Hospital already has an LNU (level 2)
  - The projected patient flow to NWL in option A would be easier to manage than the projected flows to NEL in option B.
- Further mitigations have been developed for option A only, as the recommended option

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Identifying the potentially impacted catchment population

Summary: identifying the potentially impacted catchment population

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- We identified the people who may be impacted by the proposals (the ‘catchment population’) based on travel times. We identified the catchment population by identifying the geographies whose closest hospital based on travel time is currently Whittington Hospital or the Royal Free Hospital.
- We looked at people who may be impacted by our proposals for maternity and neonatal units when driving (or being driven) at peak times. There is a slightly smaller population that could potentially be impacted for option A (~98,000 women of childbearing age) versus option B (~ 113,000 women of childbearing age)
- The catchment population when driving at off-peak times was also looked at with a difference in population size in both option A (~100,000 women of childbearing age) and option B (~ 111,000 women of childbearing age)
- We also looked at people who may be impacted by our proposals when using public transport. There is a larger population that could potentially be impacted for option A (~91,000 women of childbearing age people) versus option B (~66,000 women of childbearing age people)
- We also looked at where people impacted by option A and option B may access care if their nearest unit (by travel time) were no longer available

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

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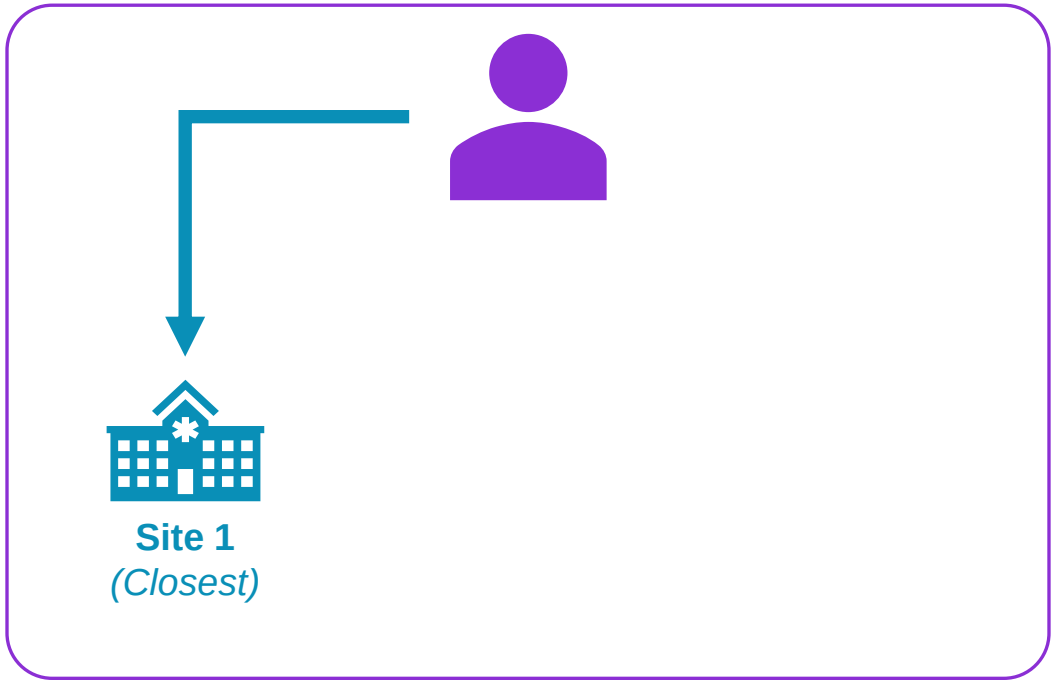
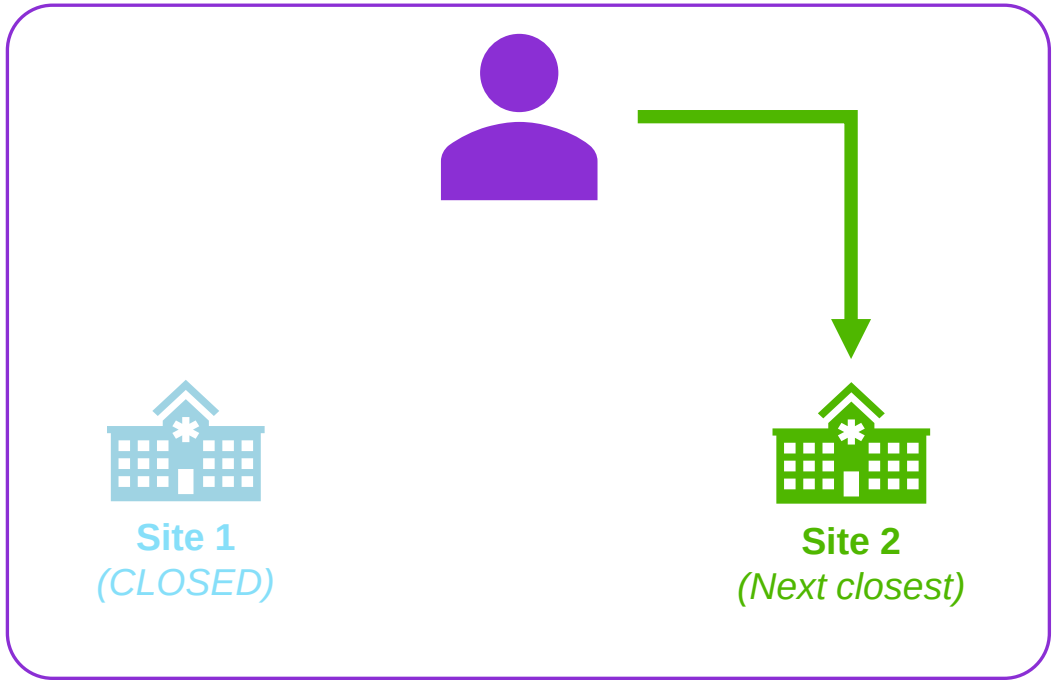
- We looked at where people live and identified populations whose closest hospital is Royal Free Hospital (option A) or Whittington Health (option B), who may be impacted by the proposals
- For the catchment populations we looked at what the next closest hospital would be and assessed what the travel impact would be by off-peak driving (car, taxi and ambulance), peak driving (car and taxi) and public transport
- Other possible impacts of potential changes have been explored as part of this IIA

Currently: where people go now (the closest)



Future: Predicted site for accessing care if maternity and neonatal unit at Site 1 closed



Several assumptions have been used to generate travel times

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

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

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

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

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

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

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

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

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

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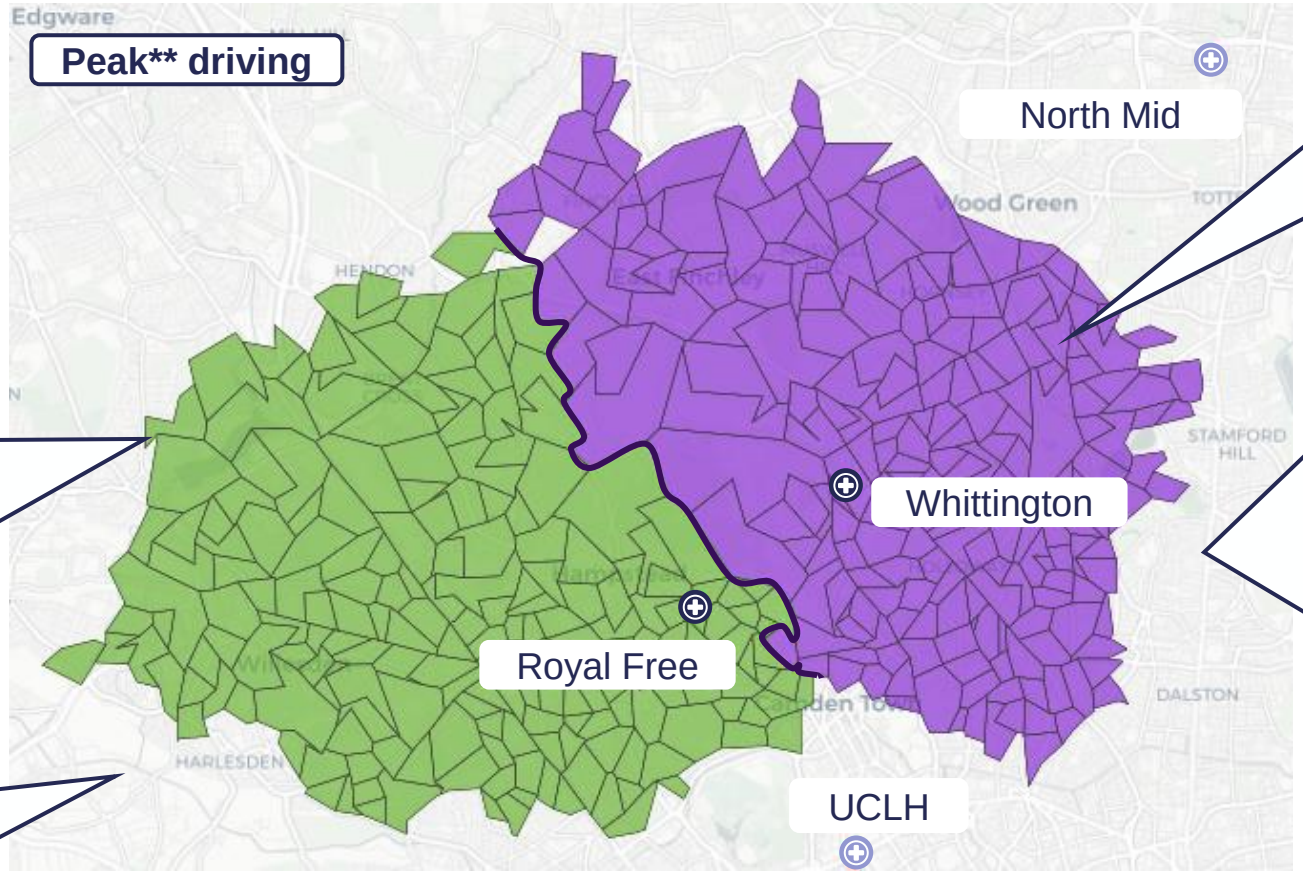
Option A catchment includes:
Population*: 98k
Households: 142k
LSOAs*:** 199

Option B catchment includes:
Population*: 113k
Households: 160k
LSOAs*:** 219



Whittington Hospital catchment area (people whose travel time is shortest to the Whittington Hospital)

Royal Free Hospital catchment area (people whose travel time is shortest to the Royal Free Hospital) The catchment includes some NWL residents, but this only accounts for less than 8% of all women of childbearing age in NWL

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

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

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

**Population defined as women of childbearing age (15-49 inclusive)*
***Peak (private car / taxi) is defined as 08:30 AM on a Tuesday*
****LSOAs are lower super output areas and are populations of around 1,000 – 3,000 people that are used to do travel analysis*

Source: Traveltime API, CF Analysis (2024)

The catchment population when driving at off-peak times was also reviewed

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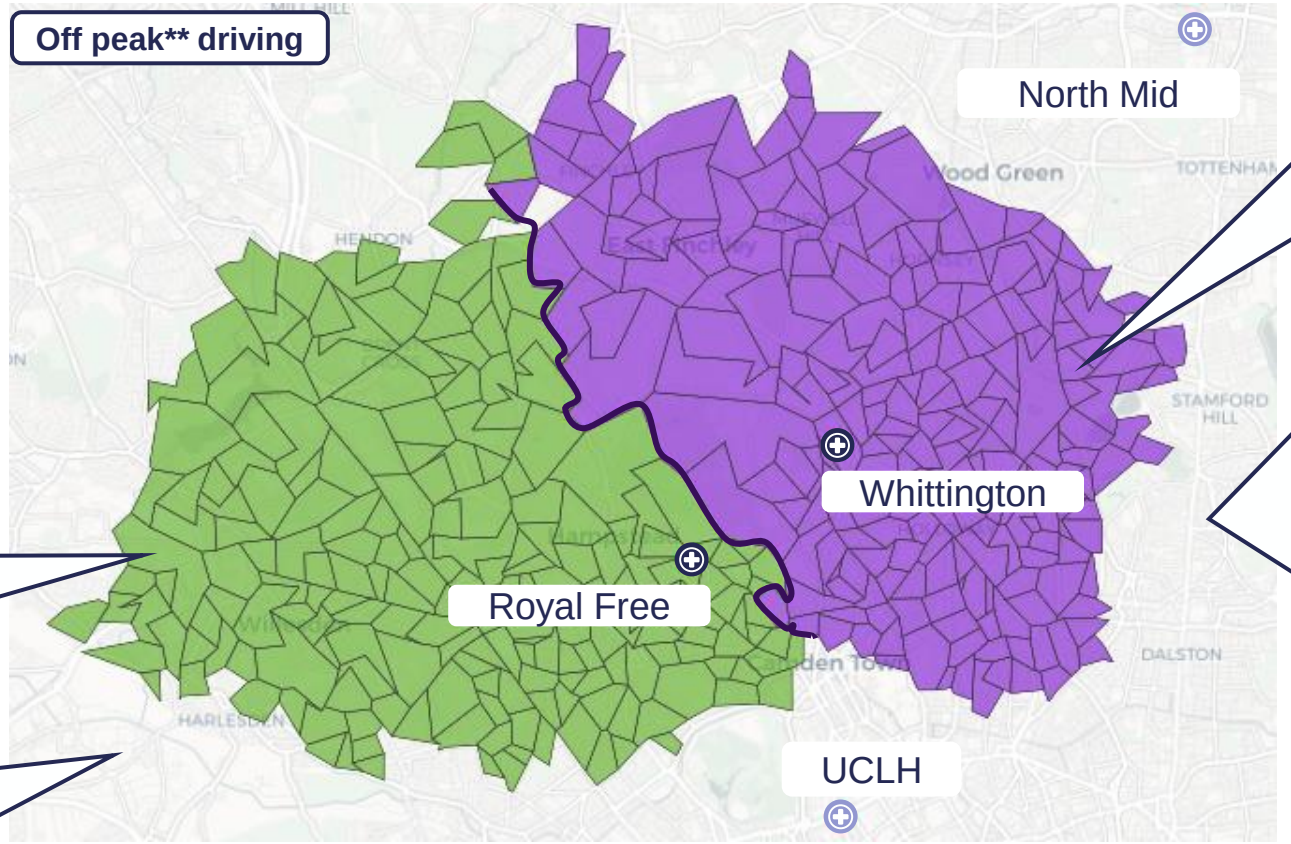
Option A catchment includes:

Population*: 100k
Households: 146k
LSOAs*:** 204

Option B catchment includes:

Population*: 111k
Households: 158k
LSOAs*:** 217



Whittington Hospital catchment area (people who's travel time is shortest to the Whittington Hospital)

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

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

Royal Free Hospital catchment area (people who's travel time is shortest to the Royal Free Hospital)

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

**Population defined as women of childbearing age (15-49 inclusive)*
***Off peak (private car / taxi / ambulance) is defined as 03:00 AM on a Tuesday*
****LSOAs are lower super output areas and are populations of around 1,000 – 3,000 people that are used to do travel analysis*

Source: Traveltime API, CF Analysis (2024)

We also looked at people who may be impacted by our proposals when using public transport

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Option A catchment includes

Population*: 91k
Households: 130k
LSOAs*:** 186

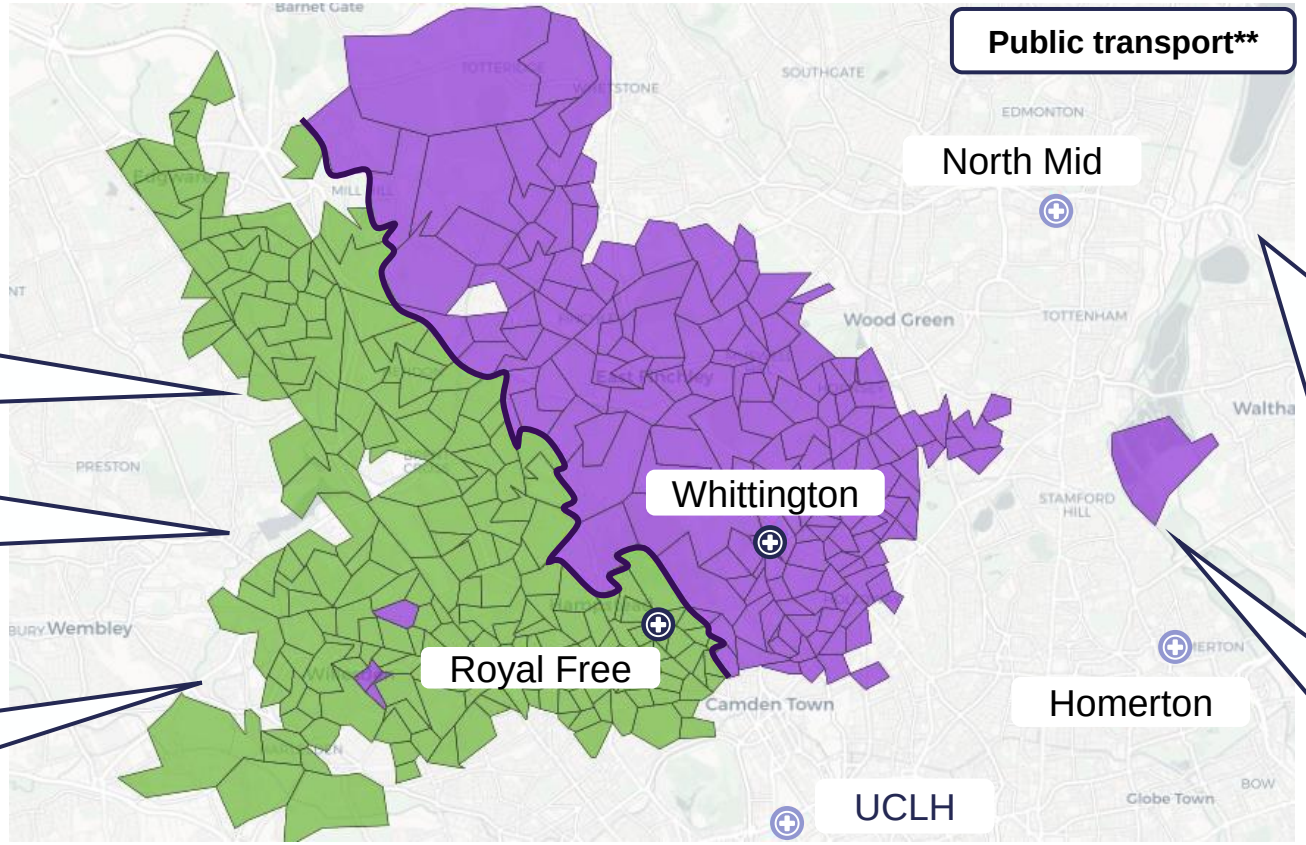
Option B catchment includes

Population*: 66k
Households: 98k
LSOAs*:** 138

Royal Free Hospital catchment area (people whose travel time is shortest to the Royal Free Hospital)

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

There are some areas in the west of the catchment, closest to the Whittington due to travel routes



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

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

Whittington Hospital catchment area (people whose travel time is shortest to the Whittington Hospital)

**Population defined as women of childbearing age (15-49 inclusive)*
***Public (public transport) is defined as 12:00 PM on a Tuesday*
****LSOAs are lower super output areas and are populations of around 1,000 – 3,000 people that are used to do travel analysis*

Source: Traveltime API, CF Analysis (2024)

People impacted by option A may access care at other nearby hospitals

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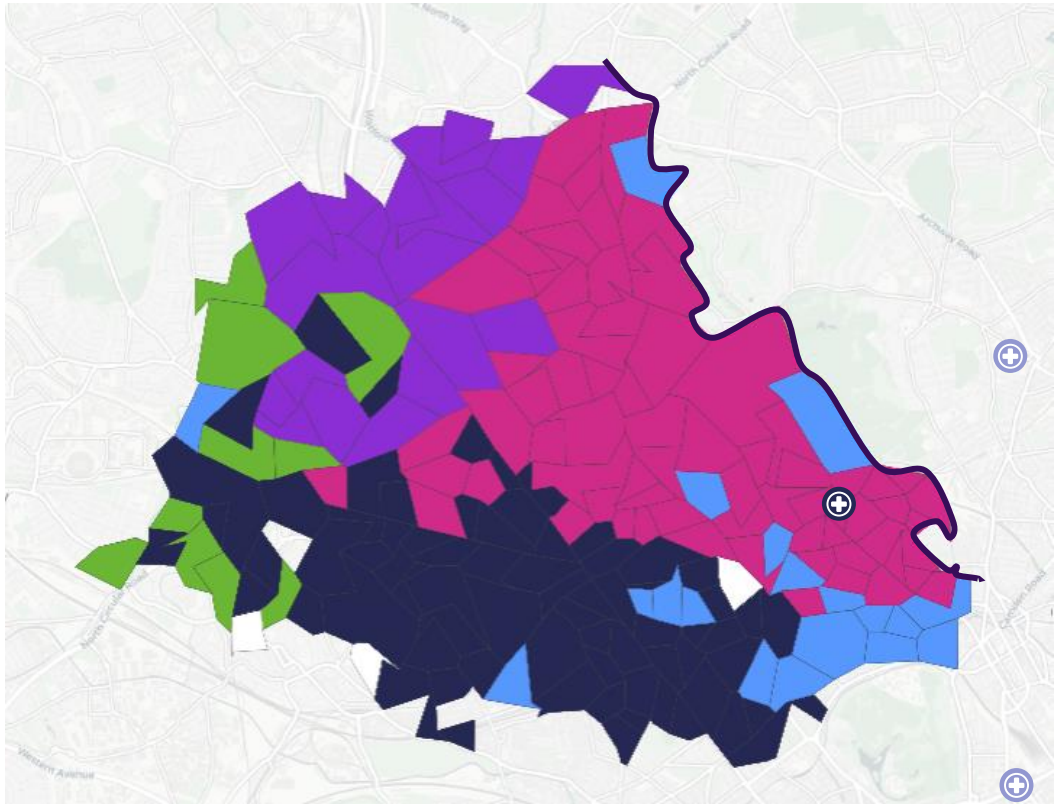
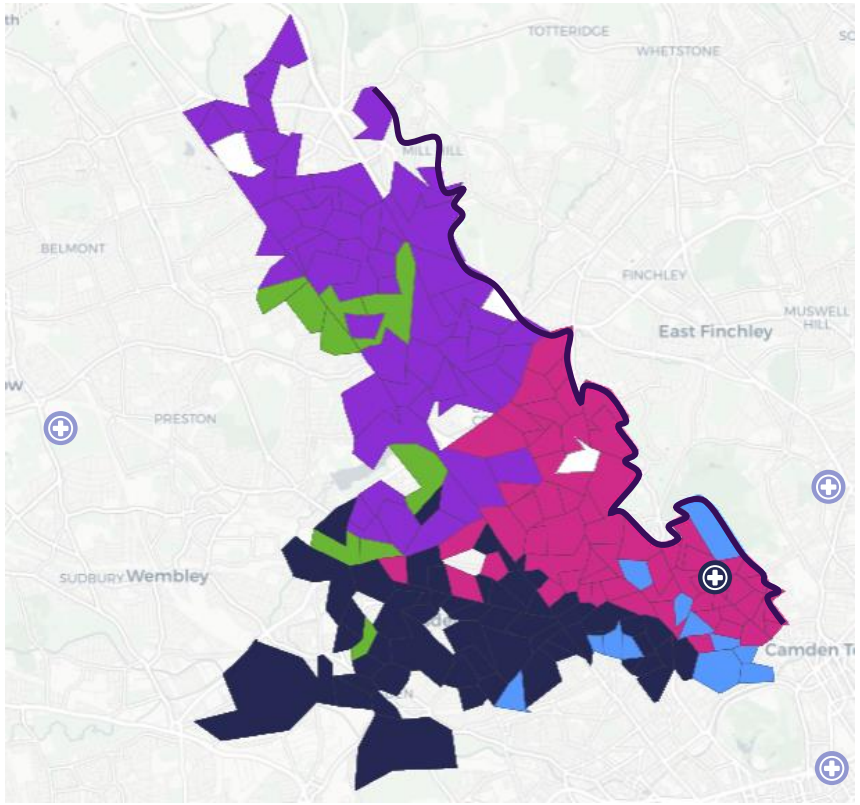
Peak driving



Public transport



Key

- **Potential flow to Barnet**
- **Potential flow to Northwick Park**
- **Potential flow to St Mary's**
- **Potential flow to UCLH**
- **Potential flow to Whittington**

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

Source: Trust deliveries data, Traveltime API, CF Analysis (2024)

People impacted by option B may access care at other nearby hospitals

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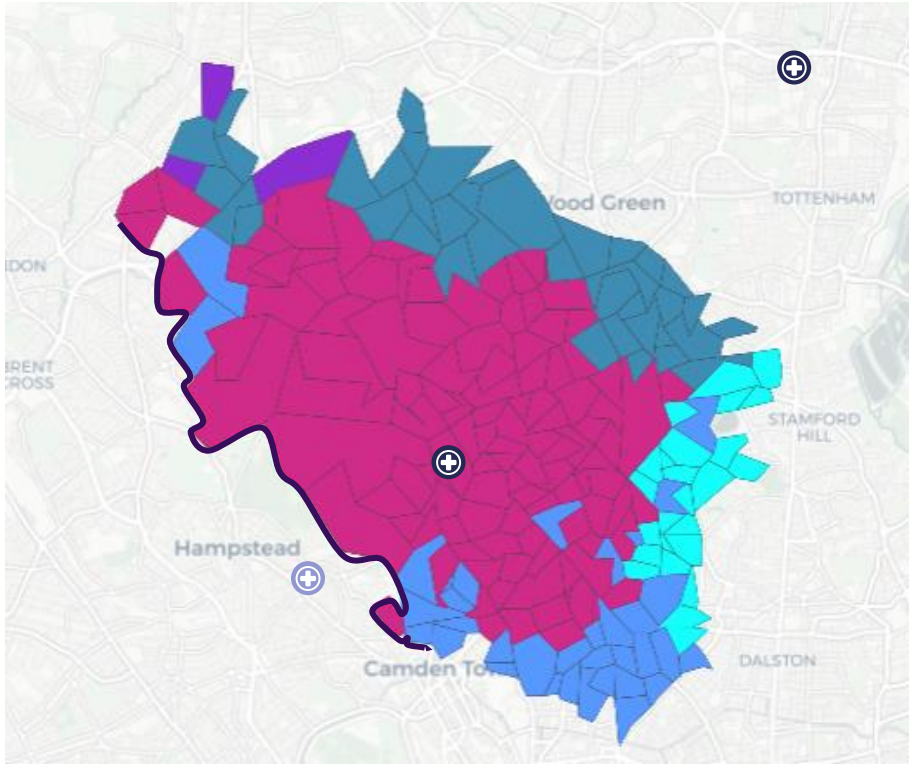
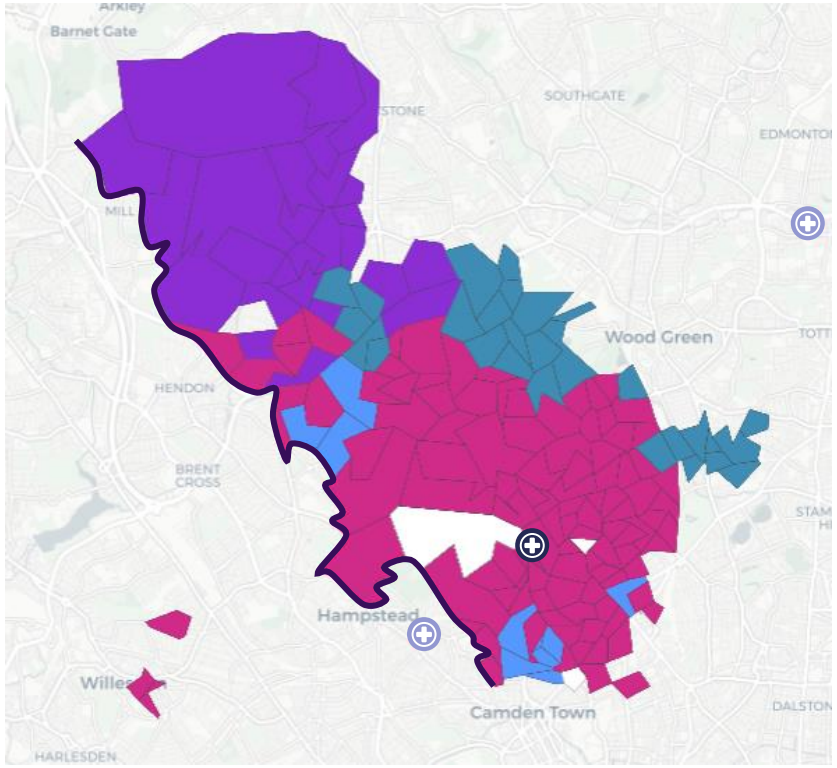
Peak driving



Public transport



Key

- **Potential flow to Barnet**
- **Potential flow to Homerton**
- **Potential flow to North Mid**
- **Potential flow to Royal Free Hospital**
- **Potential flow to UCLH**

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

Source: Trust deliveries data, Traveltime API, CF Analysis (2024)

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Understanding the potentially impacted catchment population

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

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- We engaged extensively and undertook a public health-led literature review to identify people who may be impacted by our proposals
- Our case for change identified vulnerable groups that may be disproportionally impacted by the proposals: we undertook a supplementary evidence review examining inequalities in maternal and neonatal outcomes in the UK, we considered potentially impacted groups using the national CORE20PLUS5 framework and there are nine protected groups that we must consider to fulfil our legal duties
- The public consultation sought feedback on how the proposed changes to maternity and neonatal services may impact populations and this updated IIA considers the feedback received
- Our IIA is therefore focused on people who may be disproportionately impacted by our proposals
- Nine populations were analysed with quantitative data, alongside engagement and qualitative assessment, which was undertaken using available data sources:
    - Most **people living in areas of deprivation (defined by Core20 areas)** are concentrated on the western part of the catchment for option A and the eastern part of the catchment for option B. The populations with the fewest people living in areas of deprivation lie around Hampstead and Highgate, which are relatively affluent areas. Whilst the people living in areas of deprivation around Whittington Hospital are relatively close to the hospital site, people living in areas of deprivation for Royal Free Hospital are further away.
    - There is a concentration of people who are **economically inactive** in the west of the catchment (in the catchment for option A) and around the Whittington Hospital in Islington (the catchment for option B).
    - The largest proportion of people from **minority ethnic groups** who could be impacted by potential changes are concentrated in the west around the Royal Free Hospital in Kilburn, Harlesden and Willesden.
    - The largest concentrations of people who have **poor English proficiency (including literacy)** are in the west, closer to the Royal Free Hospital (catchment for option A). There is also a large concentration of non-English speakers around Wood Green close to the Whittington Hospital (catchment for option B).
    - People with **poor health** are concentrated to the south of the Whittington Hospital and to the east of the Royal Free Hospital. There are also some pockets of people with poor health in the west of the catchment (impacted under option A) in Harlesden and Willesden.

