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27 May 2008

To: All Members of the Overview & Scrutiny Committee

Dear Member,

Overview and Scrutiny Committee, 2nd June 2008

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. PROPOSAL BY BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST TO RESTRUCTURE HARINGEY MENTAL HEALTH ACUTE CARE SERVICES (PAGES 1 - 20)

To consider proposals by Barnet, Enfield and Haringey Mental Health Trust to close an acute adult inpatient ward at St. Ann's Hospital in order to allow reinvestment of resources into the Community Home Treatment Team and remaining inpatient wards.

8. DEVELOPING WORLD CLASS PRIMARY CARE IN HARINGEY - HARINGEY TPCT PRIMARY CARE STRATEGY (PAGES 21 - 50)

Haringey covering report and appendices to the PCT report which was distributed in the agenda pack.

Please note that Item 6, Developments in Haringey Mental Health Services, will take the form of a presentation at the meeting.

Yours sincerely

Jeremy Williams
Principal Committee Coordinator

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Agenda Item 7

HARINGEY COUNCIL

Agenda item:

Overview & Scrutiny Committee **On 2 June 2008**

Report Title: **Proposal by Barnet, Enfield and Haringey Mental Health Trust to Restructure Haringey Mental Health Acute Care Services**	
Report of: **Chair of Overview and Scrutiny Committee**	
Wards(s) affected: **All**	Report for: **Non-Key Decision**

1. Purpose

To consider proposals by Barnet, Enfield and Haringey Mental Health Trust to close an acute adult inpatient ward at St. Ann's Hospital in order to allow reinvestment of resources into the Community Home Treatment Team and remaining inpatient wards.

2. Recommendations

2.1 That the proposals by the Mental Health Trust be considered to constitute "substantial variations" to services due to:

- Number of patients affected
- Changes to methods of service delivery

and therefore subject to consultation under Section 7 of the Health and Social Care Act 2001.

2.2 That the Committee comment on the proposals as appropriate their response the Mental Health Trust, appropriate.

2.3 That the Committee submit comments thereon, as appropriate, and consider further engagement with the TPCT as part of the ongoing consultation process.

Contact Officer: **Rob Mack, Principal Scrutiny Support Officer**

Tele: **020 8489 2921** E-Mail: **rob.mack@haringey.gov.uk**

4. Reasons for any change in policy or for new policy development (if applicable)

Not applicable

5. Local Government (Access to Information) Act 1985

The background papers relating to this report are:

Substantial Variations and Developments of Health Services – A Guide (CfPS)

These can be obtained from Robert Mack – Principal Scrutiny Support Officer on 020 8489 2921, 7th. Floor, River Park House

e-mail: rob.mack@haringey.gov.uk

6. Report

The Trust's Proposals

6.1 Barnet, Enfield and Haringey Mental Health Trust have made proposals to make changes to their inpatient services within the Borough. The proposals involve the closure of an acute adult inpatient ward at St. Ann's Hospital. This is intended to allow re-investment of resources into (i). their Community Home Treatment Team to enable more people to benefit from Home Treatment and (ii). the remaining inpatient wards in order to improve establishments and reduce reliance on temporary staffing.

6.2 The Trust views the change as urgent. They state that their Home Treatment Teams, as currently established, are meeting their national targets and could treat more people at home, prevent more admissions and support people to return home earlier if there were more staff to enable this. The proposed change was identified as a requirement of the Haringey Joint Health and Social Care Mental Health Strategy 2005-2008, which cited the Haringey model as being over-reliant on institutionalised, hospital based care and requiring a shift of resource from hospital to community. This has been confirmed by benchmarking undertaken by the Trust. They also feel that the current inpatient staffing establishments are insufficient to meet modern requirements.

6.3 The Trust is of the view that the changes will improve the quality of care to service users within the Borough. National audits identify that people prefer the opportunity to receive their care at home rather than having to be admitted to hospital. They feel that avoiding admission also improves opportunities for recovery. Research has shown that some communities, particularly BME communities, also prefer home treatment where this is appropriate and available.

6.4 Individuals will be assessed for their suitability for home treatment. Risk assessment will form part of the process for deciding whether hospital admission or home treatment is appropriate. Some people will benefit from an increased opportunity to receive their treatment in their own environment. The Trust comments that this is not a new method of delivery in itself but a proposal to re-allocate further resources to more modern and effective models of service delivery. These are effective for a particular group of users who require care for

an acute episode of illness but not necessarily hospital care if an alternative to admission can be provided.

6.5 The Trust feels that the changes will contribute to the delivery of local targets, increase, choice for patients and provide better value for money. In particular:

- There are local and national targets set for the number of home treatment episodes and a requirement for services to be delivered as close to home as possible.

- Increasing the resource in Home Treatment Teams will enable more people to receive their care at home and more people to return home earlier in their stage of recovery.

- Not only is hospital admission expensive, it has a big impact on the individual's chance of recovery. The Trust feels that keeping people connected with their networks reduces the possibility of state-dependency.

6.6 The Trust accepts that the change does mean that there will be a fewer number of male acute admission beds. There are currently 95 adult acute beds and closing 19 male beds would reduce this to 76. The resources freed up will be transferred to enable more home treatment episodes and an improved level of staffing on the remaining wards to improve the therapeutic environment. Increasing the number of staff on the remaining wards will reduce the need for additional temporary staffing to cover periods of sickness absence, training etc, resulting in some efficiencies and improving continuity and quality on the wards.

6.7 The Trust reports that is has undertaken some consultation with users already. Whilst there is support for the direction of travel, there is also concern about how the transition of resources is undertaken. Further information on the proposal, s provided by the Trust, is attached.

Comments of the Director of Adults, Culture and Community Services (ACCS)

6.8 The Director of Adults, Culture and Community Services (ACCS) comments that, in broad terms, the MHT proposal to reduce inpatient capacity and redeploy resources into community Crisis services is in keeping with the existing Joint Mental Health Strategy. Following more detailed partnership discussions of the proposal due to take place at the Mental Health Executive on the 12th June, ACCS will be able to comment more meaningfully on the possible implications of the ward closure. The proposal has caused some concern amongst service users and carer organisations in the borough particularly due to a perception that community services are still adjusting to the service reconfiguration, which took place in October 2007. Whilst there are still some difficulties, the service is continuing to improve and there has been some positive feedback on the single point of access to services now in place. Management support and action is under constant review to ensure that the teams are pro-actively working with the service users and carers affected by the changes.

6.9 The service considers that at this stage the proposal to close the ward needs to be reviewed in the context of the whole system of community services and current planning across the partner organisations. The areas for consideration include the possible impact on the existing community teams; the relationship between this development and plans to enhance and define community rehabilitation services and the potential for unplanned demand against purchasing budgets. In addition, for the council, ACCS will need to work closely with Housing colleagues to ensure that the pathways for Mental Health service users to obtain independent accommodation remain effective.

Consultation Arrangements

6.10 There is a general requirement for NHS bodies to consult with patients and the public, including a duty to consult with Overview and Scrutiny Committee (OSC) under Section 11 of the Health and Social Care Act 2001. In addition, there is also a specific duty to consult on what are termed as "substantial variations" to local services under Section 7 of the Act. Legislation and relevant guidance does not define exactly what is a "substantial development" in service. Instead, NHS bodies and overview and scrutiny committees are advised to aim for a local understanding of the definition, taking into account;

- Changes in accessibility e.g. reductions or increases of services on a particular site or changes in opening times for a clinic
- The impact of the proposal on the wider community e.g. economic, transport, regeneration
- Patients affected e.g. changes affecting the whole population or specific groups of patients accessing a specialist service
- Methods of service delivery e.g. moving a particular service into a community setting rather then being hospital based.

6.11 Discussions have taken place with the Trust on their proposals and, in particular, if they could be described as constituting a "substantial variation" services. Discussion has also taken place with relevant stakeholders, including service user groups. Any proposals that are considered to be "substantial variations" are subject to a statutory consultation process with OSC.

6.12 The consensus of views obtained is that proposal does constitute a "substantial variation" to services due to:

- The number of patients potentially affected
- The nature of the changes in the method of service delivery, which involves moving a significant proportion of services from a hospital setting into the community,

6.13 The Committee is therefore recommended to approve this designation. The purpose of formal consultation with the Overview and Scrutiny Committee is to consider:

(i) whether, as a statutory body, the OSC has been properly consulted within the consultation process;

(ii) whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation; and

(iii) whether, a proposal for changes is in the interests of the local health service.

6.14 The above matters are therefore the issues that the Committee will need to consider in making its formal response.

6.15 Cabinet Office guidelines recommend that full consultations should last a minimum of twelve weeks and that consultations should ensure that groups that are traditionally hard to engage are involved, in addition to the wider community and OSCs. The guidelines set out the basic minimum principles for conducting effective consultation and aim to set a benchmark for best practice. However, the guidance states that it may be possible for OSCs and NHS bodies to reach agreement about a different timescale for consultation, if appropriate.

6.16 The MHT has indicated that it plans to undertake detailed consultation on the proposal. Members may wish to consider as part of their deliberations how they wish to engage the MHT within this consultation period and the views of other stakeholders, including ACCS and Haringey TPCT. In addition, they may also wish to consider input from patient, user and carer groups. Relevant organisations have been invited to attend the meeting and Members may wish to obtain their input.

10. Legal and Financial Implications

7.1 Whilst there are no direct financial implications for the Council, there are likely to be long term indirect effects as the move to provide more care away from hospitals and closer to the community has the potential to place additional demands on social care services provided by the Council, for which no additional provision has yet been made.

7.2 Regulation 2 of the Local Authority (Overview and Scrutiny Committees Health and Scrutiny Functions) Regulations 2002 allows the Overview and Scrutiny Committee to "review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority". Thus the Overview and Scrutiny Committee is empowered to consider the proposals of Barnet and Enfield and Haringey MHT. The committee is further empowered 'to make reports and recommendations on such matters'. These regulations are made under section 21 of the Local Government Act 2000 as amended by section 7 of the Health and Social Care Act 2001.

7.3 The 'long term indirect effects' stated above have to be considered in light of the After Care duties placed on the Primary Care Trust and the local social services authority under Section 117 of the Mental Health Act 1983 . The duties applies to those persons who having been detained under section 3 of the Mental Health Act 1983 cease to be detained and leave hospital.

8. Chief Financial Officer Comments

8.1 The Director of Adults, Culture and Community Services has indicated that more detailed discussions on the proposal to close an acute adult inpatient ward at St. Ann's Hospital, and to reinvest resources into the Community Home Treatment Team and remaining inpatient wards, are to take place at the Mental Health Executive on the 12th June. At this stage he is unable to comment more meaningfully on the possible implications of the ward closure. Similarly, it not possible at this stage to provide detailed financial implications for the Council although there is a risk that the closure will place additional demands on social care services.

10. Head of Legal Services Comments

9.1 As set out above.

10. Equalities Implications

10.1 Disproportionate numbers of people from some black and ethnic minority communities suffer from metal illness, such as the African Caribbean community. The proposals are therefore likely to have particular impact on them. In addition, mental illness can be source of particular stigma within some communities, which the proposals aim address through reducing reliance on hospital base care.

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Proposal to Restructure Mental Health Acute Care Services -
Increasing capacity of home treatment teams and reducing over reliance on in-patient beds

Background

The National Service Framework for Mental Health has shaped the design and delivery of mental health services over the past nine years.

