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

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Clear case for change: outdated model	- Some wanted to see no change – happy with way things are - Some welcomed changes - OSC were convinced of need to develop and improve services.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

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

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

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

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

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

Appendix 2: Summaries of consultation and EIA

Executive summary of Consultation

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

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

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

Executive Summary of Equalities Impact Assessment

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

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

Appendix 3: Who uses primary care and why?

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

Data from the surveys reviewed have shown that:

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

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

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

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

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

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

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

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

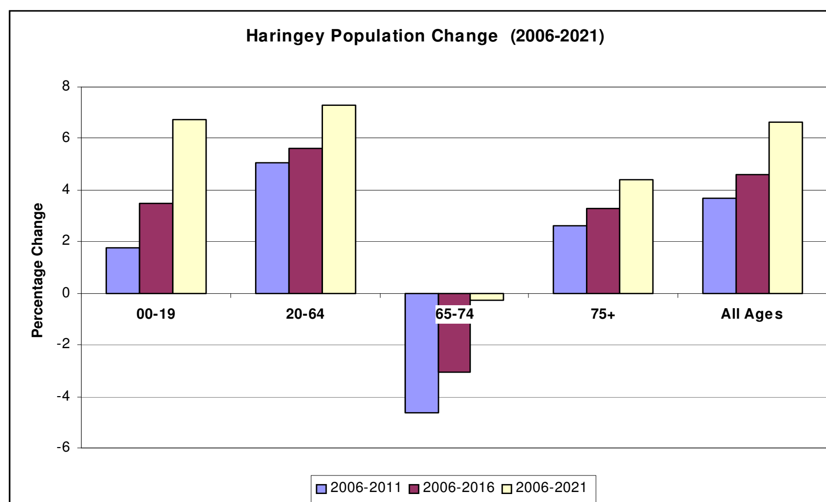
Appendix 4: The people of Haringey and their health needs

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

Demographic changes

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

Figure 6



Source: LRC

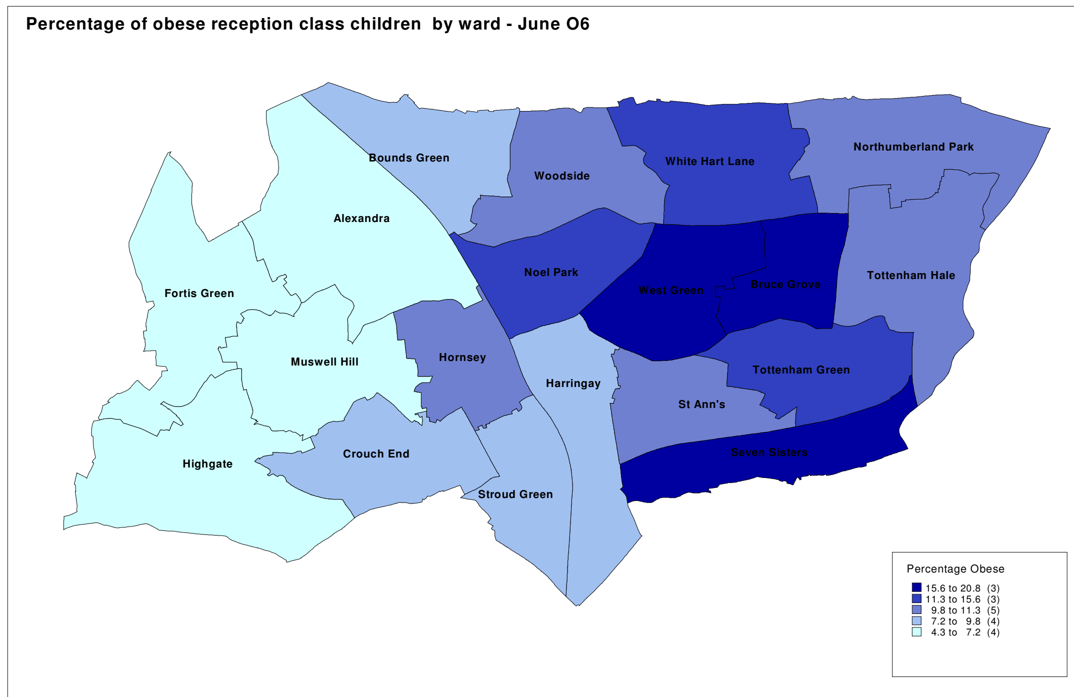
The registered population is somewhat larger and as at November 2005 there were 264,988 people registered with a GP practice in Haringey. Of these 24,600 (9.3%) lived outside the borough, over 90% of whom live in Enfield. We do not have access to data about how many Haringey residents are registered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