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

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  - The percentage of **women and people of childbearing age** is distributed across the catchment population for the Royal Free Hospital whilst there is a concentration of women and people of childbearing age east of the Whittington Hospital (impacted under option B).
  - There are pockets **single pregnant women and people** across the catchment population
  - The largest concentration of **people with disabilities** are between the Royal Free Hospital and the Whittington Hospital, with an above-average concentration of people with disabilities around the Whittington Hospital
  - The largest concentration of **Jewish people** are to the north west of the Royal Free and Whittington

- It is worth noting that the demographics of the catchment population is slightly different for each option
- Feedback from public consultation outlined the need to consider pregnant women and people with complex (or pre-existing) health conditions as part of the IIA. Quantitative analysis was not possible for this population due to the very small population size and the quality of the data, but qualitative analysis has been undertaken.

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

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

People who are LGBTQ+ and **people who are transgender** because:
- There may be **poorer maternal outcomes**
- They may experience **discrimination** or **stigma** that act as barriers to accessing healthcare and increased risk of mental health conditions

People living in areas of deprivation (Core20 areas defined as the 20% most deprived areas nationally) because:
- There are **higher stillbirth rates**
- There is a **higher prevalence** of health behaviours which could negatively impact on maternal health outcomes such as **smoking and obesity**

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

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

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

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

We considered potentially impacted groups using the national CORE20PLUS5 framework

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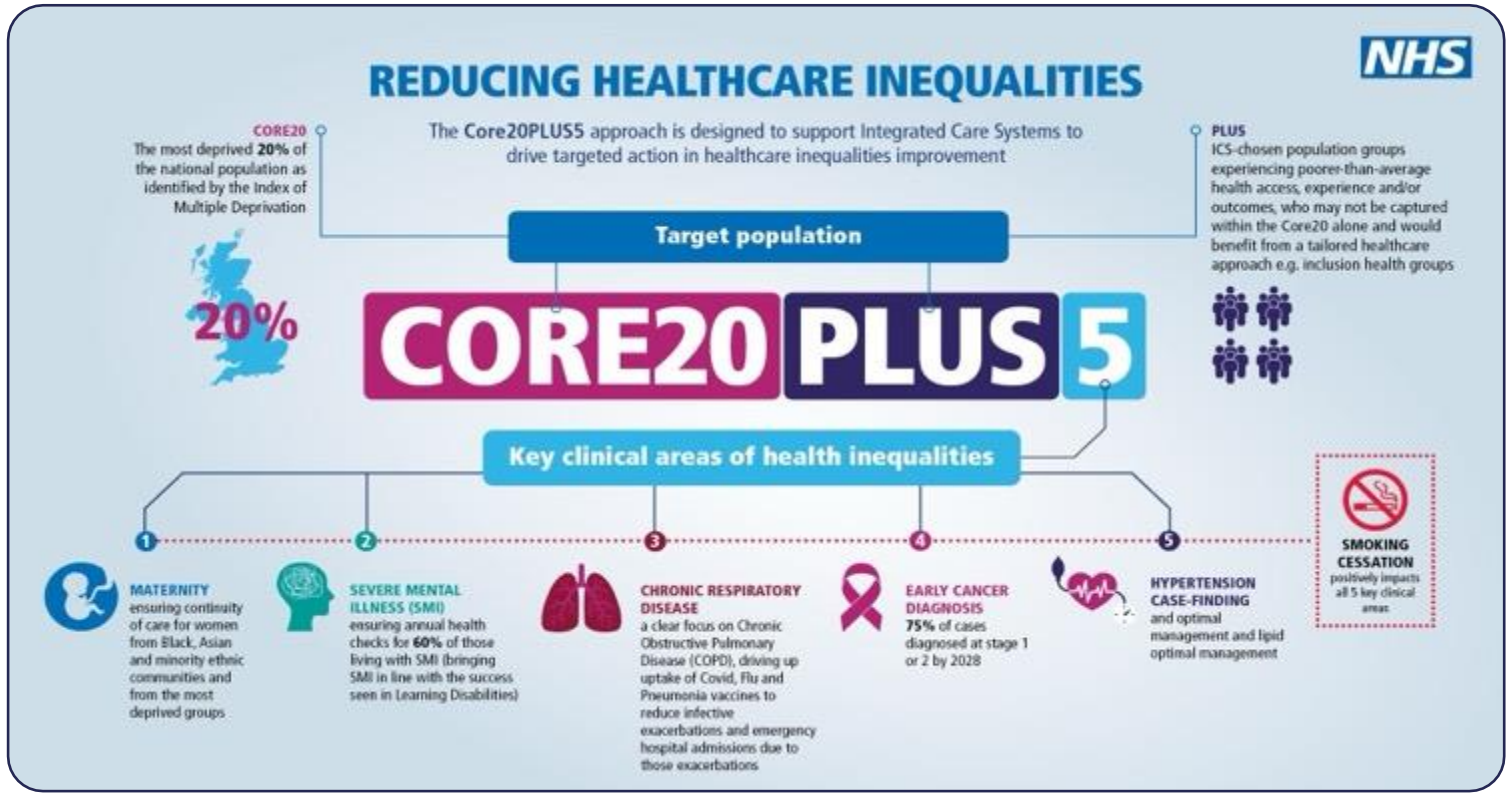

***Inclusion health** is an umbrella term used to describe people who are **socially excluded**, who typically experience multiple overlapping risk factors for **poor health**, such as poverty, violence and complex trauma.
**Chronic respiratory disease, early cancer diagnosis and hypertension case finding are not directly impacted by our proposals and therefore have not been assessed further

"**CORE20**" represents those living in the 20% most deprived areas nationally as identified by the indices of multiple deprivation.

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

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

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

Source: NHS England, https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/#:~:text=Core20PLUS5%20is%20a%20national%20NHS,clinical%20areas%20requiring%20accelerated%20improvement.

Extensive engagement and a thorough public consultation identified people who may be impacted by the proposals

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Case for change engagement and population identification

- A 10-week case for change engagement period took place in summer 2022 to identify whether the themes highlighted from the case for change resonated with patients, residents, staff and wider stakeholders
- The engagement established what was important in planning good care and worked in partnership with local authority, voluntary and community sector partners and established patient groups and networks
- Forty-three events took place with 389 questionnaires completed, and 207 in-depth conversations took place
- Diverse communities and groups with specific insights were targeted to ensure a wide range of views were captured
- People who have vulnerabilities or disproportionally impacted by our proposals were identified through the case for change and engagement:
  - People from minority ethnic groups
  - Specific age groups
  - People living in areas of deprivation
  - Single pregnant women and people
  - Women or people with specific religions or faiths
  - Women or people with disabilities
  - Women or people with learning disabilities
  - People who are transgender or people who are LGBTQ+

Public consultation activities

The public consultation activities were extensive and supported by the Start Well Programme team and in some cases voluntary organisations for specific groups:

- 199 meetings reaching just under 3,400 people including:
  - 32 in-depth staff sessions reaching 470 participants
  - 26 drop-ins reaching nearly 600 people
  - 46 targeted sessions reaching 503 people
  - 34 in targeted geographies reaching 582 residents
  - 8 GP meetings reaching 279 GP staff
- Social media promotion leading to over 720,000 impressions, 3,670 clicks through the consultation website and 1,310 views of video content
- Almost 7,000 letters sent to target geographies
- Adverts in 13 local papers
- 40 items of new coverage
- 1:1 briefings with a wide range of key stakeholders

There are nine protected groups that we considered to fulfil our legal duties under the Equality Act 2010

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Protected characteristic groups:

- **Race (inc. colour, nationality, ethnic or national origin)**
- **Age**
- **Sex (male/female)**
- **People with disabilities**
- **Being pregnant or on maternity leave**
- **Gender reassignment**
- **Religion or belief**
- **Sexual orientation**
- **Being married or in a civil partnership**

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

For completeness we also considered marriage and civil partnership. However, we have not identified any potential disproportionate impact from being married or in a civil partnership, and this has not been raised as a potential issue in engagement, therefore this has not been assessed further than looking at single-person households

Source: [1]https://www.gov.uk/discrimination-your-rights

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

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Potentially impacted populations	How we identified potentially impacted populations					Quantitative analysis possible?
	Protected characteristic	CORE20	Engagement	Case for change	Public consultation	
People living in Core20 areas*		✓	✓	✓	✓	Y
People who are economically inactive					✓	Y
People from minority ethnic groups	✓	✓	✓	✓	✓	Y
People who have poor English proficiency			✓		✓	Y
People with poor health		✓			✓	Y
Inclusion health groups		✓	✓	✓	✓	
People who are LGBTQ+	✓		✓	✓	✓	
People who are transgender	✓				✓	
Religion (particularly Orthodox Jewish community)	✓		✓		✓	Y
Women and people of childbearing age (sex)	✓		✓		✓	Y
Younger pregnant women and people	✓			✓	✓	
Older pregnant women and people	✓		✓	✓	✓	
Pregnant women and people with complex (or pre-existing) health conditions					✓	
Single pregnant women and people					✓	Y
People with disabilities	✓		✓	✓	✓	Y
People with learning disabilities		✓	✓		✓	
People with serious mental illness		✓			✓	

- A public consultation was completed in early 2024 seeking feedback on our proposals. Following the public consultation pregnant women and people with complex (or pre-existing) health conditions have been included as a specific population that may be impacted by the proposals.
- We have also considered the impact of changing the location of tongue-tie, out of hours interventional radiology, neonatal retinopathy of prematurity screening services, ED, gynaecology, early pregnancy unit and maternal medicine services on these populations and can be found on slide 222 in the appendix

***Note:** Core20 areas refers to people living in the 20% most deprived areas nationally*

Nine populations were analysed where quantitative data was available

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Nine populations were analysed using quantitative data alongside stakeholder engagement to assess whether they may be impacted by the proposals, and other groups were analysed qualitatively, as shown in slides 118-152.

1 **People living in CORE20 areas***	People living in areas of deprivation have worse outcomes and poorer maternal health. They also face barriers to accessing healthcare (e.g. due to cost of travel)
2 **People who are economically inactive**	People who are economically inactive may face barriers to accessing healthcare (e.g. due to cost of travel)
3 **People from minority ethnic groups**	People from minority ethnic groups have worse outcomes, poor experience of accessing care and may experience racial discrimination
4 **People who have poor English proficiency (including literacy)**	People with who are not proficient in English may have difficulty travelling to, and accessing health services
5 **Poor general health**	People with poor general health may require more complex care and may have difficulty accessing services
6 **Women and people of child-bearing age**	Women and people of a child-bearing age would be impacted by any changes to maternity services
7 **Single pregnant women and people**	Single pregnant women and people might find accessing healthcare difficult due to childcare requirements
8 **People with disabilities**	People with disabilities may have difficulty in travelling to services and accessing sites. They may have health conditions that impact on pregnancy
9 **Orthodox Jewish community**	Orthodox Jewish community have specific religious needs that would need to be met

***Note:** Core20 areas refers to people living in the 20% most deprived areas nationally*

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

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Demographics of the people in the catchment population

Proportion of the catchment population by each demographic group

Catchment area		People living in CORE20 areas	People who are economically inactive	People from minority ethnic groups	People who have poor English Proficiency (including literacy)	Women and people of child-bearing age	People with poor general health	Single parent households	People with disabilities	Jewish people
Option A	Peak	15.7%	12.3%	71.2%	4.5%	28.2%	4.5%	7.2%	13.1%	8.7%
	Public transport	12.4%	11.7%	68.9%	4.3%	27.8%	4.2%	6.8%	12.6%	11.4%
Option B	Peak	19.1%	11.0%	58.5%	3.5%	30.2%	4.7%	7.0%	14.7%	4.9%
	Public transport	11.8%	11.0%	57.3%	3.0%	28.4%	4.8%	6.9%	14.8%	8.0%

- These nine demographic metrics are intended to provide an overview of the characteristics of the catchment population for each Option.
- Within the peak driving catchment area, 142,168 households are closer to the Royal Free Hospital and would be potentially impacted by option A whilst 159,621 households are closer to the Whittington Hospital and would be potentially impacted by option B.
- Within the public transport catchment area, 159,621 households are closer to Royal Free Hospital and would be potentially impacted by option whilst 98,452 households are closer to the Whittington Hospital and would be potentially impacted by option B.
- The catchment population in option A has a greater proportion of people from minority ethnic groups and Jewish people whereas option B has a greater proportion of people that live in areas of deprivation

The population size of each demographic population also varies between each catchment

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Demographics of the people in the catchment population*
Number of people in the catchment population by each demographic group

Catchment area		People living in CORE20 areas	People who are economically inactive	People from minority ethnic groups	People who have poor English Proficiency (including literacy)	Women and people of child-bearing age	People with poor general health	Single parent households	People with disabilities	Jewish people
Option A	Peak	54,478	42,495	246,923	15,562	97,628	15,616	10,264	45,445	29,995
	Public transport	40,823	38,504	226,323	14,120	91,221	13,785	8,837	41,490	37,450
Option B	Peak	71,134	40,975	217,977	12,981	112,519	17,700	11,115	54,728	18,243
	Public transport	27,314	25,606	132,950	7,052	65,876	11,019	6,753	34,411	18,659

*Note: These figures relate to the total population size in each demographic group and therefore it should be noted that not all of these people are women or people of childbearing age

Demographics: People living in CORE20 areas of deprivation

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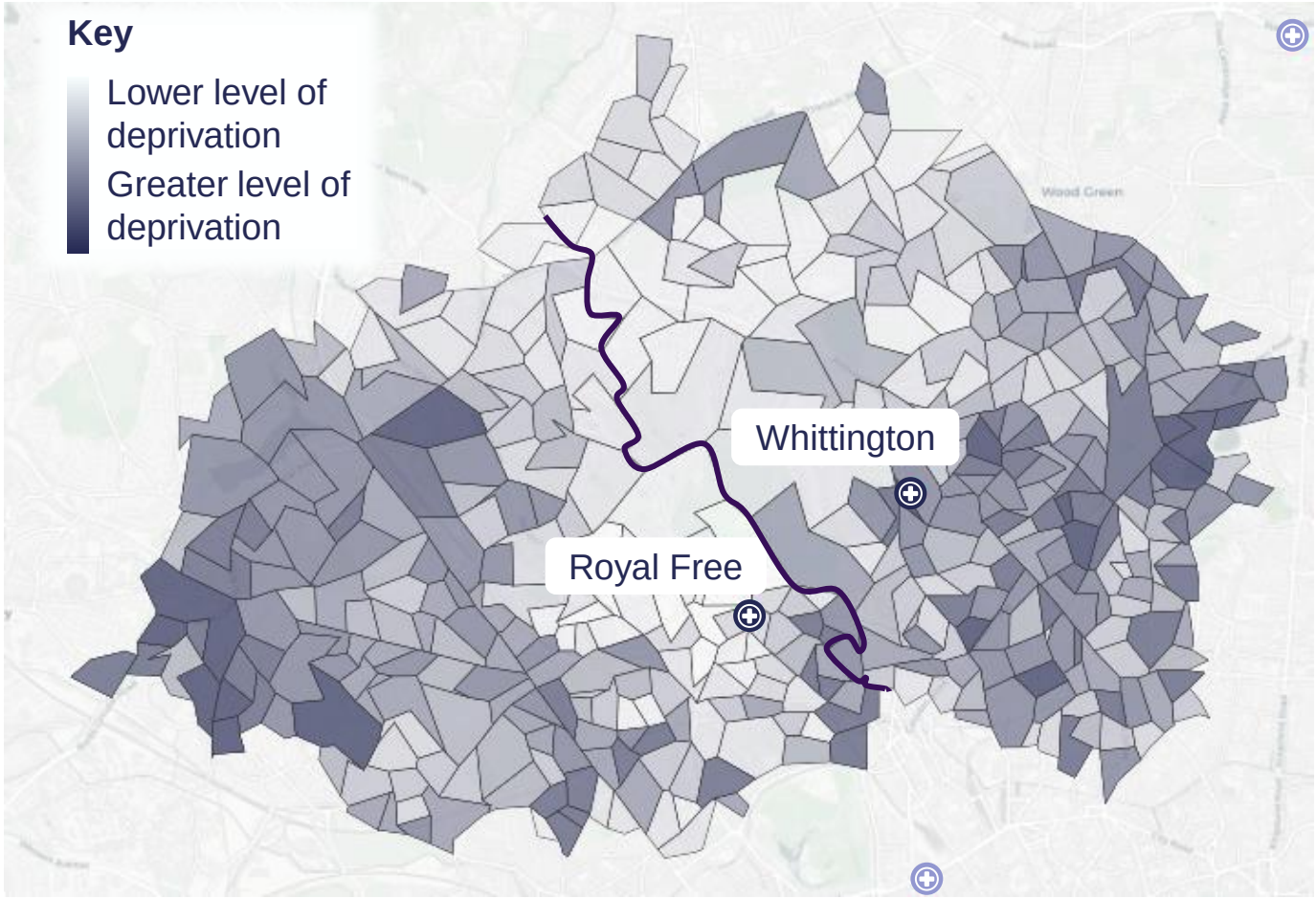
People living in areas of deprivation
Deprivation decile of each LSOA, from 1-10



Definition

The Index of Multiple Deprivation (IMD) deciles divide neighborhoods (LSOAs) into ten equal groups, ranging from 1 (most deprived 10%) to 10 (least deprived 10%). Each decile represents one-tenth of all neighborhoods in England, ranked according to their level of deprivation based on factors including income, employment, education, health, and housing. The Core20 population live in the most deprived 20% of areas nationally.

Observations

The most people living in areas of deprivation are concentrated on the eastern (impacted by Option B) and western (impacted by Option A) parts of the catchment area (peak catchment). The areas with the fewest people living in areas of deprivation lie around Hampstead and Highgate, which are relatively affluent. Whilst people living in areas of deprivation around the Whittington Hospital are relatively close to the hospital site, the people living in areas of deprivation for Royal Free Hospital are further away.

Source: ONS, Traveltime API, CF Analysis (2024)

Demographics: People who are economically inactive

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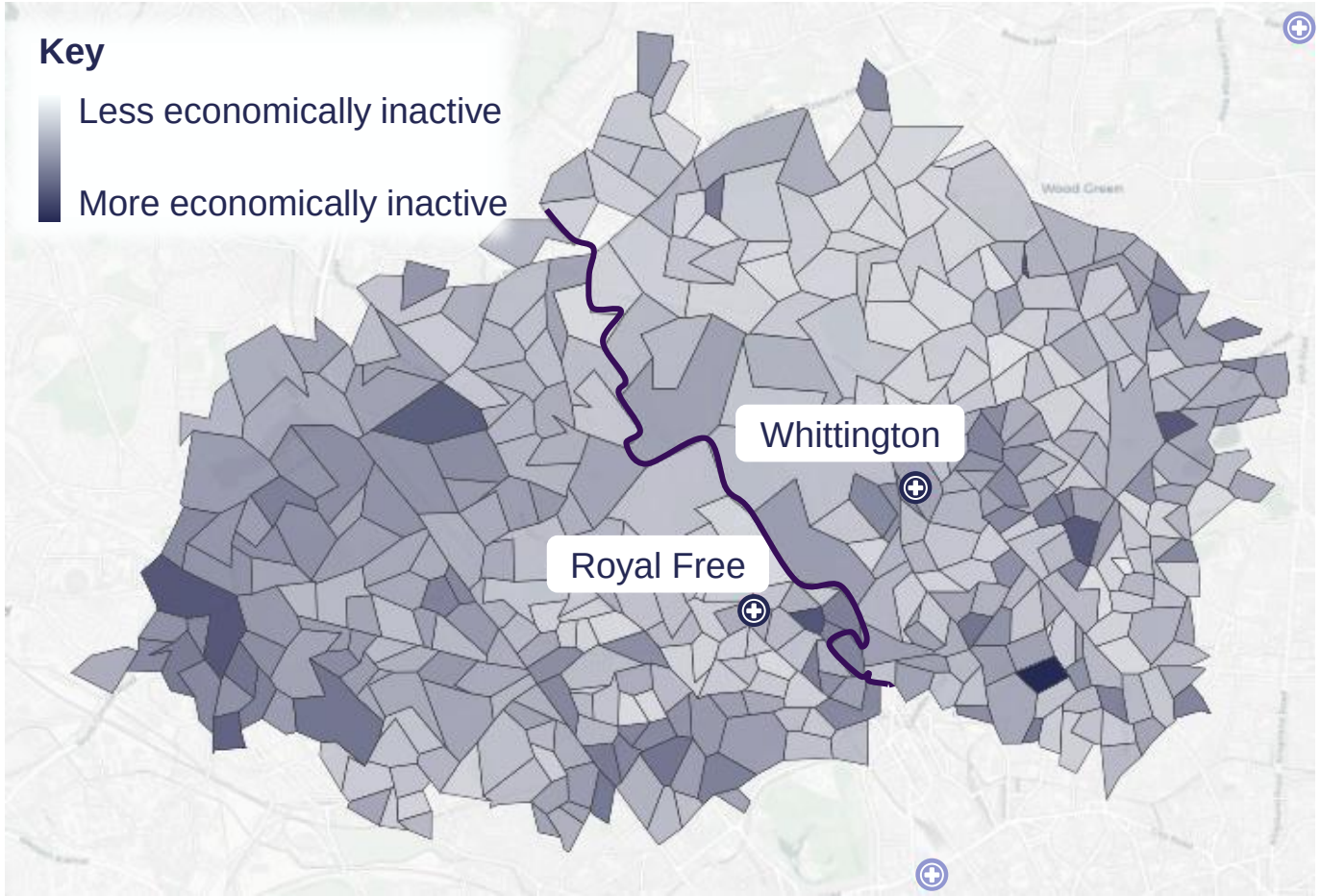
People who are economically inactive
Rate (%) of economically inactive population



Definition

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

Observations

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

Source: ONS, Traveltime API, CF Analysis (2024)

Demographics: People from minority ethnic groups

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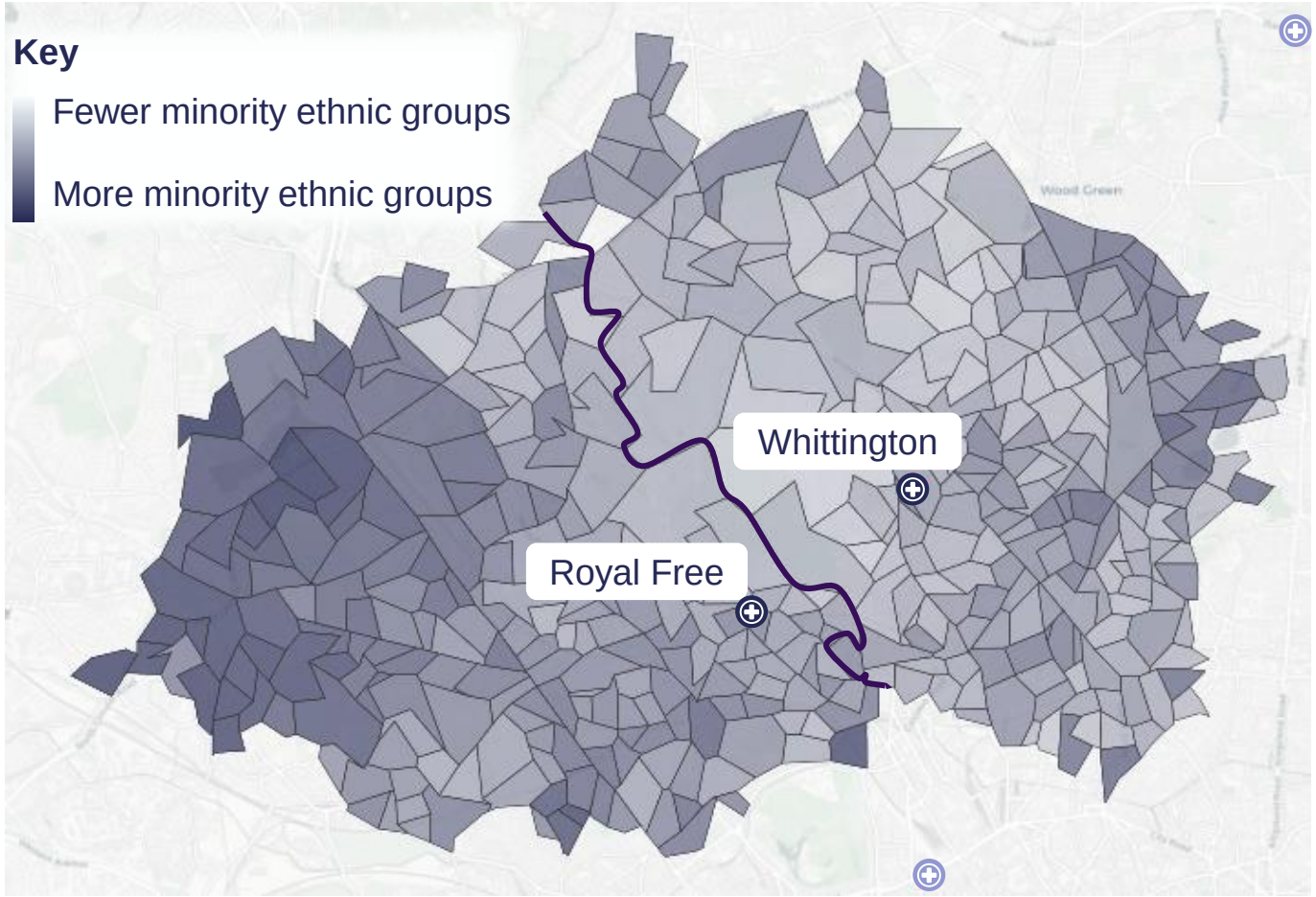
People from minority ethnic groups
Rate (%) of people from minority ethnic groups



