# **Chapter 6: Service Utilisation**

Demand on health and social care services results from the health status of the population discussed in the last chapter. This chapter discusses health and social care service provision, quality and usage in Thurrock.

# 6.1 Children's Social Care Services

### 6.1.1 Childcare Sufficiency

Thurrock's 2010 – 2011 Childcare Sufficiency Assessment focuses on how Thurrock Council could address the issue of ensuring there are enough formal childcare places accessible in the locality for those residents and working parents who need them. The assessment was put together following a large scale consultation with parents, childcare providers, local employers, stakeholders and children and young people. The availability of the following types of childcare provision was assessed: Day Nurseries, Pre Schools and Playgroups, maintained school nursery classes, out of school childcare providers and registered child minders. The results of the analysis which identified unmet need for five Thurrock geographical 'clusters' are shown below:

#### Wards:

- Corringham and Fobbing
- East Tilbury
- Orsett
- Stanford East and Corringham Town
- Stanford le Hope West
- The Homesteads

Areas where need is being unmet:

- The availability of holiday play scheme type provision across the cluster
- Day care provision in the Homesteads ward
- Out of school childcare places within pre-schools/playgroups across the cluster
- Sessional childcare places within pre-schools/playgroups across the cluster
- Extended hours opening across the cluster

#### South Cluster:

#### Wards:

- Chadwell St. Mary
- Tilbury Riverside and Thurrock Park
- Tilbury St. Chads

#### Areas where need is being unmet:

- The availability of child minding across the cluster
- Sessional childcare places within pre-schools/playgroups across the cluster

#### West Cluster:

#### Wards:

- Aveley and Uplands
- Belhus
- Ockendon
- West Thurrock and South Stifford

#### Areas where need is being unmet:

- Childcare provision in Ockendon
- Sessional childcare places within pre-schools/playgroups across the cluster

Central (	Cluster:
Wards:	
•	Chafford Hundred and North Stifford
•	Grays Riverside
•	Grays Thurrock
•	Little Thurrock and Blackshots
•	Little Thurrock Rectory
•	South Chafford
•	Stifford Clays
Areas w	here need is being unmet:
•	Childcare provision across the cluster, particularly in Grays and Stifford Clays

# 6.1.2 Initial Contacts, Children in Need and Child Protection cases to children's social care

The table below shows the numbers of initial contacts, referrals and child protection cases broken down by ward.

number from each ward				%	% from each ward		
Ward	Contacts	CIN	СР		contacts	CIN	СР
Aveley and Uplands	372	30	8		5%	4%	4%
Belhus	546	65	15		7%	8%	8%
Chadwell	745	61	24		9%	8%	13%
Chafford and North Stifford	260	24	1		3%	3%	1%
Corringham and Fobbing	105	3			1%	0%	0%
East Tilbury	296	22	12		4%	3%	6%
Grays Riverside	709	54	19		9%	7%	10%
Grays Thurrock	590	53	11		7%	7%	6%
Little Thurrock Blackshots	245	18	2		3%	2%	1%
Little Thurrock Rectory	93	18	1		1%	2%	1%
Ockendon	507	38	10		6%	5%	5%
Orsett	68	15			1%	2%	0%
South Chafford	280	18	7		3%	2%	4%
Stanford East and Corringham Town	278	35	5		3%	4%	3%
Stanford-le-Hope West	207	31	3		3%	4%	2%
Stifford Clays	172	33	1		2%	4%	1%
The Homesteads	193	23	1		2%	3%	1%
Tilbury Riverside	830	80	17		10%	10%	9%
Tilbury St. Chads	446	61	14		6%	8%	7%
West Thurrock	843	81	24		10%	10%	13%
No Ward matched	266	15	15		3%	2%	8%
Grand Total	8051	778	190		100%	100%	100%

# Ethnicity of Children in need, children subject to child protection plan and in care

Ethnicity	CIN	СР	LAC
A1 - White British	605	146	171
A2 - White Irish	2		
A3 - Any Other White Background	18	2	6
A5 - Gypsy / Roma	5	1	9
B1 - Mixed White/ Black Caribbean	18	3	5
B2 - Mixed White/ Black African	8		3
B3 - Mixed White/ Asian	7	2	3
B4 - Any Other Mixed Background	19	12	9
C1 - Indian	5		
C2 - Pakistani	1		1
C3 - Bangladeshi	6		
C4 - Any Other Asian Background	6		16
D1 - Caribbean	6	2	
D2 - African	44	16	8
D3 - Any Other Black Background	10		3
E2 - Any Other Ethnic Group	13		7
E4 - Information not yet obtained	3	6	3
Not Recorded	2		
Grand Total	778	190	244

Current Age	CIN	СР	LAC
-1	20	3	
0	44	26	13
1	44	16	5
2	36	11	9
3	41	16	7
4	43	11	12
5	54	15	6
6	40	14	5
7	47	13	7
8	40	10	11
9	42	4	12
10	35	11	17
11	37	6	18
12	38	8	11
13	46	9	12
14	40	5	17
15	44	8	24
16	41	4	28
17	32		26
18	10		4
Grand Total	774	190	244

Gender	CIN	СР	LAC
Female	322	90	101
Male	436	97	143
Unknown	20	3	
Grand Total	778	190	244

# CIN category of Need Type

Category of Need Type	Total
N0 - Not Stated	2
N1 - Abuse or neglect	446
N2 - Child's Disability	204
N3 - Parental illness or disability	9
N4 - Family in acute stress	27
N5 - Family dysfunction	64
N6 - Socially Unacceptable Behaviour	10
N8 - Absent Parenting	11
N9 - Cases other than children in need	4
Not Recorded	1
Grand Total	778

#### CP category of Need

CP Category	Total
Emotional Abuse	35
Multiple	23
Neglect	118
Physical Abuse	10
Sexual Abuse	4
Grand Total	190

#### 6.1.2.1 Thurrock Multi-Agency Group Services (MAGS) panels

Thurrock's Multi-Agency Group Services (MAGS) panels accept referrals made primarily but not exclusively from schools for cases where there is a concern with a child or young person who will not meet the statutory threshold for a social care intervention. Cases are referred by a Common Assessment Framework (CAF) and discussed in a multi-agency group meeting on a monthly basis in one of four localities in Thurrock. Should a multi-agency approach be required, services are then identified and put in place to address these needs proving that there is agreement from the family to this voluntary non-statutory service. Cases are monitored on a monthly basis whilst open.





Figure 6.1 shows the volume of referrals to MAGS panels from 2010/11, since when accurate data has been collected. As figure 6.1 shows, there has been a decline in the number of referrals from 2010/11 to 2011/12. This can be partially attributed to open cases being scrutinised more closely and cases where support is no longer required being appropriately closed. However there has been a decline in referrals generally with a need for the current process to be re-invigorated and refreshed. This will start to be the case once Thurrock's Early Offer of Help (Early Intervention) programme comes on stream from April 2013.



Fig 6.2

Figure 6.2 shows a breakdown of referrals to MAGS by ward, and also the electoral population of that ward. Data is only held for 2010/11 and covers around 300 cases presented in that year. Referrals are high across some areas of deprivation; Tilbury Riverside, Tilbury St. Chads and Belhus having the largest number of referrals. As figure 6.2 shows, Tilbury Riverside and Tilbury St. Chads have a percentage of MAGS referrals by ward population compared to other wards. However these numbers are statistically small and do sometimes relate to certain schools being more regular referrers to MAGS Referral data into Social Care may be a more accurate reflection of need by ward. It should also be noted that the number of children per registered electoral population in a given ward may also vary.

#### Fig 6.3



As evidenced in the figure 6.3, the overwhelming majority of referrals to MAGS are from White British families with almost double the number of referrals for boys than for girls. Around one in 10 referrals were from families where there was a child with a self-stated disability. Referrals from ethnic groups are very small in comparison to both the level of referrals to Social Care statutory services and the ethnic diversity of the borough. For example referrals to Social Care from Black African families present at around 8.5% (2.5% referrals to MAGS) and from mixed families around 6.5%. There is a clear commissioning need to ensure that services are accessible and utilised by these groups. The Early Offer of Help Project will be seeking greater promotion of services to ethnic groups from the Voluntary, Community and Faith Sector as well as Private Sector providers. Focus needs to be given to these groups to ensure they match the need that is clearly demonstrated in the ethnic breakdown of referrals to Social Care, as detailed within this needs analysis.

During the consultation with children and young people for the Early Offer of Help project, children and young people spoke of the need to have culturally sensitive support services and that there was often stigma attached with accessing some services for those from particular ethnic backgrounds. This will be strongly emphasised within the standards of expected delivery that providers will need to ensure all ethnic groups are able to effectively access services and to promote these services within all hard to reach communities.



Fig 6.4

Figure 6.4 shows referrals into MAGS by age. As figure 6.4 shows, referrals generally rise steadily from age 6 peaking at around age 12 to 13 and then falling off sharply at age 15. Referrals to Social Care peak at the 0-3 age range indicating a commissioning need to perhaps intervene as early as possible in a child's life to equip parents effectively with the relevant skills and potentially reduce the number of referrals in later years, accepting that the teenage year groups will bring their own challenges for parents.

Fig 6.5



Figure 6.5 is taken from a sample of 300 cases that were presented to the MAGS panel during 2010/11 and 2011/12 and shows the presenting issues identified in MAGS referrals. This sample was taken for the Early Offer of Help Project needs assessment. It should be noted that not all presenting issues will be represented in the above as it was only a sample of current and closed cases. However the major presenting issues that are noted at MAGS panels are represented. Figure 6.5 shows, the common issues evidenced are domestic abuse, family break-up, bereavement and parental substance misuse. The Early Offer of Help Project will work to focus resource on tackling the effects of these issues as well as other key need areas i.e. sexual violence that would not always be seen at MAGS panels.





Figure 6.6 is also taken from a sample of 300 cases that were presented to the MAGS panel during 2010/11 and 2011/12 and shows the effects on the sample of the presenting issues shown in figure 6.5. It should be noted that not all evidenced effects will be represented in the above as it was only a sample of current and closed cases. However the major presenting effects that are noted at MAGS panels are represented. As figure 6.6 shows, the common issues evidenced are development of behavioural issues, deteriorating self-esteem, deteriorating school attendance and self-harm. The Early Offer of Help Project will work to focus resource on tackling the effects of these issues as well as other key need areas that may not always be seen at MAGS panels. The needs assessment reflected the views of young people who were surveyed and consulted with during the needs assessment process. Young people were concerned about their self-esteem, their behaviour and about advice so that they do not start using drugs and alcohol. They spoke of the need for peer support services, strengthened PSHE delivery to cover the issues that concerned them and more mediation services to work with families.

#### 6.1.3 Children in Need

The numbers of Children in Need have dropped from 2009/10 to 2010/11; this has bought Thurrock to in line with national and statistical neighbour averages. This means that there are approximately 750 children currently recorded as 'children in need' in Thurrock.



# 6.1.4 Child Protection

Whilst the numbers of contacts taken has remained high those that progress to referrals has dropped. In 2009/10 Thurrock excepted a higher number of referrals than the national average following work done around the service thresholds 2010/11 saw the numbers of referrals accepted fall below national averages. 98% of these referrals progressed to Initial assessments, this is above the national averages and the number of initial assessments that Thurrock carries out is above the national average. The numbers of core assessments completed is also above the national average.





The numbers of children subject to a child protection plan have risen in Thurrock and the rates remain amongst the highest numbers in the country. Only 16 authorities with had a higher rate in 2010/11.



Trend data -Children subject to Child Protection plan - rate per 10,000

Early information indicates that the number of children subject to a Child Protection Plan is rising during 2011/12 this is a nationally reflected picture with the numbers of contacts, referrals and children becoming subject to a child protection plan rising nationally. There is likely to be multiple reasons around this increase including

- Current economic climate leading to increased pressures on families
- Possible reduction in early intervention as a rest of cuts
- Increased awareness of child protection issues following some high profile cases (including domestic violence cases leading to increase in referrals from the police)

# 6.1.5 Children in Care

The number of looked after children in Thurrock fell slightly at the end of 2010/11 bringing Thurrock to just below the National average. The figure has risen during the current year.

There are currently around 240 children 'in care' in Thurrock.



Data from the 2011 CIN census

The numbers of children becoming and ceasing to be looked after in Thurrock is higher than National figure. Thurrock has higher 'turnover' of children in care than most other authorities.

Care leavers in suitable accommodation has dropped and is now 4th quartile as is the percentage of care leavers in employment, training or education.

The latest education performance of looked after children is really good and hopefully will bring our performance to 1st quartile once the National benchmarking is published. This indicator is liable to large swings due to small numbers.

Early information indicates that the number of children in care is increasing, this is a nationally reflected picture with the numbers of looked after children generally rising. There is likely to be similar reasons around this increase to those listed above.

## 6.1.6 Disabled Children

The Thurrock Council Children with Disabilities Team provides information and support to children and young people aged 0-18 years. The Team meets with the child and the people important in their lives, including other professionals, to assess their needs and look to provide services to meet those needs. The Team works with children and young people who have a substantial difficulty in achieving their full potential.

This may be due to:

- Severe hearing impairment
- Severe visual impairment
- Severe communication difficulties
- Severe physical disability
- A chronic illness
- A mental disorder
- A severe learning disability

The Team does not work with children and young people whose sole problem is:

- Behavioural difficulties or
- Attention Deficit and Hyperactivity Disorder (ADHD)

Figure 6.7 shows the number and percentage of children known to the Children with Disabilities Team, together with the reason for referral. As figure 6.7 shows, nearly 90% (221) of children are classed as 'children in need'.





Figure 6.8 details the percentage of children known to the Children with Disabilities from each ward. As figure 6.8 details, the greatest percentage of children come from the Grays Riverside and Belhus wards. The lowest percentages of children known to the 'Children with Disabilities Team' come from the Corringham and Fobbing ward.



Figure 6.8 Children active with Children with Disabilities Team -Home address (not placement) % breakdown

Source: Thurrock Council

Figure 6.9 shows the gender split in terms of children known to the Children with Disabilities Team.





Source: Thurrock Council

The larger proportion of males is mainly due to the high proportion of Asperger's/Autism within the overall type of disability within the Children with Disabilities Team (see figure 6.10 below) given that this disability appears more in boys than girls.





Figure 6.10 shows a breakdown of the type of disability that children known to the Team have. Given the high prevalence of children with Asperger's and Autism within the Children with Disabilities Team commissioners may need to focus on commissioning specific services specialising for children with these disabilities.

Source: Thurrock Council

Figure 6.11 shows the age range of children known to the Children with Disabilities Team.



Figure 6.11: Age Range of Children within the Disabilities Team

As figure 6.11 shows, the biggest proportion of children known the disabilities team fall within the 13 to 15 age band.

# 6.1.7 The Youth Offending Service

The Youth Offending Service (YOS) is a statutory, multi–disciplinary service staffed and funded by Thurrock Council, Essex Police, National Probation Service and the NHS. Its primary function is to prevent offending and re-offending of young people between the ages of 10 and 17 years.

To this aim it delivers interventions and enforces criminal court orders made in the Youth (magistrates) Court and the Crown Court.

