haringey strategic partnership

Well-Being Partnership Theme Board

Date: **4 March 2008**

Report Title: **Primary Care Strategy Next Steps**

Report of: **Helen Brown, Acting Deputy Chief Executive.**

Summary

This paper sets out the next steps for the development of the primary care strategy for Haringey, taking into account the outcome of the recent consultation and equalities impact assessment (EIA). Full reports of the consultation and the EIA are now available at http://www.haringey.nhs.uk/publications/primary_care_strategy/index.shtm

Recommendations

- To note the report.

For more information contact:
Helen Brown
Telephone Number: 020 8442 5400
E-mail: helen.brown@haringey.nhs.uk

Final version of primary care strategy

We will be producing a final version of the primary care strategy. The full list of recommendations (previously circulated and attached for ease of reference at Appendix A) will also need to be reflected in the changes made to the final strategy document.

Case for change

- Restate the case for change to respond to those who during the consultation did not want any change, and add further reasons for change noted during the consultation (e.g. current problems with access to primary care services).

The model of service delivery

- Set out an adapted model of primary care service provision that will comprise 4 super health centres based in each of the collaborative areas each networked with a number of other larger general practices in that area as follows:

  North East – Lordship Lane/Tynemouth Road (plus further consideration of provision in Northumberland Park)
  South East – Laurels/St Ann's
  West – Hornsey Central
  Central – Wood Green/Turnpike Lane (new development)

- Proposed centres based at the Whittington and North Middlesex hospitals to be focused on the provision of urgent care. We will need to set out clearly how these hospital-based urgent care centres would operate differently from community based super health centres and to explain how they will fit into the broader context of urgent care provision across the borough in future.

- The development of the model to be based broadly around and jointly led by the existing 4 PBC collaborative groups. This will include developing a local approach to needs assessment and engagement alongside the PCT-wide work on these areas. The intention remains to significantly reduce the number of small GP practices (ie with less than 4,000 patients) over time and phase out sub-standard premises. Whilst it is recognised that some small GP practices perform well, this mode of service delivery will not provide a sustainable model for Haringey in the future. The name "super health centre" could also be reviewed.

- Criteria will be developed to select the practices that will remain or need to be developed in addition to the super health centres, to include:
  - Minimum list size
  - Standard of premises
  - Standards of quality of care
  - Ability to work within networked model
  - Ability to offer extended opening hours
  - Location (ensuring appropriate geographical spread to assist with access and transport issues and ensure appropriate coverage especially in North East of the borough).

- Greater detail to be provided of how services will be delivered in this new model to include for example sexual health/family planning, foot health, diabetes, phlebotomy, physiotherapy, dietetics.

Health inequalities

- More information to be provided on how the primary care strategy can help tackle health inequalities through targeting resources and improving access, especially in the deprived areas of Haringey.

Workforce

- Plans for developing a workforce strategy including engagement with staff side and clinicians. This is potentially wide-ranging as it could pick up on issues as diverse as GPs and PBC to extended opening hours to role and function of receptionists.

Access

- We should provide some detail as to how we will be taking forward the recommendations of the EIA in order to improve access especially for groups experiencing discrimination and disadvantage, and developing indicators for measuring how successful the strategy is at doing this.

Transport

- The final version of the strategy should provide illustrations of how travel time will be affected (based on real life examples/illustrative case studies), this will be informed by the criteria relating to location noted above and the detail of how services might be delivered.
- A joint review of transport issues to be instigated, the outcome of this to include recommendations as to how transport difficulties can be minimised.

Governance and engagement

- Include options for governance arrangements of super health centres and principles of stakeholder engagement

Pharmacy

- Set out the parameters for developing a strategy on the role of community pharmacy.

Clinical quality

- Information on how the PCT will approach monitoring and managing performance during transitional periods to ensure that the primary care strategy supports GPs to maintain good practice and over time deliver measurable improvements in quality.

Levers for change

- Further clarification if possible on the incentives and drivers that will result in independent contractors adopting the new model proposed.

Table 1 below summarises the original proposals, the consultation and EIA outcomes and how the final strategy has taken these into account.

Next steps

Once the board has considered this paper, the final strategy will be produced, taking into account the outcome of Healthcare for London (consultation ends on 7 March) as noted above, and brought back to the board for their final decision in May.