Definition

People from minority ethnic backgrounds are defined in the 2021 Census of England and Wales as individuals who self-identified with any ethnicity other than "White: English, Welsh, Scottish, Northern Irish or British"

Observations

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

Source: ONS, Traveltime API, CF Analysis (2024)

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

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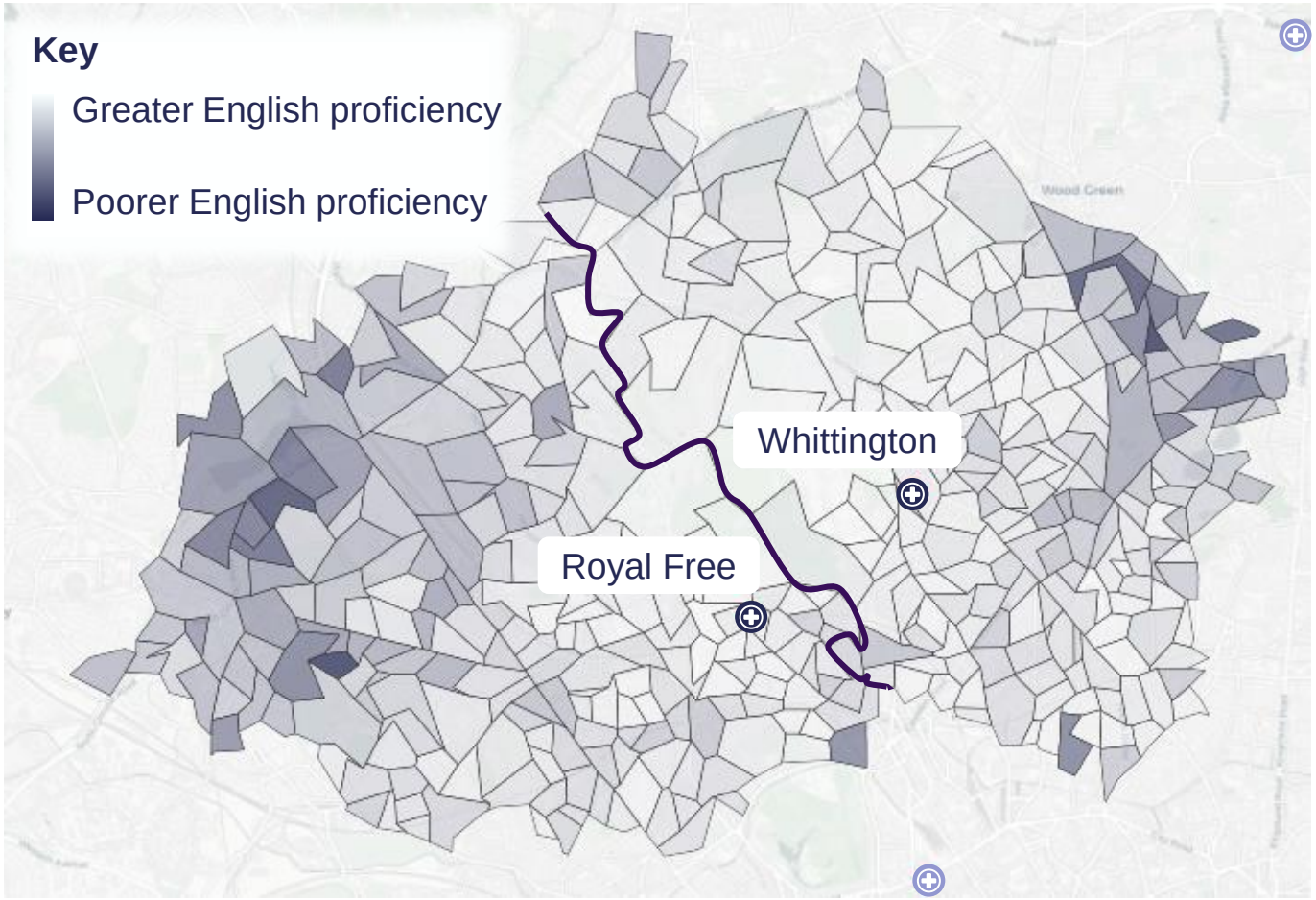
People who have poor English proficiency (including literacy)
Rate (%) of people who have poor English proficiency (including literacy)



Definition

English language proficiency is defined in ONS statistics as individuals who self-reported speaking English "Not well" or "Not at all" where English was not their main language

Observations

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

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

Source: ONS, Traveltime API, CF Analysis (2024)

Demographics: People with poor health

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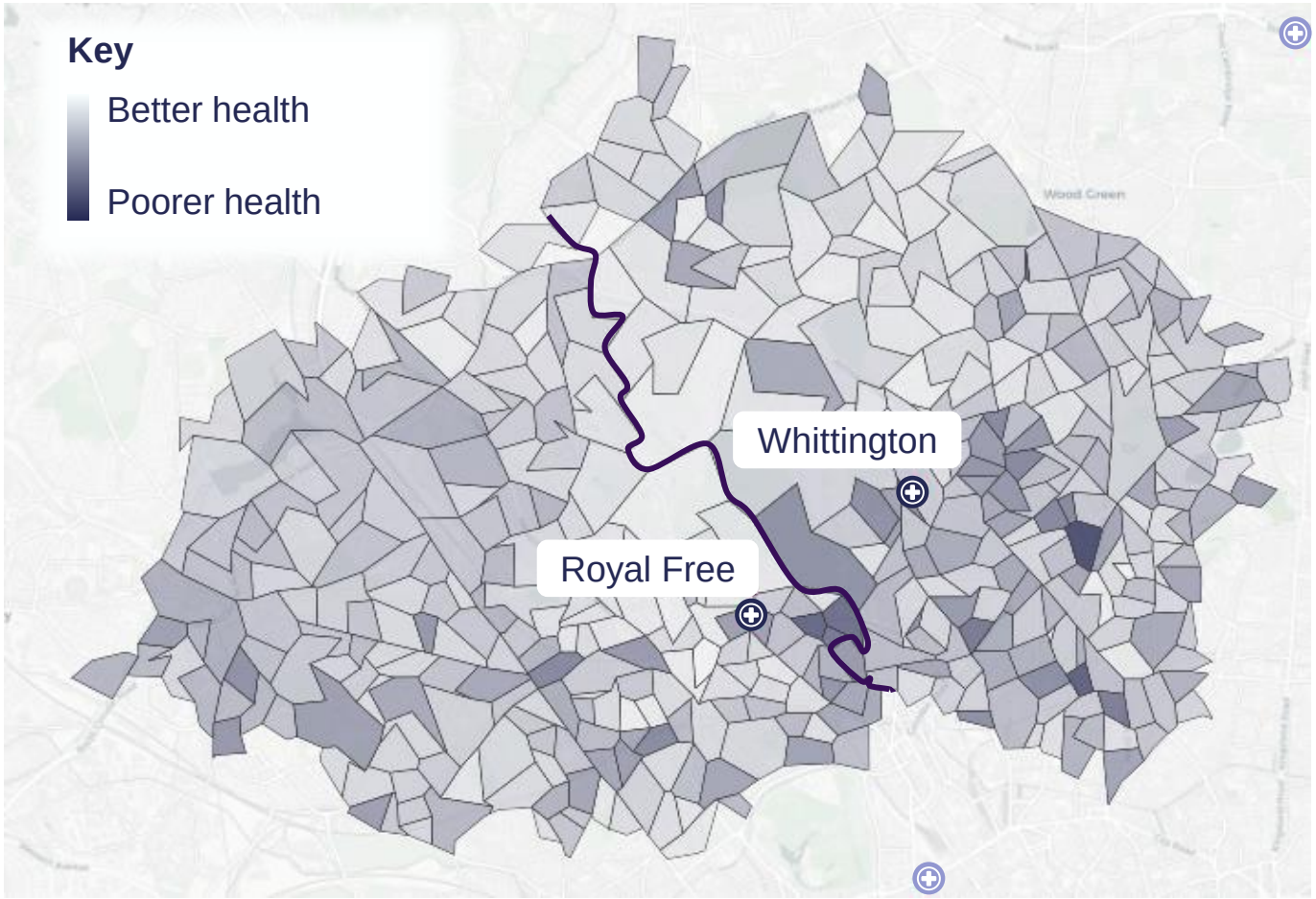
People with poor health
Rate (%) of population with poor health



Definition

Poor health is a self-assessed census measure where respondents rate their general health on a five-point scale: "Very good," "Good," "Fair," "Bad," or "Very bad." Those who select "Bad" or "Very bad" are classified as having "poor health."

Observations

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

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

Source: ONS, Traveltime API, CF Analysis (2024)

Demographics: Women and people of child-bearing age

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

Definition

Women and people of child-bearing age are defined in the 2021 census as any self-identified woman between the ages of 14 and 49, inclusive of both 14 and 49. There are issues in data collection for people who are transgender, making any collection of age versus gender identity difficult. As such, this metric uses the ONS self-defined terms of “man” or “woman”

Observations

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

Source: ONS, Traveltime API, CF Analysis (2024)

Demographics: Single parent households

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Single parent household populations
Rate (%) of households containing a single parent with dependent children

Definition

Single parent households are defined using ONS census data as any household with a single parent and dependent children

Observations

There are pockets of single parent households across the catchment population. One area with more single parent households is in the far west of the catchment

Source: ONS, Traveltime API, CF Analysis (2024)

Demographics: People with disabilities

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People with disabilities
Rate (%) of people with disabilities

Definition

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

Observations

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

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

Source: ONS, Traveltime API, CF Analysis (2024)

Demographics: Jewish people

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Jewish population
Proportion of Jewish populations

Definition

Jewish people are defined using ONS census data as anyone that identifies as being of 'Jewish' religion. As per the ONS, the different sects of Judaism can be identified by the self-reporting of Judaism as "Ethnicity" or "Religion". We identified Jewish populations by religion. Not all those who identify as religiously Jewish will be Orthodox Jewish and it is not possible to identify only those that are Orthodox Jewish, although much of the consultation feedback related to impacted communities relates to the Orthodox Jewish community.

Observations

The largest concentration of Jewish people are to the north west of the Royal Free and Whittington. These populations appear to be more within the Royal Free Hospital catchment area and would be impacted should Option A be implemented.

Source: ONS, Traveltime API, CF Analysis (2024)

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Potential impact of proposals on quality and outcomes

Summary: potential impact of proposals on quality and outcomes

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

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

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Maternity and neonatal care model benefits based on the case for change

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

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

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

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

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

Benefits and the proposed measures to track these have been developed (1/4)

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Category	Benefit description	Outcome	Measure	Expected to be realised by	Frequency	Data source
Care that ensures equity of provision and experience	• Pregnant women, people and babies have access to the same services. This includes community neonatal outreach services accessible across all boroughs and the same provision of neonatal care no matter which unit the baby is born in. • Provide a more personalised experience and ensure the individuals are supported and communicated with that best suits their own needs	Improved patient experience and outcomes	• Improve patient experience	Within 24 months of implementation	Annual	CQC survey Healthwatch Friends and Family test
			• Reduce number of avoidable term admissions to a neonatal unit	Within 12 months of implementation	Annual	BadgerNet / Epic
			• Increase CQC rating	Within 3 years post implementation	Annual	CQC website
			• Reduce maternity and Newborn Safety Investigations (MNSI) referrals	Within 12 months of implementation	Quarterly	Trust referrals to MNSI
		Reduced Maternity clinical negligence scheme premium for Trusts (CNST)	• Reduce maternity CNST premium per delivery	7 years post implementation	Annual	Trust finance teams
		Reduced normal care days delivered in an acute setting through enhanced delivery of community services	• Reduce number of special care neonatal care days delivered in neonatal units	Within 6 months of implementation	Quarterly	BadgerNet EPIC (UCLH)

Benefits and the proposed measures to track these have been developed (2/4)

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Category	Benefit description	Outcome	Measure	Expected to be realised by	Frequency	Data source
Services which are clinically sustainable	• Redesigning and reconfiguring our neonatal units in NCL, ensuring all units are either a designated LNU (level 2) or NICU (level 3).	Reduced neonatal transfers between units	• Reduce number of neonatal transfers for higher level of medical care	From go live	Quarterly	Neonatal ODN
Capacity to meet projected demand	• Neonatal units are running at less than the 80% recommended occupancy rate	Reduced risk of separating women or person from their baby and improving their experience	• Reduced number of non intensive care days delivered at UCLH for babies that live outside the catchment	Within 12 months of implementation	Quarterly	Neonatal ODN
			• Reduce number of in utero transfers	Within 12 months of implementation	Quarterly	Neonatal ODN

Benefits and the proposed measures to track these have been developed (3/4)

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Category	Benefit description	Outcome	Measure	Expected to be realised by	Frequency	Data source
Training and development opportunities	• Supporting training and development opportunities for staff through delivering sustainable volumes of neonatal activity at all neonatal units. • Reducing vacancies to make sure cots can be kept open and ensure there are sufficient staff (specialist nurses, allied healthcare professionals, etc) to provide expert care when required	No consultant workforce rota supporting the SCU (level 1) Consolidation of existing workforce into four units	• Improve staff satisfaction	Within 24 months of implementation	Annual	Staff survey National Education and Training Survey GMC training survey
			• Reduce staff turnover	Within 24 months of implementation	Annual	Trust data
			• Increase number of neonatal nursing QIS	Within 24 months of implementation	Annual	Neonatal ODN data
		Improved recruitment and retention	• Reduce vacancy rates	Within 24 months of implementation	Annual	Trust data
			• Reduce agency and bank spend	Within 24 months of implementation	Annual	Trust data
			• Reduce number of suspensions of alongside midwifery led service	Within 24 months of implementation	Annual	Trust data
			• Improve safe staffing levels against standards	Within 24 months of implementation	Annual	Trust data
			• Improve staff experience	Within 24 months of implementation	Annual	Staff survey National Education and Training Survey

Benefits and the proposed measures to track these have been developed (4/4)

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Category	Benefit description	Outcome	Measure	Expected to be realised by	Frequency	Data source
Up to date estate and buildings which are fit for purpose	• Investment in our existing maternity and neonatal estate so that all units are fit for purpose facilities and are designed to provide a positive birth experience • Any new capacity delivered will meet the latest space standards and this will have a role in delivering clinical benefits	Improved efficiencies	• Reduce backlog maintenance costs	Within 24 months of implementing	Annual	Trust ERIC data
		Improved staff and patient experience by enhancing staff environment	• Increase friends and Family test score	Within 24 months of implementation	Annual	Friends and Family Test
			• Improved staff survey results	Within 24 months of implementation	Annual	Trust staff survey GMC staff survey
			• Improvement in how trainees rate the support and fairness of their working environment	Within 24 months of implementation	Annual	National Education and Training Survey
			• Improved CQC Maternity survey results	Within 24 months of implementation	Annual	CQC survey

Key quality metrics would also continue to be monitored during and after implementation

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Metric	Measure	Timeframe for monitoring	Frequency	Data source
Quality	Reduce still birth rate	Ongoing during and after implementation	Annual	Maternity Services Data Set (MSDS) Trust data
	Reduce neonatal mortality rate	Ongoing during and after implementation	Annual	BadgerNet / Epic
	Reduce number of maternal deaths	Ongoing during and after implementation	Annual	Maternity Services Data Set (MSDS)
	Reduce unexpected maternal admissions to intensive care	Ongoing during and after implementation	Annual	Trust data
	Reduce rates of hypoxic ischemic encephalopathy	Ongoing during and after implementation	Annual	Trust data

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Potential impact of proposals on accessibility on the catchment population

Summary: potential impact of the proposals on accessibility

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- Engagement and the public consultation found people have concerns about **travel times, travel cost, and parking.** Following engagement, four access statistics and five impact metrics were identified to review the potential impact of the proposals on access across different demographic groups.
- During public consultation, we heard that the key concerns were the additional travel times and associated costs of the proposed changes and the ability to access an unfamiliar unit via public transport or if there was insufficient parking available. We have further explored these concerns within the statistics and metrics already developed and no additional statistics or metrics were identified as part of the public consultation.
- We therefore reviewed **four access statistics** (digital access, public transport accessibility, car ownership and parking spaces) and **five impact metrics** (travel time (peak/public transport), travel time (peak taxi/private car), travel time (off-peak taxi/private car/ambulance, taxi costs and driving costs) to assess the potential impact of our proposals on access
    - A potential impact of the proposals on access for the catchment population would be an **average increase in taxi costs of around £5**
    - There would be a **limited increase in average travel times** for peak, off-peak and public transport for options A and B. People would be able to access services within 30 minutes at peak driving time for options A and B. People would be able to access services within 25 minutes at off-peak driving time for options A and B. There is limited impact on public transport travel times for options A and B, with a maximum average increase of 8 additional minutes
    - There would be a **similar number of on-site car parking spaces** retained for options A and B compared to the status quo
    - The catchment population for options A and B have a **similar level of public transport accessibility**. People generally have better public transport accessibility closer to the centre of London.
    - **Average additional driving costs would be minimal**, and similar for options A and B, with a maximum increase of around £3 per journey. The largest increase in driving costs would be for people who live closest to the potentially closing maternity and neonatal unit.
    - **Average additional taxi costs would be similar for options A and B** and around £5 more. People closest to the Royal Free may need to **pay up to an additional £28 per taxi journey under option A**.
    - There is a **similar, high, level of digital access** within the catchment population for options A and B
    - **People have similar access to cars** for options A and B, with just under 50% of the population having access to a car. Car ownership varies, with people with a disability substantially less likely to own a car and a slightly higher population of people with disabilities in option A.
- Mitigations for these impacts can be found in slides 183-199.

Engagement and the consultation outlined concerns about travel times, travel cost, parking and wayfinding

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Getting to hospital

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

Access within hospital

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

Engagement on the integrated impact assessment was done with 124 people during 2023 and focussed on groups that were identified through the case for change as facing differential outcomes / inequalities. During public consultation, we heard that the key concerns were the additional travel times and associated costs of the proposed changes and the ability to access an unfamiliar unit via public transport or if there was insufficient parking available.

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

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Following engagement, four access statistics and five impact metrics were identified to review the potential impact of the proposals on access across different demographic groups. No additional statistics or metrics were identified as part of the public consultation.

1 **Digital access**	Poor digital access might create barriers for accessing care if people cannot access equipment or data
2 **Public transport accessibility**	Lack of public transport accessibility may make it difficult for people without access to a car to access services
3 **Car ownership**	Lack of car access may mean people find it difficult to access services, particularly if public transport is not good
4 **Parking spaces**	Lack of parking might make accessing sites difficult, particularly for vulnerable populations (such as those with disabilities)

1 **Public transport travel time**	Additional public time to travel to sites can be difficult and might dissuade people who rely on public transport
2 **Peak travel time**	Additional time to travel to sites can be difficult for people and might dissuade them from attending
3 **Off-peak travel time**	Additional time to travel to sites can be difficult for people and might dissuade them from attending
4 **Taxi costs**	People without access to a car may need to catch a taxi and high taxi costs may be unaffordable
5 **Driving costs**	Long / expensive journeys might place financial strain on some households

There would be an average increase in taxi costs of around £5 for the catchment population

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Catchment population
Access statistics for catchment population

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces retained
Option A	95.8%	15.0	48.1%	2,463
Option B	95.9%	17.1	44.6%	2,199

Impact on catchment population
Average impact across catchment population

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
A	Current	32.2	14.2	11.1	£17.59	£2.01
	Future	+ 4.4	+ 5.4	+ 3.8	+ £5.54	+ £0.63
B	Current	27.0	13.4	10.1	£13.52	£1.54
	Future	+ 8.2	+ 6.5	+ 4.9	+ £4.38	+ £0.50

Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi by 5-7 min and by public transport by 4-8 min
- A potential impact would be an increase in average taxi costs of around £5

Difference between options

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

Source: TravelTimeAPI, NimbleFinns, ERIC data, PTAL data, CF Analysis (2024)

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

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Catchment population

Access statistics for catchment population

Option	Transport method	Average travel time to current closest unit (mins)	Average travel time (mins) to next closest unit	Difference for average (mins)	Maximum travel time to current closest unit (mins)	Maximum travel time (mins) to next closest unit	Difference for maximum (mins)
Option A	Off-peak	11.1	14.9	+ 3.8	20.3	22.2	+ 1.9
	Peak	14.2	19.6	+ 5.4	27.1	29.2	+ 2.1
	Public transport	32.2	36.6	+ 4.4	72.9	86.5	+ 13.6
Option B	Off-peak	10.1	15.1	+ 5.0	17.3	20.4	+ 3.1
	Peak	13.4	19.9	+ 6.5	23.5	27.4	+ 3.9
	Public transport	27.0	35.2	+ 8.2	43.9	59.1	+ 15.2

Source: TravelTimeAPI, CF Analysis (2024)

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

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Future travel time

Future travel time (mins) for peak driving by option

Additional travel time

Average & max travel time (mins) - peak driving

	Option A	Option B
Current average travel time	14.2	13.4
Average travel time under option	19.6	19.9
Difference in average travel time	**+ 5.4**	**+ 6.5**
Current max. travel time	27.1	23.5
Max. travel time under option	29.2	27.4
Difference in max. travel time	**+ 2.1**	**+ 3.9**

- These maps show the new travel time if options A or B were implemented (a darker colour represents **longer travel times**)
- In option A, the population closest to the Royal Free Hospital would have **increased travel times of 5.4 minutes on average**, with a maximum travel time of 29.2 minutes
- In option B, the population closest to the Whittington Hospital would have **increased travel times of 6.5 minutes on average** with a maximum travel time of 27.4 minutes
- **Note:** the LSOA with the maximum travel time currently may be different to the LSOA with the maximum travel time in the future

Source: TravelTimeAPI, CF Analysis (2024)

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

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Available parking spaces on-site

Available parking spaces on-site

Site	On-site parking spaces*
Barnet	989
North Mid	973
Royal Free	374
UCLH	127
Whittington	110
Total	**2,573**

Available parking spaces on-site per option

Available parking spaces on-site (total spaces)

Option	On-site parking spaces retained*	Total number of spaces across all sites in Option
Option A	110	2,199
Option B	374	2,463

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

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

Source: ERIC (2021) – CF Analysis (2024)

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

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Public transport accessibility
Average public transport accessibility, peak catchment

Option	Public transport accessibility (peak)
Option A	15.0
Option B	17.1

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

Public transport accessibility

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

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

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

The analysis then examines how **well-connected the catchment areas of the providers are, in each option**. The average PTAL score across London in the status quo is 13.34

Source: PTAL (2015/16) – CF Analysis (2024)

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

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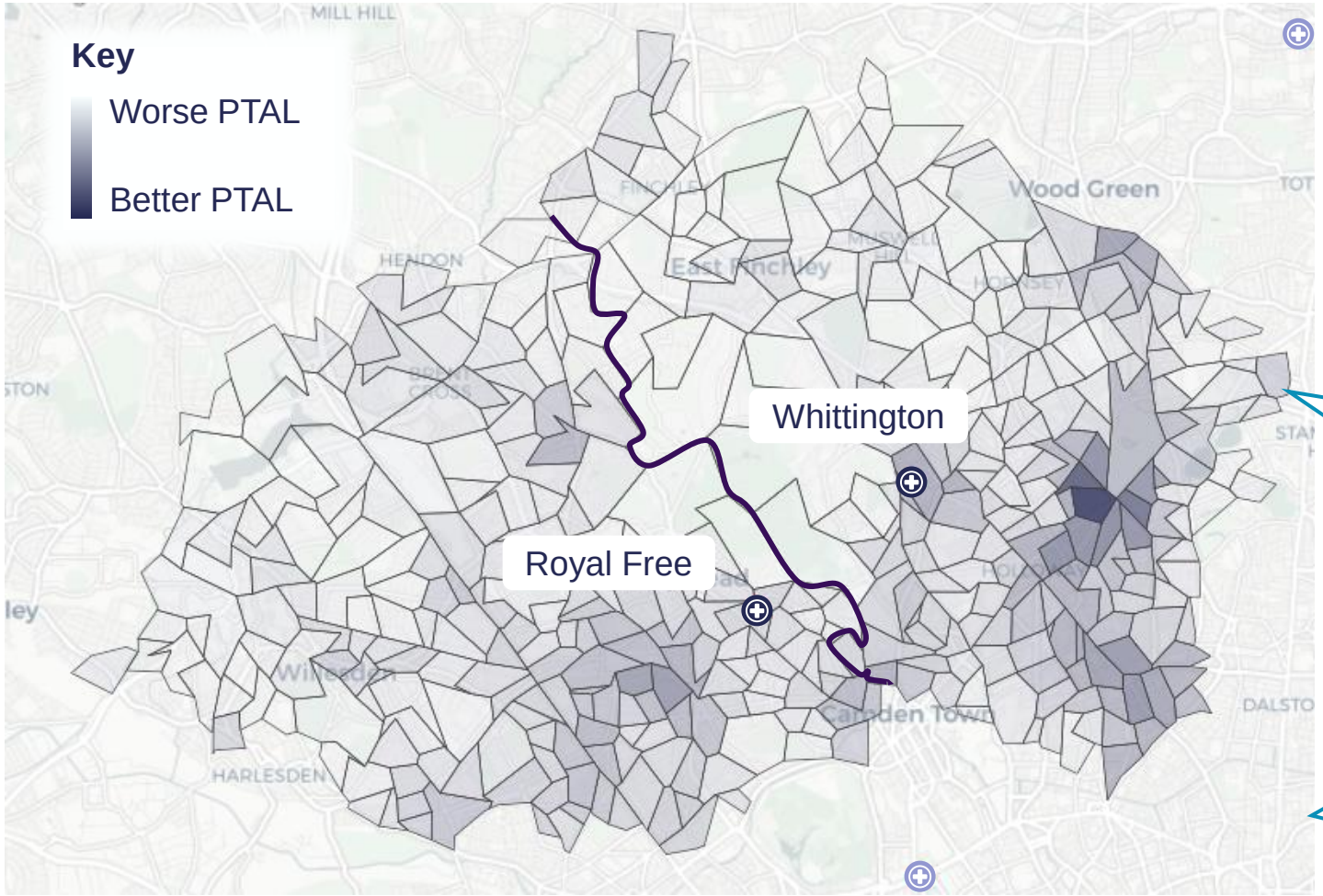
Public transport availability

Public transport availability by option, peak catchment



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

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

Source: PTAL (2015/16), TravelTimeAPI, CF Analysis (2024)

Average additional driving costs would be minimal, and similar for the options, with a maximum increase of ~£3

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

Option	Average additional cost per journey (£) compared to now	Maximum additional cost per journey (£) compared to now
Option A	+ £0.63	+ £3.22
Option B	+ £0.50	+ £2.21

Driving costs

- The average cost of travel was calculated using NimbleFinn's 2024 calculation of the average cost of running a car per mile of £0.57/mile. This cost has been multiplied with the average additional time for travel from **every LSOA to their nearest unit in each option.**
- The result is the **average additional cost of driving (£) per LSOA.**
- Driving costs may also be impacted by the **ULEZ charge** for some people which is £12.50 per day
- For each population group, the average increase in driving cost is weighted by the size of that specific population to understand the impact for that group.

