NHS

North Central London

The Case for Change

Key headlines emerging from the analysis to date

1. Executive summary

As part of the development of the next NHS North Central London Commissioning Strategy and Quality, Innovation, Productivity and Prevention (QIPP) Plan, the original NHS North Central London Case for Change is being updated, with a greater emphasis on the five component Primary Care Trusts (Barnet, Camden, Enfield, Haringey and Islington) within the cluster rather than the cluster as a whole. This paper provides an analysis of the refresh as it currently stands and provides some emerging headlines.

2. Introduction

The Case for Change seeks to provide an overview of the key health needs, clinical priorities and other commissioning issues facing the NHS in North Central London. The analysis is intended to both inform and assist with addressing the challenge of making the best use of the available resources, working towards maximising the value derived from NHS North Central London's health investments while reaching and maintaining financial balance.

The work at this point remains at a formative stage, with the main body of the Case for Change developed concurrently, and in discussion with, the development of the Primary Care strategy and its own case for change, and the refresh of the financial forecast position. It has drawn on a range of work carried out across NHS North Central London for a variety of purposes and in a variety of contexts, as well as new work. Further work will be carried out over the next few weeks to complete and more fully cross-reference all of the work produced to date for the Case for Change.

This document begins with a summary of the key headlines that emerge from the work and analysis to date, and then goes on to present a summary of the analysis (covering population health needs), clinical priorities, quality, safety and patient experience, provider landscape, workforce and financial challenge. The key headlines section concentrates mainly on those major themes emerging from the population health needs and clinical priorities analyses.

3. Key Headlines

There is considerable population change projected including relatively faster growth (in most areas) in the 40+ age groups. Provision of health services will need to respond to address the growth in the resident population in the next decade, particularly in those areas where the greatest population growth is expected.

- The increases in older groups will have implications for the prevalence of long-term conditions, and on current patterns of service, both for primary and secondary care, in particular with a disproportionately high share of inpatient beds occupied by people aged over 65 and over 85
- Additionally, the relative youth of the North Central London population when compared to the national age structure means there is considerable potential for influencing lifestyle factors that determine longevity and healthy living before associated diseases take hold and that opportunities for innovative ways of reaching this population will be needed
- Population turnover presents challenges for service delivery and integration as familiarity with local services is important in helping to promote access to local primary, community and out-of-hours health services, rather than accident and emergency or other secondary care services, particularly amongst those with conditions more likely to lead to use of unscheduled care.

Many of the clinical priorities and issues facing the five Primary Care Trusts in NHS North Central London are similar. Common factors relate to management of long-term conditions, the balance between primary, community and secondary care, access to unscheduled care, the challenges of designing and implementing the QIPP agenda and tighter financial environment, population changes, variation in quality, activity, cost and patient experience between and within Primary Care Trusts and services.

It is striking, however, how much the boroughs within NHS North Central London differ in other regards. There are:

- Differing socio-demographic profiles, in terms of age structure, ethnicity, deprivation, mobility and projected population growth
- Differing patterns of service use, investment and expenditure
- Disease issues – varying priorities in terms of mortality and life expectancy, long-term conditions and other key diseases
- Healthy lifestyles, such as smoking or alcohol, and other protective factors for health, such as environmental or social and economic factors
- Averages between boroughs can also disguise significant variations within boroughs and between groups.

This means that even when there are similar challenges or interventions, these factors are important to take into account. Although, there are important learning points and experience to draw on across the cluster, it also points to the use of benchmarking to similar Primary Care Trusts or boroughs with similar populations rather than necessarily to NHS North Central London (or London or England) as a whole to assist with planning and analysis.

Cardiovascular disease (CVD) and **cancer** are the two leading causes of premature and all-age mortality in NHS North Central London's five PCTs, and two of the three biggest areas of spend by health condition. There is good evidence of the link between higher investment and better outcomes in CVD. In both CVD and cancer, lifestyle changes, notably smoking and diet and physical activity levels linked to obesity risk, will provide the greatest health gain and most cost effectively.

- There is significant under-diagnosis of CVD conditions across NHS North Central London, which reduces the opportunity for patients to benefit from effective secondary lifestyle and medical prevention through primary care and in the community, and is linked to a pattern of late diagnosis, higher secondary care use including for emergency care and poorer outcomes. There are also issues about quality, use of effective technologies and outcomes for patients in secondary care. Addressing variations in care and prescribing offer opportunities to reduce costs and improve patient outcomes
- Analysis of cancer services in NHS North Central London has demonstrated that outcomes in terms of survival are similar to national averages. However, there is the need to take steps to encourage earlier presentation and diagnosis and to improve the uptake of screening, which will contribute to improvements in outcomes and reductions in mortality.

Respiratory disease is also a significant cause of mortality and potentially preventable admissions in NHS North Central London. Reducing smoking, steps to improve earlier diagnosis and improved management in primary care of Chronic Obstructive Pulmonary Disease (COPD) and increases in flu immunisation may reduce admissions and mortality.

Alongside CVD and cancer, **mental health conditions** comprise the other largest programme of spend. Mental health conditions (child and adolescent mental health services, serious mental illness, dementia, drug and alcohol misuse) account for the single largest area of programme spend, and overall expenditure across NHS North Central London is about 16% above the London average. However, once the significant skew in prevalence in inner NHS North Central London and other factors, such as the two prisons, are taken into account, this differential becomes much less apparent.

Nonetheless, continuing the shift in the model of care towards more community-based rather than inpatient-based services, together with steps to provide local pathways of services to reduce high cost out-of area placements and support better integration of care, offer the potential to improve patient experience, maintain or improve outcomes, and reduce costs.

In terms of **unscheduled care**, there is relatively greater use of accident and emergency services across NHS North Central London which in turn is linked to higher levels of emergency admissions. In the recent period, costs have increased significantly faster than activity in accident and emergency and new tariffs may increase this discrepancy further. A proportion of accident and emergency attendances are clearly linked to urgent care, but others could be seen and managed more appropriately through primary care. Reasons why people use accident and emergency or other unscheduled services are multi-factoral, but at least a proportion could be addressed through improved access to primary care or the availability of other services or advice out-of-hours.

There are indications for the need to have better linked up and co-ordinated information, advice and services and address duplication of access points so that patients are better able to receive the right care, in the right place, at the right time. There are also indications for initiatives that promote access to GPs, whether within urgent care centres or accident and emergency departments, or through improved access to GPs and other primary care staff in their practices.

Care Closer to Home initiatives, including in long-term conditions, reflect changes in models of care and technology that can enable more patients to be managed in the community, primary care or their own homes, and offer the opportunity for more integrated and holistic pathways of care between providers of services, including between primary and secondary care. Evidence of successful outcomes is mixed, however, and careful selection, commissioning and implementation and monitoring of initiatives is important. This may argue for selection of fewer (and bigger) programmes, rather than a larger number of initiatives. It also has important implications for the workforce and estate needs of the future.

High-quality **maternity services** are important in supporting the best and healthiest start in life. There is a need to encourage a less medicalised approach to pregnancy for women having a normal, low risk pregnancy, whilst ensuring that those women with greater risks receive the necessary health and social care support. There is a continuing need to ensure early access and reduce late booking, for consistent approaches to the management of risk and care pathways across NHS North Central London and to develop locations outside of hospital to facilitate improved access and reduce costs.

The **primary care strategy** as it develops for the cluster will set out in more detail the issues and case for change in primary care, linked closely to the overall case for change. Its focus on meeting the changing needs of the population, assessing

variation and access, the capacity and capability for primary care of the future to address the productivity and quality challenge will provide important additional analysis and exposition in the overall case for change.