Deprivation and health outcomes

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

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

Figure 7



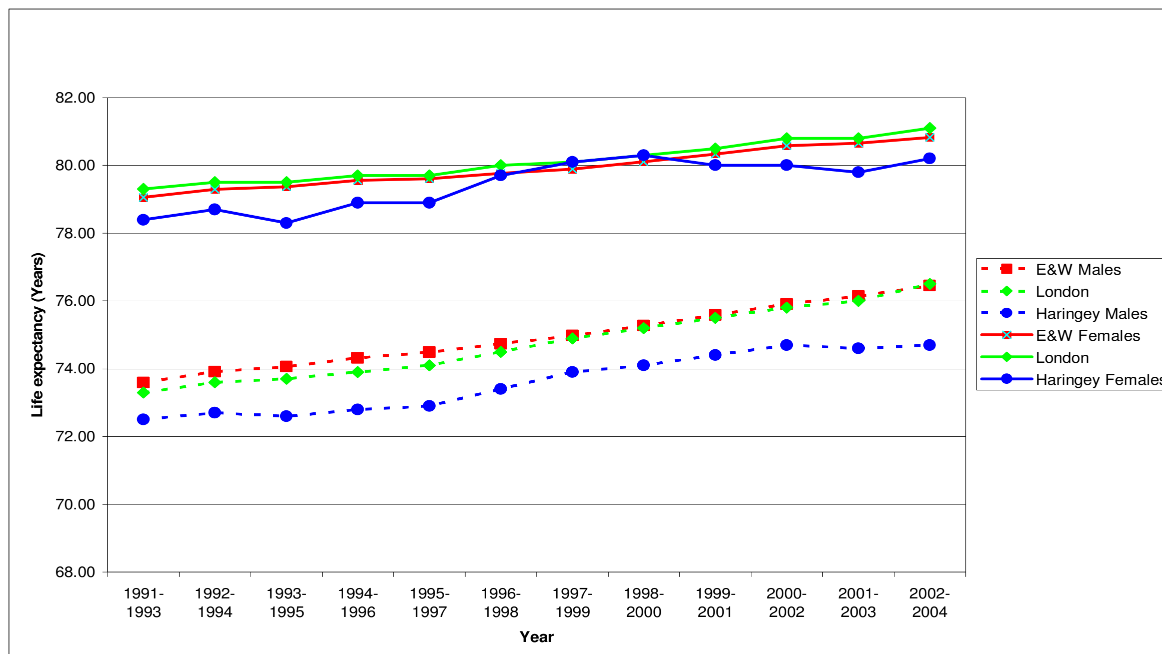
Haringey also has a broad ethnic mix and the proportion of people from minority ethnic communities is set to increase, with more people from BME communities in the older age groups. This will have implications for long term conditions, although the overall proportion of people aged 65-74 is set to decrease,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