Average cost of running a car per mile (£0.47 per mile) × Average additional distance of travel (mile)

There is a similar additional cost for options A and B.

Source: TraveltimeAPI (2024) & NimbleFinns (2024) – CF Analysis (2024)

The largest increase (£3 per journey) in driving costs would be for people living north west of the Royal Free Hospital

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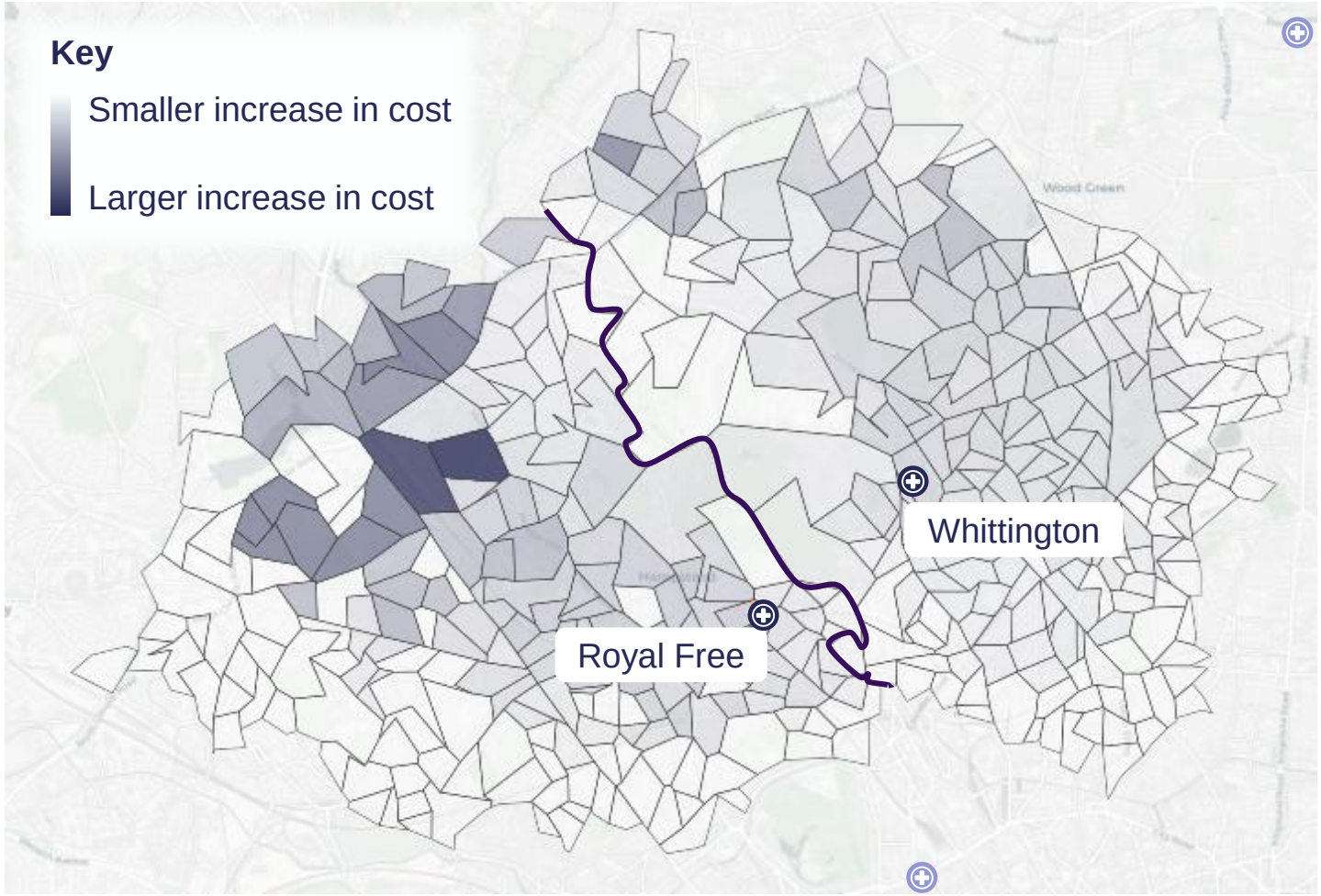
Increase in driving costs

Average increase in driving cost by Option



Driving costs

The largest increase in driving costs would be for people living closest to the potentially closing maternity and neonatal unit although this would be around £3 per journey under options A and B.

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

Source: TraveltimeAPI (2024) & NimbleFinns (2024) – CF Analysis (2024)

Average additional taxi costs may increase by around £5 in both options

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

Option	Current average cost per taxi	Average additional cost per taxi (£) compared to now	Maximum additional cost per taxi (£) compared to now
Option A	£17.59	+ £5.54	+ £28.29
Option B	£13.52	+ £4.38	+ £19.37

Taxi costs

The average cost of travel by taxi was calculated using NimbleFinn's 2024 calculation of the average cost of running a taxi per mile of £5.0/mile. This cost has been multiplied with the average additional time for travel from **every LSOA to their nearest unit in each Option.**

The result is the **average additional taxi cost (£) per LSOA.** For each population group, the average increase in taxi cost is weighted by the size of that specific population to understand the impact for that group.

Average cost of a taxi (£5 per mile) × Average additional distance of travel (mile)

Source: TraveltimeAPI (2024) & NimbleFinns (2024) – CF Analysis (2024)

People to the north-west of the Royal Free Hospital may need to pay up to an additional £28 per taxi journey

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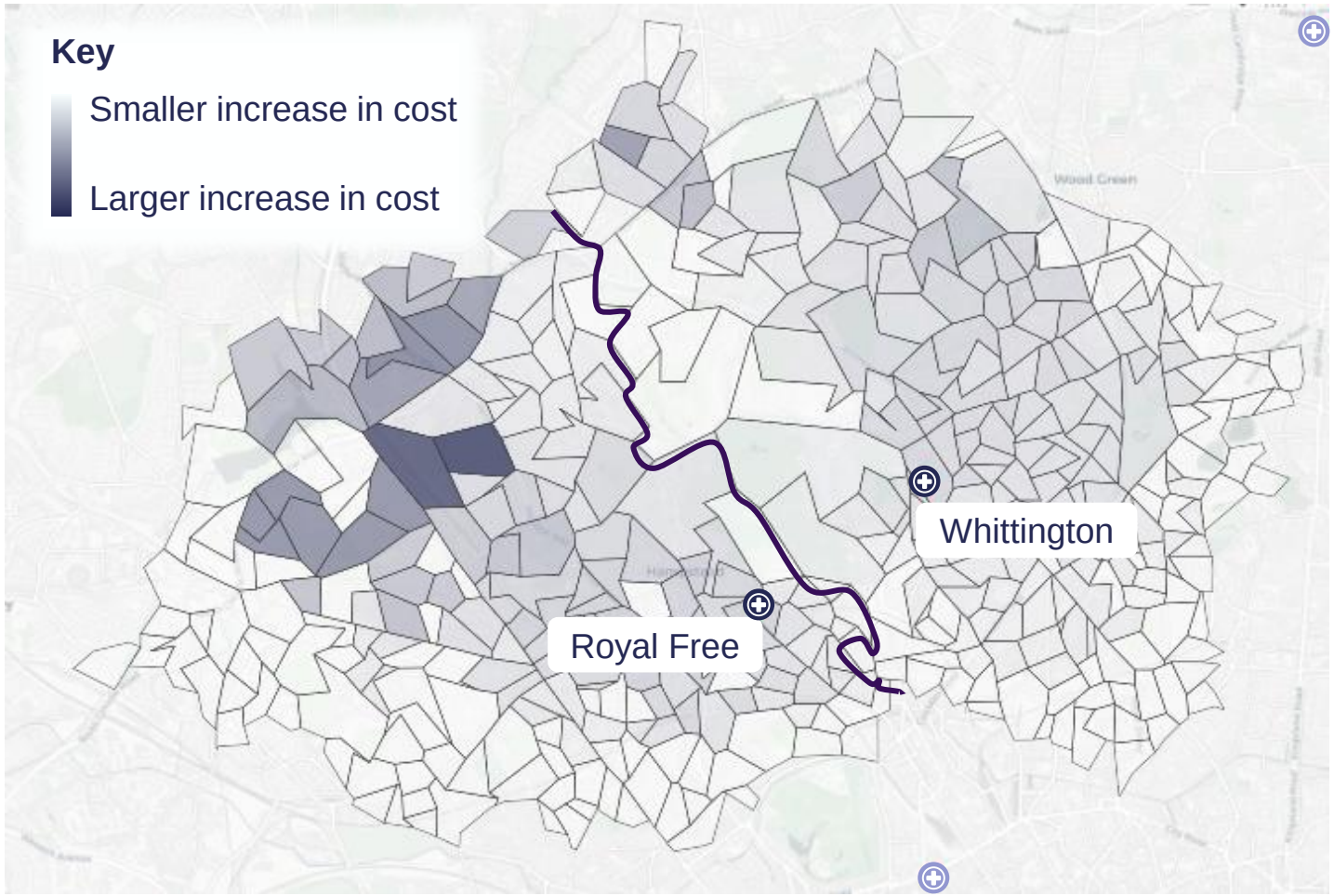
Increase in taxi costs
Average increase in taxi cost by option



Taxi costs

The average increase in taxi costs is £4-6 per journey, which is similar between both option A and B.

People to the north-west of the Royal Free Hospital may need to pay up to an additional £28 per taxi journey

Source: TraveltimeAPI (2024) & NimbleFinns (2024) – CF Analysis (2024)

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

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Digital access
Mean digital propensity scores for options A and B

Option	Digital propensity index (DPI) of catchment population
Option A	95.8%
Option B	95.9%

Digital Propensity Index (DPI)

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

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

Source: Digital Propensity Index (ONS) 2021 – CF Analysis (2024)

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

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Car ownership
Average rate (%) of car access (2024 ONS estimate from 2021 data)

Option	Car ownership rates (%)
Option A	48.1%
Option B	44.6%

Car ownership

The ONS measures rates of vehicle access (defined as any household that owns any number of vehicles) per LSOA, with estimates for 2024 taken from the 2021 census.

Note: car access rates measure household access to a vehicle of any type, be it van or car. However, this does not consider the household size and specific situations per household. For example, a household with only one car and a person who uses it for work would be similar to a household without any cars in terms of access to healthcare during working hours.

Source: ONS (2021) – CF Analysis (2024)

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

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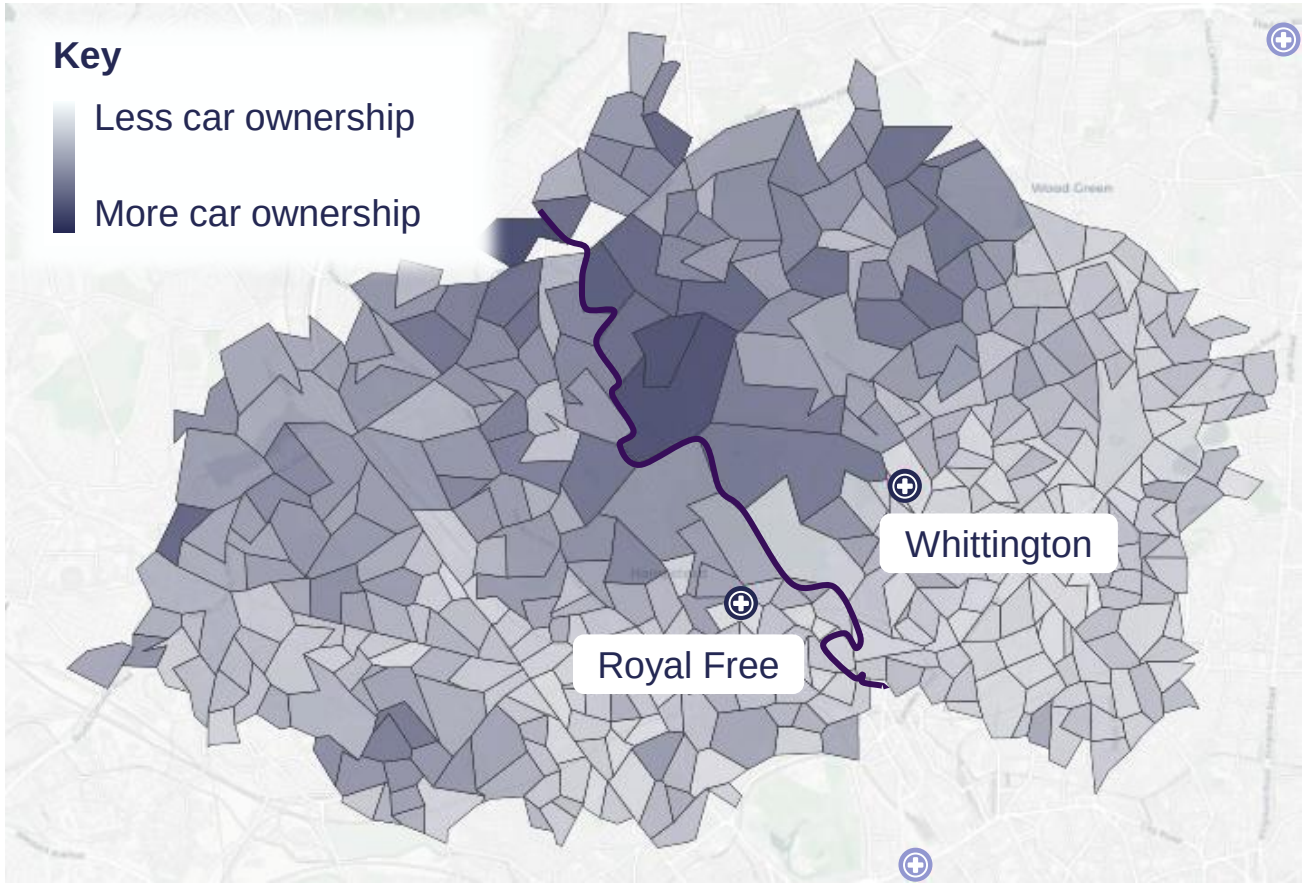
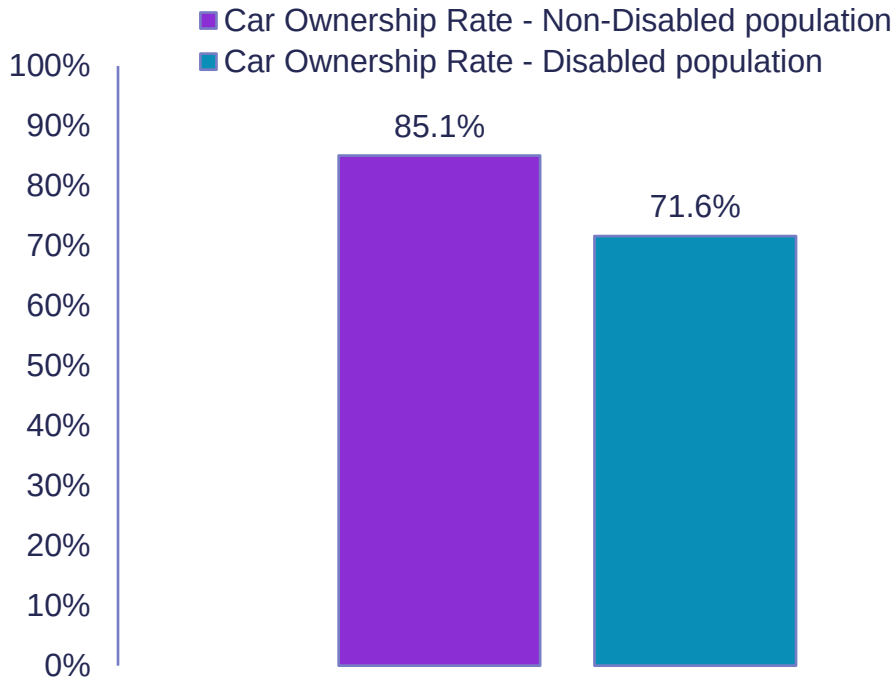
Car ownership

Car ownership rate (2021) by LSOA



Car ownership for people with disabilities

Vehicle ownership rates (2021) with disability



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

Source: ONS, TravelTimeAPI, CF Analysis (2024)

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

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

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- The impact of the proposals on groups who share protected characteristics and people who have vulnerabilities has been reviewed, in line with legal duties, and it is similar to the potential impact on the general catchment population
- We identified some groups sharing a protected characteristics, or who may be more impacted by our proposals:
  - **Race:** there is evidence Somali pregnant women and people have very poor outcomes and may need to travel further or switch hospitals in Finsbury Park (option B) and Kilburn (option A). There is little difference between options A and B for people from minority ethnic groups, but they may require mitigations to be put in place to address language and cultural barriers. The Orthodox Jewish community share the race characteristic as Jewish people are defined by a reference to ethnic origins. This population has specific needs, with a greater impact in option A on this community because they live near to the unit that may close. Specific mitigations have been developed and would continue to be iterated with this population
  - **Age:** younger and older pregnant women and people may need to attend more appointments throughout their pregnancy and could be impacted if these were further away
  - **People with disabilities:** people with disabilities may need additional support to access services on an unfamiliar site for options A and B. Some people may find it more difficult to attend a unit that is further away, or on a different site, on a more frequent basis due to an underlying health condition that impacts on the complexity of their pregnancy
  - **People living in Core20 areas of deprivation:** the main impact on access for people living in areas of deprivation, people who are economically inactive and people with poor health is an average increase in taxi costs of almost £5 and lower car ownership than average. There is a greater impact in option B for people living in areas of deprivation, but these people may face barriers to travelling further or accessing a different site due to cost of transport, digital exclusion and already having children in both options compared to now
  - **Pregnant women and people with complex (or pre-existing) health conditions:** people with complex health conditions affecting pregnancy may need to access their specialist care at a different site to their obstetric care
  - **Orthodox Jewish community:** the Orthodox Jewish community have specific needs, with a greater impact in option A on this community because they live near to the unit that may close. Specific mitigations have been developed and would continue to be iterated with this population
  - **Other inclusion health groups:** groups such as homeless people, refugees, victims of domestic abuse and travellers have been considered. There is little difference between options A and B for other inclusion health groups, but these people may face barriers to travelling further or accessing a different site due to barriers for cost of transport, digital exclusion and language barriers would need to be addressed in both options compared to now

- Further details of mitigations that have been developed are shown on slides 183-199

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

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- There is a duty under the Equality Act 2010 and the Health and Care Act 2022 to consider the impacts of the proposals
- Where there is quantitative data available, we used this data to review the impact on groups with protected characteristics and people who have vulnerabilities such as living in a deprived area, travellers, single parent families and homeless people (there may be some overlap between the groups, for example, people who have poor English proficiency are likely to overlap with people who belong to an minority ethnic group, and we have assessed where this may be the case). The outcome of this quantitative analysis is shown on some of the following slides. We have also used engagement and qualitative assessment.
- We have not identified any potential disproportionate impact from being married or in a civil partnership, and this has not been raised as a potential issue in engagement or public consultation, therefore this has not been assessed further than looking at single-person households
- Our analysis shows where some people with protected characteristics and people who have vulnerabilities may be disproportionally impacted by the proposals and we have therefore developed mitigations against these potential impacts
- We considered the concerns raised during public consultation about the affordability of additional travel expenses, difficulties in travelling further, language barriers, inability to drive, and women and families from the Orthodox Jewish community who cannot drive or use public transport on Shabbat (Sabbath) or Jewish festivals

Some groups may be disproportionally impacted by the proposals (1/2)

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		Potential impacts that may require mitigations
Protected characteristic	Race	• Impact on the Orthodox Jewish community has been considered as a set of bespoke analysis as they share both the race and religion protected characteristic • No difference between the options for other groups that share this protected characteristic • Language barriers would need to be addressed if people not proficient in English need to access an unfamiliar unit to ensure that they understand the changes and seek the care that they need • The Somali communities in Harlesden and Willesden and Finsbury Park may need to travel further or switch hospital compared to now
	Age	• No difference between the options • Older and younger women of childbearing age may need to attend more appointments throughout their pregnancy due to increased complexity and therefore could be impacted if the appointments were further away compared to now
	Sex	• No difference between the options • No specific impacts of the proposals that require mitigations
	People with disabilities	• No difference between the options • People with a disability may have difficulty accessing services on an unfamiliar site compared to now particularly those who may be less likely to drive or be able to afford any additional travel costs
	Being pregnant or on maternity leave	• No difference between options • The proposals are to change services for pregnant women and people and this IIA considers barriers they may face in accessing services when pregnant, in labour or with a newborn baby
	Gender reassignment	• No difference between the options • No specific impacts of the proposals that require mitigation but improved education of staff and healthcare processes would be considered
	Religion of belief	• Impact on the Orthodox Jewish community has been considered as a set of bespoke analysis as they share both the race and religion protected characteristic • No specific impacts of the proposals that require mitigations for any other religion
	Sexual orientation	• No difference between the options • No specific impacts of the proposals that require mitigations but improved education of staff and healthcare processes across the system should be considered
	Being married or in a civil partnership	• No difference between the options • No specific mitigations required

Some groups may be disproportionally impacted by the proposals (2/2)

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		Potential impacts that may require mitigations
Other	Orthodox Jewish community	• Greater impact on the Orthodox Jewish community under option A • The proximity of the Royal Free Hospital to the local area means there may be impacts in the future, particularly for visitors arriving on foot on religious festivals* and Shabbat • Initial mitigations have been developed (slides 195-199) and will be iterated with this community
	People living in Core20 areas	• There is a greater impact on people living in Core20 areas in option B • Potential overlap with race, other inclusion groups and disabilities that should be considered • People living in Core20 areas may have difficulties with cost of transport, digital exclusion and barriers for people who already have children compared to now as a result of the additional travel time
	People in poor health	• No difference between the options • People in poor health may have more complex pregnancies that require additional antenatal appointments during pregnancy which will therefore cause a greater travel time and cost impact of accessing services at an alternative unit
	Pregnant women and people with complex (or pre-existing) health conditions	• No difference between the options (potential overlap with deprivation and disabilities) • People with complex (or pre-existing) health conditions affecting pregnancy may need to access their obstetric care at a different (unfamiliar) site to their specialist care • Some people with complex (or pre-existing) health conditions affecting pregnancy may need to travel further than their next nearest hospital for obstetric care
	Other inclusion health groups	• No difference between the options (potential overlap with race, deprivation and disabilities) • People in other inclusion groups may have difficulties with cost of transport, digital exclusion and language barriers compared to now

*Note: We use the term religious 'Festivals' following feedback from the Orthodox Jewish community that this term is more appropriate in this context than religious 'Holidays'

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Race (includes people from minority ethnic groups and poor English proficiency)

There would be an average increase in taxi costs of around £5 for people from minority ethnic groups

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People from minority ethnic groups
Access statistics for people from minority ethnic groups

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces retained
Option A	95.9%	15.1	48.9%	2,199
Option B	95.9%	18.2	44.1%	2,463

Impact on people from minority ethnic groups
Average impact people from minority ethnic groups

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
A	Current	28.3	15.0	12.3	£17.55	£2.00
	Future	+ 3.9	+ 5.3	+ 3.8	+ £5.47	+ £0.62
B	Current	16.2	13.7	10.3	£13.77	£1.57
	Future	+ 4.7	+ 6.3	+ 4.7	+ £4.26	+ £0.49

Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (peak) by 5-7 minutes, by 4-5 minutes (off-peak) and by public transport by 4-5 min which is similar to the catchment population
- A potential impact would be an increase in average taxi costs of £4-6 which is similar to the general population. Car ownership for Option B is slightly lower than average for people from minority ethnic groups (44.1% compared to 44.6%)
- Public transport accessibility is slighter higher for people from minority ethnic groups than for the general catchment population (A: 15.1 compared to 15.0, B: 18.2 compared to 17.1)

Difference between options

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

There would be an average increase in taxi costs of almost £5 for people with poor English proficiency

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People who have poor English proficiency
Access statistics for people who have poor English proficiency

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces retained
Option A	95.8%	14.4	49.0%	2,199
Option B	95.7%	18.8	41.6%	2,463

Impact on people who have poor English proficiency
Average impact people who have poor English proficiency

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
A	Current	29.2	16.6	13.6	£20.66	£2.36
	Future	+ 3.4	+ 4.8	+ 3.5	+ £5.71	+ £0.65
B	Current	14.8	15.0	11.1	£14.91	£1.70
	Future	+ 3.7	+ 5.9	+ 4.3	+ £3.82	+ £0.44

Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (peak) by 5-6 minutes, by 3-5 minutes (off-peak) and by public transport by 3-4 min, which is similar to the catchment population
- A potential impact would be an increase in average taxi costs of around £4-£6 which is similar to the general population, although car ownership is slightly lower than for the option B catchment population 41.6% compared to 44.6%
- Public transport accessibility is higher for with poor English than for the catchment population for option B (18.8 compared to 17.1)

Difference between options

- Options A and B would have **similar impacts** on people not proficient in English (including literacy)
- Option A has a **higher car ownership, lower public transport accessibility** alongside a **higher increase in average taxi costs.** The lower car ownership for Option B means they may be more impacted by taxi costs but they have higher **public transport accessibility**

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

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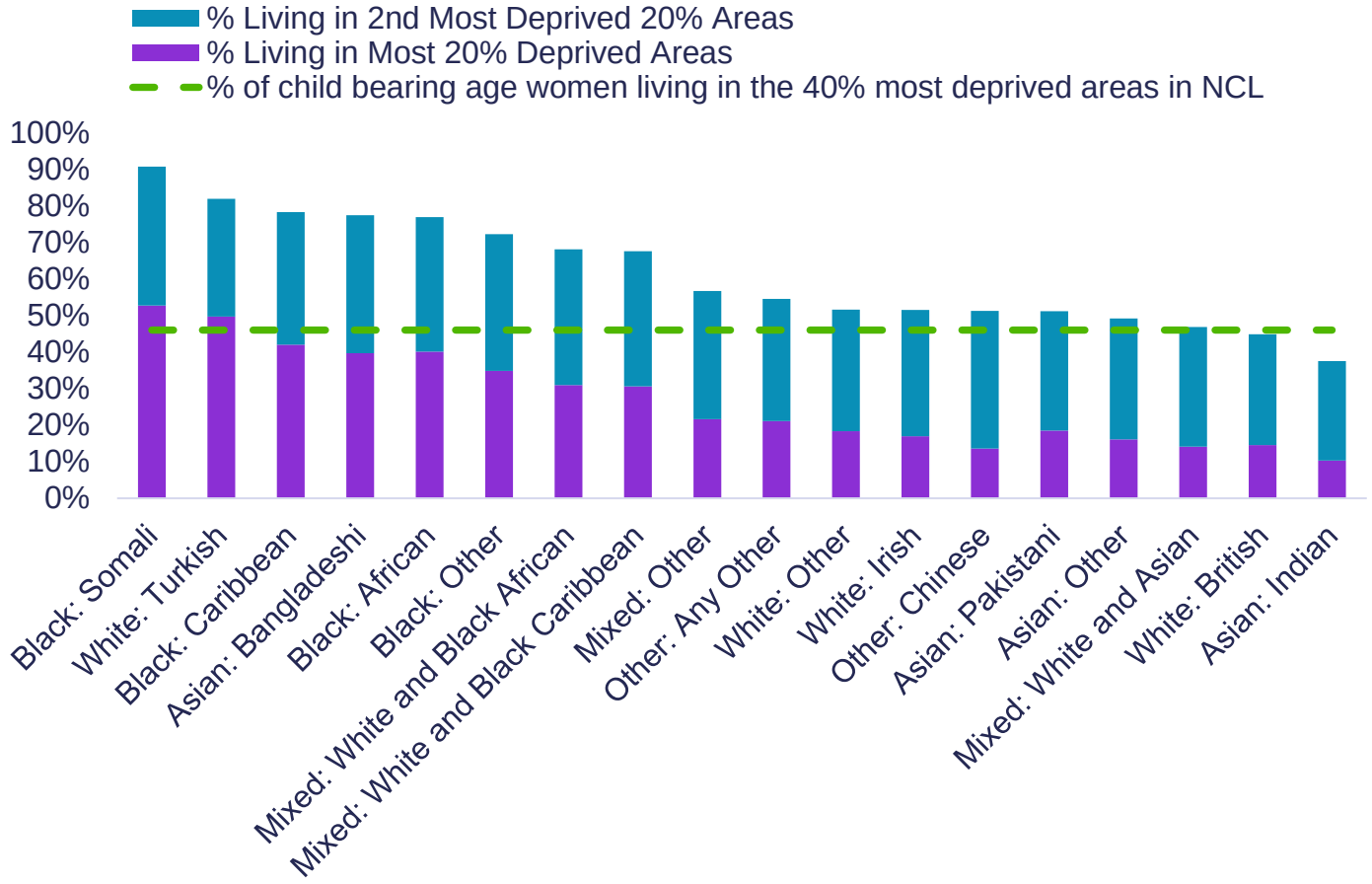
Deprivation by ethnicity

People living in areas of deprivation by ethnic group



Population

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

Impacts

- There is a large Somali community in Finsbury Park which would be impacted by Option B and would access services at the Royal Free Hospital rather than the Whittington Hospital. Given their proximity to the Whittington Hospital, they may be impacted by the relatively higher increases in taxi costs to an alternative maternity unit.
- There is a smaller Somali community in Kilburn that would be impacted by Option A. Their closest hospital would change from the Royal Free Hospital to Northwick Park Hospital or St Mary's Hospital.

