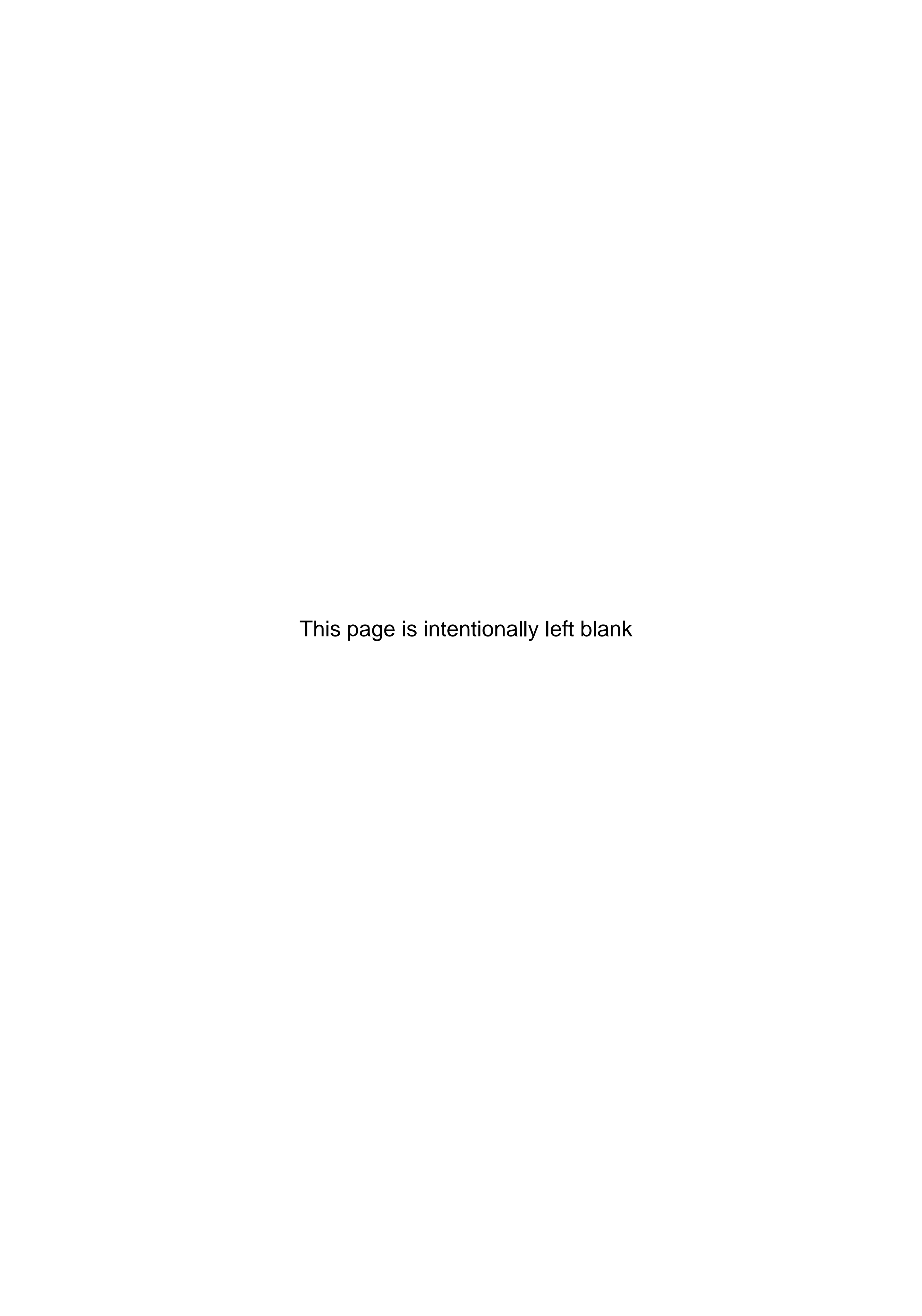
JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE FOR NORTH CENTRAL LONDON SECTOR

Thursday, 30th November, 2023 at 10.00 am in the Council Chamber, 1st Floor, Camden Town Hall, Judd Street, London WC1H 9JE

AGENDA – PART 1 – SUPPLEMENTARY PAPERS

1. AGENDA PACK (Pages 1 - 62)



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Agenda Item 1

Dominic O'Brien,
Principal Scrutiny
Officer

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28 November 2023

To: All Members of the North Central London Joint Health Overview and Scrutiny Committee

Dear Member,

North Central London Joint Health Overview and Scrutiny Committee - Thursday 30th November 2023

I attach a copy of the following reports for the above-mentioned meeting which were not available at the time of collation of the agenda:

7. START WELL PROGRAMME (PAGES 1 - 42)

To receive an update on Start Well - a long-term change programme focusing on children & young people's and maternity & neonatal services in a hospital context.

Yours sincerely

Dominic O'Brien,
Principal Scrutiny Officer

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NCL Start Well

JHOSC – 30 November 2023

Agenda Item 7

This presentation is an update on the NCL Start Well programme

This pack contains the following:

- Context and background to the Start Well programme
- Maternity and neonatal services proposals
- A proposal for the birthing suites at the Edgware Birth Centre
- Proposals for surgery for babies and children
- Our proposed consultation activity

The content of these materials has been informed by a number of documents which are being considered by the NCL ICB Board at their meeting on 5th December. **These documents can be viewed here:** **https://nclhealthandcare.org.uk/wp-content/uploads/2022/07/NCL-ICB-Board-Meeting-5.12.23.pdf**

Background and context

Purpose of today’s briefing

Today we are giving an update to the JHOSC on the Start Well programme. At the end of the update JHOSC members are asked to:

- **Note** the programme update
- **Support** the consultation plan, subject to the outcome of the ICB Board meeting on 5 December 2023
- **Agree** how JHOSC would like to be consulted with during the formal public consultation phase, including any additional information or meeting requirements for members
- **Agree** to receive a report on the the public consultation responses following its completion

The drivers for this programme and the need for change are rooted in our relentless focus on improving outcomes and reducing inequalities within our population

North Central London ICS has an ambition to provide services that support the best start in life, both for our residents and for people from neighbouring boroughs and beyond who choose to use our services.

We know that care received at the beginning of life is a powerful force against health inequalities and a catalyst for improved life chances which is why Start Well is a key priority in our Population Health and Integrated Care Strategy.

Central to the Start Well programme are the needs of pregnant women and people and their babies. We want to ensure our services are in the best position to support families through the life changing journey of pregnancy and birth.

We have ten principles which will guide our new ways of working

To make our transition to a population health and integrated care system that is needs-driven, holistic and integrated, we have identified 10 principles to guide us and given examples of what that looks like in terms of changed ways of working.

Trust the strengths of individuals and our communities
We listen to our communities and develop care models that are strengths-based and focussed on what communities need, not just what services have always delivered

Break down barriers and make brave decisions that demonstrate our collective accountability for population health
We understand each other's viewpoints and take shared responsibility for achieving our ICS outcomes and our role as anchor institutions

Build from insights
We create digital partnerships and use integrated qualitative and quantitative data to understand need

Strengthen our Borough Partnerships
We build a system approach for local decision making and accountability to support local action on physical and mental health inequalities and wider determinants

Mobilise our system's world class improvement and academic expertise for innovation and learning
We build the evidence base for population health improvement and innovative approaches to improve integrated working

Break new ground in system finance for population health and inequalities
We shift our investment toward prevention and proactive care models and create payment models based on outcomes.

Build 'one workforce' to deliver sustainable, integrated health and care services
We maximise our workforce skills, efficiencies and capabilities across the system

Support hyper-local delivery to tackle health inequalities and address wider determinants
We make care more sustainable by creating local integrated teams that coordinate care around the communities they serve

Relentlessly focus on communities with the greatest needs
We embed Core20PLUS5 in all our programmes with a particular focus on inclusion health to make sure no-one is left behind

Deliver more environmentally sustainable health and care services
We prioritise activity which impacts our communities' health and environment, such as transport

Source: North Central London ICS Population Health and Integrated Care Strategy

https://nclhealthandcare.org.uk/our-working-areas/population-health/

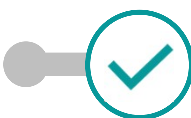
The Start Well programme will support us to tackle inequalities and improve population health outcomes

The Start Well programme was initiated to ensure services are set up to meet population needs and improve outcomes. The drivers for starting the work demonstrate that the programme is key to delivering against our duties around population health improvement and tackling inequalities

- **Improving care at the start of life has the potential to have far reaching impacts on overall population health and life outcomes**
- **There is longstanding inequity in service provision across maternity, neonatal and paediatric services – with not everyone having access to the same care as others**
- **The quality of services could be improved, and some service users face differential outcomes and experience**
- **Our workforce is constrained and, in some instances, our people are working in environments that are not set up for them to provide the best possible patient care**
- **Ensuring we are in a position to respond to national reviews and best practice guidance such as the Three Year Delivery Plan for Maternity and Neonatal Care**

The ICS also has a number of other programmes which are aiming to achieve population health improvements and integration of care such as a review into community services, mental health services and the implementation of a Long Term Conditions Locally Commissioned Service for Primary Care.

Start Well is a collaborative programme involving a wide range of patients, carers, community representatives, clinical leaders and ICS partners



Start of review
November 21

Agreement across all organisations to commence the programme following Trust Board engagement.

Case for change development
November 21 – May 22

The clinical case for change was co-developed through significant clinical engagement, including: 60 interviews, 12 reference group meetings, 2 large clinical workshops and 5 surgical deep dive sessions

Case for change engagement
July – September 22

Engagement with patients and the public on the case for change, including:

- 207 in depth discussions
- 389 questionnaire responses
- 16 stakeholder meetings
- 2 youth summits

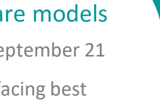
Over **75% of respondents agreed or strongly agreed with opportunities identified**

New care models
July – September 21

Future facing best practice care models were developed. This involved **over 100 clinicians** through workshops and task and finish groups

Options appraisal
November 22 – May 23

Evaluation of options was undertaken through **10** clinical reference group meetings, **8** finance group meetings and **3** patient and public engagement group meetings



Options appraisal workshop
May 23

Programme board workshop where options were narrowed involving local authority partners, Trust reps as well as NEL, NWL and Herts.

Pre-consultation business case development
May 23 – September 23

Drafting of pre-consultation cases that outline proposals and new clinical model to be implemented

IIA engagement
May – June 23

Engagement with **over 120 service users** about their experiences of maternity and neonatal care to build up an understanding of the impact of implementing changes

Clinical senate review
July 23

A panel of over 30 senate panel members reviewed and feedback on proposals. Lead clinicians from NCL represented the programme

Finance assurance
August 23 – September 23

Assurance of capital assumptions for each option through 1:1 assurance meetings with CFOs

Further assurance of wider finance case through CFO group, and sign off in September

NHSE Assurance
November 23

Assurance of proposals by NHSE, a requirement in advance of commencing a consultation. Trust Board sign up to proposals is needed for this

ICB Board
December 5th 23

Seeking approval to commence consultation on proposals

Proposed public consultation
December 23 – March 24

Seeking feedback on proposals which will inform subsequent decision making

The programme, which began in November 2021, has benefited from extensive clinical and service user input.

Maternity and neonatal services proposals

Neonatal care is organised into different unit types – ranging from level 1 to level 3

Neonatal care unit types

Special Care Unit (SCU)	Local Neonatal Units (LNU)	Neonatal intensive Care Units (NICU)
Level 1	Level 2	Level 3
Care for: Babies born after 32 weeks with the least complex conditions	**Care for:** Babies born between 27 and 31 weeks who need a higher level of medical and nursing support	**Care for:** The most premature or unwell babies, often who are born before 28 weeks
Hospitals in NCL: Royal Free Hospital	**Hospitals in NCL:** Barnet Hospital, North Mid, Whittington Hospital	**Hospitals in NCL:** UCLH, Great Ormond Street Hospital

The maximum level of care offered at each hospital is shown.
They can also offer care to babies with less complex needs.