Morbidity and mortality

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

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

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



Source: ONS/LHO

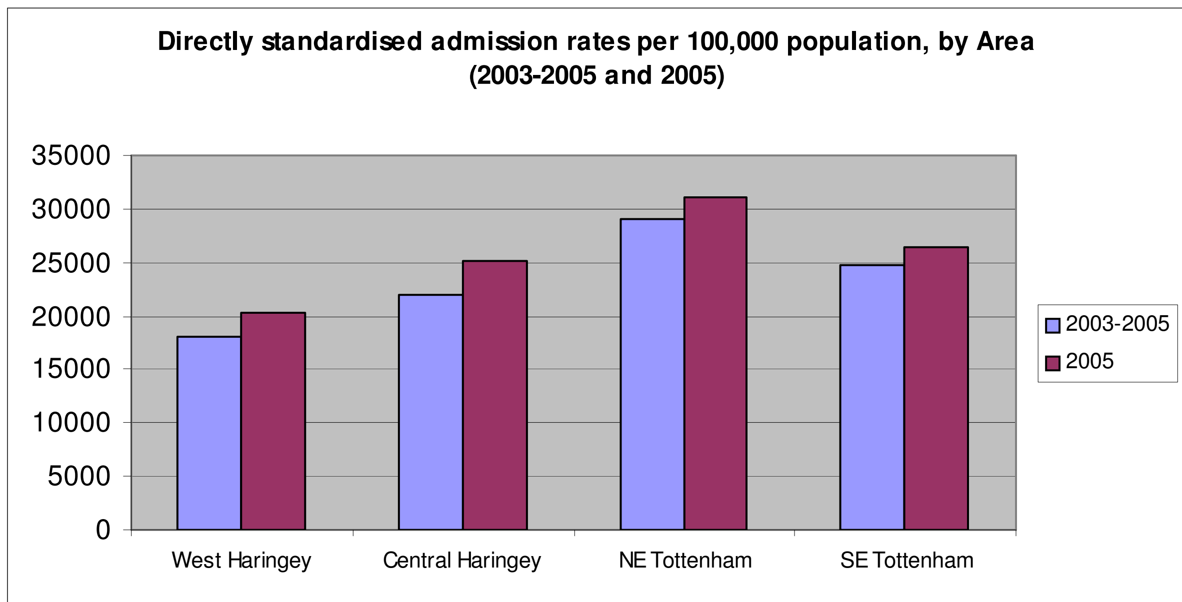
Health Service Use

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

Inpatient admissions

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

Figure 9



Source: Clearnet

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

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

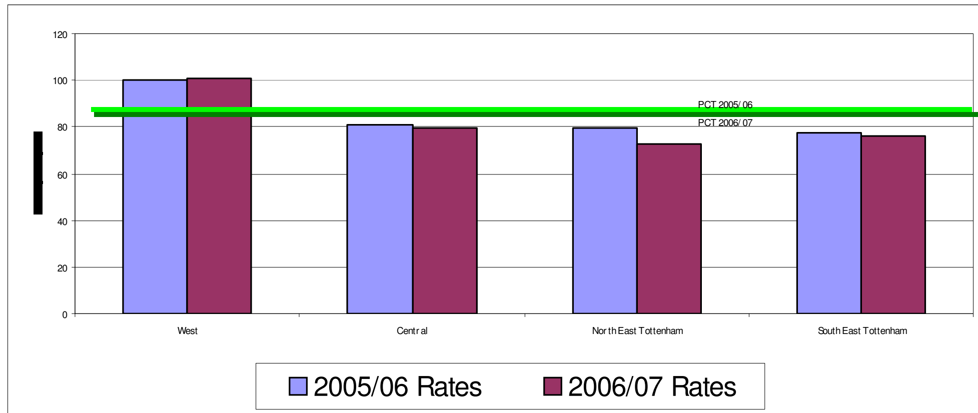
Outpatient Care

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

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

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

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



Appendix 5: What patients want

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

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

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

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

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

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

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

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

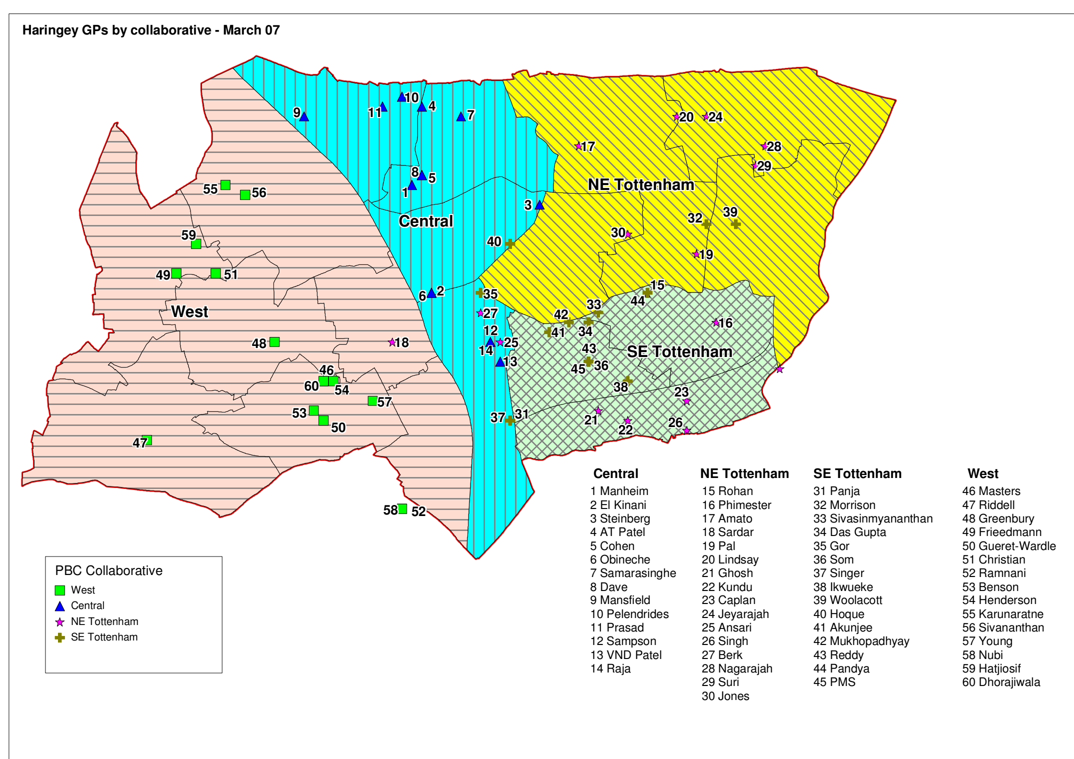
These findings from our local consultation reflect what we already know about what patients say they want from a primary care service from published studies and other public consultations as set out above. Much of the work on seeking patients' views has focused on accessibility and continuity of care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

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

Appendix 6: Current GP services in Haringey

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

Figure 11 Geographical distribution of practices



Practice populations

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

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

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

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

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

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

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

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

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

Geographical distribution of practice lists

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

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