The Youth Offending Service (YOS) works with young people who have been identified as being "at risk" of entering the criminal justice system. It also offers interventions to young people who have received Final Warnings from the police via the Final Warning and Reprimand Panel. It also receives referral orders of from the Courts for young people pleading guilty or being convicted of crime. Courts also impose parenting orders where there has been a problem with a young person's behaviour that require that person and/or their parents/guardians to attend counselling or guidance sessions provided by YOS.

Source: Thurrock Council

The YOS also supervises young people receiving other court sentences such as Youth Rehabilitation Orders, Reparation Orders and Detention and Training Orders (custody). YOS Officers will devise a supervision plan that addresses those factors that contribute most to a young person's offending behaviour.

Figure 6.12 shows the rate of reduction in first time entrants to the YOS since the previous year compared to the Eastern region, Thurrock's peer group local authorities and England.





Thurrock achieved the rate of reduction largest reduction in first time entrants to the criminal justice system in the country as a result of the introduction of TRIAGE diversion programmes. This figure is impressive as the scheme did not go live until October 2010 – half way through the reporting year. YOS used existing prevention staff who agreed different working arrangements to ensured cover to police stations in the evening and weekends in order to assess young people who had been arrested for voluntary intervention rather than prosecution. Protocols were put in place with the police and CPS who have been fully supportive especially as re-offending rates following intervention have been less than 7%.

Figure 6.13 shows the percentage of young people known to the YOS receiving custodial sentences compared to the Eastern region, Thurrock's peer group local authorities and England.

Source: Thurrock Council YOS

#### Fig 6.13 Custodial sentences



Source: Thurrock Council YOS

As figure 6.13 shows, 2009/2010 saw Thurrock's rate of custody at 2.4%. This was a substantial decrease and one of the lowest in the country. The national decrease in custodial sentences was 24% between 2008/2009 and 2009/ 2010 but in Thurrock the decrease was 64%, one of the highest in the country. The subsequent increase in 2010/2011 although nearly double the previous year has to be seen in context. Because the number of overall convictions had reduced as a result of Triage, of convictions increased from 2009-10 to 2010-11 although the actual numbers in custody only increased from 7 to 11.

Figure 6.14 shows the number of young people known to the YOS who are in education/training and employment (ETE), compared to regional, national and peer group LA comparators.





#### Source: Thurrock Council YOS

As figure 6.14 shows, Thurrock's performance has increased from 2009-10 but is still below all our comparators. Thurrock's offending population largely comes from areas where aspirations are low and there is an intergenerational culture of benefit dependency. In the current climate of high youth unemployment this continues to be our biggest challenge.

Figure 6.15 shows re-offending rates after 9 months for young people known to the YOS.



Fig 6.15 Re-offending rate after 9 months

Source: Thurrock Council YOS

As figure 6.15 shows, for successive years, young people whom the YOS has worked with have had a lower re-offending rate after 9 months compared to regional, peer group and national comparators.

Figure 6.16 shows the ethnic minority of breakdown of YOS clients compared to that of the general population in 2008-9 and 2009-10. Figure B suggests that a greater percentage of YOS offenders are black compared to the general population in both 2008-9 and 2009-10. The reasons for this may be complex and it is an issue that would warrant further investigation prior to drawing conclusions.





Source: Thurrock Council YOS

Figure 6.17 shows the gender breakdown in YOS clients between 2008 and 2010. As figure 6.17 shows, around 80% of clients are male and 20% female for each year.



Fig 6.17 YOS Clients Gender Breakdown 2008-11

Figure 6.18 shows the age at time of offence (in terms of a proportion of all YOS clients) for 2008-9, 2009-10 and 2010-11. As figure D shows, the majority of YOS clients are aged 15 - 17, and this percentage has increased from 2008 to 2011.

Source: Thurrock Council YOS

#### Fig 6.18



Source: Thurrock Council YOS

Figure 6.19 shows the total numbers of different types of offence committed by YOS clients in 2010-11. As figure 6.19 shows the most common offences are shop lifting and assault, followed by criminal damage and harassment. Fraud, arson, burglary, indecent assault and intent to supply drugs are all rare offences in terms of YOS clients.





# 6.2 Adult Social Care

# 6.2.1 Overall service provision

The number of service users receiving care packages is the most commonly used method of comparison in terms of the demand and level of service provision for people with adult social care services. It provides an indication of the number of people in an area that have social care needs that have been met and are in receipt of a service. It does not take into consideration those that are self-funding their own provision and may not be known to public agencies.

Thurrock has consistently provided fewer services per 100,000 populations than the national and regional average. Since 2005-06 the level of provision in Thurrock has increased from a rate of 2775 per 100,000 in 2005-06 to 2945 per 100,000 people in 2009-10. However, within this period the level of provision has fluctuated. Nationally and regionally over the same period show a small decrease in the rate of provision.





Source: NASCIS

Since 2005-06, Thurrock has experienced the most change in service provision among those service users with a physical disability – increasing from 2425 in 2005-06 to 2610 in 2009-10. There appears to have been a small decline in other client groups over the same period.

Thurrock has also historically provided fewer community-based social care services than its CIPFA comparator councils. This has remained consistent since 2005-06.



# 6.2.2 Learning Disability

Research provides clear evidence that people with learning disabilities often face significant disadvantages in terms of their access to services and support and consequently their health can be adversely affected. People with learning disabilities are more likely to die early from preventable illnesses than the rest of the population. It is estimated that around 40% of people with learning disabilities will experience mental health problems at some point in their life.

The number of people with learning disabilities receiving services in Thurrock has remained fairly consistent since 2005-06. In 2009-10 225 users per 100,000 populations received services compared with 345 nationally and 335 regionally. Thurrock does not maintain a register of learning disabled adults so it is difficult to estimate the additional scope of prevalence that may exist in Thurrock but are either not known to public agencies or receive services as self-funders.



Source: NASCIS

Many people with learning disabilities want to lead lives that enable them to be part of their local communities and contribute to those communities like the rest of the population. The implementation of Valuing People Now (2009) details the wide range of support and opportunities that are need in Health and Social Care and the wider community:

- Making sure people are included
- Making sure personalisation is at the heart of service provision
- People have the best quality of life possible, including health, accommodation, work, education, relationships and the right to support their children where possible.
- Making sure that changes happen for learning disabled people

A key area is being in employment and living in settled accommodation. This is reflected in outcomes that are set for housing-related support services in Thurrock, ensuring that people with learning disabilities are supported into meaningful occupation which includes training, education or paid employment.

However, employment levels for people with learning disabilities in Thurrock are low. 5% of people with learning disabilities known to the Council and receiving services are recognised as being in paid employment. Of those that are, very few work more than a few hours per week. This compared to 7.2% of learning disabled people in paid employment nationally. While it is acknowledged that the current economic downturn and financial climate make it difficult to increase the employment rate, the Council needs to work with partnerships agencies to maintain and try to improve this rate.

Over half of people (57.3%) with learning disabilities known to the Council are recognised as living in settled accommodation. This compares to 61% nationally and 55% among Thurrock's CIPFA comparator group. Support is also offered in housing-related support schemes, to enable service users to be supported into obtaining settled accommodation, where appropriate.

The Council currently commissions three supported housing schemes for people with learning disabilities in addition to a specialist floating support scheme. However it has been recognised that there is a need to develop other types of supported housing that can support people with learning disabilities moving out of residential care and also for younger people coming through transition who may wish to experience living in a supported environment before moving on to live independently in the community.

A number of pilot schemes are currently in development in partnership with the Council's Housing Department and subject to successful outcomes for service users, it is anticipated that further schemes could be commissioned in the future to better meet the needs and aspirations of these people with learning disabilities.

Demand for learning disability services and support in the future will grow. As a result of improving life expectancy due to better quality health care people are living longer. This means that people with learning disabilities are also experiencing an increased complexity of conditions and needs. Nationally, the prevalence of learning disability is expected to increase by around 1% every year for the next 15 years.

The Council is in the process of initiating a project for people with learning disabilities currently living in residential care to move to more independent living in the community. Eligible service users for this pilot are those people who are currently living in residential care, who have been assessed as having the ability to live independently without support. The project is a transition phase for individuals with intensive support to develop those individuals' skills and abilities, with a view to reducing the support until it is no longer required.

As the personalisation agenda continues to focus on supporting more people with a range of disabilities and needs to take up direct payments or personal budgets, the number of learning disabled people in receipt of self-directed support is projected to grow by some 30% over the next three years.

To meet the expected growth and complexity of needs associated with this increase, Thurrock will need to continue to develop new approaches and services to ensure people have the correct support to have direct payments and personal budgets and that the market develops appropriately to meet those needs whilst maintaining robust budgetary control.



Source: NASCIS and PANSI

#### 6.2.2.1 Autistic spectrum disorders

There are currently estimated to be around 1,000 people living in Thurrock with autistic disorders. This is projected to rise by around 5% by 2015.

### **Recommendations for commissioners**

- Commissioners across health and social care need to ensure the continued delivery of the outcomes identified in Valuing People Now (2009) to ensure that all aspects of learning disability are monitored and addressed.
- Commissioners need to ensure that the outcomes of the learning disability health selfassessment are implemented across Thurrock.
- Commissioners will need to ensure that robust support is in place to monitor and review the pilot projects for supported housing
- Commissioners will need to ensure that person centred planning and personalisation's are appropriately linked to support individuals to have more choice and control in their lives.
- Consider whether introducing a register or similar framework to enable improved knowledge of learning disabled people and to enhance their well-being support is required
- Commissioners need to support the development of a framework to extend employment opportunities for people with disabilities, including learning disability, to support more people into settled employment.
- Commission the provision of learning disability day opportunities to local social enterprise to optimise support for and put people with learning disabilities at the heart service design and provision

## 6.2.3 Adult Social Care - Mental Health

In 2009-10 Thurrock provided social care services to over 700 adults with mental health issues, of whom a third were aged over 65. This represents a rate of some 635 per 100,000 populations compared to a much higher rate nationally and regionally – 995 and 920 respectively. The rate of service provision in Thurrock appears to show a small decline in recent years.



Source: NASCIS

Many people with mental health conditions want to live and lead lives in the same way as others. Mental health problems are associated with social exclusion and disadvantage. People are more likely to be socially and financially disadvantaged, unemployed, have poor quality housing and have poor physical health. Mental health problems often adversely affect social and family relationships and are poorly understood by the wider community.

The three overarching outcomes recently identified within the new South Essex Mental Health Strategy (January 2012) are:

- People get better
- People have good physical and mental health
- People achieve the best possible quality of life

Giving a clear foundation for work on the significant areas that support the recovery and improvement for an individual's mental ill health

A very significant area is having settled accommodation and employment. In 2009-10 89% of adults with mental health problems were living in settled accommodation and 13.8% were in settled employment. This compares favourably with the national average of 51.5% in settled accommodation and 6.85 in settled employment.

The Council currently commissions a supported housing scheme for people with mental illhealth in addition to a specialist floating support scheme. Achieving meaningful occupation (which includes involvement in education, employment or training) and moving into settled accommodation are two outcomes that are set for housing-related support services in Thurrock and there has been some success in this area. The service supports up to 40 service users at any one time and its aims are to provide low level support to establish and maintain individuals' independence in the community, to prevent tenancy breakdown and the need for more intensive services, and to reduce the level of hospital admissions. In 2010/11, 100% of service users supported in the service maintained independent living.

However the supported accommodation is limited and over-subscribed and it has been recognised that there is a need to develop more supported accommodation to meet the needs and aspirations of people with mental ill-health.

The number of adults with mental health needs who receive self-directed support and opt to receive their money through either a personal budget or direct payment is very low and remains an under-developed area. In a recent consultation exercise across mental health services to support the development of the South Essex Mental Health Strategy (January 2012) it was clear that there is the desire for recovery focused services amongst service users, carers and professionals. People do not want to be managed by professionals for the rest of their life, they want to reach a point where they can take control to manage their condition and become as socially included and independent as possible. This is very positive in supporting the development of self-directed support.

Partner organisations will need to work together with service users and carer to ensure the key aspects of personalisation, having choice and control are practiced and developed in a mental health setting with service users. Modelled projections show that the take-up of personalised support will increase in future years.



### 6.2.3.1 Dementia

Dementia presents an increasing demand on services as the population ages and complexity of needs grows. Dementia can affect people of any age, but is most common in older people and in women (especially Alzheimer's). Given the ageing population, this is an important indicator to plan and provide services.

The prevalence of dementia in Thurrock is predicted to increase in future years, particularly, among the over 65s – rising by 13% by 2015. The rate of increase will be particularly evident among those people aged 85+ where it is expected that instances of dementia will rise by 17% to nearly 800 people by 2015.



% growth in the number of people aged 65+ with dementia 2010-2015

#### Source: POPPI

Growth in the number of people aged 65+ with dementia 2010-2015



The current recording and categorisation of social care service users with dementia is low. This is however, likely to be an under-reporting due to the categorisation of client needs. Systems and practice development is needed to ensure that service users with dementia can be recorded as such in future to provide accurate representation of the levels of dementia known to the Council.

#### **Recommendations for commissioners**

- Commissioners across Health and Social Care will need to ensure that the JSNA links with the South Essex Mental Health Strategy to support the local Thurrock delivery plan for Mental Health.
- Commissioners need to support the development of employment opportunities for people with mental health needs, to support more people into settled employment.
- Develop opportunities that enables people with mental health needs to access personalised budgets in order to meet their needs so having more choice and control in their lives focusing on recovery.
- Improve outcomes and provision for dementia including integrated awareness, education, early diagnosis and intervention strategies.
- More evidence is needed to understand the effectiveness of local interventions around dementia and their impact on improving well-being and conditions.

## 6.2.4 Adult Social Care – Clients with Physical Disabilities

People with physical disabilities can often be a very varied group with long-term conditions. As with people other disabilities, those with physical disability can experience inequality and deprivation arising from exclusion in the jobs market and in access to other services for example. Research also evidences that people with physical disabilities are more likely to live in inadequate or inappropriate housing and to experience problems with transport.

The 2001 Census indicated that there are some 16,000 people in Thurrock with a limiting –long-term illness or disability – the majority of whom were older people.

In 2009-10 Thurrock provided services to 2100 people with a physical disability. This represents a gradual rise since the 2005 provision of 1660. This growth is in contrast to both the national and regional picture over the same period – both of which have experienced an overall, small decline in provision.

Projections show that Thurrock can expect to see a further increase in the number of people with moderate and serious physical disabilities in future. It is reasonable to expect that there will be a growing level of complexity of need among this group of people and that the level and type of care and support needed will require interventions such as extra-care provision as an alternative to residential placement.



## 6.2.4.1 Visual and hearing impairments and dual sensory loss



#### 6.2.4.2 Hearing impairments


### 6.2.4.3 Dual sensory loss



# 6.2.5 Adult Social Care for Older People

Helping older people to maintain their health and well-being into later life is key to having lifelong quality of life, retaining independence and control for as long as possible and enabling public agencies to target resource at those areas where it is most needed.

