Haringey Council

NOTICE OF MEETING

Scrutiny Review - Primary Care Strategy

TUESDAY, 17TH JULY, 2007 at 18:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Councillors Baker, Edge, Kober, Mallett (Chair), Patel, Peacock and Reid

AGENDA

1. APOLOGIES FOR ABSENCE (IF ANY)

2. URGENT BUSINESS

3. DECLARATIONS OF INTEREST

4. SCOPE AND TERMS OF REFERENCE

To consider the scope, terms of reference and workplan for the review.

(TO FOLLOW)

5. PRIMARY CARE STRATEGY - HARINGEY TEACHING PRIMARY CARE TRUST (PAGES 1 - 90)

To receive evidence in relation to the Primary Care Strategy from the following officer from Haringey Teaching Primary Care Trust:

- James Slater, Director of Performance and Primary Care, Haringey TPCT

The strategy plus appendices is attached.

6. NEW ITEMS OF URGENT BUSINESS

7. DATE OF NEXT MEETING.

Yuniea Semambo
Head of Local Democracy and Member Services
5th Floor
River Park House
225 High Road
Wood Green
London N22 8HQ

Martin Bradford
Research Officer
5th Floor
River Park House
225 High Road
Wood Green
London N22 8HQ 0208 489 6950
martin.bradford@haringey.gov.uk

Agenda Item 5

Haringey NHS
Teaching Primary Care Trust

Developing World Class Primary Care in Haringey

A Consultation Document

Consultation Period
28th June – 19th October 2007

Contents		**Page Number**
Foreword and executive summary		5
1.	**Introduction**	9
2.	**Vision**	10
2.1	What is "world class primary care"?	10
2.2	Who is primary care for?	11
2.3	What will this strategy mean for patients? *Outcome statements*	12
2.4	What will this mean for services? *Availability and access*	13
2.5	Clinical standards	14
2.6	Our challenges	15
2.7	Understanding the trade offs	15
2.8	Recognising the primary care team	16
2.9	Resources	17
2.10	Links to other strategies and plans	17
2.11	Your views and next steps	20
3.	**The Case for Change**	21
3.1	The people of Haringey and their health needs	21
3.2	What patients want from primary care	22
3.3	National context – what works in primary care	23
3.4	Current service issues: GP services, resource allocation, clinical quality, premises, community health services	24
3.5	Making best use of services and resources	27
3.6	Sustainability	27
4.	**The Delivery Model**	29
4.1	The super health centre	29
4.2	What a super health centre will look like	34
4.3	A staged approach to buildings	35
4.4	Implementation issues	39
5.	**Making Change Come About**	41
5.1	New models of provision	41
5.2	Primary care contracting	41
5.3	Practice based commissioning	41
5.4	Service development	42
5.5	Developing the workforce	43
5.6	Community pharmacy	44
5.7	Infrastructure	45

List of Tables and Figures

Foreword and Executive summary

Barnet, Enfield and Haringey Primary Care Trusts have been working together to plan safer and stronger health care services for the 3 Boroughs. Our plans are set out in the consultation document on the future of healthcare in Barnet, Enfield and Haringey: *Your Health, Your future: Safer, Closer, Better*. In order to take advantage of the benefits described in that document, we will need to make changes to the way we provide primary care services in Haringey. This document describes these proposed changes.

Health services do not stand still. Services continually change in response to challenges and opportunities such as new diseases like AIDS, new drugs for disabling conditions like rheumatoid arthritis, and new diagnostic technology like body scanners. Health professionals work in new ways to make the most of their skills: specialist nurses and therapists can now prescribe drugs, GPs can manage illnesses such as coronary heart disease without patients having to go to hospital, diagnostic tests can now be carried out locally in community based and mobile units.

For the NHS, and particularly in London, today and in the near future, one of the biggest challenges for the health service is that the model dating from the 1940s and 50s of 'small' stand-alone, local general practices providing a limited amount of health services, often in outdated buildings, cannot be maintained. Haringey is no exception to this. The health service in the United Kingdom has also been almost unique in separating hospital doctors and general practitioners from other professional clinical staff in the community. For most patients with continuing health problems, a spell in hospital or a referral to a hospital doctor is often only a small part of their overall care and treatment. This strategy provides the basis on which better integration can take place and also the framework on which other services for local people in

Haringey can be linked e.g. leisure, education, social care and the voluntary sector.

Some changes have already taken place…

In Haringey our GPs now work within 4 collaborative/geographical areas, West, Central, South East and North East. GPs are already developing new services in the community e.g musculo-skeletal services (managing back and other bone/joint pain), dermatology (management of skin conditions) and community based anticoagulation services (blood thinning). They are also heavily involved in planning and funding local hospital services. New kinds of health care professionals such as Community Matrons who can support people at home with physical, psychological or social concerns or specialise in looking after patients with cancer are in place. Many GPs have developed special interests in conditions such as diabetes so their patients can be managed without continual hospital visits. Health and Local Authority services are working together to provide integrated services for children and young people, older adults and vulnerable people.

As well as expanding the services that can be given outside a hospital setting, greater emphasis is being placed on enabling people to adopt healthier lifestyles through services like stopping smoking clinics. This means there is a greater focus on preventing ill health and promoting good health and minimising the need for patients to attend hospital.

Meeting the future needs of people living in Haringey…

The case for change includes meeting the needs of the growing population of Haringey, and to address current service issues. These include unplanned variation in: availability of GP services, clinical quality, suitability of premises,

and integration of community health and pharmacy services. The strategy also takes into account what is already known about what patients want from primary care, and attempts to ensure more appropriate use of services and resources. It draws on national strategy and the evidence of what works in primary care.

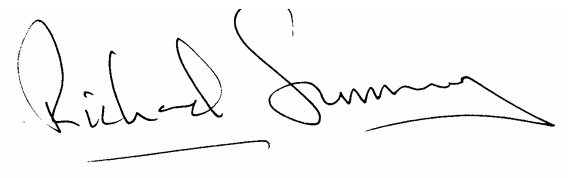
The delivery model includes plans to reduce the number of primary care premises over time and to create a network of super health centres across Haringey. The super health centres will provide a wider range of services with better facilities and longer opening hours than existing primary care services and will bring some services that are currently provided in hospital closer to people. They will also offer opportunities for innovative joint working with other community services including those provided by the voluntary sector.

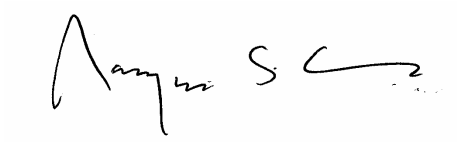
A staged approach to delivery of the model is set out, with 6 super health centres planned across Haringey in 10 years time. In 5 years time we would expect to see significant progress made towards establishing these 6 super health centres, supported by a small number of other primary care premises. Improvements will be seen in planned care, urgent care and long term conditions management.

We plan to underpin these proposed changes by developing innovative ways of delivering these services, for instance, telemedicine, expanding the role of community pharmacy, making greater use of electronic media, developing new contractual arrangements with GP and improving buildings and premises.

To conclude…

We all want for ourselves, our families and our community, lives that are healthy and fulfilled. Everyone has a part to play in improving health. We feel that a major step forward to achieve this goal will be in the implementation of this strategy to deliver world class primary care services, linked to changes in hospital and community services. This strategy will commit the TPCT to significant investment in primary care services. We believe that together we can make real change.





Richard Sumray
Chair
Haringey Teaching PCT

Dr Mayur Gor
Professional Executive Chair
Haringey Teaching PCT

1. Introduction

This document sets out a vision of primary care services for Haringey.

Our vision is of world class, high quality, responsive primary and community services for all Haringey residents. By working in partnership with patients, the public, the local authority, voluntary sector and others, these services will contribute fully to improving the health of our population, including reducing inequalities and maximising independence.

We put the case for change; describe a model for service delivery and the methods for achieving this vision including an overview of the financial strategy. The purpose of this document is to:

- Share the strategy with our stakeholders
- Get the views of local residents and patients about what a 'world class' primary care service would look like
- Get the views of local residents and patients about where they would like to see these services delivered
- Stimulate a lively debate that will inform the next steps in the process of improving local services.

Details of how to tell us your views can be found in section 8.

2. Vision

2.1 What is "world class primary care?"

The way health care is organised varies significantly around the world – with different systems having very different strengths and weaknesses. Whilst we have looked at some of the evidence about 'what works' elsewhere as part of developing this strategy it is clear that there is no one blueprint as to how services should be delivered. In setting ourselves the goal of delivering 'world class' primary care for all Haringey residents what we are aiming to achieve is clinical outcomes and patient experience comparable to that delivered by the very best services both nationally and internationally. The British primary care system at its best is widely admired across the world – when it is working at its best this admiration is well founded, but as is explored in more detail in this document, we believe that services in Haringey are currently some way from consistently delivering world class care.

Primary health care can currently be defined as services that:

- Are accessible to everyone – i.e. universal not targeted
- Are 'first level' – i.e. generalist rather than specialist
- Promote health and prevent ill health
- Diagnose and treat health conditions
- Assess for onward referral to more specialist care where needed.

This strategy focuses mainly on services provided by general practice teams, community pharmacy services and how they link with community health services such as district nursing and therapy services. It incorporates the contribution made by the local authority, community and voluntary sector to primary care and how health services can work closely with these organisations particularly around a broad-based approach to prevention. Importantly it also includes developing specialist skills in primary care to enable more services to be provided closer to home rather than in hospital.

It does not specifically cover General Dental services or Optometry services. Whilst we acknowledge that these services are key elements in developing world-class primary care further work needs to be done to define our strategy for these services and which we will do in 2008. This will include refining our understanding of the current context for these services and our local health needs, involving local dentists and optometrists in developing our strategy and understanding the opportunities available for developing services in the context of our contractual arrangements. We will use the outcome of this consultation to inform our thinking on developing these key primary care services to complement our approach set out here.

2.2 Who is primary care for?

Primary care services need to respond in a safe, effective and equitable way to:

- Well people (health surveillance, health promotion, community health)
- People with urgent care needs – including minor ailments or injuries as well as more serious illnesses
- People with acute / time limited conditions.
- People with long-term health conditions (e.g. diabetes, heart failure, respiratory disease, mental health problems)
- People throughout their lives -children, young people, adults and older people.

Primary care practitioners need to know when to refer patients on for more specialist care and play an important co-ordinating role for people with more complex health needs who are in contact with lots of different parts of the health and social care system. Please see Appendix A for more information on who uses primary care.

2.3 What will this strategy mean for patients?
(Outcome statements)

In developing the strategy we wanted to keep at the forefront of our thinking what any changes would mean in real terms for people who use health services in Haringey. We have developed the following outcome statements[1] that aim to capture the essence of what we are trying to achieve from a patient perspective.

Table 1 Outcome statements

1	*I can register with a local GP practice of my choice – **whoever I am and wherever I live in Haringey**.*
2	*The care I receive meets **my needs and that of my family**.*
3	*I can rely on getting the right care **whenever** I need it and **whoever** I am.*
4	*I will be given advice, support and screening to **keep me well.***
5	***My opinions** are clearly heard and taken into account.*
6	*I know what to do when I or my family need **urgent care***
7	*In an emergency I can get care **quickly and simply.***
8	*Providing the **best care** is important to everyone who cares for me.*
9	*I can access (planned) care **at a time that suits me**.*
10	*In most **non-urgent** situations I can see a clinician who is familiar with my health history, situation and circumstances.*
11	*If I have a more complex or long-term health need, my care will be **agreed and co-ordinated** with my clinicians. Care will be provided in a way that is as convenient for me as possible.*
12	*I can book a **longer appointment** with my doctor or primary care clinician if I need it.*
13	*I have a relationship of **mutual respect** with my clinicians and care givers.*
14	*I am able to have **diagnostic and specialist treatment** (for some conditions) in primary care rather than having to visit hospital*

[1] A number of these statements are drawn from the Department of Health consultation document on the future of urgent care services.

