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) between1972 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 [1]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%) and
- 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 House hold 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.

Appendix B – Relevant local strategies

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

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

[DN TO BE COMPLETED AND TO INCLUDE]
Health inequalities action plan
Infant mortality strategy
Experience counts
MH strategy
SSDP

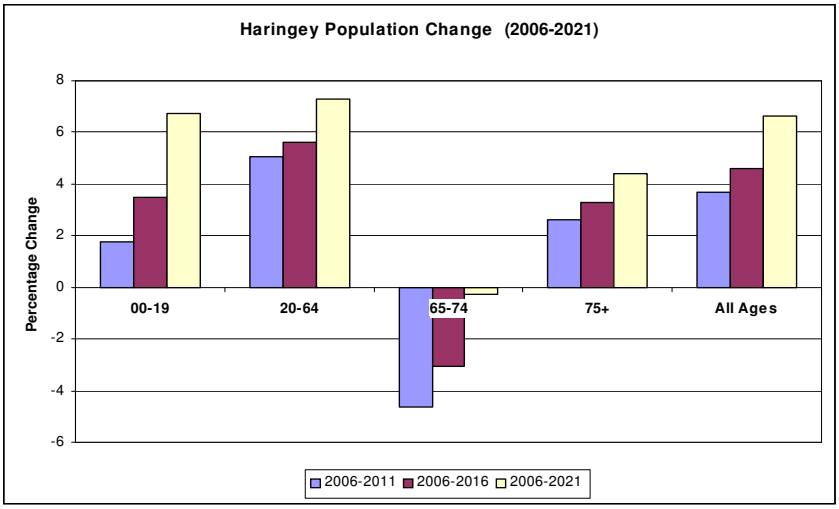
[4] Goldberg D & Huxley P *Common mental disorders: A biosocial model (Routledge 1992);* Foster, 2003. Availability of Mental Health services in London. GLA.

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 1).

Figure 1



Source: LRC

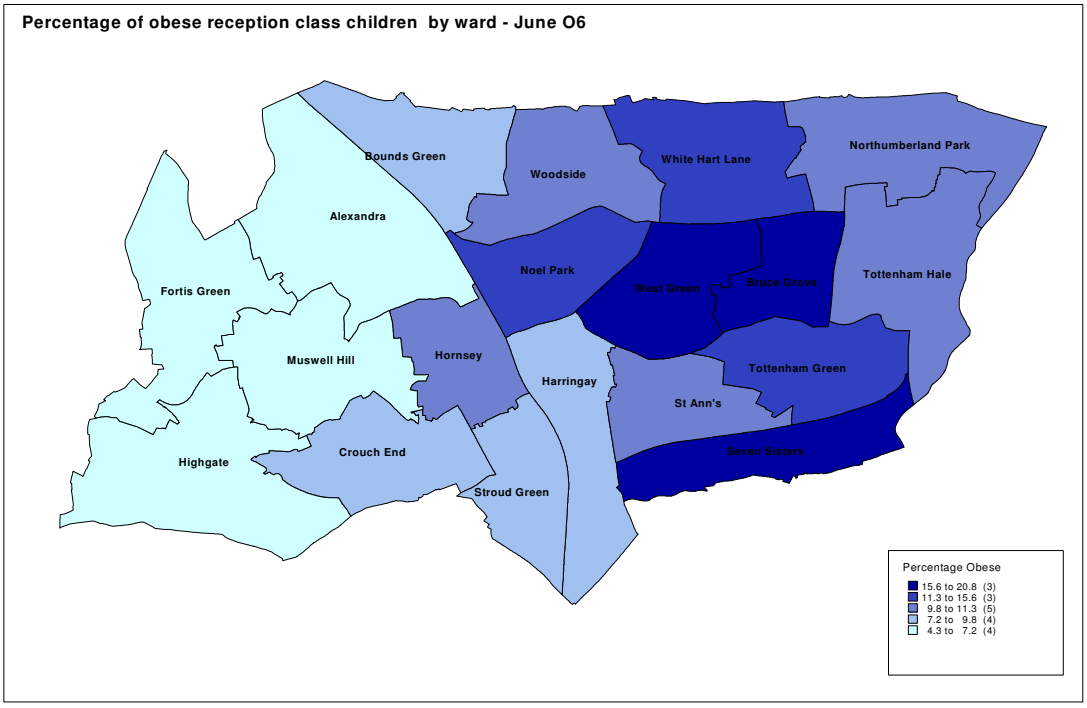
The registered population, which this strategy relates to, is somewhat larger and as at November 2005 there were 264,988 people registered with a GP practice in Haringey. Of these 24,600 (9.3%) lived outside the borough, over 90% of whom live in Enfield. We do not have access to data about how many Haringey 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 2).