Increasingly the focus on doing this is about prevention and early intervention – helping older people to recover from illness quickly, receive timely and comprehensive enablement and rehabilitation to promote faster and more complete recovery to independence and seamless pathways and services that provide joined up and personalised health and social care services.

Thurrock has increased its provision to older people by 27% since 2005-06. This is in contrast to the national and regional pattern, both of which show a small decrease in provision over the same period. In 2009-10 Thurrock provided services to 12150 people per 100,000 population compared to 13605 nationally and 12170 regionally.



Much of this service provision remains more traditional however. The chart below shows the changing levels of demand and service provision for community based services in Thurrock over the last five years. Homecare, day-care, meals and short-term residential remain predominant among the older ages.

There is yet to be a significant increase in the take up of direct payments or personal budgets among older people and people need to be given the advocacy support and confidence to be creative in how their needs and outcomes can be met through self-directed support. Direct payments and personal budgets are used by a small minority of older people.



# 6.2.5.1 Older people in residential care

Thurrock has historically placed more people in residential care as a proportion of its population than the national average. In 2009-10 around 800 adults were supported in residential care. This represents a rate of some 670 per 100,000 population. In comparison the national rate was 525 per 100,000 population.

This is particularly acute among older people aged 65+. In 2009-10 3025 per 100,000 older people received residential care in Thurrock. This compares to the national rate of 1985 per 100,000.

High dependency (high cost) complex packages are growing – particularly amongst over-65s. Since 2007-08 there has been an 81% growth in the number of older people whose package of residential care exceeds or is equal to the high dependency declared rate. Over the same period the proportion of older people service users who are declared as higher dependency has grown by 43% and in 2010-11 represents around 45% of the total older people service users.

Similarly, pressure on mental health and learning disabled budgets is growing significantly as needs are becoming more complex and packages of care become more complex and costly to meet this need.

Thurrock needs to identify alternative models of care support for people with complex needs other than residential care. This must include models of extra care provision.



### Growth in number of older people on high dependency/residential greater care

A sample of service user satisfaction surveys undertaken in 2011/12 for the Home Care services provided by Thurrock Council, showed that 91.5% of service users (of those surveyed) thought their service was "very good" overall. 100% of service users stated that the care they receive enables them to stay in their home, and 98.3% stated that the care had improved their day to day life (based on 59 surveys).

Thurrock Council has a significant amount of sheltered housing, both Council owned and externally commissioned, to support older people to maintain their independence in the community, preventing them from requiring more intensive care packages such as residential care. In 2010/11, 99.3% of all service users living in sheltered housing (including extra care) maintained their independence with this low level support.

# 6.2.6 Support for Carers

Carers are people who spend a significant proportion of their life providing unpaid support to a relative, partner, friend or neighbour who is ill, frail, elderly, disabled or has Mental health or substance misuse problems. They are a diverse and significant group of people – over 3 in 5 people in the UK will become carers at some point in their lives. Nationally 1 in 8 adults (6 million people) are carers and of these, 1.2million carers provide more than 50 hours of care per week.

In Thurrock it is estimated that some 15,000 people are carers. However, of these under 5% are actually known to public services and formally recognised and receiving caring support.

Caring can be a rewarding experience but many face isolation, poverty, discrimination, ill health, frustration and resentment as a result of their caring role. For example, a carers survey carried out in Thurrock in 2010 found that 94% of respondents said that caring had either a big or some impact on their day to day life and a third (34%) said that their health had deteriorated in the previous 6 months

Currently, Thurrock identifies, assesses and provides services to less carers than nationally and regionally. Just under 500 carers were assessed or reviewed in 2009-10 and of these just under 400 received a service. This represents a rate of around 300 carers assessments/reviews per 100,000 population compared to a national rate of 885 per 100,000 population.



There have been historical problems with both the systems used to record and assess being able to access the right information to help them is a key requirement for carers.

A carers survey carried out in 2010 found that 51% of respondents had been provided with information they needed for their caring role, the majority receiving this via social workers or the Carers Centre. However, over a third of respondents (38%) said they had not been provided with any information to help them.

With Thurrock facing a growing and ageing population, there is likely to be an increase in the demands on carers who are themselves becoming older and are already providing the bulk of care and support. It is therefore essential that public agencies have in place robust systems and plans that can identify, assess and offer the right information, advice and support to those already caring and those who may become carers in the future.

Half (49%) of respondents to the carers survey in 2010 had been helped by Thurrock Council to have a break from their caring role and three-quarters (77%) of these said ithad helped them to continue caring.



### **Recommendations for commissioners**

- Effective means of identifying carers need to be developed. As carers are not a generic group with common circumstances and problems, specific strategies may be appropriate for different groups of carers.
- Information and advice services for carers need to be further developed to ensure that current and potential carers and carers currently unknown to health and social care are able to access appropriate information advice and support to help them continue caring.
- Specifically engage with under-represented carer groups e.g. by location, ethnicity or by the condition of the person being cared-for.
- Provide culturally sensitive ways of encouraging Black and Minority Ethnic carers to access services and participate in determining future service provision.
- Support needs to be provided aimed at improving carers wider well-being, including their ability to access employment, education and volunteering opportunities.
- Involve carers fully in the design, planning and running of services and encourage carers to become peer supporters and volunteers.
- Public agencies need to work closely with Jobcentre Plus regarding replacement care opportunities for carers who wish to return to or remain in work.

- The rights of carers to request flexible working and the business benefits of supporting carers, needs to be promoted among the business community and the wider public.
- Extend the provision of direct payments and personal budgets to carers as a means of enabling more choice and independence, and ensure the local market can offer suitable services and support.
- Provide support to help avoid a crisis which could adversely affect or end a caring role.
- Raise awareness of carers issues and the overall profile of Thurrock carers and their contribution to the community with professionals and the public.
- Extend the provision of respite services to enable carers to sustain a caring role and support them to continue to care for as long as they feel able to continue.

### 6.2.7 Personalisation and self-directed support

Direct payments and personal budgets are designed to give people control and choice over their lives by giving them the opportunity and means to choose how they wish to receive and to use their resources. They are an alternative to the traditional means of adult social care services and are designed to maximise and embrace people's independence. However, they are not always the most suitable form of support and will not be a feasible choice for everyone.

The provision of direct payments and personal budgets are a key element of the national strategy to transform adult social care. First set out in the *Putting People First* concordant in 2007, the strategy has been further developed in 2010/11 through the *Think Local, Act Personal: Next Steps for Transforming Adult Social Care* – a partnership agreement that aims to continue moves towards personalisation and community-based support.

In 2009-10 Thurrock provided direct payments or personal budgets to over 400 service users representing around 262 per 100,000 population. In 2011-12 this increased to around a 1000 people. Despite this showing an increase on previous years, it remains below the comparative national and regional rates – 415 and 515 per 100,000 respectively.



Analysis of the trend in take up of direct payments since 2008-09 shows a steady increase. This is relatively consistent across all key client groups apart from mental health which remains low. The costs associated with this increase in direct payments presents additional pressures on long-term social care funding and additional future increases in direct payments will need careful managing.



### Growth in the number of people taking up direct payments

Ensuring that people are able to access consistent, timely and high quality information and advice about local services and support and ensuring that this provision is seamless across public agencies is a key part of the aim to give people choice and control. Consideration should also be given to the development of information and advice strategies that align with commissioning strategies.

### **Recommendations for commissioners**

- Commissioners need to ensure that information and advice about health and care services is made more accessible to enable local people to find out about the range of local services and support. Information and advice about services needs to be better integrated between health and social care – for example with the development of a single integrated information hub.
- A review of existing advocacy services is needed to ensure people can access the right support and advice to help them take control of their own services and support.
- Ensure that a transparent resource allocation model is developed.
- Establish direct payments of individual budgets as the first offer for all service users.
- Commission a direct payments user group.
- Extend the market locally to increase the range of services, support, activity that can be used for direct payments.
- Further research is required to understand the effectiveness of signposting and provision of information and advice through the adult social care community solutions service.
- Local agencies (including adult social care) need to provide services and support within the community where they are most needed and where they make the best use of centralised or focal community hubs.
- Explore the potential offered through social media and technology, including textmessaging, to provide information for visually-impaired and hard-of hearing service users in a more accessible format.

# 6.2.8 Supporting people to live at home and remain independent.

### 6.2.8.1 Homecare re-enablement

Homecare re-enablement is a service that aims to help people with poor physical or mental health to accommodate their illness by learning, or re-learning, the skills necessary for daily living. Re-enablement focuses on a person's ability and supports them to regain or adapt skills which have been temporarily lost because of ill health. The provision of re-enablement support aims to help maximise people's independence by enabling them to remain or return to their own homes within the community.

Thurrock launched a new model of homecare re-enablement services in December 2011. In the first six months of 2011-12 over 130 people completed a period of re-enablement. On average, of those completing a six week re-enablement period, around 28% resulted in either a reduction in on-going services or end to services.

As part of the re-enablement services, a pilot project was initiated in 2011 for 6 interim beds positioned in a Council residential care home. This pilot aims to provide re-enablement to individuals to enable them to return to their own home following a period of ill-health or hospital admission, preventing further hospital admissions and the need for more intensive care packages. The project so far has been in high demand with occupancy levels at 95% (as at December 2011), and there is a view to increasing the number of beds to 8. Of the 23 people who have completed a period of re-enablement so far in the interim beds, 52.2% have been able to return home.

Thurrock Council is also running a Duty Pilot with increased crisis support from social care at the duty stage. In the period of September 2011 to December 2011 (4 months), 88 individuals have been supported to avoid hospital admission, a success rate of 97.8%. In this period only 2 individuals were admitted to hospital.

In addition, increased support was provided to the hospital social work team to prevent delayed transfers of care. In the period April 2011 to December 2011, there have only been 2 days delayed transfers of care attributable to adult social care in acute. This is a significant improvement on 2010/11 which had 20 days delay. Similarly in the non-acute, there have only been 38 days delayed transfers of care attributable to adult social care for the same period. This is a significant reduction from 2010/11, which had 568 days.

A key priority of the service in 2012-13 is to increase the proportion of users completing reenablement and resulting in a reduction or end to on-going service levels and subsequently, the costs associated with this. It is planned for 2012-13 that staff from Health work alongside the Homecare Re-enablement Team to offer a joint re-enablement service

### 6.2.8.2 Intermediate Care

In 2010 Thurrock along with South West Essex PCT commissioned a report into the intermediate care offer within Thurrock.

The report made recommendations which have been agreed to by both organisations and it is the priority of the jointly appointed Intermediate Care Coordinator to realise the vision of intermediate care service in Thurrock.

A key focus of the service will be to ensure that joint working across health and social care is improved and that pathways for each service are clear in order that the most appropriate service/s can be provided. Some progress has been made and to this end all services are now part of an intermediate care directory which is available to all stakeholders across the health and social care economy.

By focusing on improving intermediate care, alternative models of care other than residential care are being explored.

There is currently a pilot underway within Thurrock's in-house residential care home offering interim beds. The 6 interim beds are located in a separate wing of the home and focus on rebuilding skills and confidences following a hospital stay where returning to home would be premature. This is now in year 2 of a 2 year pilot; early results are indicating that this service is preventing further hospital re-admissions and residential care placements.

Furthermore Thurrock now has a joint Rapid Response and Admission Avoidance Team and work is well underway to move to 6 day hospital discharging for the Hospital Social Work Team.

The work that was recommended as part of the Commission of enquiry will be progressed throughout 2012 to develop and agree a prevention and early intervention strategy in conjunction with the PCT, Essex and Southend to enable integrated working between Housing, Health and Adult Social Care to target ill health resulting from poor or unsuitable housing conditions.

### 6.2.8.3 Telecare and Equipment

Telecare services are a core element of Thurrock's strategy to provide early intervention and preventative services that support people to remain in their homes. Telecare services are built on a core alarm system. This is a small unit located in the home which is linked to telephone. Service users also have a pendant alarm which can be operated in the event of an emergency. When an alarm is triggered, an alert is received by the monitoring service (24 hours) who then alerts the appropriate services e.g. emergency, relative or on-call duty team.

Telecare also includes a wide range of other items such as smoke, gas, fire and temperature detectors and sensors, medicine dispensers, fall detectors. All are linked to the alarm system and can trigger an alert to the monitoring service.

Since 2005-06, Thurrock has consistently been just below average for the number of people receiving Telecare and/or equipment when compared to our CIPFA group.

Within the next 6 months a Telecare Strategy will be produced with the main aim of looking at how Thurrock can increase the take up of Telecare.

It has been recognised that more work needed to be undertaken within social care to increase awareness and therefore Thurrock now employs a Telecare Specialist Practitioner. The practitioner is also engaging with health.



# 6.2.8.4 Extra-care housing provision

Extra Care Housing is housing designed with the needs of frailer older people or adults with particular disabilities and support needs in mind and with varying levels of care and support available on site. People who live in Extra Care Housing have their own self-contained homes, their own front doors and a legal right to occupy the property. Extra Care Housing is also known as very sheltered housing, assisted living, or simply as 'housing with care'. Housing-related support and care are provided by on-site staff.

Thurrock currently operates two extra care housing sites with a total of 73 units. Demand for these units is high. New provision for extra care housing has been modelled previously. A new extra care housing provision is scheduled for opening in September 2012 and will provide a total of 18 one bedroom and 47 two bedroom extra care flats The new scheme will also accept people with dementia; existing extra-care schemes in Thurrock are currently unable to do so.

### **Recommendations for commissioners**

- Commissioners need to ensure that the provision of Telecare/Telehealth is enhanced and integrated within health, social care and housing pathways as a preventative service, to ensure targeting of Telecare/Telehealth to those people who it can support and benefit most
- Improve access to early prevention services for older people to manage dependency on more expensive support services including Telecare, equipment, enablement
- Commissioners need to extend the range of joint services and support accessible through intermediate care provision to help keep people independent for longer and reduce dependency on more costly support services
- Develop and commission interim beds provision to increase capacity/facilities to deal with people medically fit for discharge from hospital and to help facilitate enablement
- Develop joint intermediate care service provision and integrated pathways to ensure that people enter the right service at the right point to support their on-going independence
- Evaluate the medium-long term impact of enablement service
- Explore potential through the Commission of Enquiry and extension of this work to develop integrated models of information and advice and enablement service models

### 6.2.9 Adult safeguarding

In 2010-11 there was a significant increase in the number of referrals made to the Adult Safeguarding Team at Thurrock Council. There were 348 referrals made during 2010/11, up from 283 in 09/10 (23%) and 196 in 08/09 (78%). This represents a rate of 30 referrals per 10,000 population. This rate is above both the regional and Thurrock CIPFA group average.



Of the 348 referrals, 113 were substantiated, 2 were partly substantiated and 65 were inconclusive. 145 were not substantiated. Nearly two thirds of these cases related to abuse of vulnerable adults living in their own homes (202) or in the alleged perpetrators home (12) and in 30% of cases, the alleged perpetrator was living with them.

70% of referrals were for those aged 65 and over (243), with 109 relating to those aged 85+. Of this 31%, 35 were substantiated with 7 cases where there was restricted access to the vulnerable adult and 4 disciplinary actions taken; 25 were inconclusive or not determined but the alleged perpetrator undertook training or counselling and 41 were not substantiated.