We are in discussion with LBH Overview and Scrutiny Committee about the detailed planning of services in each area and in particular engagement with the public, GPs and other key stakeholders and the phasing of those planning/engagement processes, ie should we draw up detailed plans for each super health centre network before engagement with stakeholders or would it be more appropriate to phase this so that we develop plans in one area and consult before moving on to the next.

The TPCT will also endeavour to learn from similar developments in other areas throughout the next stages of the strategy development and implementation.

Table 1: Brief summary of how the strategy will change in response to the consultation and EIA

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

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

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

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

travel and more and better services	many concerns about increased travel distance	travel problems. Any worsening of the situation would adversely affect certain groups more	worth while and take steps to mitigate against greatest difficulties around travelling further
Acknowledging contribution of workforce	Need to ensure workforce have right skills including new skills needed to work in new model	As noted above competency around diversity needed as well as clinical skills, importance of role of receptionists and other non-clinical staff noted in promoting access to services	Develop detailed workforce strategy with involvement of staffside, clinicians etc
Links to other strategies	VCS noted need to link with wellbeing strategic framework Also to ensure needs of specific groups e.g. children and young people, mental health and people with learning disabilities are taken into account and services planned in conjunction with the strategic work underway in these and other areas	Key link needs to be between the primary care strategy and the strategic work to address health inequalities	Review other related strategies to identify common ground and how the primary care strategy can help deliver on these
6 super health centres proposed in Haringey	Queries raised as to if 6 would be enough (especially given that 2 are located outside the borough). Wish to retain other practices in addition to the new super health centres including concerns re Hornsey Central being sole provision in West of borough	Need to better understand travel issues and to mitigate against any particular difficulties faced by different groups	Go ahead with model of 4 super health centres within Haringey, 2 hospital-based, supported by network of other larger practices meeting set of agreed criteria.
Specific locations	Generally accepted locations	Need to ensure NE of borough	Developments to be focused

	specified with proviso regarding coverage/transport noted above	has sufficient provision	around the 4 collaborative areas, with the super centres sited broadly as set out in the original strategy but with networked practices providing “spokes” to these hubs to ensure appropriate coverage across the borough
Reduction to number of GP practices	Mixed views, concerns re reduction of service and travel	Transport issues raised	Number of single-handed GPs to reduce and substandard premises to be phased out over time, but retain networked practices as noted above
PBC	Few comments made	Not covered in detail	Strategy to be delivered through the PBC collaborative localities
Primary care contracting	Queries as to how GPs and pharmacists will be moved – concerns that they will not want to move and will be forced to do so	Not covered in detail	Further detail to be provided on contracting mechanisms likely to be used. Also further consideration of local governance arrangements for the networked super health centres
Role of community pharmacy	Concerns re affect on businesses, and potential loss of local pharmacies		Further work with LPC/local pharmacists to inform a pharmacy strategy
Transport	Biggest single area of concern	Big area of concern and will affect some groups more than others	A transport review to be carried out.
Premises	Some welcomed improvements to premises, comments made as to how to improve premises e.g.	Need to improve premises are not accessible. Design of new premises can help access	As noted above, substandard premises to be phased out. New build to be designed to high

	accessibility and comfort	especially for disabled people.	standard including in terms of accessibility
Financial strategy	Queries of the financial modelling and affordability, some concerns of LIFT and some opposition to privatisation/use of private providers	Reducing unplanned variations in services can help address inequalities. The financial strategy wasn't commented on in detail in the EIA process but the equity audit shows lack of link between need and resource allocation	All options to be explored in terms of financing new developments including ongoing liaison with the local authority Consider target re resource distribution more closely related to need
Engagement with stakeholders	Desire to influence the strategy	Need to engage range of stakeholders	Ongoing engagement in the overall strategy and in locality developments

Appendix A

DRAFT

Recommendations for primary care strategy from consultation report and equalities impact assessment

This paper sets out the main themes identified in the primary care strategy consultation and suggests how these issues might be responded to in the next version of the primary care strategy or other responses that might be required. We have also set out below where we cannot respond in the way people wanted us to in the consultation and the reasons for this.