2.4 What does this mean for services?
(Availability and access)

We will measure the success of our strategy based on the extent that we are able to deliver these statements in practice. The principles set out above are based on a patient's perspective of how they experience primary and community care services. This will mean improvements in the availability of and access to services in primary care. In terms of services this will mean longer opening hours, including weekend opening. Access to GPs for planned care will be available 12 hours per day, with access to GPs or other health professionals for urgent care available 18-24 hours per day. An overview of the kinds of services that will be provided in primary care and how they fit together follows.

Figure 1 Overview of services proposed for primary care

Health promotion, traditional health services (GPs, nurses, allied health professionals) working in partnership with other independent contractors and across agencies and with voluntary sector	Facilities for **procedures**, including endoscopy and minor/day case surgery
Diagnostic facilities including automated pathology and plain x -ray +/- CT scanning and facility for mobile MRI	Extended opening for **urgent care** for minor and moderate cases including facilities for suturing and basic fracture management

Benefits

- Opportunities to work in closer and more innovative ways across health and social care and with the voluntary/community sector to bring real benefits particularly around addressing inequalities and promoting health. This could include working with community groups to identify and commission services addressing specific local needs or developing a one stop shop approach with social care partners to addressing a

range of issues that underlie the determinants of health (housing, education, employment)

- Locating a wider range of services in larger practices brings care closer to patients
- On-site diagnostic testing is more convenient for GP patients and is necessary to provide better urgent care facilities
- Urgent treatment rooms can also be used to undertake endoscopies and day procedures as there are similar staffing, equipment and product requirements
- Day procedures can be performed closer to home rather than in centralised acute hospitals.

2.5 Clinical standards

We have already embarked on a process to measure the quality of services provided and strive to achieve the highest possible standards. Information from providers of primary care services will be made available for scrutiny on the Haringey Teaching Primary Care Trust (TPCT) website on a quarterly basis. We will expect services to achieve well above minimum standards, and strive to achieve world-class standards of:

- Health surveillance and health promotion - implementing national guidance such as NICE public health guidance, National Service Frameworks, locally agreed care pathways, national targets for screening & immunisation – cancer, sexual health, flu, childhood illnesses
- Core and developmental standards as measured by the Healthcare Commission
- GP quality standards as measured through the Quality and Outcomes Framework
- Long term condition management including recorded prevalence of long term conditions, multi-disciplinary and integrated regimes
- Referral management
- Prescribing management.

2.6 Our challenges

Our most significant challenges currently are equity of access across Haringey, particularly relative to variations in health need, and inconsistency of service quality and responsiveness. The aim of this strategy is to improve the quality of all services across Haringey and by doing this as well as improving access (a key feature of the delivery model proposed) we will enable primary care services to play a much stronger role in reducing health inequalities.

It is particularly important to us that 'vulnerable' people are able to access services easily and that they get appropriate clinical care and support. People may be vulnerable for a number of different reasons – due to a disability such as mental illness, learning disability, physical or sensory disability or due to their economic and social status such as asylum seekers. We will, for example, be working to take forward the outcome of the Overview and Scrutiny Committee's Review on Improving the Health of People with Profound and Multiple Learning Disabilities.

There will be a challenging programme of implementation required to deliver this strategy, one of the areas we will need to look at in much more detail is transport within the borough, as discussed below.

2.7 Understanding the trade offs

We believe that the vision we have described above and the delivery model set out later in this document will deliver vastly improved care for the people of Haringey. This will mean changes to current services. We put the case for change in the next section of this document.

We know that people have different requirements from their primary care services at different times. Sometimes there is a pressing need to see a healthcare professional immediately who can provide the right kind of treatment, at other times there is a need to see someone familiar. We

believe that the model we set out provides greatly improved access and availability without losing continuity of care. Existing GPs will have the opportunity to work in the new super health centres. People will still be able to see their GP of choice, but they will be able to do so in an improved physical environment and they will be able to access a wider range of services at the same location as their GP during more convenient hours.

As there will be fewer primary care premises in future, with more services being located at the same place, some people will have to travel further to get to their nearest primary care service. We are aware that people might be concerned about the longer distance to their GP. However from our analysis of GP registration in Haringey we can see that many Haringey people already choose to attend a GP practice in a different post-code area to the one in which they live. We believe that the trade off between slightly further to travel and the convenience of more and better services available will be worth it. It is intended that the distance to travel will still be no further than a reasonable walking distance. We will be considering transport and travel issues further in the more detailed planning of the super health centres and welcome your views on this aspect of the strategy.

It is important that we hear your views about the trade offs described above so that we can work together to minimise any concerns.

2.8 Recognising the Primary Care Team

We recognise that we cannot deliver this strategy without the range of skills, commitment and hard work that clinical and administrative staff put in to delivering and developing community and primary care services. We recognise also the challenges that primary care service providers face, and we want to commission services and ways of working that are attractive to clinical staff and enable them to develop and make best use of their skills to contribute as effectively as possible to the delivery of high quality and responsive primary care services. We will not be able to deliver world-class

primary care for Haringey without high calibre staff and a framework that enables them to flourish. We acknowledge that the implementation of this strategy will require significant changes to the way that people work in primary care. Change can be a difficult process, so we need to work together to identify and address any areas of concern.

2.9 Resources

This strategy is being developed in the context of significant additional resources having been invested in primary care services over recent years, notably through the new GP contract and the Quality and Outcomes Framework, and proposes further significant investment in primary care. We need to ensure that we get the best possible service for local residents for the money currently invested and that any new investment is well targeted to achieve maximum benefit and help us move towards our vision.

We have recently reviewed how resources for primary care practices are distributed at practice level and across Haringey. It is clear that resources are not currently distributed equitably according to need and we will need to address this issue as we move forward to deliver the strategy.

2.10 Links to other strategies and plans

The vision contained in this document is in line with the overall vision for better primary care and community services closer to home that is outlined in the Department of Health's White Paper: *Our Health, Our Care, Our Say* – itself based on extensive public consultation. We are also guided by the *Choosing Health* White Paper. This document aims to provide the framework for developing better primary care services in Haringey to help progress in the direction set out by national strategy. In particular this strategy underpins the Barnet, Enfield and Haringey Clinical Strategy, an overview of which follows.

Barnet, Enfield and Haringey Clinical Strategy

There are three hospitals serving Barnet, Enfield, Haringey and South Hertfordshire – Chase Farm, Barnet and North Middlesex – which provide services to around 900,000 people in a variety of very different areas with equally varied health needs. The different needs of this very diverse population mean that health services need to be better organised to bring services closer to people's homes and prevent unequal access to treatment. Locally, there are not enough doctors, up-to-date buildings or other resources to provide safe, high quality care for all specialties in all three hospitals.

Two main proposals are currently out for consultation for reorganising hospital care in those three hospitals. These are in summary:

- Option 1: Planned care concentrated on the Chase Farm site. Planned care would be expanded on the Chase Farm site to incorporate planned inpatient surgery moving in from the Barnet site and some from North Middlesex Hospital, for treatment other than major surgery. Planned and emergency services would be separated with Barnet Hospital and North Middlesex Hospital providing major emergency services, Urgent Care Centre for non-life threatening conditions and day surgery. A local Accident and Emergency service (incorporating an Urgent Care Centre) would be based at Chase Farm and would be senior clinican-led. Consultant-led paediatric and older people's assessment units at Chase Farm Hospital would be created. Inpatient services for women and children and obstetrician-led maternity services based at Barnet and North Middlesex. Intermediate care beds provided at Chase Farm, to be used for admission avoidance and to allow some patients to move closer to home once they are past their acute inpatient phase. A Midwife-led Birth Unit could be located at Chase Farm. There will be a strengthening of services available in a community setting.

- Option 2: Chase Farm becomes a community hospital. All inpatient and major emergency services concentrated at Barnet and North Middlesex.

Planned inpatient services would be provided at Barnet and North Middlesex but not at Chase Farm. Chase Farm would provide day surgery and intermediate care beds. A local Accident and Emergency service (incorporating an Urgent Care Centre) would be based at Chase Farm. Consultant-led paediatric and older people's assessment units at Chase Farm Hospital would be created. Inpatient services for women and children and obstetrician-led maternity services based at Barnet and North Middlesex. Intermediate care beds provided at Chase Farm, to be used for admission avoidance and to allow some patients to move closer to home once they are past their acute inpatient phase. A Midwife-led Birth Unit could be located at Chase Farm. There will be a strengthening of services available in a community setting.

More information is available at http://www.behfuture.nhs.uk/

Our primary care strategy aims to complement this planning in acute care by providing a greater range of services traditionally provided in hospital more conveniently within the community in super health centres and to play a crucial role in developing the range of urgent/unplanned care available more locally to people, enabling hospital Accident and Emergency Departments (A&Es) to focus on the most serious and complex needs.

However, notwithstanding planned changes in acute care, the need for change in primary care is clear and overdue and, whilst we will continue to work collaboratively to improve acute provision, we will also seek to take forward these necessary changes to primary care independently.

This strategy has been developed with consideration of the plans of our other neighbouring PCTs and takes forward the relevant sections of Haringey TPCT's Strategic Service Development Plan of March 2007.

Haringey TPCT is also engaged in developing an over-arching commissioning strategy that will be produced by October 2007. The commissioning strategy

will draw on this primary care strategy and two other important discussion documents due for completion in 2007 that are designed to support us to deliver improved care in primary and community care settings; the Joint (Haringey Council and HTPCT) Intermediate Care and Rehabilitation strategy and the Children's Health Commissioning Strategy.

We will also seek to ensure that this strategy supports the delivery of other relevant local strategies such as our Health Inequalities Action Plan, Infant Mortality Strategy, Children and Young People's Policy, Experience Counts, Mental Health Strategy and our Local Area Agreement. A full list of related strategies is available at Appendix B.

2.11 Your Views and Next Steps

We need your views about what this document says so that it can help us shape your local health services. You can do this by completing the questionnaire at the end of the document or if you prefer you can put your views in writing in a different format or you can attend one of a series of public meetings where the strategy will be discussed and comments fed back into the process. Details of all the ways you can contribute are set out at the end of the document. Following a three-month discussion period Haringey TPCT expects to review the strategy, publish a final version and develop a more detailed implementation plan setting out how we move forward and how we will measure success. There will be further opportunities for discussion as we develop and implement our plans for specific elements of the strategy. We think that the vision we have for Haringey's primary care services is both exciting and challenging. We look forward to hearing your views.

In this section we have described our vision for improving primary care services in Haringey. In the next section we set out why we feel these changes need to be made.

3. The Case for Change

This section of our strategy explains why we need to make changes to our services. These reasons include the need to:

- Respond to what we know about the health needs of our population and what we predict those needs to be in the future
- Give patients what they want in terms of better access and continuity of care
- Draw on what we know works in primary care and ensure that we are working within the broader national strategic context.
- Reduce unplanned variability in GP services
- Improve and integrate community health services
- Ensure the best use of services and resources
- Develop a sustainable approach to providing services, ensuring we can recruit the new generation of GPs and other health and social care professionals.

3.1 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. Some key facts about Haringey's population and health needs follow, with more information available at Appendix C.