Variation is a recurring theme that emerges throughout most of the clinical priorities – in terms of quality, cost, activity and patient experience and outcome. There are significant potential opportunities here to improve or maintain outcomes and patient experience while reducing costs and increasing productivity.

Finally, the opportunity and need to promote **healthier lifestyles** is evident through the description of causes of variation in health needs, long-term conditions prevention and management, and inequalities in mortality between boroughs and between population groups. Smoking prevalence is falling in the general population, although not in all groups, but prevalence still remains as high as 29% and smokers are over-represented in the use of health services.

Smoking cessation remains one of the most cost-effective health service interventions, with a range of health benefits beginning to accrue within hours and days of stopping, and there remain opportunities to improve the offer in a range of settings, including maternity and mental health services, as well as through primary care services.

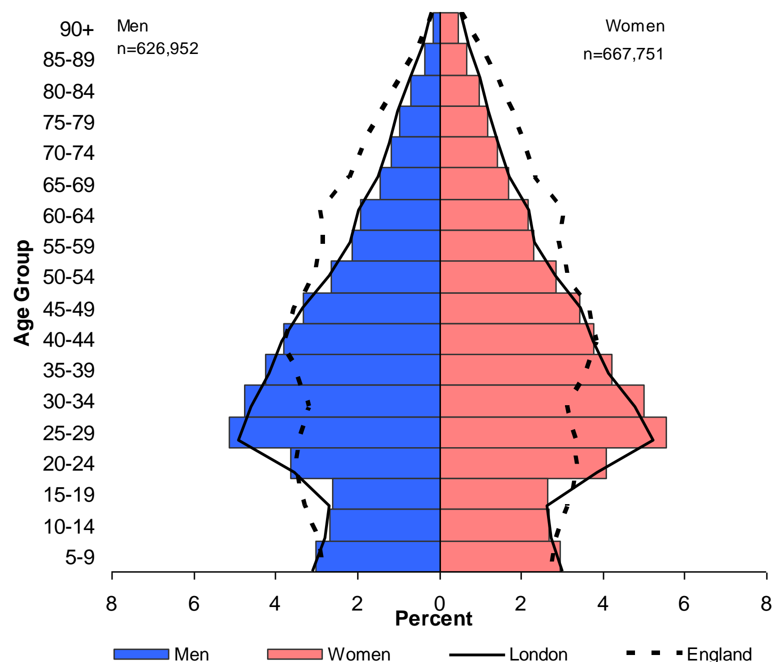
Similarly, immunisations are highly cost effective compared to other health service interventions and offer protection to the whole community not just the person immunised. Other important interventions include: brief advice in alcohol harm, which is linked to reductions in particular in the use of emergency services as well as to a range of other health benefits; sex and relationships education and promotion of safer sex; promotion of emotional health and wellbeing, with particular benefits In children and older people; breastfeeding, healthy eating and physical activity and other measures to reduce obesity.

4. Population Health Needs

4.1 Population change: period to 2014 and over the next 10 years to 2021

The figure below shows the age and sex structure for NHS North Central London as a whole in comparison to London and England in 2011. The total resident population is estimated at 1.295 million. The age and sex profile of NHS North Central London is very similar to that of London, but markedly younger than the England average, with significantly greater proportions of younger adults (20-39 year olds) and lower proportions aged 50 and over in both men and women.

Population pyramid showing the proportion of the resident population by five yearly age groups in 2011: NHS North Central London, London and England, 2010 projections



Population growth will be divergent across NHS North Central London's five boroughs over the lifetime of the QIPP strategy and in the 10 years to 2021. The age structure of most of NHS North Central London will remain relatively young compared to England, with the largest numerical increases in population in adults aged 18-40 in all NHS North Central London boroughs but Enfield. However, in all five boroughs, the largest percentage increases will be seen in the over 85 age group, with significant percentage increases in the 65-84 age group also expected.

These age groups have significantly higher rates of health service use compared to other age groups, particularly in terms of hospital admissions and use of community services; the rates of most long term conditions also significantly rise with age.

In Islington and Haringey, there will be faster percentage growth in the 0-17 year-old age group than in the other boroughs, with implications for maternity and children's services, and in Barnet a relatively large growth in younger adults (18-40) is expected, with potential implications for services for younger adults such as mental health and sexual health. Unusually, slight reductions in the young adult (18-39) population are projected for Enfield.

Table. Projected changes in population by age group, NHS North Central London boroughs, 2011, 2014, 2021 (percentage figures relate to population changes on 2011)

Borough	Year	0-17	18-39	40-64	65-84	85+	Total
Barnet	2011	77,386	109,689	101,519	38,035	7512	**334,141**
	2014	83,212	119,245	107,041	40,920	8367	**358,784**
		7.5%	8.7%	5.4%	7.6%	11.4%	**7.4%**
	2021	91,194	123,283	114,330	44,473	10336	**383,614**
		17.8%	12.4%	12.6%	16.9%	37.6%	**14.8%**
Camden	2011	40,010	89,130	62,174	18,705	3126	**213,146**
	2014	40,905	89,131	63,753	20,058	3433	**217,279**
		2.2%	0.0%	2.5%	7.2%	9.8%	**1.9%**
	2021	41,977	89,691	66,668	22,355	4151	**224,842**
		4.9%	0.6%	7.2%	19.5%	32.8%	**5.5%**
Enfield	2011	70,902	95,209	90,880	33,402	5944	**296,337**
	2014	72,279	93,783	91,256	34,798	6461	**298,578**
		1.9%	-1.5%	0.4%	4.2%	8.7%	**0.8%**
	2021	74,005	92,168	92,822	36,261	8163	**303,419**
		4.4%	-3.2%	2.1%	8.6%	37.3%	**2.4%**
Haringey	2011	52,684	104,726	60,866	60,866	2549	**281,691**
	2014	54,851	108,119	62562	62,562	2704	**290,799**
		4.1%	3.2%	2.8%	2.8%	6.1%	**3.2%**
	2021	57,538	109,523	66,104	66,104	3462	**302,730**
		9.2%	4.6%	8.6%	8.6%	35.8%	**7.5%**
Islington	2011	40,073	102,775	51,624	15,065	2396	**211,934**
	2014	42,298	106,557	53,971	15,580	2593	**220,999**
		5.6%	3.7%	4.5%	3.4%	8.2%	**4.3%**
	2021	46,498	111,047	60,342	16,367	3123	**237,377**
		16.0%	8.0%	16.9%	8.6%	30.3%	**12.0%**
NCL	2011	281,055	501,529	367,063	166,075	21,527	**1,337,249**
	2014	293,544	516,835	378,584	173,918	23557	**1,386,438**
		4.4%	3.1%	3.1%	4.7%	9.4%	**3.7%**
	2021	311,211	525,713	400,265	185,559	29,235	**1,451,982**
		10.7%	4.8%	9.0%	11.7%	35.8%	**8.6%**

4.2 Births

Birth rates vary significantly across NHS North Central London, ranging from 46.6 per 1,000 in Camden to 76.8 per 1,000 in Enfield. Pregnant women are more ethnically diverse than the general population, partly reflecting the age groups and also differences in fertility in some groups. A high proportion of maternities in NHS North Central London are in women who were not born in the UK. Women at either end of the maternity age spectrum are more likely to have higher health needs and risks of poorer outcomes than those aged 20-35. Teenage conception rates have fallen in all the five boroughs (remaining high in both Haringey and Islington compared to London averages), but older maternities have been increasing (high in Camden, Haringey and Islington relative to London). Infant mortality has decreased over time, but there remain significant social class inequalities.

