



Needs Assessment to Support Development of an Accountable Care Organisation for Tilbury

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1. Introduction

This needs assessment report has been produced by the Thurrock Council Health and Social Care Public Health Team on behalf of South East Essex Partnership NHS Foundation Trust (SEPT), North East London Foundation NHS Trust (NELFT), Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH), Thurrock Council and NHS Thurrock Clinical Commissioning Group.

Following production and publication of the Annual Report of the Thurrock Director of Public Health (APHR) in November 2016, SEPT, NELFT, BTUH and Thurrock Council Adult Social Care's Provider Arm expressed an interest in working collaboratively to pilot a new approach to delivering health and care in the Tilbury locality of Thurrock, in order to address some of the issues highlighted in the APHR. As such they contracted the Thurrock DPH for two days a week for three months to lead development of a business case in collaboration with all key partners, setting out a new way of delivering integrated health and care through an 'Accountable Care Organisation' structure that aimed to reduce demand on acute and residential care settings and improve the health and well-being of the population of Tilbury.

This report marks the completion of the first stage in that process: to set out a detailed assessment of the health and care needs of the population of Tilbury and to understand and quantify how residents and why residents flow through different services within the current system. By setting out the current state of demand on the health and social care system, along with the key influences on activity, this report aims to quantify and link activity and spend in terms of:

- Demand on all parts of the system
- How clinical practice in one part impacts on demand in another
- The most cost-effective system wide solutions to reduce demand and improve the health of our local population.

It is divided into 12 chapters.

Chapter two: *Background and Purpose* provides a high level summary of the current issues and explores some of the background and challenges that have led us to embark on this journey.

Chapter three: *Tilbury the Place* considers the current and future demographic challenges, the community assets and third sector, the epidemiology within the locality and describes in more detail the current health and care services being provided including where available, current workforce data.

Chapters four to 11 consider key issues faced by different parts of the system, and the system as a whole. These include: Adult Social Care demand and demand reduction; Delayed Transfers of Care from Hospital; Avoidable Unplanned Hospital Admissions and their causes; The effectiveness of Long Term Conditions Management within Primary and Community Care and the interface between the two; The effectiveness of early diagnosis of patients with long term conditions (case finding); Primary prevention and health improvement programmes; Avoidable A&E attendances and how many patients attending A&E could be treated in more appropriate clinical settings; and Primary care Capacity and workforce development.

Finally, chapter 12 sets out some overarching conclusions and suggested next steps in terms of the business case development.

Describing a system as complex as the above has required analyses of a huge amount of data and intelligence. Presenting it all in one report would make this document unwieldy and as such, each chapter confines itself to presenting a few examples that demonstrate the key findings it concludes. A Supplementary Data Pack containing more detailed analysis behind each chapter is available to accompany this report, for readers with an interest in particular issues presented in any given chapter.

1.1 Summary of the key findings of Chapters 3 to 11.

Chapter 3: Tilbury the Place

DEMOGRAPHY

KEY MESSAGES:

- TILBURY LOCALITY HAS A HIGHER PROPORTION OF CHILDREN AND YOUNG PEOPLE THAN THE REST OF ENGLAND, ALTHOUGH THERE IS SOME VARIATION WITHIN THE LOCALITY BOUNDARY.
- THE RATE OF POPULATION GROWTH IN THE 65+ AGE GROUP HAS BEEN LARGE OVER RECENT YEARS, AND THE POPULATION IS SET TO EXPAND RAPIDLY.
- THE LOCALITY CONTAINS SOME OF THE MOST DEPRIVED PARTS OF THURROCK.

EPIDEMIOLOGY

KEY FINDINGS:

- PREMATURE MORTALITY RATES IN TILBURY ARE SIGNIFICANTLY ABOVE THE NATIONAL AVERAGE.
- TILBURY HAS A HIGHER PREVALENCE OF A NUMBER OF LTCs THAN THURROCK AND ENGLAND.
- RESIDENTS OF TILBURY ARE MORE LIKELY TO EXPERIENCE A RANGE OF ADVERSE ENVIRONMENTAL FACTORS WHICH COULD ALSO IMPACT ON THEIR HEALTH, INCLUDING OVERCROWDING, LOW EDUCATIONAL ATTAINMENT AND REDUCED ACCESS TO SERVICES BY CAR/VAN.
- TILBURY HAS RELATIVELY HIGH RATES OF WORKING AGED ADULTS CLAIMING EMPLOYMENT SUPPORT ALLOWANCE FOR MENTAL HEALTH CONDITIONS.
- THERE ARE A NUMBER OF ESTABLISHED ASSETS DELIVERING SERVICES; HOWEVER THERE IS FURTHER POTENTIAL WITHIN THE COMMUNITY TO DELIVER CARE IN A DIFFERENT WAY.

Chapter 4: Adult Social Care

KEY FINDINGS:

- HOMECARE IS THE MOST COMMON ADULT SOCIAL CARE PACKAGE PROVIDED BUT RESIDENTIAL CARE PACKAGES COST THE MOST IN TOTAL
- DEMAND FOR HOMECARE AND RESIDENTIAL CARE BEGINS TO RISE SIGNIFICANTLY AT THE AGES OF 55 AND 70 RESPECTIVELY, PRESENTING KEY WINDOWS OF OPPORTUNITY FOR PREVENTION AND EARLY INTERVENTION PROGRAMMES PRIOR TO THESE INCREASES IN DEMAND
- OVERALL SPEND ON RESIDENTIAL AND HOMECARE IS FALLING OVER TIME IN LINE WITH REDUCING ADULT SOCIAL CARE FUNDING. THIS SUGGESTS THAT CARE IS BEING RATIONED AND THAT ONLY THOSE WITH A HIGH LEVEL OF ACUITY QUALIFY FOR CARE PACKAGES.
- PREVENTION AND EARLY INTERVENTION PROGRAMMES SUCH AS LIVING WELL IN THURROCK AND LOCAL AREA COORDINATION APPEAR TO BE PREVENTING SOME LEVEL OF ADULT SOCIAL CARE DEMAND, ALTHOUGH THE NATURE OF THESE PROGRAMMES MAKE IT DIFFICULT TO QUANTIFY BY HOW MUCH.
- WORK IS CURRENTLY UNDERWAY TO IMPLEMENT FURTHER TRANSFORMATIONAL APPROACHES TO DELIVERING ADULT CARE INCLUDING REDESIGN AND IMPLEMENTATION OF AN EMPOWERMENT 'COMMUNITY SOLUTIONS' BASED APPROACH TO DELIVERING CARE. THIS NEEDS TO BE INCORPORATED INTO THE RE-DESIGN OF OTHER NEW APPROACHES TO CARE DELIVERY WITHIN A FUTURE ACO.

Chapter 5: Delayed Transfers of Care

KEY FINDINGS

- DELAYED TRANSFERS OF CARE (DTCOS) HAVE BEEN INCREASING RAPIDLY IN RECENT MONTHS
- DTCOS CAUSED BY LACK OF SOCIAL CARE PROVISION ARE INCREASING RAPIDLY WHILST THOSE CAUSED BY THE NHS ARE FALLING BUT ARE STILL TOO HIGH
- INADEQUATE AND FALLING CAPACITY WITHIN OUR LOCAL ADULT SOCIAL CARE SYSTEM IS EXASPERBATING THE ISSUE OF DTCOS
- FAILURE TO ADDRESS THIS ISSUE IS WASTING SYSTEM RESOURCES AND LEADING TO OPERATIONAL UNSUSTAINABILITY.
- ADDRESSING THE ISSUE REQUIRES INTEGRATION OF HEALTH AND SOCIAL CARE BUDGETS

Chapter 6: Avoidable Emergency Hospital Admissions

ADMISSION RATES IN THOSE AGED 65+

KEY FINDINGS

- WHILST SEPSIS IS CODED AS THE MOST COMMON REASON FOR AN UNPLANNED HOSPITAL ADMISSION, RESPIRATORY AND CARDIO VASCULAR DISEASES WHEN COMBINED ACCOUNT FOR THE MOST COMMON REASONS IN THOSE AGED 65+
- RESPIRATORY AND CARDIO-VASCULAR DISEASE IS BOTH HIGHLY PREVENTABLE AT A PRIMARY, SECONDARY AND TERTIARY LEVEL WITHIN THE COMMUNITY
- INVESTING IN PRIMARY PREVENTION WILL REDUCE HOSPITAL ADMISSIONS FOR THESE CONDITIONS IN THE MEDIUM TERM AND IMPROVING CASE FINDING AND CLINICAL MANAGEMENT OF THEM IN PRIMARY AND COMMUNITY CARE WILL REDUCE THEM IN THE SHORT TO MEDIUM TERM

EMERGENCY ADMISSIONS DUE TO LONG TERM CONDITIONS

KEY FINDINGS

- THERE IS SIGNIFICANT VARIATION IN RATE OF HOSPITAL ADMISSION PER 50 PATIENTS ON GP PRACTICE DIABETES AND COPD REGISTERS ALTHOUGH THE REASONS FOR THIS ARE UNCLEAR.
- POSSIBLE EXPLANATIONS COULD INCLUDE VARIATION IN CASE FINDING AND/OR MULTIPLE ADMISSIONS BY INDIVIDUAL PATIENTS WHICH CANNOT CURRENTLY BE CAPTURED BY THE DATA AVAILABLE

HOSPITAL ADMISSIONS DUE TO AMBULATORY CARE SENSITIVE CONDITIONS

KEY FINDING:

- THERE WERE 453 ADMISSIONS FROM TILBURY PATIENTS IN 2015-16 DUE TO CONDITIONS THAT WERE AMENABLE TO EFFECTIVE HEALTHCARE. ACSC ADMISSIONS HAD AN EXCESS COST OF £19K IN 2015-16 AND 100 EXCESS BED DAYS

RAPID RESPONSE ASSESSMENT SERVICE

KEY FINDING:

- RRAS IS A SERVICE THAT AIMS TO PREVENT AVOIDABLE HOSPITAL AND CARE ADMISSIONS. REFERRAL RATES FROM TILBURY PRACTICES TO RRAS ARE LOW, YET HOSPITAL ADMISSIONS ARE HIGH SUGGESTING RRAS IS BEING UNDER USED.

MENTAL HEALTH ACTIVITY

KEY MESSAGE:

- THERE IS CONSIDERABLE VARIATION IN RATE OF HOSPITAL ADMISSIONS FOR SERIOUS MENTAL HEALTH PER 50 PATIENTS ON GP PRACTICE SMI REGISTERS. THE REASONS FOR THIS ARE UNCLEAR BUT INADEQUATE CASE FINDING BY GP PRACTICES MAY BE ONE EXPLANATION.

Chapter 7: Long Term Conditions Management

KEY FINDINGS:

- WHEN COMPARED TO COMPARABLE PRACTICES, MANY TILBURY PRACTICES ARE NOT MANAGING CERTAIN LONG TERM CONDITIONS PARTICULARLY WELL. THIS IS PUTTING SOME PATIENTS AT RISK OF SERIOUS HEALTH EVENTS AND DRIVING AVOIDABLE UNPLANNED CARE HOSPITAL ADMISSIONS
- THERE APPEAR TO BE VERY HIGH LEVELS OF EXCEPTION REPORTING IN SOME PRACTICES.
- CONTROL OF HYPERTENSION IS INADEQUATE IN A CONSIDERABLE COHORT OF PATIENTS WITH CARDIOVASCULAR DISEASE AND DIABETES
- CONTROL OF HbA1c NEEDS TO BE IMPROVED FOR A CONSIDERABLE COHORT OF PATIENTS WITH DIABETES AND THERE IS A NEED TO INCREASE REFERRAL OF NEWLY DIAGNOSED PATIENTS TO STRUCTURED EDUCATIONAL PROGRAMMES
- UPTAKE OF FLU VACCINATION IN PATIENTS WITH LTCs NEEDS TO BE INCREASED
- IMPLEMENTING A STRETCHED QOF PROGRAMME MAY BE HIGHLY COST EFFECTIVE IN TERMS OF CVD AND COPD CLINICAL MANAGEMENT

INTERFACE BETWEEN GP SURGERIES AND COMMUNITY LTC MANAGEMENT SERVICES

KEY FINDING:

- LONG TERM CONDITION MANAGEMENT OF TILBURY PATIENTS BY GP SURGERIES AND COMMUNITY SERVICES IS NOT SUFFICIENTLY INTEGRATED AND AS SUCH PATIENTS DON'T ALWAYS ACCESS SERVICES DESIGNED TO HELP THEM MANAGE THEIR LONG TERM CONDITIONS

INTERFACE BETWEEN GP SURGERIES AND IAPT

KEY FINDINGS

- RATE OF ACCESS TO IAPT SERVICES PROVIDED IN 2015-16 BY PATIENTS IN TILBURY WITH A DIAGNOSIS OF DEPRESSION WAS VERY LOW ALTHOUGH THIS DATA MAY NOT REFLECT THE CURRENT SITUATION.
- FURTHER ANALYSIS OF 2016-17 DATA SHOULD BE UNDERTAKEN ONCE AVAILABLE TO ASCERTAIN ACCESS TO AND EFFECTIVENESS OF IAPT SERVICES

Chapter 8: Early Identification of Long Term Conditions (Case Finding)

KEY FINDINGS

- THERE ARE A SIGNIFICANT NUMBER OF PEOPLE IN TILBURY WITH UNDIAGNOSED STROKE, HYPERTENSION, CHD AND DEPRESSION WHO WILL NOT BE RECEIVING TREATMENT AND WILL BE AT INCREASED RISK OF SERIOUS HEALTH EVENTS
- PATIENTS WITH EXISTING DIAGNOSED PHYSICAL LTCs ARE AT MUCH GREATER RISK OF HAVING DEPRESSION AND AS SUCH SCREENING OF PATIENTS ON EXISTING QOF DISEASE REGISTERS FOR DEPRESSION IS IMPORTANT
- CASE FINDING AND TREATING THESE COHORT OF PATIENTS IS HIGHLY COST EFFECTIVE AND WILL MAKE THE HEALTH AND SOCIAL CARE SYSTEM BOTH OPERATIONALLY AND FINANCIALLY MORE SUSTAINABLE, AND IMPROVE PUBLIC HEALTH
- THERE IS VARIATION BETWEEN DIFFERENT PRACTICE POPULATIONS IN TILBURY ACROSS ALL LTCs

CANCER SCREENING

KEY FINDING:

- SCREENING RATES FOR BREAST AND BOWEL CANCERS ARE BELOW THE NATIONAL AVERAGE, AND THERE IS WIDE VARIATION AT PRACTICE LEVEL IN TILBURY.