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

Access

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

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

Out of Hours provision

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

Appendix 7: Resource allocation

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

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

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

When analysed in more detail the audit demonstrates:

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

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

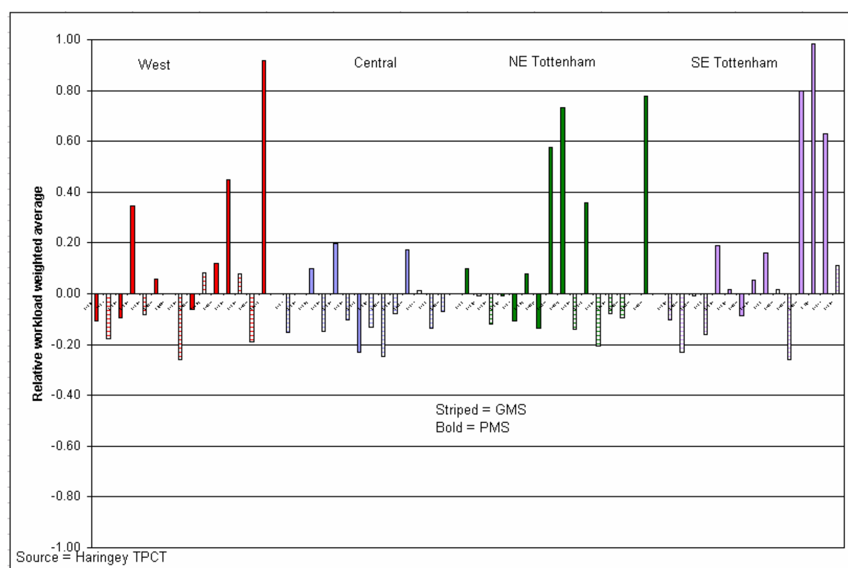
- When lists are weighted for deprivation practices in North East Haringey are on average relatively less well resourced than practices in other areas of Haringey.

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

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

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

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



Appendix 8: Clinical Quality

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

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

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

Quality and long term conditions – Diabetes as an example.

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

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

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

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

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

Appendix 9: Primary care premises

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

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

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

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

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

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

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

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

Other studies suggested that:

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

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

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

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

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

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

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

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