- Neonatal units differ in their ability to care for the range of needs of babies that are born unwell or premature
- Each unit type is staffed in a different way, with level 3 NICUs units having the most specialist staff and highest staff to baby ratio
- There is evidence that babies looked after in neonatal units that look after a lot of unwell or premature babies have better outcomes
- The British Association of Perinatal Medicine produce guidelines around activity numbers and staffing standards for each type of neonatal unit. This covers things like the number of days that the unit has looked after a baby needing ventilation support, and the on-call cover arrangements for each unit
- There is a network that oversees the neonatal units in London, and they are organised on a regional basis, which ensures that each hospital with either an LNU or SCU has a hospital with a NICU that they are associated with
- Where possible, maternity and neonatal teams work together to ensure that where it is known a baby will need a high level of neonatal care (e.g., they are born very prematurely) they give birth at a hospital site where there is a NICU. This avoids transfers of babies after they have been born and a woman or person who has just given birth being separated from their newborn baby
- when babies have put on sufficient weight and can breathe and feed unaided, or have made improvements if they have been unwell, they are then transferred back to a neonatal unit closer to their home

There are a range of birth settings where pregnant women and people can give birth

Out of hospital settings

Home birth

Pregnant women and people give birth at home, supported by midwives. They can be transferred to an obstetric-led unit by ambulance if there are complications during or after labour.

Standalone midwifery-led unit

A birth unit that is not located with an obstetric-led birth unit or neonatal unit, where care is delivered by a team of midwives. The unit has a more homely, less medicalised feel, often offering the opportunity to use birth pools. Pregnant women and people can be transferred to an obstetric-led unit by ambulance during labour if there are complications during or after labour.

In hospital settings

Alongside midwifery-led unit

A birth unit where care is delivered by a team of midwives. The unit is located in the same hospital as a neonatal unit and an obstetric-led birth unit but has a more homely, less medicalised feel, often offering the opportunity to use birth pools. Pregnant women and people can easily be transferred to the obstetric-led unit during labour if they need additional support with pain relief or delivering their baby.

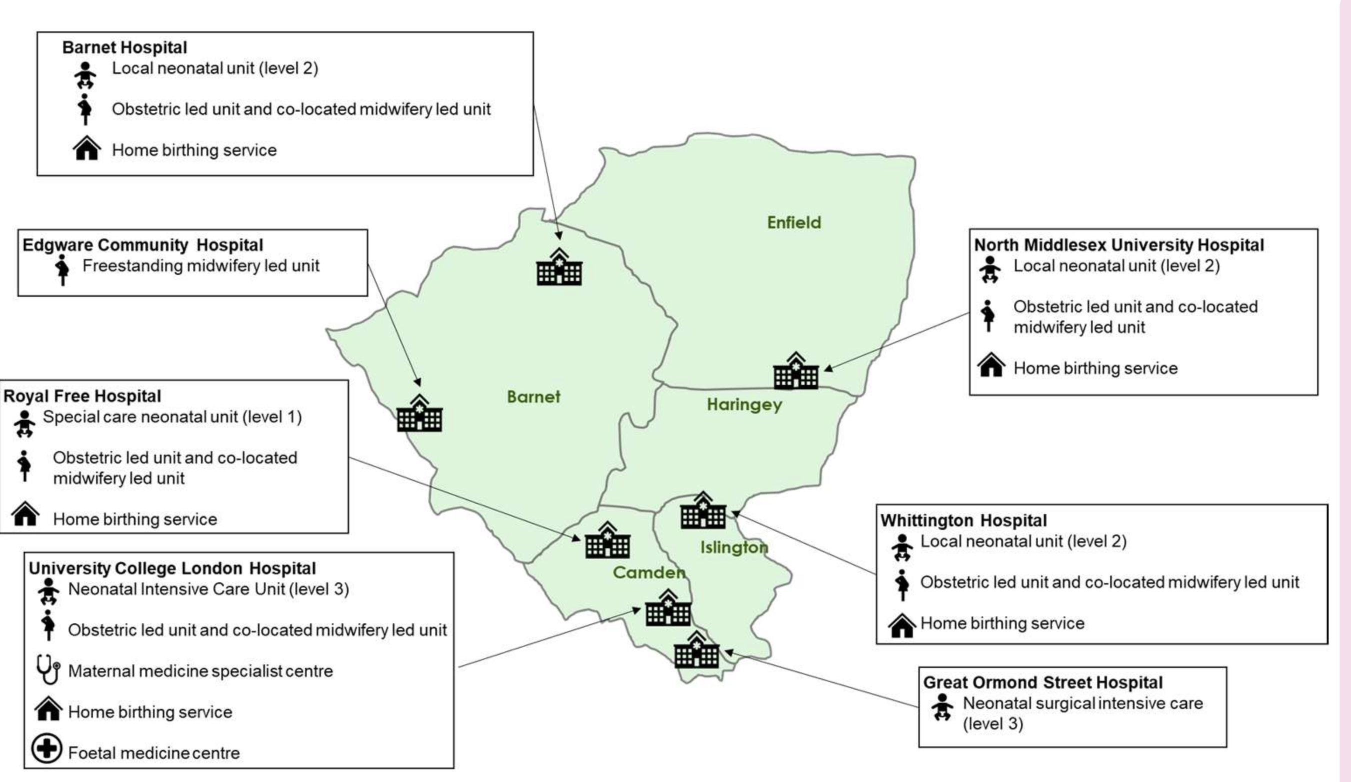
Obstetric unit (labour ward)

Care is delivered by obstetricians (specialist doctors trained to provide care during pregnancy and labour) and midwives. Anyone can give birth at these units and some pregnant women and people who are higher risk may be advised to give birth in an obstetric-led unit.

Women and people are clinically assessed during pregnancy to determine an appropriate birth setting. Those considered to have more ‘high risk’ pregnancies will be advised to give birth in a setting that has more medical support available. People may be considered to have high risk pregnancies if:

- They have pre-existing comorbidities such as obesity or diabetes
- If they have developed complications during their pregnancy

Our current configuration of maternity and neonatal care includes five maternity and neonatal units



NCL has **five maternity and neonatal units** and a **standalone midwifery led birth centre**:

- Five obstetric units
- Five alongside midwifery-led units
- One standalone midwifery-led unit at Edgware Community Hospital
- One special care neonatal unit (level 1)
- Two local neonatal units (level 2)
- Two NICUs (level 3 – one of which is at GOSH and out of scope of the proposals)

There are important clinical drivers for change in our maternity and neonatal services

NCL has a declining birth rate, with increasing complexity of service users. There is insufficient activity and staff to sustain five maternity and neonatal units in the long term

Staffing levels do not always meet best practice guidance and there are high vacancy rates which frequently compromise service provision. This often leads to the inability to staff birth centres – meaning the choice of midwifery-led care is often compromised

The level 1 unit at the Royal Free Hospital was only 37% occupied in 2021/22. The number of admissions to the unit have been falling and there are expensive and complex mitigations in place to maintain its safety. This unit does not provide equitable care to service users and it represents a clinical risk, which requires a long-term solution as identified by the London Neonatal operational delivery network and the Trust

The maternity and neonatal estate at the Whittington Hospital does not meet with modern best practice building standards. It has no ensuite bathrooms in its labour ward, its neonatal unit is cramped with risks around infection control which must be mitigated. This was identified by a recent CQC inspection as a cause for concern

The maternity CQC reinspection programme has identified challenges with maternity services in NCL and there are opportunities to improve their quality

Edgware Birth Centre supports an ever-decreasing number of women to give birth – in 22/23 only 34 women gave birth there. Given the declining birth rate and increasing complexity of births it is unlikely this will increase in the future

Not for onward circulation

Our vision for maternity and neonatal care is delivered through our new care model

The new care model proposes:

- **Bringing together maternity and neonatal care into four units as opposed to our current five**
- **Three level 2 neonatal units as well as the specialist NICU at UCLH**
- **No longer having a level 1 neonatal unit**
- **No longer having a standalone midwifery-led birth centre**

Our vision for maternity and neonatal services

Provision of high-quality equitable care: all units being able to provide the same level of neonatal care will address the current inequity of having a level 1 neonatal unit as local provision for those closest to that level 1 unit is less comprehensive than the local provision for those closer to any of the level 2 centres

Units that provide sustainable activity numbers: through consolidation, we will have larger units which are more clinically sustainable in the long term given the declining NCL birth rate and the need to make best use of our scarce workforce

Workforce resilience: units staffed in line with best practice, supporting our teams to deliver high quality care. Delivering this over four units as opposed to five means increased workforce resilience and units will be less vulnerable to short term closures – ensuring that choice of birth setting can be facilitated in a more consistent way. This may also help deliver greater continuity of care to parents, which is currently a challenge to deliver as our workforce are spread thinly

The right capacity to meet demand: ensuring that NCL has access to the right level of capacity to meet changing needs of our population – including access to specialist care where it may be needed

Environment that provides a positive patient experience: investing in our estate and making improvements that will address current issues. We will invest in making sure we have optimally sized units, meaning better value for money and wider benefits of adopting the new care model

Not for onward circulation

The options appraisal considered all viable options for the proposed service changes

We conducted a thorough options appraisal process for the proposed maternity and neonatal care model to:

- Set out all possible site-specific options for having four obstetric led birthing units co-located with four neonatal units (three of which will be level 2 and one will be level 3), instead of the current five (excluding the specialist level 3 at GOSH)

Care models *help to shape the breadth of potential options*

Hurdle criteria applied (if applicable)

Evaluation criteria applied

Full list of potential options (long list)

Filter

Short list of potential options (3-15)

Filter

Final list of potential options (1-5)

PCBC

Final options

Fixed point criteria was applied to a long list of five options. Application of the fixed point resulted in four options.

No hurdle criteria were identified by the Programme. All four options were taken forward for a full evaluation.

After application of the evaluation criteria, two options were identified as viable options for public consultation

The options appraisal was supported by a number of different groups including our patient and public engagement group

Criteria development	Initial evaluation	Final evaluation

Clinical Reference Group: develop **quality and workforce** criteria	• Undertake the initial evaluation for **quality and workforce criteria**.
	• The group have recommended proposed scores against the agreed evaluation measures using a ++, +, /, -, -- evaluation.
		Evaluation event
		The programme board undertook the final evaluation based on the inputs from other groups. The workshop was attended by all members of the programme board including:
		• Executive leads from all impacted Trusts
		• Representatives from neighbouring ICS regions (NEL, NWL, Herts)
		• Local authority reps including:
		  • Haringey DCS
		  • Camden DPH
		  • Enfield Chief Executive

Patient and Public Engagement Group: develop **access** criteria	• Undertaken the initial evaluation for **access criteria** • The group have recommended proposed scores against the agreed evaluation measures using a ++, +, /, -, -- evaluation.	
Finance and Analytics group: develop **affordability and value for money** criteria	• Undertaken the initial evaluation for **affordability and value for money** • The group have recommended proposed scores against the agreed evaluation measures using a ++, +, /, -, -- evaluation.	