DEMENTIA DIAGNOSIS AND SUPPORT

KEY FINDING:

- CASE FINDING OF DEMENTIA IN TILBURY APPEARS TO BE VARIED, WITH SOME PRACTICES DIAGNOSING MORE THAN THE ESTIMATED NUMBER.

Chapter 9: Public Health Commissioned Services

KEY FINDINGS

- PUBLIC HEALTH ISSUES SUCH AS OBESITY, SUBSTANCE MISUSE AND SMOKING ARE PREVALENT IN TILBURY; YET THE REFERRALS TO COMMISSIONED SERVICES ARE FAIRLY LOW.
- REDUCING SMOKING PREVALENCE IN THOSE PATIENTS WITH EXISTING LONG TERM CONDITIONS HAS BEEN DEMONSTRATE TO REDUCE UNPLANNED RESPIRATORY HOSPITAL ADMISSIONS OVER THREE YEARS.
- INTEGRATING DELIVERY OF HEALTH IMPROVEMENT SERVICES INTO THE DAY JOB OF ALL STAFF WITHIN ANY FUTURE HEALTH AND CARE MODEL FOR TILBURY RATHER THAN REFERRING PATIENTS TO DISCRETE SERVICES PROVIDED SEPARATELY COULD HELP ADDRESS THIS SITUATION

Chapter 10: Potentially Avoidable A&E Attendances

KEY FINDINGS:

- 77% OF THE A&E ATTENDANCES BY TILBURY LOCALITY PATIENTS IN 2015-16 COULD HAVE POSSIBLY BEEN TREATED ELSEWHERE HAD THE FACILITIES AND CAPACITY EXISTED. 31% OF A&E ATTENDANCES (4,156) PATIENTS RECEIVED NO INVESTIGATION OR TREATMENT AND 46% RECEIVED THE MOST MINOR CATEGORY OF CLINICAL INVESTIGATION OR TREATMENT
- THE EXCESS COST TO THE NHS OF THIS COHORT OF PATIENTS WAS AN ADDITIONAL £1,018,369.
- THERE APPEARS TO HAVE BEEN HIGH USAGE OF THE IC24 OUT OF HOURS SERVICE FOR CALLS THAT RECEIVED ADVICE ONLY. IN ADDITION THERE APPEARS TO BE A GOOD LEVEL OF AWARENESS AROUND THIS SERVICE, INDICATING THAT INCREASING UPTAKE OF THIS SERVICE MAY STILL NOT REDUCE INAPPROPRIATE A&E ATTENDANCES

Chapter 11: Primary Care Capacity and Workforce

KEY FINDINGS:

- TILBURY IS SIGNIFICANTLY UNDER DOCTORED AND UNDER NURSED IN TERMS OF PRIMARY CARE
- THE CURRENT SITUATION IS HIGHLY LIKELY TO BE NEGATIVELY IMPACTING ON ABILITY OF GP PRACTICES TO CASE FIND AND CARE FOR PATIENTS WITH LONG TERM CONDITIONS AND CONTRIBUTING TO AVOIDABLE A&E ATTENDANCES AND ADMISSIONS
- IMPLEMENTING A MIXED SKILLED WORKFORCE IN PRIMARY CARE COULD HELP SOLVE THE CURRENT SITUATION

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2. Background and Purpose

As a population, we are living longer but not necessarily healthier lives. The rate of growth in the population aged 65+ locally is increasing at a rate that far exceeds that of the general population (Figure 1). In addition, older patients are more likely to develop multiple long term conditions (Figure 2), resulting in increased demand for health and social care services with fewer working age people that can be taxed to pay for this increased demand.

Currently approximately 70% of all health and social care funding is now spent on treating and caring for people with long term conditions. Effective demand management to create an operationally and sustainable Adult Health and Social Care System requires a system response.

Our local adult Health and Care economy is facing unprecedented financial and operational challenges. There is currently a £101M financial deficit across the three hospitals within south and Mid Essex.

Thurrock Council is predicting an £18-22M financial deficit over the next three years without strategic transformational action.

The main reason for this is rising, unsustainable demand for emergency care within the most expensive part of our Health and Care system; hospitals and residential care homes.

However, this is largely a symptom of failures elsewhere within the system rather than a cause of the crisis itself. Actions taken by one organisation alone in isolation of others cannot achieve system sustainability.

This is because the lifestyle behaviour of our population, their ability to self-care, their ability to access Primary and Community Healthcare, the ability of the system to diagnose and treat their long term conditions early, and the quality of long term conditions management in Primary and Community Care all directly influence demand on NHS secondary care, and Adult Social Care services.

Some of the fundamental reasons driving demand and hence spend in the two most expensive parts of our system; secondary and social care services are demonstrated in the simplified diagram of it in figure 3. Without understanding how and why our residents flow through the entire system, we have little chance of making it sustainable

Figure 1 Predicted Population % Change, All Age and those aged 65+

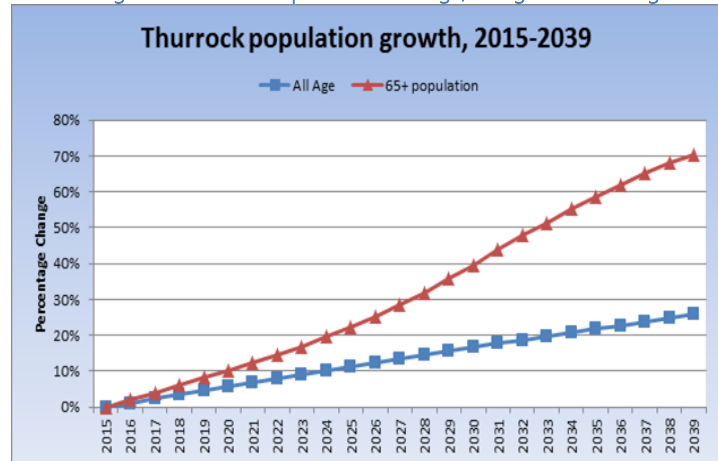
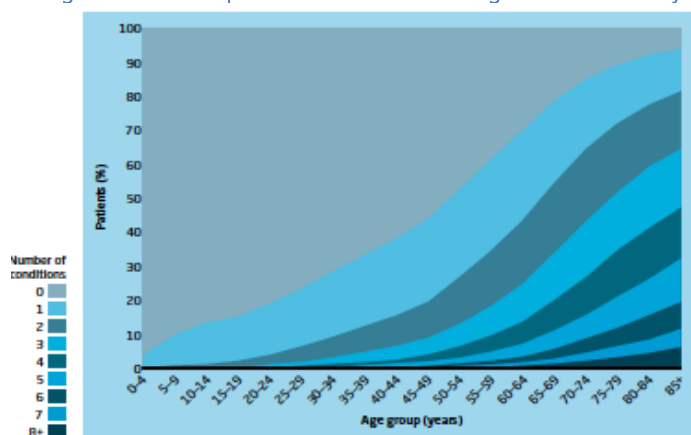


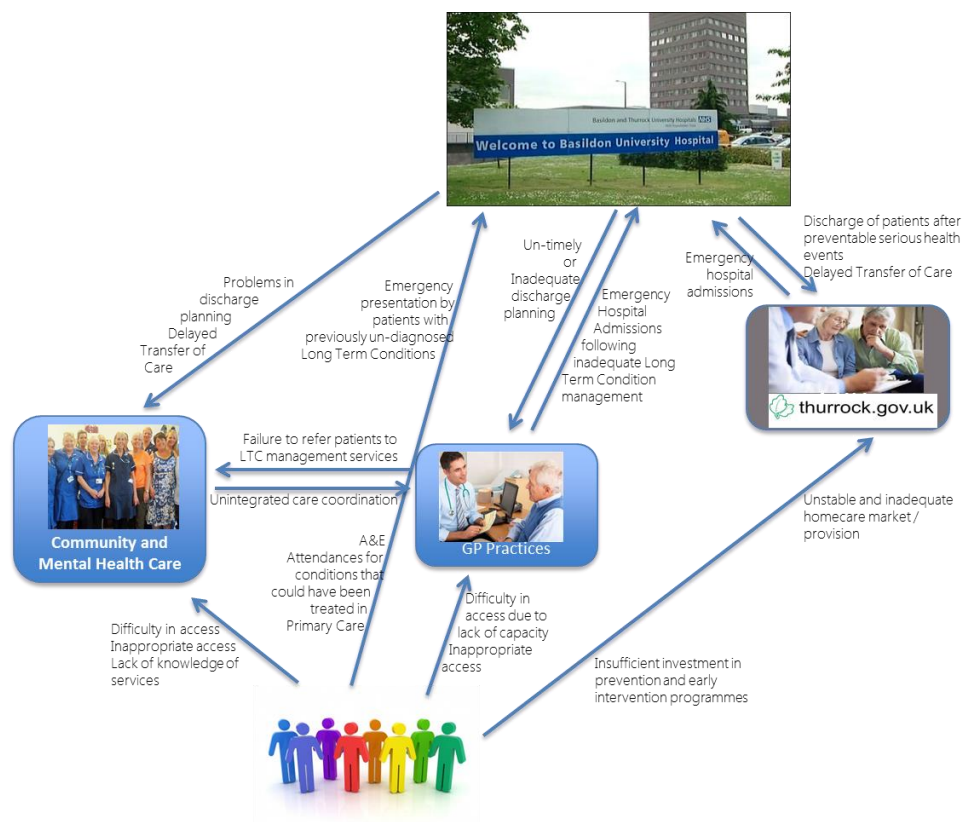
Figure 2 % of UK Population with numbers of Long Term Conditions by Age



Source: Barnett et al 2012
Reprinted from *The Lancet* vol 380, pp 37-43, © 2012, with permission from Elsevier.

2.1 What is the problem we are trying to solve?

Figure 3: A Simplified Diagram of our Health and Social Care System and factors affecting how our residents move between parts of it



This report makes a series of assertions that we believe can be concluded from Figure 3 and we will demonstrate in the chapters that follow:

- 1) **The money and the patients are often in the wrong place.** Too many patients are ending up in the most expensive parts of the system: NHS Secondary Care and Adult Residential and Homecare
- 2) **The current system is fragmented into significant number of constituent parts with referral pathways between them.** This is both inefficient and confusing to our population. Our current approach to care is to think about services and not people
- 3) **The capacity and quality of each part of the system has a direct impact on another part.** For example, if patients are unable to get a GP appointment they will access A&E directly. If there is insufficient residential care placement places, patients cannot be discharged from hospital.
- 4) **Until we can understand and quantify the impact that each part of the system is having on each other we have no hope of solving the problem.**
- 5) **Inadequate capacity and clinical quality in Primary, Community and Care services keeps the people and the money in the wrong place – hospitals,** making the entire system operationally and financially unsustainable. This is bad for our residents as tax payers and as service users.
- 6) **Solving the capacity and quality issues in Primary, Community and Adult Social Care will solve the financial issues in secondary care.** Conversely, starting with a focus on secondary care deficits and attempting to work backwards will have the opposite effect.
- 7) **Solving the capacity and quality issues requires integrating both the system and the money around the person.**
- 8) **In order to solve the problem we require a period of financial 'double running' or pump priming.** It is both unethical and counterproductive to restrict secondary care services to deliver savings if investment has not first been made further 'upstream' to fix the issues highlighted in points 2-6.

2.2 Deficit versus Asset?

A new approach that aims to address the eight points in previous section requires the integration of services provided by the NHS, Local Government, the third sector, and the harnessing of the capacity within the community itself. Bringing these different elements together in a new way of working presents a challenge in the sense that different parts of the system work in very different ways and have very different cultures and philosophies. The NHS has traditionally worked through a medical 'deficit based' model. Residents accessing its services are seen as 'patients'. The function of its services is to 'diagnose what is wrong with the patient' – the deficit, and then to 'fix' the deficit through treatment hopefully leading at best to cure, though more recently with the increase of long term conditions, to management and control of the deficit. The relationship is largely one of services full of highly skilled experts doing "to" patients. The services are provided free at the point of delivery. Figure 3 is largely an example of a deficit based view of the system.

The third sector, and increasingly Adult Social Care work more on an "asset" based model. They see their role as trying to diagnose and fix problems, but to empower citizens to maintain or re-regain independence and/or improve wellbeing. What 'wellbeing' looks like is a more loosely defined concept that is negotiated between the practitioner and resident accessing the service. Service users are referred to as 'clients' or residents rather than 'patients' and the services provided are more likely to consider more holistic issues of 'well-being' that encompass individual and community resilience and wider determinant of wellbeing such as employment, education and social connectivity. Furthermore, when services are delivered they are not necessarily free at the point of delivery but are paid for in part or full by the resident.