Neglect and acts of omission, financial abuse and physical abuse continue to be the main categories of reported abuse. We have seen an increase in reported neglect or acts of omission which accounted for 33% (112 referrals). Of these 18 were inconclusive, 33 substantiated, 1 partly substantiated and 51 were not substantiated. Financial or material abuse also rose with 27% of referrals (95). 27 cases were substantiated with 6 involving Police action. 7 cases resulted in the Council taking over as Corporate Appointee for the vulnerable adult and 1 case was taken to the Court of Protection.

### Referrals per 10,000 population



# 6.2.10 Transition from young people to adulthood

For all young people the transition to adulthood is a risky time. Many face difficult challenges that may relate to money, employment, accommodation, health, self-esteem and relationships. Most will deal successfully with such challenges and make the transition to adult life without experiencing serious or lasting difficulties.

# 6.2.11 Satisfaction with adult social care services

The key outcome sitting at the heart of the personalisation agenda is that people are supported to feel in control.

### 6.2.11.1 Overall satisfaction and quality of life

Service users' overall satisfaction with the care and support services they receive has shown a gradual increase over time. In 2010, 89.1% of respondents to the PSS Social Service Users Survey (PSS Survey) were satisfied with their care and support compared to 89.7% nationally and 88.7% regionally.



Service users in Thurrock also rated their quality of life highly. 89.7% of respondents said that their quality of life was either so good it could not be better, very good, good or alright – compared to 88.6% nationally and 88.1% regionally.

### 6.2.11.2 Satisfaction with information and advice

Three-quarters (77%) of service users responding to the survey found it easy (27%) or fairly easy (50%) to find information and advice about local services.

### 6.2.11.3 Feelings of safety and dignity

People receiving social care services have a right to be treated with dignity and respect and to feel safe and protected.

64% of service users in Thurrock reported that they feel as safe as they want – compared to 62.1% nationally, 64.5% regionally and 60.9% among CIPFA comparators.

A slightly lower proportion of service users in Thurrock said that the way they are helped and treated make them think and feel better about themselves – 54% compared to 57% nationally, 54% regionally and 57% among CIPFA comparators.



### 6.2.11.4 Feelings of control over daily life

Feelings of having control over daily life – a central tenet of the personalisation agenda for adult social care are similar in Thurrock to the national, regional and CIPFA picture – around three quarters of service users in all areas said they have either have as much control as they want or adequate control over their daily life.



In Thurrock, around one in three service users (28.7%) said that they have as much control over their daily life as they want and 46% reported that they have adequate control over the daily life.

# Recommendations for commissioners Local agencies need to ensure there is increased opportunity for service users and local people to engage with the JSNA and commissioning process Commissioners need to engage service users and carers in the evaluation of health and care services and interventions to ensure that their views inform planning Commissioners and local agencies need to build the analysis and understanding of the effectiveness of services on improving people's outcomes into all services and ensure feedback informs service design and planning

# 6.3 Primary Health Care

The term 'Primary Health Care' refers to services provided by GP practices, dental practices, community pharmacies and high street optometrists. These services are generally the 'gateway' to the NHS, with around 90% of the population's first contact the health service being through these services.

Primary Care services are vitally important in terms of our ability to influence health and wellbeing and should be the key focus of health inequalities work, because of both the level of access they provide to our population, and the fact that they afford the opportunity to target key population groups systematically using GP clinical databases, and to measure impact.

Primary Heath Care services, particularly GP services, play a pivotal role in coordinating NHS care, particularly for people with long-term conditions, and in helping patients to access wider or more specialised NHS services through the thousands of daily referral decisions they make. GPs and other primary health care professionals have a real opportunity to make preventative interventions and to improve decisions on referral and prescribing. They can both improve the quality of care for patients and avoid unnecessary costs elsewhere in the system.

Pharmacy provides an excellent setting in which to deliver many public health services, and a move from seeing pharmacies purely as dispensing contractors, to one of the 'health promoting pharmacy' has occurred in recent years with a range of public health services including NHS checks, smoking cessation and sexual health services being commissioned through pharmacy. Our local social marketing research suggests that our population welcome pharmacy as a setting in which to access health improvement services, both in terms of ease of access and positive relationships with community pharmacists.

The commissioning of primary health care is complex and have a number of distinctive features including a large number of independent contractors, services provided from a large number of community based locations and services which operate within a range of differing contractual and governance arrangements. However, these challenges also present benefits in the opportunity to deliver holistic, easy to access, continuous care close to patients' homes.

The current financial challenges faced by the health and social care system bring the importance of improving quality and access within the primary health care system. Evidence<sup>1</sup> shows the importance of a robust system of quality primary care for health economies and that high-quality health systems and healthy populations require strong and effective primary health care services.<sup>2</sup> In short, an effective high quality health service is dependent on high quality primary care.

This section considers the provision, quality and access of Primary Health Care services within Thurrock.

### 6.3.1 GP Practice Provision

There are 36 GP practices in Thurrock, serving a total registered practice population of 160,814. When this figure is 'weighted' to allow for the age and deprivation characteristics of the Thurrock population (and hence their likely health needs) compared to that of England, it equates to 153,206.

The names and locations of each GP Practice in Thurrock are shown in figure 6.20, which also shows the five quintiles of deprivation (IMD, 2010) by MSOA.



### Fig 6.20

- 1 Pear Tree Surgery
- 2 Aveley Medical Centre
- 3 Dr Yasin
- 4 Sancta Maria Centre
- 5 Dr Colburn M Practice
- 6 Chadwell Medical Centre
- 7 Dilip Sabnis Medical Centre
- 8 Dr Abela and Partners
- 9 Dr K K Masson & H.Masson
- 10 Dell Medical Centre
- 11 Balfour Medical Centre
- 12 Dr S Sidana
- 13 Dr Joseph L Practice

- 19 Suntharalingam R Tilbury Health Centre
- 20 Dr.Jones
- 21 East Tilbury Medical Centre
- 22 Purfleet Care Centre
- 23 St Clements Health Centre
- 24 Dr Deshpande
- 25 Dr Tresidder Nj Practice
- 26 Dr Devaraja
- 27 Dr Roy surgery
- 28 Dr Pattara (The Surgery)
- 29 Ash Tree Surgery
- 30 Belhus Medical Practice
- 31 The Shehadeh Medical Centre Grays (PMS)

- 14 Dr N Yadava
- 15 Dr Patel Pj Practice
- 16 Doctors Surgery (Dr P Mukhopadhyay)
- 17 Dr Shehadeh
- 18 Dr Ramachandran

- 32 The Shehadeh Medical Centre Grays (GMS)
- 33 Dr Headon Ot Practice
- 34 Acorns
- 35 Dr Saha PK
- 36 Thurrock Health Centre

### 6.3.1.1 GP Practice Provision and Health Inequalities

For the majority of the population, Primary Care provides the first point of contact/access to health services, and it is essential that its provision is adequate to meet the needs of the populations it serves. Under resourcing of primary care in disadvantaged areas will impact negatively on health inequalities in terms of access and quality of health service provision to those populations who need it most.<sup>3 4</sup>.

Thurrock GP practices serve a diverse population in terms of their deprivation levels. Individual GP Practice Population Deprivation Scores can be calculated as a sum of the each MSOAs deprivation score multiplied by the number of patients in a practice living in each MSOA. Figure 6.20 shows GP Practice Deprivation Scores ranked for all of the practices in Thurrock from the practice serving the least deprived population to the one serving the most deprived population, based on the Index of Multiple Deprivation (IMD, 2007). This is the most up to date data we currently have relating to GP practice population deprivation.

Practice Code	Practice Name	Score	Rank	Quintile	Least Deprived
F81088	DR ROY BB PRACTICE	13.23	21		
F81153	DR TRESIDDER NJ PRACTICE	13.44	24		
F81644	DR CHEUNG KK PRACTICE	13.45	25		
F81113	DR ABELA T PRACTICE	14.54	26		
F81697	DR DEVARAJA VC PRACTICE	14.94	27		
F81177	DR DESHPANDE AM PRACTICE	14.97	28		
F81198	DR PATTARA AJ PRACTICE	15.27	29		
F81082	DR JONES SR PRACTICE	15.34	30		
F81691	DR KHAN RS PRACTICE	15.64	31		
F81192	DR HEADON OT PRACTICE	15.95	32		
F81137	DR COLBURN M PRACTICE	16.48	33		
F81219	DR ABEYEWARDENE AK PRACTICE	17.36	35		
F81155	DR BANSAL A PRACTICE	20.23	37		

		-			
F81641	DR MASSON KK PRACTICE	21.16	39		
F81211	DR YADAVA N PRACTICE	21.67	40		
F81134	DR GARNER SD PRACTICE	23.00	41		
F81623	DR SIDANA SS PRACTICE	23.36	42		
F81659	DR KARIYAWASAM RG PRACTICE	23.60	43		
F81218	DR JOSEPH L PRACTICE	23.64	44		
F81643	GRAYS HEALTH CENTRE PRACTICE	23.96	45		
F81742	ACORNS	24.24	46		
F81010	DR LEIGHTON L PRACTICE	27.05	50		
Y00999	ST CLEMENTS HEALTH CENTRE	27.53	51		
F81698	DILIP SABNIS MEDICAL CTR PMS	27.68	53		
Y00033	PURFLEET CARE CENTRE	28.30	54		
F81197	DR BELLWORTHY SV PRACTICE	29.08	55		
F81084	DR MOHILE RV PRACTICE	29.25	56		
F81632	DR YASIN SA PRACTICE	29.46	57		
F81669	DR DEY KR PRACTICE	29.57	58		
F81652	DR RAMACHANDRAN MK PRACTICE	30.00	59		
F81719	DR MUKHOPADHYAY PK PRACTICE	37.02	78		
F81206	DR SHEHADEH E PRACTICE	38.09	79		
F81708	DR PATEL PJ PRACTICE	38.13	80		
F81110	DR SUNTHARALINGAM R PRACTICE	38.44	81	$\leftarrow$	Most depri
F81734	DR SAHA PK PRACTICE	40.29	82		practice populati

Figure 6.21 shows Quintiles of Unified Weighted Population by MSOA per WTE GP for South West Essex in 2008. This data is used here as it is the most up to date available to the authors at present. The DH recommends that to ensure adequate primary care provision for a population, GP practices have a maximum of 2000 weighted population per whole time (WTE) equivalent GP. Please note, the quintiles presented in the map relate to south west Essex and not to Thurrock. The map suggests that in 2008, the areas of Grays, West Thurrock, Belhus, Ockendon and East Tilbury were 'under doctored' in the sense that they had unified weighted populations per WTE GP greater than 2000.



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Figure 6.22 shows the 2011 weighted population per WTE GP per practice in Thurrock (shown by the red or blue bars against the left had axis). Practices highlighted in red have weighted practice population/WTE GP above the 2000 recommended limited and could be said to be 'under doctored'. In total, 18 of the 36 practices in Thurrock can be said to be 'under doctored'.

The red square dots in figure 6.22 denote the practice IMD (2007) deprivation score, against the right hand axis. Practices with red bars and high IMD scores are of particular concern as this data suggest that they are both under doctored and serving deprived populations. Increasing the number of doctors within practices serving deprived populations is of key importance if health inequalities across Thurrock are going to be reduced.

Figure 6.22 also shows the overall Thurrock weighted population per WTE GP. This is also slightly over the recommended level of 2000 weighted practice population / WTE GP.





### 6.3.1.2 Patient Experience of GP Practices

The National GP Survey gives a comprehensive view of patient experience of GP Practices. Figure 6.23 shows positive responses to five of the questions that sum up access to the GP Practices for Practices in Thurrock:

- 1) Can you easily get through to your practice on the 'phone?
- 2) Are you able to see a doctor fairly quickly?
- 3) Have you been able to book ahead for an appointment with a doctor in the last six months?
- 4) How frequently can you see your preferred doctor?
- 5) Are you satisfied with your practice's opening hours?

Survey responses for Thurrock are compared to those for all GP Practice in the East of England and England.





\*Excludes patients who answered Haven't tried or Don't know from the Denominator

\*\*Excludes patients who answered Can't remember from the Denominator

\*\*\*Excludes patients who answered Not tried at this GP surgery from the Denominator

\*\*\*\*Excludes patients who answered I'm not sure when my GP surgery is open from the Denominator

The overall average for GP Practices within Thurrock is above or with the East of England Average for four of the five questions. The exception is satisfaction with Opening hours shown in figure 6.23.

However, there is a wide variation in scores achieved for each question between individual GP Practices within Thurrock. These are shown in figures 6.24,6.25,6.26,6.27 and 6.28 below, each of which shows each practice achievement in ascending order. The practices with red bars in the graphs have performance that is statistically significantly below the East of England average (at 95% confidence).





Figure 6.24 shows the percentage of patients registered to each practice on the 6.24 axis that answered "Easy" to getting through on the phone. There is a wide variation in scores between each practice with 7 of the 36 GP Practices which have over 46,000 registered patients (29% of the total registered population of thurrock), that have performance that is statistically significantly below the East of England average at 95% confidence.



Figure 6.25 shows the percentage of patients registered to each practice on the 6.25 axis that were able to see a doctor within 48 hours. There is a wide variation in scores between each practice with 6 of the 36 GP Practices (having 23% of the total registered population of thurrock), that have performance that is statistically significantly below the East of England average at 95% confidence.





Figure 6.26 shows the percentage of patients registered to each practice on the 6.26 axis that were able book ahead to see a doctor 3+ days ahead. There is a wide variation in scores between each practice with 9 of the 36 GP Practices (having 36% of the total registered population of thurrock), that have performance that is statistically significantly below the East of England average.



### Fig 6.27

Figure 6.27 shows the percentage of patients registered to each practice on the X axis that were able to see their preferred doctor most of the time. There is a wide variation in scores between practices with 7 of the 36 GP Practices (having 29% of the total registered population of thurrock), are significantly below the East of England average.



1) Figure 6.28 shows the percentage of patients registered to each practice on the X axis that were satisfied with opening hours. The overall score for Thurrock is below the EOE and England average.

# 6.3.1.3 GP Practices Clinical Quality

# Quality and Outcomes Framework

The national Quality and Outcomes Framework (QOF) was introduced as part of the new General Medical Services (GMS) contract on 1 April 2004. Financial rewards are given to practices depending on the quality of care they provide to their patients. Participation by practices in the QOF is voluntary, though participation rates are very high. The QOF contains four main components, known as domains. The four domains are: Clinical Domain, Organisational Domain, Patient Experience Domain and Additional Services Domain. Each domain consists of a set of achievement measures, known as indicators, against which practices score points according to their level of achievement. The 2009/10 QOF measured achievement against 134 indicators, and practices scored points on the basis of achievement against each indicator, up to a maximum of 1,000 points.

The objective of the QOF is to improve the quality of patient care.

Figure 6.29 shows the percentage of QOF points achieved across different clinical domains for Thurrock GP Practices compared to the national achievement for 2009/10. Achievement for Thurrock practices for Thurrock practices across the clinical domains is largely similar to that achieved nationally with the exception of the depression and mental health clinical domains where Thurrock's performance is 4% lower than the national average, and the Palliative Care Clinical Domain where Thurrock's performance is 15% lower than that achieved nationally.