Overall the number of births over the years 2008-2018 is projected to be broadly steady in NHS North Central London, with around 19,000 births a year. It is expected that births will rise by 7.1% in Islington (from 2,800 a year to 3,000) and at the other end of the range fall by 7.0% in Enfield (from 4,300 to 4,000). Women may move between health providers during the course of their pregnancy, and there is also significant movement of women across PCT and cluster boundaries, which adds complexity to the commissioning and planning of future services.

The table below summarises key health indicators for maternities and births in comparison to London averages.

Sector PCT	Indicators that are worse than London average				
	Barnet	Camden	Enfield	Haringey	Islington
Crude teenage pregnancy rate					
Proportion of mothers > 35 years					
% breastfeeding in hospital					
% breastfeeding at 6/8 week visit*					
% mothers smoking at birth					
% babies with birthweight <1500g					
% newborn hearing screens within 4/5 weeks					
Crude infant mortality rate					
Perinatal mortality rate					

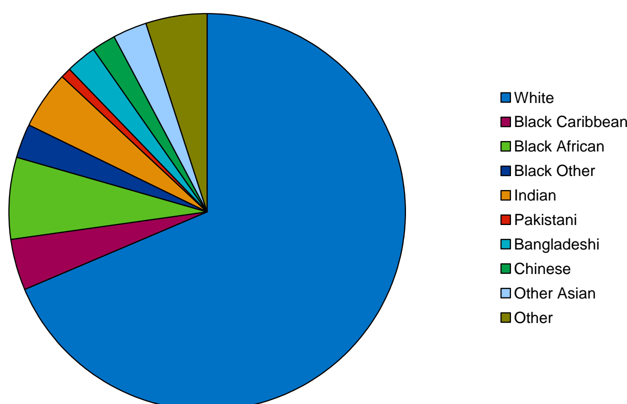
Source: Cluster profile Maternal Health, January 2011

4.3 Ethnicity

The ethnic diversity of the five boroughs varies significantly, although compared to England averages all have relatively diverse and large ethnic populations. Within boroughs, the proportion of people from Black Minority Ethnic (BME) communities is significantly greater in younger age groups than older. Health needs vary across BME communities, with greater risk of diabetes, stroke or renal disease in some BME communities than in the White English population; sexual health needs are greater in some groups; and men and women from some BME

communities, including Black Caribbean, African and British and Irish are over-represented in secondary care services. Some of the higher health needs or risks experienced by BME communities are strongly linked to higher rates of deprivation and poverty (i.e. shared with other groups experiencing similar levels of deprivation or poverty), as well as to other factors such as the impact of discrimination or differential access to services.

NHS North Central London cluster resident population by ethnic group - 2010



4.4 Deprivation

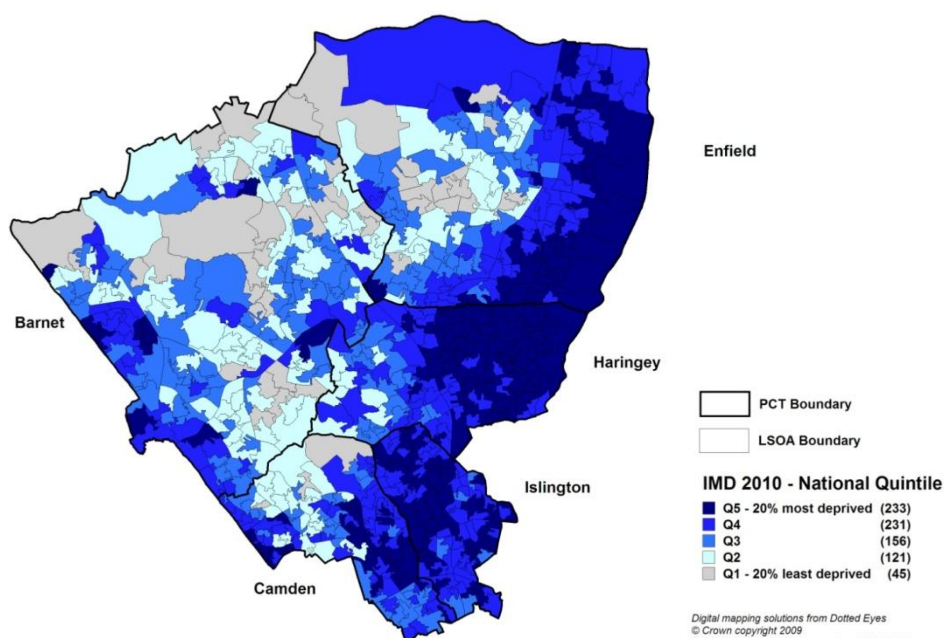
The table below shows the deprivation ranking for the five boroughs within London (and nationally) as identified within the Index of Deprivation 2010. There are significant differences in levels of deprivation between boroughs as well as marked differences within boroughs.

	Ranking – London [England] Rank of average score/rank of average rank*	% LSOAs in most deprived 20% nationally (numerator / denominator)	% LSOAs in most deprived 40% nationally (numerator / denominator)
Barnet	25/24 [176/165]	6% (12/210)	22% (47/210)
Camden	15/14 [74/55]	24% (32/133)	59% (78/133)
Enfield	14/16 [64/63]	27% (48/181)	59% (107/181)
Haringey	4/7 [13/11]	56% (80/144)	83% (119/144)
Islington	5/4 [14/6]	52% (61/118)	95% (112/118)

Source: Index of Multiple Deprivation 2010 (IMD2010)

* There are two differing ways of calculating overall deprivation at borough level, hence two rankings.

As the map below shows, deprivation increases as one goes from west to east, with the greatest concentrations of deprivation across most of Islington, the eastern half of Haringey, eastern edge of Enfield and parts of Camden.



4.5 Life expectancy

The table below shows average life expectancy for males and females in 2007-9 in each of the five boroughs, compared to the range of life expectancy in similar comparator boroughs.

- In 2007-9, **male** life expectancy at birth in Islington at 75.6 was the lowest in London. In both Haringey (76.6) and Camden (78.0) life expectancy was lower than the London (78.6) and England (78.3) averages. Male life expectancy in Enfield was 79.1 and in Barnet 80.2
- **Female** life expectancy is generally higher than that for males. In 2007-9 female life expectancy in Islington (81.2) and Enfield (82.9) was lower than the London (83.1) and England (82.3) averages. Female life expectancy in Camden was 83.3, Haringey 83.7 and Barnet 84.3.

For both men and women, deprivation and lifestyle factors account for much of the variation.

Life expectancy (2007-09)

	Male	Benchmark range	Female	Benchmark range
Barnet	80.2	(77.1 – 81.2)	84.3	(81.6 – 84.6)
Camden	78.0	(75.4*-84.4)	83.3	(80.9 – 89.0)
Enfield	79.1	(77.1 – 81.2)	82.9	(81.6 – 84.6)
Haringey	76.6	(75.4* – 78.1)	83.7	(80.5 – 84.3)
Islington	75.4	(75.4* – 78.1)	81.2	(80.5 – 84.3)

**this is Islington.*

4.6 Mortality

There are approximately 8,000 deaths per year in the cluster (in the same period there were around 19,100 births). The three leading causes of death are cardiovascular disease (CVD), cancer and respiratory disease. These accounted for approximately 75% of all deaths in NHS North Central London, including 70% of all premature deaths (deaths under the age of 75).

