Commentary – Alma Ata

Participation, equity and inter-sectoral collaboration in general practice: the case of Vauxhall Primary Health Care

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Our practice, Vauxhall Primary Health Care was set up in 1993 with the vision of Alma Ata firmly in its founding principles. Fifteen years later our belief in this approach remains. Working this way takes commitment, and there have been struggles and doubts along the way but we still feel that we, and hopefully the community that we serve have gained through this approach. We, like all practices now face the challenges of the current health and political systems how do we handle the current rapid change and make it work and not lose what we believe is the best of general practice.

Initial conditions

In 1992 Liverpool was one of the most deprived cities in England. It was the only city in England to achieve 'Objective One' status – receiving European funds given only to the most disadvantaged cities in Europe. Once, Liverpool was the 'Gateway to Empire'. People from all over Europe came here to get on boats to hopeful futures. With the end of the working docks, there was out-migration of the healthy, leaving one of the most cosmopolitan and sick cities in the developed world. The health figures for the city were poor and there were difficulties attracting doctors to the inner city.

The Alma Ata Vision resulted in the Healthy City 2000 programme – intending to embed the principles of participation, equity and inter-sectoral collaboration within mainstream policy. The first international Healthy City conference was held in Liverpool in 1988. The following year the Primary Care Facilitation Project was set up, driven by the same principles, but

focused on the development of general practice. This partnership provided mechanisms to achieve collaboration for health in many different ways. The City Council and Family Health Service Authority (FHSA) met regularly to plan coordinated policy. Shared policy for issues such as heart disease was developed through a participatory process that involved big business, the voluntary sector, trade unions, community groups, faith communities and Liverpool football club. A multi-disciplinary teambuilding programme helped general practices to become reflective, inquiring places. A pan-organisational programme (Common Purpose) helped middle managers to network, bringing those skills with them when they advanced to more senior positions.

The new Vauxhall Health Centre

In 1992 the Liverpool FHSA deprived area strategy focused on Vauxhall, a section of the city that was most disadvantaged. Local people had approached the FHSA to express their unhappiness as they felt that this was an area of high need, and that there was inadequate primary health care services in the area. Vauxhall Health Centre had already been built largely initiated by local people. However, it was a poorly used building. Barbed wire surrounded it. Break-ins were common. Over a year or so, supported by both universities, the FHSA funded a Community Diagnosis, community consultation, and a community development programme. One main focus was the setting up of a new General Practice. Actively involved local people set up the Vauxhall Health Forum.

Representatives of the Vauxhall Health Forum and the FHSA interviewed and appointed us, the two co-authors as a job share to set up the new practice. We spent a year meeting regularly with the Vauxhall Health Forum, and others of the local community in schools, youth clubs, carers groups, to listen to what they saw as their health priorities, and how health services could be responsive to them. We agreed with the Vauxhall Health Forum that the already existing health centre was the right place to build the new practice but it needed to be transformed to become an attractive, accessible place.

In 1993, we opened the practice. The first few years were an intense period of building a patient list, building up a primary health care team to deliver services, and working with the Health Forum and an appointed architect to physically transform the health centre. Each major decision we took about the direction of the practice and the health centre was taken in consultation with the health forum, and this was a new experience for us. A representative of the Forum was involved in the recruitment of all our early staff, including new doctors and nurses. The Health Centre, with community input, evolved into an open plan welcoming space, and the glass barriers (and non visible barriers) of reception came down. We introduced daily drop in GP surgeries as well as regular appointments as the Health Forum felt that drop in sessions worked best for this community but we also advised them that appointments allowed GPs to provide continuity of care and safety netting.

Now, in 2008, nine GPs work here, serving a population of 6500. The health service has been through a series of reorganisations and the FHSA is now replaced by the Liverpool Primary Care Trust (PCT). We continue to juggle the work of servicing the needs of the more chaotic. However, the practice has become more organised so that we can deliver planned services and focus on effective management of people with chronic illnesses and deliver on 'gold standard' targets. As our team has expanded, we have the constant tension of trying to provide enough appointments to encourage people to book with the same doctor for ongoing problems and yet providing flexibility so that the more chaotic are not excluded. This group includes people with drug dependency and the Irish Travellers for whom we are the main practice. In 2007, we provided 668 consultations (a 'consultation' refers to open access; booked appointment; home visit or telephone) to 107 travellers, averaging six consultations per traveller. Our rate on cervical screening in 1993 was 58%; currently in 2008 is 72%.

We get good feedback of the doctors and nurses' consulting style, with people stating that they feel listened to and offered practical help; patients also remark positively about our tendency to consider non-medical ways to improve things. Three of our

doctors practice acupuncture and one hypnotherapy. In 2007, we provided 317 acupuncture sessions and 35 for hypnosis. Where local people had in the past perceived receptionists as a barrier to accessing their GPs, ours are praised as the patients' advocates, and for their helpful friendly manner.

We try to maintain the health centre an accessible community space. A few mornings each week, volunteers from the community serve tea and toast. Every week members of a reading club share their views about a book, or read to others. There have been various initiatives, for example yoga classes, sociable diabetic days, where community food workers made healthy food along with the patients.

We try to have an open team atmosphere. There are opportunities for the whole team to be aware of and debate any potential major changes in the way of working. We have regular meetings for all team members, regular journal clubs, palliative care meetings and meetings to discuss vulnerable people. Medical students and registrars often join us and we have previously taught refugee doctors.

We continue inter-sectoral collaboration. Where possible we signpost to external resources and help to develop them. Vauxhall has a close community and a long history of local people working to improve things for themselves. For example, the Rotunda College is an Adult Education College which local people use and we have been mutually supportive to each other since the beginning. We signpost patients to their various courses. We have worked with them to develop a course for people with personality disorders.

Similarly we signpost people to the Vauxhall Neighbourhood Council for advice on welfare rights or to the Community Law Centre. The PCT runs programmes and projects (e.g. 'walk for health' or 'back to work') that we encourage patients to use.

The Vauxhall Health Forum remains a constant 'critical friend'. Our practice manager and a receptionist attend their meetings regularly, and we consult when we are planning changes (e.g. when we wanted to change our open access surgeries to urgent access and increase booked GP appointments).

Data

We employ a full time IT facilitator to generate data about our work. This helps us to anticipate what we need to do to do well with the GP contract Quality Outcome Framework, and other quality measures. It also allows us to examine things that particularly interest us, such as auditing care of people with drug dependence and we try to find ways of measuring how we work that is not target based.

What we have learned

The most important thing we have done is simple and difficult at the same time. It is about listening to people. Listening to the patient, and the importance of the long term relationships. Listening to our team members and ensuring that their input really shapes how the practice develops. As our team expands, this is more complex – new people may see possible better ways of working. This needs to be heard, without losing the original vision.

Like all GPs, we have seen constant change around us and have to make the change work for us. We support the drive to improve quality of care across all practices. We recognise that there needs to be some objective measures, but are concerned that the measures and targets are becoming overwhelming and that we are at risk of forgetting that what can be measured is only a small part of what matters to people. Currently, we are working with our neighbouring practices and

with our Practice Based Commissioning Consortium. This is a relatively new way of working and we hope it will help to improve collaboration, equity and participation across the whole area and drive up care by all practices. But we have to keep in mind the centre of it, the patients with their complex needs need to be at the heart of our planning and collaborative work, and this might sometimes contradict the measurable 'gold standard' targets.

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