Figure 2



Haringey also has a broad ethnic mix and the proportion of people from minority ethnic communities is set to increase, with more people from BEM 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.

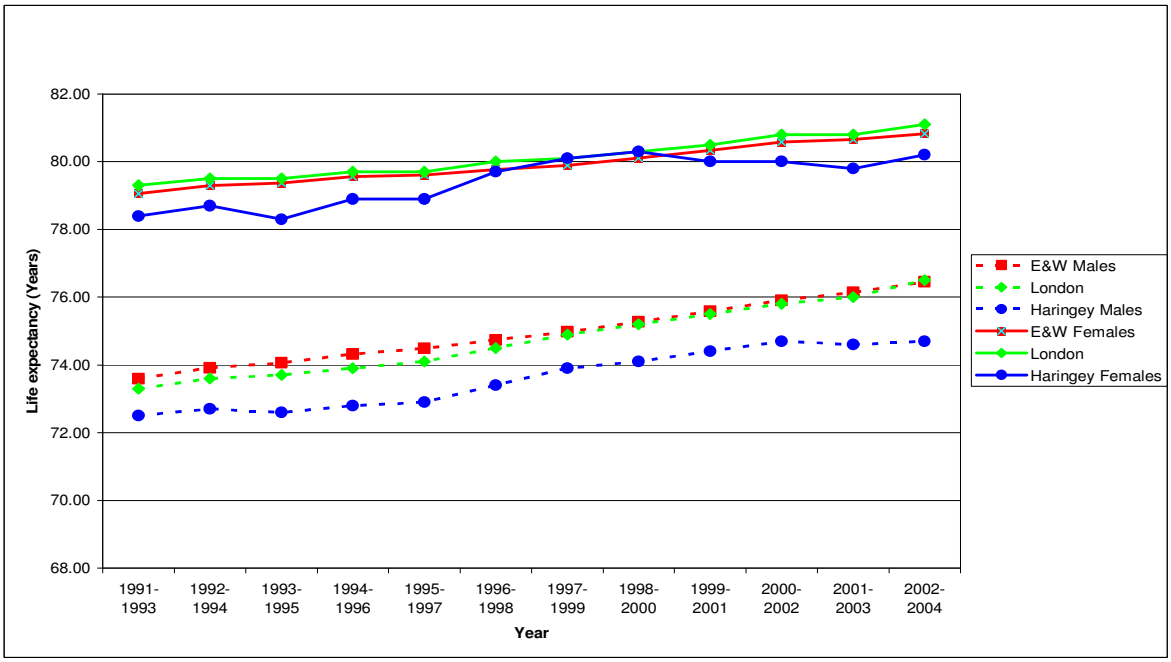
Morbidity and mortality

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 3).