Not for onward circulation

Proposed options for consultation – maternity and neonates

Our preferred option

Option A: *UCLH, North Mid, Barnet, Whittington*	
UCLH	Consultant-led obstetric unit with co-located NICU (level 3) neonatal intensive care unit, alongside midwife-led unit and a home birth service
North Mid	Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service
Barnet	Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service
Whittington Hospital	Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service
Royal Free Hospital	Maternity and neonatal services would cease to be provided

Option B: *UCLH, North Mid, Barnet, Royal Free*	
UCLH	Consultant-led obstetric unit with co-located NICU (level 3) neonatal intensive care unit, alongside midwife-led unit and a home birth service
North Mid	Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service
Barnet	Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service
Royal Free Hospital	Consultant-led obstetric unit with co-located LNU (level 2), alongside midwife-led unit and a home birth service
Whittington Hospital	Maternity and neonatal services would cease to be provided

Closure of the birthing suites at Edgware Birth Centre

Not for onward circulation

Both options being put forward for consultation are deemed to be implementable

The status quo is not an option for consultation because:

- The way services are currently set up won't meet the long-term needs of our population and doesn't resolve the challenges identified in our case for change
- Staffing services across five sites as opposed to four would continue to be a challenge and not make best use of our skilled workforce
- The neonatal unit at the Royal Free Hospital would continue to need support to maintain the skills of staff and this does not represent a long term, sustainable solution

Both proposed options being put forward for consultation have been deemed to be implementable and we are consulting on both options.

Option A has been identified as the preferred option for consultation because:

- It would be significantly easier to implement option A than option B from a workforce perspective because Whittington Hospital already has a **Local Neonatal Unit (level 2)** while the Royal Free Hospital currently has a **Special Care Unit (level 1)** neonatal unit. Therefore, in option A there would be a smoother transition to the new model of care with minimal need for staffing changes
- Option A would result in projected patient flows of **850 deliveries per year to hospitals in North West London** which NWL ICB has confirmed **could be delivered within existing capacity**. In **option B** patient flow to North East London would be **more difficult to manage**

Not for onward circulation

We have built up an understanding of the impact of our proposals through our Interim Integrated Impact Assessment

Our IIA draws on multiple strands of work which has supported us to build a picture of what the impact of our proposals could be, and who may be impacted:

1. Our case for change took a population health approach and identified service users with characteristics who may be at risk of health inequalities
2. We undertook a supplementary literature Review to identify inequalities in maternal and neonatal outcomes undertaken by public health professionals
3. We engaged with potentially impacted groups to understand their views on the possible impact of proposals
4. We have undertaken extensive analysis on:
   - Accessibility (travel time, cost, parking, public transport access, car ownership)
   - Population demographics
   - Sustainability impact by looking at carbon emissions

We have identified the following impacts of our proposals:

- **Accessibility**: relatively small average increases in travel time across both options (both by public transport and car)
- **Cost of travel:** additional expenses when travelling by taxi on average of £4, but close to the closing sites up to £11
- **Accessing an unfamiliar hospital site:** changes may mean people having to travel to and navigate around a hospital site which they are unfamiliar with
- **Understanding changes:** service users need to be able to understand their choices of maternity care and what change could mean for them

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

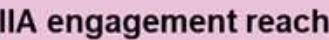
2. Identify potentially impacted populations
- Assess which local people may be impacted by the proposals

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 who are vulnerable

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 are vulnerable

5. Agree mitigations
- Agree steps to mitigate against any negative impacts and enhance any benefits

IIA engagement reach



38 engagement meetings facilitated

124 patients, 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

Start Well

Literature Review to identify inequalities in maternal and neonatal outcomes to support the NCL Integrated Impact Assessment (IIA)

Executive Summary

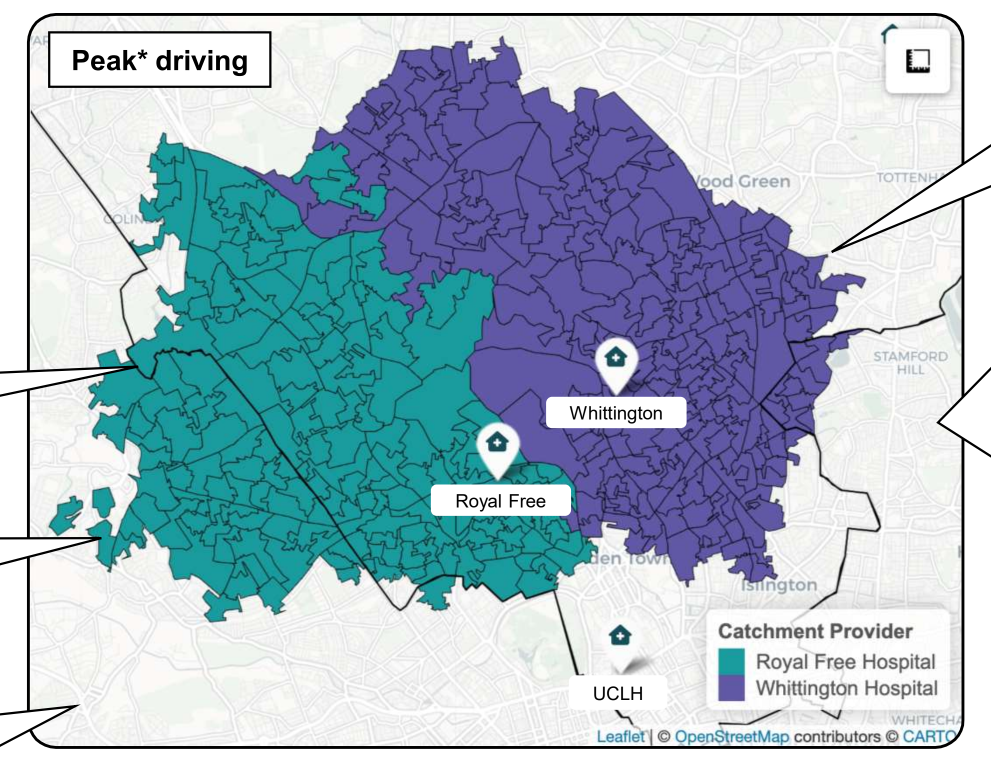
This work involved a review of the literature to identify studies that reported on maternal and neonatal outcomes across several population groups known to experience inequalities. It found the following:

- **Deprivation:** Women living in deprived areas were up to 50% more likely than those in less deprived areas, to experience a stillbirth or neonatal death
- **Protected Characteristics:**
  - **Age:** Advanced maternal age is associated with a range of adverse pregnancy outcomes including low birth weight, pre-term birth, and stillbirth
  - **Ethnicity:** Pregnant women in the UK from mixed or multiple ethnic backgrounds experience a mortality rate 1.9 times higher than White women; with Black women having 4.1 times higher mortality rate. Babies that are Black, or Black British Asian or Asian British have a more than 50% higher risk of perinatal mortality compared to White
  - **Single parent**: For unmarried women there are increased chances of preterm birth, low birth weight and small for gestational age births
  - **Religion**: Limited evidence is available, but studies available suggest Islamic woman report worse maternal care while Jewish women make late antenatal bookings which itself is associated with poor pregnancy outcomes and poor infant health

We looked at people who might be impacted by our proposals when driving (or being driven)

Option A catchment includes:
Population: 373k
Households: 122k
LSOAs:** 188

Option B catchment includes:
Population: 378.5k
Households: 146k
LSOAs:** 204



ICB boundaries

Royal Free Hospital catchment area (people who are closest 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

Whittington Hospital catchment area (people who are closest to 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 blue-coloured area can drive more quickly to Royal Free Hospital (A) than another site.

*Peak (private car / taxi) is defined as 9:00 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

We looked at people who might be impacted by our proposals for maternity units when using public transport

North Central London Integrated Care System

Option A catchment includes

Population: 230K
Households: 74.5k
LSOAs:** 114

Option B catchment includes

Population: 298k
Households: 97.5k
LSOAs:** 164

ICB boundaries

Royal Free Hospital catchment area (people who are closest to the Royal Free Hospital)

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

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 who are closest to the Whittington Hospital)

**Peak (public transport) is defined as 9:00 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*

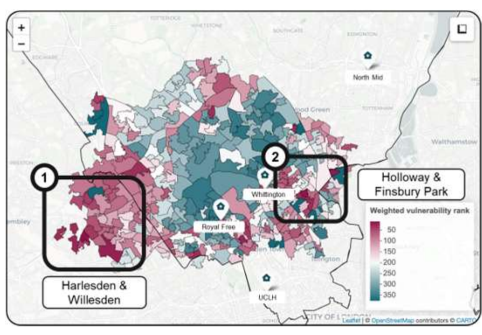
Not for onward circulation

There are a range of population groups who may be impacted if we were to implement either option A or B

Women and people who live in deprived areas: there is a link between people living in deprivation and adverse outcomes from maternity and neonatal care. People living in these areas may be particularly impacted by increased taxi costs if either option A or B were to be implemented.

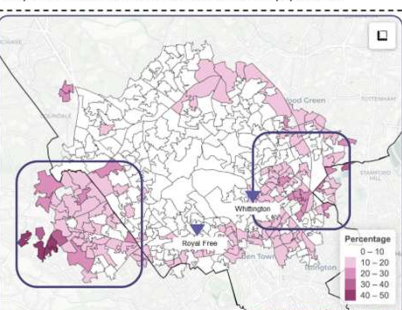
Deprived population
Rate (%) of deprived population

People living in geographic areas who may have vulnerabilities: we identified two neighbouring areas with a higher concentration of people who may be vulnerable to service changes. **Harlesden and Willesden** would be more impacted by option A and **Holloway and Finsbury Park** would be more impacted by option B. The reason that these areas have been identified is due to their higher concentration of people who belong to an ethnic minority, people with poorer English proficiency and areas of higher deprivation. Mitigations for these populations include a focus on continuity of care and ensuring there is integration with other local services



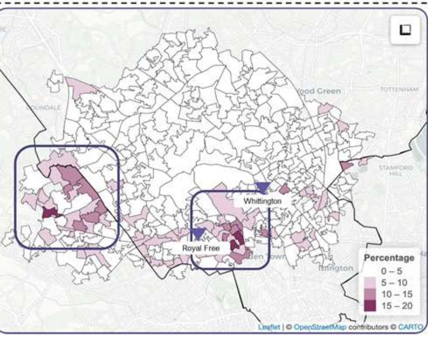
Black African (including Somali) and Black Caribbean women and people of childbearing age: there is evidence that Black African and Black Caribbean women and people may experience poorer maternity outcomes. The impact on Black African and Black Caribbean women of proposed changes may be around navigating to a potentially unfamiliar hospital site, language, additional transport costs and consideration of their wider health needs during pregnancy.

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



Asian women and people of childbearing age: there is evidence that Asian (particularly Bangladeshi and Pakistani) women and people may experience worse outcomes from maternity care. The impact for them may be around navigating to a potentially unfamiliar hospital site, language, additional transport costs and consideration of wider health needs given evidence of higher prevalence of conditions such as diabetes.

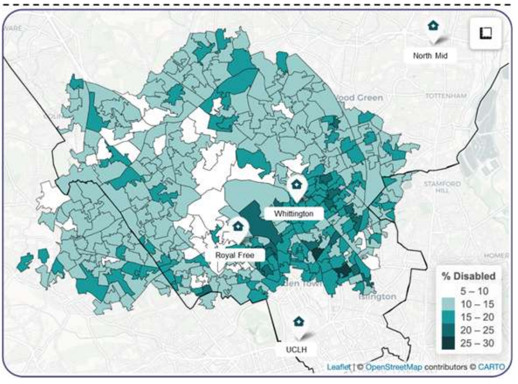
Asian (Bangladeshi and Pakistani) populations
Proportion of Bangladeshi and Pakistani populations



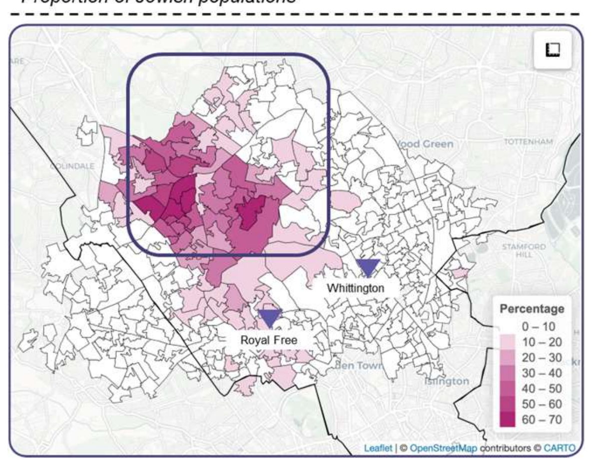
There are a range of population groups who may be impacted if we were to implement either option A or B

Women and people of childbearing age with disabilities (including learning disabilities): people with disabilities may be more impacted by proposed changes due to challenges navigating to an unfamiliar hospital site, taxi costs due to lower car ownership and the physical accessibility of hospital sites.