Source: NCL ICB Public Health team

There is little difference in impact between the options for people from minority ethnic groups but language and cultural barriers

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Interim IIA engagement and consultation feedback

- Language barriers and lack of interpretation impact on people's experience of care
- There was a feeling that people were treated differently as they didn't speak English
- Lack of interpretation available meant they did not always know what was happening around them and did not feel involved in their maternity care
- There was a desire to have female interpreters, and this was not always available
- Cultural differences were not always understood or accommodated by staff
- The public consultation did not identify impacts in either option that were specific to people from minority ethnic groups. Much of the preferences expressed regarding each option were related to proximity of the hospital, experience of care and ease of travel to an alternative site

Impact on people from minority ethnic groups

- There appears to be **no difference between the options for people from minority ethnic groups.**
- Mitigations for **language barriers** where people are not proficient in English would need to be addressed as proposals are implemented, and for people from minority ethnic groups who live in areas of deprivation (see slides 183 - 194)**.**
- Particular attention would need to be paid to the **Somali communities in Finsbury Park and Kilburn** who may need to travel further or switch hospital**.**
- We would continue to engage with this group following publication of this IIA and beyond.

Bespoke analysis has been undertaken to understand the impact on the Orthodox Jewish community as they share the religion and ethnicity protected characteristics

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Age and sex

There would be an average increase in taxi costs of almost £5 for women of child-bearing age

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Women of child-bearing age
Access statistics for women and people of child-bearing age

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces retained
Option A	95.9%	15.8	48.2%	2,199
Option B	95.9%	18.7	43.6%	2,463

Women of child-bearing age
Average impact across women and people of child-bearing age

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
A	Current	27.8	14.2	11.6	£15.99	£1.82
	Future	+ 4.1	+ 5.5	+ 4.0	+ £5.54	+ £0.63
B	Current	15.1	13.5	10.1	£13.33	£1.52
	Future	+ 4.6	+ 6.5	+ 4.8	+ £4.24	+ £0.48

Impact of the proposals compared to now

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

Difference between options

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

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

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Service provision and outcomes

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

Interim IIA engagement and public consultation feedback

- Older mothers who took part in the IIA engagement were happier to travel than other groups of people, saying that they would prefer to travel further for their first choice of maternity care, based on previous experience or recommendations for others
- The public consultation did not highlight particularly significant impacts due to age but older women and pregnant people may require additional appointments

Potential impacts that may require mitigation

- Considering the work to date and the public consultation, there appears to be **no difference between options A and B** for older and younger pregnant women.
- As this population may need to attend more appointments throughout their pregnancy, the additional travel times and associated costs **could have a larger impact if these appointments were further away**.
- We would continue to engage with this group following publication of this IIA and beyond.

Source: MBRRACE-UK. 2021. Saving Lives, Improving Mothers Care

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Pregnant women and people with complex (or pre-existing) health conditions

Some people with complex (or pre-existing) health conditions may have specific needs

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Population

- The number of pregnant women and people of childbearing age with complex (or pre-existing) health conditions that may be impacted by our proposals is very small
- The population has been identified as pregnant women and people that have more complex (category B and C) medical conditions during pregnancy and receive specialist care at either the Royal Free Hospital in option A or Whittington Hospital in option B. People with less complex (category A) health conditions would be cared for at their local hospital, as now.
- For further information on the specific conditions and numbers of pregnant women and people with complex (or pre-existing) health conditions see section 11.4 in the DMBC

Service provision and outcomes

- These pregnant women and people have complex underlying medical conditions which means they require care from specialists in their condition before, during and after pregnancy alongside specialists in obstetric care
- In NCL, there is already a Maternal Medicine Network (MMN) which is responsible for ensuring that these pregnant women and people in NCL receive timely specialist care and advice
- This population has very specific needs, which are different to the rest of the potentially impacted population, and need to be managed on an individual basis with specialist input

New model of care

- Under the new model of care, this population would continue to receive safe and high-quality care that meets their individual needs on a networked basis with UCLH continuing in its role as the maternal medicine centre for NCL

Interim IIA engagement and public consultation feedback

- During consultation, concerns were raised that our proposals may impact on access and continuity of care for pregnant women and people with complex (or pre-existing) health conditions

Potential impacts that may require mitigation

- Pregnant women and people with the most complex (or pre-existing) health conditions who attend Royal Free Hospital or Whittington Hospital would need to access their obstetric care at a different site to their specialist care in the future, which would mean accessing an unfamiliar unit. In either option, this may result in less joined up care
- Some of these pregnant women and people may need to access obstetric care at a unit that is not their next closest, because of their needs, which means they would need to travel further than the general population
- Some minority ethnic groups and people living in areas of deprivation associated with poorer maternity outcomes are likely to be disproportionately represented amongst those with the most complex (or pre-existing) health conditions, although these are very small numbers
- From work to date, there appears to be no difference between options in potential impact for people with complex (or pre-existing) health conditions
- We would engage with this group throughout the implementation process and work with them to develop mitigations as needed

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Single parent households

There is an average increase in taxi costs of £5 for single parent households

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Single parent households
Access statistics for single parents

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces retained
Option A	95.7%	14.8	47.1%	2,199
Option B	95.6%	18.5	41.9%	2,463

Impact on single parent households
Average impact across single parent households

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
A	Current	28.5	15.4	12.8	£18.39	£2.10
	Future	+ 3.6	+ 5.0	+ 3.7	+ £5.05	+ £0.58
B	Current	15.2	13.6	10.2	£13.37	£1.52
	Future	+ 4.8	+ 6.3	+ 4.7	+ £4.05	+ £0.46

Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (peak) by 5-6 minutes, by 4-5 minutes (off-peak) and by public transport by 4-5 min, which is similar to the catchment population
- The biggest impact would be an increase in average taxi costs of £4-5 which is similar to the catchment population. Car ownership is lower than average for single parents (A: 47.1% compared to 48.1%, B: 41.9% compared to 44.6%)
- Public transport accessibility is higher for single parents than for the catchment population in Option B: 18.5 compared to 17.1

Difference between options

- Options A and B would have **similar impacts** on single parents
- Option A has a **higher car ownership,** slightly **lower public accessibility** alongside a **higher increase in average taxi costs**
- This population are most likely to be impacted by driving costs, which are lower than for the catchment population

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People with disabilities

There would be an average increase in taxi costs of almost £5 for people with disabilities, who have lower car access

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People with disabilities
Access statistics for people with disabilities

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces retained
Option A	95.7%	15.3	47.9%	2,199
Option B	95.7%	18.0	43.8%	2,463

Impact on people with disabilities
Average impact for people with disabilities

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
A	Current	27.4	14.4	11.9	£16.42	£1.87
	Future	+ 3.9	+ 5.3	+ 3.8	+ £5.33	+ £0.61
B	Current	16.1	13.2	9.9	£13.08	£1.49
	Future	+ 5.0	+ 6.6	+ 4.8	+ £4.33	+ £0.49

Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (peak) by 5-7 minutes, by 4-5 minutes (off-peak) and by public transport by 4-5 min, which is similar to the catchment population
- A potential impact would be an increase in average taxi costs of £4-6 which is similar to the catchment population, car ownership is slightly lower than average people with disabilities for Option B: 43.8% compared to 44.6%
- Public transport accessibility is higher than average for people with disabilities (A: 15.3 compared to 15.0, B: 18.0 compared to 17.1)

Difference between options

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

During consultation we heard feedback from people who are deaf and people experiencing mental illness

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Feedback IIA engagement and public consultation

- Feedback was received during engagement and the consultation from people experiencing mental illness and people who are deaf or hard of hearing
- It should be noted that not all people experiencing a mental illness would be defined as having a disability*

People experiencing mental illness

- Valued being seen by the same midwife throughout their pregnancy and delivery and we therefore need to consider how to support this when accessing care at an unfamiliar hospital

People who are deaf and hard of hearing

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

From work to date, there appears to be **no difference between the options for people with disabilities**. Mitigations for **people changing the place where they access services** would need to be addressed as proposals are implemented**.** This may include additional communication and support for this group would be required to support continued access to services. We would continue to engage with this population following publication of this IIA and beyond.

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

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

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People with learning disabilities

Population

- It is estimated that nationally 1 in 7 people have learning disabilities to some extent[1]
- This equates to 13,032 women and people of childbearing age with learning disabilities who would be impacted in option A and 9,411 in option B

Service provision and outcomes

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

Feedback IIA engagement and public consultation (people with learning disabilities and autism)

- Information is not always available in formats they require such as easy read, including on how to find hospital sites and clinics.
- Travelling to unfamiliar places is difficult, and often there is little information to help with this.
- Travel and transport can sometimes present problems. Issues such as transport not arriving, taxis or public transport not being able to accommodate wheelchairs
- Not having sufficient information on how to get to unknown or unfamiliar locations
- Double appointments might be needed for some parents with disabilities
- Participants at a public consultation focus group for people with learning disabilities outlined the difficulties in moving hospitals if they are comfortable with staff and have good support at the hospital they currently use

From work to date, there appears to be **no difference between the options for people with disabilities**. Mitigations for **people changing the place where they access services** would need to be addressed as proposals are implemented**.** This may include additional communication and support for this group would be required to support continued access to services. We would continue to engage with this population following publication of this IIA and beyond.

Source: [1]https://dceg.cancer.gov/about/diversity-inclusion/inclusivity-minute/2022/neurodiversity

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LGBTQI+ populations

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

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Population

- The overall transgender population in the UK is 0.1%, with the ratio of female to male (FtM) people in the transgender population being typically around 30%[1]
- An estimate of the number of FtM people of childbearing age that are potentially impacted by the proposals is therefore 29 people for Option A and around 34 people for Option B

Service provision and outcomes

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

Impacts

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

Feedback from the public consultation

- Engagement was carried out with the LGBTQI+ community during, including transgender men who said that their needs were often overlooked
- This included the incorrect use of their preferred pronouns, misgendering and having to repeat their story to each new person they met
- The population all reported that healthcare service providers had made assumptions about their pregnancies and their relationships
- Transgender men outlined that they were often the first pregnant transgender man a midwifery team had encountered, and they had to educate the team

- The public consultation outlined that there was **no difference between the options for people who are transgender.**
- Mitigations have been developed which we would implement regardless of whether a decision is taken on the proposals which include educating staff and improved two-way engagement
- We would continue to engage with this population following publication of this IIA and beyond.

Source: [1]https://www.stonewall.org.uk/the-truth-about-trans

The potentially impacted population who are LGBTQI+ is very small but can have complex needs

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Population

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

Service provision and outcomes

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

Impacts

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

Feedback from interim IIA engagement and public consultation

- Participants said they felt there was a lack of inclusivity of language on information, forms and posters
- LGBTQI+ participants said that healthcare service providers had made assumptions about them, their pregnancies and their relationships
- Participants shared that they felt they had to explain their pregnancy story to every new person that they met during their maternity care

- From work to date, there appears to be **no difference between the options for people who are LGBTQI+**.
- Mitigations have been developed which we aim to implement regardless of whether a decision is taken on the proposals which include educating staff and improved two-way engagement
- We would continue to engage with this group following publication of this IIA and beyond.

Source: [1]https://www.stonewall.org.uk/the-truth-about-trans

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Orthodox Jewish community

There is potential impact of the proposed changes on the Orthodox Jewish community

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- The interim IIA stated that the proposed changes to maternity and neonatal services may have an impact on the Orthodox Jewish community
- The Orthodox Jewish community are defined by a reference to ethnic origins and therefore share the protected characteristics of both race and religion[1]
- We also heard during the public consultation that the potential impact on the Orthodox Jewish community, particularly for option A, should be further considered

[1]The public consultation did not identify any other religious groups that may be disproportionately impacted by the proposed changes

There would be an average increase in taxi costs of up to £7 for Jewish populations

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Jewish people
Access statistics for Jewish people (includes Orthodox Jewish community)

Option	Digital access*	Public transport accessibility	Car ownership	Parking spaces retained
Option A	96.0%	13.7	59.8%	2,199
Option B	95.4%	10.3	61.4%	2,463

Jewish people
Average impact for Jewish people (includes Orthodox Jewish community)

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
A	Current	38.8	13.5	11.4	£14.83	£1.69
	Future	+ 4.7	+ 4.7	+ 3.4	+ £7.17	+ £0.82
B	Current	31.9	14.8	11.0	£17.35	£1.98
	Future	+ 6.8	+ 4.5	+ 3.4	+ £3.60	+ £0.41

Impact of the proposals compared to now

- The potential impact of the proposals would be an increase in average travel time by car/taxi (peak) by 4-5 minutes, by 3 minutes (off-peak) and by public transport by 5-7 min
- Public transport accessibility is slightly lower for Jewish people than for the catchment population in both options (A: 13.7 compared to 15.0, B: 10.3 compared to 17.1), which means people in this group may be slightly more likely to use taxis and be impacted by cost increases
- *We know that digital access and proficiency is very low amongst the Orthodox Jewish community which is not reflected in this data and that the Orthodox Jewish community would not be able to use cars, taxis or public transport on Shabbat or religious festivals unless in a medical emergency (which includes labour)

Difference between options

- The increase in taxi costs is higher for Jewish people in option A (~£7) compared to option B (~£4) - it is not possible to look at Orthodox Jewish community only due to data availability
- Jewish people in option B have **lower public transport accessibility** than Option A**,** but there is higher car ownership in Option A

The Orthodox Jewish community have specific requirements, with a potentially greater impact in option A

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

Jewish people (includes Orthodox Jewish community)
Proportion of Jewish people in the population

*The Jewish population in option A is 30,000 people (9% of total population) and in option B is 18,000 people (5% of total population)

The Orthodox Jewish community has specific needs:

1. **Food requirements:** The Orthodox Jewish community have Kosher food requirements. From engagement, it was found that hospitals are not always adequately prepared to provide for varying dietary requirements
2. **Religious requirements around the observance of Shabbat:** many Orthodox Jewish communities have restrictions on electricity usage on the Shabbat, requiring Shabbat-compliant lifts and restricting travel on public transport.
3. **Digital access:** feedback from engagement highlighted that people from the Orthodox Jewish community are less likely to have smartphones. This may impact on how they interact with maternity services and receive information about their care
4. **Larger families:** Consultation respondents explained that larger families are common in these communities and that they may therefore be more impacted by the closure of their nearest units

The Orthodox Jewish community appears to mostly be within the Royal Free Hospital catchment area and would be impacted should Option A be implemented. In the modelling projections, the next closest site to people living in this area is Whittington Hospital.

As per the ONS, the different sects of Judaism can be identified by the self-reporting of Judaism as “Ethnicity” or “Religion”. We identified Jewish populations by religion. However, not all those who identify as religiously Jewish will be Orthodox Jewish and it is not possible to identify only those that are Orthodox Jewish, although much of the consultation feedback related to impacted communities relates to the Orthodox Jewish community. The World Jewish Congress suggests that 12% of the Jewish population in the UK are from the Orthodox Jewish community[1].

[1] Source: https://www.worldjewishcongress.org/en/about/communities/UK#demography

The Orthodox Jewish community have specific requirements, with a potentially greater impact in option A

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Consultation engagement with the Orthodox Jewish community

- The interim IIA identified the Orthodox Jewish community as a specific population group could be impacted under option A and therefore they were a group that we wanted to hear from in the consultation period.
- We recognised that many members of the Orthodox Jewish community do not have social media and may not be reached by the wider advertising that was being undertaken. We used other mechanisms to gather feedback from the community as well as placing print advertisements in local Jewish circulars/papers.
- This resulted in feedback opportunities being set up which included **eight 1:1 in depth interviews with Orthodox Jewish women and two roundtable meetings** with community leaders or those that work closely with the community

Feedback from interim IIA engagement and public consultation

- Lack of access to smartphones or computer means that information on public websites isn't always effective and paper options are best
- The quality of the Kosher food varies and options are not always available for the Orthodox Jewish community which causes an impact on their care experience
- Restriction on the use of cars or public transport on Shabbat and religious festivals means that closure of local services could be impactful to the community, particularly for visitors
- Religious requirements around observing Shabbat and religious festivals may also mean visitors may need to travel further by foot to visit people in hospital
- Care closer to home such as community antenatal clinics is preferred
- A deep understanding of the workings of the community at the Royal Free Hospital has led to patients feeling safe and heard and able to progress with treatments safe in the knowledge that their religious beliefs are respected, and this has made for an easier working environment for the staff too

There would be **greater impact on the orthodox Jewish community under option A which has been explored in detail.** Mitigations are shown on slides 195-199. We would continue to engage with this community during implementation of our proposals.

Key concerns raised during consultation regarding the Orthodox Jewish community in option A

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Concern	Detailed feedback
Religiously and culturally sensitive care	The consultation feedback highlights that the Orthodox Jewish community value the care that is provided by the Royal Free Hospital in relation to their religious and wider needs given the ties that have been built up between the community and the hospital over time. Examples are given around: - Staff knowledge and understanding of religious needs and requirements - The availability of high-quality Kosher food - The set up of the Shabbat room - The RFH has some clinical services that support conditions that have a higher incidence in the Orthodox Jewish community - The trust and working relationships that have been built with the community and staff at the hospital including Birth Coaches who often support women during labour Other sites in NCL currently provide maternity care to members of the Orthodox Jewish community and therefore have in place provision to support their care however engagement suggests there are aspects of this which could be enhanced. These other sites can be supported in enhancing certain aspects of their provision through sharing good practice from the Royal Free Hospital. This is particularly in the context that it is likely other sites may see an increase in numbers of women from the Orthodox Jewish community accessing services. Mitigations for this impact can be found on slides 195-196.

Key concerns raised during consultation regarding the Orthodox Jewish community in option A

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Concern	Detailed feedback
Proximity of the hospital to the local area, particularly impacting visitors arriving on foot on religious festivals and Shabbat	The proximity of the Royal Free Hospital to the area where many members of the Orthodox Jewish community live has been highlighted as a key consideration in accessing maternity care which becomes particularly important when observing Shabbat and religious festivals. Some members of the Orthodox Jewish community do currently use sites other than the Royal Free Hospital and so considerations around travel on Shabbat and religious festivals are successfully managed, however there is an impact for those that choose to use the Royal Free Hospital that would need to be considered and mitigated during implementation. **Women in labour and their partners** It is important to note that for women in labour and their partners, travel to hospital by vehicle is permitted on Shabbat and religious festivals as this is considered a medical emergency. If option A were to be implemented, this would continue to be the case and women in labour could travel to alternative hospitals in NCL, for example Whittington Hospital, UCLH and Barnet Hospital. Should a woman give birth on Shabbat, or a religious festival their partner would often stay with them in hospital until discharge. Their partner may travel to and from home on foot during the day depending on other caring responsibilities. Consideration would need to be given to enable a family to stay in hospital rather than being discharged over Shabbat. Mitigations for this impact can be found on slide 197. **Visitors to hospital** For those that wish to travel to or from hospital on Shabbat to visit a woman who is in labour or who has recently had a baby there is an impact that is more difficult to mitigate. Given that visiting is not a medical emergency, we understand that the visitor would need to walk to and from hospital. The closest alternative sites in NCL: Barnet, UCLH, Whittington are further from the area where a large proportion of the community live, which may make it more difficult to make the journey on foot on Shabbat or a religious festival. These alternative sites are not within an Eruv which allows for those observing Shabbat to carry items (e.g., keys) on Shabbat.

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People living in areas of deprivation (Core20 and economically inactive)

There is an average increase in taxi costs of almost £5 for people living in Core20 areas

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People living in Core20 areas
Access statistics for people living in Core20 areas

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces retained
Option A	95.1%	12.5	43.6%	2,199
Option B	95.1%	23.0	32.0%	2,463

Impact on people living in Core20 areas
Average impact for people living in Core20 areas

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
A	Current	33.6	17.7	13.9	£27.10	£3.09
	Future	+ 2.2	+ 3.0	+ 2.1	+ £2.61	+ £0.30
B	Current	18.8	13.5	10.2	£12.58	£1.43
	Future	+ 9.6	+ 6.9	+ 5.1	+ £3.79	+ £0.43

Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (peak) by 3-7 min, by 2-5 minutes (off-peak) and by public transport by 2-10 min, which has differences to the catchment population
- This proposal may lead to an increase in average taxi costs of £2-4 which is less than the catchment population but may cause financial hardship for this group. Car ownership is lower than average for the people living in areas of deprivation (A: 43.6% compared to 48.1%, B: 32.0% compared to 44.6%), which means people in this group may be slightly more likely to use taxis and impacted by cost increases
- Public transport accessibility is slightly higher for people living in areas of deprivation than for the catchment population in Option B: 23.0 compared to 17.1

Difference between options

- There is a slightly greater impact on people living in Core20 areas in Option B
- The population impacted by Option B has **lower car ownership than Option A,** with a **slightly higher increase in average taxi costs** but this may be offset by **higher public transport accessibility**

Mitigations for the cost of transport, digital exclusion and people with children need to be considered for people living in Core20 areas

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Feedback from IIA engagement and public consultation (Core20)

- Digital exclusion may be a factor for those that can't afford data/WIFI
- SMS is often possible but opening links from these can be difficult without data/WIFI
- The additional cost of transport to reach an alternative site may impact on people living in Core20 areas accessing services and could mean non-attendance of appointments is more likely
- There may be barriers for those that already have children as a result of the additional travel time or travelling to an unfamiliar site including the cost of arranging childcare
- Travel was a consideration for people who had children; they either needed to take the children with them to appointments or arrange childcare
- People who were unable to use public transport and did not have access to a car sometimes took taxis to hospital appointments, but this was costly and unaffordable for many people that live in areas of deprivation

- From work to date, there is a slightly greater impact on people living in Core20 areas of deprivation in Option B
- A key consideration is the link between deprivation and increased complexity which may result in more appointments and therefore have a larger impact on travel to an alternative unit
- Mitigations for the **cost of transport**, **digital exclusion** and **people who already have children** need to be addressed as proposals are implemented.
- We have developed some initial mitigations, shown on slides 183-194.
- We would continue to engage with this group during implementation

There is an average increase in taxi costs of almost £6 for people who are economically inactive

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People who are economically inactive
Access statistics for people who are economically inactive

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces retained
Option A	95.7%	15.0	48.5%	2,463
Option B	95.7%	18.2	43.1%	2,199

Impact on people who are economically inactive
Average impact for people who are economically inactive

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
A	Current	27.3	14.9	12.2	£17.38	£1.98
	Future	+ 3.7	+ 5.2	+ 3.7	+ £5.43	+ £0.62
B	Current	16.2	13.5	10.1	£13.45	£1.53
	Future	+ 4.9	+ 6.4	+ 4.7	+ £4.12	+ £0.47

Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (peak) by 5-6 minutes, by 4-5 minutes (off-peak) and by public transport by 4-5 min, which is similar to the catchment population
- The biggest impact would be an increase in average taxi costs of £4-£5 which is similar to the catchment population but may cause financial hardship. Car ownership for option B is lower than average for people who are economically inactive, 43.1% compared to 44.6%
- Public accessibility is higher for people who are economically inactive than for option B: 18.2 compared to 17.1

Difference between options

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

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People in poor health

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

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People with poor health
Access statistics for people with poor health

Option	Digital access	Public transport accessibility	Car ownership	Parking spaces retained
Option A	95.6%	15.2	47.3%	2,463
Option B	95.6%	18.4	42.4%	2,199

Impact on people with poor health
Average impact across people with poor health

Option		Public transport travel times (mins)	Peak car/taxi travel times (mins)	Off-peak car/taxi/ ambulance travel times (mins)	Taxi costs	Driving costs
A	Current	26.9	14.8	12.2	£16.93	£1.93
	Future	+ 3.8	+ 5.1	+ 3.7	+ £5.31	+ £0.61
B	Current	15.7	13.2	9.9	£13.03	£1.49
	Future	+ 5.0	+ 6.5	+ 4.8	+ £4.19	+ £0.48

Impact of the proposals compared to now

- The impact of the proposals would be to increase average travel time by car/taxi (peak) by 5-7 minutes, by 4-5 minutes (off-peak) and by public transport by 4-5 min, which is similar to the catchment population
- This biggest impact would be an increase in average taxi costs of £4-5 which is similar to the catchment population. Car ownership is lower than average for people with poor health (A: 47.3% compared to 48.1%, B: 42.4% compared to 44.6%)
- Public transport accessibility is higher for people with poor health than for the catchment population in option B: 18.4 compared to 17.1

Difference between options

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

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Inclusion health groups

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

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Inclusion health groups

Population

- Inclusion health groups include homeless people, refugees, those fleeing domestic abuse, Gypsy and Roma Traveller communities and those that misuse substances
- These populations tend to be very small and dispersed

Service provision and outcomes

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

Public consultation engagement reach

- Engaged with refugees and people seeking asylum, people who were homeless, and Gypsy, Roma and Traveller people

Feedback from interim IIA engagement and consultation

- Feedback outlined that there were language barriers with people whose first language isn't English having difficulty accessing and using services and there are often difficulties using digital services
- People seeking asylum, people who are homeless and Roma people all reported having difficulty understanding how services worked including GPs
- People who were homeless feared their children would be removed by social services and those seeking asylum and refugees said that Muslim parents can be suspected of FGM
- Homeless people said that service providers, including maternity services, seemed not to understand their sometimes complex needs and potential vulnerabilities, for example, how to deal with addictions or mental health needs

From work to date, there appears to be **no difference between the options for people from inclusion health groups** and the potential **mitigations include additional communication and support for this group would be required to support continued access to services.** We would continue to engage with this group during implementation.