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



Source: ONS/LHO

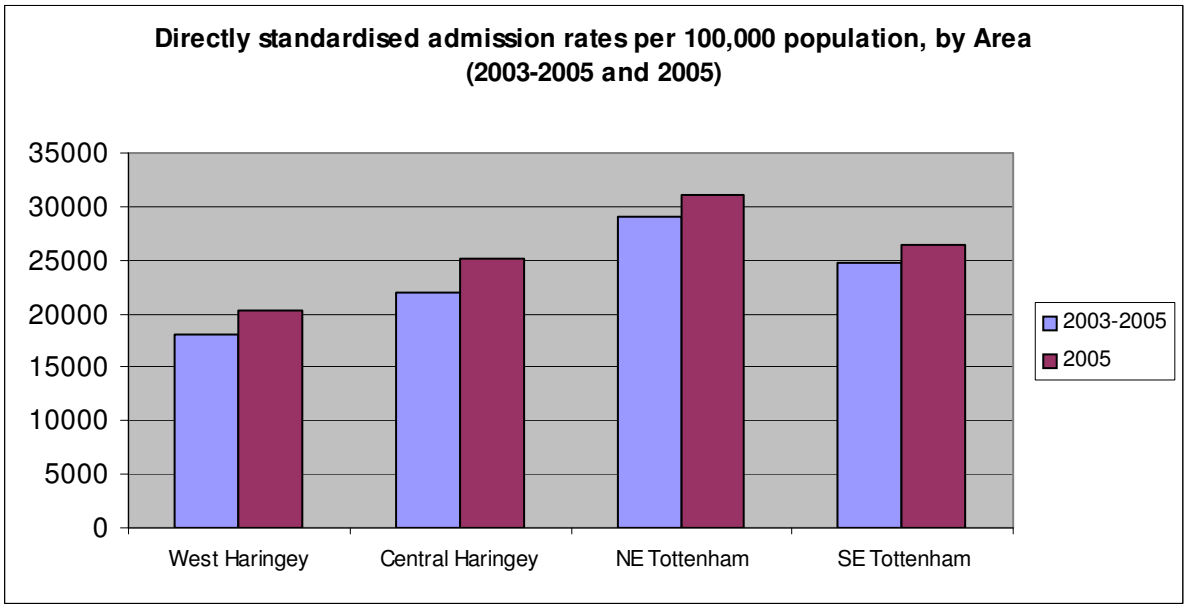
Health Service Use

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 4).

Figure 4



Source: Clearnet

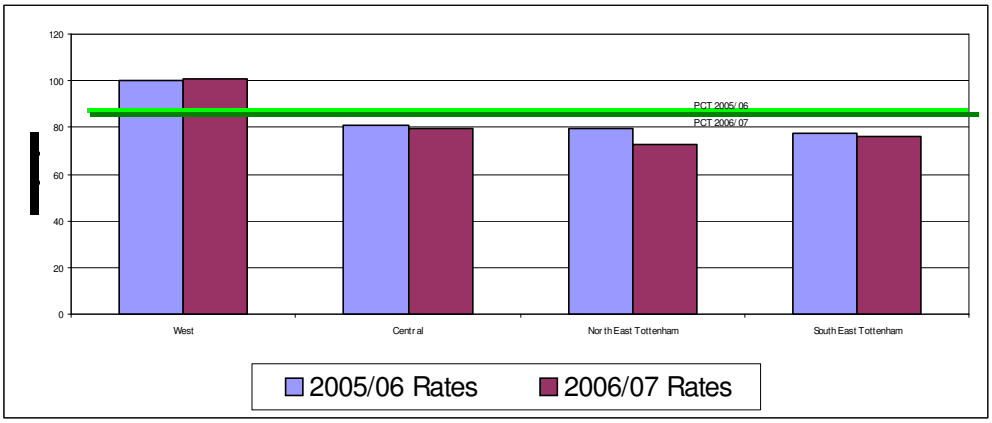
The most common reasons for admission to hospital for Haringey are heart disease and stroke, genito-urinary disease, renal failure and cancer. Patterns of admission for selected causes vary considerably between different parts of Haringey with the West having consistently lower admission rates for all 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), 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, reveals 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 5 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].