People with a disability
Rate (%) of people with a disability



Jewish Population
Proportion of Jewish populations



Women and people from the orthodox Jewish community: Orthodox Jewish people may be impacted by the proposed changes, particularly around Option A. Consideration may need to be given for the specific needs of this group around maternity care. This includes requirements around Kosher food, observance of Shabbat and the impact on travel and ability to access online or digital materials.

Through engagement with service users to date, we have developed mitigations that may need to be put in place to support service users with a range of different needs should a decision be taken to implement proposals. This covers areas such as:

- Communication and information sharing
- Travel and transport
- Ongoing engagement with communities

There are a number of other service users who have characteristics that make them potentially more impacted should we implement option A or B which our IIA identifies. This includes older and younger pregnant women and people, people with poor literacy, women and people in inclusion health groups and

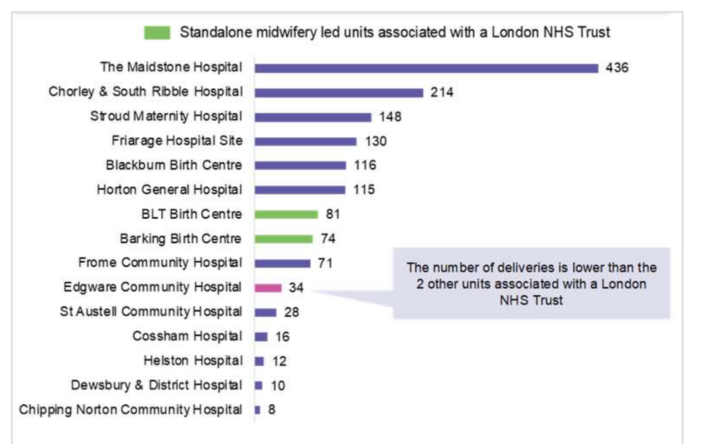
We would seek as a priority to engage with all of these groups during the proposed consultation period.

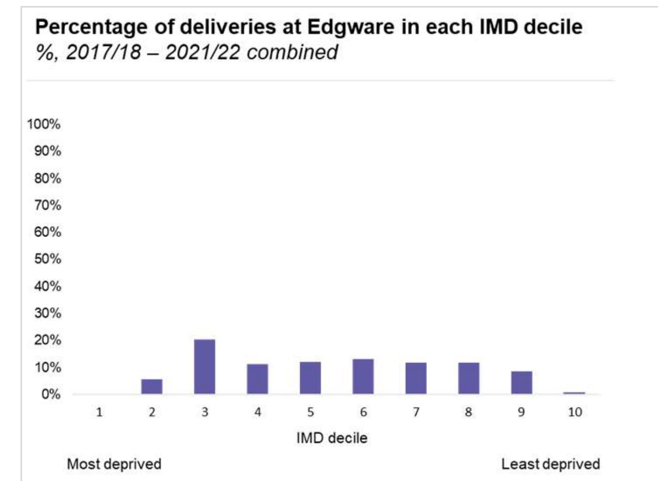
The birthing suites at Edgware Birth Centre

We are also proposing closing the birthing suites at Edgware Birth Centre

Case for change for Edgware Birth Centre

- Edgware Birth Centre does not provide the right type of capacity for our population, with analysis suggesting only 30% of women across NCL would be clinically appropriate to give birth there and an even smaller number of this 30% would be within close travelling distance of the unit
- Births are becoming more complex and anticipated to decline over the next 10 years, meaning it would be very difficult to increase activity numbers at the unit
- The number of births at the unit has been declining every year since 2017 and it is one of units with the smallest number of births in the country, with only 34 births in the last financial year
- We do not have the workforce to support the unit as well as our other alongside midwifery-led units which leads to short term closures of the service
- There are opportunities to use the space at the site in a more efficient way and provide antenatal and post natal services for our local population there that are more in line with their needs





We propose to consult on this as a separate proposal alongside the maternity and neonatal proposals. They are not dependent on one another.

Surgery for babies and children

There are several important clinical drivers for change in our paediatric surgical services

There is currently a lack of defined emergency surgical pathways for young children meaning that clinicians in emergency departments make multiple enquires to secure the right pathway for individual children.

Some children are transferred up to three times before receiving emergency surgical treatment in the right setting. From April 2020 to March 2021, 144 children and young people were transferred from an NCL provider to other hospitals for an emergency surgical procedure

Access to surgical and anaesthetic workforce to deliver care for young children is limited at local sites and scarce nationally, with the ability to undertake an operation often dependent on the skills of the individual staff on duty that day

There are some operations being undertaken in very low volumes at local sites which raises questions about the ability of staff to maintain their skills

There is lack of clarity on the role of Great Ormond Street Hospital in caring for local NCL children and young people requiring surgery, alongside its tertiary and quaternary work

Children are not always looked after in age-appropriate environments, or on child-only lists which does not represent a high-quality patient experience

There are long waits for planned operations, particularly in ENT and Dentistry, and there are opportunities to consider how these high-volume specialties better manage demand and capacity

There were broader opportunities to improve identified through the case for change which are being addressed through other programmes of work.

Not for onward circulation

Our proposals will improve quality outcomes and patient experience for paediatric surgical care

Paediatric surgery care model benefits

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

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

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

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

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

Not for onward circulation

Proposed option for consultation – paediatric surgery

- We developed and appraised options for the location of planned and emergency surgical services for children and young people in NCL
- Following our options appraisal, there is one option for consultation for the location of the 'Centre of expertise: day case' and 'Centre of expertise: emergency and planned inpatient'

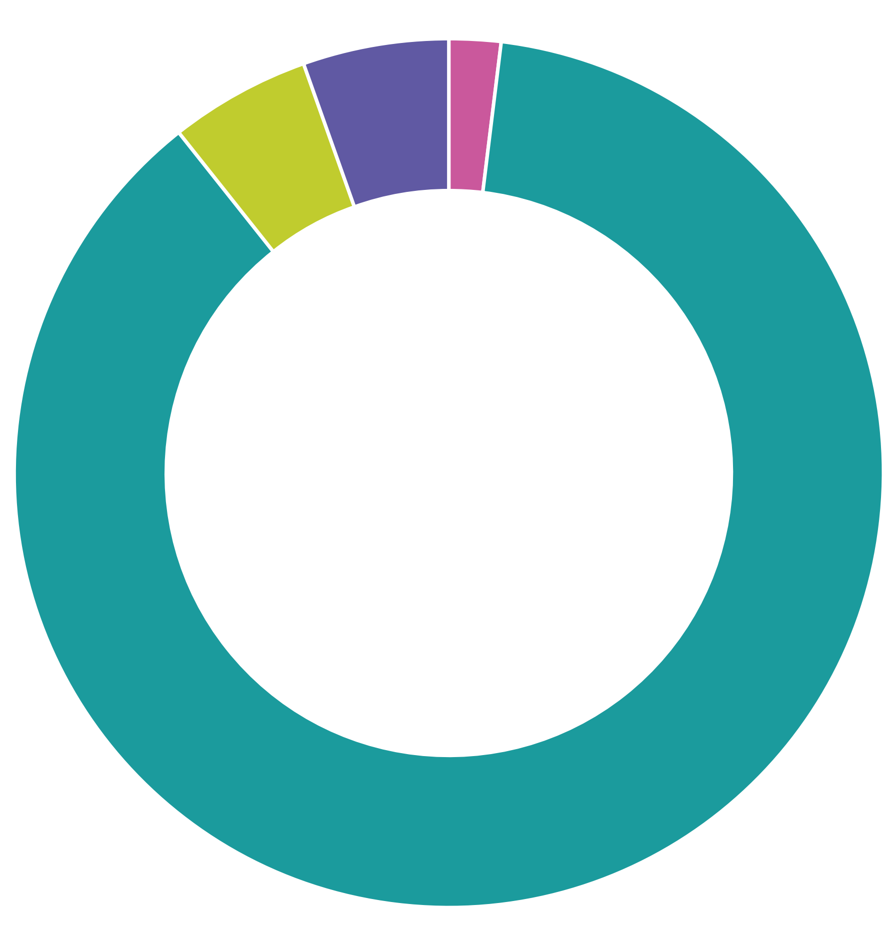
Option for consultation

Centre of Expertise: emergency & planned inpatient		Centre of Expertise: day case	
GOSH	**Would deliver majority of surgical care for children under 3 years and under 5 years (general surgery and urology). Would provide planned inpatient surgery for children age 1 years and over for low volume specialties.**	**UCLH**	**Would delivers all day case surgery for children age 1 and 2 years. Would provide day case activity for all children age 3 years and over for low volume specialties.**

The proposed care model would move less than 10% of paediatric surgical care in NCL

Centre of Expertise: Daycase – c.300 children
Bringing together planned daycase activity

Centre of Expertise: Emergency & planned inpatient – c. 300 children for surgical care and c.1,000 children for surgical assessment
Bringing together emergency for very young children and planned inpatient care



Out of area
Emergency paediatric surgical activity that would continue to be delivered outside NCL (e.g., major trauma)

Local and specialist units
Most of the emergency and planned activity would remain at local units or at specialist units. This means that children and young people are seen at the place best suited to their needs.

We think that our proposals will improve quality and safety of paediatric surgical care, but there could be an impact on travel times

- Our engagement to date has highlighted that for planned care, parents are willing to travel to receive care from the right specialists, and our proposals formalise arrangements that to some extent are already in place which will lead to improve quality and safety of paediatric surgical care
- The main impact of the proposals are the travel times and cost to both UCLH and GOSH, especially for those who may live furthest away from these sites.

Potential impacts

- **Two geographical areas** were identified as being vulnerable geographies that face barriers to accessing services
- As a result of the proposals at GOSH and UCLH, people in **Tottenham and Edmonton (1)** and **Cricklewood and Dollis Hill (2)** may need additional support to:
  - **Access the hospital site** if the children and young people or the families and carers are disabled/in poor health or are not proficient in English
  - **Travel to hospital by taxi**, if required, as it will cost on average an additional £20 for population living in Tottenham and Edmonton
  - **Access services online** as the families and carers of young children and people may have low digital proficiency
  - **Care for other family members** as they may be a lone parent

Mitigations for any disbenefits have been developed involving clinicians and service users

- Further engagement with service users to understand the impact of changes on them
- Communicating around implementation should changes be agreed and clear information about how to access care that is needed
- Mitigations for those who may need extra support to access an unfamiliar hospital
- Information about how to travel to a hospital site
- Providing as much care locally as possible
- Support with the costs of travel to hospital
- Support for particularly vulnerable populations
- Mitigations around sustainability

The proposed consultation

The programme has benefited from substantial input from service users and local communities and public consultation will expand the reach of the engagement to date

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

Case for change engagement

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

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

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

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

Public Consultation (TBC)

- Widely promoted high volume engagement with all staff, stakeholders and residents
- Some in-depth conversations with targeted groups
- A formal part of our statutory duties around major service change and ongoing involvement of people and communities

Subject to ICB Board approval we are proposing a 14-week public consultation from mid-December

We are proposing a **14-week consultation** to gather views from service users, stakeholders, residents and staff. The suggested dates for the consultation are **11 December – 17 March** (subject to ICB Board approval).