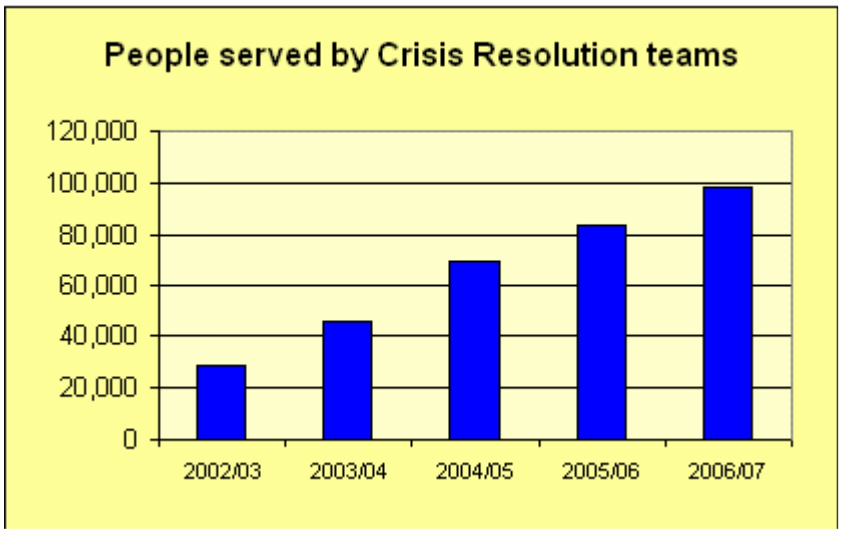
The NSF set national standards and defined service models for promoting mental health and treating mental illness

A number of requirements, expectations, outcomes and targets were set, spelling out how services should be developed, delivered and what they should achieve.

One of the many expectations of the NSF was for services to be delivered as close as possible to home so that family and community links could be sustained. A major programme of the NSF was to deliver Home Treatment as a standard intervention and alternative to hospital admission.

This was in recognition that people had improved recovery outcomes if they could be maintained in their own environment and also that most people, and particularly people from black and minority ethnic backgrounds, found this form of treatment to be far more acceptable than hospital admission.

Seen as a great success there are now some 343 home treatment teams operating nationally. Almost 100,000 people used these services last year and as a result, admissions to hospital are falling.



Current Situation in Haringey

Home Treatment

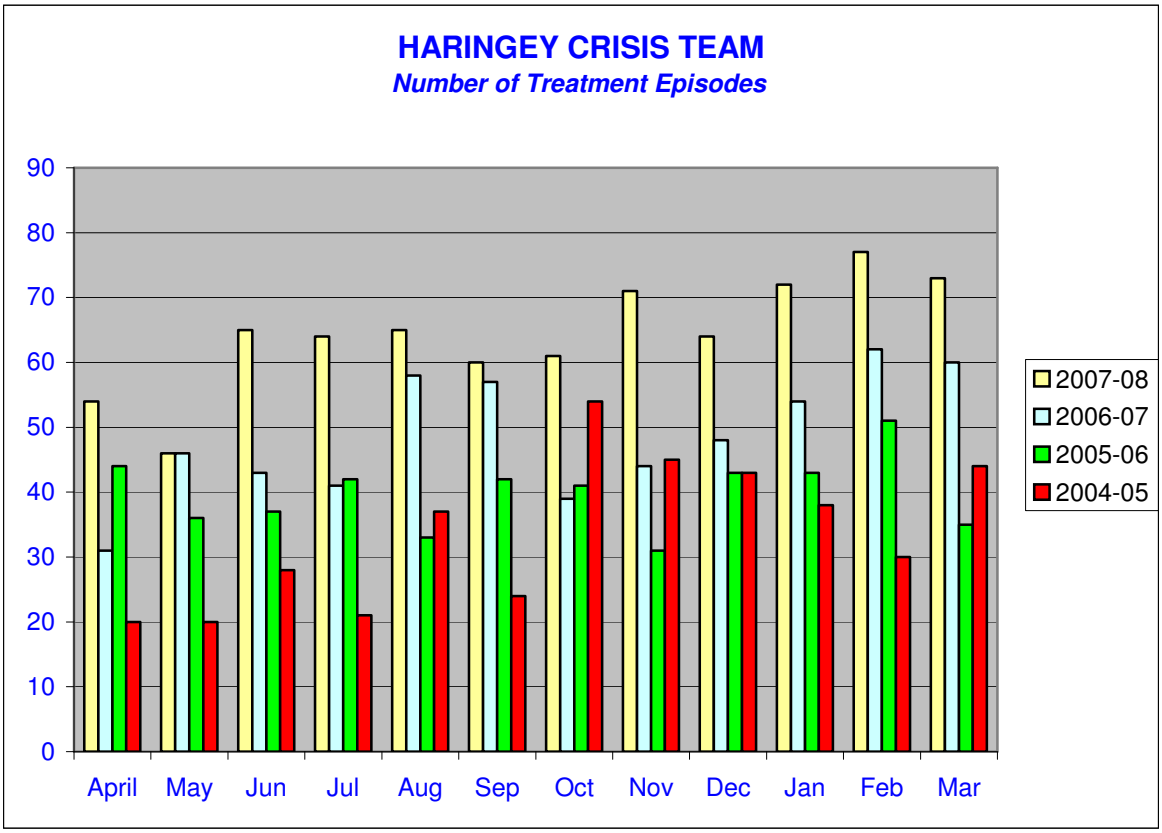
In Haringey, Crisis Resolution Home Treatment Teams (CRHTT) were established in 2004. The East Team was set up in February followed by the West Team in October.

Originally these teams were designed to accept all and any referrals for assessment as well as offer treatment to people as an alternative to hospital admission. With this broad remit it was very difficult for the teams to reach their targeted number of home treatment episodes.

With the reconfiguration of community services last year this initial assessment function moved to the START team freeing up more time for the CRHTTs to focus on providing treatment at home and also to help more people to return home earlier in their recovery.

This has enabled Haringey's Home Treatment Teams to not only reach their nationally set target of 727 episodes for the first time but to achieve a final total of 772 in 07/08. The experience of the staff working in those teams is that with further investment an even greater number of individuals would be able to benefit from being treated at home and particular focus could be given to those able to return home with additional support.

With a clear demand for home treatment beyond the set target and with the teams delivering more treatments than they are resourced to provide there is now an obvious requirement for the Trust and its partners to review the current resource allocation and assess whether this needs to be adjusted to allow the further development and modernisation of services.



HARINGEY CRISIS TEAM

Number of Treatment Episodes

HARINGEY	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	increases on the previous year
2007-08	54	46	65	64	65	60	61	71	64	72	77	73	772	+32%
2006-07	31	46	43	41	58	57	39	44	48	54	62	60	583	+22%
2005-06	44	36	37	42	33	42	41	31	43	43	51	35	478	+18%
2004-05	20	20	28	21	37	24	54	45	43	38	30	44	404	

In-patient Beds

With the introduction of home treatment teams nationally there has been an expectation that the number hospital admissions would fall and the need for inpatient beds would reduce allowing re-investment into more modern ways of providing interventions.

Some areas have been more successful in this than others.

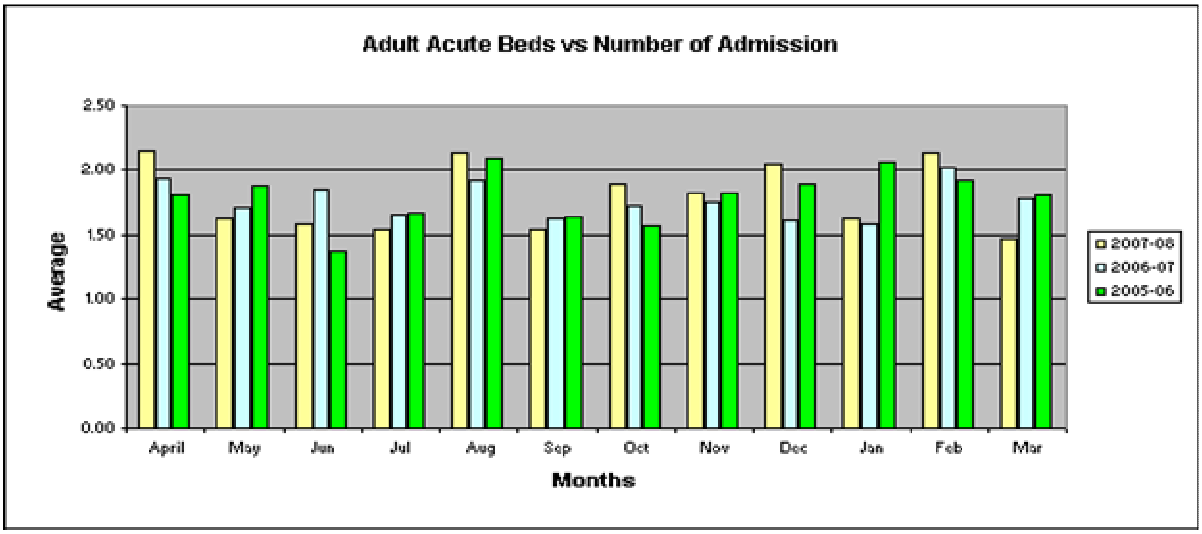
Comparing the use of inpatient beds in Haringey with other providers, the findings can be quite striking. In a recent benchmarking exercise it was found that Haringey uses up to four times as many beds per 100,000 weighted population than the lowest bed users nationally; almost twice as many as neighbouring boroughs and almost 20 more than one of its closest bed number comparators. Even after a further ward reduction, Haringey would have a higher number of beds than most other London providers.

Looking at these two factors; the high number of beds and the obvious demand for home treatment, there is evidence to suggest that limited provision at one point in the system is causing pressure and maintaining demand in another.

Haringey Adult Acute Beds

Acute Beds vs Number of Admission

HARINGEY	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Ave**
2007-08	2.15	1.63	1.58	1.54	2.13	1.54	1.89	1.83	2.05	1.62	2.13	1.47	1.80
2006-07	1.93	1.71	1.85	1.66	1.93	1.62	1.73	1.75	1.62	1.59	2.02	1.78	1.76
2005-06	1.81	1.88	1.38	1.66	2.09	1.64	1.57	1.82	1.89	2.06	1.92	1.80	1.79

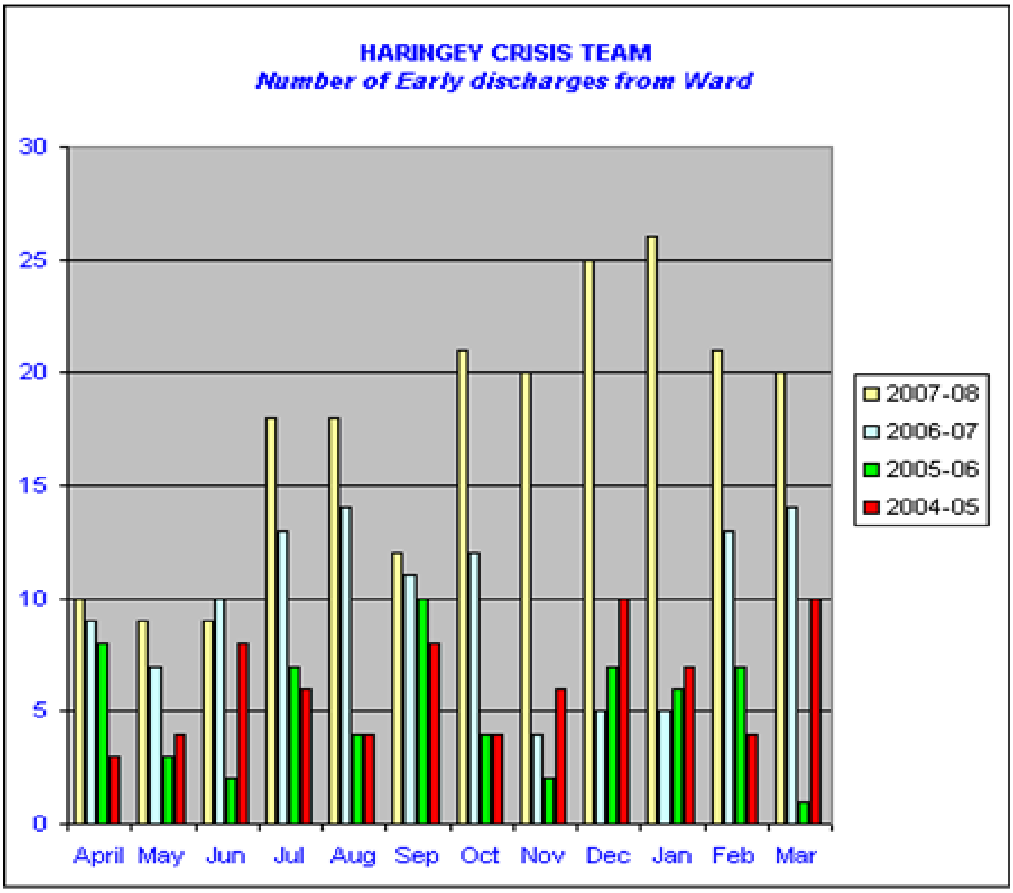


There is clearly an existing demand on beds but viewed alongside the capacity in the home treatment teams there is a suggestion that a shift of resource could enable more people to be treated at home and more could be supported to return home more quickly and safely following a stay in hospital. The fact that admission rates have stayed stable whilst bed numbers have reduced may support this.