Haringey's population:

- Is relatively young and mobile
- Is very diverse in terms of socio-economic status and ethnicity
- Is increasing for all ages, except for those age 65-74

- Has increasing proportions overall of people from Black and Minority Ethnic (BME) communities and more older people from a range of communities
- Experiences high levels of health need, admission rates and early deaths in the east of the borough.

It should also be noted that the number of people registered with GPs in Haringey is larger than the number of people resident in Haringey.

The projection for Haringey's population growth has been used to shape the proposal for the distribution of primary care services set out in the delivery model below.

3.2 What patients want from primary care

We hope to hear from lots of patients and residents of Haringey in response to this consultation. We have also referred to what we already know about what patients say they want from a primary care service from published studies and other public consultations. 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. See Appendix D for a review of the evidence of what patients want.

The primary care strategy is intended to provide better access in terms of opening hours and availability of a wider range of services in primary care than currently available. We will need to ensure that continuity of care is also

available in terms not only of choice of GP but also through better integration with community and hospital services.

3.3 National context - what works in Primary Care

Two key national documents set the context for the changes suggested in this document:

- *Our Health, Our Care, Our Say* sets out a national plan for expanding primary and community services. There are now greater opportunities to deliver services in the community that in the past could only be provided in hospitals. This is good for equity, health and is what people want.
- *Choosing Health* puts an increased focus on prevention and self care.

Defining Quality In Primary Care

Based on a review of the evidence we have identified two main elements that contribute to producing a good quality primary care service. These are:

Clinical and Cost Effectiveness: This is the extent to which specific clinical interventions maintain and improve health and secure the greatest possible health gain from the available resources.

Responsiveness: This relates to patient satisfaction and respect for the expectations and preferences of service users and providers. This incorporates:

- **Accessibility** – promptness and ability to visit a primary care clinician and ease of accessing specialised and diagnostic services
- **Continuity** - extent to which services are offered as a coherent succession of events in keeping with the health needs and personal context of patients.

In implementing the changes required to strengthen primary and community care services (which will aim to promote well being as well as treat ill health), we need to drawn on the evidence of what works in primary care. A review of the evidence does not provide one clear model for delivering quality. Some

of the evidence is conflicting, however, larger practices appear to be better for clinical quality and poor quality is associated with deprived areas. The challenge is to ensure that we commission the right type of practices and develop quality markers to test their quality.

Therefore, in Haringey we need to commission primary care services which:

- Have the flexibility and organisational structure to provide access, continuity and availability of services for all
- Ensure equity so that high quality primary care is available to all wherever they are registered in Haringey
- Have systems for those patients who find it difficult to access the kind of care they want and need including those who may experience difficulties e.g. people with disabilities or from minority ethnic communities
- Have systems in place to make it easy for patients to express a choice of health professional.

Appendix E provides an overview of the evidence of what works in primary care.

3.4 Current service issues

A wide range of primary and community health services are currently provided to Haringey residents – many of these services are high quality and cost effective and have been modernised in line with best practice guidance. However we know that current services are variable, some services are under developed and under resourced relative to levels of need and that many are provided in traditional models that do not meet our aspiration for world class services.

The variation in use of health services is of particular importance to this strategy. The 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 reflect different capacity and capability in primary care services to prevent, identify and treat ill health. Our vision is to achieve a greater consistency in primary care.

GP services: The key point to note in relation to current GP service provision in Haringey is the unplanned variability of:

- The sort of practice population served by each practice and the likely workload related to the needs of that population;
- Access in terms of opening hours and service availability;
- Allocation of resources relative to likely workload / needs;
- Performance against key clinical and health improvement targets;
- Spend on prescribing
- Referral rates to secondary care and emergency secondary care activity;
- Suitability of premises for service delivery.

Please see Appendix F for further information on current configuration of GP services in Haringey.

Resource allocation: There is significant variation in resource allocation to different GP practices that reflect historical patterns but not patient needs. For example there is more than 100% variation in the level of funding to the lowest resourced practice relative to the highest resourced practice even when weighted for deprivation or workload. Further information can be found at Appendix G.

Clinical quality in primary care: As noted above there is wide variation in the quality of primary care available in Haringey, as measured through a range of indicators including GP time available to patients and achievement of

clinical targets such as screening, flu vaccination and prescribing. For example although at September 2006 20 practices achieved the national target of 80% uptake of cervical cytology, 9 practices attained less than 60%, 3 practices less than 50% and 1 less than 40%. Please see Appendix H for more information.

Premises: The premises from which primary and community health services are currently provided are not of a world class standard. Although some primary care practice premises, including new centres, are of a high standard, a significant number of practices – 48% - fall below minimum building standards and many of these do not have the potential to be improved. In addition a number of community services including those currently provided at St Ann's Hospital site are operating in unsuitable premises. See Appendix I for more information on the current condition of primary care premises.

Community Health Services: The community health services in Haringey have a number of strengths, including:

- Good partnership relationships with other health providers and Haringey Council, particularly in the development of new children's networks
- Our providers have good recruitment and retention of clinical staff
- Commitment to service development and working to deliver services in new ways – for example the successful implementation of the Common Assessment Framework – a multi-agency approach to working more effectively with children and the development of new community matron roles that work with people with very complex long term health needs, designing and co-ordinating individual care plans and

However these services could be improved by:

- Having a greater focus on health improvement, prevention and the wider determinants of health
- Being better integrated e.g. improved access to and support from primary care practitioners for those people resident in nursing care homes in Haringey

- Services to be organised to better meet patients' needs and to be more accessible
- Being better co-ordinated, particularly for patients with long term and complex health conditions so patients don't need to see different professionals, at different times without one overall plan of care.

The vision for primary care is to strengthen the relationships between community health services and GP services, with clear co-ordination of care across different services where appropriate and, for example, the full implementation of the Single Assessment Process (the integrated multi-agency approach for assessing and managing the care of older people).

3.5 Making best use of services and resources

Current national data shows that Haringey residents are much more likely to be referred for hospital based outpatient care than people living in other parts of the country. This is particularly the case for people who live in West Haringey. We also have evidence that a large percentage of people currently presenting to A&E services have needs that could be met in a less specialist setting.

We believe that by strengthening primary and community care services we can improve services for patients by making them more convenient and more joined up, as well as enabling us to use our resources more efficiently. This strategy attempts to do just that.

3.6 Sustainability

In order to meet the needs of our current and future population we have to keep abreast of new developments and carry out succession planning to ensure that we can attract the workforce that we need now and in the future. We have to take account of changing medical technology as well as public and patient wishes in terms of less reliance on hospital care, increase in self-management and a focus on promoting health rather than reactively treating

illness. Our existing services are not configured in a way to respond effectively to these developments or to attract the new generation of GPs and other health and social care professionals we will need in Haringey to sustain an effective primary care strategy.

Having set out the case for change, the next section provides the delivery model we expect to put in place to realise our vision of world-class primary care services in Haringey.

4. The Delivery Model

This document has laid out the case for why we need to change the way we provide care outside hospital and specifically the changes we need to make for the provision of general practice across Haringey. This section sets out a 10-year plan to create a sustainable primary care service for the future. It describes a model of how services could be delivered. The model proposes to create a network of "super health centres" across Haringey, providing a comprehensive range of health services for local people. The model will also reduce the reliance on hospital facilities and be able to provide many previously traditionally based hospital services in the community, closer to home. This model will also provide better opportunities for developing closer and more innovative partnership working with the local authority and the voluntary sector to provide more coherent and better joined up care and in tackling health inequalities. Patients will be able to register at these super health centres, and, over time the number of general practice premises will reduce. This reduction will take place on a planned basis and the pace will depend on the success of the super health centre model as it evolves and will be carried out in consultation with local people and general practitioners.

4.1 The super health centre model

The model offers the opportunity to provide a wider range of services with better facilities and longer opening hours than most existing general practices can provide at the moment. Each super health centre will provide care for a significant proportion of Haringey's population including registration of approximately 50,000 people. Given that Haringey shares borders with a number of other boroughs, synergy in developing centres will be important as super health centres could serve residents across borough boundaries. These super health centres will also be linked into a network of general practices, providing a hub and spoke type model. Clinicians and non-clinicians will work across this network. We have not attempted to estimate the number of general practice premises that will remain in place in 10 years time. These

decisions will be taken over time, when we are able to evaluate the success of this new model in terms of clinical quality, affordability and how local people feel about the new services. However we do expect that some practices and their registered lists will move swiftly into the existing new facilities including Lordship Lane, Tynemouth Road, The Laurels and Hornsey Central.

The benefits of the super health centre approach include making available a wide range of services in the community, closer to home and being more convenient in terms of infrastructure, e.g. on site diagnostics being more convenient for both planned and urgent care. This will also help us achieve economies of scale. We expect to drive up the quality of services, not least through multi-disciplinary learning and to reduce the unplanned variability in services we currently experience.

The proposed kinds of services to be provided across this network, and their opening hours are:

Health promotion and screening (including GP and specialist care and allied health services including midwifery/antenatal care, physiotherapy and pharmacy). Our vision includes supporting people to stay well and improve their health and quality of life. We will commission comprehensive services delivering access to health improvement programmes such as stopping smoking and physical activity. General practice is at the heart of this approach using their patient registers to identify people with long term conditions or at risk of such conditions and work with them to identify their individual needs, and access health improvement programmes that meet their needs. Improving health and quality of life also requires integration with a range of other organisations and groups such as the local authority, the community and voluntary sector. This will be supported by the development of care pathways that will include a focus on preventing ill-

I will be given advice, support and screening to keep me well

I can rely on getting the right care whenever I need it and whoever I am

health. To achieve this super health centres will offer new opportunities to co-locate or provide sessional space for a range of community services and facilities.

- General practice and community services available 12 hours per day.
- Interactive health information services including healthy living and mental well-being will be available 18 – 24 hours per day.

I will be able to use diagnostic and specialist treatment (for some conditions) in primary care rather than having to visit hospital

Diagnostic facilities (including automated pathology and plain x ray +/- CT scanning and mobile MRI) Fundamental to all primary care service provision is the assessment and diagnosis of health conditions, with treatment provided either within a primary care setting or through onward referral to more specialist parts of the system. To do this, primary care clinicians need greater access to diagnostic facilities and it is intended that these will be available in super health centres and be linked by telemedicine further a-field. This will mean fewer patients needing to travel to hospital for these services.

- Diagnostics – point of care pathology and radiology available 18-24 hours per day.

Procedures More procedures will be able to be performed locally, away from the hospital site and closer to people's homes. These procedures include endoscopy and minor/day case surgery.

- Minor procedures will be available 12 hours per day.

I can access (planned) care at a time that suits me

In most non-urgent situations I can see a clinician who is familiar with my health history, situation and circumstances

I can book a longer appointment with my doctor or primary care clinician if I need it

Planned care Our approach to planned care aims to improve access and continuity. The super health centre model outlined above would provide improved access in terms of appropriate skill mix, surgery hours, a named health

professional and links to other appropriate community services.

- Planned care will be available 12 hours per day.

Urgent care The super health centres will have an urgent care facility open for between 18 and 24 hours per day which will subsume the existing Out of Hours services and include facilities for suturing and basic fracture management. Whilst 999 ambulance to Accident & Emergency is the most appropriate route into urgent care services in emergency situations, we also need to develop greater access to a wider range of urgent care services in primary care to reflect the range of urgent care situations that occur and ensure we make the best use of our A&E services.

I know what to do when I need urgent care

In an emergency I can get care quickly and simply

- Urgent care will be available 18 – 24 hours per day.