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

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	Demographics	Digital access	Public accessibility	Average additional public transport travel times	Average current public transport travel times	Average additional peak travel times	Average current peak travel times	Average additional off-peak travel times	Average current off-peak travel times	Car ownership	Average additional taxi costs	Average current taxi costs	Average additional driving costs	Average current driving costs	Parking spaces
Option A	Catchment population	95.8%	15.0	+ 4.4	32.2	+ 5.4	14.2	+ 3.8	11.1	48%	+ £5.54	£17.59	+ £0.63	£2.01	
	Women and people of childbearing age	95.9%	15.8	+ 4.1	27.8	+ 5.5	14.2	+ 4.0	11.6	48%	+ £5.54	£15.99	+ £0.63	£1.82	
	People living in Core20 areas	95.1%	12.5	+ 2.2	33.6	+ 3.0	17.7	+ 2.1	13.9	44%	+ £2.61	£27.10	+ £0.30	£3.09	
	People with disabilities	95.7%	15.3	+ 3.9	27.4	+ 5.3	14.4	+ 3.8	11.9	48%	+ £5.33	£16.42	+ £0.61	£1.87	
	People who are economically inactive	95.7%	15.0	+ 3.7	27.3	+ 5.2	14.9	+ 3.7	12.2	49%	+ £5.43	£17.38	+ £0.62	£1.98	
	People from minority ethnic groups	95.9%	15.1	+ 3.9	28.3	+ 5.3	15.0	+ 3.8	12.3	49%	+ £5.47	£17.55	+ £0.62	£2.00	2,463
	People with poor health	95.6%	15.2	+ 3.8	26.9	+ 5.1	14.8	+ 3.7	12.2	47%	+ £5.31	£16.93	+ £0.61	£1.93	
	Single parent household	95.7%	14.8	+ 3.6	28.5	+ 5.0	15.4	+ 3.7	12.8	47%	+ £5.05	£18.39	+ £0.58	£2.10	
	People with poor English proficiency	95.8%	14.4	+ 3.4	29.2	+ 4.8	16.6	+ 3.5	13.6	49%	+ £5.71	£20.66	+ £0.65	£2.36	
	Jewish population	96.0%	13.7	+4.7	38.8	+4.7	13.5	+3.4	11.4	60%	+£7.17	£14.83	+£0.82	£1.69	

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

North Central London Health and Care
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	Demographics	Digital access	Public accessibility	Average additional public transport travel times	Average current public transport travel times	Average additional peak travel times	Average current peak travel times	Average additional off-peak travel times	Average current off-peak travel times	Car ownership	Average additional taxi costs	Average current taxi costs	Average additional driving costs	Average current driving costs	Parking spaces
Option B	Catchment population	95.9%	17.1	+ 8.2	27.0	+ 6.5	13.4	+ 4.9	10.1	45%	+ £4.38	£13.52	+ £0.50	£1.54	
	Women and people of childbearing age	95.9%	18.7	+ 4.6	15.1	+ 6.5	13.5	+ 4.8	10.1	44%	+ £4.24	£13.33	+ £0.48	£1.52	
	People living in Core20 areas	95.1%	23.0	+ 9.6	18.8	+ 6.9	13.5	+ 5.1	10.2	32%	+ £3.79	£12.58	+ £0.43	£1.43	
	People with disabilities	95.7%	18.0	+ 5.0	16.1	+ 6.6	13.2	+ 4.8	9.9	44%	+ £4.33	£13.08	+ £0.49	£1.49	
	People who are economically inactive	95.7%	18.2	+ 4.9	16.2	+ 6.4	13.5	+ 4.7	10.1	43%	+ £4.12	£13.45	+ £0.47	£1.53	
	People from minority ethnic groups	95.9%	18.2	+ 4.7	16.2	+ 6.3	13.7	+ 4.7	10.3	44%	+ £4.26	£13.77	+ £0.49	£1.57	2,199
	People with poor health	95.6%	18.4	+ 5.0	15.7	+ 6.5	13.2	+ 4.8	9.9	42%	+ £4.19	£13.03	+ £0.48	£1.49	
	Single parent household	95.6%	18.5	+ 4.8	15.2	+ 6.3	13.6	+ 4.7	10.2	42%	+ £4.05	£13.37	+ £0.46	£1.52	
	People with poor English proficiency	95.7%	18.8	+ 3.7	14.8	+ 5.9	15.0	+ 4.3	11.1	42%	+ £3.82	£14.91	+ £0.44	£1.70	
	Jewish population	95.4%	10.3	+6.8	31.9	+4.5	14.8	+3.4	11.0	61%	+£3.60	£17.35	+£0.41	£1.98	

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

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

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- Two geographical areas were identified as being more vulnerable to the impact of our proposals because they face barriers to accessing services as they live in areas of deprivation and have high levels of poor general health. These are: Harlesden and Willesden (option A) and Holloway and Finsbury (option B). This is because:
    - There are Black and Caribbean populations concentrated in these geographies, which are also areas of deprivation, and there is evidence they have poorer maternity outcomes and poor general health
    - Harlesden has a large proportion of Bangladeshi and Pakistani populations, who also live in areas of deprivation, who have poor general health and are more likely to have worse maternal health outcomes
- As a result of the proposals, people in this Harlesden and Willesden (option A), and Holloway and Finsbury Park (option B) may need additional support to:
    - Access the hospital site if they have a disability/in poor health or are not proficient in English
    - Travel to hospital by taxi, if required, as it will cost an additional £2-3 for people in Harlesden and Willesden and an additional £5 for people in Holloway and Finsbury Park
    - Access services online as they may have low digital proficiency
    - Care for other family members as they may be a single parent
- These populations were specifically targeted as part of the public consultation doing 12 events and activities in Harlesden and Willesden and 8 events and activities in Holloway and Finsbury Park
- Mitigations have since been developed based on the feedback that was received during the consultation (slides 193-194)

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

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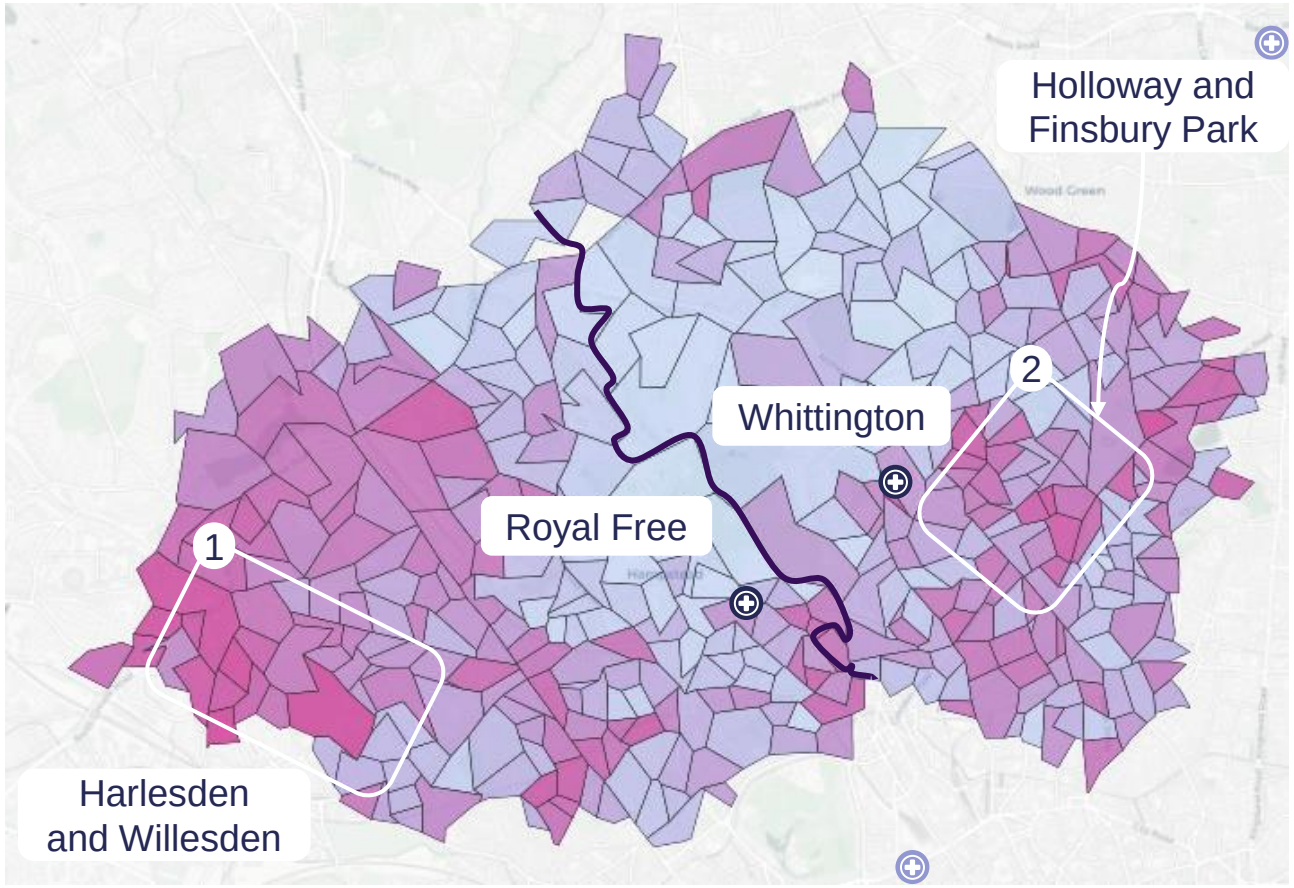
Vulnerability index
Weighted vulnerability rank by LSOA



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

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

Weighted vulnerability rank scale

400 = Best

1 = Worst

We used an index with an equally weighted average of the rank of the percentage of people from minority ethnic groups, deprivation and poor health outcomes by LSOA to identify particularly vulnerable populations

*The potentially impacted population in Harlesden and Willesden (option A) is around 35,000 people and in Holloway and Finsbury Park (option B) is around 25,000 people

Harlesden and Willesden was identified as a geography with residents who may be impacted by option A

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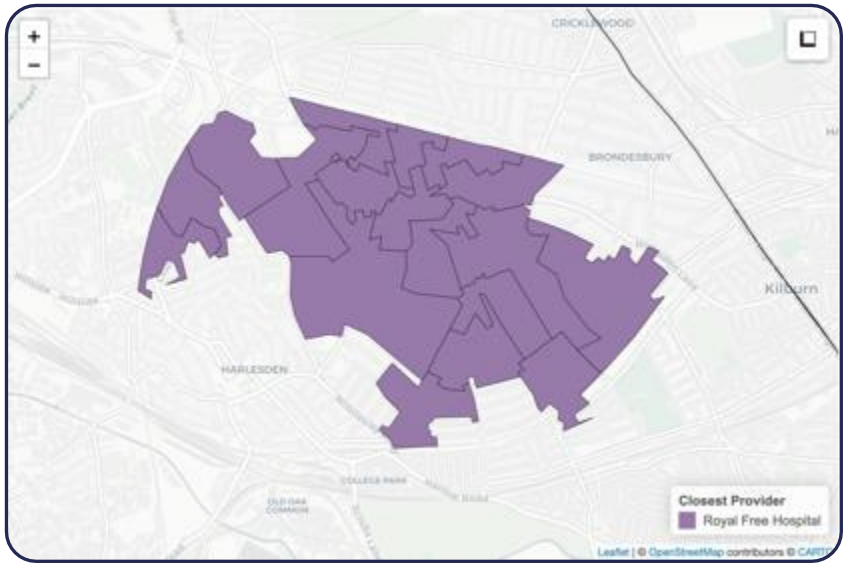

Impact on transport access to maternity care

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

- **Public transport:** There is no impact on public transport as the travel time to alternative hospitals is quicker than to the Royal Free Hospital currently
- **Private transport:** Travelling by car would take on average an additional 5 minutes. Taxi costs would increase by £2-3 per journey

Population characteristics

- 13.2% of people have a disability with 4.7% reporting to be in poor health
- 6.4% are not proficient in English
- 23.1% of people live in Core20 areas and 13% are people who are economically inactive
- 4.0% of parents are single
- 47% of people have access to a car
- 79.5% are people from minority ethnic groups

Public consultation feedback

- Concerns were raised during consultation regarding reduced access to high quality services in the local area which would result in longer travel times
- Feedback also outlined concerns that there may be a disproportionate impact on people from minority ethnic groups and those living in areas of deprivation

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

- Access the hospital site if they have a disability/in poor health or are not proficient in English
- Travel to hospital by taxi, if required, as it will cost an additional £2-3
- Access services online as they may have low digital proficiency
- Care for other family members as they may be a single parent

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

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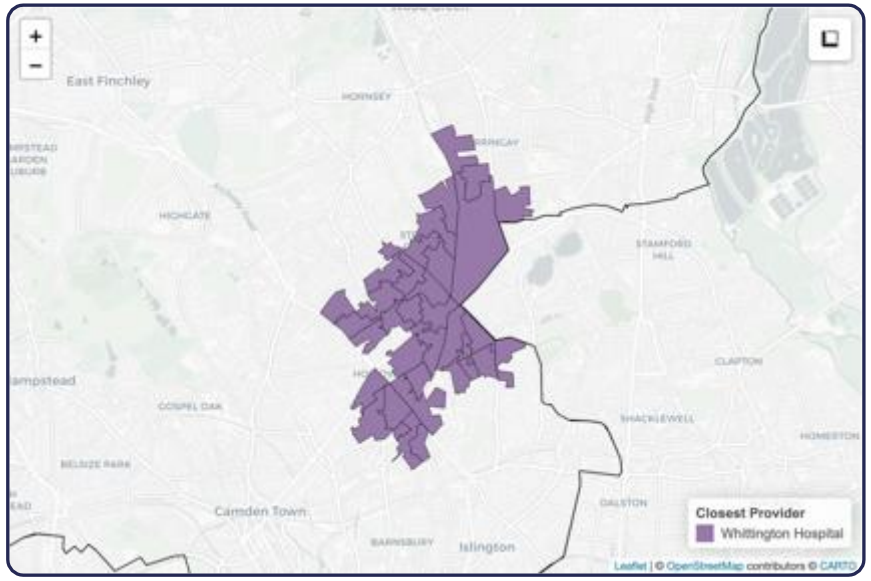

Impact on transport access to maternity care

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

- **Public transport:** Would have to travel an additional 3 minutes despite having good access to public transport
- **Private transport:** Travelling by car would take on average an additional 8 minutes. Taxi costs would increase by around £5 per journey

Population characteristics

- 16.3% of people have a disability with 5.8% reporting to be in bad general health
- 4.4% are not proficient in English
- 51.9% of people live in Core20 areas and 12.4% are people who are economically inactive
- 3.6% of parents are alone
- 31.3% of people have access to a car
- 65.9% of people in this area are from minority ethnic groups

Public consultation feedback

- Concerns were raised during consultation regarding reduced access to high quality services in the local area which would result in longer travel times, noting difficulties for those in later pregnancy and for those that already have children
- Residents of Finsbury Park outlined it would be a great loss of their local service, with many people that engaged having an experience of care at Whittington Health

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

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

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

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Black African and Black Caribbean populations
Proportion of Black African and Black Caribbean populations

11% of the Royal Free catchment and 10% of the Whittington catchment are from Black African or Black Caribbean populations

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

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

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

Source: ONS, Traveltime API, CF Analysis (2024)

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

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

4% of the Royal Free catchment and 3% of the Whittington catchment are from Asian (Bangladeshi and Pakistani) populations

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

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

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

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

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

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

Source: ONS, Traveltime API, CF Analysis (2024)

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Potential impact of proposals on sustainability

Summary: potential impact of the proposals on sustainability

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- Following engagement, the analysis identified four sustainability metrics to explore the potential sustainability impact: travel carbon impact, building carbon impact, protected air quality and anchor institutions. No further metrics were suggested during the public consultation, but mitigations have been further developed to reduce any impact on the environment.
- There would be a small, similar travel carbon impact for options A and B due to the small increase in travel distances and increased vehicular emissions may need to be mitigated as options A and B are within air quality management areas (AQMAs)
- Refurbishment carbon emissions for the Whittington Hospital and Royal Free Hospital would be mitigated as part of their net zero strategy for their wider refurbishment programme
- In options A and B, there would be little impact on the hospitals in their wider role as anchor institutions compared to now
- We have considered how potential negative impacts for sustainability could be mitigated. These mitigations are set out on slide 191.

The proposals may impact on sustainability with an increase in emissions within air quality management areas

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Impact	Travel carbon impact	Protected air quality	Building carbon impact	Anchor institution
Option A	+ 251 g per average journey	AQMA: NO2 and vehicular particulates	Additional refurbishment as part of Whittington's net zero strategy	214.2 WTE moved (nurses, midwives, consultants & middle level)
Option B	+181 g per average journey	AQMA: NO2 and vehicular particulates	Additional refurbishment as part of Royal Free Trust net zero strategy	290.2 WTE moved (nurses, midwives, consultants & middle level)

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

- There would be a similar carbon impact for options A and B due to the slight increase in travel distances and mitigations have started to be explored as options A and B are within air quality management areas (AQMAs) for NO2 emissions and vehicular particulates (see slide 165)
- There may be some carbon impact due to refurbishing buildings in both Option A and B but there would be substantial environmental gains to be made in making buildings more energy efficient, in line with government policy
- In Option A and B, the number of people that would be moved between sites would be small and the estate would be retained and repurposed, so there would be little impact on hospitals as anchor institutions

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

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

There would be a similar travel carbon impact for options A and B due to the small increase in travel distances

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Distances and Co2 cost per journey

Increase in average distance per average journey and average increase in CO2 cost per journey

Option	Average increase in distance travelled per journey (miles)	Average increase in carbon emissions per journey (g)
Option A	1.0	216
Option B	0.9	195

Average additional distance from LSOA to provider × **Average Car Carbon Emissions (g of CO2 per mile)**

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

Source: GOV.UK (2023), EPA (2021), Travel Time API (2024)– CF Analysis (2024)

Mitigations to limit increased vehicular emissions have started to be explored as options are within AQMAs

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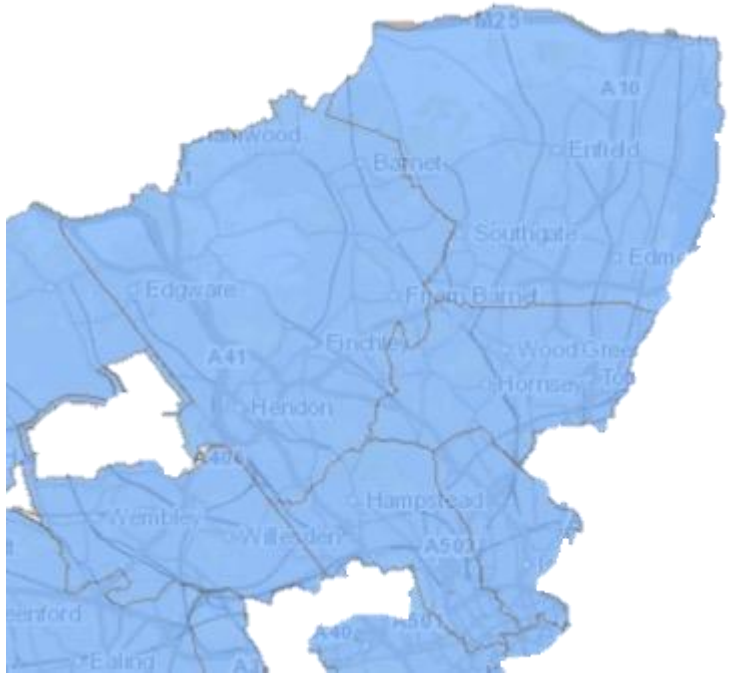
AQMAs (Air Quality Management Areas)

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

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

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

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



DEFRA outlines that the areas that may be impacted by the proposals have an AQMA associated with them. We have considered mitigations for the potentially increased emissions as a result of slightly longer travel times, as shown on slide 191.

Source: DEFRA, GOV.UK (2023), CF analysis (2023)

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

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

Whilst some workforce will be moved, the overall impact as a proportion of the total available workforce, meaning the impact on the resources available to local communities would be **relatively small.**

Total impact on the workforce
Current workforce by funded establishment WTE that would be moved as a % of the total clinical workforce (2023/24)

Option	Total workforce moved (clinical staff only)	Percentage of total workforce
Option A	214.2	5.6%
Option B	290.2	8.4%

It is assumed that 46% of the total clinical staff at Royal Free London Trust are at the Royal Free Hospital (the rest being at Barnet Hospital), with this split based on non-elective admissions activity in 2023/24

Source: King's Fund (2021), CF Analysis (2023)

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Potential impact of proposals by option

Summary of the potential impacts of option A (1/2)

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	Option A
Population	• There is a slightly smaller population that could potentially be impacted for option A when driving (~98,000 people) compared to option B (~113,000 people) but there would be a larger impacted population for public transport in option A (~91,000 people) compared to option B (~66,000 people) • There is a larger proportion of people from minority ethnic groups and the Orthodox Jewish community that may be impacted in option A compared to option B
Quality	Option A and B would deliver the proposed maternity and neonates care model, and would therefore deliver many benefits: • Care that ensures equity of provision and experience • Services which are clinically sustainable • Capacity to meet projected demand • Up to date estate and buildings which are fit for purpose • Training and development opportunities • Provide choice for pregnant women and people
Access	• Average increase in taxi costs would be ~£5.54 and the average increase in driving costs per journey would be ~£0.63 compared to now, with 48% car ownership in the local population. • Average travel times would increase by ~5.4 mins by car and ~4.5 mins by public transport compared to now. People in the catchment population would be able to access services within ~30 mins at peak driving time and within ~23 mins at off-peak.
Sustainability	• There would be an increase in carbon emissions of ~251g per average journey as a result of slightly increased travel times • There would be environmental gains to be made in making buildings more energy efficient compared to now • ~214 WTE of staff may move between sites, with the estate being retained and repurposed so there would be likely to be little impact on hospitals as anchor institutions

Summary of the potential impacts of option A (2/2)

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Option A	
Populations with protected characteristics and people who have vulnerabilities	• Greater impact on the Orthodox Jewish community compared to option B due to the ties with the Royal Free Hospital built up over time, the religiously and culturally sensitive care provided there and the proximity of the hospital, particularly impacting visitors arriving on foot on religious festivals and Shabbat. • People from minority ethnic groups may face language barriers when travelling to, and accessing, a different site • Somali community in Kilburn may face difficulties travelling to, and accessing, their closest hospital which would change from the Royal Free Hospital to Northwick Park Hospital or St Mary's Hospital • People with disabilities may have difficulties changing service location, especially without access to a car, compared to now • People from single parent households may have difficulties travelling further if they already have children compared to now • People living in areas of deprivation and those that are economically inactive may face difficulties with cost of transport, digital exclusion and already having children • People in poor health may have more complex pregnancies that require additional antenatal appointments during pregnancy which will therefore cause a greater travel time and cost impact of accessing services at an alternative unit • Some pregnant women and people with complex (or pre-existing) health conditions who attend Royal Free Hospital would need to access their obstetric care at a different site to their specialist care in the future, which would mean accessing an unfamiliar unit. In either option, this may result in less joined up care • Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language • The Bangladeshi and Pakistani population in Chalk Farm are close to a maternity unit that may move in option A, and therefore would be more impacted in terms of travel times compared to option B
Geographical populations	• Harlesden and Willesden was identified as a geography that could be particularly vulnerable to the proposed changes in Option A compared to now, with poor health outcomes, poor digital access, and poor English proficiency. This population also a high number of Black African and Black Caribbean people in it alongside Bangladeshi and Pakistani people • This population, by public transport, are already able to access Northwick Park Hospital and St Mary's Hospital more quickly than the Royal Free Hospital. Therefore, they may not be significantly impacted by increased transport costs compared to now. • This population may face barriers to attending an unfamiliar site

Summary of the potential impacts of option B (1/2)

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	Option B
Population	• There is a larger population that could potentially be impacted for Option B when driving (~113,000 people) compared to Option A (~98,000 people). There are fewer people impacted for Option B via public transport in Option B (~66,000 people) compared to Option A ~91,000 people) • There is a larger proportion of people that may be impacted that live in areas of deprivation in option B compared to option A
Quality	Option A and B would deliver the proposed maternity and neonates care model, and would therefore deliver positive clinical impact: • Care that ensures equity of provision and experience • Services which are clinically sustainable • Capacity to meet projected demand • Up to date estate and buildings which are fit for purpose • Training and development opportunities • Provide choice for pregnant women and people
Access	• Average increase in taxi costs would be ~£4.38 and the average increase in driving costs would be ~£0.50 per journey compared to now, with ~45% car ownership. • Average travel times would increase by ~6.5 mins by car and ~8.1 mins by public transport compared to now. People in the catchment population would be able to access services within ~28 mins at peak driving time and within ~21 mins at off-peak compared to now.
Sustainability	• There would be an increase in carbon emissions of ~181g per average journey as a result of slightly increased travel times. • There would be environmental gains to be made in making buildings more energy efficient • ~290 WTE of staff may move between sites, with the estate being retained and repurposed so there would be likely to be little impact on hospitals as anchor institutions

Summary of the potential impacts of option B (2/2)

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	Option B
Populations with protected characteristics and people who have vulnerabilities	• People from minority ethnic groups may face language barriers when travelling to, and accessing, a different hospital site • The Somali community in Finsbury Park would access services at the Royal Free rather than the Whittington Hospital. Given their proximity to the Whittington Hospital, they may be impacted by the relatively higher increases in taxi costs to an alternative maternity unit compared to now. • People living in areas of deprivation in option B are nearer to the maternity unit that may move, so the impact may be more significant for this population compared to option A (people may pay up to ~£11 more to travel by taxi). These people and those that are economically inactive may face difficulties with cost of transport, digital exclusion and already having children when travelling further or to a new site • People from single parent households may have difficulties travelling further if they already have children compared to now • People with disabilities may have difficulties changing service location, especially without access to a car, compared to now • People in poor health may have more complex pregnancies that require additional antenatal appointments during pregnancy which will therefore cause a greater travel time and cost impact of accessing services at an alternative unit • Some pregnant women and people with complex (or pre-existing) health conditions who attend Whittigton Hospital would need to access their obstetric care at a different site to their specialist care in the future, which would mean accessing an unfamiliar unit. In either option, this may result in less joined up care • Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language when travelling further or to a new site
Geographical populations	• Holloway and Finsbury Park was identified as a geography that could be particularly vulnerable to the changes in Option B, with poor health outcomes, poor digital access, and poor English proficiency - this population has a high number of Black African and Caribbean in it • This population is located close to the maternity unit that may move, and are therefore likely to be more impacted by increased travel time and cost compared to now, although public transport accessibility in this area is better than for Option A • This population may face barriers to attending an unfamiliar site compared to now