Further evidence to support this suggestion is presented in the remainder of this document:

Number of Early Discharges from Ward		

HARINGEY	April	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2007-08	10	9	9	18	18	12	21	20	25	26	21	20	209
2006-07	9	7	10	13	14	11	12	4	5	5	13	14	117
2005-06	8	3	2	7	4	10	4	2	7	6	7	1	61
2004-05	3	4	8	6	4	8	4	6	10	7	4	10	74



CRHTT Staffing

CSIP recommends 14 wte Home Treatment staff per 100,000 weighted population. For Haringey this means there should be 38 wte staff working in the CRHTTs. Haringey currently operates with 23 wte.

Bed Usage

Current numbers of adult acute beds across Barnet Enfield and Haringey

Service	Barnet	Enfield	Haringey	Total
Adult acute	45	50	95 (excluding Lea ward (Edmonton))	190

The following identifies some targets for the suggested appropriate number of beds per population in a number of worldwide locations.

England – 16-20 adult acute beds per 100,000 (CSIP/NIMHE)

Canada – 18 adult acute beds per 100,000 (+12 rehab and EMI beds): 'Putting People First' 2003

Australia – 15-20 adult acute beds per 100,000 (National MH Report 2000 – Commonwealth Dept' of Health and Aged Care)

Oregon – 8 adult acute beds per 100,000 (Oregon Office of MH)

Vermont - 7 adult acute beds per 100,000

Applying targets of 16-20 beds per 100,000 weighted population suggests the following number of beds for Barnet, Enfield and Haringey.

16-20 Beds per 100,000

	Population	Local MINI score	Lower Range	Upper Range
Barnet	327,000	0.67	35	44
Enfield	283,000	0.93	42	53
Haringey	225,000	1.16	42	52

Using existing bed numbers in Barnet and Enfield as targets for Haringey also indicates a current high bed base in Haringey

Barnet & Enfield weighted for Haringey

Service model	Beds per 100,000 people	Local MINI score	Beds adjusted for Haringey MINI score	Total Haringey bed requirement
Barnet	14	0.67	24	54
Enfield	18	0.93	22	50
Current Haringey service	42	1.16	42	95

The following shows how this compares with some of the lower bed using areas nationally.

Northumberland, Tyne & Wear – 51 acute beds for 318,000 (16 per 100,000)

Norfolk & Waveney – 20 acute beds for 130,000 (15 per 100,000)
Service model based on an integrated team of staff working across in-patient and crisis/home treatment services

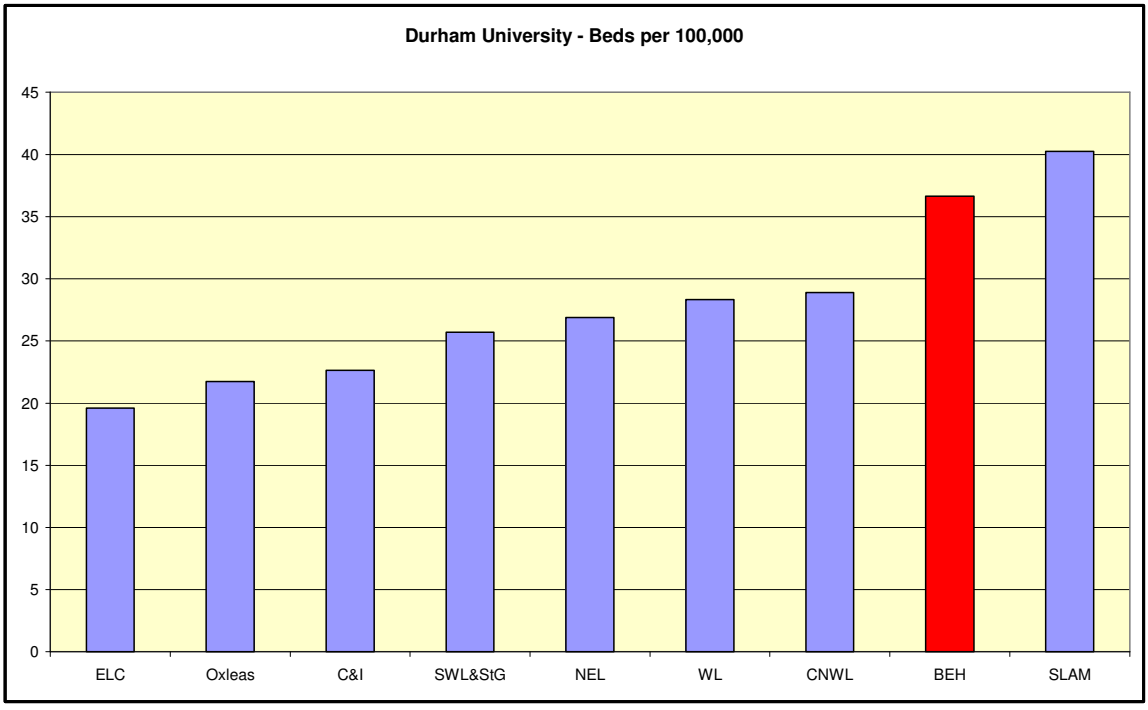
Tees, Esk & Wear - 20 acute beds for 152,000 (13 per 100,000)
Service model based on collocation of adult and OPMH wards and crisis/home treatment team.

Sussex (Worthing area) – 32 acute beds for 300,000 (11 per 100,000)
Service model based on collocation of 2 adult wards, 1 OPMH ward and crisis/home treatment team

Applying these best practice benchmarks to Haringey provides an even more marked illustration of bed usage to population.

Service model	Beds per 100,000 people	Local MINI score	Beds adjusted for Haringey MINI score	Total Haringey bed requirement
Northumberland,Tyne & Wear, Morpeth unit	16	1.09	17	38
Norfolk & Waveney, Lowestoft unit	15	1.14	15	34
Tees, Esk & Wear, Hartlepool unit	13	1.59	9	21
Sussex, Worthing unit	11	0.95`	13	30
Current Haringey service	42	1.16	42	95

It is also possible to benchmark the trust as a whole with other more local providers. Data collected by The Durham University as part of the annual mapping exercise demonstrates that BEH-MHT has significantly more beds, after adjusting for need, than all other London Trusts except the South London and Maudsley Foundation Trust.



The Trust has been able to obtain a borough breakdown of adult acute beds for the South London and Maudsley Foundation Trust (SLAM). It is interesting to note that SLAM's own figures show a total compliment of 329 adult acute beds, a figure that differs significantly from the numbers reported by Durham University (524).

BEH-MHT and SLAM's respective borough based bed provision is shown in the following table.

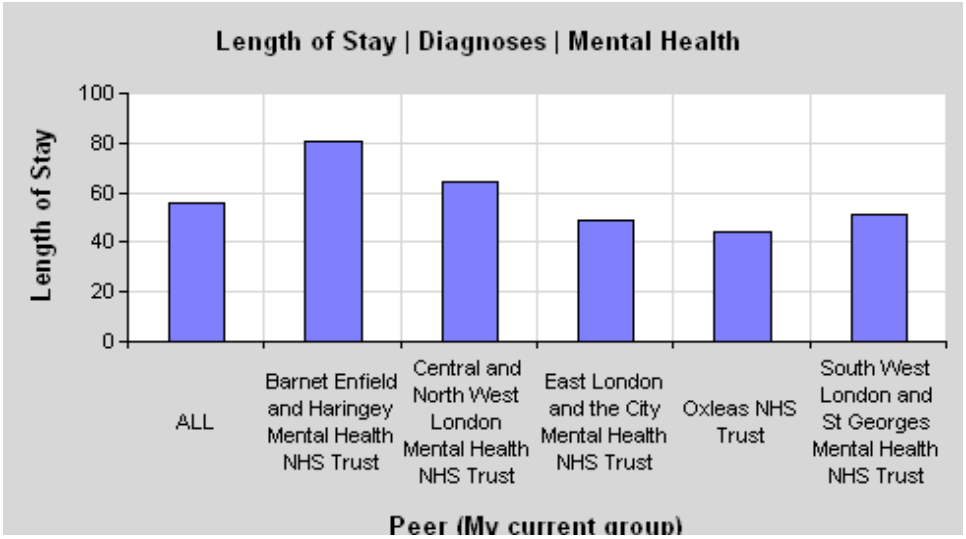
Service model	Beds per 100,000 people	Local MINI score	Beds adjusted for Haringey MINI score	Total Haringey bed requirement
Southwark	36	1..61	26	58
Lambeth	36	1.40	30	68
Lewisham	28	1.14	29	65
Croydon	23	0.76	35	78
Current Haringey service	42	1.16	42	95

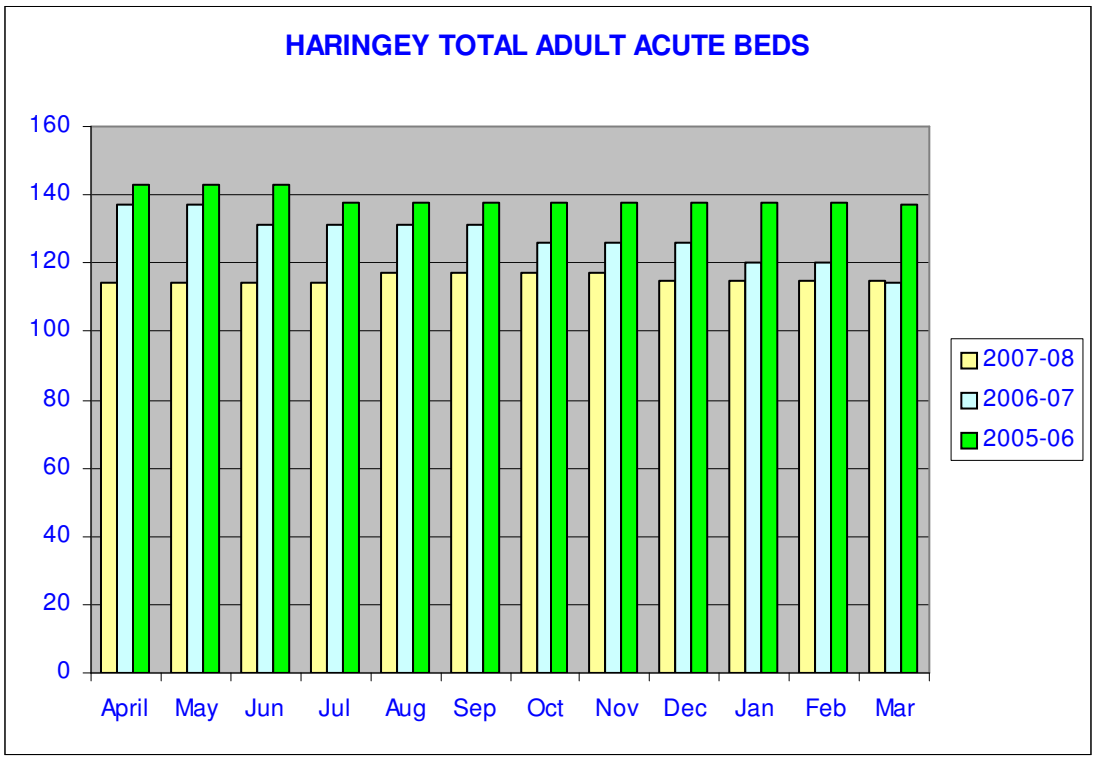
Length of Stay

Another factor which it is important to consider when comparing numbers of beds is the average length of time any individual stays in hospital during an admission.

Service	Length of Stay	Variance from Lowest
Barnet adult acute	52	N/A
Enfield adult acute	64	+ 23%
Haringey Adult Acute	76	+ 46%

Again, comparing the trust as a whole with other London Trusts the data suggests that individuals stay for longer in BEH-MHT.