1. No change – keep things as they are

The primary care strategy clearly sets out a case for change that we feel is compelling, we cannot continue with the current model of service provision. Although we understand that there is lots of good work underway already and many people are satisfied with their primary care service, our current model is not sustainable and does not provide the opportunities for delivering improved services to Haringey residents. In particular it is not possible for us to keep some of our current premises as they are not fit for purpose and cannot be developed to an acceptable level. This is not an option for us.

2. Develop a networked model of super health centres and retain some existing primary care premises

The consultation documentation set out an approach focusing on six super health centres with a small number of additional GP practices. Concerns about this approach were expressed in the consultation and, although further work will need to be done on the financial implications to ensure it is affordable, a greater emphasis on a networked model is suggested. This would seem to answer many of the concerns raised during the consultation, including those in relation to transport, and would allow the improvements in opening hours and range of services available that people would like to see.
The adapted model would include the development of super health centres (in a phased way) at:

- Lordship Lane and Tottenham Hale (or environs)
- Hornsey Central
- Wood Green/Turnpike Lane
- St Ann's, The Laurels and Tynemouth Road.

Development of super health centres at the Whittington and North Middlesex to be taken forward as well, but with a different emphasis around better management of urgent care than the community based services that would develop in the four super health centres listed above.

In addition, a number of existing primary care practices would be retained and developed as appropriate. These practices would be linked with the super health centres to provide a network of primary care that would be accessible to all Haringey residents and most importantly would work together in an integrated way. Small/single-handed GPs in unsuitable premises would not fit

with our model of service delivery, and over time, we would like to see these GPs move to provide services as part of the new model.

In order to identify those primary care practices that are likely to be retained and/or developed as part of our networked model of primary care, it would be helpful to develop some criteria that they would need to meet, taking into account the population needs of the area they serve. This is likely to include for example:

- Minimum list size
- Premises meeting certain standards
- Minimum standards of quality of care
- Ability to work with local super health centre
- Ability to offer extended opening hours.
- Location which ensures appropriate geographical spread to assist with access/transport.

A number of other PCTs have already done some work in this area (including Heart of Birmingham PCT) and we would look to learn from their experiences.

It may or may not be desirable at this stage to identify those practices that are likely to meet these criteria and hence to be retained, or to respond to the particular calls for certain practices to be retained that were made in the consultation.

We may also wish to respond to the calls from a small but vocal group who want to see a fully functioning DGH on St Ann's site. The BEH Clinical Strategy sets out the options for acute provision in Barnet Enfield and Haringey. That detailed process did not identify a need for another acute provider based at St Ann's. However, we are clear that the sort of community based access to a much wider range of specialist services called for could be met through the super health centre model we are proposing.

3. Amount of provision/coverage especially in the North East

The proposal above should address this issue, however in addition it is recommended that there is a clear statement that we will look again at the north east of the borough and undertake further modelling to identify how best to meet the challenges of need and access posed by that area. Also we need to do more to either counter the perception that we are under-doctored or to take specific action to improve distribution of primary care services/increase establishment if necessary.

4. Transport

We should acknowledge the difficulties that people currently face in travelling to health services and consider undertaking a review of this and the PCT's role in providing/facilitating transport to health services and the role of other key partners e.g. the local authority, Transport for London. Many people responding to the consultation said they would have to travel further if they were to go to a super health centre instead of their current GP practice. However, most did not take into account the potential for reducing journeys to hospital by having services currently only provided in hospital available in the

super health centres, and organised in such a way as to have a one-stop shop type approach. We have drafted some illustrative case studies that attempt to show how travel might be affected. These need to be finalised. If the networked model outlined above is accepted, further work should be undertaken to see what kinds of journeys people would need to take. If a review is carried out, a transport strategy could be devised that would clarify what transport can be provided/commissioned by the PCT and what other partners can do to improve travelling to health services and how we would work together to influence Transport for London. This strategy should be informed by the expertise of local disability groups.

We should acknowledge that any increase in difficulties in travelling will adversely affect people with disabilities and mobility problems including older people, as well as those on lower incomes more than other people.

The issue of freedom passes not being valid before 9.30 a.m. and therefore older people not being able to access early appointments came up on several occasions in the consultation – this may be something we want to comment on. However, this is presumably something that can be addressed between the patient and the practice – as patients could simply ask for appointments after this time, unless there are other issues here that need to be addressed.