Long term conditions There is much we can do to improve and streamline the care that people with conditions such as heart failure, respiratory diseases and mental health problems currently receive to increase their self care and ability to stay in the community including: developing care pathways, improving access to support for self care, developing specialist clinics and case management. Please see Appendix K for more information on these types of developments including examples of work already underway. At the moment we have fewer people registered on general practice databases for long-term conditions than we would expect using our public health data. Streamlining, providing improved diagnostics and co-ordinating care for people with long term conditions across this new network of service provision will also ensure we are able to identify better this "hidden population" and provide the appropriate care and support. This will help people living with long term conditions live as healthy and productive lives as possible.

If I have a more complex or long-term health need, my care will be agreed and co-ordinated with my clinicians. Care will be provided in a way that is as convenient for me as possible.

- Proactive management of long-term conditions will be available 12 hours per day.

Co-location with other facilities

The development of super health centres will bring significant opportunities for greater integration of health services with other community facilities, such as leisure and sports facilities, children's centres, and libraries with exciting possibilities for innovation in terms of service delivery and health promotion. Mental health services could be provided at super health centres. There are likely to be opportunities for voluntary sector organisations to work more closely in partnership with health and social services to provide more joined up services. We intend to make better use of planning with the local authority to ensure that services respond appropriately to the local needs of the population and maximise opportunities to develop schemes in partnership with other providers. Pharmacy, dentists, opticians and other health professionals could also be co-located with the services listed above, as could borough-wide services e.g. sexual health services.

The care I receive meets my needs

I can register with a local GP practice of my choice whoever I am and wherever I live in Haringey

- Pharmacy services to be available 18-24 hours per day.

Examples of super health centres

Within the UK, a number of local health communities are exploring the super health centre model, including Macclesfield & Warrington in Cheshire where GP and allied services are being re-located in one town-centre site in Macclesfield (70,000 patients) and into 5 centres across Warrington. There are successful international models where community health centres house a wide range of primary care clinicians and secondary care (not in-patient) and great strides have been made in delivering integrated managed care.

Professor Ara Dazi has been asked by NHS London to carry out a review of health services across London. The emerging delivery model envisages each local hospital housing a super health centre as well as a number based in the community. The model suggests these super health centres work as a network both between themselves and across the wider health service including specialist hospitals and social care. Our vision for primary care is in line with these proposals.

4.2 What would a super health centre look like?

Figure 2 View of the proposed Hornsey Central Health Centre

A super health centre would offer the following kinds of activities and opening hours.

Activities	**Hours open per day**
General practice services	12
Community services	12
Most outpatient appointments (including antenatal/postnatal care)	12
Minor procedures	12
Urgent care	18 - 24

Diagnostics – point of care pathology and radiology	18 - 24
Interactive health information services including healthy living and well-being	18 - 24
Proactive management of long term conditions including mental health	12
Pharmacy	18 - 24

Other health (e.g. dentists, opticians) and social care professionals including services provided through voluntary sector agencies could also be co-located with the services outlined above, as could borough-wide services, such as sexual health.

4.3 A staged approach to buildings

The model describes how over a 10-year period we would move to see 6 super health centres available in Haringey. Change will not happen over night and we are proposing a staged approach, interspersed by periods of evaluation and consultation.

Stage 1. Where we are now 2007

- 60 separate general practices- working within 1 of the 4 collaborative areas across Haringey
- 57 premises- including 7 health centres (Crouch End, Bounds Green, Stuart Crescent, Lordship Lane, Tynemouth Road, Broadwater Farm, Laurels Healthy Living Centre)
- 31 of these premises assessed as falling below minimum standards. (23 of these owned by GPs and 8 leased by GPs from external landlords).
- 55 community pharmacies

New facilities planned or in place now:

- Laurels Health Centre- opened 2004
- Newly opened Lordship Lane Health Centre

- Recently approved business case for new facility at Hornsey Central.

Stage 2. 5 to 7 years time 2012-2013

In 5 years time we would expect to see progress towards establishing 6 super health centres, supported by a reduced number of other primary care premises. In the West and Central parts of Haringey we are proposing that the super health centres would be located in one building, but in North East and South East we are proposing to spread services across sites to best meet the needs of the local population. Sites at Lordship Lane and Tottenham Hale would be linked, as would the sites at St Ann's, the Laurels and Tynemouth Road. Services are planned around four geographical clusters or general practice collaboratives. The following table sets out an overview of how services could be configured in 5- 7 years.

Table 2 Configuration of primary care services at 5-7 years.

Clusters/ General Practice Collaboratives	**Post codes served**	**Super health centres location**	**Current development status**	**General Practice linked to super health centres**
West	N10, N6, the Haringey part of N4, the west part of N8	**Super health centre 1** Whittington Hospital super health centre	New development required	Practices in N10 N6 and N4
		Super health centre 2 Hornsey Central super health centre	Business case approved by TPCT Board May 07	
North East	N17	**Super health centre 3** North Middlesex super health centre	New development required	Practices in N17
		Super health centre 4 Lordship Lane/Tottenham Hale *(Lordship Lane and Tottenham Hale operating together as one super health centre).* *NB. Somerset Gardens likely to be incorporated as well.*	Lordship Lane Opened April 07 Tottenham Hale, new development required alongside area regeneration, programme	Practices in N15
South East	N15	**Super health centre 5** Laurels/St Ann's/Tynemouth Road *(Laurels, St Ann's and Tynemouth Road working as one super health centre)*	Laurels and Tynemouth Road - current modern facilities, St Ann's new development required	
Central	N22, the east part of N8, the Haringey part of N11	**Super health centre 6** Wood Green Tube **Or** Turnpike Lane	New development required	Practices in N22, N8, N11

We will be reviewing the remaining number of primary care premises at this 5-7 year stage to ascertain whether they are still viable, providing the care people want in order to plan for the number of practices we will support at year 10.

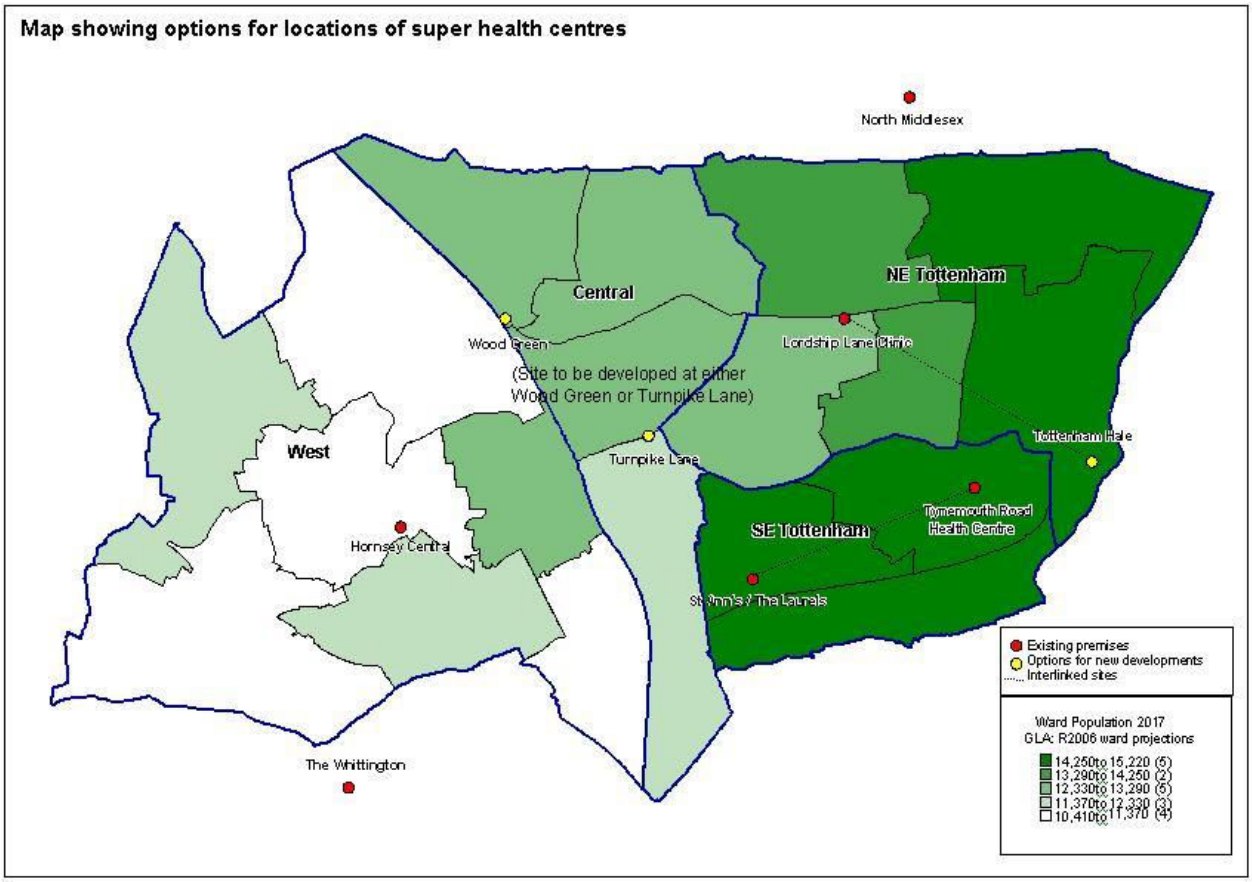
Stage 3: 2017

Super health centres operational on following sites:

- Whittington Hospital (in Islington but serving both Islington and Haringey)
- North Middlesex Hospital (in Enfield but serving both Enfield and Haringey)
- Hornsey Central
- Lordship Lane linked with Tottenham Hale site.
- St Ann's linked with Laurels and Tynemouth Road.
- Wood Green High Street or Turnpike Lane

At this stage, based on patient choice, clinical quality and cost effective services, we envisage there will be a network of super health centres and potentially a greatly reduced number of general practices. The map below shows the options for locating the super health centres in relation to population projections.

Figure 3



4.4 Implementation issues

Whilst we have set out different options above, the ability of the PCT to implement these options will depend on a number of factors including the availability of sites.

The phasing of the implementation process will depend on prioritising developments and on making the most of opportunities as they arise. We will, for example, need to explore potential sites for super health centres as opportunities arise rather than risk missing out on possible developments, although no commitments will be made without following the appropriate processes.

We will also need to take into consideration the plans of our neighbouring PCTs as these develop, which will influence the location and size of super health centres in Haringey.

We are enthusiastic about the possibilities for improving primary care services in Haringey but are aware of the radical nature of change that is required. Our next section sets out the ways in which we hope to drive the developments needed.

5. Making Change Come About

This section considers how we will seek to implement our vision and identifies some priority areas for development. The changes required are system-wide, and further work will be required to draw up a detailed implementation plan.

5.1 New models of provision

This primary care strategy sets out a new model of provision. Change will be required in terms of where services are provided, when they are provided, how they are provided and potentially who provides them. In order to deliver this strategy we will need to increase capacity of services. As well as working with existing providers we will be open to working with new providers or new configurations of existing providers. We will ensure that the information is available in order for local people to make the appropriate choices about services.

5.2 Primary care contracting

Haringey TPCT has a contractual relationship with its practices, and is also responsible for the management of their performance. The GP contract includes the Quality & Outcomes Framework which incentivises practices to deliver high-quality care, focusing on a range of long-term conditions and maintaining a good managerial infrastructure. Haringey TPCT will expect practices to make full use of this Framework and to demonstrate world-class performance against it. Further definition of contractual obligations will be needed to ensure delivery of mutually agreed standards. Performance will be monitored and reported regularly and openly. Practices that fail to meet these local standards will be offered structured support to improve. However, the onus will be on practices to achieve.