Development of the consultation plan

The Consultation Plan is a working document which details the purpose, scope and plan of how we will deliver this public consultation.

The proposals are being put forward NCL Integrated Care Board, on behalf of the Integrated Care System and its partner organisations.

The plan has been reviewed by our Programme Board, NHSE at a formal assurance meeting, and Healthwatch representatives. The plan will be iterative, and we will monitor progress throughout the consultation to ensure we are meeting our objectives.

The consultation will be overseen by the Start Well Programme Board, and we will provide regular updates on planning and delivery. Responses will be independently collected and analysed by an external organisation in line with best practice.

At the end of the consultation period, we will have an independently drafted report detailing the feedback received during the 14-week period.

Key Legal Duties

This consultation will fulfil our duty under the

- **NHS Act 2006** (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022)
  - to ensure that people who use NHS services are involved in the development and consideration of proposals for change in the way services are provided and decisions about how they operate
  - to consult local authorities
  - To regard the need to reduce health inequalities in access and outcomes
  - consider the ‘triple aim’ with regard to the health and wellbeing of people, quality of services and efficient and sustainable use of resources
- **Equality Act 2010** (Public Sector Equality Duty) to demonstrate how we have taken account of the nine protected characteristics and given regard to:
  - Eliminate discrimination, harassment and vicitmisation
  - Advance equality of opportunity
  - Foster good relations
- **The Gunning Principles for a fair consultation**

Through consultation we are seeking to gather views from a diverse range of voices

As well as our direct consultation with JHOSC and borough specific health and well being boards we will deliver a 14-week formal public consultation, in line with best practice that complies with our legal requirements and duties. Our aims are:

- To inform stakeholders about how proposals have been developed in a clear, simple and accessible way that allows for 'intelligent consideration'
- Provide adequate time and opportunities for staff, residents and stakeholders to give their views on proposals, and the potential impacts
- Ensure a diverse range of voices are heard
- Seek alternative proposals or evidence not yet considered
- Understand the advantages and disadvantages of the proposed change and any unintended consequences
- Explore what mitigations might be used to reduce the impact of disadvantages
- Find out what matters most to patients and how this might affect implementation
- Provide analysis of responses to enable conscientious consideration before a decision is made

Consultation aims

Raise awareness of consultation with staff, patients, service users and residents and encourage to participate

Remind people that their views matter and encourage them to share feedback through direct engagement

Encourage participation from a diverse range of voices by providing adequate time and opportunities for people to respond

Focus resources on hearing from people with protected characteristics and more impacted groups

Provide staff engagement mechanisms all for health and care staff in NCL during the consultation period.

Capture stakeholder attitudes of key groups and influencers on the proposals and the consultation process

Our consultation approach includes a focus on the groups identified through our IIA

We will:

- Build on previous engagement contacts, over 300 organisations will be contacted to take part in the consultation
- Conduct comprehensive stakeholder mapping to identify groups to engage with, prioritising those identified by the IIA or with protected characteristics or at greater risk of health inequality
- Focus on geographical areas where there may be particular impacts
- Ensure we develop a range of opportunities for stakeholders to respond to the consultation
- Identify the best ways of reaching and engaging priority groups
- Provide an easy read version of documents, different formats and translated versions relevant to the community
- Make sure there is equality monitoring of participants to ensure the views received reflect the whole of the local population
- Target activity to the local geographical areas most impacted
- Arrange any events and meetings in accessible venues and offer interpreters, translators and hearing loops where required
- Inform partners, including councils and VCSE organisations, of the consultation and share our plans for engagement.

Resident groups we will be targeting through the consultation

- Black African (including Somali) and Black Caribbean women
- Asian women and people of childbearing age who (with a particular focus on Pakistani and Bangladeshi women)
- People living in areas of deprivation
- Orthodox Jewish women
- People with disabilities
- People living in Harlesden and Willesden
- People living in Holloway and Finsbury
- Older women of childbearing age (40+)
- Younger women of childbearing age (under 20)
- Women with mental health problems
- People from LGBTQ+ communities
- People who are carers
- People with poor English proficiency
- People with poor literacy
- People belonging to inclusion health groups such as people who are homeless, dependent on drugs and alcohol, asylum seekers and Gypsy, Roma and Traveller

Consultation promotion and questionnaire

We will promote and encourage participation in the consultation in a number of ways:

- **Displays:** in key locations we will promote the opportunity to respond to the consultation such as in NCL hospitals and clinics and other healthcare settings such as GP surgeries and pharmacies

- **Online promotion:** social media channels, such as Facebook, Instagram, X and Linkedin, will be used to reach out to potential participants in the consultation. Branded graphics will be produced that are aligned with the look and feel of printed consultation materials and shared by partner organisations

- **Partner channels:** all providers and partners such as councils will be asked to profile the consultation on their websites and through newsletters and other public facing channels and drive traffic to the NCL ICB website. We will ask for support from councils in accessing channels that will reach families, such as school newsletters and information going to women and family centres

- **VCSE networks:** we will provide content including information and visual materials and ask colleagues in voluntary and community sector organisations to use their channels to promote the consultation.

- **Media:** We will seek to promote the consultation through earned (free) or paid-for content in local newspapers, newsletters and local radio.

Consultation questionnaire

In line with best practice, we have commissioned an experienced independent organisation to collate and analyse responses to the consultation.

This includes the hosting of a questionnaire that will cover the three components of our proposals:

- Maternity and neonatal services proposals
- Edgware birthing suites proposals
- Surgery for babies and children

The response to the questionnaire will be monitored throughout the consultation period and included in the eventual evaluation report that will be compiled taking into account the range of feedback obtained through consultation.

We will tailor our engagement techniques during the consultation period

- Broad range of techniques will be used, tailored to each audience and their level of interest.
- Opportunities online and face to face
- Working with third-party advocates (VCSE) to reach communities who may not engage directly
- Materials in accessible formats including Easy Read and translations
- Mechanisms in place to capture and analyse outputs.

Light engagement → **Deeper engagement**

Survey distributed on email	Drop in event/stall: face to face	Attendance at meeting: short agenda slot	Presentation and feedback: Start Well Team	Presentation and feedback: commissioned	Small group discussion online	Small group discussion: face to face	Interactive workshop: Start Well Team	Interactive workshop: commissioned	Telephone / online interviews

This type of engagement will be **promoted widely** to allow **a range of people to participate** in the consultation and give their views

This type of engagement will **focus on groups with protected characteristics** to understand their views and impact of the options in a meaningful way

Stakeholder Engagement

Formal Committees

- Update to **JHOSC** to share plans for consultation at formal committee meeting on 30 November 2023
- Briefings offered to **NCL Health and Wellbeing Boards after board decision**
- Briefing to JHOSC chairs for **NWL and NEL**. Will also attend Brent JHOSC and North East London Inner JHOSC during consultation period
- Direct consultation with JHOSC on our proposals

Elected representatives

- **Letters with an update and offer of briefing** prior to December Board sent to all **NCL MPs,**
- **Council** leaders/Cabinet leads for health and CYP/ and HWBB Chairs briefed on advice and with support from local authority colleagues.
- **Letters confirming board decision to launch consultation to NCL MPs, Council** leaders/Cabinet leads for health and CYP/ and JHOSC and HWBB Chairs on 11 December

Other stakeholders

Invitation to take part in consultation will be sent to:

- Unions / staff side
- Healthwatches and VCSE
- Directors of public health
- Directors of children's services
- Primary care
- Royal Colleges and education providers
- Neighbouring ICS areas
- Specialised commissioning
- Mayor's office
- Local media

Staff Engagement

Information sharing

- **Progress updates** in internal Trust channels explaining proposals and consultation timeline
- **Coordinated email from Exec leads** to be shared to confirm the **outcome of the ICB Board meeting**
- **Staff messages** promoting awareness of proposals and consultation and invite participation
- **Frequently asked questions** updated regularly on staff intranets

Briefings

- **Coordinated staff briefings** led by Start Well Executive Leads to begin w/c 27 November (when papers for the Board are made public).
- A **presentation will be provided** to support briefings to **ensure consistency of messaging**

Feedback

- **Staff invited** to fill in questionnaire
- **Alternative mechanisms** to ask questions and respond to the consultation

We are seeking JHOSC endorsement of our consultation plan

Today we are seeking support for our consultation plan. JHOSC members are asked to:

- Provide any feedback on our consultation plan
- Support the approach we are taking with our public consultation activity, as outlined in the plan
- Indicate how the JHOSC would like to be engaged with through the consultation period to ensure views on the proposals are captured

Next steps

Next Steps

Subject to decision by the ICB Board on 5th December the next steps would be:

- Work with an independent partner to evaluate consultation responses.
- Following the consultation period, we will publish an evaluation of the responses, in a report produced by this independent organisation, this will include who we reached during the consultation.
- Subject to the outcome of the consultation, we will **review, improve or amend our proposals.**
- Feedback received will inform and influence our future decision-making, the next steps of the programme and how plans will be implemented.
- Following consultation and depending on the responses we expect the ICB Board on behalf of the Integrated Care System, alongside specialised commissioning who commission neonatal services and some specialist surgery for children, after consideration of the consultation outcome. to make a decision on the proposals to implement by the end of 2024 or early 2025.

NCL Joint Health Overview & Scrutiny Committee – Action Tracker 2023-24

MEETING 4 – 11th September 2023

No.	ITEM	STATUS	ACTION	RESPONSE
23	Work Programme	**ADDED TO WORK PROGRAMME**	Suggestions for additional work programme items: - healthcare data and analytics/privacy issues - a community-based meeting (similar to the mental health meeting) on a different topic (TBC)	To be added to Work Programme for 2024/25.
22	Winter Planning	**ADDED TO WORK PROGRAMME**	Future winter planning update to include details on: - how the 'single point of access' intervention would work in practice. - whether data the modelling for Winter 2023/24 reflected the data from what actually happened.	To be added to Work Programme for 2024/25.
21	Winter Planning – Ambulance handover pilot	**ADDED TO WORK PROGRAMME**	On the ambulance handover pilot – consideration to be given to the London Ambulance Service to be invited to speak to the Committee about handover delays.	To be added to Work Programme for 2024/25.
20	Winter Planning – Ambulance handover pilot	**COMPLETED**	On the ambulance handover pilot – the evaluation of the pilot to be circulated when available.	The evaluation is provided. (ATTACHMENT B). Further work on this area is ongoing.
19	Winter Planning – Hospital Discharge	**COMPLETED**	On discharge from hospital a Member commented that: - information about the specific arrangements for discharge was not always shared well with the families which could make the post-discharge period more difficult. - there was particular concern that the next of kin for patients with dementia were not always consulted about the patient's needs and suggested that this needed to be addressed.	This feedback has been noted. Where there are opportunities to improve discharge communications, the ICB will support these. We have a wide-ranging programme to support hospital discharge and will feed this information into that work.

18	Camden Acute Day Unit	**MONITOR**	Committee to be kept updated on progress.	
17	Camden Acute Day Unit	**OVERDUE**	Service specification to be circulated to the Committee. (Alice Langley)	Response requested and being awaited.
16	Finance update	**ADDED TO WORK PROGRAMME**	Information on mental health funding, including the sustainability of funding for voluntary sector organisations, to be provided for the March 2024 JHOSC meeting.	To be added to Work Programme.
15	Finance update	**COMPLETED**	Update to be provided on the major St Pancras Hospital capital project.	An update has been included in the Estates presentation at the JHOSC meeting on 30th Nov 2023.
14	Finance update	**COMPLETED**	For the Committee to be kept updated on the conclusions for the pilot and timescales of the roll out for the project detailed in the report as follows: *"The roll out of the CYP Home Treatment Team (£1.2m). Due to MH need, this started as a pilot in Barnet and will roll have a phased roll out across NCL. To ensure we are meeting the needs of the most complex CYP, addressing the rising acuity in MH presentations post pandemic and preventing inpatient admissions."*	CYP mental health intensive 'Home Treatment Team' (HTT - £1.2m) roll out: • Objectives: ○ expand HTT service offer across all five NCL boroughs; ○ increase the number of young people supported; and ○ reduce inpatient occupied bed days and lengths of stay. • Progress this month: ○ Fully operational in BEH with bases in Barnet Enfield and Haringey. Hot desk areas identified in Camden. ○ All vacant service posts are out to advert with 50% of the team filled.