### Fig 6.29



QOF has incentivised practices to have a more organised approach to chronic disease management, and provides a strong incentive to engage in secondary prevention, it has provided only limited incentives for primary prevention or public health activities

Data on the prevalence of specific diseases or conditions is an important element of the QOF and will be of particular interest to many parties. Prevalence is a measure of the burden of a disease in a population at a particular point in time (and is different to incidence, which is a measure of the number of newly diagnosed cases within a particular time period). Prevalence data is used within QOF to calculate points and payments within each of the clinical domain areas. Specifically:

- Points can only be awarded to a practice for a given clinical domain area if the practice can produce a register of patients with that disease or condition; and
- The number of pounds per point in each clinical domain area is adjusted up or down according to each practice's prevalence for each disease or condition, relative to the estimated regional Northern Ireland prevalence for that disease or condition.

In order for practices to manage patients with chronic diseases effectively, they first need to patients with a given chronic disease (known as case finding), and then place them on an appropriate chronic disease register. Practices are expected to implement evidence based packages of clinical care with patients on different disease registers, in order to reduce the risk of the chronic condition worsening and further negative clinical patient outcomes. For example, for patients on the Hypertension disease register, practices are expected to ensure regular monitoring of blood pressure and prescribing of appropriate drugs to control blood pressure. Practices are awarded QOF points relating to how effectively they care for patients on each disease register.

In order to assess a GP Practice's success in identifying appropriate patients to place on chronic disease registers (case finding), the following ratio is used:

### Observed Prevalence (Actual Cases on Disease Register per 1000 population)

Expected Prevalence per 1000 population

The expected prevalence is a 'synthetic estimate' of the GP Practice's prevalence of a specific chronic condition based on a national evidence based formula that uses the practice population's characteristics such as age structure and deprivation to calculate how many patients within the practice population are likely to have a specific chronic disease.

The observed prevalence is calculated from the actual number of cases that a practice has found of a specific disease. An expected/actual prevalence of '1' would suggest that the practice had found all of the potential patients with a specific disease and placed them on the appropriate register.

An observed/expected prevalence of significantly less than 1 would suggest that the practice has not adequately identified all of the potential patients with a specific disease.

An observed/expected prevalence of significantly more than 1 would suggest that the practice may be over diagnosing cases, and that not all of the patients on a specific disease register may need to be there.

### 6.3.1.4 Management of CHD in Primary Care

Coronary heart disease (CHD) is preventable yet kills more than 70,000 people and 110,000 people have a heart attack in England every year. Around 2 million people suffer from angina in the UK. Such statistics mean CHD is the biggest killer in the country<sup>5</sup> Coronary heart disease (CHD) affects people in some sections of society more than in others. It is more common in lower socio-economic groups and certain ethnic minorities. Rates are also higher in certain geographic areas.

In order to call and recall patients effectively in any disease category and in order to be able to report on indicators for coronary heart disease for the QOF, practices must be able to identify their patient population with CHD. Evidence relating to the management of CHD is well established and if implemented can reduce the risk of death from CHD and improve the quality of life for patients.

### Fig 6.30 - CHD Prevalence by GP Practice



Source: QMAS March 201

Figure 6.30 is a 'funnel plot' that shows the observed/expected ratio of patients discussed previously for the CHD Disease QOF Register of each GP practice in Thurrock (represented by a grey dot). As discussed previously, the target ratio of observed/expected prevalence for a chronic disease register is 1.0 and this is shown by the black horizontal line running through the funnel plot.

The further the practice is below the 1.0 black line, the more likely it is that they are not adequately case finding all of their practice population that should be on the CHD disease register.

The purple horizontal line shows the mean observed/expected prevalence ratio for all Thurrock practices and the purple and dotted red curved lines show 2 and 3 standard deviations from the 1.0 perfect observed / actual ratio respectively.

For practices that fall below the 2 and 3 Standard Deviation (SD) lines we can say with 95.4% and 99.73% confidence that they have failed to identify all of their patients that should be on the CHD disease register. This is important, as patients not on the CHD register are unlikely to be receiving appropriate clinical care to manage the CHD and reduce the risk of emergency admissions and/or worsening clinical outcomes.

Funnel plot 6.30 suggests that a significant minority of GP practices in Thurrock have inadequate levels of case finding for CHD patients, with 15 (42%) of practices having and observed/expected prevalence ratio for CHD below the 2SD line and seven (19%) having an observed/expected prevalence ratio for CHD below the 3SD line. This suggests that a significant minority of CHD patients in Thurrock are not on CHD disease registers and unlikely to be receiving appropriate clinical management of their CHD.

Table 6.31 shows and observed/expected ratio for GP practice CHD registers in Thurrock, the East of England and England. As table 6.31 shows, Thurrock's ratio of 0.75 is lower than the regional and England average. Increasing Thurrock's ratio to the England average of 80% would require case finding a further 304 patients with CHD.

Practice Code	Observed Prevelance <sup>*1</sup>	Observed Register Size	Expected Prevelance	Expected Register Size <sup>*2</sup>	GP Practice Observed / Expected	Total Population <sup>*3</sup>		
Thurrock Total	2.9%	4,629	3.8%	6,166	0.75	160,579		
England <sup>*4</sup>	3.5%		4.4%		0.8			
EOE <sup>*4</sup>	3.3%		4.2%		0.79			
Number on register based on national observed/Expected ratio:         4,933								

Table 6.31

Number on register based on national observed/Expected ratio:	4,933
Number of patients to add to register	304
Prevelance based on national observed/Expected ratio.	3.1%

Notes:

- \*1 QMAS for March 2011 as at 22/09/2011
- \*2 ERPHO model as at October 2009
- \*3 Population as at January 2011
- \*4 taken from NHS Comparators as at March 2009

Figure 6.32 plots GP practices (represented by individual diamonds) against two dimensions – their observed/expected ratio of patients on their CHD register along the x axis, and their directly standardised emergency admission rate for CHD (for period ending June 2011) on the y axis. The black vertical line signifies an observed/expected ratio of 1 which would represent accurate case finding of patients with CHD. The black horizontal line represents the mean directly standardised emergency admission rate for Thurrock GP Practices.

This two lines produce four quadrants. Practices is quadrant 1 have higher than average emergency admission rates for CHD and an observed/expected CHD prevalence below 1 signifying poor case finding. For practices within this quadrant, high emergency admissions for CHD may be as a direct result of patients with CHD not being placed on the CHD register and so not receiving appropriate clinical care due to them being unknown to the practice.

Practices in quadrant 2 have an observed/expected prevalence for CHD above 1.0, suggesting adequate case finding, but still have a higher than average emergency admission rate for CHD. This could suggest that although patients are known to the practices in question, that their clinical disease management of these patients is inadequate.

Practices in quadrant 3 have an observed/expected prevalence for CHD below 1.0 but lower than average emergency admission rates for CHD. Practices in this quadrant are likely to have patients with either more begin forms of CHD, or whose CHD is being managed well by the practice despite them not being on the CHD disease register.

Practices in quadrant 4 have an observed/expected prevalence for CHD above 1.0 and lower than average emergency admission rates for CHD. These practices are likely to be excellent at both case finding and subsequent management of the disease.



Fig 6.32

It is practices in quadrant 1 and 2 that are significantly above the average directly standardised emergency admission rate for CHD that are most cause for concern. Figure 6.32 suggests that four practices in quadrant 1 (1,2,3 and 4) have case finding that could be impacting negatively on emergency admission rates and two practices in quadrant 2 (17 and 18) that could have inadequate clinical management of patients with CHD on their CHD disease registers

# 6.3.1.5 Management of Chronic obstructive pulmonary disease in Primary Care

Chronic obstructive pulmonary disease (COPD) is the co-occurrence of chronic bronchitis and emphysema, a pair of commonly co-existing diseases of the lungs in which the airways become narrowed. This leads to a limitation of the flow of air to and from the lungs, causing shortness of breath. COPD is common in later life: it is likely that over a million individuals currently have the disease in Great Britain and there are over 25 000 deaths each year.

The most important cause of COPD is smoking, but past exposures to fumes, chemicals and dusts at work will have also contributed to causing many currently occurring cases.

Table 6.33					
Practice Code	Observed Prevelance <sup>*1</sup>	Observed Register Size	Expected Prevelance	Expected Register Size <sup>*2</sup>	GP Practice Observed / Expected
Thurrock Total	1.6%	2,584	2.5%	3,943	0.66
England <sup>*4</sup>	1.5%		3.0%		0.52
EOE <sup>*4</sup>	1.4%		2.5%		0.57

Table 6.33 shows details of the COPD observed and expected prevalence for Thurrock, England and the East of England. There are 2,584 people on the COPD registers of practices within Thurrock in March 2011, giving a prevalence of 1.6%. This prevalence is a little higher than the England and EOE prevalence. Overall the expected register size for Thurrock practices as at October 2009 is 3,943 giving an observed / expected percentage of 66%. This percentage is the estimated completeness of the practice registers. This percentage is higher than the National (52%) and EOE (57%) percentage

Figure 6.34 is a 'funnel plot' that shows the observed/expected ratio of patients on the COPD disease register of each GP practice in Thurrock (represented by a grey dot). An explanation of a funnel plot is given in the CHD previously.

Funnel plot 6.34 suggests that a significant minority of GP practices in Thurrock have inadequate levels of case finding for COPD patients, with 10 of the 36 practices (28%) estimated completeness is more than 3 standard deviations below 100%. This suggests that a significant minority of CHD patients in Thurrock are not on COPD disease registers and unlikely to be receiving appropriate clinical management of their COPD.

Total Population<sup>\*3</sup>

160.579




Notes:

- \*1 QMAS for March 2011 as at 22/09/2011
- \*2 ERPHO model as at October 2009
- \*3 Population as at January 2011
- \*4 taken from NHS Comparitors as at March 2009

Figure 6.35 plots GP practices (represented by individual diamonds) against two dimensions – their observed/expected ratio of patients on their COPD register along the x axis, and their directly standardised emergency admission rate for COPD (for period ending June 2011) on the y axis. The black vertical line signifies an observed/expected ratio of 1 which would represent accurate case finding of patients with COPD. The black horizontal line represents the mean directly standardised emergency admission rate for Thurrock GP Practices.

A more detailed description on how to interpret the quadrants in figure 6.35 is given previously in the Managing CHD in Primary Care section. A significant number of Thurrock practices are falling within quadrant 1, which suggests that their inability to adequately case find and manage patients with COPD within Primary Care may be impacting on higher than average hospital emergency admissions for COPD.





# 6.3.1.6 Management of Diabetes in Primary Care

Diabetes mellitus, often simply referred to as diabetes, is a group of metabolic diseases in which a person has high blood sugar, either because the body does not produce enough insulin, or because cells do not respond to the insulin that is produced. This high blood sugar produces the classical symptoms of frequent urination, increased thirst and increased hunger. There are three types, type 1 resulting from the body's failure to produce insulin, type 2 resulting from a condition in which cells fail to use insulin properly and Gestational diabetes which occurs when pregnant women have high blood glucose during pregnancy.

All forms of diabetes have been treatable since insulin became available in 1921, and type 2 diabetes may be controlled with medications. Both type 1 and 2 are chronic conditions that usually cannot be cured. Diabetes without proper treatments can cause many serious long-term health complications including cardiovascular disease, chronic renal failure and retinal damage.

Table 6.36 shows details of the diabetes observed and expected prevalence for Thurrock, England and the East of England.

Table 6.36

Practice Code	Observed Prevelance <sup>*1</sup>	Observed Register Size	Expected Prevelance	Expected Register Size <sup>*4</sup>	GP Practice Observed / Expected	Total Population <sup>*3</sup>
Thurrock Total	5.7%	7,141	5.3%	6,630	1.08	125,281
England <sup>*4</sup>	5.1%		5.7%		0.88	
EOE <sup>*4</sup>	4.8%		6.0%		0.81	

Notes:

\*1 QMAS for March 2011 as at 22/09/2011

\*3 Population as at January 2011

\*4 taken from NHS Comparitors as at March 2009

There are 7,141 people on the Diabetes registers of practices within Thurrock in March 2011, giving an observed prevalence of 5.7%. This prevalence is greater than the England and East of England observed prevalences. The size of the practice registers is as expected with the observed / Expected ratio of 1.08.

Figure 6.37 is a 'funnel plot' that shows the observed/expected ratio of patients on the Diabetes disease register of each GP practice in Thurrock (represented by a grey dot). An explanation of a funnel plot is given in the CHD section previously. The vast majority of Thurrock practices fall within the 2 standard deviation funnel limit, and all practices within the three standard deviation limit suggesting that Thurrock GP practice Diabetes registers are largely complete and that case finding for diabetes is not an issue within Thurrock.





### 6.3.1.1.7 Management of Hypertension in Primary Care

Hypertension (more commonly known as high blood pressure) is a cardiac chronic medical condition in which the systemic arterial blood pressure is elevated. This means that the heart is having to work harder than it should to pump the blood around the body. Hypertension is classified as either primary (essential) hypertension or secondary hypertension; about 90–95% of cases are categorized as "primary hypertension," which means high blood pressure with no obvious medical cause. The remaining 5–10% of cases (Secondary hypertension) are caused by other conditions that affect the kidneys, arteries, heart or endocrine system.

Persistent hypertension is one of the risk factors for stroke, myocardial infarction, heart failure and arterial aneurysm, and is a leading cause of chronic kidney failure. Moderate elevation of arterial blood pressure leads to shortened life expectancy. Dietary and lifestyle changes can improve blood pressure control and decrease the risk of associated health complications, although drug treatment may prove necessary in patients for whom lifestyle changes prove ineffective or insufficient.

Table 6.38 shows details of the hypertension observed and expected prevalence for Thurrock patients and for England and the East of England.

Practice Code	Observed Prevelance <sup>*1</sup>	Observed Register Size	Expected Prevelance	Expected Register Size <sup>*2</sup>	GP Practice Observed / Expected	Total Population <sup>*3</sup>
Thurrock Total	14.2%	22,722	20.9%	33,522	0.68	160,579
England <sup>*4</sup>	13.1%		24.1%		0.55	
EOE <sup>*4</sup>	13.4%		24.4%		0.55	

Table 6.38

Notes:

\*1 QMAS for March 2011 as at 22/09/2011

\*2 ERPHO model as at October 2009

\*3 Population as at January 2011

\*4 taken from NHS Comparitors as at March 2009

There are 22,722 people on the Hypertension registers of practices within Thurrock in March 2011, giving an observed prevalence of 14.2%. This prevalence is greater than the England the East of England prevalence.

The size of the Thurrock Hypertension practice registers is lower than expected with the observed / expected ratio of 68%. However, this is still higher than the national and East of England Hypertension observed/expected prevalence ratio.