More detailed mitigations have been developed for the potential impacts of the recommended option (1/6)

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Impacts	Mitigations	What we think
Average increase in taxi costs would be £5.54 and the average increase in driving costs per journey is £0.63, with 48% car ownership compared to now.	• Ensure that patients understand what is available to help with the cost of travel to hospital such as a discussion at time of booking and providing information on Trust-level arrangements. • Ensure that any additional travel costs do not create a barrier to accessing care including supporting patients with travel costs through Healthcare Travel Costs Scheme and working with charitable partners and the voluntary sector	• We believe that the mitigations would reduce the potential impact, especially as the additional driving costs are small
Average travel times would increase by 5.4 mins by car and 4.5 mins by public transport compared to now. People in the catchment population would be able to access services within 30 mins at peak driving time and within 23 mins at off-peak.	• Aim to deliver as much care as close to home as possible as part of the proposed care model including utilising family hubs and children's centres to minimise travel times. • Where possible, provide more virtual appointments when clinically recommended as part of the proposed maternity care model	• We believe that the mitigations would reduce the potential impact especially as the additional travel times are small
There is an increase in carbon emissions of 251g per average journey as a result of slightly increased travel times	• Appropriate appointments would be provided in community settings or online which reduce the need to travel to a hospital site and would support a reduction in the overall number of journeys taken to access maternity care. • Expansion of neonatal community care through hospital at home as part of the proposed neonatal care model would reduce the need for families to travel to hospital therefore reducing carbon emissions • Through the refurbishment that would be undertaken, buildings would increase in their energy efficiency which would offset some impact of increasing emissions	• We believe that the mitigations would reduce the potential impact
214 WTE of staff moved between sites, with the estate being retained and repurposed so there is likely to be little impact on hospitals as anchor institutions	• Whilst some workforce would be moved, the overall impact as a proportion of the total available workforce, meaning the impact on the resources available to local communities, would be likely to be relatively small. • We believe no mitigations are necessary as the number is so small it would not impact the local community	• We believe no mitigations are necessary

More detailed mitigations have been developed for the potential impacts of the recommended option (2/6)

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Impacts	Mitigations	What we think
People with disabilities may have difficulties changing service location, especially without access to a car, compared to now	• When scheduling appointments, steps would be taken to ensure service users with a disability, or those with a family member with a disability, particularly children, are offered appointments at the most suitable time to allow them to travel into central London when it is most convenient	• We believe that the mitigations would remove/reduce the potential impact
People from single parent households may have difficulties travelling further if they already have children compared to now	• When scheduling appointments, steps would be taken to ensure single parents who already have children are offered appointments at the most suitable time to allow them to travel into central London when it is most convenient	• We believe that the mitigations would remove/reduce the potential impact
People living in areas of deprivation and those that are economically inactive may face difficulties with cost of transport, digital exclusion and already having children	• Ensure that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care • We would ensure appointments are at the most appropriate times for service users • We would ensure there is accessible information about choices of maternity care available in non-digital formats for those who are less able to access the internet	• We believe that the mitigations would remove/reduce the potential impact
People in poor health may have more complex pregnancies that require additional antenatal appointments during pregnancy which will therefore cause a greater travel time and cost impact of accessing services at an alternative unit	• Aim to deliver as much care as close to home as possible to minimise travel times and where possible, provide virtual appointments when clinically recommended • Ensure that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care	• We believe that the mitigations would reduce the potential impact

More detailed mitigations have been developed for the potential impacts of the recommended option (3/6)

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Impacts	Mitigations	What we think
People from minority ethnic groups may face language barriers when travelling to, and accessing, a different site as they are less familiar with the journey, which may also be more complex, and therefore this population may need support to travel elsewhere	• Clear information would be provided to service users about travel and transport options to all maternity units. • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted	• We believe that the mitigations would reduce the potential impact
Somali community in Kilburn may face difficulties travelling to, and accessing, their closest hospital which would change from the Royal Free Hospital to Northwick Park Hospital or St Mary's Hospital. Additional difficulties may arise from English not being their first language so may need additional support in travelling to one of these alternative units	• Patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments • We would offer detailed information about how to navigate to the right area of the hospital where appointments or admissions are scheduled, as part of communication with service users • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted	• We believe that the mitigations would reduce the potential impact
The Bangladeshi and Pakistani population in Chalk Farm are close to a maternity unit that may move in Option A, and therefore may be more impacted in terms of travel times compared to other groups	• Aim to deliver as much care as close to home as possible to minimise travel times and where possible, provide virtual appointments when clinically recommended • Ensure that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care	• We believe that the mitigations would reduce the potential impact

More detailed mitigations have been developed for the potential impacts of the recommended option (4/6)

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Impacts	Mitigations	What we think
Other inclusion health groups may face difficulties with cost of transport, digital exclusion and language	• Ensure that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care • We would ensure there is accessible information about choices of maternity care available in non-digital formats for those who are less able to access the internet • Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted	• We believe that the mitigations would reduce the potential impact
Harlesden and Willesden was identified as a geography that could be particularly vulnerable to the proposed changes in Option A compared to now, with poor health outcomes, poor digital access, and poor English proficiency. This population also a high number of Black African and Black Caribbean people in it alongside Bangladeshi and Pakistani people. This population may face barriers to attending an unfamiliar site.	• Some specific mitigations that would be taken forward for this population are around the communication of changes being available in accessible formats and in different languages, supporting continuity of carer in the community to deliver care as close to home as possible, supporting populations with the cost of travel • Working with NWL partners we would continue to engage with residents of Harlesden and Willesden during implementation to understand any unanticipated impacts and develop further mitigations if necessary	• We believe that the mitigations would reduce the potential impact

More detailed mitigations have been developed for the potential impacts of the recommended option (5/6)

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Impacts	Mitigations	What we think
• Pregnant women and people with the most complex (or pre-existing) health conditions who attend Royal Free Hospital would need to access their obstetric care at a different site to their specialist care in the future, which would mean accessing an unfamiliar unit. In either option, this may result in less joined up care • Some of these pregnant women and people may need to access obstetric care at a unit that is not their next closest, because of their needs, which means they would need to travel further than the general population • Some minority ethnic groups and people living in areas of deprivation associated with poorer maternity outcomes are likely to be disproportionately represented amongst those with the most complex (or pre-existing) health conditions, although these are very small numbers	• Support clinicians to work together to deliver care within current networked arrangements, utilising technology and virtual appointments where appropriate to link in all relevant clinicians, to minimise the impact on pregnant women and people with complex (or pre-existing) health conditions that may need to access specialist and obstetric care at different sites and ensure care remains joined up. • Provide clear information to service users about travel and transport options to all alternative units where they may need to access specialist or obstetric care to meet their specific needs. Ensuring that information is available in different languages that meets the needs of the population and is in accessible formats including non-digital to support those with poor digital access • We would offer women and pregnant people opportunities to visit unfamiliar sites outside of planned appointments or birth to familiarise themselves with the unit and patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments • Raise awareness of schemes to support patients with travel costs, as well as how to make a claim. Ensure that all information is available in different languages and formats to suit needs of service users. Including: - Healthcare Travel Costs Scheme - financial assistance for patients, who do not have a medical need for ambulance transport, and their carers but who require assistance with their travel - ULEZ and Congestion Charge reimbursement schemes where applicable - Blue badge schemes - support key groups with travel and increasingly being made available to those with a mental health conditions	• We believe that the mitigations would reduce the potential impact

More detailed mitigations have been developed for the potential impacts of the recommended option (6/6)

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Impacts	Mitigations	What we think
Greater impact on the Orthodox Jewish community compared to option B due to the ties with the Royal Free Hospital built up over time, the religiously and culturally sensitive care provided there and the proximity of the hospital, particularly impacting visitors arriving on foot on religious festivals and Shabbat.	• Remaining units would work with the community to develop Trust-level action plan to build on existing provision of culturally and religiously sensitive care • Action plans may cover areas such as staff training, Kosher food, communication, religious requirements around the observance of Shabbat including families remaining in hospital and working relationships between the population and NCL hospitals • Following a decision, the proposed mitigations would be further tested with the Orthodox Jewish community and its leaders throughout implementation to ensure key concerns are captured and mitigated against. Agreed mitigations would be monitored and evaluated by a working group which would include members of Orthodox Jewish community	• We believe impacts related to the provision of religiously and culturally sensitive care can be fully mitigated at alternative units in NCL through the measures identified and careful close working with the Orthodox Jewish community • We believe the impact regarding the religious requirements of the observance of Shabbat for families staying in hospital can be fully mitigated through the measures identified and careful close working with the Orthodox Jewish community • Members of the Orthodox Jewish community currently access maternity care, and other forms of care, from other hospital sites within NCL, so we know that it is possible to mitigate these impacts, and we need to learn from and build on these experiences • However, we acknowledge that for those who wish to visit someone in hospital on Shabbat or visitors who need to leave hospital on Shabbat, there may be impacts that cannot be mitigated. Specifically, those walking to and from the hospital are likely to have to walk further, as overall travel times will be greater. Further, Royal Free Hospital is in an eruv (enabling some relaxation of the prohibition of carrying items outside the house on Shabbat), whereas other hospitals are not. • We will continue to work with the community to mitigate the impact of these issues as far as possible, including by scheduling procedures around Shabbat wherever possible, but they cannot be completely eliminated.

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Detailed mitigations

Summary: mitigations

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- There are several issues that we have heard through engagement and public consultation, that we aim to address regardless of whether these proposals are implemented
    - Information about how to travel to a hospital site
    - Providing as much care locally as possible
    - Access to midwifery-led care
    - Providing training to address some of the issues raised during consultation that are specifically linked to the changes eg the impacts on LGBTQI+ and trans people
- To address or reduce the potential negative impacts of the proposals identified in this IIA, so far as possible, we are considering the following broad types of mitigations:
    - Supporting staff training and understanding
    - Service user involvement in maternity services
    - Access to appropriate interpretation services
    - Use of digital tools
    - Supporting people with learning disabilities
    - Provision of continuity of carer
    - Personalised care and support plans
    - Improving the quality of communication with service users
    - Improving maternity data quality
- The potential impacts of our proposals further have been considered following consultation, and consider a) negative impacts can be completely mitigated and (b) if not, the impact is justified as a proportionate means of achieving a legitimate aim
- Mitigations for the recommended option have been further developed, building on the interim IIA, following feedback received during the public consultation. Specific mitigation for option A include consideration of the impact on the Orthodox Jewish community and on residents of Harlesden and Willesden

We have been through a detailed process to review potential mitigations

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Mitigations have been developed which address impacts identified both through the in-depth IIA analysis and the engagement with service users. There are several issues that we have heard through engagement and consultation, that we aim to address regardless of whether these proposals are implemented. These are being addressed through the NCL Local Maternity and Neonatal System (LMNS) equity and equality action plan. To address or reduce the potential negative impacts of the proposals identified in the sections above, so far as possible, we are considering several types of mitigations. The potential impacts of our proposals have been considered further, following consultation, and consider a) whether any negative impact can be addressed or reduced through mitigation measures and (b) consider whether any negative impact that cannot be mitigated is justified as a proportionate means of achieving a legitimate aim.

NCL LMNS equity and equality action plan	Haringey stillbirth audit	Start Well IIA engagement	Start Well public consultation
• Developed in response to NHSE requirement of all local maternity and neonatal systems • Actions derived from both case for change and feedback from previous engagement exercises	• Commissioned as a result of the high stillbirth rate in Haringey identified in the case for change • Recommendations derived from review of the still births and themes identified through the review of the cases	• Commissioned to support with the Start Well IIA. Engagement targeting those known to be at risk of differential outcomes or experience • Recommendations and themes derived from patient feedback about their experience	• Undertaken to support the legal duties of the Start Well programme proposals to gain views of the public, staff and service users on the proposed service changes • Recommendations derived from feedback about service user experiences

The overlapping themes arising from the four areas require a single action plan, the delivery of which is not contingent on any changes to services. The LMNS will therefore take this forward as a matter of priority.

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

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

We are considering several potential impacts that may require mitigations

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As the programme progresses, we need to **continue to understand the impact of proposals** through **further engagement** with potentially impacted groups. It is particularly important to ensure we **hear from groups that are less likely to engage**, or **where there are barriers** for them to do so. (See slide 183)

Should a decision be taken to implement changes, the **changes need to be well communicated and accessible to residents**. Mitigations will need to be put in place to ensure that **all groups are informed of changes**, and they **understand their choices for maternity care**. **Clear information needs to be available** to support both **choice of maternity unit** and **birth setting** to meet the needs of expectant parents. (See slide 184)

There are some service users for whom **changes may mean attending a different hospital than they are used to**. This change may be more **difficult** for some service users, and they would need **extra support to manage this and consider accessibility to this site.** (See slides 185-186)

Should a decision be taken to implement any changes, it may result in service users going to a different hospital they are unfamiliar with. This may lead to **changes to journeys to hospital that people are used to**. Mitigations would be needed to ensure that people have **information to plan their journeys to hospital.** (See slides 187)

There may be an impact on the **cost of travel** should changes be implemented – **particularly for people who travel by taxi**. There will be some service users who are more impacted by this than others, and it is important that patients **understand what is available to support them with cost of travel to hospital** and that any **additional travel costs do not create a barrier to accessing care.** (See slide 189)

Access to parking spaces is variable across NCL sites. **Parking** has been raised as a particular consideration for parents who have a baby **admitted to a neonatal unit** given their need to visit their child on an ongoing basis and in some instances over an extended period. Mitigations may be needed around **parking to ensure that families can easily visit their child by car.** (See slide 190)

Women and people with complex (or pre-existing) health conditions are currently looked after under networked arrangements with input from both obstetric physicians and other specialists. Mitigations would be needed to ensure that pregnant women and people with complex (or pre-existing) health conditions could continue to access the specialist and obstetric care they need. (See slide 192)

Some mitigations are specific to the recommended option based on analysis, engagement and consultation feedback

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Mitigations have been developed in response to the possible impact of the proposals on the impacted population based on the IIA analysis, engagement and feedback from the public consultation. There has also been a specific focus on mitigations for specific population groups that have been identified as being potentially more impacted by the recommended option, which is option A:

- We have developed specific mitigations for the population **of Harlesden and Willesden** should a decision be taken in the future for the recommended option A to be implemented (see slides 193-194)
- We have developed specific mitigations to put in place to support the **Orthodox Jewish** community should a decision be taken for the recommended option A to be implemented. (see slides 195-199)

Ongoing input into, and feedback on, our proposals

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During implementation, we need to continue to understand the impact of our proposals and develop mitigations through further engagement with potentially impacted groups. It is particularly important to ensure we hear from groups that are less likely to engage, or where there are barriers for them to do so.

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

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

Our ambition is to engage with the range of service users identified through the IIA, and hear from those that we were less successful in engaging with during the public consultation

The programme would continue to review the impact of changes on different groups during implementation and ensure any new impacts are reviewed and mitigations developed to address potential negative impacts.

Communicating around implementation should changes be agreed

North Central London Health and Care
Integrated Care System

Should a decision be taken to implement changes, changes need to be well communicated to residents. Mitigations would need to be put in place to ensure that all groups are informed of changes, and they understand their choices for maternity care. Clear information would need to be available to support and promote a choice of a maternity unit and birth setting that meets the need of expectant parents.

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

We would pursue uniformity in how information about maternity services is hosted on individual trust webpages to help users better navigate to the information that they need

We would provide information in different formats to meet the communication needs of a range of service users, including different languages, easy read, large and small print, audio, braille and sign language.

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

We would disseminate information through local community groups and local GPs to help ensure that pregnant women and people have accurate information regarding the service changes and what this means for them

We would ensure there is suitable provision of translation services for appointments and during intrapartum care.

Mitigations for those who may need extra support to access an unfamiliar hospital (1/2)

North Central London Health and Care
Integrated Care System

There are some service users for whom changes may mean attending a different hospital than they are used to. This change may be difficult to manage for some service users, with particular needs such as people for whom English is a second language (which may include members of the Somali community), neurodivergent people and people with learning disabilities, and they would need extra support to manage this.

We would offer women and pregnant people opportunities to visit unfamiliar sites outside of planned appointments or birth to familiarise themselves with the unit

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

We would offer detailed information about how to navigate to the right area of the hospital where appointments or admissions are scheduled, as part of communication with service users

Where possible, we would use innovative tools or technology to support wayfinding or giving directions within a hospital

We would ensure appointments are at the most appropriate times for service users where a family member has a disability, particularly children, to allow them to travel into central London at the most convenient time

We would ensure sensory adjustments can be put in place where appropriate in clinical areas, such as access to a private room and the ability to dim lighting

Mitigations for those who may need extra support to access an unfamiliar hospital (2/2)

North Central London Health and Care
Integrated Care System

There are some service users for whom changes may mean attending a different hospital than they are used to. This change may be difficult to manage for some service users, with particular needs such as people for whom English is a second language (which may include members of the Somali community), neurodivergent people and people with learning disabilities, and they would need extra support to manage this.

Patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments

We would work with the neonatal care coordinator as part of implementation to ensure that there is consistent information and support available to parents who have a child admitted to a neonatal unit

Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted

Information about how to travel to a hospital site

North Central London Health and Care
Integrated Care System

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

Clear information would be provided to service users about travel and transport options to all maternity units

Information would be made available in different languages and formats to suit the range of communication needs of service users likely to be impacted.

We would link to live journey planners such as TFL to ensure that accurate, up-to-date information about journeys can be accessed

We would work with the neonatal care coordinator to ensure that there is information available to families about travel when their child is admitted to a neonatal unit.

Providing as much care locally as possible

North Central London Health and Care
Integrated Care System

The cost and time spent travelling to a hospital site would increase for some people, and we would want to deliver care as close to home as possible. This may be more of an issue for some groups such as people with disabilities or people living in areas of deprivation

Where possible, we would provide appointments in community settings, for example, family hubs and children's centres

Virtual appointments would be offered, where appropriate and clinically recommended

We would implement hospital at home / community neonatal care to help babies avoid admission to a neonatal unit or can be discharged as early as possible – reducing the burden of travel to visit babies during an admission to a neonatal unit

Support with the costs of travel to hospital

North Central London Health and Care
Integrated Care System

£ There may be an impact on the cost of travel should changes be implemented. There will be some service users who are more impacted by this than others, and it is important that patients understand what is available to support them with cost of travel to hospital and that any additional travel costs do not create a barrier to accessing care. Any information on support would be available in different languages and accessible formats.

We would raise awareness of schemes to support patients with travel costs, as well as how to make a claim, including:

- Healthcare Travel Costs Scheme - financial assistance for patients, who do not have a medical need for ambulance transport, and their carers but who require assistance with their travel
- ULEZ and Congestion Charge reimbursement schemes where applicable
- Blue badge schemes - support key groups with travel and increasingly being made available to those with a mental health conditions
- Information about these schemes to be available in different languages and formats to suit needs of service users

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

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

We would support patients by working with charitable and voluntary and community sector partners to consider the feasibility of a pre-paid travel card for service users identified as being particularly impacted by the proposals for whom travel costs would limit their access to maternity care

Arrangements for patients who have eligibility for hospital patient transport schemes would be continued.

We would ensure service users are aware of other financial support schemes available during pregnancy, such as NHS Healthy Start where they can get help to buy food and milk, and the maternity exemption certificate.

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

Access to parking

North Central London Health and Care
Integrated Care System

Access to parking spaces is variable across NCL sites. Parking has been raised as a particular consideration for parents who have a child admitted to a neonatal unit given their need to visit their child on an ongoing basis and in some instances over an extended period. Mitigations may be needed around parking to ensure that families can easily visit their child by car.

We would ensure that there are consistent arrangements in place for families with a baby admitted to a neonatal unit in relation to parking. As part of this, we would work with charitable partners to see if we can explore providing a permit to allow discounted parking for the duration of the baby's admission.

Capacity would be put in place that meets demand to ensure fewer neonatal transfers out of NCL, thereby reducing the overall travel distance for families.

Particular consideration would be given to those with disabilities, ensuring access to disabled parking spaces

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

Supporting sustainability

North Central London Health and Care
Integrated Care System

The impact assessment identifies a small impact on carbon dioxide emissions as a result of changes to journey times as well as an impact of refurbishment of estate to deliver the capacity needed. Mitigations needed to address the impacts identified fall within the wider green agenda for the ICS and sites that are impacted. The NHS has a target to reach net zero by 2040 and the ICS and each individual Trust has their own plans to deliver on this.

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

How building work required to implement changes could be done in the most sustainable way and ensure any new buildings are made as energy efficient as possible

Ensuring that building capacity would be used effectively - we know that some of our capacity is currently underutilised, and if this could be repurposed or used differently it would have a positive impact on sustainability.

Expansion of neonatal community care through hospital at home as part of the proposed neonatal care model would reduce the need for families to travel to hospital therefore reducing carbon emissions

Appropriate appointments would be provided in community settings or online which reduce the need to travel to a hospital site and would support a reduction in the overall number of journeys taken to access maternity care.

In line with national targets of a 40% reduction in nitrous oxide emissions, providers would determine if it is possible to reduce waste that may be associated with leaks in pipes.

We would continue to work on the travel components of the ICS and local trust green plans and encourage active travel or travel via public transport where possible.

Care for pregnant women and people with complex (or pre-existing) health conditions

North Central London Health and Care
Integrated Care System

Women and people with complex (or pre-existing) health conditions are currently looked after under networked arrangements with input from both obstetric physicians and other specialists. Mitigations would be needed to ensure that pregnant women and people with complex (or pre-existing) health conditions could continue to access the specialist and obstetric care they need.

Support clinicians to work together to deliver care within current networked arrangements, utilising technology and virtual appointments where appropriate to link in all relevant clinicians, to minimise the impact on pregnant women and people with complex (or pre-existing) health conditions that may need to access specialist and obstetric care at different sites and ensure care remains joined up

Provide clear information to service users about travel and transport options to all alternative units where they may need to access specialist or obstetric care to meet their specific needs. Ensuring that information is available in different languages that meets the needs of the population and is in accessible formats including non-digital to support those with poor digital access

We would offer women and pregnant people opportunities to visit unfamiliar sites outside of planned appointments or birth to familiarise themselves with the unit and patients' needs would be considered when scheduling appointments, and, where possible, we would offer appointments that may better meet the needs of those travelling to hospital for appointments

Raise awareness of schemes to support patients with travel costs, as well as how to make a claim. Ensure that all information is available in different languages and formats to suit needs of service users. Including:

- Healthcare Travel Costs Scheme - financial assistance for patients, who do not have a medical need for ambulance transport, and their carers but who require assistance with their travel
- ULEZ and Congestion Charge reimbursement schemes where applicable
- Blue badge schemes - support key groups with travel and increasingly being made available to those with a mental health conditions

Support for specific geographic populations outside of NCL if the recommended option is implemented (1/2)

North Central London Health and Care
Integrated Care System

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

- **Communicating changes:** should changes be agreed, a specific communication campaign would be undertaken. We would work with providers in NWL and the NWL ICB alongside the Brent local authority to communicate with service users about the proposed changes, so they understand the impact and the timeline for implementation. This would factor in the most commonly spoken languages within this area, and also non-digital formats given the lower than average IT proficiency of this population
- **Access to care:** We would work with NWL providers to ensure that maternity care continues to be provided as close to home as possible through community settings. We would produce accessible information about where residents can access care
- **Cost of travel:** When travelling by taxi, slight increases in costs have been identified. We would work with NWL partner to ensure that NWL hospitals also have clear arrangements in place for re-imbursement of expenses and other travel cost reimbursement (including transport and ULEZ reimbursement). These include schemes offered by NWL providers, as well as broader schemes such as NHS Health Start and those offered by the voluntary sector. We would ensure that accessible information is available for service users and also raise awareness of schemes to provide financial support including wider financial support schemes available during pregnancy such as NHS Healthy Start. Work with NWL partners to see if they would consider working with local VCS organisations who may be able to mitigate the impact for groups that are particularly vulnerable.
- **Continuing engagement:** working with NWL partners we would continue to engage with residents of Harlesden and Willesden during implementation to understand any unanticipated impacts and develop further mitigations if necessary.

Support for specific geographic populations outside of NCL if the recommended option is implemented (2/2)

North Central London Health and Care
Integrated Care System

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

Continuity of carer: We would explore with NWL partners the possibility to prioritise residents of Harlesden and Willesden for continuity of carer given the vulnerability of these service users, building on the existing community pathways:

London North West Hospitals Trust (LNWH) have community provision covering areas of Harlesden and Willesden. This means that those accessing one of their sites for maternity care will be supported antenatally and postnatally by staff from this Trust. In terms of how this provision is set up currently they provide:

- Ante and post-natal continuity to all those that book. This means that service users will see the same midwife and team throughout the pre- and post-natal pathway
- Appointments are provided in local family wellbeing centres and other community locations which means that for many service users they aren't required to travel to hospital for all their antenatal care
- They have a specific midwifery team that works with particularly vulnerable service users (e.g., those that are experiencing domestic violence or severe mental illness)
- LNWH have provisions in place to support communication with service users who do not speak English, or where English is not their first language. They use a telephone interpreter service and also equip their staff with Card Medic (a resource that contains a series of common questions and phrases). They can also book a face-to-face interpreter where required.
- All patient information materials are translated into local community languages
- LNWH work closely with the local council in Brent, including the public health teams to support join up of pathways for universal services and to ensure any public health messaging or campaigns are aligned

Support for the Orthodox Jewish community if the recommended option is implemented (1/3)

North Central London Health and Care
Integrated Care System

Actions that may need to be taken forward to further support culturally and religiously sensitive care at NCL sites

Other sites in NCL currently provide maternity care to members of the Orthodox Jewish community and therefore have in place provision to support appropriate care. However, development of Trust level action plans would ensure that culturally and religiously appropriate care continues to be provided and built upon to build confidence of the community in the level of sensitive provision that is in place for service users. A pregnant woman or person from the Orthodox Jewish community who has gone into labour would be classed as a medical emergency and therefore they and their husband or birth companion would be permitted to use a vehicle to travel to hospital on Shabbat or a religious festival. Trust-specific action plans may cover the following areas that would mitigate the impact of option A:

- **Staff training:** Orthodox Jewish women may have specific needs during their maternity care. There would be staff training across all NCL maternity units to ensure an understanding of Orthodox Jewish community observances for maternity care including religious requirements around the observance of Shabbat and Kosher food. Training would be co-developed either with a voluntary and community sector organisation or individuals from the Orthodox Jewish community and delivered to clinical and non-clinical staff across the service at all sites.
- **Kosher food**: we would work with all Trusts to review the Kosher food that is currently available for pregnant women and people during labour and permit food to be brought in from outside the hospital.
- **Communication:** through engagement with the Orthodox Jewish community, it has been identified that non-digital communication is more effective. We would ensure communication of changes, and subsequent communication about maternity care, are provided in a non-digital way. We would work with the community and voluntary and community sector partners to be more effective in reaching the Orthodox Jewish community in NCL. We would also use circulars that are produced and read by the local community for wider messaging.
- **Religious requirements around the observance of Shabbat and religious festivals:** specific considerations would be made around religious requirements around the observance of Shabbat. Shabbat protocols would be put in place with guidance produced for NHS staff and trusts on religious requirements. This would include a review of all NCL hospital site Shabbat rooms and other observance requirements to ensure they meet the needs of the community, allowing flexibility for any non-urgent care to take place outside of Shabbat, avoiding discharge on Shabbat and not using the call bell.