5. Access

A series of actions need to be taken to ensure that the primary care strategy will not reduce access especially for vulnerable groups. This includes considering the issues related to transport outlined above but also issues around workforce training and development, language services, appointment systems, building design and supporting people to access primary care.

Suggestions for improving the outcome statements for patients in the primary care strategy are made in the PHAST report carried out as part of the EIA. These could be incorporated into the next version of the strategy, and linked to key indicators which should be developed to monitor issues around access over time e.g. 'did not attends' by specific groups, ethnicity recording.

6. Working with GPs and Practice-based Commissioning Collaboratives

More description of how the PBC collaboratives will implement and support the developments should be included in the next version of the strategy. However, it is clear that the Practice Based Commissioning (PBC) collaboratives will be instrumental in developing and refining the networked care pathway and responsible for commissioning care for the super health centre network populations along those pathways.

7. Implementation, governance and performance monitoring

In order to benefit from the wealth of ideas from the voluntary and community sector organisations in relation to improving primary care, and to continue to involve public, patients and other key stakeholders in the development and

implementation of the primary care strategy, ongoing stakeholder involvement is recommended. Service users and other stakeholders should be integral to the implementation process for each super health centre. This should be through representation of proposed patient and public involvement structures linked to PBC collaboratives with collaboratives taking a lead in the development of health centres for their locality. This structure will need to feed into HTPCT's commissioning structures as well as into its governance and performance structures.

8. Organisation of services including continuity of care, appointment systems

It needs to be clearly stated that patients will be able to continue to see their same GP if that GP moves to a super health centre, and that they will be able to make appointments with that same GP for planned care. However, for urgent care, as at present, patients might need to see another professional. The feasibility of having different types of appointment systems should be explored e.g. some drop-in non-urgent sessions as well as booked appointments in order to address some of the issues about access. Concerns about waiting times will be difficult to allay, but should be noted and taken into account in appointment systems.

9. Services provided in super health centres

Foot care and blood testing should be priorities for inclusion in super health centres and reference to the full list of services required should be made in terms of service planning, as well as full local needs assessments and greater involvement of local stakeholders in planning/commissioning services.

10. Workforce

A workforce strategy needs to be developed to ensure that the right staff are in the right place to deliver the strategy and to address some of the issues in relation to access that have arisen during the consultation. This should include raising awareness of the specific needs of vulnerable people and of other specific groups such as carers, children/young people, older people and those with mental health problems and include all of the workforce.

11. Hospital based model

Further work needs to be done to define how the super health centres might work that would be located at the acute hospital sites, and how they might work differently to those within the community/primary care settings and focus on urgent care.

12. Health inequalities

The development of the individual super health centre networks should be informed by a clear understanding of the needs of the populations they serve. This should underpin what services are commissioned and what performance measures are used to monitor the implementation and success of the super health centre model in addressing health inequalities.

It would also be helpful to raise awareness of what the PCT is currently doing to address health inequalities. The issues in relation to the distribution of services noted above also need to be addressed. More widespread access should be given to preventative interventions and health information as part of the strategy.

13. Pharmacy

Further work to be undertaken with pharmacists to develop an approach that would support the new model.

14. Children and Young People

The primary care strategy should include more detail as to how it will help implement the children and young people's agenda and work with children's services.

15. Older People

Action related to concerns raised about transport will be particularly important for older people; other issues for older people could be specifically addressed in the next version of the primary care strategy.

16. Mental health

Further work to be carried out to plan how people with mental health problems might benefit from the primary care strategy and how mental health services might work alongside primary care.

17. Learning disabilities

The work that has been done to date to identify the needs of people with learning disabilities needs to be incorporated into the implementation of the strategy. This to include the recent review and recommendations by the Overview and Scrutiny Committee

18. Carers

The specific needs of carers in relation to primary care services could be considered further, and included in workforce training and development.

19. St Ann's site

As noted above, there were some calls for a hospital on St Ann's, the mental health trust were also keen to work together on proposals for this site. It might be helpful to have a position paper on proposals/options for the site.

20. Privatisation concerns

We need to be clear that the super health centre model is not about privatisation but about quality. We will look to commission services from a range of providers including local NHS providers, 3rd sector providers as well working with private providers. This will be in line with Department of Health policy that the TPCT is expected to develop and work with a range of providers to deliver the best possible services for its population.