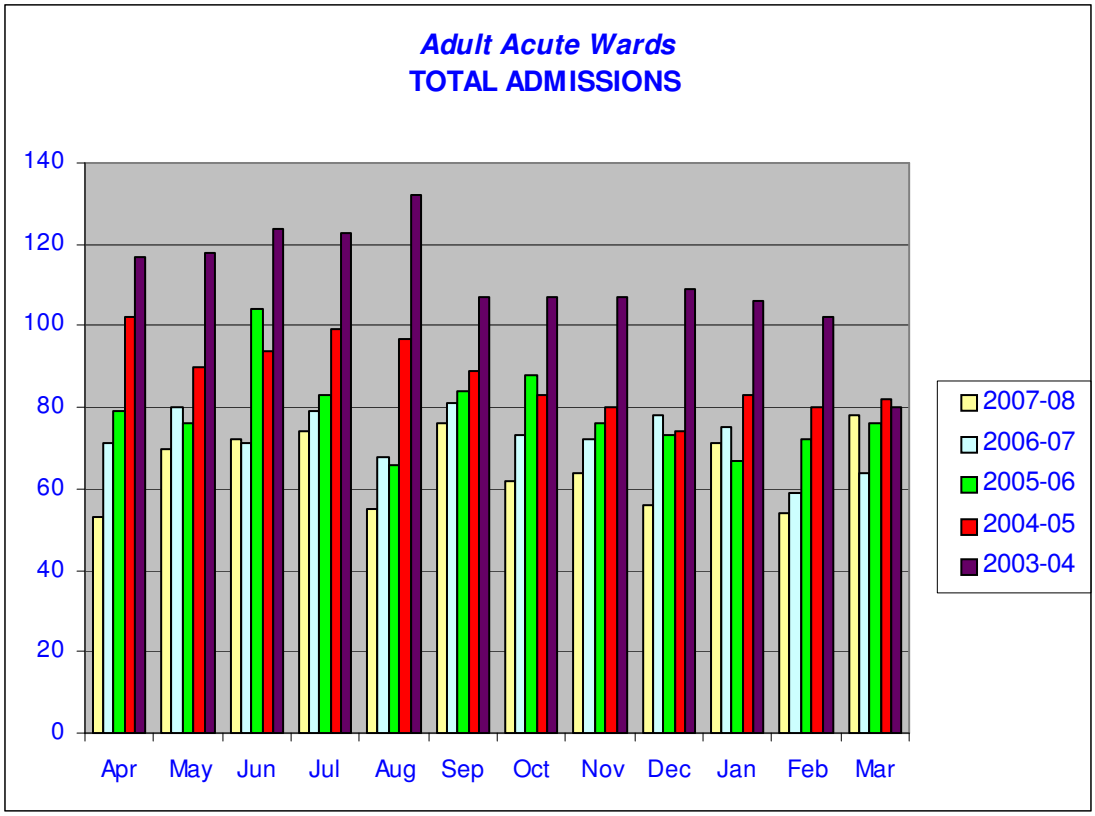




Note:

Theses figures do not include bed for PICU
Lea ward 20 beds is included although 5 of the 20 beds are for Haringey

			Changes in bed number		
2005/06	Beds	143-138	Wards were reorganised by sector		
		138-137	Lea ward reduced by 1 bed		
2006/07	Beds	137-131	Alexandra ward closed	-15	beds
	Beds		Lordship reduced beds by	-3	beds
	Beds		Finsbury.Northumberland/B. Castle increased +12		beds
	Beds	131-126	Lea & Downshill reduced beds	-5	beds
	Beds	126-120	Jan, Jubilee reduced beds	-6	beds
	Beds	120-114	March, Jubilee finally closed	-6	beds
2007/08	Beds	114-117	Aug, Increase beds due capacity issues	3	
		117-115	Dec, bed reduced	-2	



Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year Total
2007-08	53	70	72	74	55	76	62	64	56	71	54	78	785
2006-07	71	80	71	79	68	81	73	72	78	75	59	64	871
2005-06	79	76	104	83	66	84	88	76	73	67	72	76	944
2004-05	102	90	94	99	97	89	83	80	74	83	80	82	1053
2003-04	117	118	124	123	132	107	107	107	109	106	102	80	1332

Much of this information indicates that whilst home treatment activity has increased and bed usage has reduced there remain areas of challenge, particularly around the further reduction of length of stays. The information also indicates that capacity has been managed throughout the successful transition to a new way of delivering services. It also suggests that a further transfer of resource could deliver similar outcomes bringing the service closer into line with comparators.

Mental Health Strategy 2005-2008

All of this suggests that now is the time to revisit The Haringey Joint Health and Social Care Mental Health Strategy 2005-2008 and shift the focus of the service yet further along the strategic pathway already set and agreed nationally and locally.

This document laid down a clear strategy ‘to reduce the reliance on hospital-based care in keeping with the strategic aim of developing community based services and to improve the quality of care provided within in-patient services.’

Even when written, it was identified that there was an ‘over-reliance on outdated institutional forms of care’ and a need to redirect resource from in-patient to community care.

What the proposed closure of an adult acute in-patient ward will do is allow these aims to be achieved.

Redirecting some of the resource to improve the availability of home treatment staff is almost guaranteed to reduce length of stay and reduce the over-reliance on hospital beds, bringing Haringey closer to its comparators in these areas.

What it could also achieve is an improvement to the therapeutic environment on the remaining wards for those people who do need to come into hospital. Just as the Home Treatment teams could benefit from additional staffing, increasing the establishment on the remaining wards would help to reduce the current over-reliance on temporary staffing and support initiatives such as Protected Engagement Time and the Star Wards II initiative.

Service Model

Through carrying out this benchmarking it has become apparent that in a number of those areas where bed use is at its lowest, a similar type of ‘functionalised’ service model has been introduced. This has involved consultant psychiatrists focussing on one part of the care pathway.

This exists to some extent now in Haringey where there are dedicated consultants for the Start Teams, Home Treatment, Host and Antenna Teams.

For the Support and Recovery Teams, however, consultant time and responsibility remains split across the work in the community and that which needs to be undertaken on the wards.

It is envisaged that to enable a re-allocation of resources in the way discussed in this paper that a similar model would need to be introduced to ensure the best and most effective outcomes.

Current Situation

Preliminary consultations have begun with a number of staff and stakeholders.

Key to enabling the successful implementation of the model is to have the support of clinicians. There is much ongoing consultation with consultant psychiatrists about 'New Ways of Working' which would support and promote less restrictive forms of treatment and engagement.

Staff on Finsbury Ward in particular have also been identified for early consultation. If the proposal to close a ward and re-invest does move ahead this will have beneficial effects on the overall plans to refurbish a number of wards at St Anns Hospital. Identification of this ward would support early enablement and decant processes.

Further discussion is ongoing with service user and carer groups, through, for example, the Consultation Subgroup of the mental health partnership board as well as individual meetings with a number of representatives from those groups.

Other partners are signed up to this strategic development through the Mental Health Strategy 2005-08 and are involved in detailed discussion through, for example the MH Exec, about benefits or disadvantages to the mental health system overall.

The Overview and Scrutiny Committee will be meeting with representatives from The Mental Health Trust, The PCT and the Local Authority to gain a more detailed understanding of these proposals and advise on further consultation requirements.

Risk Management

The aim of this proposed resource shift is to increase capacity in remaining teams and services, supporting the delivery of increased opportunities for being treated in the community and delivering greater quality of services in the in-patient areas.

As staff will continue to be employed in the organisation, there remains flexibility to provide capacity and resource where most needed.

During the transition from ward to home treatment it will be possible to flex staff resource between in-patient and home treatment teams. This also means that if the model is implemented or piloted but found not to work there is always the option to reverse the decision, shift resource back and re-open additional in-patient beds.

Because of this ability to reverse or flex the arrangements the strategy carries a very low risk if the expected outcomes are not achieved.

Agenda Item 8

HARINGEY COUNCIL

Agenda item:

Overview & Scrutiny Committee **On 2 June 2008**

Report Title: **Developing World Class Primary Care In Haringey – Haringey TPCT Primary Care Strategy**	
Report of: **Chair of Overview and Scrutiny Committee**	
Wards(s) affected: **All**	Report for: **Non-Key Decision**

1. Purpose

To consider and comment on the latest update of the Haringey Primary Care Strategy

2. Recommendations

2.1 That the latest version of the Primary Care Strategy and the proposed ongoing consultation plans be noted

2.2 That the Committee submit comments thereon, as appropriate, and consider further engagement with the TPCT as part of the ongoing consultation process.

Contact Officer: **Rob Mack, Principal Scrutiny Support Officer**

Tele: **020 8489 2921** E-Mail: **rob.mack@haringey.gov.uk**

4. Reasons for any change in policy or for new policy development (if applicable)

Not applicable

5. Local Government (Access to Information) Act 1985

The background papers relating to this report are:

Response by the Overview and Scrutiny to Haringey Primary Care Strategy – October 2007

These can be obtained from Robert Mack – Principal Scrutiny Support Officer on 020 8489 2921, 7th. Floor, River Park House

e-mail: rob.mack@haringey.gov.uk

6. Report

6.1 Haringey Teaching Primary Care Trust (TPCT) originally set out its plans for the future development of primary and community health services in Haringey in June 2007. It's Primary Care Strategy proposed fundamental changes in the way in which primary care services were delivered within the Borough. Given the significance of the proposed changes, they were considered to represent a "substantial variation" to local health services by the Committee. There was therefore a requirement, under Section 7 of the Health and Social Care Act 2001, for the TPCT to consult formally with the Committee on this issue.

6.2 The Committee produced a detailed response to the strategy during the autumn. Whilst it was satisfied that the TPCT had engaged appropriately with Overview & Scrutiny Committee and that the TPCT had also provided sufficient opportunities for the public to participate in the strategy consultation process, it was of the view that the consultation did not provide sufficient detail to allow the public or the Panel to fully appraise the proposals or assess the likely impact of the planned changes.

6.3 The Committee had a number of additional reservations about the strategy, which were outlined in the response.

- It was noted that the current distribution of primary care services within the Borough was effectively unplanned. As the strategy lacked details as to how the nature, level and location of primary care services would be directed across the Borough, the possibility existed that those areas which are poorly served by primary care services and experience significant health inequalities would continue to be so. The Committee was therefore of the opinion that the TPCT should adopt a planned approach to the future structure and location of primary care services so that general practices were located where the need was greatest and in a manner that addressed health inequalities. Any incentives or encouragement that were to be offered to GP practices to relocate to super health centres should therefore be applied selectively so that services were distributed according to these principles.

- Further information was required on the proposed locations of super health centres and how these 'hubs' would operate and interact with remaining general practice 'spokes'. In addition, more detail needed to be provided on the anticipated number of GP practices that would be within the super health centres, as well as those remaining outside. Without this information, the Committee indicated that it was difficult to assess the full implications of the strategy and therefore provide a meaningful and constructive response.

- The Committee established from its visits to health centres in other London boroughs that having multiple GP practices in one building did not necessarily lead to either greater collaborative working or longer opening hours for

patients. This would be a challenge for the TPCT to address due to the semi independent nature of GPs and further work would have to be undertaken to ensure that it became a reality.

- The Committee had reservations about the financial framework to support the development of the Primary Care Strategy. Whilst it was clear that resources would be released through the centralisation of GPs in super health centres and through commissioning of secondary services through primary care, realistically these would only yield additional revenue in the medium to long term. Given the scale of the proposed developments, the Committee were sceptical that the level of new investment (£3.7 million) would be sufficient for delivering fully on the strategy. The Committee considered that a more detailed financial plan would be needed to be developed to fully appraise its viability.

- There was a need for there to be a clear monitoring and audit process to make sure that the planned outcomes were achieved, with full community involvement.

6.4 Despite these reservations, the Committee indicated their full support for the need to develop and improve primary care services in Haringey, particularly in the need to shape and deliver services to areas of greatest need but was unable to conclude that the principles and objectives of the Primary Care Strategy would necessarily be fulfilled and delivered on the basis of the plans or documentation submitted. The response stated that, until the additional information referred to was received, the Committee was unable to conclude that the proposals were in the interests of local health services.