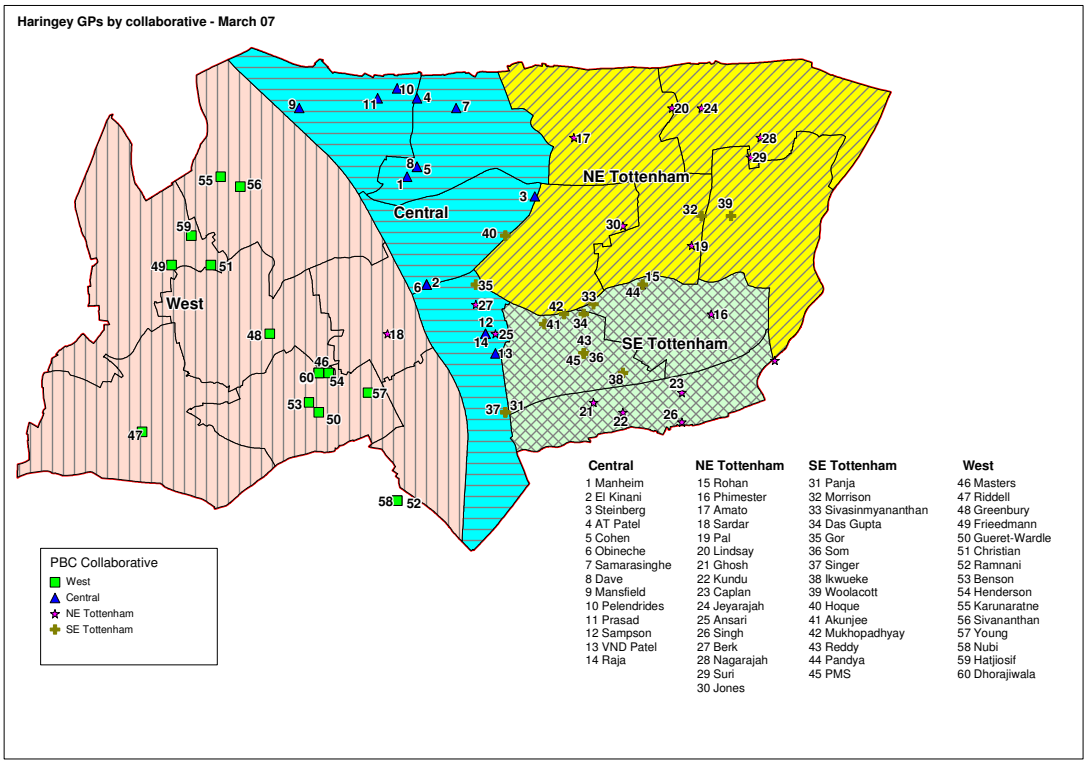
This suggests that there is not one type of practice that provides high quality primary[13].[14],[15] care overall. Larger practices appear to be better for clinical quality and poor quality is associated with deprived areas.

[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 1 Geographical distribution of practices



Practice populations

Table 4 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, 37 practices have list sizes of less than 4,000 of which 6 practices have list sizes of less than 2000 patients.

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 (eg 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.

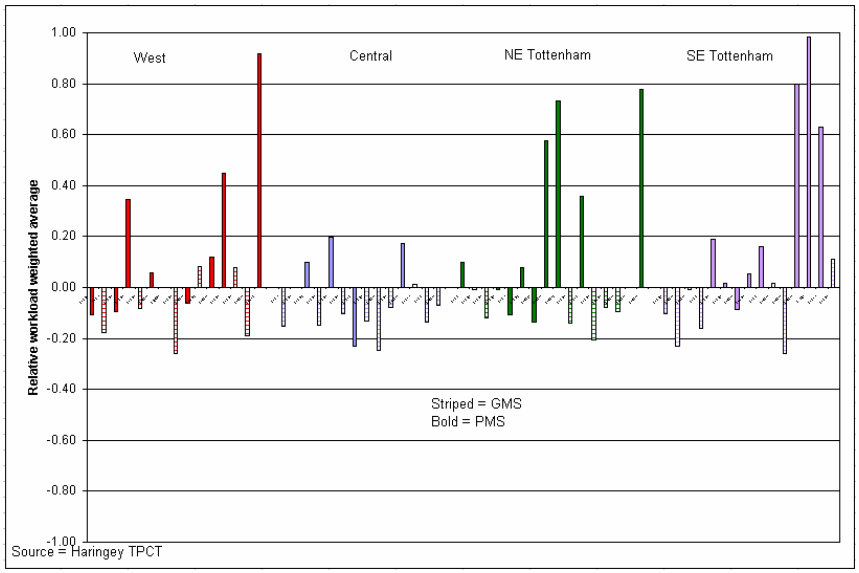
- In all three scenarios there is a markedly higher level of resource on average to PMS practices than to GMS practices. When weighted for deprivation the range is 0.86 for GMS practices vs. 1.12 for PMS practices. (I.e. for every 86p a GMS practice receives on average a PMS practice receives £1.12)
- 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.

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.

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 is 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 2007/2008.

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 pathways** 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 2007/2008.

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.