5.3 Practice-based commissioning

Practice based commissioning (PBC) places primary care professionals including GPs, nurses and practice teams at the heart of commissioning

decision-making for their local population. Currently we have four PBC collaboratives based around the four areas of Haringey (West, Central, North East and South East). These collaborative arrangements will support work to deliver this strategy by:

- Focusing developments on the needs of the local population
- Providing clinical leadership for service redesign
- Developing and commissioning the new care pathways and enhanced services in primary care required to deliver the strategy.
- Refocusing commissioning in primary and community care services where appropriate

Over the next year collaboratives will be working to develop links with local consultative forums to ensure that the views of local people are built in to their development programmes.

My opinions are clearly heard and taken into account

5.4 Service development

We believe that by strengthening primary and community care services we can improve services for patients by making them more convenient and more joined up, as well as enabling us to use our resources more efficiently. The establishment of the following new services in the past year demonstrates the capacity for improvement that will be built upon over the coming years:

- A primary care led clinical assessment service for people with bone and muscle problems. This service is led by a GP with a special interest in rheumatology and orthopaedics as well as a senior physiotherapist with extended skills in this area. Where appropriate patients are referred on to see a hospital consultant but in most cases the patients are now treated in primary care – including a much quicker access to physiotherapy services.

- A primary care led anti-coagulation service to support regular monitoring in community settings.

- We have enhanced the Children's Community Nursing team (provided by Great Ormond Street Hospital at North Middlesex University Hospital Trust) to provide additional support to children with complex needs at home.

- From April 2007 we have commissioned significant new primary care focused diagnostic provision. This will support GPs to effectively diagnose and treat their patients with less reliance on referral to hospital-based services.

5.5 Developing the workforce

We have already identified the central role of the primary care workforce in delivering our vision. There will be opportunities for new ways of working and the development of new and diverse roles in the primary care workforce. The existing workforce; doctors, nurses, pharmacists, therapists, receptionists, administrative and managerial staff will be changing the ways services are provided and driving up the quality of services. As such our detailed implementation planning will include a workforce and education plan for primary care that will complement the recently refreshed Haringey TPCT Human Resources Strategy and Nursing & Allied Health Professions Strategy. Workforce development will include:

- Changing workload and case mix for primary care practitioners
- Supporting clinical leadership development
- Multi-disciplinary education for the primary care teams
- Significant recruitment of Practice Nurses
- Enhancement to the role of Practice Manager.

It will be through the development and skill of the workforce that we will be able to deliver the outcome statements. We will need to ensure that the services provided meet the

Providing the best care is important to everyone who cares for me

I will have a relationship of mutual respect with my clinicians and care givers

needs of our diverse population and are culturally sensitive. Haringey TPCT will continue to develop its capability to ensure that it is an organisation fit for its purpose. We will need to adapt to and learn from the changes we will be implementing through this primary care strategy.

5.6 Community pharmacy

The traditional role of community pharmacy as predominantly a source of supply and advice about medicines is in the process of radical change. The new pharmacy contract, which allows commissioning of a wider variety of services, enhancement of the pharmacy IT structure, new clinical opportunities for pharmacists, for instance as prescribers – all contribute to a potentially very different service. The challenge is not only to harness these changes, but to create the right environment for the services to flourish and make significant contributions to the health of the people of Haringey. With expertise and skills that are increasingly being used to provide a wider range of services to patients, it is vitally important that we fit the contribution of our community pharmacists into the wider primary care arena. We want to encourage pharmacists to work alongside doctors, nurses and other healthcare professionals to improve the health of patients in Haringey. Whether promoting healthy lifestyles and preventing disease, treating and monitoring long-term conditions, providing services to those who do not generally access primary care, community pharmacists need to be part of multi-disciplinary teams. As GPs become more involved in commissioning care for their patients, we expect them to use pharmacists as service providers, with appropriate roles and responsibilities in well-designed pathways of care.

Appendix L gives more detail on how community pharmacy services can deliver our vision, including examples of service developments already underway.

5.7 Infrastructure

Information Technology (IT) Communication and managing information will be vital to the success of our vision. We will develop an Information & IT Plan that will set out how this will be achieved. We will continue to work with Connecting for Health in implementing the National Programme for IT in terms of developing the Care Records Service (which will enable any NHS organisation to access your health information and provide you with care) and more specifically in developing IT systems in practices, our community services and acute services in tandem with changes in service development. A good example of this is the development of electronic prescriptions and disease registers (which enable better care for patients with long term conditions).

Transport We are well aware that transport links across the borough will need to be improved if we are to implement this strategy. Public transport travelling North and South in the borough is relatively good, but travelling East-West/West-East is more problematic. The Local Authority is keen to explore how we might improve this position and we will be working closely with them and other partners to make real improvements. Being clear about the locations of super centres will help us to do this.

Premises We need to develop the appropriate premises to accommodate the extended range of services we need to provide, these will be purpose built and will contribute to creating an attractive working environment for the workforce we will need to recruit and the needs of the patients using the services. We will also need to look at making best use of existing premises to contribute to the proposed model. The development and ongoing maintenance of premises is a key component in the design and delivery of new services.

We are confident that we will be able to deliver a significant programme of growth over the next 10 years and will be working with the Local Authority to

find additional opportunities for developing health premises in the context of s106 planning obligations (a means of ensuring that local developers contribute towards local infrastructure for the benefit of the wider community).

This section has focussed on how we make our vision happen. The next section sets out the financial strategy we will need to have in place to deliver our vision.

6. Financial Strategy

6.1 Overview of resources required

We have created a high level financial model to support the implementation of this strategy. The model assumes a 5-year plan from 2007 to 2011/12. The model makes the following assumptions:

- It is assumes each super health centre will serve a GP list population of 50,000, with the exception of sites at North Middlesex and the Whittington Hospitals, which will serve a population across 2 PCTs i.e. North Middlesex will serve both Enfield and Haringey residents and the Whittington will jointly serve both Haringey and Islington residents, with the costs shared in proportion.
- Each super health centre is costed on the basis of providing a mixture of GPs, community services and flexible third party space eg pharmacy. The costs are based on indicative 'LIFT' type funding i.e. no upfront capital funding required, but repaid over a 25- 30 year term. There may be other more economical ways to fund the new building, which will be explored should the model be adopted.
- It is assumed that the savings from reducing the current number of GP premises will be reinvested into this model.
- The costs are for infrastructure only. Current pay and non-pay is assumed to be cost neutral. New services provided in these settings will be funded from savings made in secondary care, as this activity will transfer from hospitals to the community.

Table 3 Haringey TPCT Primary Care Strategy Financial Model Costs of the super health centre model in a full year at 2007/08 rates

Super health centre Grouping	Population Served	- £'000 - Gross Super health centre Costs	Current GP Premises Costs	Other Income	Net Total New Expenditure
1. NMH	35,000	840	(254)	(98)	488
2. Whittington	35,000	840	(254)	(98)	488
3. Lordship Lane/Tottenham Hale	50,000	1,200	(363)	(140)	697
4. Hornsey Central	50,000	1,200	(363)	(140)	697
5. Tynemouth Rd/Laurels/St Anns	50,000	1,200	(363)	(140)	697
6. Turnpike Lane or Wood Green	50,000	1,200	(363)	(140)	697
Total	**270,000**	**6,480**	**(1,960)**	**(756)**	**3,764**

If the model were approved, there would be a staggered opening of the new facilities. We have created a high level financial model to estimate the financial consequences of this approach. The opening date assumptions have been incorporated into the financial model and are as follows:

- Tynemouth Road and the Laurels already funded
- Lordship Lane open in 2007/08
- Tottenham Hale open in 2009/10
- Hornsey Central open in 2009/10
- St Ann's refurbishment open 2009/10 (before new building ready)
- Turnpike Lane or Wood Green open 2010/11
- North Middlesex open 2011/12
- Whittington open 2011/12.

Our financial model is based on our 5 year Operating Plan where we are assuming the TPCT having circa £7.1m recurring monies available for new

investments in 2008/09. The table below shows an analysis of the net financial change each year. If we were to adopt this model, we would be using some £3.7m of this money to fund the infrastructure of the new buildings. This strategy would therefore commit the bulk of Haringey TPCT's investments to improving primary care over the next 5 years.

Table 4 Phased affordability of the super health centre model

Income v Expenditure	**2007/ 08**	**2008/ 09**	**- Year - 2009/ 2010**	**2010/ 2011**	**2011/ 2012**	**Full Year Total Roll Fwd**
Available Income	880	7,150	7,150	5,939	5,242	**8,030**
New Expenditure						
NMH	0	0	0	0	(488)	**(488)**
Whittington	0	0	0	0	(488)	**(488)**
Lordship Lane/Tottenham Hale	(480)	0	(217)	0	0	**(697)**
Hornsey Central	0	0	(697)	0	0	**(697)**
Tynemouth Rd/Laurels/St Anns	(400)	0	(297)	0	0	**(697)**
Turnpike Lane or Wood Green	0	0	0	(697)	0	**(697)**
Total	(880)	0	(1,211)	(697)	(976)	**(3,764)**
Net Surplus / (Deficit)	**0**	**7,150**	**5,939**	**5,242**	**4,266**	**4,266**
Available for Other Investments	*0*	*7,150*	*5,939*	*5,242*	*4,266*	***4,266***

6.2 Variation in resource allocation

We have described earlier in the document how the current resources for primary care are not equitably distributed across practices. We are committed to offering practices a 'level playing field' on which to perform. We will seek to address these issues in delivering this strategy whilst being mindful of the

contractual constraints and implications of moving funds from practices. In doing this, we will involve practices and the Local Medical Committee as fully as possible.

Looking to the future, we will explore and set up phased ways to move towards 'fair shares' allocation and budgets based on need. This applies to primary care provision, prescribing and secondary care commissioning.

7. Conclusion

We have set out a picture of large-scale system change in this document in order to take primary care from its current status into a modernised and sustainable form, which will provide the strong and safe services Haringey needs. We are confident that we will be able to deliver a significant programme of growth over the next 10 years. We are working closely with our partners including the Local Authority to make our services more integrated and seamless. Overall we feel that our primary care strategy will be a major contribution to creating a healthier Haringey, by providing access to world-class health care and advice when people need it and regardless of where people live in the borough. We hope that you are as excited as we are by the possibilities that are open to us and will work with us to deliver the potential of this vision.

8. Consultation process and questionnaire

We intend to consult widely on this strategy. We have already drawn on previous consultations and on views of some stakeholders including clinicians during the pre-consultation phase and are now keen to hear more views from the people of Haringey, all our stakeholders including those working in health services. The consultation period is from 28th June to 19th October 2007. This section tells you how you can let us know what you think.

If you, or someone you know, would like this document or a summary of this document in another language or format, or if you need the help of an interpreter, please call 020 8442 6859.

Your views on our vision for primary care

We need your views on the changes we want to make to local health services. There are a number of ways you can have your say.
You can:

- Return the questionnaire and post it to
  Charlotte Murat
  Haringey Teaching PCT
  B1 St Ann's Hospital
  St Ann's Road
  London N15 3TH
- Or you can fill out the form online via our website www.haringeypct.nhs.uk
- Or ring us on our **consultation hotline 020 8442 6859**
- Or email us primarycare@haringey.nhs.uk
- Or attend one of the public meetings – details below.

The changes we want to make

We want to establish 6 super health centres for Haringey, supported by services provided from a smaller number of general practices. These would provide:

- General Practice services (e.g. GPs and practice nurse clinics)
- Community health services (e.g. physiotherapy)
- Services currently only available in hospital (e.g. diagnostic testing such as ultrasound and MRI)
- Other services which support healthy living (e.g. keep fit sessions).