				○ Presentation of service model delivered to NCL provider and commissioning leads. ○ Communications and engagement roll out including Camden and Islington CAMHS, and scheduled engagement sessions. • Forward view: ○ Working with Tavistock and Portman and Whittington to progress Electronic Patient Record (EPR) systems interoperability/read only access. ○ Developing Standard Operating Procedures and Pathways to include south NCL provision. ○ Most new starters likely be in post from quarters 3 and 4, enabling the expansion; increased activity and impact. • Performance and impact: ○ On target for 85 cases supported within 2023/24 - 40 CYP have been supported since Apr23, with 61 since Jan23. ○ Occupied Bed Day/Length of Stay impact seen in support to CYP who would otherwise require mental health inpatient care, plus step down support for earlier discharge from

				inpatient care.
13	Finance update	**MONITOR**	Committee to monitor the relocation of services from Moorfields Eye Hospital and the review of the ophthalmology pathway.	To be added to Work Programme for monitoring.
12	Finance update	**ADDED TO WORK PROGRAMME**	Future finance update to include details on: - The impact on people with disabilities. - Whether there was a direct impact on services resulting from deficits within the system. - The reasons for the highest deficits within the system. - Risks and slippage/overspend associated with capital projects including any impact of revenue budgets (due to interest costs for example). - Figures on the amount spent on agency workers.	To be added to Work Programme for 2024/25.
11	Finance update	**COMPLETED**	Details to be provided on support after hospital discharge for people with disabilities who also have mental health conditions.	Health, social care and GP practice teams work together in a coordinated and integrated way to deliver a range of health, care and support services to people with disabilities, with mental health needs being discharged from a hospital setting. Health, social care, support service including the VCSE and GPs, will ensure that needs are met in accordance with statutory duties under the Mental Health Act, Care Act and other legal Frameworks, alongside drawing on good practice models of care aimed at prevention, reducing deterioration and recovery.

				The patient and their family/carers, where appropriate, will be at the centre of developing a personalised and holistic discharge plan to support them to return home or to a community setting, with a clear set of outcomes, focussed on recovery and improvement principles.

MEETING 3 – 26th June 2023

No.	ITEM	STATUS	ACTION	RESPONSE
10	Ophthalmology Hubs	**ADDED TO WORK PLAN**	Main concerns of Committee to be addressed in the next report on this issue: - The additional journeys times being asked of residents, balanced against the potential benefits of being treated earlier; - The potential impact on disadvantaged communities who could be disproportionately affected by the changes; - The financial implications, including knock-on effects (positive or negative) on other NCL hospitals. - What was learnt from the previous experience of developing surgical hubs in NCL for other types of treatments.	Report expected to be tabled for Committee Meeting on 29th Jan 2024.
9	Cancer Prevention Plan	**IN PROGRESS**	Details to be provided on the effectiveness of interventions through the voluntary sectors and community/faith groups in the promotion of cancer screening in hard-to-reach demographic groups.	A report on the NCL Cancer Awareness Campaign and a summary of activities for the NCL Public Awareness Campaign are attached. **(ATTACHMENTS A1 and A2)** Work is underway on a more detailed report on the latter which

				can be shared with the JHOSC once it has been completed if the Committee wishes to have further information on that campaign.
8	Cancer Prevention Plan	**IN PROGRESS**	Heat map of cancer detection and GP referral rates in NCL to be shared with the Committee when available. (Ali Malik)	Work has commenced on this and it is hoped that it will be available for circulation by the end of September 2023.
7	Cancer Prevention Plan	**COMPLETED**	Suggestion from the Committee to be considered – that an initiative aimed at university students be rolled out to raise awareness of HPV immunisation. (Fanta Bojang)	This suggestion has been discussed with the vaccination team who have advised that there are currently some challenges with taking forward boosting uptake of HPV vaccinations amongst young adults and other adults eligible, due to the commissioning and delivery arrangements. The team expect that it may be possible in the medium term to do more work to boost uptake but for now, the focus will be on promoting it so that people can get their vaccinations done via their GP.
6	Maternity services update	**MONITOR**	Main concerns of Committee to be addressed in the next report on this issue: - poorer outcomes for those from more deprived areas or from BAME backgrounds, including greater understanding of causes and risk factors; - continuity of care, including progress of the Magnolia team; - workforce issues, including cost of living/housing issues and improving support for staff overall; - training for staff, including the development of the maternity support workers role. - the findings of future CQC reports in the areas which are currently rating as requiring improvement;	To be noted ahead of next report on this issue.

			- monitoring the statistics on smoking cessation; - cuts to the running costs of the NCL ICB;	
5	Maternity services update	**IN PROGRESS**	Report on factors relating to higher rates of stillbirths in Haringey to be provided to the Committee (expected Sep/Oct 2023) (Rachel Lissaeur)	This report is due to be finalised in October 2023 and will then be shared with JHOSC members.
4	Minutes	**COMPLETED**	Action points to be added to minutes of the meetings of 6th June 2023 and 7th June 2023.	Actions points added (see meetings 1 & 2 below for further details).

MEETING 2 – 7th June 2023

No.	ITEM	STATUS	ACTION	RESPONSE
3	Quality Accounts (Whittington Trust)	**MONITOR**	The minutes of the meeting recorded that: *"Asked by Cllr Connor about the other CQC inspections referred to in the table on page 19, Sarah Wilding explained that the only recent inspection had been on maternity services, whereas the others referred to the existing rating status based on inspections from previous years. Cllr Connor commented that it would be useful to include a brief explanation of this in the report, including links to reports and details of actions being taken in response. Sarah Wilding explained that there was a regular governance meeting that oversaw all of the actions needed in response to the findings of the 2020 report, most of which had been completed. However, she accepted that more information about this would be useful."* The Committee requested that this information about the actions being taken in response to the CQC inspection should be provided to the Committee.	Request made to Whittington NHS Trust.

MEETING 1 – 6th June 2023

No.	ITEM	STATUS	ACTION	RESPONSE
2	Quality Accounts (BEH and C&I Trusts)	**MONITOR**	The minutes of the meeting recorded that: *"Cllr Connor requested further details on how the performance of services was monitored. Vincent Kirchner said that there were clinical strategies setting out how services should work along with a governance structure, performance indicators and deep dives into service delivery. Amanda Pithouse added that a recent CQC inspection had been carried out on BEH-MHT crisis services which had recognised recent improvements in staffing with more manageable caseloads. Cllr Connor said that, in future reports, it would be useful for details to be included about how these deep dives worked, how evidence was captured about how people were using services and how issues were identified when things were going wrong."* The Committee requested that this should be included in the following year's Quality Accounts.	Request made to BEH and C&I Trusts.
1	Quality Accounts (BEH and C&I Trusts)	**IN PROGRESS**	The minutes of the meeting recorded that: *"Cllr Connor said that the feedback she had received on the NHS talking therapies service was that, if the person was deemed to have risk factors relating to suicide/self-harm, then they were told that the service was not appropriate for them. In contrast, people contacting the crisis line were often not admitted to services unless their mental health crisis was deemed to be sufficiently serious. This led to some groups of patients being turned away from services and potentially having to go back to their GPs before any support would be provided. Vincent Kirchner acknowledged the risk of some patients falling between the middle of these types of service but said that this was an issue that the community mental health teams were designed to be able to address and to direct people to the right services (e.g. referral to a psychologist or other types of*	Haringey Council's Adults & Health Scrutiny Panel to be provided to JHOSC ahead of its meeting on mental health on 18th March 2024.

			support).” The Committee requested that this should be investigated further. Haringey Council’s Adults & Health Scrutiny Panel is due to receive further information about this at its next meeting on 18th Sep 2023 and the details will subsequently be provided to the JHOSC.	

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North Central London Integrated Care System

Improving hospital handovers in NCL (45-minute protocol) – Evaluation

18th September 2023

Key Messages

- In the 9 weeks while the 45 minute protocol has been trialled in NCL, there has been a **significant improvement** in the proportion of handovers occurring within 45 minutes, from **82% to 91%**

- The improvement has been particularly significant at NMUH, which has the lowest performance, but has seen a **27% point improvement** in performance

- The **average time lost per handover has also improved**: across the system there has been a **37% reduction**, from 17 to 11 minutes

- Other ambulance handover metrics have also seen improvement over this period: there have been only **average 3~ 2 hour delays** in the 9-week period, compared with average 26 in the previous 9-week period

- Total ambulance conveyance volumes have remained steady across this period, despite the seasonal reduction in total A&E attendances

- NCL-specific response time data, shows improves for Cat 1 and 2 response times. Cat 1 has been able to **fluctuate around 7-minute target**. Cat 2 has improved, ranging between 31-39 minute response time from the 30-minute target.

- NCL has shown significant improvements and has reduced the gap against London for the response time for Cat 2 (light blue). The average response time for **NCL has dropped from 54 to 37 mins (-32%)** vs London also dropping 42 to 34 mins (-20%) when comparing 60 days before and after the trial started.

% Handovers within 45 Minutes

% Handover within 45mins (Weekly) : Barnet Hospital - starting 15/01/23

45 mins trial start

% Handover within 45mins (Weekly) : Royal Free Hospital - starting 15/01/23

45 mins trial start

% Handover within 45mins (Weekly) : North Middlesex Hospital - starting 15/01/23

45 mins trial start

% Handover within 45mins (Weekly) : University College Hospital - starting 15/01/23

45 mins trial start

% Handover within 45mins (Weekly) : Whittington Hospital - starting 15/01/23

45 mins trial start

% Handover within 45mins (Weekly) : NCL- starting 15/01/23

45 mins trial start

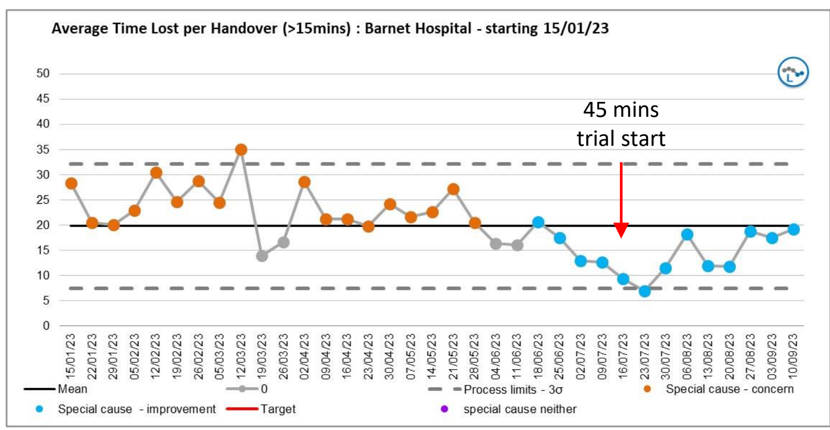
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target — special cause neither