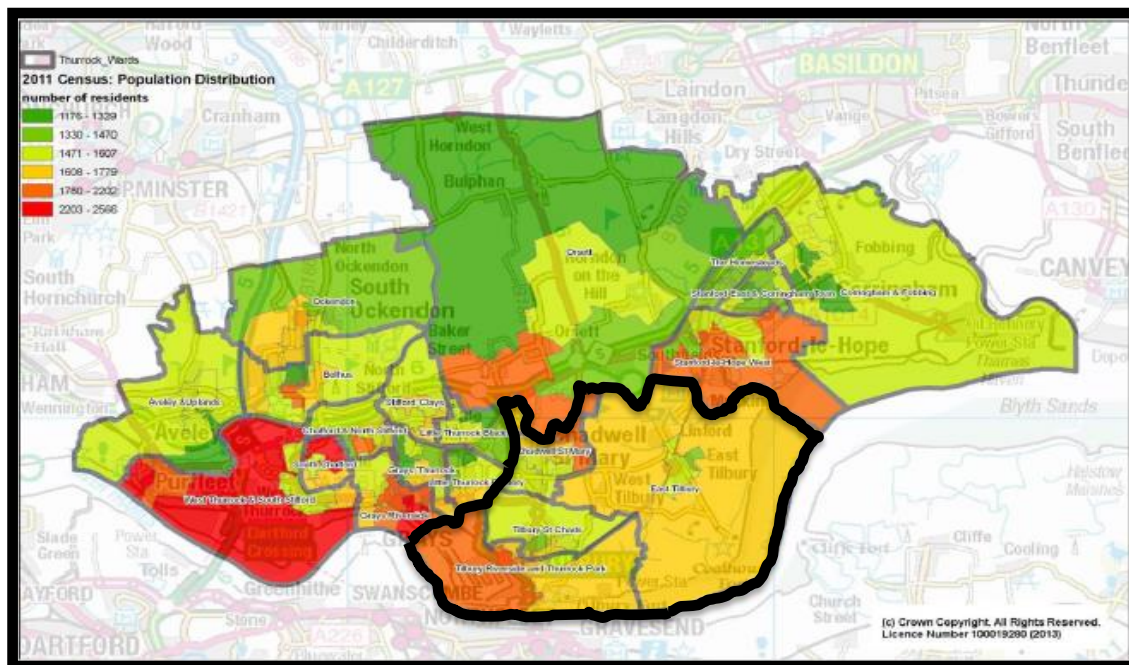
Both models of care have merit. It would be highly inappropriate to take an asset based approach with a resident going into a cardiac arrest, but equally prescribing medication to a person who is depressed because they are unemployed, lonely or in debt may not necessarily be the most effective solution.

A new approach to health and care that integrates both philosophies in a flexible and appropriate way around the person is highly desirable, but this also requires front line health and care front line staff who may have worked purely to one model for decades, to break down historical professional hegemony and embrace new ways of seeing the world. The challenge in terms of changing in organisational and professional cultures in order to achieve this should not be under-estimated, and a new integrated health and care system that incorporates community groups, third sector organisations, social care staff and NHS clinical staff will fail unless careful consideration is given to addressing cultural ways of working from day one.

This report aims to consider both approaches and encompasses data and analyses on both community assets and capacity and health and social deficits.

3. Tilbury the place

The Tilbury Locality is made up of four wards; Tilbury St. Chads, East Tilbury and Thurrock Park, Chadwell St.Mary and East Tilbury, shown by the thick black boarder in the map below.



For the purposes of this work, we were interested in the population of the eight GP practices in the Tilbury locality area:

Tilbury	East Tilbury	Chadwell St Mary
College Health [Tilbury Health Centre/Dr Suntharalingham]	College Health [East Tilbury Medical Centre]	Dilip Sabnis Medical Centre
College Health [Dr Shehadeh]	The Rigg Milner Medical Centre / Dr Jones	Chadwell Medical Centre / Dr Mohile
Dr Ramachandran / Medic House		
Sai Medical Centre / Dr Patel		

At present they have a combined practice population list size of circa 35,000 residents.

3.1 Demography

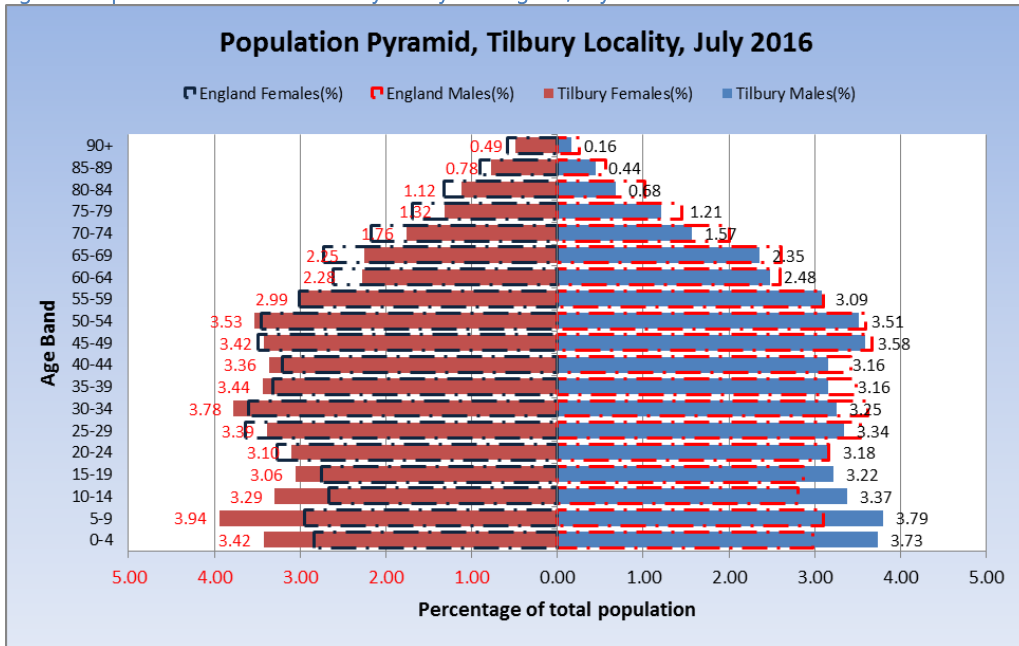
KEY MESSAGES:

- TILBURY LOCALITY HAS A HIGHER PROPORTION OF CHILDREN AND YOUNG PEOPLE THAN THE REST OF ENGLAND, ALTHOUGH THERE IS SOME VARIATION WITHIN THE LOCALITY BOUNDARY.
- THE RATE OF POPULATION GROWTH IN THE 65+ AGE GROUP HAS BEEN LARGE OVER RECENT YEARS, AND THE POPULATION IS SET TO EXPAND RAPIDLY.
- THE LOCALITY CONTAINS SOME OF THE MOST DEPRIVED PARTS OF THURROCK.

3.1.1 Population age distribution

As of July 2016, the population of these practices totalled 37,410 residents – 49.3% male and 50.7% female. Proportionally speaking, the Tilbury population has a higher proportion of children/young people but a lower proportion of middle-aged adults and older adults than the rest of England (see figure below).

Figure 4: Population Distribution of Tilbury locality and England, July 2016

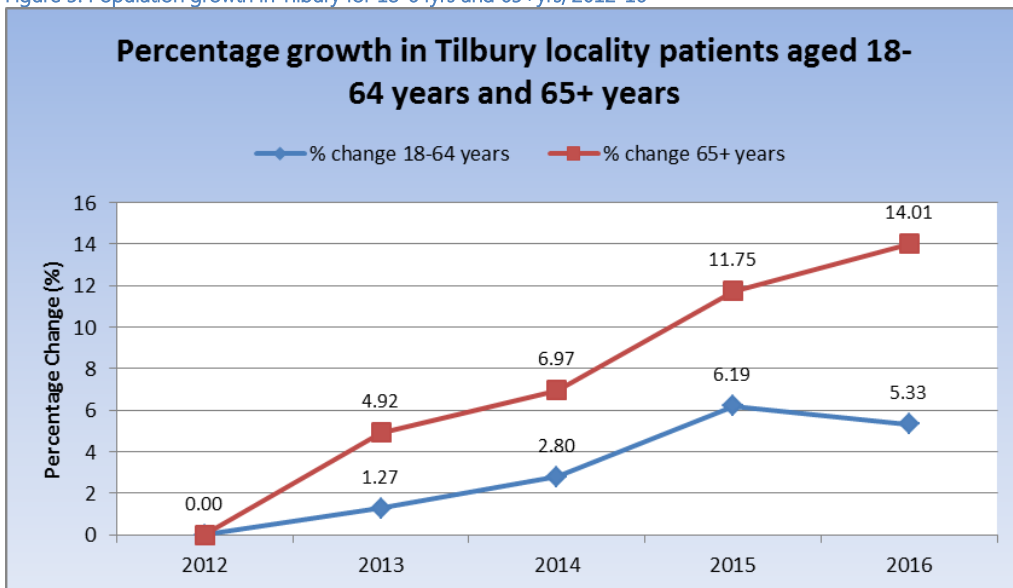


Source: NHS Digital

3.1.2 Population growth

The population of Tilbury has increased in recent years. Whilst an expected level of population growth would be around 1.02% per year, this is not the case for all sectors of the population. The figure below shows the percentage population growth for Tilbury patients aged 18-64 years and 65+, and it can be seen that whilst the change in 18-64 year olds is 5.33% between 2012 and 2016 (i.e. about 1.07% per year), the 65+ age group have increased by 14.01% between 2012 and 2016, which is about 2.8% per year.

Figure 5: Population growth in Tilbury for 18-64yrs and 65+yrs, 2012-16

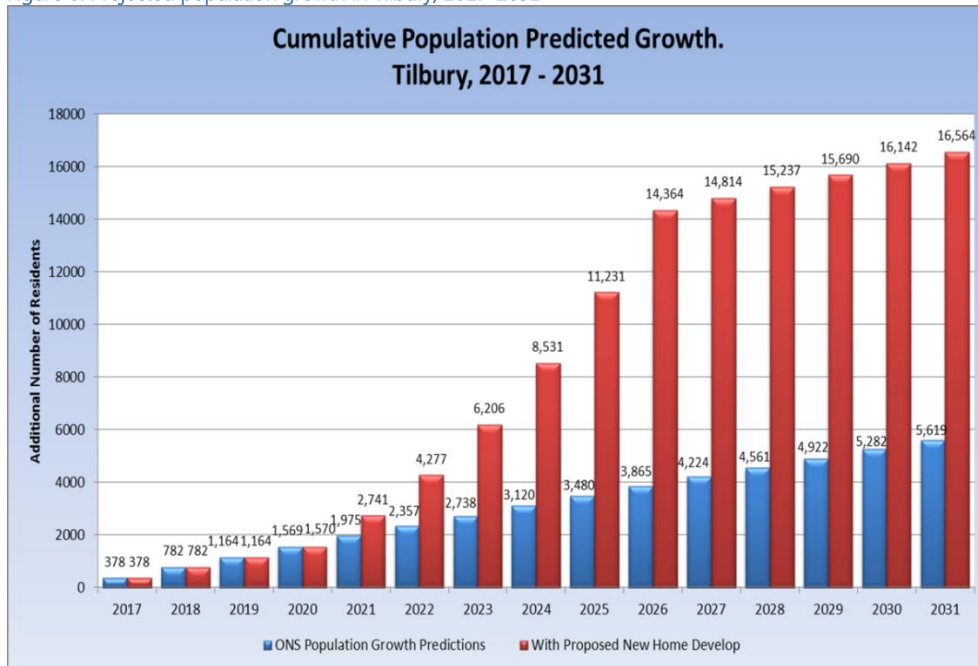


Source: NHS Digital and ONS

The population of Tilbury locality is set to continue to grow. Whilst the published ONS population projections estimate an additional 5,619 residents by 2031 (an increase of 13.06% from 2016), the regeneration ambitions of Thurrock

Council could mean as many as 16,564 additional residents could live in Tilbury locality by 2031, which would be an increase of 44.27% in 15 years.

Figure 6: Projected population growth in Tilbury, 2017-2031

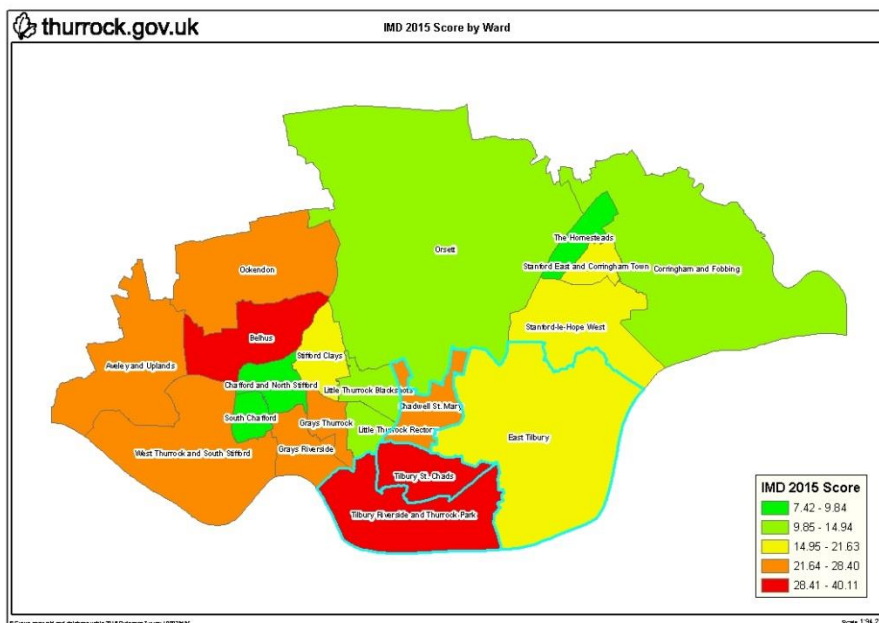


Source: ONS and Thurrock Council

3.1.3 Deprivation levels

Deprivation in the locality is varied, with East Tilbury having a similar level of deprivation to the Thurrock average, but Tilbury St Chads and Tilbury Riverside and Thurrock Park amongst the most deprived areas in Thurrock. This can be seen in the figure below.