Figure 6.39 is a 'funnel plot' that shows the observed/expected ratio of patients on the hypertension disease register of each GP practice in Thurrock (represented by a grey dot). An

explanation of a funnel plot is given in the CHD section previously. The majority (29 out of 36) of Thurrock practices (81%) fall below the 3 standard deviation funnel from the 1.0 observed/expected prevalence ratio. This suggests that there is a significant problem in terms of completeness of hypertension disease registers in Thurrock practices and that many patients with hypertension remain undiagnosed and on a hypertension register.





#### 6.3.1.8 Management of Cancer in Primary Care

General practitioners often have a key role in the referral and subsequently in providing a support role and in ensuring that care is appropriately co-ordinated. A register is a prerequisite for ensuring follow-up of patients with cancer. The register can be developed prospectively as the intention is to ensure appropriate care and follow-up for patients with a diagnosis of cancer. For the purposes of the register all cancers should be included except non-melanomatous skin lesions.

Table 6.40 shows details of the cancer observed and expected prevalence for Thurrock patients and for England and the East of England.

Practice Code	Observed Prevelance <sup>*1</sup>	Observed Register Size	Expected Prevelance	Expected Register Size <sup>*2</sup>	GP Practice Observed / Expected	Total Population <sup>*3</sup>
Thurrock Total	0.8%	1,347	0.7%	1,071	1.26	160,579
England <sup>*4</sup>	1.3%		0.7%		1.68	
EOE <sup>*4</sup>	1.3%		0.8%		1.64	

Table 6.40

Notes:

\*1 QMAS for March 2011 as at 22/09/2011

\*2 taken from NHS Comparators as at March 2009

\*3 Population as at January 2011

There are 1,347 people on the cancer registers of practices within Thurrock in March 2011, giving a prevalence of 0.8%. The size of the practice registers is slightly greater (26% greater) than expected. National and EOE average are also greater than expected.

Figure 6.41 is a funnel plot that shows the observed/expected ratio of patients on the cancer register of each GP practice in Thurrock (represented by a grey dot). An explanation of a funnel plot is given in the CHD section previously. All but one practices are within 3 standard deviations from the expected register size and all but two within 2 standard deviations from their expected register size. All of this data suggests that GP practices in Thurrock are adequately case finding patients with cancer and placing them on an appropriate cancer register.



Fig 6.41

# 6.3.1.9 Management of Stroke in Primary Care

A stroke is a rapidly developing loss of brain function due to disturbance in the blood supply to the brain. This can be caused by a blockage (thrombosis/arterial embolism) or a haemorrhage (leakage of blood). A stroke is a medical emergency that can cause permanent neurological damage, complications and death and is the leading cause of disability in the UK.<sup>6</sup>

Table 6.42 shows details of the stroke observed and expected prevalence for Thurrock patients and for England and the East of England.

Table 6.42

Practice Code	Observed Prevalence <sup>*1</sup>	Observed Register Size	Expected Prevalence	Expected Register Size <sup>*2</sup>	GP Practice Observed / Expected	Total Population <sup>*3</sup>
Thurrock Total	1.4%	2,309	1.7%	2,724	0.85	160,579
England <sup>*4</sup>	1.7%		2.0%		0.85	
EOE <sup>*4</sup>	1.6%		1.9%		0.84	

Notes:

\*1 QMAS for March 2011 as at 22/09/2011

\*2 taken from NHS Comparators as at March 2009

\*3 Population as at January 2011

There are 2,309 people on the Stroke registers of practices within Thurrock in March 2011, giving a prevalence of 1.4%. The size of the practice registers is lower than England or the East of England. However the GP Practice observed/expected ratio of 0.85 is the same as England.

Figure 6.43 is a funnel plot that shows the observed/expected ratio of patients on the stroke register of each GP practice in Thurrock (represented by a grey dot). An explanation of a funnel plot is given in the CHD section previously. All but two practices are within 3 standard deviations from the expected register size, but 5 practices fall below 2 standard deviations from their expected register size. This data suggests that the majority of GP practices in Thurrock are adequately case finding patients with stroke and placing them on the stroke disease register.





Figure 6.43 plots GP practices (represented by individual diamonds) against two dimensions – their observed/expected ratio of patients on their stroke register along the x axis, and their directly standardised emergency admission rate for stroke (for period ending June 2011) on the y axis. The black vertical line signifies an observed/expected ratio of 1 which would represent accurate case finding of patients with stroke. The black horizontal line represents the mean directly standardised emergency admission rate for Thurrock GP Practices.

A more detailed description on how to interpret the quadrants in figure X is given previously in the Managing CHD in Primary Care section. A significant number of Thurrock practices are falling within quadrant 1, which suggests that their inability to adequately case find and manage patients with COPD within Primary Care may be impacting on higher than average hospital emergency admissions for COPD.

As figure 6.44 shows, a small number of practices (2,5,6 and 8) in quadrant 1 have directly standardised admission rates significantly greater than the mean, and low observed/expected prevalence ratios suggesting that inadequate case finding may be causing increased emergency admission rates for stroke. For other practices with higher than average directly standardised emergency admission rates e.g. (1,3 4 and 11), observed/emergency prevalence ratios are near one, suggesting that clinical management of stroke patients within primary care may need to be improved.





# 6.3.1.10 Management of Dementia in Primary Care

There are 625 people on the Dementia registers of practices within Thurrock in March 2011, giving a prevalence of 0.4%. The size of the practice registers is lower than expected with the observed / expected ratio of 44%. This ratio is still higher than the National and EOE ratio.

Practice Code	Observed Prevelance <sup>*1</sup>	Observed Register Size	Expected Prevelance	Expected Register Size <sup>*2</sup>	GP Practice Observed / Expected	Total Population <sup>*3</sup>
Thurrock Total	0.4%	625	0.9%	1,408	0.44	160,579
England <sup>*4</sup>	0.4%		1.1%		0.39	
EOE <sup>*4</sup>	0.4%		1.2%		0.36	

Notes:
*1 QMAS for March 2011 as at 22/09/2011
*2 ERPHO model as at October 2009
*3 Population as at January 2011
*4 taken from NHS Comparitors as at March 2009

Figure 6.45 is a 'funnel plot' that shows the observed/expected ratio of patients on the dementia disease register of each GP practice in Thurrock (represented by a grey dot). An explanation of a funnel plot is given in the CHD section previously. A significant minority of 14 out of 36 practices in Thurrock (39%) fall below the 3 standard deviation funnel from the 1.0 observed/expected prevalence ratio. This suggests that many practices are failing to adequately identify patients with dementia and place them on an appropriate disease register. This in turn is likely to impact on the quality of clinical care that they receive.



#### 6.3.1.11 Summary and Recommendations – GP Practices

#### **GP** Provision

- There are 36 GP practices in Thurrock serving a total registered practice population of 160,814 patients.
- 'Under doctoring' is in issue in Thurrock with half of the practices serving weighted practice populations/WTE GP of more than the recommended maximum of 2000.

#### Patient Satisfaction

- The overall average for GP Practices within Thurrock is above or with the East of England Average for four of the five questions. The exception is satisfaction with opening hours shown in figure 6.45.
- However, there is a wide variation in scores achieved between individual GP Practices within Thurrock against five key patient satisfaction criteria. Whilst most Thurrock Practices have patient satisfaction scores that are better or not statistically worse those for the East of England region, a minority of practices regularly fall below regional scores. Of the five questions responded to in the patient satisfaction survey, the same two practices fall below the EoE average in all five questions, the same five practices fall below the EoE in four of the five questions, and the same six practices fall below the EoE in three of the five questions.
- Further investigation is warranted for Practices with poor patient satisfaction scores across a number of different markers, with a view to ensuring that they improve. The new Clinical Commissioning Groups (CCGs) provide an excellent mechanism through which high performing GPs can share best practice to drive up quality.

#### Clinical Quality

- Achievement for Thurrock practices across key QOF clinical domains is largely similar to that achieved nationally with the exception of the Depression and Mental Health clinical domains where Thurrock's performance is 4% lower than the national average and the Palliative Care clinical domain where Thurrock's performance is 15% lower than that achieved nationally.
- There is variation in practice in the recording and management of patients with chronic diseases across Thurrock GP practices.
- All GP practices generally perform well in terms of completeness of diabetes and cancer registers.
- The majority of practices also perform well in terms of completeness of their CHD and Stroke registers although with only six and two practices respectively having observed/expected prevalence ratios below 3 standard deviations from the ideal ratio of 1.0.
- For Dementia, Hypertension and COPD disease registers, completeness is poor for a significant minority of practices and this in turn may be translating into unnecessary emergency admissions into secondary care.

Development of an integrated approach that will target all major common risk factors of cardiovascular diseases (CVD), diabetes mellitus (DM), cancer and chronic respiratory diseases is the most cost-effective way to prevent and control them. An integrated approach responds not only to the need of intervention on major common risk factors with the aim of reducing premature mortality and morbidity of chronic non-communicable diseases, but also the need to integrate secondary and tertiary prevention, health promotion, and related programmes across sectors and different disciplines. It is recommended that further investigation is undertaken with practices with low observed/expected prevalence ratios for CHD, Stroke, Dementia, Hypertension and COPD, and / or with greater than average emergency admission rates, to ascertain possible ways to improve case finding and clinical management of patients with these chronic diseases to achieve such an integrated approach. Once again, the new CCGs could provide an excellent mechanism for GPs to share best practice to drive up clinical standards, improve patient outcomes and reduce secondary care commissioning costs.

# 6.3.2 Pharmacy

# 6.3.2.1 Pharmacy Provision

Thurrock has 29 Pharmacies of which three offer a '100' hour service. NHS South West Essex produced a Pharmacy Needs Assessment (PNA) in 2010<sup>7</sup>. Pharmacy Needs Assessment regulations require that PCTs divide their area into localities which are then used as a basis for structuring the assessment. For the purposes of the PNA, NHS South West Essex decided that the PNA should adopt the **virtual ward** structure which is used for the purposes of the PCT's Strategic Services Plan (SSP) and Primary and Community Care Strategy.

The virtual wards are discrete units of geography that have been defined to encompass natural populations within NHS SWE. The virtual wards boundaries are not coterminous with ward boundaries, but are, generally, coterminous with lower super output areas (LSOAs). Each of the virtual wards is approximately associated with a local authority and Thurrock has six 'virtual wards':

- 1. Grays North East
- 2. Grays Town
- 3. Purfleet and Ockendon
- 4. Tilbury and Chadwell St. Mary
- 5. West Thurrock
- 6. Corringham and Stanford-le-Hope

Table 6.46 shows the number of Pharmacies and 100 hour Pharmacies in each 'Virtual Ward' These are also mapped onto figure Y, which also shows deprivation levels for Thurrock by LSOA.

Virtual Ward	Number of Pharmacies	Number of 100 hour Pharmacies
Corringham and Stanford	5	0
Grays North East	2	0
Grays Town	5	0
Purfleet and Ockendon	5	0
Tilbury and Chadwell	7	2
West Thurrock	5	1
Thurrock Total	29	3

Table 6.46



Figure 6.46 and 6.47 shows the number of pharmacies per 100,000 population in Thurrock, and compares this figure to that for other PCTs in East of England and the Office for National Statistics (ONS) PCT Comparator Group for NHS South West Essex. (PCTs with similar population characteristics to that of NHS South West Essex). PCT comparator groups are used as opposed to CIPFA local authority groups, as national data sets on pharmacy distribution by local authority area are not available, and this figure has been calculated locally for Thurrock.

Thurrock has 18.5 pharmacies per 100,000 population which is equal to the median for the East of England and slightly below the NHS South West Essex and England figures which are 19.9 and 20.7 pharmacies per 100,000 population respectively.











igure 16: Map showing population within 20 minute drive time of a community pharmacy or dispensing GP

Figure 6.50

#### 6.3.2.2 Pharmacy Access

Figure 6.50 shows the areas of population coverage for south west Essex that are within a 20 minute car drive of a pharmacy. As figure 6.50 shows, the vast majority of the Thurrock population fall into this category.

#### 6.3.2.3 Pharmacy Extended Services

Table 6.51

Local social marketing research undertaken by the Public Health Directorate of NHS South West Essex has demonstrated that our local population like accessing health improvement / lifestyle services through pharmacy. As such, a number of additional 'locally enhanced services' have been commissioned through pharmacy including stop smoking, cardiovascular disease health checks and sexual health services including chlamydia screening and emergency hormonal contraception. Pharmacies who are currently commissioned to provide these services in Thurrock are shown in table 6.51 below.

Name		Addres	55		Sexual Health	Stop Smoking	CVD Health Checks
Allcures Pharmacy	23 High Street		Stanford-le-Hope	SS17 0HD			
Allcures Pharmacy	62 High Street		Grays	RM17 6NA		?	?
Allcures Pharmacy	19 Lampits Hill		Corringham	SS17 9AA	?	?	
Allcures Pharmacy	16 Kings Parade		Stanford le Hope	SS17 OJE		2	?
Allcures Pharmacy	Unit 1 Stanford House	Princess Margaret Road	East Tilbury	RM18 8JB	2	2	
Armada Pharmacy	1 Drake House	Drake Road	Chafford Hundred	RM16 6QA		2	
Asda Pharmacy	Thurrock Park Way		Tilbury	RM18 7HJ	?	2	2
Asset Chemist	128 Dock Road		Tilbury	RM18 7BJ	?	?	
Boots Pharmacy	83/85 St Johns Way		Corringham	SS17 7LL			
Boots Pharmacy	17 Derwent Parade		South Ockendon	RM15 5EF	?	?	?
Boots Pharmacy	Lakeside Shopping Centre	74-75 Thurrock Lakeside	West Thurrock	RM20 2ZG	?	?	?
Boots Pharmacy	Unit 1B The Junction Retail Park	Western Road	Thurrock	RM10 3LP		2	
Boots Pharmacy	35-43 High Street		Grays	RM17 6LU			
Chapharm	2/3 Civic Square		Tilbury	RM18 8AD			
Dave's Chemists	Purfleet Care Centre	Tank Hill Road	Purfleet	RM16 1SX	?	2	
Dips Chemist	12 Defoe Parade		Chadwell St. Mary	RM16 4QR	?	?	
Hemants Chemist	10 Derwent Parade		South Ockendon	RM15 5EE	?	?	

Lloyds Pharmacy	31 Lodge Lane		Grays	RM17 5RY		2	
River View Pharmacy	22 Riverview		Chadwell St. Mary	RM16 4BJ			
Sainsbury's Pharmacy	Sainsbury's Superstore	Burghley Road	Chafford Hundred	RM16 6QQ	?	?	
South Road Pharmacy	1 South Road		South Ockendon	RM15 6NU	?	2	
Steve's Chemist	36 Bridge Road		Grays	RM17 6BU			
Allcures Pharmacy	34 East Thurrock Road		Grays	RM17 6SP		?	
Unicare Pharmacy	89 Orsett Road		Grays	RM17 5HH	?	?	
Unicare Pharmacy	22 St Johns Way		Corringham	SS17 7LJ	?	?	
St. Clements Pharmacy	643 London Road		West Thurrock	RM20 3HD	?	?	?
онмѕ	32 High St		Aveley	RM15 4AD			

As Table 6.51 shows, many pharmacies have chosen to provide additional lifestyle based services over and above their core contracts. 21 out of 29 (72.4%) offer stop smoking services, 15 out of 29 (51.7%) offer additional sexual health/contraceptive services and 6 out of 29 (20.7%) offer Cardio Vascular checks.