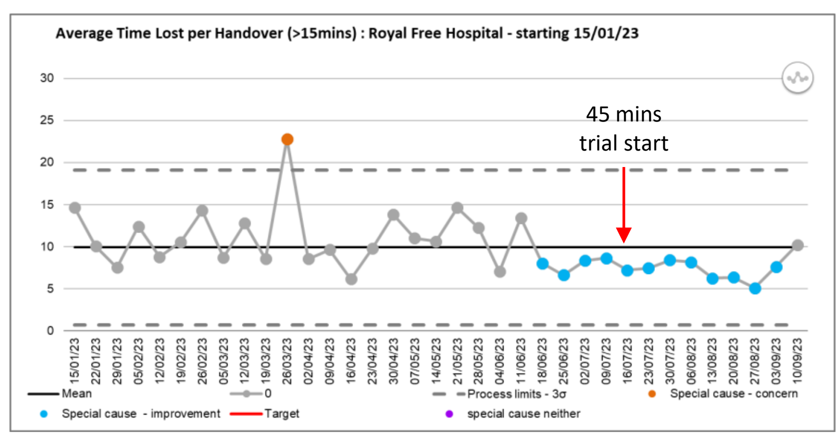
	Pre Trial %	9-week Trial %	% Point Change
Barnet	83.7%	87.7%	4.0%
North Middlesex	55.2%	82.7%	27.5%
Royal Free	92.3%	96.7%	4.3%
University College	96.4%	97.7%	1.2%
Whittington	89.5%	97.0%	7.5%
NCL	**82.1%**	**91.4%**	**9.3%**

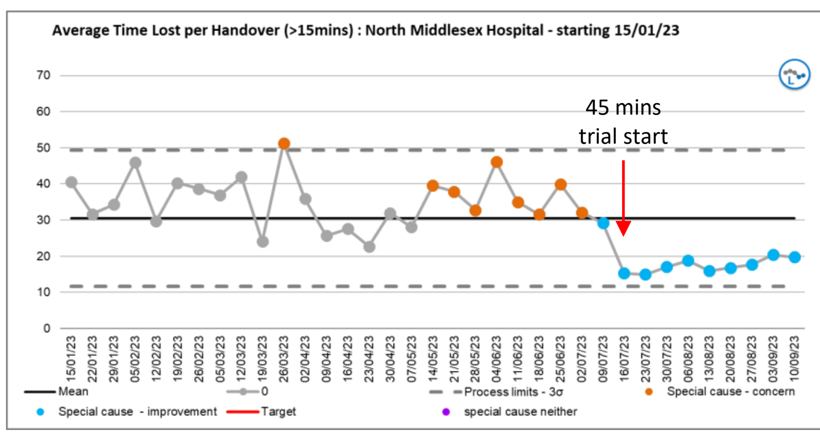
Trial started 11th July. We can see improvements to majority of the providers for within the 45min handover. NCL has improved by **9.3%** when comparing 9 weeks before and after the trial.

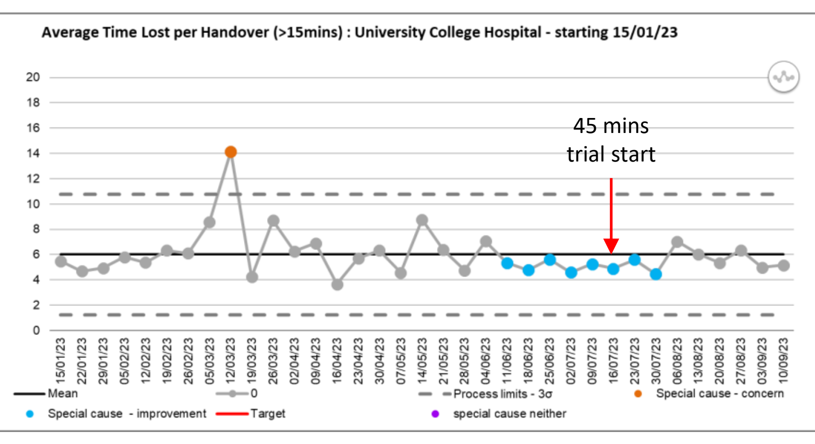
Source: Daily LAS Handover Report

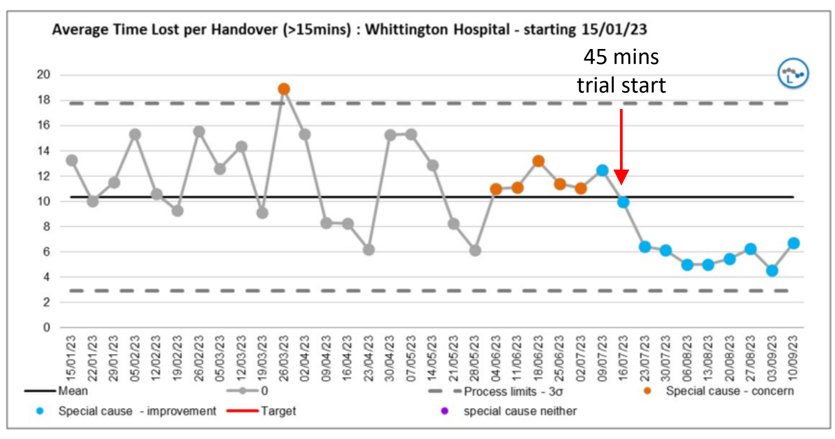
Average Time Lost (Mins) per Handover











Average Time Lost per Handover (>15mins) : NCL- starting 15/01/23

45 mins
trial start

Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target — special cause neither

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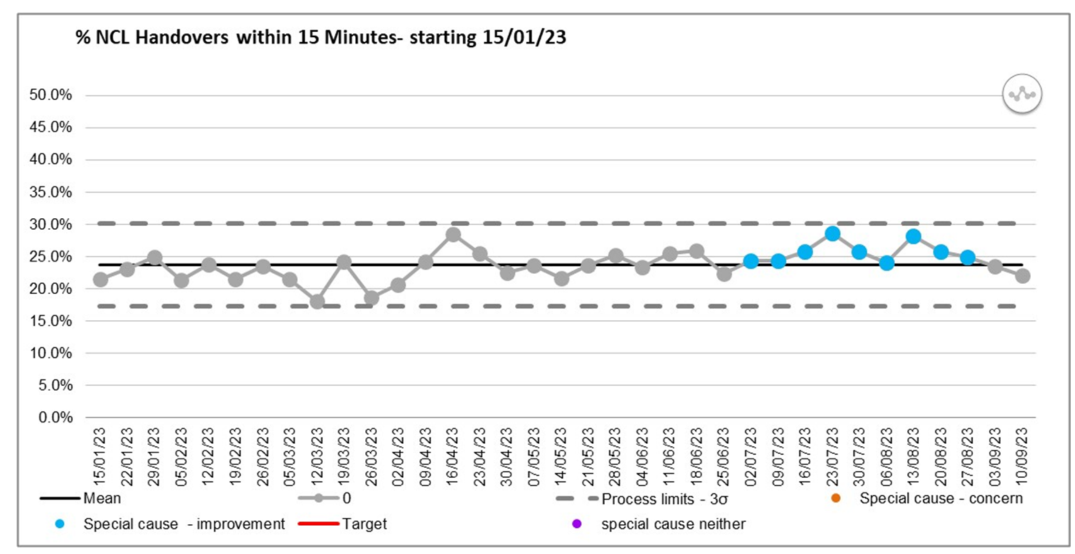
	Pre Trial Average (Mins)	9 week Trial Average (Mins)	% Change
Barnet	18.5	13.9	-25%
North Middlesex	36.0	17.4	-52%
Royal Free	9.9	7.4	-25%
University College	5.8	5.5	-5%
Whittington	10.8	6.2	-43%
NCL	**17.1**	**10.8**	**-37%**

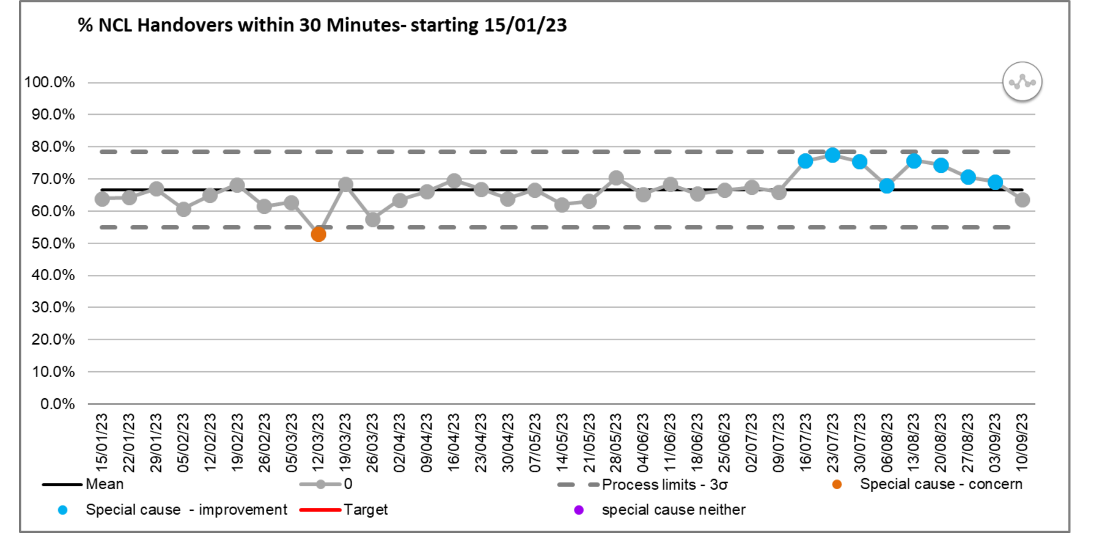
All providers were able to reduce their average time lost per handover (> 15mins). NCL has improved by -**37% (saving an average 6mins~ per handover)** when comparing 9 weeks before and after the trial.

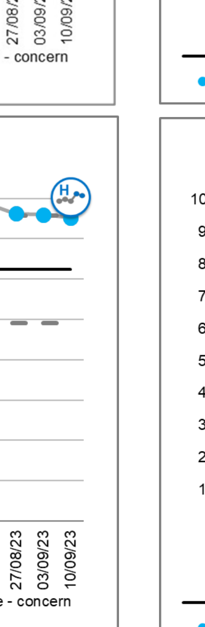
Source: Daily LAS Handover Report

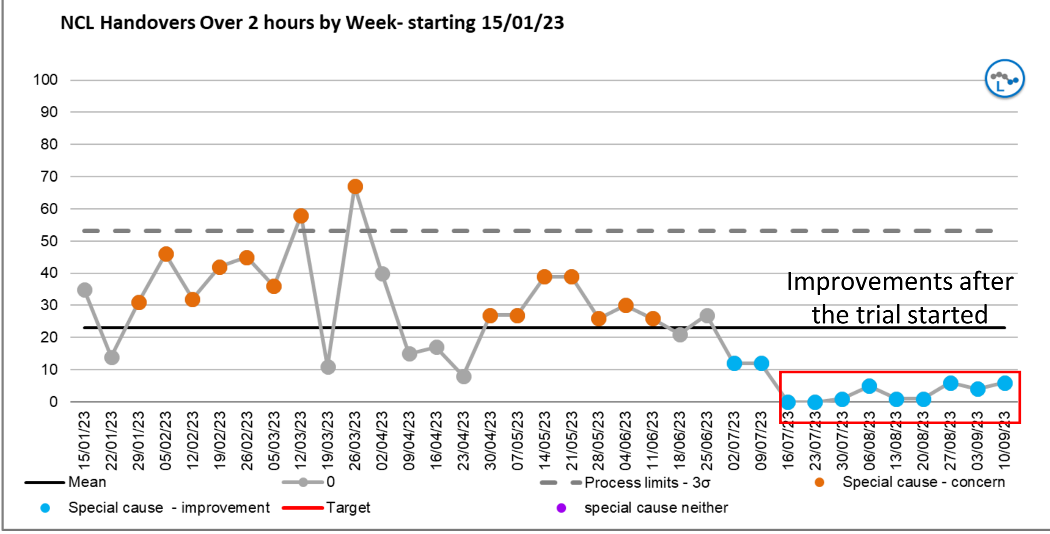
Handovers within 15, 30 and 60 Minutes (NCL Wide)