Figure 7: IMD 2015 by ward

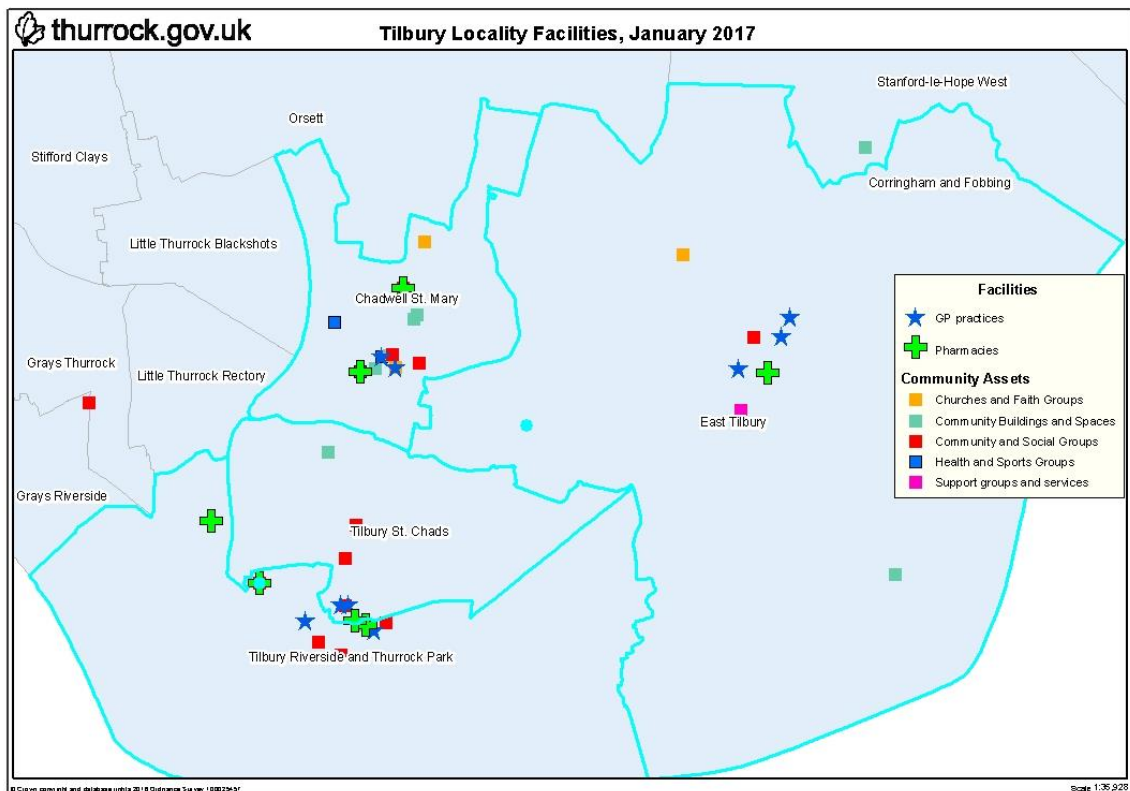


Source: Department for Communities and Local Government

3.2 Community and Assets

Tilbury has a strong sense of community and identity. There are a number of third sector/community assets such as sports groups, community hubs, Food Bank, Churches etc. which all deliver support to Tilbury locality residents. The map below depicts the distribution of some of the key assets, along with GPs and pharmacies. Note that the map shows 8 GP practices in East Tilbury as one is a branch site from Dr Ramachandran in Tilbury.

Figure 8: Tilbury locality facilities, 2017



Source: Thurrock Council and Council for Voluntary Services

The Stronger Together partnership is working to populate this map of known assets further.

3.2.1 Community and third sector

The Building Positive Futures initiative has led to the development of communities that support health and wellbeing: It established Stronger Together Thurrock – a partnership with the voluntary and community sector designed to promote local community activities that strengthen connections between people. This includes initiatives such as Community Hubs and Time Banking; Implementing Local Area Coordination – further information below ; Asset Based Community Development – developing a strength-based approach includes the development of a number of Community Hubs and the delivery of a ‘small sparks’ fund to support small-scale community projects Introduction of time banking – allowing people to contribute their time in terms of activities (assets), in exchange for similar support; and Promoting Thurrock as a dementia-friendly place – raising awareness through the recruitment of ‘dementia friends’ and the development of ‘dementia-friendly communities’. This includes the Council becoming a dementia-friendly council and plans in place to develop a Dementia Action Alliance.

The community and third sector have also been key stakeholders in the *For Thurrock in Thurrock* model of care, which is the development of community-based and integrated models of health and care that respond to the need for accessibility, but also respond to the desire for less fragmentation across health and social care.

The integrated vision for the future is called *My Thurrock: My Place, My Health, My Care*. It is a programme that will be delivered through the development of a number of projects and initiatives. Many of these will build on what has already been started under BPF and FTIT. New initiatives and projects will also be introduced and these will continue to evolve and expand over time.

The Programme is divided into three specific but interdependent elements:

1. Stronger Communities;
2. Housing and the Built Environment; and
3. Whole-system approach to health and social care

Workforce

There are an estimated 500 organisations operating in the voluntary sector in Thurrock. This estimate includes registered organisations, such as charities, social enterprises and co-operatives, voluntary organisations, community/neighbourhood groups, informal interest groups and faith groups. In terms of paid staff, based on the average number of FTE paid staff employed by respondents to the State of the Sector survey across Thurrock, it is estimated that the 500 organisations employed 1,315 FTE paid staff in 2014/15. There are also an estimated 7,429 volunteers, representing 4.6% of Thurrock's total population.

3.2.2 Housing and regeneration

There is a large amount of activity both currently underway and planned for the future with regard to housing and regeneration in this locality area. For example, the Building Positive Futures initiative has led to the planned development of additional HAPPI (Housing Our Ageing Population – Panel for Innovation) standard homes in Tilbury via the Council's own development arm 'Gloriana'. The principles offer an attractive alternative to the family home, and mean elements can adapt over time to meet changing needs. They reflect:

- Space and flexibility
- Daylight in the home and in shared spaces
- Balconies and outdoor space
- Adaptable and 'care ready' design
- Positive use of circulation space
- Shared facilities and 'hubs'
- Plants, trees, and the natural environment
- Energy efficiency and sustainable design
- Storage for belongings and bicycles
- External shared surfaces and 'home zones'

There is also a major regeneration programme in process which will transform the Civic Square area in Tilbury and aims to improve the quality of the environment, creating a greater sense of place and local identity. The future vision for Tilbury is shown below:

We want Tilbury to

- » be an attractive location for residents, businesses and visitors;
- » be a place where people can achieve their potential;
- » be a place where people can have fun;
- » be a place where people are healthy;
- » have a vibrant economy; and
- » feel safe.

3.3 Epidemiology

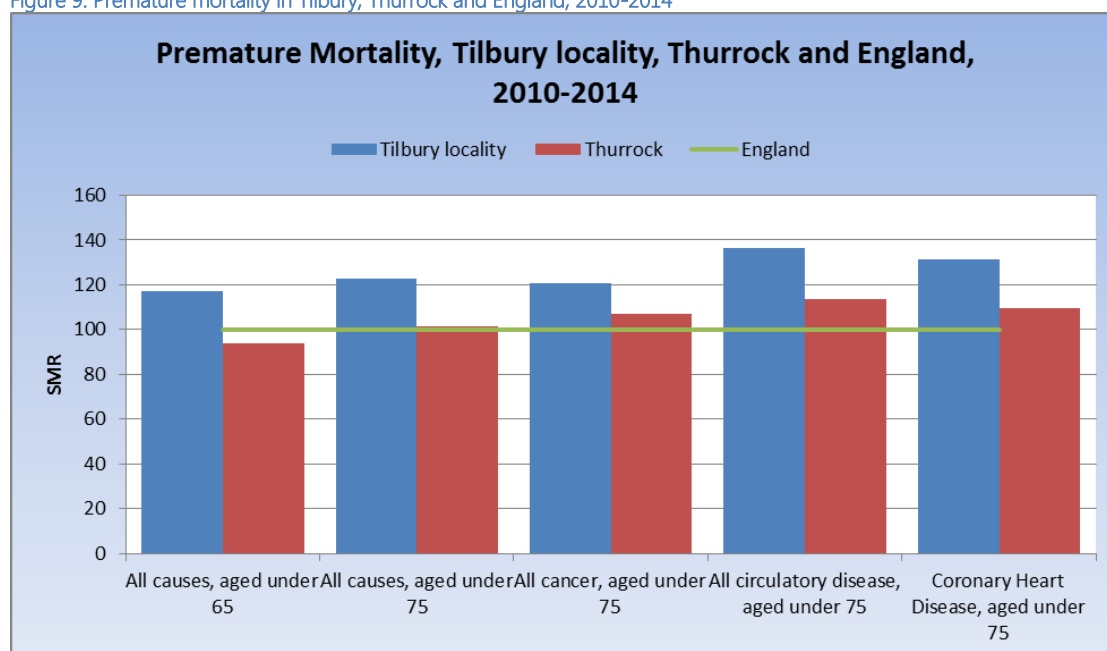
KEY FINDINGS:

- PREMATURE MORTALITY RATES IN TILBURY ARE SIGNIFICANTLY ABOVE THE NATIONAL AVERAGE.
- TILBURY HAS A HIGHER PREVALENCE OF A NUMBER OF LTCs THAN THURROCK AND ENGLAND.
- RESIDENTS OF TILBURY ARE MORE LIKELY TO EXPERIENCE A RANGE OF ADVERSE ENVIRONMENTAL FACTORS WHICH COULD ALSO IMPACT ON THEIR HEALTH, INCLUDING OVERCROWDING, LOW EDUCATIONAL ATTAINMENT AND REDUCED ACCESS TO SERVICES BY CAR/VAN.
- TILBURY HAS RELATIVELY HIGH RATES OF WORKING AGED ADULTS CLAIMING EMPLOYMENT SUPPORT ALLOWANCE FOR MENTAL HEALTH CONDITIONS.
- THERE ARE A NUMBER OF ESTABLISHED ASSETS DELIVERING SERVICES; HOWEVER THERE IS FURTHER POTENTIAL WITHIN THE COMMUNITY TO DELIVER CARE IN A DIFFERENT WAY.

3.3.1 Mortality ratios

The standardised mortality ratio (SMR) is a way of comparing death rates between populations and England (controlling for differences in age structure between different populations). The SMR for England is set at 100. An SMR above 100 indicates a mortality rate that is greater than England's. Premature mortality rates in Tilbury are significantly higher than the England average. One example is for circulatory disease – in Tilbury locality, the SMR is 136.7, compared to a Thurrock SMR of 113.6 and the England ratio of 100.

Figure 9: Premature mortality in Tilbury, Thurrock and England, 2010-2014

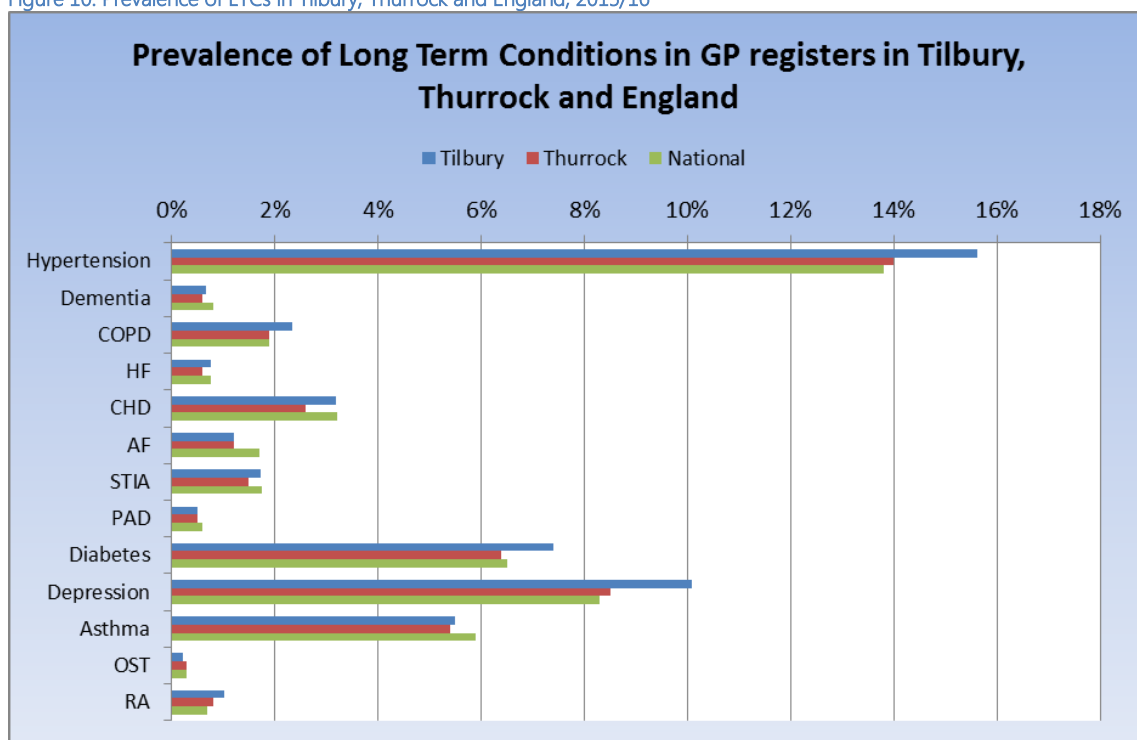


Source: Local Health

3.3.2 Recorded Diagnoses of Long Term Conditions (QOF prevalence)

The recorded prevalence of long term conditions in Tilbury locality, based on 2015-2016 GP QOF registers, is higher than Thurrock average for all conditions, except for Peripheral arterial disease (PAD) and Osteoporosis (OST). Additionally, there are six long term conditions with a higher prevalence in Tilbury than both Thurrock and England: Hypertension, COPD (Chronic obstructive pulmonary disease), Heart Failure, Diabetes, Depression and Rheumatoid Arthritis.