6.5 The TPCT considered all the responses received as part of the consultation process and responded with a report to their January Board meeting. This outlined a number of significant proposed changes, which were to be included in the final strategy when it was produced. The report stated that the final strategy would be produced after taking into account the outcome of the "Healthcare for London" consultation and brought back to the Board for their decision in May.

6.6 The TPCT has now published an update to the strategy, which is attached. The strategy is considered by the TPCT to be one that will evolve and proposals for a period of consultation, both local and Borough wide, are included. The TPCT now intend to finally approve the strategy, as well as local plans, during the summer of 2009.

6.7 In the meantime, decisions are due to be taken in response to the "Healthcare for London" consultation by a Joint Committee of PCTs on 12 June and the results of this may also have an influence on the final strategy

7. Legal and Financial Implications

7.1 Whilst there are no direct financial implications for the Council, there are likely to be considerable long term indirect affects as the move to provide more healthcare away from hospitals and closer to the community has the potential to

place additional demands on social care services provided by the Council, for which no additional provision has yet been made.

8. Chief Financial Officer Comments

8.1 There are no anticipated financial implications to the Council. It is noted that the PCT are yet to finalise their financial intentions in relation to the Primary Care Strategy. This will need to be reviewed when further information becomes available.

9. Head of Legal Services Comments

9.1 The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (the Regulations) require the local NHS body to consult the overview and scrutiny committee where proposals for substantial development or variation in provision of the health service in the local authority area are under consideration. The proposals set out in "Developing World Class Primary Care in Haringey" would fall within these provisions and the Overview and Scrutiny Committee has made comments on the proposal accordingly. If the Overview and Scrutiny Committee is not satisfied that the consultation has not been adequate either in terms of content or time allowed, the Regulations allow it to make a report to the Secretary of State who may require the NHS body to carry out further consultation. Likewise, if the Overview and Scrutiny Committee considers that the proposals would not be in the interests of the health service in the Haringey area, the Regulations allow for a report to be made to the Secretary of State who may make a final decision on the proposal.

10. Equalities Implications

10.1 The TPCT's proposals aim to address the considerable health inequalities that currently exist within the Borough. In considering the strategy, Members of the Committee may wish to give particular attention to what extent they feel that the current plans have the potential to achieve this objective.

Appendix 1: Brief summary of changes made to strategy in response to consultation and EIA

Primary care strategy consultation document – key points and questions posed	Views expressed during consultation	Related outcome from EIA	How PCT proposes to take this forward
Clear case for change: outdated model	- Some wanted to see no change – happy with way things are - Some welcomed changes - OSC were convinced of need to develop and improve services. - Some wanted to see improvements in addition to existing services (e.g. add super health centres/DGH at St Ann's to current provision)	EIA highlighted existing issues re access e.g. current problems with transport to health services	No change is not an option, current model not sustainable, some current premises not fit for purpose. However need to acknowledge what people currently appreciate about their services e.g. continuity of care and that some single handed practices do perform well.
Outcome statements	Support for greater access to promotion/prevention services Continuity of care important	Suggestions for additions made by PHAST	Consider amending outcome statements as proposed by PHAST[1]

[1] (Add to 4.) That even if I have no regular or permanent address, I can still easily access screening programmes.

i. (Add to 13.) In my general practice consultation, I feel comfortable and receive respect for my cultural identity.
ii. In all services staff are aware of and sensitive to the way in which gender may affect accessing health care.
iii. That I can receive health care with the minimum of organizational barriers, in particular without an appointment even for non-urgent care, if that is a barrier for me.
iv. That general practice consultation times will be flexible to allow more time if I have difficulty understanding advice, gaps in knowledge about how to access services or the need to be more involved with decision making.
v. That services will be planned mindful of the work that users of each service will need to do, to access them.
vi. That services will seek to comply with recommendations of the Children & Young Persons and Older People NSFs, and in particular listen to and respect my concerns even if they seem to be inappropriate for the consultation.

Extended opening hours	Welcomed by some	Of particular benefit to those in employment and welcomed by young people	Aim to offer 12 hour and weekend opening hours (Aim to achieve extended opening hours in 2 sites during 0809)
Bringing wider range of services together more locally	Support for 1-stop-shop approach although concerns re waiting times and impersonal service from some Others welcomed idea of not needing to go to hospital	Flexible appointment systems can improve access for different groups Language services can be provided more effectively	Illustrate what services might be available and how organised in the new model
Need to continue to improve quality/clinical standards	Some satisfaction with current quality of care	Workforce competency around diversity and equality needed as well as clinical skill	Ongoing development of performance monitoring and management of primary care to ensure standards are maintained during transition period and improved as the strategy is implemented
Ensuring equity of access including vulnerable people	Concerns that there would be reduced continuity of care and increased travel which would disadvantage older and disabled people Concerns that people from deprived communities would not be served well	Range of recommendations made in relation to this including for example develop performance indicators that will measure progress on inequalities	Incorporate indicators around equalities in primary care strategy implementation and assign senior leader to oversee implementation of EIA recommendations.
Integrating services better, co-location and joint working e.g. with VCS	Support for this especially in relation to mental health and enthusiasm from VCS	Potential to improve access to a range of services	Include VCS and other providers in governance and stakeholder engagement arrangements.
Trade off between further to travel and more and better services	No clear consensus although many concerns about increased travel distance	Currently people experience travel problems. Any worsening of the situation would adversely affect certain groups more	Propose that the trade off is worth while and take steps to mitigate against greatest difficulties around travelling further

Acknowledging contribution of workforce	Need to ensure workforce have right skills including new skills needed to work in new model	As noted above competency around diversity needed as well as clinical skills, importance of role of receptionists and other non-clinical staff noted in promoting access to services	Develop detailed workforce strategy with involvement of staffside, clinicians etc
Links to other strategies	VCS noted need to link with wellbeing strategic framework Also to ensure needs of specific groups e.g. children and young people, mental health and people with learning disabilities are taken into account and services planned in conjunction with the strategic work underway in these and other areas	Key link needs to be between the primary care strategy and the strategic work to address health inequalities	Review other related strategies to identify common ground and how the primary care strategy can help deliver on these
6 super health centres proposed in Haringey	Queries raised as to if 6 would be enough (especially given that 2 are located outside the borough). Wish to retain other practices in addition to the new super health centres including concerns re Hornsey Central being sole provision in West of borough	Need to better understand travel issues and to mitigate against any particular difficulties faced by different groups	Go ahead with model of 4 super health centres within Haringey, 2 hospital-based, supported by network of other larger practices meeting set of agreed criteria.
Specific locations	Generally accepted locations specified with proviso regarding coverage/transport noted above	Need to ensure NE of borough has sufficient provision	Developments to be focused around the 4 collaborative areas, with the super centres sited broadly as set out in the original strategy but with networked practices providing "spokes" to these hubs to ensure appropriate coverage across the borough

Reduction to number of GP practices	Mixed views, concerns re reduction of service and travel	Transport issues raised	Number of single-handed GPs to reduce and substandard premises to be phased out over time, but retain networked practices as noted above
PBC	Few comments made	Not covered in detail	Strategy to be delivered through the PBC collaborative localities
Primary care contracting	Queries as to how GPs and pharmacists will be moved – concerns that they will not want to move and will be forced to do so	Not covered in detail	Further detail to be provided on contracting mechanisms likely to be used. Also further consideration of local governance arrangements for the networked super health centres
Role of community pharmacy	Concerns re affect on businesses, and potential loss of local pharmacies		Further work with LPC/local pharmacists to inform a pharmacy strategy
Transport	Biggest single area of concern	Big area of concern and will affect some groups more than others	A transport review to be carried out.
Premises	Some welcomed improvements to premises, comments made as to how to improve premises e.g. accessibility and comfort	Need to improve premises are not accessible. Design of new premises can help access especially for disabled people.	As noted above, substandard premises to be phased out. New build to be designed to high standard including in terms of accessibility
Financial strategy	Queries of the financial modelling and affordability, some concerns of LIFT and some opposition to privatisation/use of private providers	Reducing unplanned variations in services can help address inequalities. The financial strategy wasn't commented on in detail in the EIA process but the equity audit shows lack of link between need and resource allocation	All options to be explored in terms of financing new developments including ongoing liaison with the local authority Consider target re resource distribution more closely related to need
Engagement with stakeholders	Desire to influence the strategy	Need to engage range of stakeholders	Ongoing engagement in the overall strategy & in locality developments

Appendix 2: Summaries of consultation and EIA

Executive summary of Consultation

- The consultation was carried out on the Haringey Teaching PCT (HTPCT) Primary Care Strategy *Developing World Class Primary Care in Haringey* between 28 June and 19 October 2007. The strategy set out a new model for primary care service provision in the borough.
- The consultation was advertised in the local press, 8,500 summary documents were distributed and 57 consultation events were attended, including attendance at each of the local area assemblies, reaching an estimated 1000 people or more. HTPCT staff, public, patients, GPs, service providers from the NHS and the voluntary and community sector were all involved. London Borough of Haringey Overview and Scrutiny Committee engaged fully in the consultation.
- Questionnaires were received from 123 individuals, formal responses were received from 17 local organisations and a range of views was collected from the consultation events.
- An equalities impact assessment was carried out to see what impact the primary care strategy might have on people who experience discrimination, disadvantage or are socially excluded in Haringey.
- There was general support for the aims of the strategy and some of the changes proposed within it, in particular the need to tackle inequalities, improve primary care across the board and ensure better integration and range of services available locally. 50% of those who completed the consultation questionnaire felt that the proposed changes would meet the needs of themselves and their families, although about half of this group qualified their response with comments on aspects of the strategy. However, many concerns were raised about the delivery model itself, particularly in relation to access and travel to services. Many of these concerns centred around longer and more difficult journeys to see a GP. These concerns were particularly strong amongst older people, who were well represented in terms of attendance at events and contributing their views on the strategy.
- Whilst some people wanted to see no real change to the current provision of primary care services, others were in favour of a model that would provide super health centres alongside a number of larger practices. It was noted that this could make good use of the existing modern facilities and would have less of an impact on travelling distance if they were geographically dispersed across the borough.
- The consultation document was explicit that the super health centre model would involve a trade off between having further to travel to get to primary care services and a wider range of services in better premises at more convenient times. There was no clear consensus as to the benefit of this trade off. Although many concerns were expressed about the increased travel, others could see the benefits of

the proposed model. Should this model be adopted, further work will be needed to mitigate the problems identified around travel, particularly for vulnerable people.

- The TPCT fully engaged with Haringey Overview and Scrutiny Committee (OSC) during the consultation. The formal response from OSC stated that it was satisfied with the nature and extent of the consultation and was convinced of the need to develop and extend primary care services. However, the OSC had some reservations and wanted to see further details regarding the model and planning, including financial planning before it could decide whether the proposed changes were to the benefit of local health services.
- The results of this consultation will now be considered by HTPCT and used to inform the final primary care strategy.

Executive Summary of Equalities Impact Assessment

- An equalities impact assessment (EIA) was carried out to see what impact the primary care strategy, *Developing World Class Primary Care for Haringey*, might have on different groups and communities in Haringey that may experience discrimination, disadvantage or social exclusion.
- A structured process was followed which included seeking advice from the London Borough of Haringey Equalities and Diversity Team and the Haringey Public and Patient Involvement Forum and PHAST an independent public health organisation.
- It was agreed that the EIA would focus in its initial phase on the implications for access to primary care given stakeholder expressed concerns about the effect of the proposed changes to primary care premises and evidence of the impact access has on health inequalities.
- The methods used to assess the strategy were a rapid review of the evidence, an equalities event with local community groups and focus groups.
- The results of the EIA indicate that the primary care strategy could have a positive impact on and improve access to primary care for Haringey residents if implemented with appropriate care and attention to equalities groups.
- The EIA also indicates that the primary care strategy could have a negative impact or reduce access to primary care if the implementation of the strategy means that travelling to health services is made more difficult, or current barriers to access for equalities groups are made worse. This will have a disproportionate impact on people with mobility problems including older people, disabled people and those on low incomes if they incur additional travel costs.
- There are a number of issues that need to be considered to ensure implementation of the primary care strategy improves access, these

are outlined in the mitigating actions and recommendations in the main report.