They would be open much longer than they are currently (for example 8am to 8pm) and up to 24 hour access would be available for urgent health needs.

Your views

1. Will these changes meet the needs of you and your family?

2. How would these changes affect you and your family?

3. What are your views on where we would like to locate the 6 super health centres?

4. Are there any particular services/facilities you would want to see provided in your local super health centre?

5. How would these changes affect your journey to your GP?

6. Are there any other things you want to tell us about the proposed changes?

7. Would you be interested in joining a patient focus group to develop your local super health centre? Please print your contact details below

About you

Please give us the following information to help us understand who has responded to our consultation. All information given will be used in accordance with the Data Protection Act 1998.

1. I am responding as

	A representative of an organization
	An individual

2. Are you a

	Patient
	Carer
	Local resident
	PCT employee
	Other health professional
	Other – please state

3. Are you

	Male
	Female

4. What age group are you in?

	Under 16		46-55
	16-25		56-65
	26-35		66-75
	36-45		Over 76

5. What is your ethnic group?

White	
	British
	Irish
	Other white background (please state)
Mixed	
	White and Black Caribbean
	White and Black African
	White and Asian
	Other Mixed background (please state)
Asian or Asian British	
	Indian
	Pakistani
	Bangladeshi
	Other Asian background (please state)

Black or Black British	
	Caribbean
	African
	Other Black background (please state)
Chinese or other ethnic group	
	Chinese
	Other ethnic group (please state)

6. How did you find out about these proposals?

7. Your name and address (you do not have to give this information)

8. Your postcode (you do not have to give this information)

9. Your email address (you do not have to give this information)

10. If you want your feedback in this form to be confidential please tick here ☐

11. If you would like to go on our mailing list for future information please tick (make sure you have given us your contact details) ☐

Thank you for completing this questionnaire. Your views will help us to decide on the location and type of services we want to develop. We will let you know the outcome of the consultation through our newsletter, which will be sent to everyone responding to our questionnaire once the consultation process has finished.

Details follow of the public meetings we have planned at which you can give us your views on this strategy:

Date/Time	Event	Location
5 July 12.00-17.00	Public Patient Involvement Forum	The Cypriot Community Centre, The Main Hall Earlham Grove, Wood Green London N22 5HJ
21 July 10.30-13.30	Lordship Lane open day	Lordship Lane Health Centre, 239 Lordship Lane, N17 6AA
23 July 14:00 - 16:30	Public meeting	Cypriot Community Centre – Main Hall Earlham Grove – Wood Green N22 5HJ
23 July 19:30 – 21.30	Local Area Assembly	Fortismere School, North Wing, Creighton Avenue, London N10 1NS
24 July 18:00 - 20:30	Public Meeting	The Cypriot Community Centre Main Hall Earlham Grove, Wood Green N22 5HJ
September	Other Local Area Assemblies	To be confirmed

9. Glossary and abbreviations

Acute care: Treatment required for a short period of time, usually for a severe but brief illness and usually required admission to hospital

A&E: Accident and Emergency

BME: Black and minority ethnic communities

Commissioning: The full set of activities that local authorities and primary care trusts undertake to make sure that services meet the health and social care needs of individuals and communities.

Community services: refer to health and social care services that are provided in the community, in local clinics or people's homes as opposed to in large hospitals

Connecting for Health: is an agency of the Department of Health which supports to NHS to deliver better care to patients by bringing in new computer systems and services.

CT: stands for computer tomography. CT uses special x-ray equipment to obtain image data from different angle round the body, and then uses computer processing of information to show a cross section of body tissues and organs. CT scans can be used to diagnose problems such as cancers, cardiovascular disease, infectious disease, trauma and musculoskeletal disorders

General Medical Services (GMS): A type of contract that PCTs can have with primary care providers. It is a nationally negotiated contract that sets out the core range of services provided by GPs and their staff. Other types of contract include **Personal Medical Services (PMS)** and **Alternative Provider of Medical Services (APMS)**

GP: General Practitioner

Healthcare Commission: The Healthcare Commission is the independent inspection body for the NH S and independent healthcare.

IT: Information Technology

Local Area Agreement: A three-year agreement setting out the priorities for a local area in certain policy fields as agreed between central government and a local area.

Local authority: Democratically elected local body with responsibility for discharging a range of functions as set out in local government legislation.

Long term conditions (LTCs): those conditions (e.g. diabetes, asthma and arthritis) that cannot, at present, be cured but whose progress can be managed and influenced by medication and other therapies.

MRI Magnetic Resonance Imaging (MRI) tests use magnetic fields to build images of soft tissues in the body. MRI is used for diagnosing and/or measuring the extent of disease.

National Service Framework: policies that set out standards of care for issues such as cancer, coronary heart disease, mental health and diabetes or for care groups such as children and older people.

NICE: the National Institute for Health and Clinical Excellence, is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

Overview and Scrutiny Committee: A committee made up of local government councillors concerned with NHS and social care matters.

Primary care: the collective term for all services which are people's first point of contact with the NHS

Practice Based Commissioning (PBC): gives GPS direct responsibility for achieving best value within the funds that the PCT has to pay for hospital and other care for their practice's population. Through PBC, front line clinicians are being provided with the resources and support to become more involved in commissioning decisions

Primary Care Trusts (PCTs): Freestanding statutory NHS bodies with responsibility for delivering healthcare and health improvements to their local areas. They commission or directly provide a range of community health services as part of their functions.

Provider: A generic term for an organisation that delivers a healthcare or care service.

Quality and Outcomes Framework: Part of the contract that PCTs have with GPs. It is nationally negotiated and rewards best practice and improving quality.

Super health centre: An emerging model of delivering a wide range of primary care and other related services at a designated site or sites as described in this document.

Telemedicine: using information technology to help deliver clinical care at a distance e.g. 2 clinicians using video-conferencing to discuss a case

Teaching Primary Care Trust: Teaching Primary Care Trusts were set up to offer development and employment opportunities within health care for local people, in recognition of the links between economic disadvantage and ill- health and the need for health care organisations to recruit and retain high quality staff

This glossary includes definitions taken from the Commissioning Framework for Health and Well-being, Department of Health, 2007

10. References

Ashworth M, Armstrong D. (2006) 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

Barnet, Enfield and Haringey Clinical Strategy http://www.behfuture.nhs.uk/

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

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

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

Chronic disease management: A compendium of information. London.

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

Department of Health (2006) Direction of Travel for Urgent Care: A discussion document

Department of Health (2006) Our health, our care, our say: a new direction for community services

Department of Health (2004) Choosing Health: making healthy choices easier, Haringey TPCT (2007) Haringey Health Report 2006

Department of Health (2007) Commissioning Framework for Health and Well-being

Department of Health (2004) Living in Britain: The General Household Survey 2002 (on ONS website)

Department for Education & Skills & Department of Health (2004) National Service Framework for Children, Young People and Maternity Services

Foster (2003) Availability of Mental Health services in London. GLA.

Goldberg D & Huxley P (1992) Common mental disorders: A biosocial model, Routledge

London Strategy, Report from London user group Your Health, Your Care, Your Say

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

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

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

Van den Hombergh P et al. (2005) Saying 'goodbye' to single-handed practices; what do patients and staff lose or gain? Family Practice; 22: 20-27

Appendix A: 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[1].

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[2].
- Use of general practice is high in pre-school children who visit their GP six times a year on average[3].
- 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.[4]

---

[1] Chronic disease management: A compendium of information. London. Department of Health, 2004

[2] Living in Britain. The General Household Survey 2002, published 2004 (on ONS website)

[3] Department for Education & Skills & Department of Health. National Service Framework for Children, Young People and Maternity Services. 2004.

[4] Goldberg D & Huxley P *Common mental disorders: A biosocial model (Routledge 1992);* Foster, 2003. Availability of Mental Health services in London. GLA.

Appendix B – Relevant local strategies

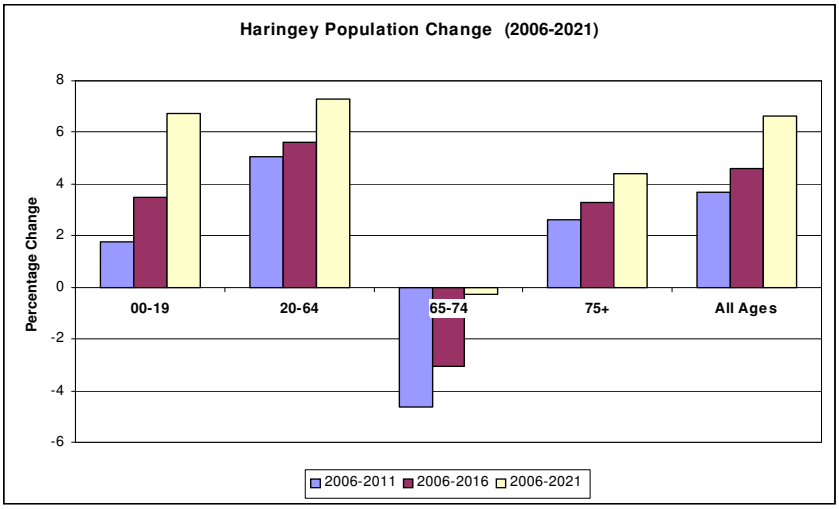
- Children's (Health) Commissioning Strategy "Every Child Matters: Improving health services for children and young people in Haringey" (currently being finalised). For more information contact: Claire Wright, Head of Strategic Commissioning – Children and Young People Tel: 020 8442 6159 or 6657 Email: claire.wright@haringey.nhs.uk
- Experience counts: Older Peoples' Strategy
- Haringey Joint Health and Social Care Mental Health Strategy 2005-2008
- Haringey Sexual Health Strategy September 2005
- Joint (Haringey Council and HTPCT) Intermediate Care and Rehabilitation Strategy (currently being finalised). For more information contact: Alex McTeare, Head of Strategic Commissioning – Adults and Older People Tel: 020 8442 6051 Email: alex.mcteare@haringey.nhs.uk
- Local Area Agreement
- Infant Mortality Action Plan
- Reducing Inequalities in Life Expectancy in Haringey by 2010, May 2007: Actions for the Haringey Strategic Partnership
- Strategic Service Development Plan, March 2007

Appendix C – The people of Haringey and their health needs

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 4).