	CVD	Cancers	Respiratory	Digestive	Other	Total deaths (all ages)
Barnet	808	652	362	104	498	2,424
Camden	375	337	148	69	261	1,190
Enfield	722	550	319	81	394	2,066
Haringey	403	348	145	58	248	1,202
Islington	367	318	149	63	235	1,132
NCL	**2,675**	**2,205**	**1,123**	**375**	**1,636**	**8,014**

Of note, although CVD accounts for a greater number of overall deaths across the cluster in people under 75 years, cancer is the greater cause of early deaths, with 1157 deaths from cancer, 714 from CVD and 326 from COPD, although in Islington both cancer and CVD make similar contributions to early deaths.

Major causes of death under the age of 75, numbers of deaths, NHS North Central London boroughs, 2007-2009

	Cancers	CVD	Respiratory	Digestive	Other	Total premature deaths
Barnet	297	160	58	35	165	715
Camden	170	121	42	41	118	492
Enfield	280	189	50	39	157	715
Haringey	204	143	42	38	138	565
Islington	170	150	44	35	118	517
	1,121	763	236	188	696	3,004

4.7 Cardiovascular disease

Premature death rates from CVD have been falling for several years although a downward trend is less striking in Islington. In 2007-9 across NHS North Central London the population under 75 years had a Directly Standardised Mortality Rate (DSMR) lower than the England (70.49) and London (75.30) averages but this masked substantial variation across the cluster with higher rates in Camden (78.41), Haringey (86.11) and Islington (120.15). The rate in Barnet was 51.47 and in Enfield 70.89.

Mortality rates from CVD are considerably higher for males than for females. Rates for males ranged from 77.4 in Barnet to 178.82 in Islington (London average 108.15, England average 99.44). Female rates ranged from 28.55 in Barnet to 68.15 in Islington (London average 45.43, England average 43.22).

General practice registers indicate significant gaps between the observed and expected prevalence of CVD conditions in all five PCTs. For Coronary Heart Disease (CHD), the difference ranges from 23% (2,403 cases) in Barnet to 47% (3,501) in Islington and 46% (3,837) in Haringey. For high blood pressure, an important early risk indicator for vascular disease, the gap between observed and expected cases was equivalent to more than 50% of expected cases in Islington and Camden. These gaps are important to address as effective secondary prevention of CVD complications is highly effective in reducing risk and medium-term mortality.

Observed (GP-registered) prevalence in 2009/10 versus estimated prevalence in 2009 of selected CVD conditions, NHS North Central London PCTs

	Expected number of cases in primary care	Number of cases on register	Gap
CHD			
Barnet	12,755	10,352	2,403
Enfield	10,364	7,505	2,859
Haringey	8,350	4,513	3,837
Camden	7,111	4,311	2,800
Islington	7,484	3,983	3,501
Stroke			
Islington	3,745	2,341	1,404
Camden	3,431	2,334	1,097
Haringey	4,284	2,305	1,979
Enfield	5,091	3,550	1,541
Barnet	5,904	4,689	1,215
High blood pressure			
Islington	41,726	19,830	21,896
Camden	46,018	20,287	25,731
Haringey	55,254	28,364	26,890
Enfield	64,578	39,006	25,572
Barnet	80,427	43,707	36,720

4.8 Cancer

Premature mortality rates from cancer have been falling for several years, although there has been differential decline between some of the major tumours. In 2007-9, directly standardised mortality rates in Islington (134.31 per 100,000) and Haringey (121.95) were higher that the England average of 108.18. Camden (110.59) and Enfield (108.18) were similar and Barnet (96.45) lower.

Overall mortality rates for cancer are higher for males than for females, particularly in those under 75 year years, which in part reflects historically higher smoking prevalence among men than women in North Central London and nationally. Cancer mortality rates range for males from 104.76 in Barnet to 164.46 in Islington. Rates for females range from 89.62 in Barnet to 108.61 in Islington. The major causes of cancer death in NHS North Central London are lung, colorectal, breast and prostate cancer.

4.9 Chronic obstructive pulmonary disease (COPD)

Approximately 80% of COPD is attributable to smoking. Directly standardised pooled rates (2007-9) indicate that Islington had the highest rates of mortality from COPD at 36.92 followed by Camden (28.34), Haringey (20.37) and Enfield

(19.87). Barnet had the lowest rate of mortality from COPD in London at 14.67. This compares to the London rate of 25.41 and the England rate of 26.17.

Mortality rates from COPD are higher for males than for females. Rates for males ranged from 21.48 in Barnet to 45.20 in Islington. Female rates ranged from 10.37 in Barnet to 30.82 in Islington.

As the table below shows, there was a significant difference in 2009/10 in all five PCTs between the number of patients on primary care COPD registers and the expected number based on prevalence modelling. Across NHS North Central London as a whole, there were 13,459 cases on primary care registers in 2009/10 compared to an expected 42,501, a difference of 29,402 (or 68%).

Observed (GP registered) prevalence in 2009/10 versus estimated prevalence in 2009, COPD, North Central London PCTs

	Expected number of cases in primary care	Number of cases on register	Gap
	COPD		
Barnet	9,757	3,649	6,108
Camden	7,929	2,375	5,554
Enfield	10,117	2,854	7,263
Haringey	8,034	1,928	6,106
Islington	6,666	2,653	4,013

4.10 Long-Term Conditions and other major health conditions

The sections above described the prevalence of some long term conditions, namely CVD and COPD. Other long term conditions that are important in NHS North Central London include:

Diabetes, which is an important risk factor in CVD, renal disease and a range of other health conditions. The gap between expected prevalence and primary care registers is generally narrower than for CVD and COPD, but ongoing increases in obesity can be expected to lead to significant increases in type 2 diabetes in future years.

Mental health conditions, including serious mental illness (SMI), problem drug and alcohol use, which are heavily skewed in terms of prevalence and risk factors into deprived, younger and ethnically diverse inner London. Serious Mental Illness registers in Islington and Camden, at 1.3-1.4% of the registered population, are the largest in the country. The prevalence of dementia is highest in NHS North Central London in Barnet, reflecting its older age structure.

HIV prevalence is above the national average in all five PCTs but is significantly higher in those boroughs with larger gay male and Black African communities, as the groups most affected by HIV – Camden, Islington and Haringey.

5. Clinical Priorities

5.1 Clinical priorities

The identified clinical priorities within the first Case for Change are included again in this refresh, but are joined by Healthy Lifestyles as an important underpinning area of health benefit. The clinical priorities described are:

- Care closer to home, including long term conditions
- Unscheduled care
- Mental health
- Maternity
- Cancers
- Cardiovascular diseases
- Paediatrics
- Healthy lifestyles.

5.2 Care closer to home

Care closer to home covers a variety of conditions and interventions that are based on bringing treatment and care out of hospital and closer to patients. The role of such initiatives in long-term conditions is particularly important, but other examples may include the use of diagnostics and other procedures in primary or community services that have previously been provided only in specialist settings or admission avoidance and early supported discharge initiatives.

By focusing delivery on community settings in ways that are attuned to individuals' home circumstances it may be possible to improve the effectiveness of the overall health system in managing patients, particularly those with long-term conditions or ongoing health needs, and improve patient satisfaction.

Although the focus is on shifting care into community and primary care settings, most initiatives will involve redesigning and specifying the whole care pathway and an important aspect of care closer to home is on improving integration of care for patients and closer working between services. The evidence on the effectiveness of initiatives aimed at providing care in community rather than acute settings, however, is mixed, which means that careful selection and monitoring of initiatives is important.