Appendix 3: Who uses primary care and why?

Everyone uses primary care, but the very young and older people are more likely to need primary care services. Young men are the least likely to access primary care. In the UK, 6 out of 10 adults report having a long-term condition that cannot currently be cured. People with long-term illnesses often have more than one condition, making their care even more complex and it has been reported that 80% of primary care consultations in the UK are related to long-term conditions[2].
Data from the surveys reviewed have shown that:

- The average number of NHS GP consultations per person per year has remained relatively constant over time at between four and five (4 -5) between 1972 and 2005[3].
- Use of general practice is high in pre-school children who visit their GP six times a year on average[4].
- Females consult more frequently than males with 6 and 4 visits per year respectively.
- Visits to primary care increase with age with people aged 75 or more attending an average of 8 times per year.

Data from the UK MEDIPLUS database showed that in 2003 the three commonest reasons for consultation were:

- respiratory illness (27.5% of total consultations for all ages)
- skin diseases (19.6%)
- bone and muscle diseases (19.5%).

Additionally there is evidence that approximately 30% of all primary care consultations have a mental health component.[5]

[2] Chronic disease management: A compendium of information. London. Department of Health, 2004
[3] Living in Britain. The General Household Survey 2002, published 2004 (on ONS website)
[4] Department for Education & Skills & Department of Health. National Service Framework for Children, Young People and Maternity Services. 2004.
[5] Goldberg D & Huxley P *Common mental disorders: A biosocial model (Routledge 1992);* Foster, 2003. Availability of Mental Health services in London. GLA.

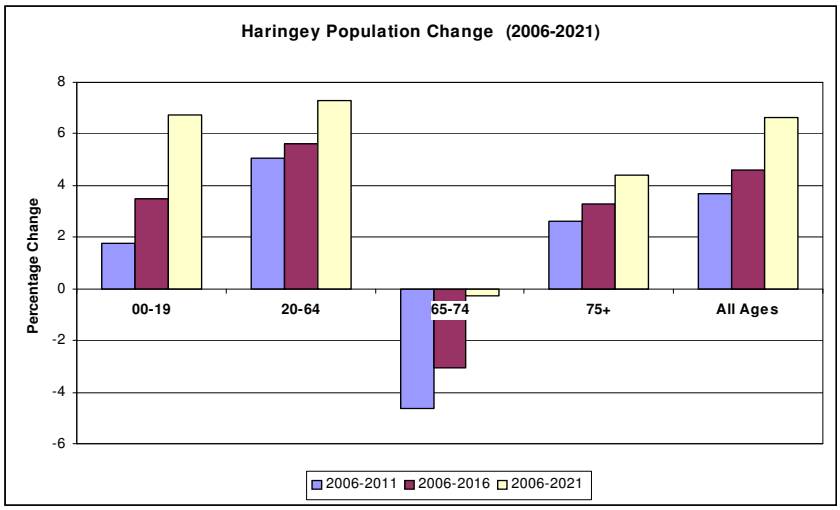
Appendix 4: The people of Haringey and their health needs

An understanding of our population and how it may change in the future is fundamental to developing our understanding of health services in Haringey. We need to ensure that the way we plan our health services responds to the needs of our population. More information is available in our Annual Public Health Report, available at www.haringey.nhs.uk.

Demographic changes

The current estimate of the resident population is 223,968. Haringey has a young population with a high birth rate. The population is set to increase over the coming years, with increases across all age groups with the exception of the 65-74 group which is set to decrease and then return to similar levels by 2020 (Figure 6). By 2021 the population is predicted to have increased to 237,700 (GLA estimates, Haringey APHR, 2006), with much of the growth predicted to take place in the East of the borough. We do not have the capacity within our primary care services as they are currently configured to meet the projected population growth.

Figure 6



Source: LRC

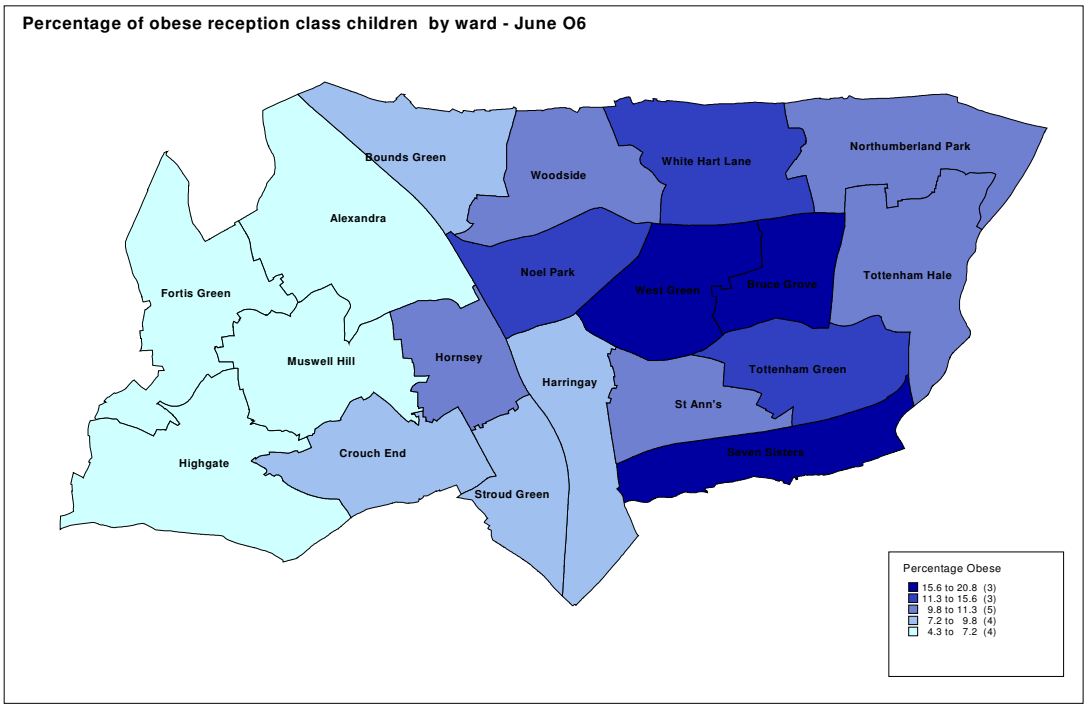
The registered population is somewhat larger and as at November 2005 there were 264,988 people registered with a GP practice in Haringey. Of these 24,600 (9.3%) lived outside the borough, over 90% of whom live in Enfield. We do not have access to data about how many Haringey residents are registered with practices outside Haringey currently.

Deprivation and health outcomes

Haringey has a very diverse population, with many people at risk of ill health, related to poverty and deprivation. The most deprived, at risk populations tend to live in the east of the borough, but with some pockets of risk in

Hornsey. This pattern can be seen when looking at health risks such as childhood obesity (Figure 7).

Figure 7



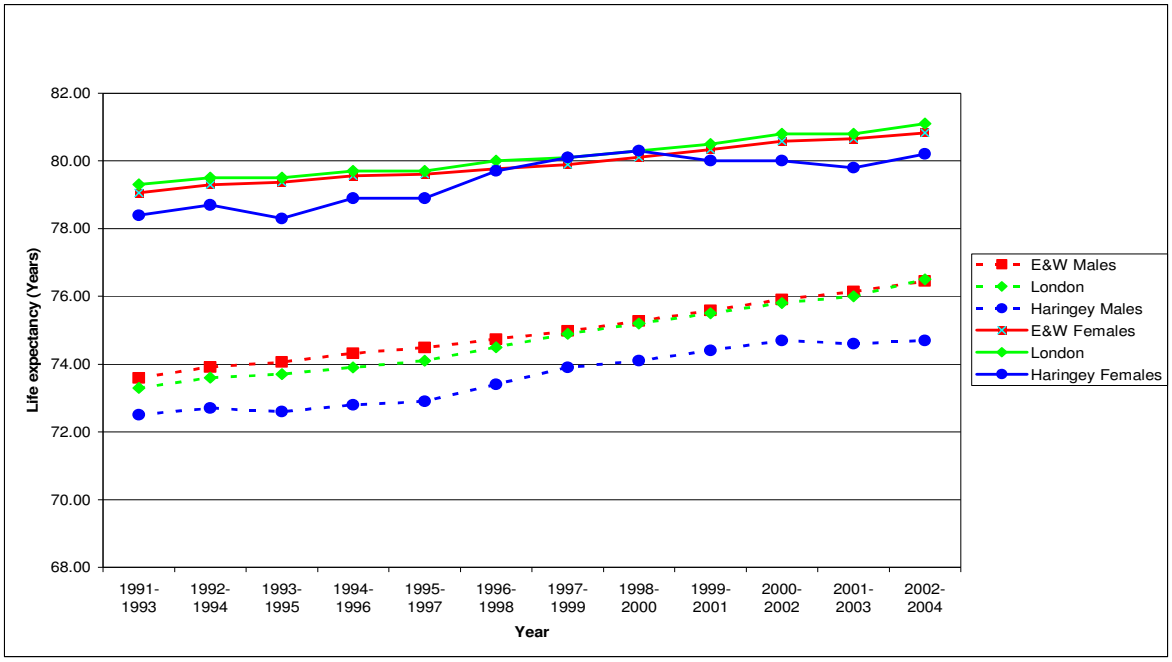
Haringey also has a broad ethnic mix and the proportion of people from minority ethnic communities is set to increase, with more people from BME communities in the older age groups. This will have implications for long term conditions, although the overall proportion of people aged 65-74 is set to decrease, a greater proportion of older people will be from communities who are more at risk of conditions such as cardiovascular disease, diabetes, hypertension and renal failure. The proportion of people aged over 75 in the West of the Borough is also forecast to increase. In addition there are high numbers of refugees and asylum seekers who are particularly vulnerable.

Morbidity and mortality

Over recent years Haringey's life expectancy has tended to increase, particularly for men, but this increase has not reduced the gap in life expectancy between Haringey, London and England and Wales (Figure 8). People in Haringey live longer than they did over a decade ago but on average they die younger when compared to the population of England.

Overall there is wide variation across the borough with the east of the borough having higher death rates and lower life expectancy than the west. White Hart Lane and Northumberland Park have the lowest life expectancy for women and Tottenham Green, Northumberland Park and Bruce Grove for men. Recent data suggest that the death rates in the east have decreased more than those in the west, perhaps showing a start to reducing inequalities.

Figure 8 Trends in Life Expectancy in Haringey compared to London and England (1991-2004)



Source: ONS/LHO

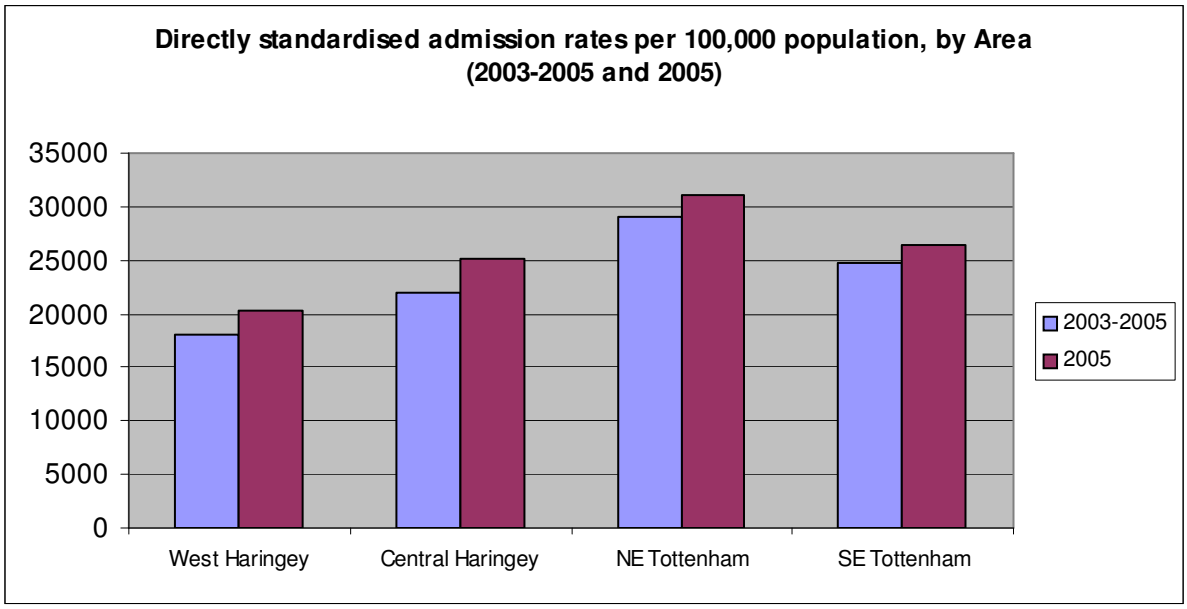
Health Service Use

Health service use is one indicator of health care need. Disease registers in primary can provide estimates of the number of people who have certain long-term conditions such as diabetes. For most conditions, disease registers in Haringey suggest a lower number than we would expect from national studies and data. This may in part be due to undercounting.