- The 45 minute trial has led to improvements against the other handover standards, particularly the proportion within 60 minutes.
- The Over 2 hours handover has dropped significantly by **<u>90%</u>**, from an average of **<u>26 down to 3</u>**, when comparing 9-weeks before and after the trial started









Source: Daily LAS Handover Report

Conveyance Volumes: Non-Blue Light (LAS Only)

Average Non-Blue LAS Conveyances (per week) : Barnet Hospital - starting 01/06/23

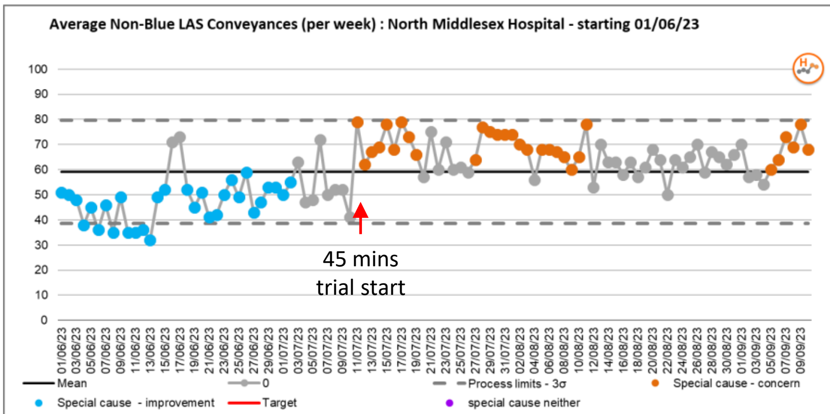
45 mins
trial start

Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target | special cause neither

Average Non-Blue LAS Conveyances (per week) : Royal Free Hospital - starting 01/06/23

45 mins
trial start

Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target | special cause neither



Average Non-Blue LAS Conveyances (per week) : University College Hospital - starting 01/06/23

45 mins
trial start

Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target | special cause neither

Average Non-Blue LAS Conveyances (per week) : Whittington Hospital - starting 01/06/23

45 mins
trial start

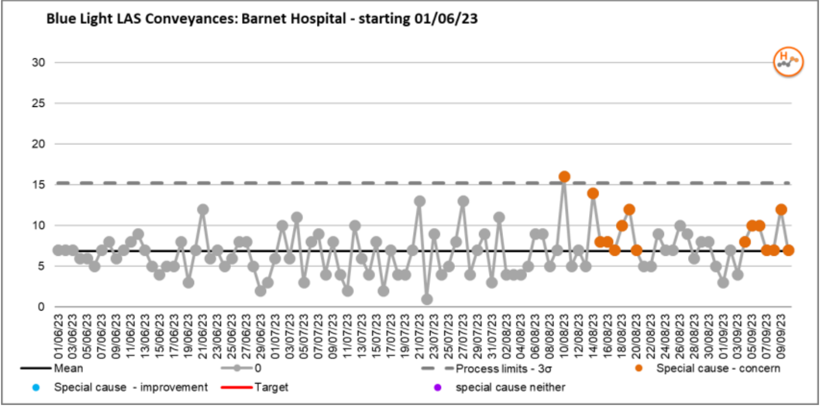
Mean | 0 | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target | special cause neither

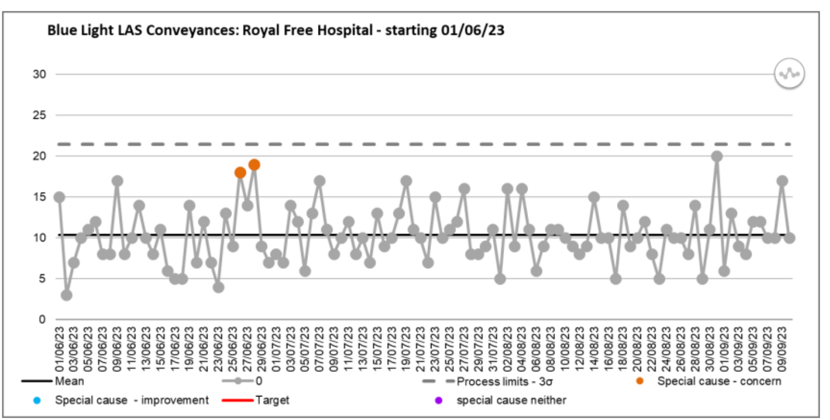
- Daily non-blue light LAS conveyances by site are shown above
- There has been no reduction in conveyance volumes in recent weeks, including during the trial period
- In addition to the LAS volumes shown, Barnet Hospital and NMUH also receive conveyances from East of England ambulances

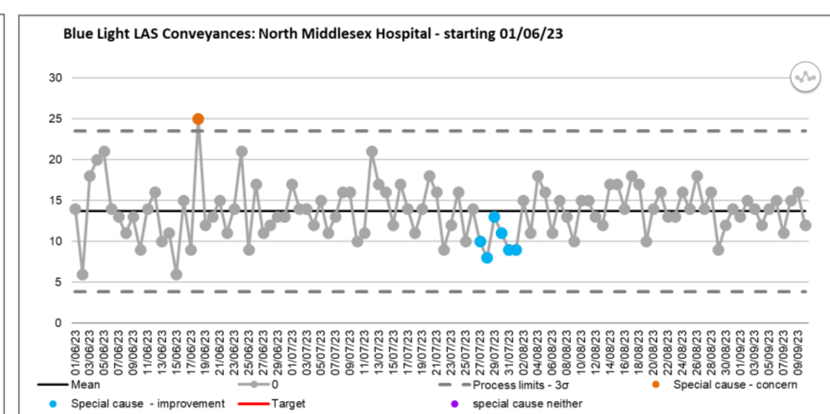
Source: Daily LAS Handover Report

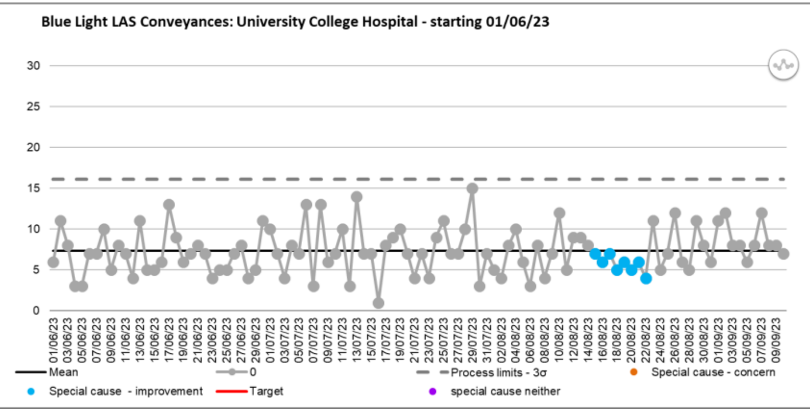
Conveyance Volumes: Blue Light Arrivals (LAS Only)

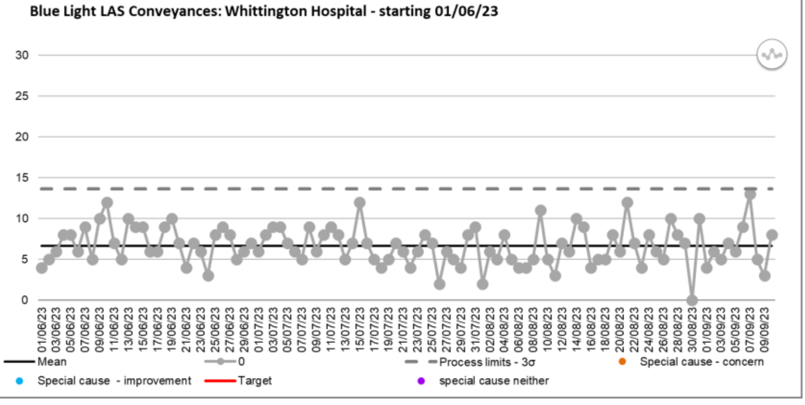
North Central London Integrated Care System











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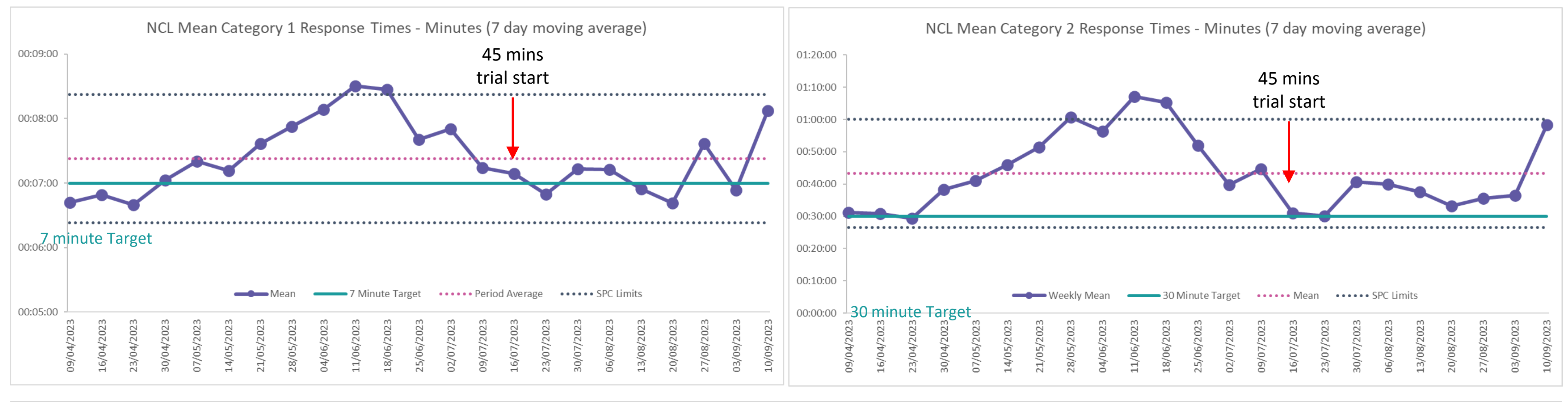
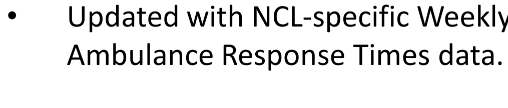
- Daily volumes of blue light LAS conveyances by site are shown above
- As with non blue light conveyances, there is a lot of daily variability shown

Source: Daily LAS Handover Report

Ambulance Response Times





- Updated with NCL-specific Weekly Ambulance Response Times data.
- During the periods after the start of the trial, **faster response times Category 1 and Category 2** response times. However, the opening week of Sept we can see this increasing.
- After the trial, we can see improvement in NCL and closing the gap to London levels.
- NCL has a **greater improvement proportion against London by 10%** when comparing 60 days before and after

- Mean (NCL -32% vs London -20%)
- 90th Centile (NCL -33% vs London -21%)

NCL vs London Category 2 Mean (Light Blue) and 90th Centile Daily Response Times

Big gaps between NCL vs London before

45min Trial Start

NCL and London gap reduced after

45min Trial Start | London - 7 day MV | NCL - 7 day MV | London - 7 day MV (90th Centile) | NCL - 7 day MV (90th Centile) | Standard 18 min | Standard 40 min

60 days average (before vs after)

	Mean (18 Mins)		90th Centile (40 Mins)	
	London	NCL	London	NCL
Before trial start	00:42:43	00:54:02	01:36:22	01:57:31
After trial start	00:34:22	00:36:42	01:16:07	01:18:59
Difference %	**-20%**	**-32%**	**-21%**	**-33%**
Difference	**00:08:21**	**00:17:19**	**00:20:14**	**00:38:33**

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Sources: Monthly data from LAS Contract Management Report; Daily Data from Daily Ambulance Dashboard – NB unvalidated data