Figure 10: Prevalence of LTCs in Tilbury, Thurrock and England, 2015/16



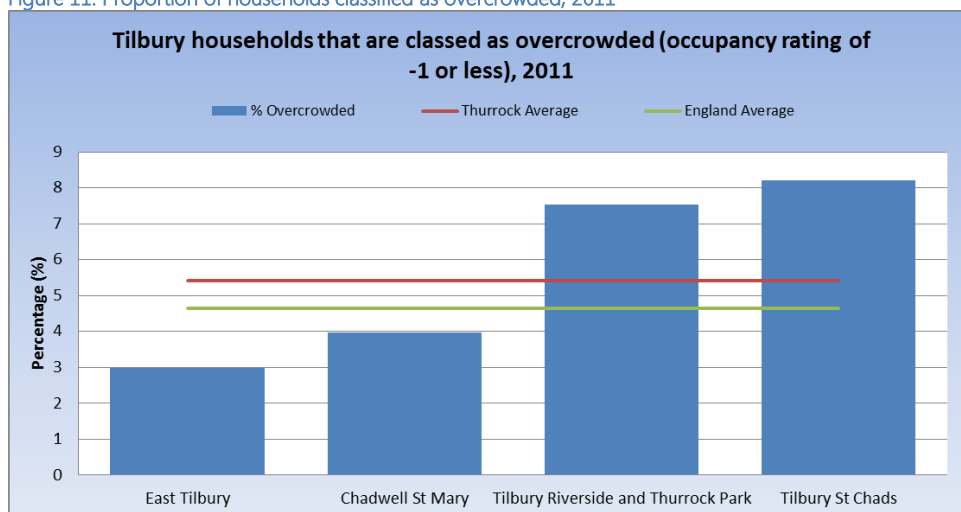
Source: QOF

3.3.3 Wider determinants of health

Housing

A household can be classified to be overcrowded if it has fewer bedrooms than the notional number recommended by the bedroom standard (a recommended notional number of bedrooms for each household, based on the size of the household, age, sex, marital status and relationship among members of the household). An occupancy rating of -1 or fewer could indicate overcrowding within a household. In two Tilbury wards, there is a higher proportion of households with an occupancy rating of -1 or fewer than the Thurrock and England averages, with 7.54% of Tilbury Riverside and Thurrock Park and 8.20% of Tilbury St. Chads households having one or more bedrooms under the bedroom standard (Thurrock average =5.42% and England average = 4.64%).

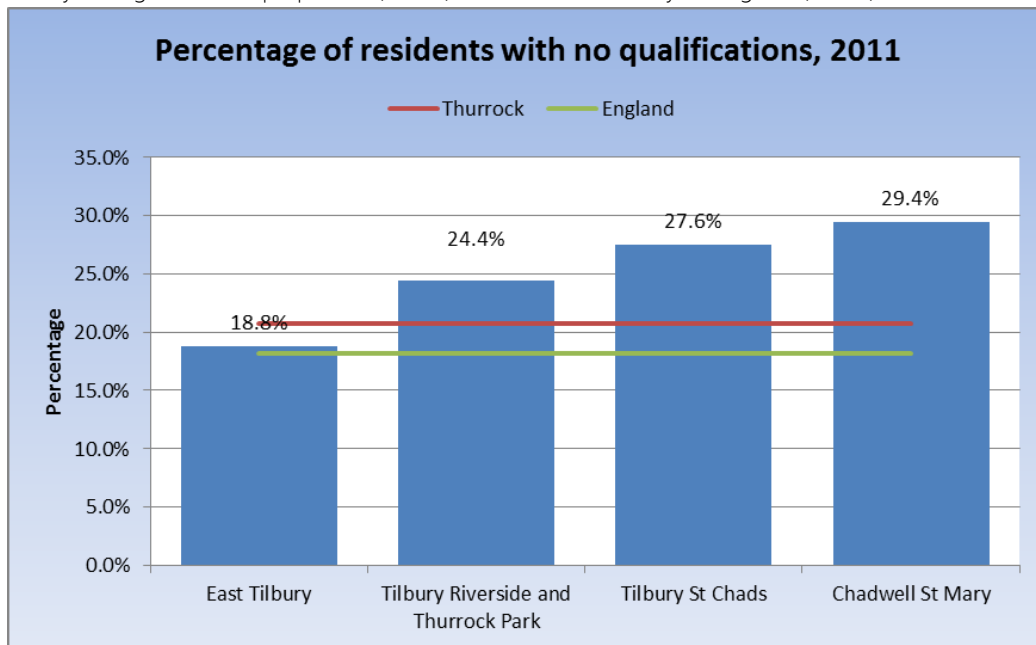
Figure 11: Proportion of households classified as overcrowded, 2011



Source: ONS

Education

There are a number of Tilbury locality residents with no formal qualifications. This varies across the area, with East Tilbury having the lowest proportion (18.8%) and Chadwell St Mary the highest (29.4%).

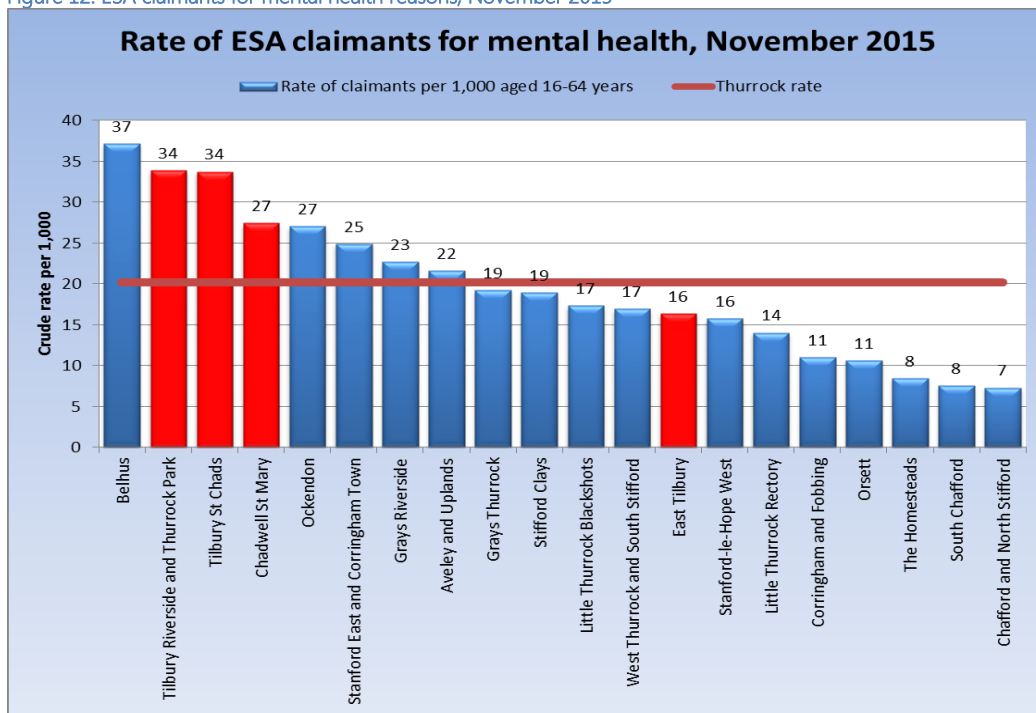


Source: ONS

Employment

Three of the four Tilbury wards have a higher rate of adults aged 16-64 years claiming Employment Support Allowance for mental health reasons than the Thurrock average.

Figure 12: ESA claimants for mental health reasons, November 2015

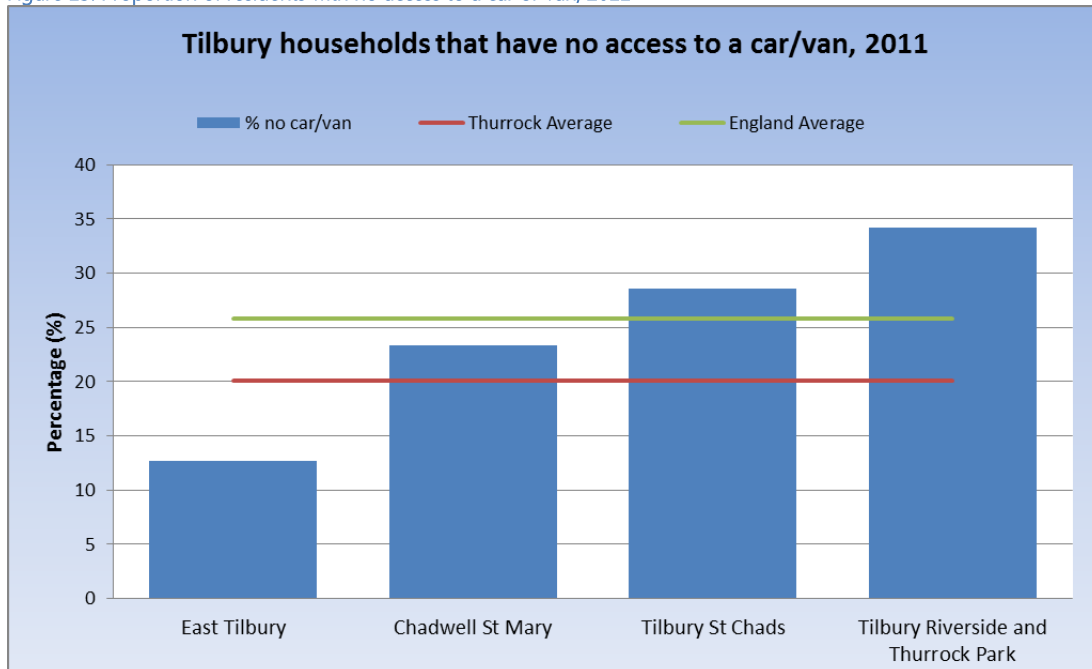


Source: NOMIS

Access to Transport

Access to a car or van is a measure of accessibility to services. It can be seen from the figure below that three of the four wards have a comparatively high percentage of households who do not have access to a car or van (23.3% in Chadwell St Mary, 28.6% in Tilbury St Chads and 34.2% in Tilbury Riverside and Thurrock Park, compared to the Thurrock average of 20.1%).

Figure 13: Proportion of residents with no access to a car or van, 2011



Source: ONS

Further information on the wider determinants influences can be found in the [Integrated Healthy Living Centre Needs Assessment for Tilbury](#).

3.4 Health and Care Services

3.4.1 High level Primary Care services

As well as the eight Tilbury locality practices mentioned above, Tilbury locality residents can also access the Thurrock-wide Out of Hours service provided by IC-24, or book appointments from the Tilbury Hub premises at Tilbury Health Centre. Currently appointments are being offered 6.30-8.30pm every weekday and 9-12pm on Saturday mornings. Walk-ins are not permitted.

As of 18th January 2016, the current providers of six of the eight Tilbury locality practices have had their premises inspected by the CQC. Of these, two received *Good* ratings, two received *Requires Improvement* and two received *Inadequate* ratings. The two that were rated as *inadequate* are both located in Chadwell St Mary. The two practices awaiting an inspection visit are being managed by College Health.

Table 1: CQC Ratings for Tilbury GPs

Code	Name	Rating	Date of visit
F81082	Rigg Milner Medical Centre	Good	29/07/2016
F81084	Chadwell Medical Centre / Dr Mohile	Inadequate	21/03/2016
F81110	Dr Suntharalingham	Not yet inspected	06/05/2015 (previous provider)
F81206	The Shehadeh Medical Centre	Requires Improvement	14/10/2015 (previous provider)
F81652	Medic House / Dr Ramachandran	Requires Improvement	11/02/2016
F81691	East Tilbury Medical Centre	Not yet inspected	
F81698	Dilip Sabnis	Inadequate	23/11/2016
F81708	Sai Medical Centre	Good	11/10/2016 (not yet published)

Source: Thurrock CCG

It appears that levels of digital maturity, and specifically the outward-facing digital services to professionals and patients, are varied amongst these eight practices. More detailed data is available in the Supplementary Data Pack.

3.4.2 Pharmacies

The latest information taken from the Pharmaceutical Needs Assessment (2014) indicates that there are 7 pharmacies in the locality area:

Tilbury	East Tilbury	Chadwell St Mary
Chapharm Chemist	Allcures Pharmacy	Dips Chemist
Boots		River View
Asda		
Asset Chemist		

Pharmacies in Tilbury provide a range of services to patients, including:

- Diabetes screening
- Respiratory and Lung Check service
- Minor Ailments
- Substance misuse
- Needle Exchange
- Waste Management
- Weight Management
- Social Prescribing
- Gluten Free Products supply and management
- Incontinence products
- Travel Vaccinations
- Well man clinics

They also have the potential to provide services such as NHS Health Checks, Medicines Use Reviews, New Medicines Service and Seasonal Immunisation where commissioned.

In addition, three of the Tilbury pharmacies offer needle exchange services and two of them offer supervised consumption services.

Workforce

Analysis of staffing information indicates that across these 7 pharmacies, there are:

Table 2: Pharmacy Workforce in Tilbury locality

Number of pharmacists	Dispensing technicians	Dispensing assistants	Medicines Counter Assistants
9	4	12	10

Further information can be found in the Supplementary Information Pack

3.4.3 NELFT services

NELFT delivers a range of acute and community health services within Thurrock and Tilbury. Within this report, the services mentioned most frequently are the long term condition management services and the public health commissioned services. The latest CQC inspection rating of NELFT was *Requires Improvement* – this is across all their services and was dated 27/09/2016.