Inpatient admissions

Between April 2005 and March 2006 there were 48,380 admissions to hospital for Haringey residents. The rate increasing since 2003/04 and 2004/05, much of this accounted for by planned admissions. People living in the North East Tottenham area had the highest admission rates and people living in the West Haringey the lowest (Figure 9).

Figure 9



Source: Clearnet

The most common reasons for admission to hospital for Haringey are heart disease and stroke, genito-urinary disease, renal failure and cancer. Patterns of admission for selected causes vary considerably between different parts of Haringey with the West having consistently lower admission rates for all conditions except for cancer, where it has a low death rate, and falls. North East Tottenham area appears to have much higher rates of admission for heart disease and stroke than the rest of Haringey. South East Tottenham has the highest rates of admission for genitor-urinary disease, renal failure and sickle cell. Central Haringey has the highest rate of mental health admissions.

The likely reasons for these variations are complex and are likely to include both real variations in health need (for example associated with deprivation) and demand for health services in terms of what people ask for (with people from more affluent areas tending to have higher expectations about the services they should be able to access). It also likely however that these variations also reflect different capacity and capability in primary care services to prevent, identify and treat ill health.

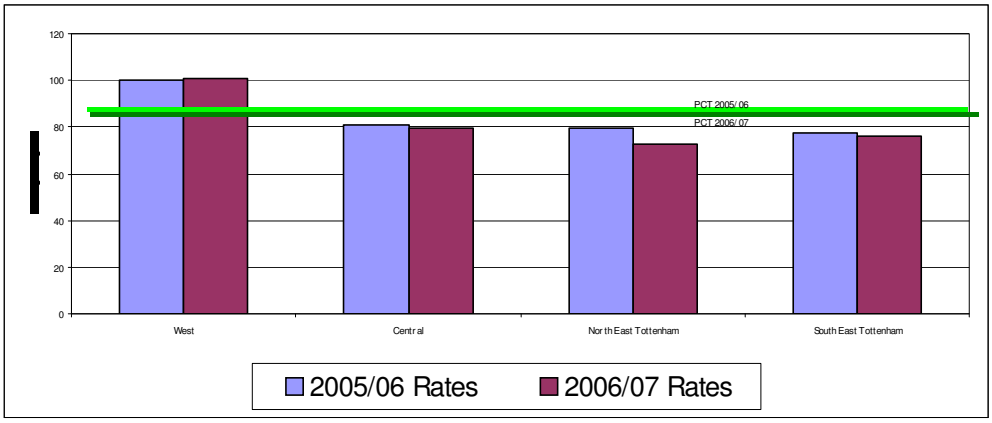
Outpatient Care

National benchmarks have demonstrated that more outpatient appointments take place for people registered with Haringey GPs than one would expect. Around half of 1st outpatient appointments are initiated by the patients' GP, the vast majority of the other half being initiated by hospital doctors and dentists. In contrast to hospital admissions, the rates for GP referred 1st outpatient attendance, which can be used as a proxy for GP referral patterns, reveal the west of Haringey to have the highest referral rate. The most

common specialties were gynaecology, general surgery, ear nose and throat and ophthalmology (eyes).

Figure 10 GP referred 1st out patient attendance per 1,000 population

(Month 10 of 2005/06 and 2006/07)



Appendix 5: What patients want

There is strong evidence to support the theory that interpersonal continuity is associated with better health outcomes and lower costs[6]. Patients want both quick access and relationship continuity from primary care[7]. Much of the evidence from published studies suggests patients place more importance on continuity of care than speed of access, especially if they are older and sicker. However, people are more willing to sacrifice relationship continuity for minor or short-term problems in order to be seen quickly.

Patients who are unemployed, from a non-white minority ethnic community or socially isolated are more likely to have problems getting what they want from primary care.

The information from public consultations, involving much larger numbers of people making a concerted effort to include the views of many hard to reach groups, seems to place more importance on speed of access with a strong desire for more responsive services with fast and convenient access. Having a wider range of times when services are available appeared as a priority. However, relationship continuity remained an important issue.

A MORI survey of over 7000 Londoners revealed that Londoners gave their GP services a lower net satisfaction rating than people nationally. This corroborates the findings of the London listening event conducted as part of the Your Health, Your Care, Your Say consultation, where people spoke of difficulty booking GP appointments in advance or being seen outside normal working hours. They could also only rarely speak to GPs directly by phone and tended to only get reactive, rather than proactive care. [8]

We have also heard much from patients and residents of Haringey in response to this consultation about what they want from primary care services. This is set out in detail in our consultation report and Equalities Impact Assessment Report in Appendix 2. Key requirements expressed during consultation included:

- Continuity of care – the ability to continue to see the same GP over a period of time
- Access – being able to easily get the right services when needed and not just during the day on weekdays and to be able to get to these services without long and difficult journeys
- Services – being able to get a range of services in a more co-ordinated way

[6] Saultz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. Annals of Family Medicine (2005) Vol3: 159-166

[7] Department of Health, Briefing Paper, The Access/Relationship Trade off: how important is continuity of primary care to patients and their carers, September 2006.

[8] Report from London user group Your Health, Your Care, Your Say – quoted from London Strategy.

- Equity – being able to get the services that are needed rather than those that happen to be available.

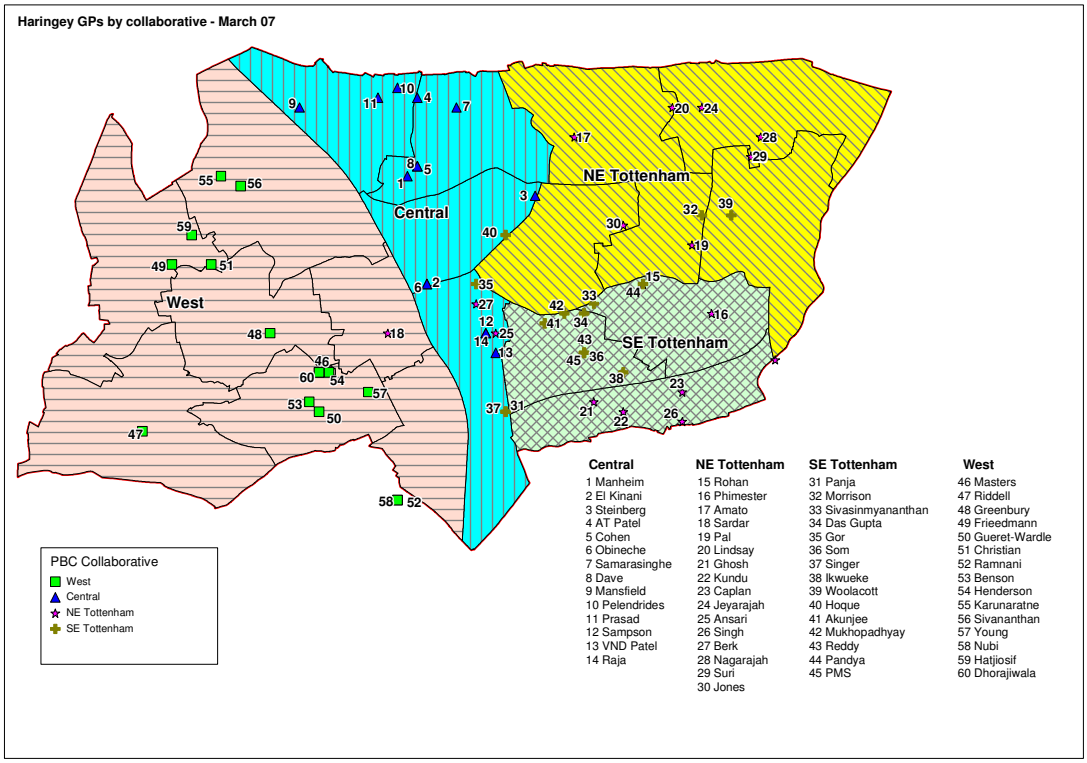
These findings from our local consultation reflect what we already know about what patients say they want from a primary care service from published studies and other public consultations as set out above. Much of the work on seeking patients' views has focused on accessibility and continuity of care and the tensions between the two. Overall public consultation suggests that although continuity is important, people want different approaches for different conditions and at different times in their lives. For example, for an older person with a long-term condition continuity is important, whereas for a younger person with an acute problem access and convenience are more important.

The service model we want to adopt is intended to resolve the tension described above by providing both better access in terms of opening hours/appointment systems/availability of a wider range of services in primary care and by ensuring that there is continuity of care not only in terms of choice of GP but also through better integration with community and hospital services and shared service user assessment regimes for children and older people with Haringey Council.

Appendix 6: Current GP services in Haringey

There are 60 practices in Haringey, structured around four geographical patches: A (West Haringey) B (Central Haringey), C (North East) & D (South East). There are 15, 18, 14 and 13 practices in patches A, B, C and D respectively. Geographically, patch D is the smallest.

Figure 11 Geographical distribution of practices



Practice populations

Table 1 shows the variation in the number of individuals registered with individual practices across the 4 patches described above. Numbers range from 1,120 to 15,686 people per practice. 8 practices have list sizes greater than 8,000 patients currently, 14 practices have registered populations between 4,000 and 8,000 patients, and 37 practices have list sizes of less than 4,000 of which 6 practices have list sizes of less than 2000 patients.

Table 1 List size by patch & range for practices in patches

Patch	Nos of Practices	List Size	% of total Registered	Range
A (West)	15	74,736	28.2	1,380-14,655 **Average 4,982**
B (Central)	17	75,782	28.61	1,165 – 15,686 **Average 4,457**

C (North East)	14	74,817	28.23	1,650-11,563 **Average 5,344**
D (South East)	13	39,653	14.96	1,120 –4,528 **Average 3,050**
All practices	**59**	**264,988**	**100**	**1,120 – 15,686 Average 4,491**

There are significant variations at practice level in the age, ethnic and deprivation profiles of practice populations. These are summarised below.

Where these data are not directly available at practice level (e.g. ethnicity / deprivation) the figures have been attributed according to area of residence based on the 2001 Census. The methodology is explained in more detail in the Health Equity Audit.

- Under 5's make up 5.1% of the total practice population, the range at practice level was from 2% to 9%.
- Over 65's make up 9% of the total practice population, the range at practice level was from 2% to 18%.
- Approximately half of the registered population are from a black or ethnic minority, ranging from 31% to 76% at practice level.
- 31% of the population of Haringey live in an area amongst the most 10% deprived nationally. At practice level this ranged from 0% to 79% of a registered population with practices in North East Haringey having the highest proportion of people living in the most deprived areas.

Age, sex, ethnicity and deprivation all influence demands on primary care. For example boys aged 5-14 years of age are associated with the lowest workload, whilst women aged 85 years and over are associated with the highest workload. Ethnicity is associated with higher prevalence of some conditions and deprivation with poorer health.

Based on the figures highlighted above it is clear that there are likely to be substantial variations in need, demand and workload between different practices based on the characteristics of their registered populations.

Geographical distribution of practice lists

While people state the wish to have a GP practice near their home, analysis shows that many Haringey people attend a GP practice in a different post-code area (e.g. N15) to the one they live in. One fear commonly expressed about NHS change is the loss of a "local" service. This analysis seems to show that most people are living without that service now – and in many cases do so through choice.

The size of a practice's "catchment area" is largely defined by the need to ensure the full range of medical services, including home visiting (GP or

nursing) to all patients. Plainly, the size of the primary care team also plays a part.