There is no single way of assessing the extent of opportunity to move more care closer to home; though, relatively higher standardised rates of first outpatient appointments and emergency admissions, including of selected ambulatory

sensitive conditions, provide some indicators, as well as identification of national and local initiatives in the field.

High-quality care closer to home initiatives should be based on:

- Robust analysis of those services or care scenarios where evidence and evaluation demonstrate clearly where defined outcomes important to patients are most likely to be achieved
- Developing clinical and managerial leadership to grasp strategic opportunities and build consensus for changes amongst all key stakeholders particularly clinicians and service users /carers
- An inclusive approach to integrated pathway development and service re-design
- Commissioning approaches, particularly in ensuring robust evaluation and performance management markers are commissioned, and in developing innovative approaches to commissioning providers through incentives to effectively manage the health system
- Developing the workforce and the premises and estates they work from to be able to support people at home and in the community
- Making greater use of technology in community settings and at home
- A substantial emphasis on enabling patient self-management.

5.3 Unscheduled care

National surveys, audits and policy and strategy documents emphasise:

- The importance of a whole system integrated model for unscheduled care to drive quality, value for money and reduce duplication
- The ability to provide access to timely and appropriate unscheduled care, information and advice across the 24-hour period.

Key interfaces for unscheduled care are with primary care access, accident and emergency services, out-of-hours services, care closer to home, admissions avoidance initiatives and mental health initiatives including alcohol and dementia liaison services.

The White Paper *Equity and Excellence Liberating the NHS* states the NHS will "develop a coherent 24/7 urgent care service in every area of England that makes sense to patients when they have to make choices about their care." A single telephone number (111) accompanied by the development of directories of unscheduled care services will provide advice and signposting to relevant health and social care services.

North Central London, in common with London as a whole, has significantly higher use of accident and emergency services than the national average and a

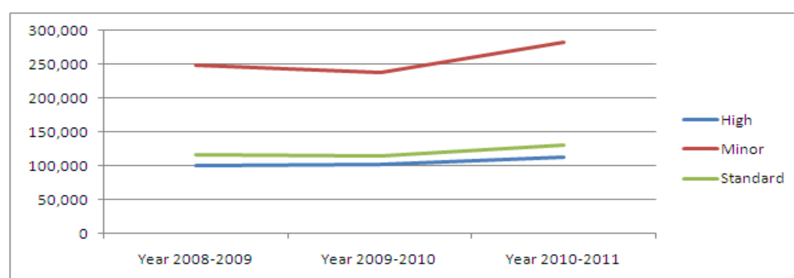
relatively less well-developed access to primary care, pointing to an imbalance at system-wide level.

The table below shows all attendances at accident and emergency departments across the cluster, showing a significant increase in 2010/11 compared to previous years.

Sum of ACTIVITY	Financial year			
tariff name/level	**Year 2008-2009**	**Year 2009-2010**	**Year 2010-2011**	**Grand Total**
High	100,150	101,331	112,773	314,254
Minor	247,908	238,489	282,183	768,580
Standard	116,607	115,068	130,144	361,819
Grand Total	**464,665**	**454,888**	**525,100**	**1,444,653**

Yearly % change in activity by HRG tariff

Year 2009-2010	Year 2010-2011
1.18%	11.29%
-3.80%	18.32%
-1.32%	13.10%
-2.10%	15.44%



Source data: SUS Extract Mart
This excludes n/a and no payment activity

Experimental statistics (which therefore need to be treated with caution) on the quality of accident and emergency services covering April 2011 and involving 1.4 million attendances included how accident and emergency departments performed in relation to two aspects of quality/patient experience:

- The percentage of patients who left A&E without being seen
- The percentage of patients who re-attended within seven days of their previous attendance.

The following table shows these indicators for NHS North Central London hospitals. All NHS North Central London hospitals recorded more patients than the England average leaving without being seen or re-attending within seven days of the previous attendance. North Middlesex University Hospital had the second highest percentage of patients in England and 10th in England for re-attendance within seven days of being seen.

EXPERIMENTAL STATISTICS **Patients leaving A&E without being seen and patients re-attending within seven days of previous attendance**

Trust/Region	**Patients leaving A&E without being seen (%)**	**Patients re-attending within seven days of previous attendance (%)**
Barnet and Chase Farm	5.7	7.2
Moorfields Eye Hospital	1.8	5.7
North Middlesex University	7	9.8
Royal Free	4.8	7.6
The Whittington	4.9	8.2
UCLH	6.8	7.2
England Average	3.4	7.5

NHS North Central London's unscheduled care plans include the streamlining of access points to 24/7 unscheduled care across all five Boroughs, to remove duplication in the system and reduce the cost of providing unscheduled care in accident and emergency departments. It aims to deliver this through:

- The co-location of urgent care services within A&E departments,
- Combined and integrated models of care including Out Of Hours GP services and reviewing points of access,
- Working with LAS on the implementation of their QIPP initiatives to reduce the number of patients conveyed to A&E and
- Implementing the Directory of Services (DoS) for the Single Point of Access (111)
- Working closely with other key commissioning initiatives as unscheduled care spans the whole system of health and social care.

5.4 Mental health

With high levels of need for mental health, particularly in Islington, Camden and Haringey, and high levels of expenditure on mental health programmes, the challenge for NHS North Central London is

- The development of a more integrated approach to providing mental health care across the boundaries of primary and secondary care
- To achieve improved access to services that support mental health and well-being
- Earlier identification of emerging mental health problems
-

- Responding to concerns which exist locally about the quality and experience of mental health inpatient services and the impact these have on people who use them.

There is clinical consensus that the move towards treating in the community whenever possible should continue, with hospital and residential treatment being focused on those who benefit most from this approach. This includes the provision of enhanced assessment services as well as case management approaches for those with longer term mental health conditions, together with effective provision of services for intervention earlier on in common mental health problems, including access to psychological therapies, and the development of more serious mental illness.

This will require the transformation of community services, working closely with primary care, including the use of the personalised recovery model which promotes individualised care planning, high quality services, early adherence to quality standards for prescribing, good access to services, and shared care between services Taken together, these actions should reduce the current level of dependence on inpatient care as well as on high cost out of area treatments, where high quality alternatives could be provided closer to service users' homes in community settings and in the least restrictive place possible, and support improvements in costs and use of resources.

The areas recognised by clinicians and others as in greatest need of attention are:

- Alcohol harm
- Dementia
- Meeting the specific needs of people from Black Minority Ethnic communities, particularly those who are over-represented in secondary care or under-represented in primary care settings
- Access to psychological therapies and other help.

In all areas, earlier identification and offer of effective interventions that can reduce health and social care costs rely importantly on primary care, accident and emergency and hospital services rather than on specialist treatment services alone.

As well as improving the quality and accessibility of mental health services, there needs to be a focus on improving the mental well-being of the population as a whole and the physical health of people with long term and serious mental health conditions. International evidence and models of effective practice demonstrate the importance of action on stigma and discrimination associated with mental ill health in improving population mental health outcomes.

Stigma and discrimination, in the self or towards others, is associated with reluctance to seek help, including suicide risk, later presentation at more serious stages of distress and illness, and greater long-term risk of social exclusion. Programmes aimed towards both public and professionals that incorporate self-efficacy, help seeking and how to recognise and respond to mental health problems in others, such as Mental Health First Aid, are an important part of such programmes.