# 6.3.2.4 Patient views of Pharmacy Services

As part of the Pharmaceutical Needs Assessment, NHS South West Essex undertook a comprehensive survey of patient views of Pharmacy in 2010, which included the residents of Thurrock. In total 1014 questionnaires were returned (a response rate of 18%). Figure 6.51 shows the distribution of response rate by 'Virtual Ward' including percentages from each of the Thurrock virtual wards:



Of the respondents that provided a valid post code, 35.6% were from Thurrock against a south west Essex population for Thurrock of 38.1%.

The patient survey of the PNA highlighted that the vast majority of participants (90%) were satisfied with the pharmacy service. A response below was typical:

"Brilliant staff, kind, caring, obliging and knowledgeable. They know me well and understand the position that I am in. They will always to everything they can in order to help me out"

The overall picture of satisfaction with pharmacy services was reflected across a range of indicators. There were also some areas where patients highlighted potential for improvement.

### **Consultations**

The majority of participants were happy with the consultations that they had experienced with their pharmacist, and rated them as 'excellent'. However some respondents stated that they were not offered a choice of location of consultation. The majority of respondents that had a consultation were happy with the level of privacy offered at the pharmacy, with only 8% being given their consultation over the counter. This suggests that consultation areas are being used actively by pharmacy contractors.

#### **Opening Hours**

Most respondents did not have problems finding a pharmacy and were generally happy with the pharmacy opening hours. However, often a reason for being unable to find a pharmacy was associated with opening hours, as some pharmacies close during lunch hours or at weekends. 13.2% of respondents had needed a pharmacy when it was closed. One area of improvement that was highlighted by respondents was opening hours and that alternative pharmacies should be signposted that offered extended opening hours.

#### Availability of medicines.

69.8% of respondents rated their experience of having their prescription processed as positive. 72.8% obtained their medication on the same visit. However 6.3% did not get medicine the last time their prescription was process. Participants either got their medication on the next day, or two or more days after requested.

#### Extended services

The survey found that consultations with pharmacists were viewed favourably by respondents and they stated that they would like pharmacists to offer additional services such as blood tests, sexual health screening, weighing facilities, heart health checks, blood pressure checks, stress management, home delivery services and services that offered advice on minor ailments and health conditions in order to minimise GP visits. This finding mirrors findings in two other pieces of social marketing research undertaken by NHS South West Essex, which found that pharmacy was one of the preferred locations to access health improvement services for our population.

Respondents stressed the importance of offering sound proofed, discrete consultation rooms within the pharmacy to ensure privacy and avoid the need for 'over the counter' consultations. Certifications should be made visable to patients, to reassure them that their pharamacist was adequately qualified to provide additional services (e.g. healthy heart checks).

Respondents also stressed the importance of better marketing of extended services and the need to ensure effective care pathways are in place between GPs and Pharmacists to ensure good communication between the two about a patient's care

### 6.3.2.5 Summary and Recommendations – Pharmacy

- Thurrock has 29 Pharmacies of which three offer a '100' hour service
- Pharmacy provision in Thurrock is adequate in terms of numbers per 100,000 population. Thurrock has 18.5 pharmacies per 100,000 population which is equal to the median for the East of England and slightly below the NHS South West Essex and England figures which are 19.9 and 20.7 pharmacies per 100,000 population respectively.
- Many pharmacies in Thurrock have chosen to provide addition health improvement / lifestyle services. 21 out of 29 (72.4%) offer stop smoking services, 15 out of 29 (51.7%) offer additional sexual health/contraceptive services and 6 out of 29 (20.7%) offer Cardio Vascular checks.
- A recent patient service which formed part of the NHS South West Essex Pharmacy Needs Assessment (2010) found that the vast majority of participants (90%) were satisfied with the pharmacy services they received

# 6.4 Hospital (Secondary) Healthcare

The majority of health care provided by hospitals (known as secondary health care) for the residents of Thurrock is currently commissioned by NHS South West Essex and provided by Basildon and Thurrock University Hospital, although under the Government's current healthcare reforms, responsibility for commissioning secondary health care will largely move to GP Clinical Commissioning Groups (CCGs) by April 2013.

Health care provided within hospital falls into two main categories – procedures that are planned (elective) and healthcare that is unplanned and provided in an emergency.

This section considers the overall burden of secondary health care by Thurrock GP practice populations and considers both emergency and planned hospital healthcare usage by Thurrock patients.

### 6.4.1 Secondary Healthcare Usage by GP Practice

Figure 6.52 shows the standardised admissions for each Thurrock GP Practice population considering all hospital admissions (both emergency and planned) together with the rate for England and the East of England region. As figure X shows, there is some variation in admission rate between practice populations, however, only four GP practices have admission rates significantly above the England average, and only nine practices have admission rates significantly below the England average (at 95% statistical significance).



Data Source: SUS Costed views as at 30/08/2011 Discharge Date: Between 01/04/08 and 31/03/11 Essex Rate: All GP Practices in Essex (PCG Codes: 5PY, 5PX, 5PW, 5P1, 5PV)

#### 6.4.1.1 Top Ten Causes of All Admissions to Hospital from Thurrock Patients

Table 6.53 below shows the top 10 causes of all admissions for Thurrock GP Practice populatons for the financial year 2010/11. The table shows the top 10 primary diagnosis in terms of number of admissions and percentage of total admissions. The highest number of admissions is for *Other Cataract* with 709 admissions which is 2% of total admissions. Overall the 10 highest volume primary diagnosis accounts for 16% of all admissions.

#### Table 6.53

Top 10 Name	Number	% of Total Admissions
Other cataract	709	2%
Abdominal and pelvic pain	579	2%
Malignant neoplasm of breast	534	2%
Other disorders of urinary system	496	2%
Pain in throat and chest	477	2%
Pneumonia, organism unspecified	424	1%
Chronic ischaemic heart disease	374	1%
Malignant neoplasm of bronchus and lung	362	1%
Follow-up examination after treatment for malignant neoplasm	336	1%
Other noninfective gastroenteritis and colitis	322	1%
Total Top 10	4,613	16%

Source: Secondary User Service Data (2010)

Table 6.54 below shows the highest volume primary diagnosis for the age bands and percentage of the total admissions for each of the age bands.

#### Table 6.54

Age Band	Name	Number	% of Total Admissions for Age Band
0-14	Acute tonsillitis	124	5%
15-64	Abdominal and pelvic pain	467	3%
65+	Other Cataract	591	6%

Source: Secondary User Service Data (2010)

# 6.4.2 Emergency (Unplanned) Care

Emergency admissions or unplanned care are admissions that are not predicted and happen at short notice because of perceived clinical need<sup>8</sup>. This type of care represents around 65 per cent of hospital bed days in England (34 million bed days and 4.75 million emergency admissions in 2007/8).<sup>9</sup>

Emergency or unplanned care is accessed via BTUH's Accident and Emergency (A&E) Department. Patients arriving at A&E are triaged and then either treated within the department in order of clinical priority and discharged, or admitted into the hospital for further assessment or treatment.

Treating a patient in A&E for conditions that could be treated within primary care is generally more expensive, and hence reducing unnecessary A&E attendances is a key mechanism through which financial waste within the health care system can be reduced, and resources diverted to be reinvested in other forms of healthcare. Reductions in unplanned care will also limit the disruption it causes to elective health care, most notably inpatient waiting lists and moreover to the individuals admitted.

### 6.4.2.1 A&E Waiting Times

Accident and Emergency Waiting Time is defined as 'the total time spent in A & E - measured from the time the patient arrives in A & E to the time the patient leaves the A&E department (by admission to hospital, transfer to another organisation or discharge)'. The previous government targeted PCTs and NHS Trusts that provide A&E to ensure that no-one wait more than four hours in accident and emergency from arrival to admission, transfer or discharge. An operational standard of 98% was employed for assessment up to and including quarter one of 2010/11.

The revised Operating Framework for NHS in England 2010-11 was released in June 2010. It announced that the four hour standard would be replaced by a set of clinical quality indicators in April 2011. It also outlined that the operational standard would be changed to 95% upon clinical advice with immediate effect.

#### 6.4.2.2 A&E Attendances by GP Practice Population

Figure 6.55 shows the standardised rate of A&E attendances for patients from GP practices in Thurrock for the third quarter of 2010/11, together with the rate for the East of England region and for England. Treating patients in A&E for health problems that could be treated within primary care is expensive and so reducing unnecessary A&E attendances is a key mechanism to reduce financial waste and divert resources into other health and social care initiatives.

Figure 6.55 shows that there is considerable variation of A&E attendances across Thurrock practices with six practices in Thurrock having a statistically significant higher rate of A&E attendances than the East of England (EoE), thirteen practices being significantly lower than the EoE rate and seventeen being in line with the regional rates. All Thurrock practices have significantly lower attendance rates than England.

There may be a number of factors that cause practice populations to access A&E at standardised rates significantly greater than regional average including practice opening times, in-ability to get a timely appointment with a GP, or culture of a particular population served by a specific practice. This data requires further investigation on a practice by practice basis to determine causes of and solutions to significantly greater A&E access.



#### Figure 6.55

Source: Secondary User Service Data (2010)

#### 6.4.2.3 Emergency Admissions by GP Practice Population

Figure 6.56 shows the standardised emergency admission rate for patients from each GP practice within Thurrock and the East of England. The graph shows that five Thurrock practices have a statistically significant greater rate of emergency admissions than the East of England (EoE), nine practices being significantly lower than the EoE rate and the majority being in line with the regional rates. All but ten Thurrock practices have significantly lower admission rates than England and none significantly greater than England rates.

Again, this data needs further investigation to determine the exact reasons why a specific practice has a standardised emergency admission rate significantly greater than the regional rate. However this may be linked to the inadequate case finding and/or poor clinical management of some of the chronic disease conditions discussed in section 6.3.1.3.

It is interesting to note that the same three practices that have significant greater emergency admission rates also have significantly greater A&E attendances, and the former may well be a result of the latter.



Figure 6.56

Source: Secondary User Service Data (2010)

#### 6.4.2.4 Emergency Admissions top 10 causes and costs

Table 6.57 shows the top 10 causes of emergency admissions for Thurrock Practices for the financial year 2010/11. The table shows the top 10 primary diagnosis in terms of number of admissions and percentage of total admissions. The highest number of admissions is for abdominal and pelvic pain with 463 emergency admissions which is 2% of total emergency admissions. Overall the 10 highest volume primary diagnosis accounts for 9% of all admissions.

#### Table 6.57

Top 10 Name	Number	% of Total Admissions
Abdominal and pelvic pain	463	2%
Pneumonia, organism unspecified	397	1%
Pain in throat and chest	378	1%
Other disorders of urinary system	322	1%
Other chronic obstructive pulmonary disease (COPD)	249	1%
Other non-infective gastroenteritis and colitis	174	1%
Unspecified acute lower respiratory infection	170	1%
Fracture of femur	160	1%
Cholelithiasis	134	0%
Fracture of forearm	132	0%
Total Top 10	2579	9%

Source: Secondary User Service Data (2010)

Table 6.58 below shows the highest volume primary diagnosis for the age bands and percentage of the total emergency admissions for each of the age bands.

#### Table 6.58

Age Band	Name	Number	% of Total Admissions for Age Band
0-14	Viral infection of unspecified site	92	6%
15-64	Abdominal and pelvic pain	367	7%
65+	Pneumonia, organism unspecified	277	7%

Source: Secondary User Service Data (2010)

Table 6.58 below shows the top 10 HRGs (Health Resource Group - which is a group of diagnosis and procedures with a nationally set cost) for Emergency Admissions in terms of cost for Thurrock GP Practice Populations for the financial year 2010/11.

The unit of care with the highest overall cost for Thurrock practices is Non-Transient Stroke or Cerebrovascular Accident, Nervous system infections or Encephalopathy where there have been 182 emergency admissions. Overall the 10 highest admission costs account for  $\pounds$ 4,840,002 of all admission costs.

#### Table 6.59

Top 10 Name			Number
Non-Transient Stroke or Cerebrovascular Accident, Nervous system infections or Encephalopathy	£	750,247	182
Kidney or Urinary Tract Infections with Major CC	£	738,108	177
Lobar, Atypical or Viral Pneumonia with Major CC	£	668,998	152
Lobar, Atypical or Viral Pneumonia with CC	£	452,593	189
Intermediate Hip Procedures for Trauma with Major CC	£	427,780	51
Percutaneous Coronary Intervention (0-2 stents) and Catheterisation	£	406,378	72
Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with CC	£	400,760	142
Non interventional acquired cardiac conditions 19 years and over	£	385,363	496
Catheter 19 years and over	£	305,593	77
Large Intestinal Disorders with Major CC	£	304,182	79
Total Top 10	£	4,840,002	1617

Source: Secondary User Service Data (2010)

Table 6.60 shows the highest cost HRGs for each specified age band and the total number of admissions these relate to.

#### Table 6.60

Age Band	Name		Number
0-14	Appendectomy Procedures 18 years and under	£90,559	36
15-64	Percutaneous Coronary Intervention (0-2 stents) and Catheterisation	£251,621	45
65+	Kidney or Urinary Tract Infections with Major CC	£690,737	164

Further investigation of the above data is necessary in order to draw more precise conclusions, as the secondary diagnosis of patients once admitted to hospital is often more preceise than the first.

# 6.4.2.5 Chronic Obstructive Pulmonary Disease (COPD).

COPD is the co-occurrence of chronic bronchitis and emphysema, a pair of commonly coexisting diseases of the lungs in which the airways become narrowed causing shortness of breath

In terms of hospital admissions, COPD is responsible for a total of 1 million in-patient bed days per annum and costs the NHS more than £800 million each year and is one of the most costly diseases in terms of acute hospital care. Readmission rates are high as over one in three patients admitted to hospital with COPD will be readmitted within 30 days.

Figures 6.61 and 6.62 show number of admissions and directly standardised admission rate for COPD for patients registered with a GP practice in Thurrock for the three years ending March 2011.

	Number of Admissions	DSR	LCI	UCI
Thurrock	898	9.62	9.37	9.89
Essex		7.15	7.08	7.22

Fig 6.61 Emergency Admissions for COPD for three years ending March 2011 Primary diagnosis for COPD (ICD10: J40-J44)

#### Fig 6.62



Figure 6.62 shows that Thurrock GP practice populations had a statistically significant greater rate of admissions for COPD compared to Essex as a whole, at 95% confidence.

Figure 6.63 shows the number of COPD emergency admissions per month for the last three years. Spells have varied per month between 14 and 44 admissions.



Fig 6.63

Further investigation of this data is required in order to draw more precise conclusions in terms of causes and solutions to Thurrock's high COPD emergency admission rate. However, COPD is clealy linked to both smoking (the prevalence of which is significant in some areas of Thurrock) and to the case finding / clinical management within Primary Care, which section 6.3.1.3.3 highlighted was inadequate for many Thurrock practices. Reducing smoking prevalence and improving COPD disease management within primary and community care is likely to impact positively on the number of these admissions, and hence the cost.