Figure 4



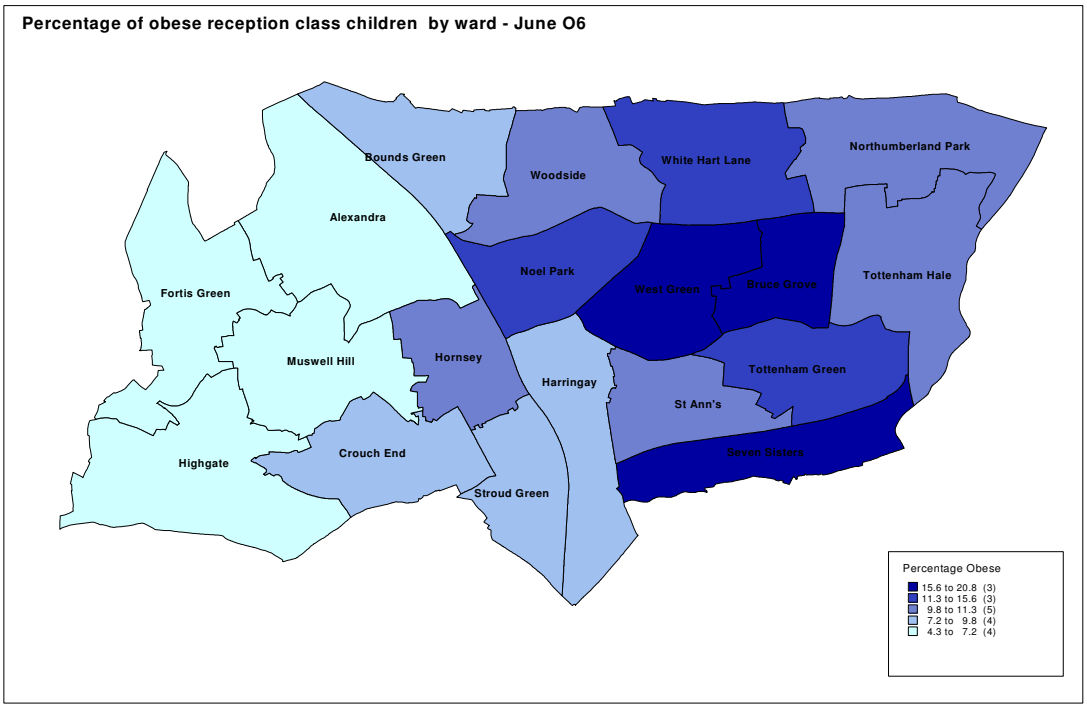
Source: LRC

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 5).

Figure 5



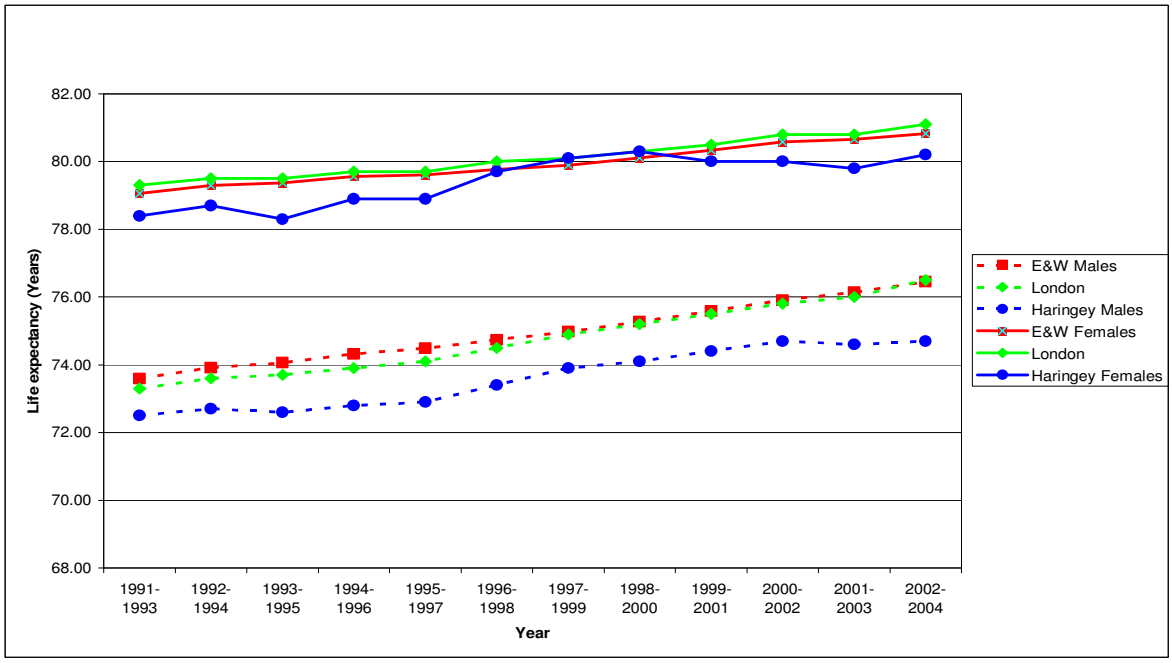
Haringey also has a broad ethnic mix and the proportion of people from minority ethnic communities is set to increase, with more people from BME communities in the older age groups. This will have implications for long term conditions, although the overall proportion of people aged 65-74 is set to decrease, 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 6). 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 6 Trends in Life Expectancy in Haringey compared to London and England (1991-2004)



Source: ONS/LHO

Health Service Use

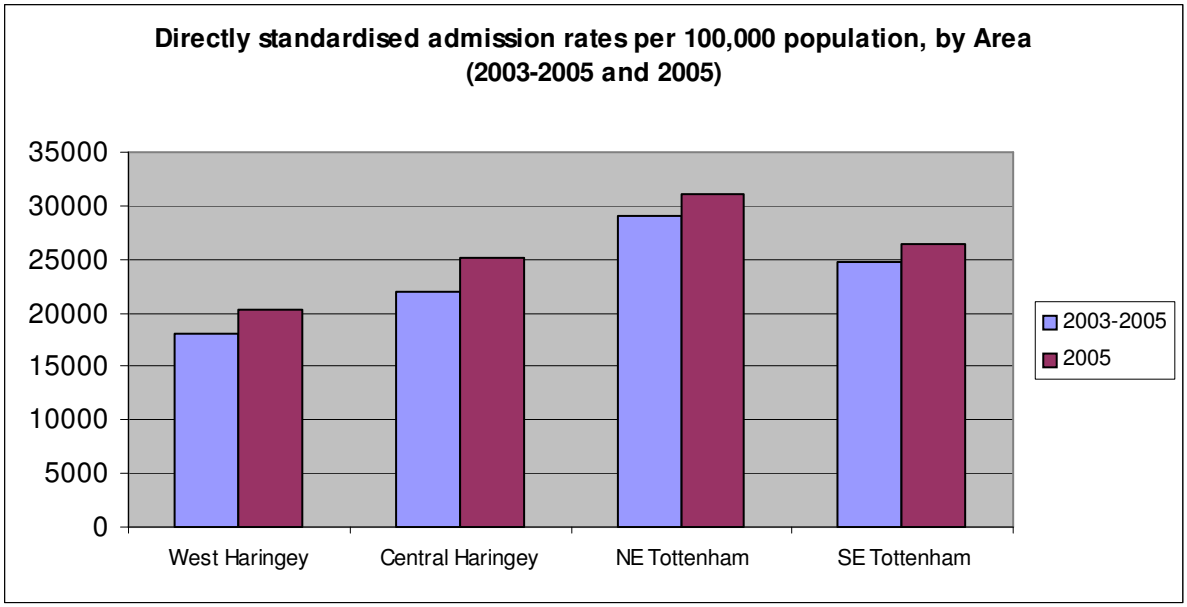
Health service use is one indicator of health care need. Disease registers in primary can provide estimates of the number of people who have certain long-term conditions such as diabetes. For most conditions, disease registers in Haringey suggest a lower number than we would expect from national studies 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 7).

Figure 7



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.

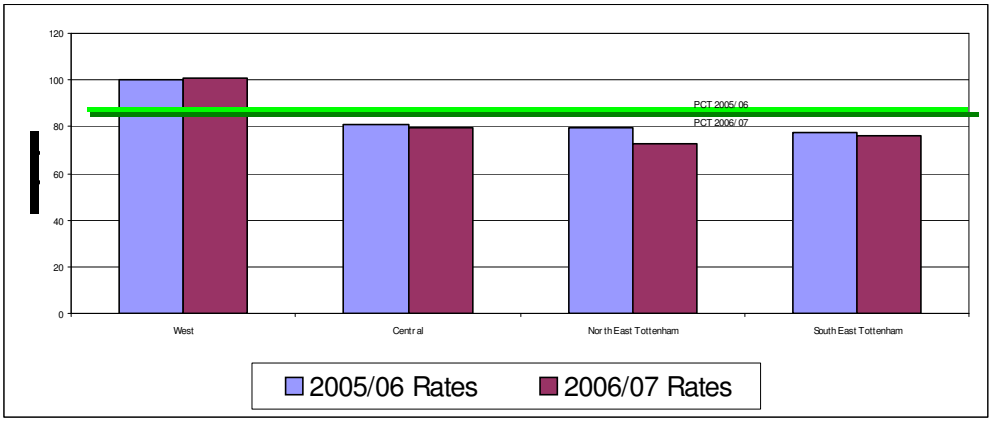
The likely reasons for these variations are complex and are likely to include both real variations in health need (for example associated with deprivation) and demand for health services in terms of what people ask for (with people from more affluent areas tending to have higher expectations about the

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 8 GP referred 1st out patient attendance per 1,000 population (Month 10 of 2005/06 and 2006/07)



Appendix D: What patients want

There is strong evidence to support the theory that interpersonal continuity is associated with better health outcomes and lower costs[5]. Patients want both quick access and relationship continuity from primary care[6]. 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. [7]

[5] Saultz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. Annals of Family Medicine (2005) Vol3: 159-166
[6] Department of Health, Briefing Paper, The Access/Relationship Trade off: how important is continuity of primary care to patients and their carers, September 2006.
[7] Report from London user group Your Health, Your Care, Your Say – quoted from London Strategy.

Appendix E: 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[8] 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[9], but there was a balance to be made around individual GP list size[10].

[8] 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

- There was no association between practice size and the quality of care of patients with ischaemic heart disease[11]
- Smaller practices scored better than larger ones for access to care, but for diabetes care, larger practices had higher quality scores than smaller ones[12].

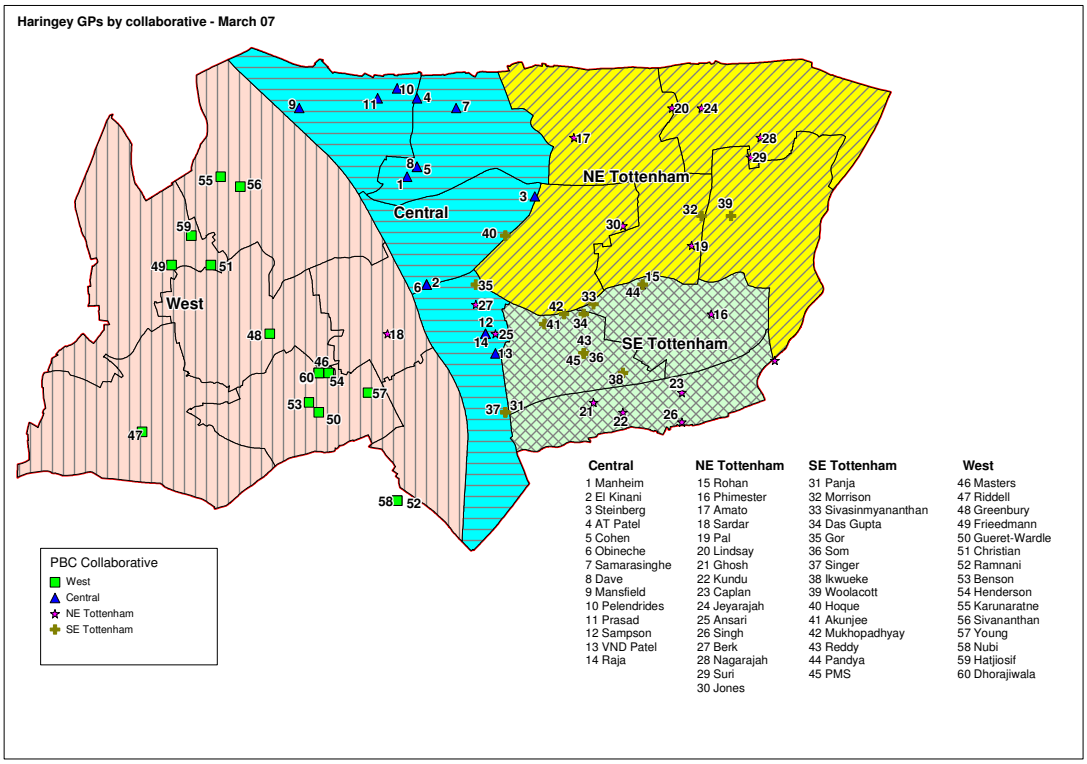
This suggests that there is not one type of practice that provides high quality primary[13].[14],[15] care overall. Larger practices appear to be better for clinical quality and poor quality is associated with deprived areas.