Finally, people with long-term, serious mental health problems are at particular risk of poorer physical health outcomes and access to other health services. It is important that models of care actively support the wider health needs of people with mental health conditions, including support to stop smoking, healthy eating and exercise, reducing drug and alcohol use, support access to NHS health checks, screening and immunisations, and management of long-term physical health conditions. The mental health needs of people with CVD and diabetes should also be recognised, with evidence of significantly poorer outcomes and increased mortality for those with untreated depression.

5.5 Maternity

About 30% of bookings in NHS North Central London are later than the 12 weeks +6 day standard for early access, although this varies by Trust. The Royal Free Hospital has achieved early access as high as 90% (95%, if taking account of late referrals). Reasons for later booking are various, and do include choice and service factors, however local work in Haringey has indicated that a high proportion of late bookers may have arrived recently in the country, while other sources indicate that many women still do not know that they can self-refer or choose their provider, which may assist in supporting earlier booking. Trusts have implemented self-referral options and streamlined booking systems, and health promotion campaigns have been run.

There is currently no agreed definition across the cluster of low and high risk pregnancies (important in ensuring that potential risks, including social, lifestyle and health risks, are recognised and managed). As a consequence, women are currently offered differing numbers of antenatal appointments, different levels of clinical support throughout pregnancy and delivery depending on the unit which they attend, impacting on patient experience and expenditure on maternity services. C-section rates vary from 22.8% at North Middlesex University Hospital to 29.6% at the Whittington Hospital, with significant variations also seen in the proportions of elective versus emergency rates.

Smoking in pregnancy is a significant risk factor linked to low birth weight, which in turn is linked to range of poorer outcomes including higher risk of infant mortality. Smoking cessation rates vary between services, but reducing smoking rates will have immediate impacts on the health and outcomes for babies.

Key to maternity sector QIPP plans will be normalising births, standardising care pathways and using more midwifery led units and community based sites for provision of care. Reductions in C-section rates and using contractual levers to ensure women follow the appropriate pathway according to their health and social needs/risks should help to reduce costs and improve the patient experience. The identification of more community based settings across NHS North Central London for midwives should also impact on the number and cost of hospital visits whilst facilitating early access to maternity services. Further detailed analytical work is also required to better understand the patterns of booking and delivery as it is thought that many women not only transfer care during their pregnancy but also 'shop around' for maternity services which leads them to booking in more than one place at a time.

5.6 Cancer

Rising incidence: London will experience an increase in the cases of cancer of 5% by 2022, whilst England as a whole will experience an increase of 33%. For NHS North Central London this translates to a real increase of 275 newly diagnosed patients a year by 2022. Incidence is affected by a range of factors; age, obesity, smoking and low levels of physical activity for example, which add weight to an increased emphasis on prevention measures.

Inequalities: There are inequalities in the incidence of cancer, both in terms of prevention measures and access to treatment. Inequalities relate to socio-economic deprivation particularly with regard to risk factors for cancer, especially smoking, but also in terms of gender, ethnicity, religion, disability and age where inequalities also exist.

Screening: Uptake of all screening in London is poorer than the national picture and this is no different for NHS North Central London where uptake of breast, cervical and colorectal screening is below national average and there are wide variations between PCTs and services in terms of uptake. The delivery of screening services is complex with issues around primary care engagement, commissioning and ensuring the quality of services.

Early diagnosis: Four PCTs within the cluster have a higher than London/South East England incidence of late diagnosis, this has a significant impact upon survival and treatment options. Improving cancer awareness in the general population, higher risk groups and primary care clinicians is needed to improve earlier recognition and diagnosis.

Use of resources: A reduction in the number of emergency admission bed days and reduction in patient length of stay could enhance quality of care, patient experience and deliver system efficiency. Currently models of follow-up and survivorship are medically and acute sector focused.

Clinical quality and outcomes: Data collection, service configuration and Improving Outcomes Guidance (IOG) compliance can all drive up quality of care.

Patient experience: Improvements are needed in patient information, coordination of care, total patient pathway delivery and support to drive up the quality, and reduce variability of the patient experience.

5.7 Cardiovascular disease

CVD is a very important cause of premature mortality and health inequalities in NHS North Central London. There is significant under-diagnosis of most CVD conditions and the effects of an ageing population, together with increasing obesity at younger ages, are likely to increase clinical demand. London-wide work shows that there is variation in the standard of care for patients with cardiovascular disease across the capital, including NHS North Central London. There is also some evidence of inequalities between groups in terms of access.

Comparison of patients on primary care registers with expected prevalence estimates shows significant gaps, and these are generally greatest in the more deprived boroughs. They include atrial fibrillation, hypertension, coronary heart disease, heart failure and stroke. This pattern of under-diagnosis and sub-optimal treatment is associated with poorer outcomes, including excess (potentially preventable) deaths, and later presentations requiring more intensive, secondary care interventions.

Optimal management requires effective, integrated pathways of care within and between primary care, secondary care and community services to support the management of patients. From a population perspective, the greatest improvements in outcomes, and most cost effective use of resources, will be delivered through population lifestyle changes and earlier diagnosis and management in primary care:

- Primary prevention includes reducing population smoking prevalence, including strong stop smoking support, dietary improvements, including reduction in salt intake, increased levels of physical activity and exercise and reducing the increase in obesity
- Primary care management includes improved and earlier recognition of risk and diagnosis, of which NHS Health Checks is one example, reducing the proportion of undiagnosed conditions, and effective medical and lifestyle management and monitoring of patients with CVD conditions.

In secondary care, some patients are treated in hospitals that do not regularly perform complex surgical procedures, and evidence shows that there are poorer outcomes, including higher mortality and longer lengths of stay. For some procedures, there is evidence that high-volume hospitals have better outcomes and shorter length of stays than lower volume, non-specialist centres. There is

also evidence that the best and most up to date technology is not being employed across London, and that this is a particular issue in NHS North Central London.

There is good evidence from programme budgeting and other sources that CVD is one area where there is a generally strong link between level of expenditure and population outcomes. There are clear indications of this pattern in the five PCTs, with programme budgeting showing Barnet categorised as high expenditure/high outcomes and Islington, Camden and Enfield as low expenditure/poorer outcomes when benchmarked with groups of similar PCTs. Haringey has high mortality and is similar in terms of outcomes and expenditure to its comparator group, but the same general point about the link between level of investment and outcomes applies. These points notwithstanding, analysis shows potentials for more effective use of resources, including prescribing and secondary care costs.