Support for the Orthodox Jewish community if the recommended option is implemented (2/3)

North Central London Health and Care
Integrated Care System

Actions that may need to be taken forward to further build on the culturally and religiously sensitive care at NCL sites

Other sites in NCL currently provide maternity care to members of the Orthodox Jewish community and therefore have in place provision to support appropriate care. However, development of action plans would ensure that culturally and religiously appropriate care continues to be provided and built upon to build confidence of the community in the level of sensitive provision that is in place for service users. Trust-specific action plans may cover the following areas that would mitigate the impact of option A:

- **Modesty**: Orthodox Jewish women may choose clothes that cover their elbows and knees, as well as a wig, scarf or other head covering. Long -sleeved gowns would be made available during birth at all hospitals to cover elbows and we would ensure that people are permitted to wear a hair covering.
- **Clinical considerations:** some medical conditions have a higher prevalence within the Orthodox Jewish community. We would engage and communicate with the community to assure them that there are alternative specialist providers for these conditions such as UCLH and the specialist haematology service which could care for those with factor 11. Pathways and standard operating procedures would also be agreed with London Ambulance Service and Hatzola around emergency care in maternity services. The additional travel time to The Whittington compared to the Royal Free Hospital is 3 to 5 minutes.
- **Providing care closer to home:** as part of our proposals, we would provide ante-natal and post-natal care as close to home as possible.
- **Working relationships and trust:** work would continue to be undertaken with local voluntary and community sector organisations with reach into the community, and the North West network of Doulas to support effective working relationships are built up between the community and all NCL sites where maternity care is accessed by the Orthodox Jewish community. This would ensure that the necessary provision is in place for the community and there is an understanding of the role of birth coaches / doulas.

Support for the Orthodox Jewish community if the recommended option is implemented (3/3)

North Central London Health and Care
Integrated Care System

Mitigations to support families remaining at hospital on Shabbat and religious festivals and supporting the religious requirements regarding the observance of Shabbat

Consideration would need to be given to enable a family to stay in hospital rather than being discharged over Shabbat or religious festivals given the longer journey from hospital to a potential alternative maternity unit and the particular difficulties for this community in travelling on Shabbat and religious festivals. This may include the woman who is in labour or who has given birth and their partner or other birth companions. Mitigations include:

- Partners need to have provision to remain comfortably on site, either in the labour room or ante / post-natal ward with the woman (this is already in place at UCLH, Barnet, North Mid and Whittington Health)
- Appropriate Shabbat protocols and facilities should be in place at each hospital to allow partners to be observant should they remain on the hospital site
- Discharge protocols that wherever possible avoid discharge over Shabbat and religious festivals

Ways of working and approach to developing mitigations for the Orthodox Jewish community if the recommended option is implemented (1/2)

North Central London Health and Care
Integrated Care System

If option A was recommended for implementation, the ICB and NHS Trusts that would continue to provide maternity and neonatal care in NCL would commit to focused joint work with the Orthodox Jewish community to ensure that the four maternity and neonatal units provide culturally sensitive and appropriate care which builds on the provision that is already in place in all trusts. Given the length of time for implementation, we believe that it would be possible to put in place robust structures and processes that would ensure issues identified could be as far as possible mitigated. The below outlines an approach for how this would be achieved through the implementation period.

The proposed approach during the implementation period would be a mechanism for refining and delivering the proposed mitigations for the recommended option. This would also be an iterative approach to identify any additional mitigations that may be required

An 'as is' analysis of the key issues that need to be addressed

Each Trust in NCL currently provides maternity and other care to service users from the Orthodox Jewish community and therefore have in place provision to support religiously and culturally sensitive care. From engagement during the consultation we have heard that these facilities could be improved and built upon, particularly to support religious observance around Shabbat and religious festivals.

We propose establishing Trust-level task and finish groups that would undertake an analysis to describe the important issues that need to be enhanced at each Trust. This analysis should:

- Be co-developed with service users and members of the community
- Be guided by 'on the ground' experience – for example through doing a 'walk through' of the maternity unit and other services such as the Shabbat room to ensure that issues are fully considered and understood
- Encompass the full range of areas that are important for religiously and culturally sensitive care

Setting up a task and finish group for each Trust providing maternity and neonatal care

The task and finish group for each Trust would need to consist of both members of staff and representative members of the Orthodox Jewish community who would be able to provide input and feedback around culturally appropriate maternity and neonatal care, it could include birth coaches, faith leaders and chaplains working with the trust and VCSE organisations representing the community. This would have senior ownership at a Trust level and report into the wider programme's implementation governance structure.

Ways of working and approach to developing mitigations for the Orthodox Jewish community if the recommended option is implemented (2/2)

North Central London Health and Care
Integrated Care System

If Option A was recommended for implementation, the ICB and NHS Trusts that would continue to provide maternity and neonatal care in NCL would commit to focused joint work with the Orthodox Jewish community to ensure that the four maternity and neonatal units provide culturally sensitive and appropriate care which builds on the provision that is already in place in all trusts. Given the length of time for implementation, we believe that it would be possible to put in place robust structures and processes that would ensure issues identified could be as far as possible mitigated. The below outlines an approach for how this would be achieved through the implementation period.

The proposed approach during the implementation period would be a mechanism for refining and delivering the proposed mitigations for the recommended option. This would also be an iterative approach to identify any additional mitigations that may be required

Development of a Trust level action plan

From the analysis, an action plan should be put in place to work through the issues identified. This action plan would describe key actions to be taken forward to build a partnership with the Orthodox Jewish community around culturally sensitive maternity and neonatal provision. The areas that this action plan may cover include training, shabbat observance protocols, facilities to stay comfortably on site, modesty, food requirements (more detail on each of these areas are outlined above)

Ongoing monitoring, reporting and feedback

To ensure progress, Trusts will need to put in place a robust structure to support the task and finish group and implementation of agreed actions. This would need to include:

- A named senior owner of the actions and plan
- Reporting mechanisms into wider Trust implementation governance (which will then feed into system-wide governance)
- An ongoing commitment to work with the community throughout the progress of implementation and once changes are implemented
- Ensuring there are mechanisms through which feedback can be provided following implementation to ensure that this remains a focus following implementation

The ICB will have a role in ensuring that the approach outlined has been put in place and this will be assessed in any implementation gateway process that would be put in place. It also through the wider governance structure would bring together the work through the overarching implementation governance structure to ensure alignment, lessons learned and consistency of approach.

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Improving patient experience and reducing differential outcomes

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

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NCL LMNS equity and equality action plan

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

Haringey stillbirth audit

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

Start Well interim IIA engagement

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

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

We have looked at a number of themes from engagement which require actions to address

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Integrated Care System

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

Supporting staff training and understanding

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Integrated Care System

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

- The undertaking of a training needs analysis to understand what training is needed across NCL sites which will support staff to provide more personalised care including those with specific needs such as the LQBTQ+ population identified in the consultation
- Using specialist staff, for example learning disability nurse specialists, to deliver training across sites to raise awareness of how to support women with specific conditions or needs in their maternity care
- Ensuring that mechanisms are in place to share learning at both an NCL and regional level
- Delivery of cultural understanding and/or unconscious bias training for maternity and neonatal staff across NCL particularly in relation to communities who are known to have an increased likelihood of adverse outcomes
- Consider how staff could be better supported and encouraged to take up training that is available
- Work with MNVPs to incorporate 'lived experiences' storytelling and language and sensitivity into regular training – this may include powerful birth stories from individuals
- Increasing awareness of staff of the range of personalised care that may be needed by different service users
- Increased joint working between maternity units in NCL to make best use of the breadth of knowledge available, increased consistency in training and to share lessons learned
- Using existing LMNS forums to share learning from incidents where it has been found to be a lack of account taken for someone's needs and preferences during maternity care

Service user involvement in maternity services

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Integrated Care System

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

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

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

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

Access to appropriate interpretation services

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Integrated Care System

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

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

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

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

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

Use of digital tools

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Integrated Care System

Use of and access to digital tools such as apps can be effective in supporting families through their maternity care. Given the era that women and people of current childbearing age have grown up in, many will be adept at using digital tools, however consideration needs to be given to ensure that as many people as possible can benefit from their use:

- Ensure Trust websites are accessible through large print and read aloud options
- Ensure there are mechanisms for people to receive key information in a non-digital way and in different languages
- Consider what can be done to promote digital inclusion, for example through loan of equipment, providing free wifi
- Consider the role of social prescribing in maternity care, and how women can be directed to undertake their own research about pregnancy, the maternity pathway and advice
- Consider the use of social media for different groups, and target information sharing on platforms known to be used by different communities - tailoring messaging to meet their preferences
- Identify the most effective digital tool to provide Personalised Care and Support Plans for women and birthing people, as well as an alternative non-digital option

Supporting people with learning disabilities

North Central London Health and Care
Integrated Care System

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

- Consider a learning disability passport being in place throughout maternity and neonatal care across all providers
- Work across NCL to ensure maternity information is available in Easy Read format
- Involvement of disability specialist staff such as clinical nurse specialists in maternity care
- Continuing to work with and hear from people with learning disabilities to ensure their needs around maternity care are understood and can be put in place
- Consideration given to longer appointments for people with learning disabilities

Supporting LGBTQI+ populations

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Integrated Care System

The public consultation highlighted that sometimes people from LBTQI+ population felt they could be better supported in their maternity and neonatal care across NCL. Some people felt that their needs were often overlooked and there was a lack of inclusivity. We aim to improve LGBTQI+ experiences regardless of the proposed changes and the actions that are needed to ensure that the right support is in place are:

Linking in training and education around LGBTQI+ needs and how gender identity can impact maternity experiences

The NCL LMNS Equity and Equality Action Plan details commitments and actions to improve services for women and birthing people and includes actions that may positively support trans birthing people in NCL.

Work to implement more personalised care plans and improving perinatal mental health

Emphasise co-production, meaning better communication and two-way engagement between services and service users to improve services, which will provide opportunities for people who have lived experience to help improve care for them and their communities

The maternity teams in NCL LMNS have also been working on their people plan as part of the NHS equality, diversity and inclusion improvement plan, which includes supporting LGBTQI+ people.

We will work to ensure that language used in communication about the change is inclusive, and if a decision is made, we will involve representatives from the closing unit's Equality, Diversity and Inclusion team as part of implementation planning where relevant

Provision of continuity of carer

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

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

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

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

Personalised care and support plans

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

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

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

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

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

Maternity data quality

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

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

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

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

Consider how HealtheIntent can be used to enhance maternity care

Summary of potential impact of option A compared to option B after mitigation

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- The impacts that potentially have a materially worse impact in option A compared to option B relate to:
  - the Orthodox Jewish community due to the ties with the Royal Free Hospital built up over time, the religiously and culturally sensitive care provided there and the proximity of the hospital, particularly impacting visitors arriving on foot on religious festivals and Shabbat.
  - the Somali community in Kilburn who may face additional difficulties travelling to, and accessing, their closest hospital which would change from the Royal Free Hospital to Northwick Park Hospital or St Mary's Hospital
  - the Bangladeshi and Pakistani population in Chalk Farm are close to a maternity unit that may move, and therefore may be more impacted in terms of travel times compared to other groups
  - people living in Harlesden and Willesden with poor health outcomes, poor digital access, and poor English proficiency – also a high number of Black African and Caribbean and Bangladeshi and Pakistani people – who may need to switch the hospital where they access services
- The impacts that potentially have a materially worse impact in option B compared to option A relate to:
  - the Somali community in Finsbury Park who would access services at the Royal Free rather than the Whittington Hospital. Given their proximity to the Whittington Hospital, they may be impacted by the relatively higher increases in taxi costs to an alternative maternity unit compared to now
  - people living in areas of deprivation around Whittington hospital who are nearer to the maternity unit that may move (these people may pay up to £11 more to travel by taxi). These populations and those that are economically inactive may face difficulties with cost of transport, digital exclusion and already having children when travelling further or to a new site
  - people living in Holloway and Finsbury Park with poor health outcomes, poor digital access, and poor English proficiency - this population has a high number of Black African and Caribbean in it - who may need to switch the hospital where they access services. These people are also likely to be more impacted by increased travel time and cost compared to now, although public transport accessibility in this area is better
- All other impacts that have been identified do not have a materially different impact between options.

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Edgware Birth Centre

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

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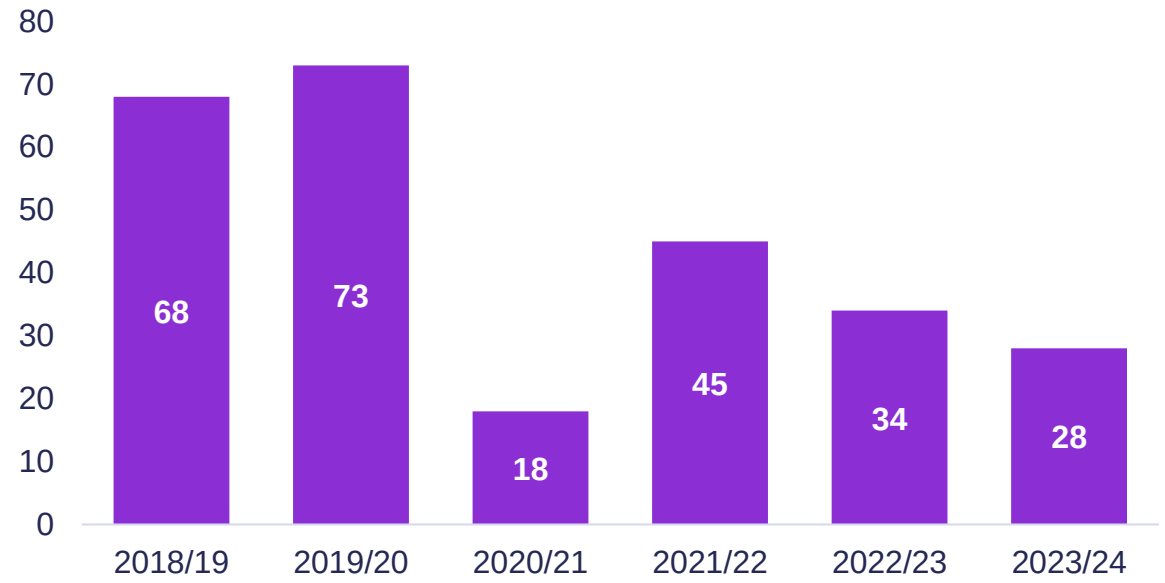
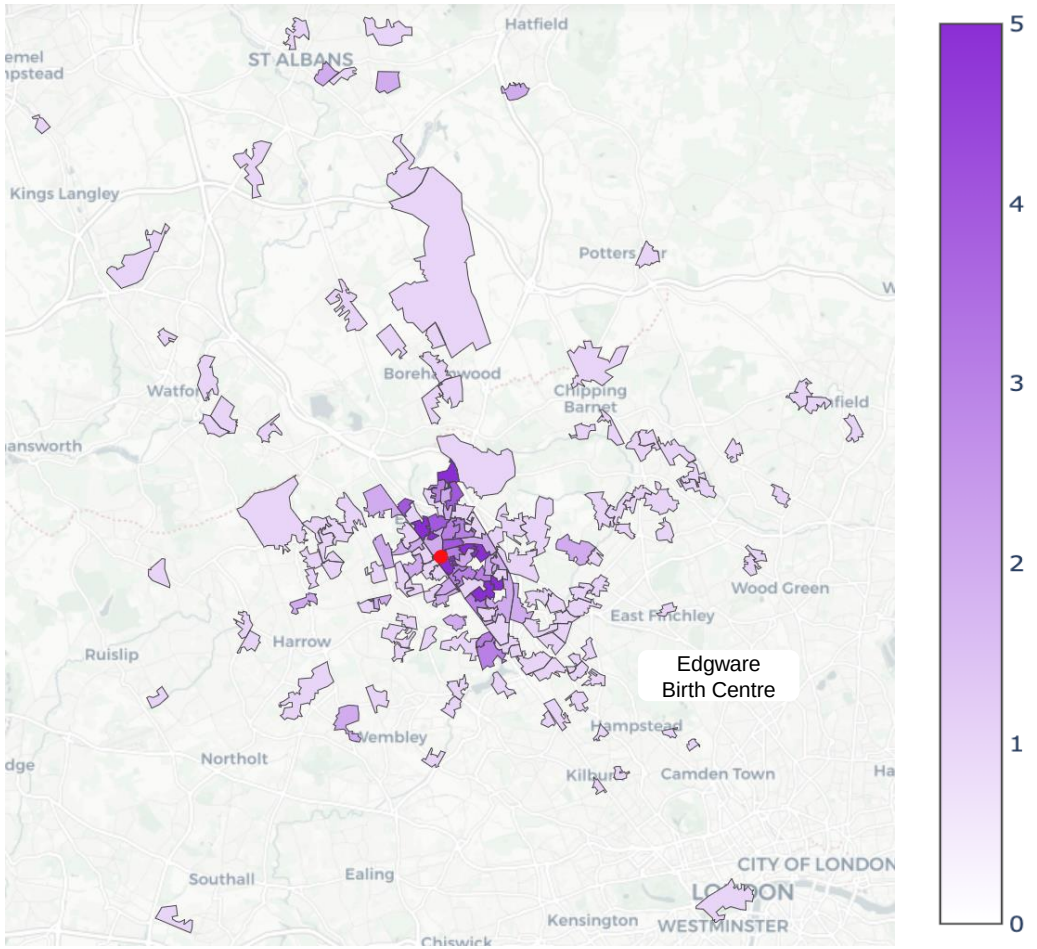
- The Start Well programme also consulted on proposals to close the birthing suites at Edgware Birth Centre (EBC)
- Our proposals for EBC would impact on people who might have wanted to give birth at the unit. This is anticipated to be a very small number given only 28 pregnant women and people gave birth there in 2023/24.
- The population who give birth at EBC are also extremely geographically dispersed.
- The number of births are so small and the geographical spread so wide, it is hard to say whether any group might be disproportionally impacted.

Number of deliveries at Edgware*, *2018/19 – 2023/24*



*Numbers of births in 2020/21 impacted by the birth centre being temporarily closed for some periods due to the COVID-19 pandemic

LSOAs that have delivered at Edgware between 18/19 and 23/24



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

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		Potential impacts that may require mitigations
Protected characteristic	Race	• No evidence to suggest there would be a differential impact. This is because of the low number of women and people who use the unit.
	Age	• Women and pregnant people are more likely to use a standalone birthing centre for a second or subsequent birth, so while the closure of the birthing suites reduces choice for all service users, this may have a disproportionate impact on older service users.
	Sex	• No evidence to suggest there would be a differential impact
	People with disabilities	• People with some disabilities may find a non-hospitalised environment less stressful so may be disproportionately impacted by the closure of the birth suites.
	Being pregnant or on maternity leave	• No evidence to suggest there would be a differential impact
	Gender reassignment	• No evidence to suggest there would be a differential impact
	Religion of belief	• No evidence to suggest there would be a differential impact
	Sexual orientation	• No evidence to suggest there would be a differential impact
	Being married or in a civil partnership	• No evidence to suggest there would be a differential impact
Other	Pregnant women and people with complex (or pre-existing) health conditions	• No evidence to suggest there would be a differential impact as pregnant women and people with complex (or pre-existing) health conditions do not have the clinical profile to use a standalone midwife led unit
	People living in areas of deprivation	• No evidence to suggest there would be a differential impact
	Other inclusion health groups	• People who have undergone some types of trauma may be more comfortable in a non-hospitalised environment

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

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Feedback from the interim IIA engagement

Feedback from IIA engagement

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

Feedback from the public consultation

Feedback from public consultation and assurance process

- Many stakeholders across various consultation activities felt that removing the service would represent an unacceptable reduction in patient choice. Specifically, they highlighted the less medicalised and more personalised, home-from-home environment offered by Edgware Birth Centre and felt that this should be maintained as an option
- Edgware Birth Centre staff felt there was a specific need to improve provision for water births at other units if the standalone birthing suites were to close
- Outline how ante- and post-natal care at Edgware Birth Centre might be used to support people at risk of adverse maternity outcome
- The Mayor's Office recommended that we add further detail on how the resources in the Centre would be reallocated

We have considered whether the feedback raised in the public consultation related to Edgware

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Feedback	Slides
During consultation, people fed back concerns around increased travel times and travel costs. In the questionnaire, ~16% of comments from individuals described concerns around increased travel distance, cost and decreased access. These themes were reiterated during in-person engagement, e.g., feedback that it is difficult to travel into central London with children that have a disability.	Not specific to Edgware
During consultation, concerns around impact were raised regarding: • Residents from low socioeconomic background (areas of high deprivation) • Residents who do not speak English • People with disabilities who may not be able to drive • The Orthodox Jewish community	Not specific to Edgware
The Mayor's office recommended that we correct the language used in PCBC about IMD deciles.	Not specific to Edgware
The Mayor's office recommended that we add detail on environmental impact mitigations specifically for maternity and neonatal care.	Not specific to Edgware
The Mayor's office recommended that we quantify the proportions of NWL residents affected by our proposals and detail mitigations for longer travel times and costs for NWL residents.	Not specific to Edgware
During consultation, it was suggested that women from some minority ethnic backgrounds could be disproportionately affected if option A is chosen, as they are statistically more likely to experience poorer maternal outcomes, especially those linked to other serious and long-term health conditions such as diabetes.	Not specific to Edgware
Difficulties of travelling further and the negative impact of longer journey times, increased costs and reassurance on the additional parking facilities	Not specific to Edgware
The potential impact on the Orthodox Jewish community has been considered during the public consultation, particularly in option A	Not specific to Edgware
Staff working at the Royal Free Hospital highlighted that they offer several services to support maternal health, including specialist transplant services, and the National Haemophilia Centre that further work was required to understand the potential impact of the proposals on these women and pregnant people. The mayor's office recommended that we quantify the impact of our proposals on women and pregnant people who use specialist clinics.	Not specific to Edgware

Mitigations have been developed for the potential impacts of the Edgware proposals

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Impacts	Mitigations	What we think
Women and pregnant people are more likely to use a standalone birthing centre for a second or subsequent birth, so while the closure of the birthing suites reduces choice for all service users, this may have a disproportionate impact on older service users.	• Investing in co-located midwife-led units and making sure that the environment is set up in a way that facilitates the best outcomes for pregnant women and people who choose them • Home birthing would remain a choice for pregnant women and people, and we would ensure that this is consistently available for those that would prefer a birth that is physically separated from a hospital site • Ensure that women for whom this is a preference can retain access to high-quality consistently available midwifery-led care	• We believe that the mitigations will remove/reduce the potential impact
People with some disabilities may find a non-hospitalised environment less stressful so may be disproportionately impacted by the closure of the birth suites.	• Investing in co-located midwife-led units and making sure that the environment is set up in a way that facilitates the best outcomes for pregnant women and people who choose them • Home birthing would remain a choice for pregnant women and people, and we would ensure that this is consistently available for those that would prefer a birth that is physically separated from a hospital site • Ensure that women for whom this is a preference can retain access to high-quality consistently available midwifery-led care	• We believe that the mitigations will remove/reduce the potential impact
People who have undergone some types of trauma may be more comfortable in a non-hospitalised environment	• Investing in co-located midwife-led units and making sure that the environment is set up in a way that facilitates the best outcomes for pregnant women and people who choose them • Home birthing would remain a choice for pregnant women and people, and we would ensure that this is consistently available for those that would prefer a birth that is physically separated from a hospital site • ensure that women for whom this is a preference can retain access to high-quality consistently available midwifery-led care	• We believe that the mitigations will remove/reduce the potential impact

Mitigations related to proposals around Edgware Birth Centre have been developed

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

For the small number of people for whom a birthing experience in an acute hospital (alongside midwifery led unit or obstetric unit) may not be their preference, we would focus on:

- Investing in co-located midwife-led units and making sure that the environment is set up in a way that facilitates the best outcomes for pregnant women and people who choose them
- Home birthing would remain a choice for pregnant women and people, and we would ensure that this is consistently available for those that would prefer a birth that is physically separated from a hospital site

Freeing up room at Edgware Birth Centre would allow us to focus on providing antenatal and postnatal appointments to support the provision of continuity of carer for local people at the highest risk of complications

Further mitigations have been developed to support access to midwifery-led care

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

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

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

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

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

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

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

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Appendix

Impact on service users of co-located services at Royal Free

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Service	Potential impact of proposals
Emergency department	• No impact as service would remain at Royal Free
London Ambulance Service emergency transfers	• No impact as London Ambulance Service have clear protocols for conveyances to only transfer pregnant women and people to hospitals which have obstetric-led units
Gynaecology services	• No impact as service would remain at Royal Free
Early Pregnancy Units	• No impact as service would remain at Royal Free
Neonatal retinopathy of prematurity screening	• No additional impact compared to overall proposed changes to obstetric and neonatal services as retinopathy screening is currently delivered on an outreach basis by clinicians which will continue
Maternal medicine services	• Pregnant women and people with complex (or pre-existing) health conditions may need to travel to an alternative site to receive the care that is required. The potential impact has been outlined on slide 126 and mitigations can be found on slide 192
Tongue tie services	• It is important that provision of this service is retained within NCL, and further work would be undertaken during implementation to understand the optimum arrangements for this clinic. Outside of the staff that support the clinic, there is no interdependency between the tongue tie service and on-site maternity services. • Therefore our intention is to retain the clinic at the Royal Free Hospital. Tongue tie is estimated to impact around 8% of newborns with no differential or unequal impact between population groups
Out of hours interventional radiology (OOH IR)	• If a decision is made, service users that require out of hours interventional radiology may need to be transferred to UCLH • Requiring OOH IR when pregnant is extremely rare and therefore the impact of the proposed changes would be minimal • There is no identified difference between population groups due to the very small number of cases

Source: https://www.nature.com/articles/s41390-020-01239-y)

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

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Method and limitations

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

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

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

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

Formula for weighing

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

mL is the metric of interest per LSOA
pL is the population of interest per LSOA
mw is the weighted metric
L represents an LSOA

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

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

Example calculation

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

$$m_w = 3.85$$

The quantitative assessment was undertaken using available data sources

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Population	Metric	Source
People living in areas of deprivation	This metric examines the number of people that live in the most deprived 20% of areas nationally based on the IMD deciles	ONS (2019)
People who are economically inactive	This metric examines the proportion of the population in any LSOA that is categorised as not economically active	ONS (2022)
People from minority ethnic groups	This metric examines the proportion of the population in an LSOA that self identifies as belonging to a minority ethnic (any categorisation on the census that is not white or mixed)	ONS (2022)
People with poor English proficiency (including literacy)	This metric examines the proportion of the population in an LSOA that has poor / no proficiency in English	ONS (2021)
People with poor health	This metric examines the proportion of the population in any LSOA that self-reports ”bad” or “very bad” general health	ONS (2021)
Women and people of child-bearing age	This metric examines the proportion of women per LSOA that are within the age of 16-45	ONS (2021)
Single pregnant women and people	This metric examines the proportion of single mothers in each LSOA	ONS (2021)
People with disabilities	This metric examines the proportion of the population in any LSOA that self identifies as disabled under the equality act	ONS (2023)
Jewish people	This metric examines the proportion of people that identify as Jewish religion by LSOA	ONS (2021)

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

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