[9] 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
[10] Campbell JL. The reported availability of general practitioners and the influence of practice list size. British Journal of General Practice 1996; 46:465-468
[11] 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
[12] 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
[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
[15] 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

Appendix F: 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 9 Geographical distribution of practices



Practice populations

Table 5 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 5 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 G: 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.

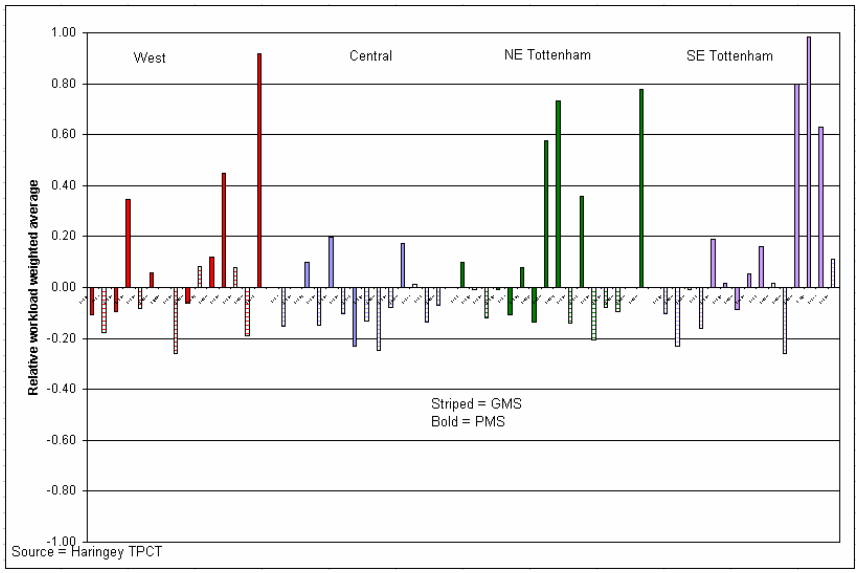
- In all three scenarios there is a markedly higher level of resource on average to PMS practices than to GMS practices. When weighted for deprivation the range is 0.86 for GMS practices vs. 1.12 for PMS practices. (I.e. for every 86p a GMS practice receives on average a PMS practice receives £1.12)
- 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 6 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 10 Workload weighted revenue per patient (October – December 2005) as per current collaborative groupings



Appendix H: 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 I: 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.[16]

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

Appendix J: Community health services

Haringey TPCT 'provider division' is the main provider of community health services in Haringey currently. The TPCT provides the following services:

- Services for children and young people including health visiting services, school nursing services, occupational therapy, physiotherapy, dietetics, speech and language therapy, specialist medical assessment and treatment.
- Services for adults and older people including district nursing services, specialist nursing services, physiotherapy, occupational therapy, speech and language therapy, dietetics and foot health services.
- Services for people with a learning disability.
- Sexual and Reproductive health services
- Special needs / specialist dental services
- Audiology services

As much as possible services for children and young people are provided in partnership with Haringey Council education and social services in settings convenient to children and young people and their families (at home, at nursery / children's centres, at school).

Services for adults and older people are provided from a range of TPCT owned health centres and clinics as well as directly to patients in their own homes where this is appropriate. Integration and co-ordination with social services and other council provided support services, particularly for vulnerable people are important for this group of patients.

Our vision for older people in Haringey is that they are enabled to remain as active and independent as possible in their own home, through the provision of person centred services that build on people's individual strengths.

To provide this, services need to be well co-ordinated across health, social care, and the independent and voluntary sectors. A care coordinator needs to be identified who best meets the individual needs of clients, who will develop a care plan in partnership with the client. The care plan will engage those services that are best able to meet the needs of the individual client.

For those people with the highest level of need, the most appropriate environment for them to live in may be a residential or nursing care home. Haringey will double its number of nursing care homes over 2007. It is vital that people living in these homes are able to access health care services in the same way as other residents, and expect the same level of care to enable them to remain as active and independent as possible, as other Haringey residents expect.

In order to ensure this, primary care needs to be able to access nursing, therapy and social services to provide the care needed to its most vulnerable clients.

There are currently 2 large nursing care homes in Haringey, with 2 more due for completion in 2007, with a total bed capacity of approximately 250. These are provided by London Borough of Haringey and the independent sector. Services are provided mainly for people aged over 65.

Barnet Enfield and Haringey Mental Health Trust provide a range of specialist mental health services in hospital and community settings. Work is underway to improve primary care support for mental health and this will form an integral part of this vision.

We do not have as much detailed data available to us at the current time regarding how well our community health services are performing. Developing a better understanding of this is a key priority for 2007/08.

Appendix K: Long term conditions development work

Development of care pathways: Care pathways can support effective management in primary care and ensure clarity and co-ordination between different elements of service provision. A **diabetes pathway** has recently been developed covering diagnosis, initial care; annual review; self-management; foot care and retinal screening. The pathway reflects current national guidance and is supported by treatment guidelines. The pathways and guidelines will be launched as part of an educational event based in each commissioning collaborative. They will be distributed to all practices and posted on the HTPCT intranet site. The pathways and guidelines will support the work currently being undertaken in primary care to repatriate patients with uncomplicated type 2 diabetes back into primary care. They could be used as the basis for developing a more community focussed and co-ordinated approach to the delivery of diabetes services in primary care

Improved access to support for self care: For people who have recently been diagnosed with a long term condition there is evidence that 'expert patient' programmes can help them to understand and manage their condition better. An Expert Patient Programme is being delivered including a focus on specific areas with poor health outcomes and communities with specific needs.

Locality clinics: It is not possible to provide all the different clinical inputs required to support people with long term conditions into each individual GP practice as currently configured. Polyclinics will provide an opportunity to develop a number of locality-based clinics for people with long-term conditions. These clinics would provide a range of clinical inputs including for example GPs with special interest in specific conditions, nurse practitioners, dieticians, physiotherapy, foot health, psychology as well as a route into a range of community and self care support services. Many of these services already exist but they work in an uncoordinated way and communication between services is not as effective as it should be. Clinical staff working in these new one stops shop clinics would co-ordinate closely with the patients individual GP in a 'shared care' model.

Case management: For people with the most complex needs there is some evidence that individual care plans and active support from a senior nurse or other clinician can help them to manage their illness more effectively and improve their experience of health services. In the last year we have commissioned a number of 'community matron' posts to support people with this very high level of need and ensure that they are able to access health and social care services that enable them to better manage their condition and ensure that they are able to access health and social care services that enable them to better manage their conditions. If the local evidence suggests that this is an effective service model the TPCT will aim to invest additional resources (through practice based commissioning) in this type of service.

Mental Health: We would like to see more primary and community led mental health service provision and better interfaces between primary and specialist mental health services. We will be developing a mental health primary care service improvement strategy, building on our recently established new primary care mental health development service. We have identified some additional resources for investment in primary mental health services in 2007/08.

Appendix L: Community pharmacy

Haringey has 55 local community pharmacies. Unlike in many other London PCTs, most pharmacies in Haringey are owned by single-handed contractors. There are only 3 branches of Boots in the west and centre of Haringey, 2 supermarket pharmacies and 7 pharmacies that belong to smaller chains.

Since October 2005, community pharmacists have been working under a new contractual framework with the NHS, and are now incentivised to offer a wide range of services outside of their traditional role of dispensing drugs. Newer services include health promotion, promoting self-care and supporting patients with disabilities in taking their medicines. About half of our pharmacists offer 'Medicines Use Reviews' to support patients in optimising the effect of the medicines they are prescribed.

The PCT also commissions other services from pharmacies in line with local needs. Appropriately accredited Pharmacists in Haringey offer services to reduce teenage pregnancy, support to smokers to help them quit and provide advice and medicines for minor ailments as an alternative to going to the GP.

Pharmacists have always been independent contractors, but previously their sole contractual obligation was the safe supply of medicines. The new contract outlines 8 essential services for them to provide.

- Dispensing
- Repeat dispensing – saving patients' and GPs' time from managing repeat prescribing
- Disposal of medication – ensuring safe disposal and reducing wastage
- Promotion of healthy lifestyles – Getting involved in locally agreed health promotion activities
- Sign-posting – so local people know what other local services provide
- Support for self care – Particularly for those with long term conditions

- Support for people with disabilities – reducing inequalities
- Clinical Governance – ensuring that their services are of high quality and there are processes in place for constant improvement.

In addition to these essential services are additional services that only some pharmacists provide. These include medication reviews, services to drug users, smokers and helping people with minor ailments.

Haringey example – All Haringey pharmacists offer a minor ailments scheme for patients who chose to see them instead of waiting for a doctor's appointment. The scheme covers 22 minor ailments such as coughs and colds, sore throats, diarrhoea and head lice infestation. A patient presenting to a participating GP practice will be able to choose any of Haringey's 55 pharmacies to attend. Once enrolled on the scheme, the patient can return if they suffer from a further minor ailment without needing to go to the doctor again.

New clinical roles for pharmacists

There are new clinical skills that are now available for pharmacists to support their changing role. It is now possible for some pharmacists to qualify as prescribers, usually in support of the work of other healthcare professionals. There are also opportunities for pharmacists to develop special interests to help treat particular patient groups.

Haringey example Three community pharmacists now provide an anticoagulation monitoring service. As prescribers, they can directly supply new doses of the drug, if required, without the patient having to make an extra visit to their GP.

Community Pharmacists and Information Technology

By the end of this year all community pharmacists in Haringey will be able to connect to the NHS net and communicate directly with other NHS users. In

the future there will be no need for paper prescriptions, and with access to related appropriate information, dispensing will become safer and more integrated with other activities related to your health. Within the bounds of patient consent, community pharmacists will be able to access parts of the electronic patient record to understand more about your health needs and provide tailored services.

Haringey example – A number of Haringey's community pharmacists are providing reviews of patients' medicine usage. By using their expertise, they are able to provide GP's with recommendations to optimize the benefits of patients' drug therapy. These recommendations will soon be sent electronically and arrive speedily into your GP record.

Choosing Health – Community pharmacists and promotion of healthy lifestyles

The potential role of pharmacy in delivering public health targets was set out in Choosing Health Through Pharmacy, published by the Department of Health in 2005. Haringey PCT has engaged pharmacists in a wide variety of health promotion campaigns, for instance, raising awareness of diabetes, sun health, winter self-care, and probably most successfully, the benefits of stopping smoking.

Haringey example – More people quit smoking in Haringey because of the support they get from the network of over 30 community pharmacy advisers. In the last three years over 1000 quitters quit with help from a pharmacist. Once quit, the pharmacists refers the patient back to their GP for further support, if needed.

Haringey pharmacists offer a minor ailments scheme for patients who chose to see them instead of waiting for a doctor's appointment. The scheme covers 22 minor ailments such as coughs and colds, sore throats, diarrhoea and head lice infestation. A patient presenting to a participating GP practice will be able to choose any of Haringey's 55 pharmacies to attend. Once enrolled on the scheme, the patient can return if they suffer from a further minor ailment without needing to go to the doctor again.