5.8 Healthy lifestyles

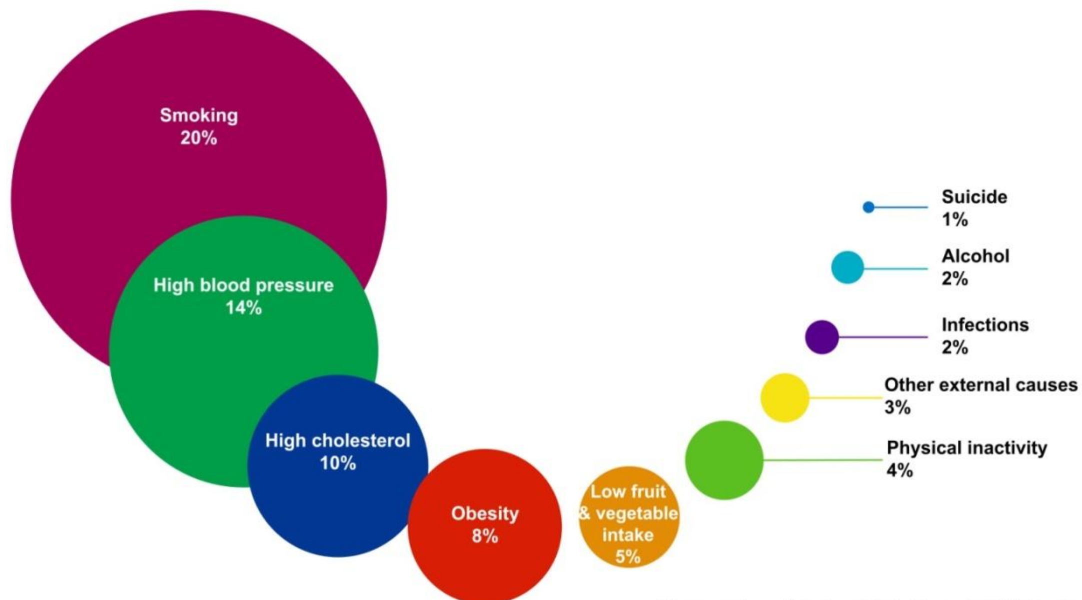
The following diagram describes the proportion of deaths attributable to key risk factors which are potentially modifiable or preventable in North Central London during 2007-9. Many of the long-term and other health conditions are at least partially modifiable through changes in life-style, principally stopping or never starting smoking, improved diet, increased physical activity and exercise and sensible drinking.

A range of interventions are needed. Some of these, such as brief advice, stop smoking support, immunisations, screening, health checks and earlier diagnosis and management of risk, fall directly within health and to an extent social care services; and there is scope to develop these offers further, ensuring that advice and support for behaviour change are more thoroughly developed and embedded in health service contacts with patients and as part of care pathways.

However, other factors or interventions can only effectively be addressed through partnerships with other public services, in particular local authorities, the community and voluntary sector, local communities and private sector organisations. These include legislative and environmental factors, such as:

- Alcohol licensing
- Stop smoking enforcement
- Environmental quality or access to green spaces
- Promoting good educational attainment
- Decent housing
- Training
- Employment
- Stronger and safer neighbourhoods etc, which are protective of good health and wellbeing.

Percentage of deaths attributable to key risk factors, NHS North Central London, 2007-2009



The role of smoking becomes even more important when explaining the pattern of inequalities in health outcomes. It is the single most important lifestyle factor in inequalities in premature mortality, with around half of the inequalities gap in early deaths between deprived boroughs such as Islington and Haringey and the national average being attributable to higher smoking prevalence in local communities.

There is some evidence to show that those living in the most deprived areas of London are likely to have a concentration of multiple lifestyle risk factors and that this helps to explain at least in part why health inequalities are widening for some of the most deprived groups in terms of poorer health outcomes relative to the general population, relatively higher risks at earlier ages for long term conditions and increased premature mortality. This indicates the need for good access and targeting towards people within the most deprived communities.

The offer of screening and immunisation, and more recently NHS Health Checks, are also important parts of the preventive offer. As mentioned previously, achieving good coverage of cancer screening programmes remains an important challenge, particularly where populations are more mobile and more deprived.

Similarly, although immunisation rates in parts of NHS North Central London compare favourably with comparator Primary Care Trusts, and in some cases with London and national rates, immunisation coverage is below national target

levels of 95% viewed as necessary to achieve sustained population level protection (‘herd immunity’), with MMR and the booster immunisations furthest from national targets. Immunisation remains one of the most highly cost effective health service interventions.

Immunisation coverage in NHS North Central London’s PCTs, 2010/11

	2010/11 annual cover data					
	% children aged 1 (DTaP/IPV /Hib)- 3Doses	**% children aged 2 (PCV booster)**	**% children aged 2 (Hib/Men C)**	**% children aged 2 (MMR)**	**% children aged 5 (DTaP/IPV) - pre-school booster**	**% children aged 5 (MMR2)**
Barnet	93.88%	86.40%	89.58%	89.62%	86.72%	82.61%
Camden	88.94%	76.34%	78.98%	77.26%	63.08%	61.00%
Enfield	83.00%	73.85%	78.35%	77.13%	69.80%	67.56%
Haringey	91.11%	82.72%	83.45%	85.32%	54.39%	77.80%
Islington	91.90%	82.18%	85.61%	85.44%	77.56%	75.01%
London	88.7%		81.9%	81.9%	71.8%	72.2%
England	93.6%		90.0%	88.2%	84.8%	82.7%

NHS Health Checks offer a programme in primary care and other settings for systematically assessing the risk of patients for CVD who have not had a previous diagnosis, as a means of closing the gap in undiagnosed prevalence of these conditions. During 2010/11, 24,951 patients aged 40-74 were offered Health Checks and 13,689 (55%) took them up.

Eligibility, offer and uptake of the NHS Health Check in NHS North Central London’s PCTs, 2010/11

	Number of people eligible	Offered a health check	Received a health check
Barnet	37,414	862	420
Camden	69,500	8090	2,548
Enfield	82,880	7,500	3,600
Haringey	37,414	862	420
Islington	50,932	7,637	6,701

6 Quality, Safety and Patient Experience

6.1 Acute

The cluster is currently undertaking a review of acute care, as measured by dashboards of clinical outcomes and indicators. The review indicates that standards of quality and safety appear to be generally comparable or favourable to national standards and benchmarks, with some variation between hospitals. Patient experience, however, is less favourable for many indicators in almost all NHS North Central London hospitals when compared to national averages. When the review is complete further detail will be included within this document.

6.2 Mental health services

The Care Quality Commission's annual health check ratings in 2009 for the provider mental health trusts in NHS North Central London were as follows. The ratings conceal the local concerns about the nature and quality of existing inpatient provision in NHS North Central London, which is distributed currently across nine different sites. There are some modern, fit-for-purpose facilities; however, some of the services are not of sufficient quality to support safe and effective service delivery in the future.

Trust	Quality of Services	Use of Resources
Barnet, Enfield and Haringey Mental Health NHS Trust	Excellent	Good
Camden and Islington Foundation NHS Trust	Excellent	Excellent
Tavistock and Portman Foundation NHS Trust	Excellent	Excellent

Source: Care Quality Commission

The CQC produces an Annual Survey which provides information on how services users rate the care that they receive. The 2011 overall results for services in NHS North Central London follow.

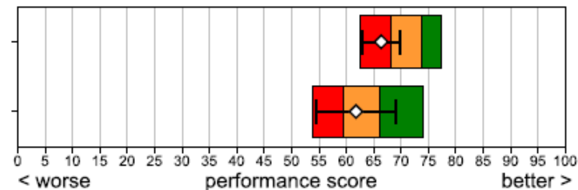
NHS North Central London, service users have expressed widespread concerns about the quality of inpatient services, the adequacy of staff skills (specifically in relation to inpatient care), the sexual safety of women and the no smoking restrictions in hospital and whether these deter people from seeking help. Service users support alternative models of care in community settings, more individualised care and increased access to psychological therapies for people with more severe mental health difficulties. Services provided by the third sector are also valued.

Barnet, Enfield and Haringey Mental Health NHS Trust

Overall

Overall, how would you rate the care you have received from NHS Mental Health Services in the last 12 months?

Have NHS mental health services involved a member of your family or someone else close to you, as much as you would like?