Workforce

NELFT employ their workforce across Basildon, Brentwood and Thurrock, so it is difficult to apportion the number of staff who specifically cover Tilbury. The split of activity across NELFT is approximately 60%:40% for Basildon/Brentwood to Thurrock. The below table shows the estimated FTE per service per band for Thurrock:

Table 3: NELFT Workforce by service and band, Thurrock

Service	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	TOTAL
Diabetes Adult Service	0.4	0.4	0	1.5	2.3	0	4.6
Heart Failure	0.4	0	0	0.6	1.28	0	2.28
COPD TEAM	0.3	0.4	0	0	1.1	0	1.8
Pulmonary Rehab	1.2	0	0	0.5	0.6	0	2.3
Oxygen Service	0	0	0	0.8	0	0	0.8
Older Adults Health and Wellbeing	0.4	0	0	0	0.4	0	0.8
Stroke Hub Service	0.96	0.16	0.96	1.44	1.34	0.2	5.06

Source: NELFT

A table with the NHS 2016/17 pay scale is below to indicate seniority and cost of the above bandings:

The information above indicates that the Stroke Hub Service has the largest number of staff aligned to it. It should however be noted that some roles are shared across organisations – e.g. there is a physiotherapist on rotation with BTUH and a social worker employed by Thurrock Council who work within the Stroke Hub.

3.4.4 IAPT services

The Improving Access to Psychological Therapies and Recovery College service has been provided by Inclusion Thurrock (South Staffordshire and Shropshire NHS Foundation Trust - SSSFT). It took over IAPT services from SEPT in April 2016. The latest CQC inspection for South Staffordshire and Shropshire NHS Foundation Trust rated the provider as *Good* overall (dated 12/07/2016). They achieved *Good* ratings for their community-based mental health services for

adults of working age and for people with learning disabilities/autism, and an *Outstanding* for their community-based mental health services for older people.

3.4.5 SEPT services

SEPT provides a number of services across the wider South/South West Essex geography, including:

- Early Interventions in Psychosis
- Eating Disorders
- Rapid Assessment Interface and Discharge (RAID)
- Street Triage
- Crisis Resolution Home Treatment (CRHT)

For Thurrock residents they also provide inpatient wards, older adult mental health services, community dementia services and memory assessment services.

The latest CQC inspection rating of SEPT was *Good* – this is across all their services and was dated 19/11/2015.

Workforce

Staffing for the Thurrock Community Mental Health Service could not be broken down into Tilbury locality, as the team works across the borough. The staff breakdown is:

- Team Manager - 1
- Assertive Outreach Team (AOT) – 3 Nurses, 3 STR (support workers - 1 of these part time), 1 Senior Social Worker, 1 Social Worker = 8 staff
- Recovery and Wellbeing Team (RWB)– 4 Nurses, 3 Support Workers - 1 of these part time), 3 Senior Social Workers, 3 Social Workers =13 staff
- First Response Team (FRT) – 5 Nurses, 1 Support Worker, 1 Senior Social Worker (1 year secondment from Thurrock LA) = 7 staff
- Occupational Therapy (OT) – 1 senior OT, 1 OT and 1 Assistant OT
- Psychologist – 2 Part Time at present
- Psychotherapy – 2 part time
- Art Therapy – 1 part time
- Family Therapy - 1 part time
- Outpatients:
 - 2 Consultants Psychiatrists
 - 1 Senior House Officer
 - 1 Senior Registrar on 6 monthly rotation
 - Variable number of junior doctors on rotation who do varying hours at Grays Hall, as well as work on the in-patient service

There are staff within the Older Adult Community Mental Health Service, Community Dementia Nurse and the Memory Assessment Service dedicated to the Thurrock area.

3.4.6 Basildon and Thurrock University Hospital / Orsett Hospital

The main hospital services used by Tilbury locality residents are either Basildon (BTUH) for acute and emergency services, or Orsett Hospital. The latest CQC inspection across all their services was dated 24/05/2016 and rated the provider as *Good* overall, with an *Outstanding* rating for their maternity and gynaecology services.

3.4.7 Current Adult Social Care services

Adult Social Care is provided by a number of different providers, with certain elements delivered in-house. Below is the breakdown of available placements and care – the entries in blue are those located in the Tilbury locality; however it should be noted that residents can be placed in these from outside of Tilbury, and vice versa. The column entitled 'Workbook rating' indicates the internal quality rating of this provision.

Table 4: Older People's Residential and Nursing Home provision

Provision	No of Beds	Address	Postcode	Workbook Rating
Nursing/Dementia				
Bluebell Court	80	Stanley Road,Thurrock,Grays	RM17 6QY	Requires Improvement
Carolyne House	51	Waterson Road,Chadwell St Mary,	RM16 4LD	Good
Grays Court	87	Church Street,Grays	RM17 6EG	Good
Willow Lodge Care Home	62	82-84 Calcutta Road,Tilbury	RM18 7QJ	Requires Improvement
Residential				
Bennett Lodge	48	Waterson Road,Chadwell St Mary,	RM16 4LD	Good
Cedar House	33	249 -251 Southend Road,Stanford Le-Hope	SS17 7AB	Good
Collins House	45	Springhouse Road, Corringham,	SS17 7LE	Good
Hollywood Rest Home	27	34 Cresthill Avenue, Grays,	RM17 5UJ	Good
Leatherland Lodge	48	Darenth Lane,South Ockenden	RM15 5LS	Good
Merrie Loots Farm	28	Merrie Loots Farm, East Tilbury Road, Linford,	SS17 0QS	Good
Oak House	13	103 Corringham Road,Stanford-le-Hope	SS17 0BA	Good
The Barn & Coach House	15	High Road, North Stifford, Grays,	RM16 5UE	Good
The Whitcroft	56	Stanford Road, Orsett,	RM16 3JL	Good

Source: Thurrock Council

Table 5: Working Aged Adults Care Home provision

Provision	CQC Registration	No Of Beds	Address	Postcode	Workbook Rating
109-111 Mollands Lane	Residential Home - Learning Disabilities	8	109/111 Mollands Lane, South Ockendon,	RM15 6DJ	Good
130 Long Lane	Residential Home - Learning Disabilities	2	130 Long Lane,Grays	RM16 2PR	Good
38a Woolifers Avenue	Residential Home - Learning, Physical Disabilities & Sensory	4	38a Woolifers Avenue Corringham	SS17 9AU	Good
44 Dexter Close	Residential Home - Learning Disabilities	2	44 Dexter Close,Grays	RM17 5AU	Good
56-58 Lodge Lane	Residential Home - Learning Disabilities and Mental Health	8	56 - 58 Lodge Lane , Grays	RM16 2YH	Requires Improvement
9 Falcon Avenue	Residential Home - Learning Disabilities and Mental Health	4	Falcon Avenue, Grays,	RM17 6SB	Good
Avalon Nursing	Residential Home - Learning, Physical Disabilities & Sensory	8	Longhouse Road,Chadwell St Mary,	RM16 4QP	Good
Aveley House	Residential Home - Learning Disabilities	7	6 Park Lane, Aveley	RM15 4UD	Good
Bellmaine Avenue	Residential Home - Learning Disabilities	3	18 Bellmaine Avenue,Corringham,	SS17 7TB	Good
Bradd Close	Residential Home - Learning, Physical Disabilities	8	1 Bradd Close, South Ockendon,	RM15 6SA	Requires Improvement
Emmanuel House	Residential Home -Learning Disabilities	2	4 Spencer Walk,Tilbury	RM18 8XJ	Poor
Gallimore Lodge	Nursing Home - Learning, Dementia, Physical Disabilities	8	Meesons Lane,Grays	RM17 5HR	Good
Hollyrose	Residential Home - Dementia, Mental Health & Substance Misuse	12	116 Lodge Lane,Grays	RM16 2UL	Good
Larwood	Residential Home - Learning Disabilities	8	Fulbrook Lane,South Ockendon	RM15 5JY	Good
Messons Lodge	Residential Home - Learning Disabilities	10	Henry De Grey Close,Meesons Lane,Grays	RM17 5GH	Good
Mollands Lane	Residential Home - Learning Disabilities	6	117-119 Mollands Lane, South Ockendon,	RM15 6DJ	Good
Sunnyside House	Residential Home - Learning Disabilities	14	130 High Street, Aveley	RM15 4BX	Good
The Coach House	Nursing Home - Physical Disabilities	13	10 Woodward Heights,Grays	RM17 5RR	Poor
The Homesteads	Residential Home - Learning Disabilities	8	216 Southend Road,Stanford Le Hope	SS17 7AQ	Requires improvement
Wharf Close	Residential Home - Learning Disabilities	4	1 Wharf Close,Stanford Le Hope	SS17 0EJ	Good
Whitehall Lane	Residential Home -Learning Disabilities and Mental Health	2	40, Whitehall Lane, Grays,	RM17 6SS	Good
(Orchid)	Residential Home - Learning Disabilities	4	51 Mollands Lane, South Ockendon,	RM15 6DA	Good

Source: Thurrock Council

Table 6: Supported Living Provision

Provision	No Of Beds	Address	Postcode	Workbook Rating
12 Bermuda Road Supported Living Accommodation	3	12 Bermuda Road Tilbury	RM18 7DA	Good
5 Falcon Avenue Outreach Service	4	5 Falcon Avenue Grays	RM17 6SB	Good
Honeywood, Supported Living	10	Henry De Grey Close, Meesons Lane,	RM17 5GH	POOR
10 Hathaway Road	3	10 Hathaway Road, Grays	RM17 5LB	Requires Improvement
23 Hathaway Road	3	23 Hathaway Road, Grays	RM17 5DX	Requires Improvement
25 Hathaway Road	3	25 Hathaway Road, Grays	RM17 5LB	Requires Improvement
Poley Road				
91 Cromwell Road				
Trinity House	2	Dock Road, Tilbury	RM17 6FL	Good
2 Crest Avenue	2	2 Crest Avenue, Grays	RM17 6RW	Good
Butel	0	13 Buttel close. Grays. .	Rm17 6UN	

Source: Thurrock Council

Table 7: Extra Care Housing and Day Care Provision

Extra Care Housing				
Provision	No of Beds	Address	Postcode	Workbook Rating
Elizabeth Gardens		Long Lane, Grays	RM16 2PQ	Good
Piggs Corner	89 flats, 40 extra care, rest independent living with extra care support	Southend Road, Grays	RM17 5RS	Requires Improvement
Day Care				
Bell House	N/A	23-25 Derwent Parade, South Ockendon	RM15 5EF	Requires Improvement
The Carers Centre	N/A	Cromwell Road, Grays	RM17 5HQ	Requires Improvement
Kynoch Court	N/A	Billet Lane, Stanford Le Hope	SS17 0AF	Requires Improvement
Grays and South Ockendon	N/A	2/4 Derwent Parade/ 13/15 Clarence Road, Grays, South Ockendon	RM15 5EE / RM17 6QA	Requires Improvement
Marisco Hall and New Hall stanford	N/A	Marisco Hall Chadwell St Mary /New Hall the Sorrells Stanford-le-Hope	RM16 4JP / SS17 7ES	Requires Improvement

Source: Thurrock Council

There are also currently four Domiciliary Care providers – two of whom have been given an internal *Requires Improvement* rating (Joint Care Reablement and Thurrock Care @ Home). The other two are TLC and John Stanleys. There are also Spot Purchase providers – Professional Care Service and Regents Care Homecare.

Workforce

The Adult Social Care workforce in Thurrock is split into two teams – EIP West and EIP East. The EIP East team covers the areas of Tilbury, Chadwell St. Mary, East Tilbury, Tilbury, Grays, Corringham, Stanford –Le- Hope, Horndon and Linford. The staff mix is:

2 x Senior Social Workers – these workers are responsible for staff supervisions and provide support to the team manager. They have to maintain HCPC registration. They are also allocated particularly complex cases, for example, those with multiple contributing factors in the family.

3 x Social workers – these are qualified workers registered with the HCPC and undertake all levels of case management, assessments and reviews. They can also provide advice to support planners.

5 x Support Planners – these are unqualified workers, and can hold cases of their own, undertaking assessments and reviews.

Additional staff such as Occupational Therapists and staff within the Rapid Response Assessment Service work with NELFT and work Thurrock-wide.

4. Adult Social Care

KEY FINDINGS:

- HOMECARE IS THE MOST COMMON ADULT SOCIAL CARE PACKAGE PROVIDED BUT RESIDENTIAL CARE PACKAGES COST THE MOST IN TOTAL
- DEMAND FOR HOMECARE AND RESIDENTIAL CARE BEGINS TO RISE SIGNIFICANTLY AT THE AGES OF 55 AND 70 RESPECTIVELY, PRESENTING KEY WINDOWS OF OPPORTUNITY FOR PREVENTION AND EARLY INTERVENTION PROGRAMMES PRIOR TO THESE INCREASES IN DEMAND
- OVERALL SPEND ON RESIDENTIAL AND HOMECARE IS FALLING OVER TIME IN LINE WITH REDUCING ADULT SOCIAL CARE FUNDING. THIS SUGGESTS THAT CARE IS BEING RATIONED AND THAT ONLY THOSE WITH A HIGH LEVEL OF ACUITY ARE QUALIFY FOR CARE PACKAGES.
- PREVENTION AND EARLY INTERVENTION PROGRAMMES SUCH AS LIVING WELL IN THURROCK AND LOCAL AREA COORDINATION APPEAR TO BE PREVENTING SOME LEVEL OF ADULT SOCIAL CARE DEMAND, ALTHOUGH THE NATURE OF THESE PROGRAMMES MAKE IT DIFFICULT TO QUANTIFY BY HOW MUCH.
- WORK IS CURRENTLY UNDERWAY TO IMPLEMENT FURTHER TRANSFORMATIONAL APPROACHES TO DELIVERING ADULT CARE INCLUDING REDESIGN AND IMPLEMENTATION OF AN EMPOWERMENT 'COMMUNITY SOLUTIONS' BASED APPROACH TO DELIVERING CARE. THIS NEEDS TO BE INCORPORATED INTO THE RE-DESIGN OF OTHER NEW APPROACHES TO CARE DELIVERY WITHIN A FUTURE ACO.