#### 6.4.2.6 Stroke

A stroke is a rapidly developing loss of brain function due to disturbance in the blood supply to the brain. This can be caused by a blockage (thrombosis/arterial embolism) or a haemorrhage (leakage of blood). A stroke is a medical emergency that can cause permanent neurological damage, complications and death and is the leading cause of disability in the UK.<sup>10</sup>

Table 6.64 and Figure 6.65 show number of admissions and directly standardised admission rate for Stroke for patients registered with a GP practice in Thurrock for the three years ending March 2011.

Table 6.64 Admissions (Hospital Spells) for Stroke for three years ending March 2011

Primary Diagnosis for Stroke (ICD10 I60-I69)

	Number of Admissions	DSR	DSR LCI	DSR UCI
Thurrock Practices	666	6.83	6.61	7.06
Essex		6.40	6.34	6.47

#### Fig 6.65



Figure 6.65 shows that Thurrock GP practice populations statistically significant greater standardised rate of admissions for stroke compared to Essex as a whole. Figure 6.66 shows the hospital number of hospital spells for strokes per month for the last three years. Spells have varied per month between 28 and 9 admissions. Thurrock emergency admissions for Stroke have remained constant over the past three years.



Further investigation of this data is necessary to determine the exact causes of and solutions to the high standardised emergency admission rate for Stroke amongst Thurrock practice populations.

#### 6.4.2.7 Myocardial Infarction

Myocardial Infarction (more commonly known as a *heart attack*) is the interruption of blood supply to part of the heart, causing heart cells to die. This is most commonly due to a blockage of the coronary artery. Heart attacks are the leading cause of death for both men and women worldwide.<sup>11</sup>

Figures 6.67 and 6.68 show the directly standarised rate of admission for Myocardial Infarction for Thurrock and Essex patients for the last three years

*Fig* 6.67 Emergency Admissions for Myocardial Infarction for three years ending March 2011 Primary Diagnosis for Myocardial Infarction (ICD10 I21-I22)

	Number of Admissions	DSR	LCI	UCI
Thurrock	340	3.64	3.48	3.81
Essex		3.83	3.77	3.88

Source: Secondary User Service Data (2011)

#### Fig 6.68



Source: Secondary User Service Data (2011)

As figures 6.67 and 6.68 show, the rate of admission for Myocardial Infarction for Thurrock patients is not statistically significantly different to the rate for Essex as a whole at 95% confidence.

Figure 6.69 shows the hospital number of hospital spells for Myocardial Infarction (MI) per month for the last three years. Spells have varied per month between 2 and 18 admissions. Thurrock emergency admissions for MI show a significant decrease since April 2010.



Source: Secondary User Service Data (2011)

### 6.4.2.8 Fracture of Femur

The fracture of femur (most commonly known as a hip fracture) is often due to osteoporosis and in the vast majority of cases is caused by a fall in someone with a weakened osteoporotic bone. Most hip fractures in people with normal bone density are the result of high energy trauma such as car accidents. The classic clinical presentation of a hip fracture is an elderly patient who has sustained a low-energy fall. In the UK, mortality following a fractured neck of femur is between 20% and 35% within one year for patients between 75 and 89, 80% of whom are women.

Table 6.70 and Figure 6.71 show the directly standardised rate of emergency admission due to fracture of femur for patients registered in Thurrock and Essex.

### Table 6.70 Primary diagnosis for Fracture of Femur (ICD10: S702)

	Number of Admissions	DSR	LCI	UCI
Thurrock	478	11.36	11.06	11.67
Essex		11.97	11.88	12.07

Source: Secondary User Service Data (2011)

#### Fig 6.71



Source: Secondary User Service Data (2011)

As figures 6.70 and 6.71 show, the rate of admission for fracture of femur for Thurrock patients is statistically lower than the rate for Essex as a whole at 95% confidence.

Figure 6.72 shows the hospital number of hospital spells for fracture of the femur per month for the last three years. Spells have varied per month between 15 and 49 admissions. Thurrock emergency admissions for fracture of femur have remained constant over the past three years.



Despite being significantly lower than the Essex emergency admission rate, fracture of femur is still in the top ten causes of emergency admissions among the population of Thurrock. (see section 6.4.2.4). Commissioning of effective falls prevention programmes should reduce the number of admissions due to fracture of femur.

# 6.4.3 Planned (Elective) Hospital Healthcare

Planned health care within hospital occurs following a referral of a patient by their GP. This can include referral to a hospital based clinician via a hospital outpatient's appointment or as an elective admission for a hospital based procedure.

Whilst the majority of elective healthcare for Thurrock residents is undertaken by Basildon and Thurrock University Hospital (BTUH), under the government's *Choose and Book* programme, patients in consultation with their GP, now have the opportunity to elect to have procedures undertaken at alternative healthcare providers.

# 6.4.3.1 Outpatients attendance

An outpatient attendance is the occasion of a patient attending a consultant or other medical clinic or meeting with a consultant or senior member of his team outside a clinic session. If the patient is a new outpatient then the attendance is a first outpatient attendance, otherwise it is a follow-up (return) outpatient attendance. Outpatient attendances may occur at any location including the patient's home. Those which take place outside a clinic session on a ward are distinguishable from ward attendances by the fact that the meeting is with a consultant or a senior member of his team rather than with a junior doctor. Patients attending clinics usually come from outside the hospital but may be inpatients. If they are inpatients then usually the inpatient specialty is different from the specialty of the clinic. Bedside consultations are *not* outpatient attendances. However, contacts subsequent to a bedside consultation with the same consultant are recorded as outpatient attendances.

Figure 6.73 shows the standardised rate of outpatient attendances for each Thurrock GP practice population, together with the England and East of England regional rate, for the third quarter of 2010.



#### Fig 6.73

As figure 6.73 shows, there is considerable variation in rate of outpatient appoints between Thurrock GP practices, suggesting differing patient referral behaviours of practice clinicians. 12 practices have referral rates, statistically significantly below the East of England and England average and 11 practices above these averages.

Figure 6.74 shows the standardised rate for total outpatient attendances for Thurrock GP practice populations, for quarter 3 of 2010/11. Like first outpatient attendance rates, there is again significant variation between different practices. The majority of practices 58% have a total outpatient attendance standardised rate that is statistically significantly greater than the average for England, and only one practice has a rate which is statistically significantly lower than England's.

Source: Secondary User Service Data (2011)





Source: Secondary User Service Data (2011)

This data suggests that Thurrock GPs could be referring some patients to secondary health care for conditions that could potentially be treated within the community. Referral management could warrant further investigation into clinical decisions and what is considered an appropriate referral within general practice. It would also be of use to review the part secondary health care has to play in influencing referrals to outpatient appointments.

Targeting high or low referrers through clinical guidelines may not be the issue. Rather, activity should concentrate on increasing the number of appropriate referrals, regardless of the referral rate. Pressure on GPs to review their referral behaviour through the use of guidelines may reduce their willingness to manage problems in primary care, resulting in an increase in referrals to secondary care or conversely avoid referring patients in need of appointments. The use of referral rates to stimulate dialogue and joint working between primary and secondary care may be more appropriate.

#### 6.4.3.2 Elective Admissions

An admission is classed as elective when the decision to admit could be separated in time from the actual admission. As per Connecting for Health admission type guidance, if it is decided the admission is an Elective Admission, the type may be recorded as one of the following:

• Waiting list admission: A patient admitted electively from a waiting list having been given no date of admission at a time a decision was made to admit.
- Booked admission: A patient admitted having been given a date at the time the decision to admit was made, determined mainly on the grounds of resource availability.
- Planned admission: A patient admitted, having been given a date or approximate date at the time that the decision to admit was made. This is usually part of a planned sequence of clinical care determined mainly on social or clinical criteria (e.g. check cystoscopy). A planned admission is one where the date of admission is determined by the needs of the treatment, rather than by the availability of resources.

If treatment is arranged and does not have to be on a specific date, then it should be waiting list or booked. If treatment is arranged for a particular date then it should be recorded as planned.

Figure 6.75 shows the standardised rate of elective (planned) admissions into hospital for patients registered to different GP practices in Thurrock, for the third quarter of 2010/11.

As figure 6.75 shows there is significant variation between practices, but the majority fall within the standardised rate for elective admissions for Thurrock GP practice populations. One practice has an elective admission rate that is statistically significantly greater than the average for both East of England and England. Four practices have an admission rate that is statistically significantly lower than the average for both East of England and England.

This data warrants further investigation but could suggest that some Thurrock GPs are over referring some patients to secondary health care and some are under referring.



Fig 6.75

Source: Secondary User Service Data (2010)

## 6.4.3.3 Elective Admissions Top 10 Causes and Costs

Table 6.76 shows the top 10 causes of elective admissions for Thurrock Practices for the financial year 2010/11. The table shows the top 10 primary diagnosis in terms of number of admissions and percentage of total admissions. The highest number of admissions is for Other Cataract with 708 elective admissions, which is 2% of total elective admissions. Overall the 10 highest volume primary diagnosis accounts for 12% of all admissions.

Top 10 Name	Number	% of Total Admissions
Other cataract	708	2%
Malignant neoplasm of breast	524	2%
Follow-up examination after treatment for malignant neoplasm	335	1%
Malignant neoplasm of bronchus and lung	306	1%
Internal derangement of knee	300	1%
Other intervertebral disc disorders	269	1%
Malignant neoplasm of bladder	269	1%
Chronic ischaemic heart disease	259	1%
Gastritis and duodenitis	232	1%
Gonarthrosis [arthrosis of knee]	225	1%
Total Top 10	3427	12%

Table 6.76

Source: Secondary User Service Data (2011)

Table 6.77 shows the highest volume primary diagnosis for the age bands and percentage of the total elective admissions for each of the age bands.

### Table 6.77

Age Band	Name	Number	% of Total Admissions for Age Band
0-14	Acute Tonsillitis	92	8%
15-64	Malignant Neoplasm Of Breast	428	4%
65+	Other Cataract	591	10%

Source: Secondary User Service Data (2011)

Table 6.78 shows the top 10 HRGs for elective admissions in terms of cost for Thurrock Practices for the financial year 2010/11. The unit of care with the highest overall cost for Thurrock practices is Major Knee Procedures for non Trauma Category 2 with Complications where there have been 130 elective admissions.

### Table 6.78

Top 10 Name		Cost	Number
Major Knee Procedures for non Trauma Category 2 with CC	£	856,765	130
Phacoemulsification Cataract Extraction and Lens Implant	£	591,981	725
Endoscopic or Intermediate Large Intestine Procedures 19 years and over	£	583,796	1,008
Major Hip Procedures for non Trauma Category 1 with CC	£	564,784	95
Diagnostic and intermediate procedures on the upper GI tract 19 years and over	£	507,536	1,016
Non-Transient Stroke or Cerebrovascular Accident, Nervous system infections or Encephalopathy	£	432,176	15
Intermediate Knee Procedures for non Trauma with CC	£	415,714	140
Intermediate Knee Procedures for non Trauma without CC	£	396,774	145
Kidney or Urinary Tract Infections with Major CC	£	291,817	28
Catheter 19 years and over	£	282,263	247
Total Top 10	£	4,923,606	3,549

#### Source: Secondary User Service Data (2011)

Table 6.79 shows the highest cost HRGs for elective admissions for each specified age band and the total number of admissions these relate to.

### Table 6.79

Age Band	Name	Cost	Number
0-14	Tonsillectomy 18 years and under without CC	£ 164,253	138
15-64	Intermediate Knee Procedures for non Trauma without CC	£ 379,999	140
65+	Major Knee Procedures for non Trauma Category 2 with CC	£ 536,766	81

Source: Secondary User Service Data (2011)

The above data warrants further investigation including considering benchmarking against other areas to ascertain where commissioning can be improved to drive efficiencies.

# 6.4.4 Summary and Recommendations – Hospital (Secondary) Health Care

## Secondary Care Usage

 There is some variation in the standardised all admission rate into hospital between different practice populations, however, only four GP practices have admission rates significantly above the England average, and only nine practices have admission rates significantly below the England average (at 95% statistical significance).

### **Emergency Healthcare**

- Thurrock GP Practice populations have an emergency standardised admission rate for COPD that is significantly greater than the regional rate. Further investigation of this data is required in order to draw more precise conclusions in terms of causes and solutions to Thurrock's high COPD emergency admission rate. However, COPD is clealy linked to both smoking (the prevalence of which is significant in some areas of Thurrock) and to the case finding / clinical management within Primary Care, which section 6.3.1.3.3 highlighted was inadequate for many Thurrock practices. Reducing smoking prevalence and improving COPD disease management within primary and community care is likely to impact positively on the number of these admissions, and hence the cost.
- Thurrock GP practice populations have a statistically significant greater standardised rate of emergency admissions into hospital for stroke compared to Essex as a whole although most practices are within the two standard deviations funnel plot for their observed/expected ratio of patients on the GP practice stroke register.
- Despite being significantly lower than the Essex emergency admission rate, fracture of femur is still in the top ten causes of emergency admissions among the population of Thurrock. (see section 6.4.2.4). Commissioning of effective falls prevention programmes should reduce the number of admissions due to fracture of femur.

## Elective Healthcare

- There is considerable variation in standardised rate of outpatient appointments between Thurrock GP practices, suggesting differing patient referral behaviours of practice clinicians. The new Clinical Commissioning Groups may provide a mechanism to address variation in referral behaviour between GPs or GP practices.
- There is significant variation in the standardised rate of outpatient attendances between GP practice populations. However, the majority of practices have a total outpatient attendance standardised rate that is statistically significantly greater than the average for England, and only one practice has a rate which is statistically significantly lower than England's. GPs may be referring some patients to secondary health care for conditions that could potentially be treated within the community. Referral management systems are a mechanism through which to query referral behaviour of clinicians and identify appropriate and inappropriate referral within general practice. It would also be of use to review the part secondary health care has to play in influencing referrals to outpatient appointments.
- Targeting high or low referrers through clinical guidelines may not be the issue. Rather, activity should concentrate on increasing the number of appropriate referrals, regardless of the referral rate. Pressure on GPs to review their referral behaviour through the use of guidelines may reduce their willingness to manage problems in primary care, resulting in an increase in referrals to secondary care or conversely avoid referring patients in need of appointments. The use of referral rates to stimulate dialogue and joint working between primary and secondary care may be more appropriate
- The majority of GP Practices within Thurrock fall within the standardised rate for elective admissions for the region.
- It is recommended that further JSNA products are developed to drill down further into all primary and secondary care data with a view to building useful profiles of Clinical Commissioning Group need, service usage, service supply and benchmarked cost, to support CCG commissioning to address some of the potential issues highlighted in this report.

## **Chapter 6 – References**

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- <sup>7</sup> Pharmaceutical Needs Assessment. NHS South West Essex 2010
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- <sup>9</sup> Hospital Episode Statistics 2007/8

<sup>10</sup> Feigin, V.L. (2005). Stroke Epidemiology. *Lancet*. 365(9478), p2160-1.

<sup>11</sup> Beaglehole, R. et.al. (2004). *The World Health Report 2004 – Changing History*. World Health Organisation. pp.120-4.