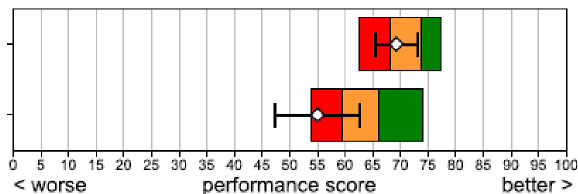


Camden and Islington NHS Foundation Trust

Overall

Overall, how would you rate the care you have received from NHS Mental Health Services in the last 12 months?

Have NHS mental health services involved a member of your family or someone else close to you, as much as you would like?



Source: Care Quality Commission

6.3 Primary Care

The annual **General Practice** survey data for 2010/11 found that fewer respondents were *very satisfied* with GP services in London as a whole than for England. The figures for the cluster varied from 40% in Haringey to 45% in Barnet. The proportion of respondents who were *very* or *fairly* dissatisfied was higher in London than in England, and there was little variation across the sector from the London average. Key findings from the survey included:

- The percentage of respondents reporting that they found it easy to get through to the practice was slightly lower in London than for England, and lower in each of NHS North Central London's PCTs than the London average. Ease of getting through was slightly lower for patients in Barnet (62%) and Camden (63%) than in Haringey (65%), Enfield (66%) and Islington (66%)
- When asked about reasons for not being able to access a GP quickly:
  - The majority of respondents said that there were no appointments available, this ranged from 84% in Barnet and Enfield (same as the England average) to 80% in Haringey (below the London average)
  - Respondents unable to access a GP due to unsuitable timings ranged from 16% of Enfield respondents to 20% of Camden respondents, compared to 15% for England as a whole (15%)

- Satisfaction with opening hours was lower in London (78%) than the England average (80%). Within NHS North Central London, Enfield respondents were more likely to be satisfied (79%) than the London average. Lowest levels in NHS North Central London were reported in Camden, Islington and Barnet where 74% of respondents were satisfied
- One of the more striking aspects of the survey regarded out-of-hours care. Only 54% of London respondents knew how to access out-of-hours care, compared to 62% in England as a whole. There was variation in the cluster from 52% in Haringey, Camden and Islington, to 56% in Barnet
- The proportion of respondents who reported physical access to primary care premises as *easy* in the five boroughs (not included in the table below) did not differ from the London or England averages of 98%

	England	London	Barnet	Enfield	Haringey	Camden	Islington
Ease of getting through on the phone	69%	67%	62%	66%	65%	63%	66%
Know how to access out-of-hours care	62%	54%	56%	55%	52%	52%	52%
For patients reporting difficulty in accessing a GP quickly:							
No appointments available	84%	82%	84%	84%	80%	81%	83%
Times didn't suit	15%	18%	19%	16%	17%	20%	18%
Satisfied with opening hours	80%	78%	74%	79%	76%	74%	74%

Source: GP Survey 2010/11

Access to **NHS dentistry** is a key Operating Framework priority, measured by the number of patients seen in 24 months. The most recent Vital Sign data (December 2010) showed that Enfield, Haringey & Islington were performing below the London average. Satisfaction levels among patients were below the London average across all the NHS North Central London PCTs.

7. Strengthening the Provider Landscape

NHS North Central London is characterised by a large number of Acute Trusts, with a high dependency on acute beds and, in general, less developed community and primary care services. Several Trusts have achieved Foundation Trust status while the others are working towards it. The Barnet, Enfield and Haringey Clinical Strategy which has begun implementation again will change the Acute Trust landscape in the cluster. Additionally, moving services out of hospitals and into the community remains a key focus for NHS North Central London.

It is currently difficult to compare community services across NHS North Central London and greater standardisation is necessary to improve service provision and outcome. Innovative community services, such as Whittington Health, may provide new opportunities for health promotion and improving the care of long-term conditions.

Primary care offers its own challenges, with variation in quality and performance of GP practices in access and patient experience. NHS North Central London has a relatively high proportion of smaller GP practices, often in facilities not fit for purpose into the future. There are also variations in access to primary care, between as well as within boroughs, duplication of services across primary and community services and a lack of integration along many care pathways.

8. A Skilled and Sustainable Workforce

Understanding the NHS workforce providing patient care to the population of North Central London is key to understanding the quality, safety, productivity and sustainability of the services.

There are 32,037 staff employed in the five boroughs. The provider workforce plans for 2015/16 indicate a reduction in the acute and mental health workforce of 9%. These plans are largely driven by known reductions in funding.

In 2011/12 the commissioning workforce reduced by 54% to meet NHS Operation Plan requirements. There is concern in some areas of the workforce about undersupply; Community and District nursing is one area where the independent working and increasing responsibility is thought to contribute to difficulties in recruiting. In maternity, aging of the midwifery workforce and ensuring medical cover is another area.

In order to ensure a sustainable and effective workforce NHS North Central London should work with employers to:

- Ensure that the workforce plans that drive workforce supply reflect future service commissioning intentions
- Influence the investment of education and training funding to areas of greatest service and system development
- Continue the development of workforce assurance as indicator of quality and safety
- Support employers with the workforce to identify the implications and implementation of commissioning decisions and changes to service provision.

9. Financial Position

Collectively, NHS North Central London Primary Care Trusts are the most financially challenged commissioners in London. Two of the five PCTs, Barnet and Enfield, received financial support from to offset deficits and enable them to achieve financial balance in 2009/10. Haringey, also moved into deficit in 2010/11 and the three PCTs received further financial support in 2010/11, again allowing financial balance to be achieved.

All three challenged PCTs were assessed by the Challenged Trust Board (CTB) to access support from other London Primary Care Trusts to cover historical and in-year deficits. There was a positive outcome from the assessment and, as a result, the cluster started 2011/12 without legacy debt. However, after stripping out the non-recurrent income support from 2010/11, the cluster entered 2011/12 with an underlying run rate deficit of £63.9m, and, in the three challenged PCTs, an underlying run rate deficit of £81.3m.

In 2011/12, NHS North Central London has an agreed control total deficit of £14.8m which is based on delivery of its £137m QIPP programme. The goal is to achieve break-even overall in 2012/13, achieving run rate balance or better in Barnet, Enfield and Haringey during 2012/13 and balance in all five PCTs in 2013/14.

It is relatively early in the year to forecast the likely out-turn for 2011/12. At month five, the reported net risk to the position is £29.6m, but there are a range of current and new actions that will affect the final position. The forecast for 2011/12 is also highly sensitive to the assumptions made on hospital spend and the success in identifying and negotiating claims for overcharging or failure to deliver agreed contract metrics with acute providers.

As part of the final Case for Change, a range of estimates will be produced for the size of the QIPP target that will be needed in 2012/13, taking account of the 2011/12 position and other key variables. A current midpoint estimate is that the QIPP target will be £75m for 2012/13.

The main acute providers in North Central London are not currently in financial difficulties, although the Royal National Orthopaedic Hospital, for which NHS North Central London is lead commissioner, posted a deficit in 2010/11. However, due to the delay in the implementation of the Barnet, Enfield and Haringey Clinical Strategy, North Middlesex University Hospital has a very challenging QIPP programme as a result of the high overhead costs associated with its PFI. The ‘cap and collar’ agreements with the Royal Free, Whittington Health and North Middlesex University hospitals’ contracts will be removed in 2012/13, returning to Payment by Results (PbR).

Further pressures on the health system have arisen from the significant reductions in funding to local Councils, with a range of reductions between 8-11% in 2011/12 as pooled and social services budgets are being reduced.

10. Conclusion

This analysis represents a summary of the work done to this point in the development of the Case for Change. Further work will be carried out over the next few weeks to complete the analysis.