4.1 Introduction

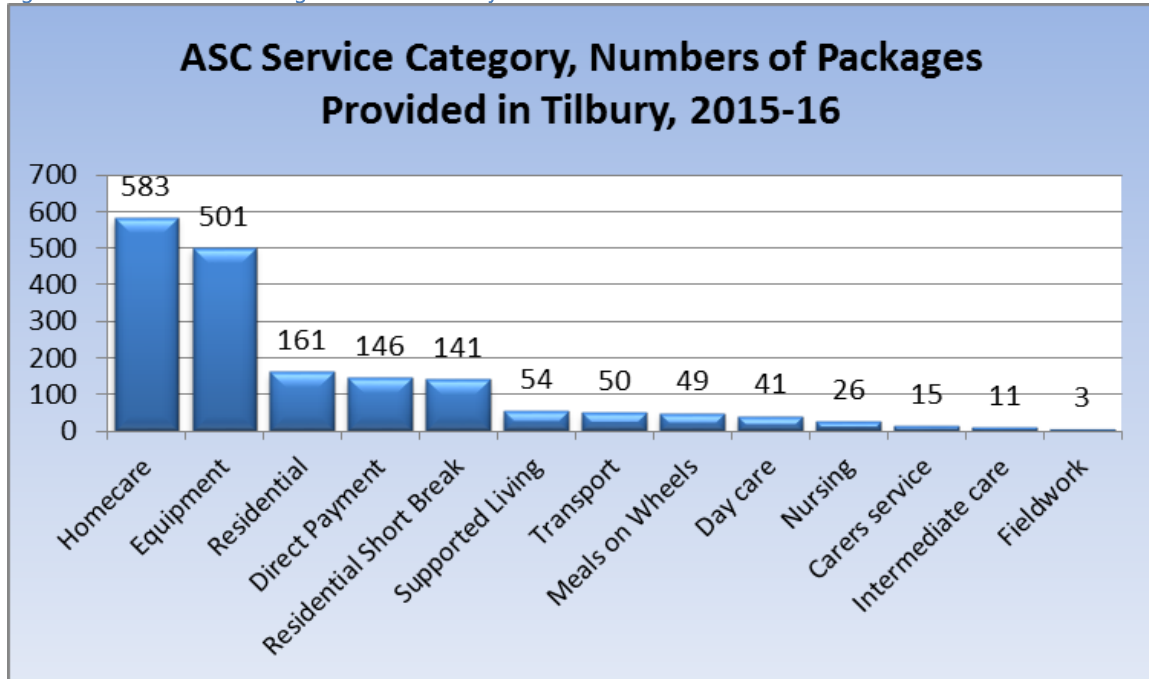
Care and support services, also known as Adult Social Care (ASC) services, help people who are in need of practical support due to mental or physical illness, disability, old age or a low income. ASC include a range of support services that assist clients with their daily lives. Unlike NHS clinical services that work on a 'deficit' model of identifying what is wrong with a patient medically and then attempting to fix it, ASC services work on an empowerment or asset based model, aiming to assist the client to achieve as full a potential in life as their condition allows. Services can also support the families or carers of people who receive social care.

Social care services are subject to rules about needs and ability to pay and unlike NHS services, are not necessarily provided free at the point of delivery.

4.2 Provision of Adult Social Care Services in Tilbury

Figure 14 shows the numbers of ASC service packages provided in Tilbury during 2015-16 by service category type.

Figure 14 Number of ASC Packages Provided in Tilbury

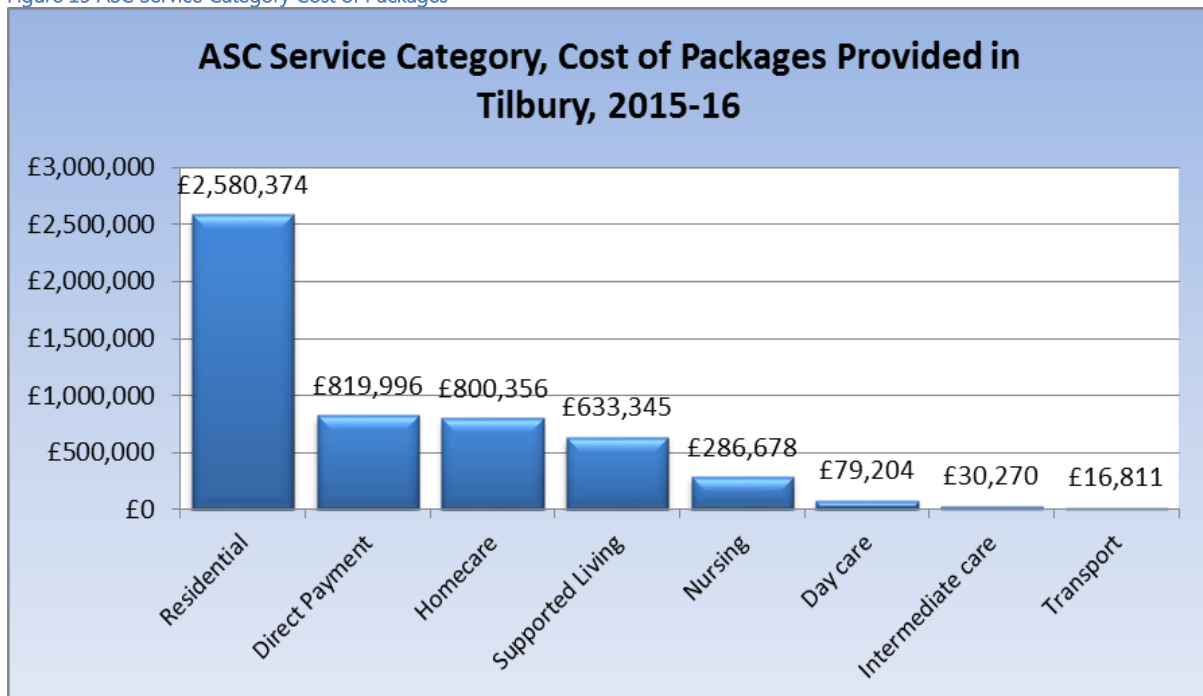


Source: Thurrock Council LAS / Public Health Team Analysis

In total 1781 ASC packages were provided to Tilbury residents in 2015-16 at a total cost of £5.247M to Thurrock Council.

The most common type of care package type was Homecare, followed by Equipment, Residential Care and Direct Payment. However in terms of total costs of packages provided, Residential Care made up almost 50% of the entire spend on ASC packages at over £2.580M compared to Direct Payments at £820K and Homecare at £800K. (Figure 15)

Figure 15 ASC Service Category Cost of Packages

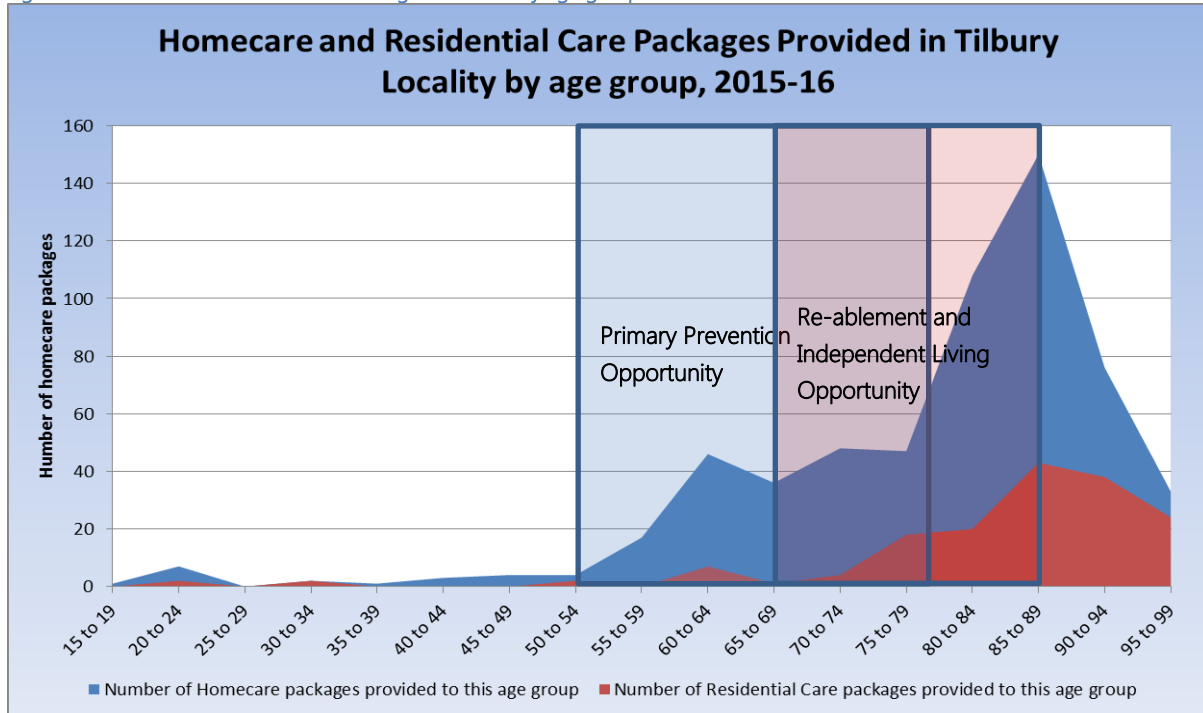


Source: Thurrock Council LAS / Public Health Team Analysis

4.3 Provision of ASC package by age of client

Figure 16 shows the number of homecare and residential care packages provided to clients in Tilbury in 2015-16 by age of client.

Figure 16 Home and Residential Care Packages Provided by age group

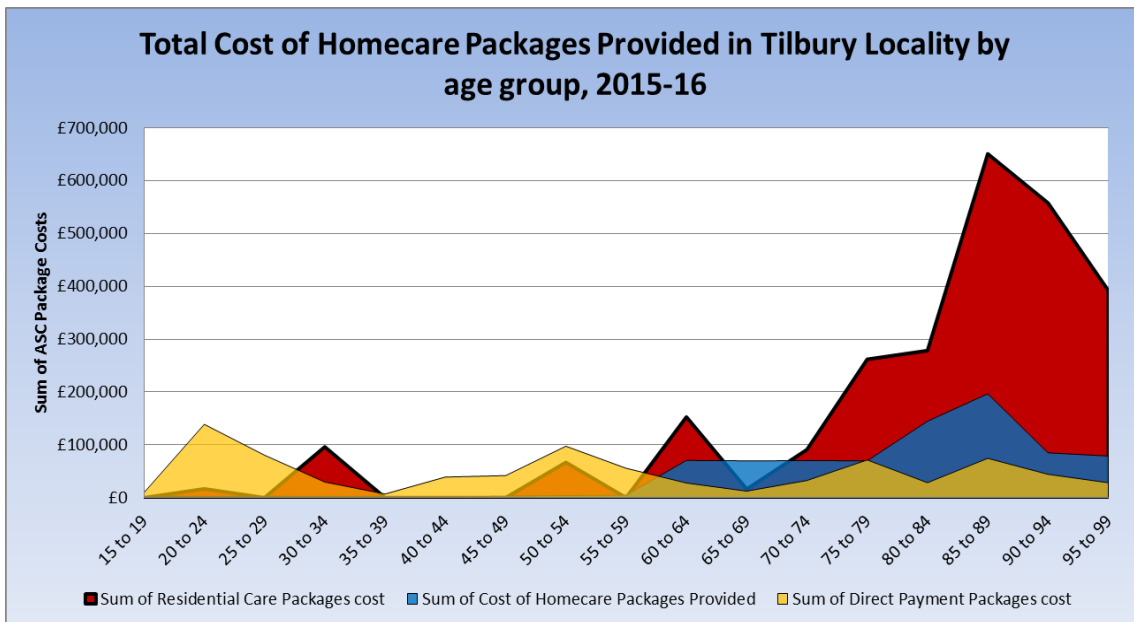


Source: Thurrock Council LAS / Public Health Team Analysis

There is a sharp increase in numbers of homecare packages provided after the age of 55 up until the age of 64. The numbers then plateau until the age of 80 when there is another sharp increase. The shape on Figure 16 for age at which residential care packages are provided mirrors that of homecare packages, but begins later, with a sharp increase after the age of 75, plateauing at the ages of 80 to 84 and then rising sharply again after the age of 85. This suggests two critical points in the ages of the Tilbury population for the targeting of successful prevention and early intervention initiatives. Primary prevention initiatives that aim to keep the population as healthy and independent as possible to mitigate the need for home care need to be targeted from the ages of 50 to 80. Similarly re-ablement and independent living programmes aimed at people as independent within their own homes such that they do not need residential care need to be targeted at those aged between 75 and 89. These two windows of opportunity are shown on the graph

Figure 17 shows the same impact but in terms of spend. It highlights the significant potential impact in terms of cost savings if we can prevent or delay entry into residential care.