Access

All Haringey GP practices are open to new registrations within their catchment area, and offer appointments to see a GP within 48 hours and a primary care professional within 24 hours. However:

- There is significant variation in the number of hours per week that Haringey practices have a GP available for patient consultation, ranging from 6 practices that offer more than 40 hours per week, through to 27 practices offering less than 20 hours per week
- Each month, between 20-30 patients, who have been unable to register with any practice within their area, require allocation to a practice list
- No Haringey GP practices offer patient services on Saturdays or Sundays.

Out of Hours provision

The core hours for the provision of routine GP services are Monday to Friday, 08.00-18.30 hrs. The periods from 18.30 through to 08.00 hrs on Monday to Friday, and all day on weekends and bank holidays, are deemed to be 'out-of-hours'. During the out-of-hours period all patients who are registered with a Haringey GP practice can receive care for urgent primary care needs from a local GP co-op, Camidoc.

Appendix 7: Resource allocation

In 2006 the TPCT undertook a Health Equity Audit that reviewed resource allocation to individual practices relative to the anticipated level of health need amongst the patients registered with a particular practice. This demonstrated that there is significant variation in resource allocation to different practices that reflect historical patterns but not patient needs. Whilst it is possible to draw out some key themes and patterns from these data, as set out below, the most significant point to note is that overall there are huge variations between practices for no apparent reason. It is intended that in the medium to long term, the primary care strategy will enable a more equitable distribution of resources.

HTPCT commissions primary care services from GP practices using two distinct contractual arrangements – the General Medical Services (GMS) contract and the Personal Medical Services (PMS) contractual framework. The nationally agreed GMS contract is used to commission 28 practices. The payment formula takes the practice population into account in terms of age and sex, mortality and morbidity and delivery of services in high cost areas. The PMS contract is used to commission 31 practices in Haringey and contracts are individually agreed.

The key finding of the equity audit related to inequity of resource allocation based on the type of contractual framework in place – this analysis clearly demonstrated that PMS practices are, on average, significantly better resourced than GMS practices – both in absolute terms and when weighted for workload or deprivation. (Although as noted above there are significant variations within this – with the lowest resourced PMS practice receiving substantially less funding than the highest resourced GMS practice)

When analysed in more detail the audit demonstrates:

- In all three scenarios (i.e. unweighted, weighted for workload and weighted for deprivation) there is a more than 100% variation in the level of funding to the lowest resourced practice relative to the highest resourced practice.
- In all three scenarios there is a markedly higher level of resource on average to PMS practices than to GMS practices. When weighted for deprivation the range is 0.86 for GMS practices vs. 1.12 for PMS practices. (I.e. for every 86p a GMS practice receives on average a PMS practice receives £1.12)
- In all three scenarios Central Haringey practices are relatively less well resourced on average compared to practices in other localities (c. 5% lower resource per patient on average).
- In all three scenarios practices in South East Haringey receive above average proportion of available resource, although when weighted for deprivation the difference is relatively low (+1%). It is highest when

weighted for workload (+11%)– reflecting the age profile of the population.

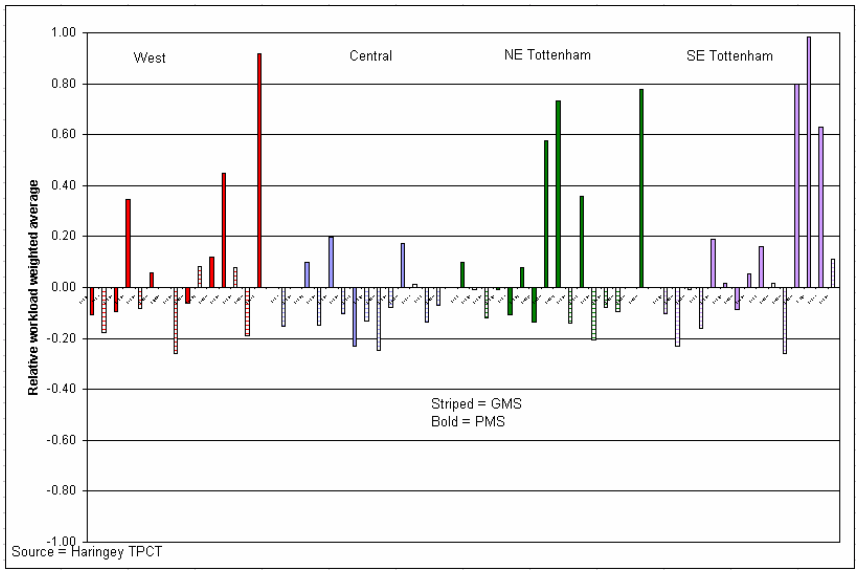
- When lists are weighted for deprivation practices in North East Haringey are on average relatively less well resourced than practices in other areas of Haringey.

Table 2 Summary of resource distribution relative to list size, workload and deprivation, by contract type and locality.

	Revenue per patient		Workload weighted revenue per patient		Deprivation weighted revenue per patient	
	av	range	av	range	av	range
GMS	0.87	0.68-1.22	0.87	0.74-1.08	0.86	0.68-1.30
PMS	1.11	0.80-1.87	1.10	0.77-1.98	1.12	0.77-1.82
West	1.00	0.80-1.80	0.97	0.74-1.92	1.09	0.86-1.82
Central	0.95	0.68-1.31	0.94	0.75-1.20	0.95	0.68-1.32
North East	1.03	0.77-1.71	1.03	0.74-1.78	0.96	0.72-1.62
South East	1.05	0.79-1.87	1.11	0.79-1.98	1.01	0.75-1.78
ALL	1.00	0.68-1.87	1.00	0.74-1.98	1.00	0.68-1.82

NB: figures quoted are a ratio and not absolute £ numbers.

Figure 12 Workload weighted revenue per patient (October – December 2005) as per current collaborative groupings



Appendix 8: Clinical Quality

There is no clear, simple way to measure quality of clinical service in primary care but there are a number of indicators that we can use as a proxy to illustrate how well practices are serving their populations. It is important to consider this information in the context of the information highlighted above – i.e. whilst there is a significant range in performance between different practices this may reflect to a greater or lesser degree the variations in need, demand, workload and resourcing that the analysis above demonstrates.

Cervical Cytology uptake. The National target for Cervical Cytology uptake is 80% - this target was met by 20 of our practices as at September 2006. However for 9 practices the uptake was less than 60%, with three practices achieving 50% or less and one practice achieving less than 40%. The poorest performers were in Central and North East Haringey.

Flu Vaccination 65+. The National target is 70% - this was met by 23 of our practices. Six practices reported less than 50% uptake and 2 practices have not submitted any data.

Quality and long term conditions – Diabetes as an example.

Chapter 6 of the annual public health report looks in detail at the information available to us about how well practices are performing in relation to diabetes. This is a condition that increasing in prevalence nationally and is a significant local health problem. There is potential to prevent diabetes and conditions such as renal failure and blindness that can result from diabetes. All practices are required to keep a register of their patients with diabetes. Recorded prevalence ranged widely between practices from 1.5% to 7.7% - whilst this is likely to reflect true variations in levels of morbidity between practices it is also likely to be a reflection of variation in practice and systems between practices.

There is some evidence from QOF data that Haringey practices are performing slightly less well than the London average in relation to identifying patients at risk of kidney failure. This is an area of concern for Haringey where we have a population with relatively high levels of risk for kidney failure due to ethnic mix and high rates of admission to hospital. Beneath these figures there is a wide range of performance across practices – including significant variations in recorded prevalence, % tested for risk of renal problems in previous 15 months and % with diagnosis who then receive appropriate drug therapy.

Prescribing – Prescribing drugs is the single most common medical intervention. In Haringey, 2.5 million prescriptions are written each year. Like other areas of medical practice, there are significant variations in what is prescribed and in what circumstances. In common with other London PCTs, Haringey GPs prescribe less than the national average.

There is a 3-fold variation of spend per patient between Haringey GPs, after taking into account list sizes and demography. This can only be explained by a different approach to prescribing by individual GPs, and work is ongoing to

reduce variations so that all GPs prescribe in line with best practice. In some cases, this will mean making more cost-effective choices and prescribing from a smaller range of the most cost-effective medicines. In others, it will mean increasing the amount of prescribing in, say, drugs for disease prevention e.g. more treatment of high blood pressure and cholesterol levels to prevent heart attacks and strokes.

Appendix 9: Primary care premises

There are significant variations between practices in terms of the quality and quantity of clinical accommodation available to them for the provision of services. Of the 57 premises (including 4 health centres) from which GP services are provided, 31 have been assessed as falling below minimum standards. Of these, 23 premises are owned by the GP practice, whilst the other 8 premises are leased by the GP practice from an external landlord.

A BMA survey in 2006 found that almost 60% of London GP practices felt their premises were not suitable for their present needs and this rose to 75% when asked about their future needs.[9]

[9] BMA Health Policy and Economic Research Unit – Survey of GP practice premises, London 2006. (Quoted from London Strategy)

Appendix 10:
Review of evidence – what works in primary care?

A review of the available literature suggests that there is not a great deal of evidence around what "works" in primary care (i.e. promotes optimum health and clinical outcomes) and much of the evidence is conflicting. Larger practices appear to be better for clinical quality and poor quality is associated with deprived areas. Literature on models of primary care also suggests that there is no one clear model which delivers quality. For example, models which deliver relatively high levels of continuity and effectiveness may not provide accessibility. However, there is some evidence that some practices can deliver high quality and the challenge is to ensure that we commission right type of practices and develop quality markers to test this.

The way that we intend to develop services in Haringey will draw on what we know about what works, and will provide an opportunity for services to perform to a high quality.

Perhaps one of the best means we have of comparing quality is the national Quality and Outcomes Framework (QOF), which was introduced in general practice in 2004. The QOF is not a quality measure in itself, but enables payments to be made to general practices according to achievement in caring for patients with certain long-term conditions. The QOF measures achievement against 146 quality indicators, 47 of which relate to clinical quality. Nationally:

- Higher QOF scores[10] were related to training practices, group practices and practices in less socially deprived areas. Social deprivation predicted lower quality.

Other studies suggested that:

- Smaller practices had shorter average consultation lengths and reduced practice performance scores compared with larger practices[11], but there was a balance to be made around individual GP list size[12].
- There was no association between practice size and the quality of care of patients with ischaemic heart disease[13]
- Smaller practices scored better than larger ones for access to care, but for diabetes care, larger practices had higher quality scores than smaller ones[14].

[10] Ashworth M, Armstrong D. The relationship between general practice characteristics and quality of care: a national survey of quality indicators used in the UK Quality and Outcomes Framework 2004-5. BMC Family Practice 2006, 7:68

[11] Campbell J, Ramsay J, Green J. Practice size: impact on consultation length, workload and patient assessment of care. British Journal of General Practice, 2001, 51: 644-650

[12] Campbell JL. The reported availability of general practitioners and the influence of practice list size. British Journal of General Practice 1996; 46:465-468

[13] Majeed A, Gray J, Ambker G, CarrollK, Bindman A B. Association between practice size and quality of care of patients with ischaemic heart disease: cross-sectional study. BMJ 2003; 326:371-372

[14] S M Campbell, M Hann, J Hacker, C Burns, d Oliver, A Thapar, N Mead, D Gelb, Safran, M O Roland. Identifying predictors of high quality care in English general practice: observational study. BMH (2001) Vol 323: 1-6

This suggests that there is not one type of practice that provides high quality primary[15].[16],[17] care overall. Larger practices appear to be better for clinical quality and poor quality is associated with deprived areas.

[15] Majeed A, Gray J, Ambker G, CarrollK, Bindman A B. Association between practice size and quality of care of patients with ischaemic heart disease: cross-sectional study. BMJ 2003; 326:371-372
[16] S M Campbell, M Hann, J Hacker, C Burns, d Oliver, A Thapar, N Mead, D Gelb, Safran, M O Roland. Identifying predictors of high quality care in English general practice: observational study. BMH (2001) Vol 323: 1-6
[17] Van den Hombergh P et als. Saying 'goodbye' to single-handed practices; what do patients and staff lose or gain? Family Practice 2005; 22: 20-27

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