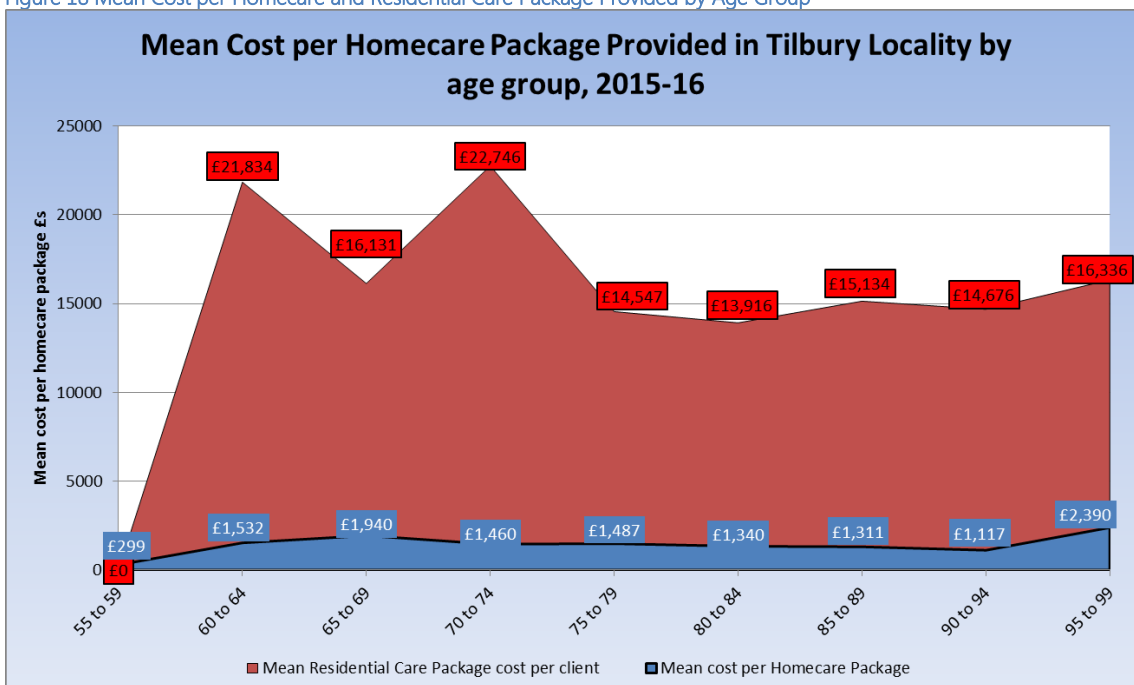
Figure 17 Total Cost of Home and Residential Care Packages Provided by Age Group



Source: Thurrock Council LAS / Public Health Team Analysis

Figure 18 shows the mean cost of Homecare and Residential Care packages age of client. The mean cost of a ASC package is a very good proxy for the acuity of the package provided.

Figure 18 Mean Cost per Homecare and Residential Care Package Provided by Age Group



Source: Thurrock Council LAS / Public Health Team Analysis

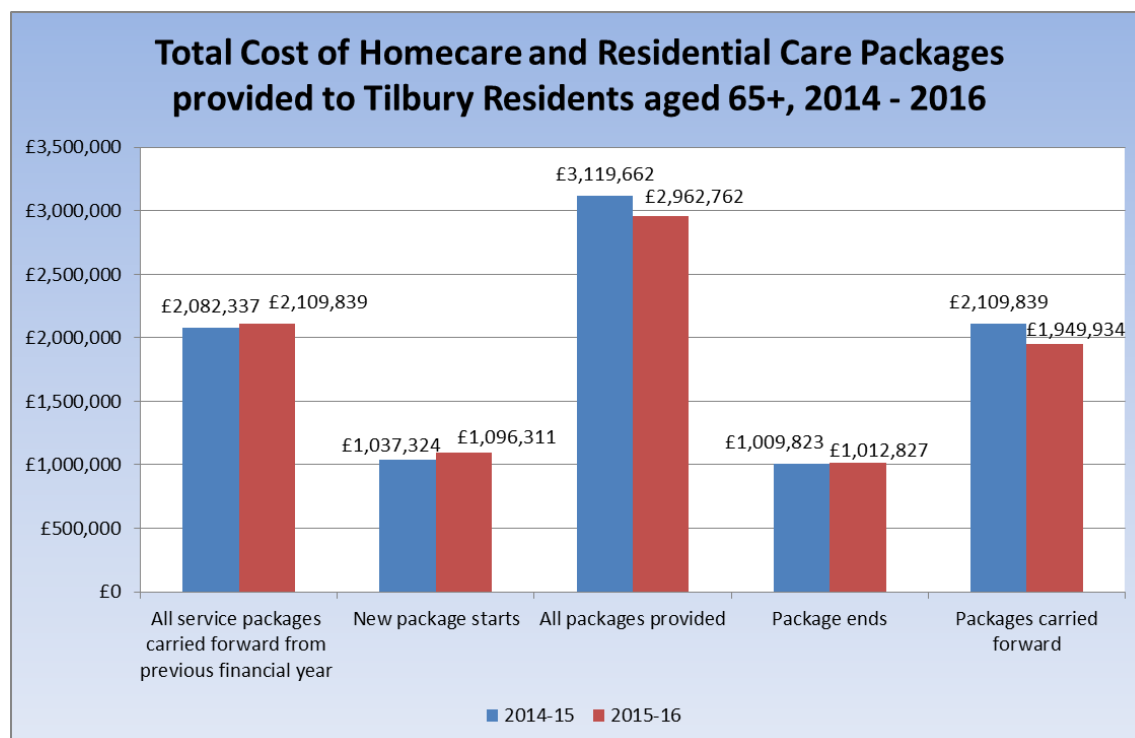
The above chart shows rising mean cost and hence acuity of homecare packages provided to clients aged between 55 and 69, with the costs then diminishing until clients reach 90+. Similarly mean costs of residential care packages rise steeply from the age of 59, reaching their height at aged 70 to 74, after which they fall back down and remain relatively constant. One possible reason for this could be that the cohort of clients in residential care aged between 60 to 74

have suffered serious health events that have caused a considerable level of disability, but exit care due to death before they reach 80 years old, leaving a cohort of the population in residential care who are there due to general frailty. However, without the ability to link health and social care records at patient/client level, (soon to be delivered through our new Integrated Dataset programme) it is impossible to establish this hypothesis as fact.

4.4 Change in Provision of Adult Social Care Packages over time

Figure 19 shows the total spend on Home and Residential Care Packages for Tilbury residents between 2014 and 2016.

Figure 19 Total Cost of Homecare and Residential Care Packages, Residents Aged 65+



Source: Thurrock Council LAS / Public Health Team Analysis

Total costs of all packages provided fell from £3.12M to £2.962M between 2014 and 2016. This is largely a product of reducing numbers of total packages provided by Thurrock Council, and further graphs that demonstrate the total numbers of packages provided by service category and the mean cost of packages provided by service category between 2014 and 2016 are given in The Supplementary Information Pack.

The explanation for this fall in spend is likely to be Thurrock Council's success and need to control costs in the face of reducing ASC budgets. The drivers for this success cannot be established from these data but may include both the success of community prevention programmes such as Living Well in Thurrock, success at driving contractual efficiencies from current ASC providers, and raising the criteria before which a client is deemed to require a statutory ASC intervention.

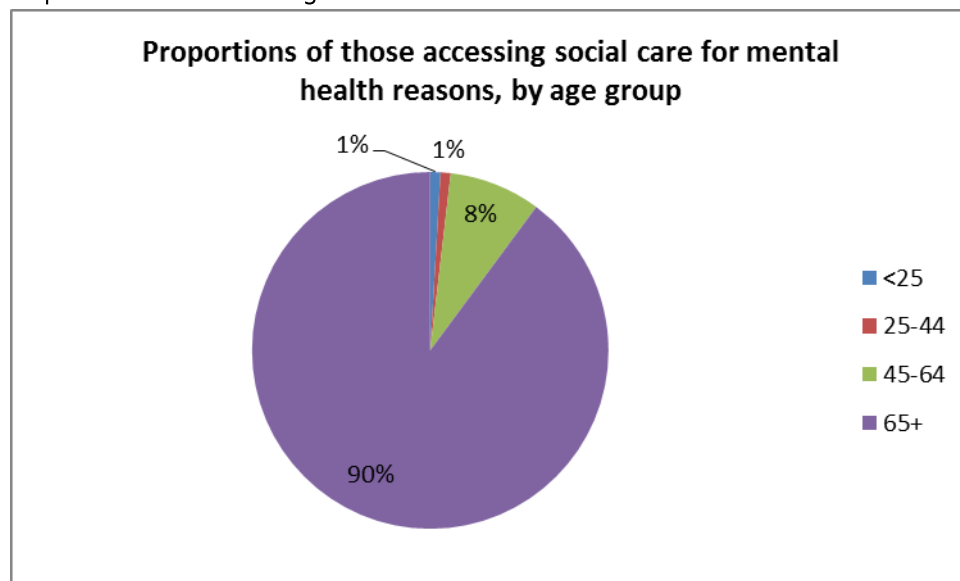
4.5 Mental Health and Social Care

Social care data show that there are currently 1781 clients accessing social care for services and care packages due to mental health reasons. Of the 1781, there are 217 (12%) individuals whose primary reason for accessing social care services is recorded as being due to mental health issues.

Age groups of those accessing social care services

Age Group	Number	Proportion
<25	2	1%
25-44	2	1%
45-64	18	8%
65+	195	90%
Grand Total	217	100%

Proportions of those accessing social care for mental health reasons



Source: Social Care Team, Thurrock Council, 2015/16 data

The vast majority of those accessing social care services (90%) are aged 65+. This is interesting as it is in direct contrast with those who access mental health services via IAPT; those patients are in the younger age groups. Therefore we can see that for those with mental health conditions accessing care, older people are more likely to access social care whilst younger people are more likely to access IAPT services.

This might also reflect a trend for older people to access social care services but not access health care for diagnosis and treatment of a mental health condition.

Costs of packages

Cost	Numbers	Proportions
Blank	70	32%
Zero	7	3%
Cost stated	140	65%
Totals	217	100%

The costs of social care packages are enormously varied. The costs for these clients are recorded as the total package cost. Over a third (35%) are listed with a blank figure or zero, which does not mean that they cost nothing; for these clients, the figure is recorded this way because the actual cost cannot be separated out from the package cost e.g. for occupational therapy packages. This makes accounting for financial spend in social care very difficult to do.

For those clients with a package cost given, there is a huge range of costs which vary from £16 to £39,214 for the individual.

4.6 Local Area Coordination

Local Area Coordinators (LACs) are in place within the Community to support with:

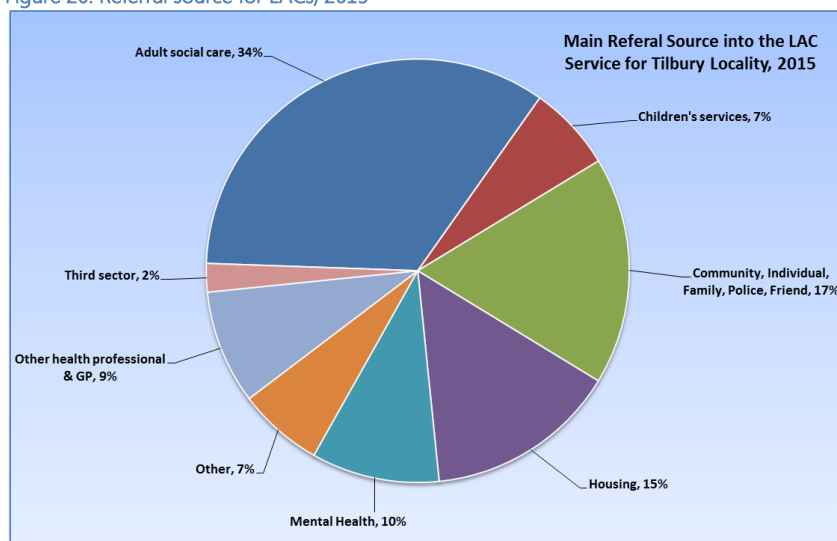
- ✓ Building community capacity
- ✓ Developing and updating asset lists (activities and clubs)
- ✓ Identifying gaps, opportunities and trends in the community
- ✓ Encouraging the use of voluntary organisations
- ✓ Enhance knowledge of community responses to replace services including micro –enterprise
- ✓ Maintain visibility within the community, having a presence known in:
 - Community hubs
 - GP surgeries
 - Children centres
 - Village halls
 - Cafes/pubs
 - Health centres
 - Schools
 - Voluntary organisation
 - Faith groups
 - Libraries

As such, Local Area Coordinators and the community capacity they seek to build and link vulnerable residents to have a key role to play in both the Primary Prevention and to some extent the Re-ablement and Independent Living early intervention opportunities referenced in figure A (section 1.2.1) required to reduce demand on both homecare and residential care.

Currently there are nine Local Area Co-ordinators working in Thurrock, with three covering the Tilbury locality geography - Helen Catterick (Chadwell St Mary / Orsett / Bulphan), Karen Dobson (East Tilbury) and Kate Williams (Tilbury).

During the 2015 calendar year, there were 184 referrals for Tilbury residents – forming 31.3% of the 588 referrals received for Thurrock as a whole. The main referral sources are shown below, with the main referral source into LACs being from Thurrock Councils Adult Social Care (34%) with Community referrals coming second with 17%.

Figure 20: Referral source for LACs, 2015



Source: Thurrock Council 2015

Many people presented with an issue of *Older Person* (see appendix for more details) – these accounted for 19% of East Tilbury referrals, 29% of Tilbury referrals and 38% of Chadwell/Orsett/Bulphan referrals.

Of the 184 Tilbury locality referrals, 21 went on to receive a funded formal service – which is 11% of referrals. 7 required Adult Social Care support and 7 required mental health support. It could be said that Local Area Coordination prevented at least some of the other 163 residents who did not go on to use a formal service.

Further details on Local Area Coordination can be found in the Supplementary Information Pack.

4.7 Community Solutions Team Development

Thurrock Adult Social Care, in partnership with colleagues in the commercial and third sector and in Public Health, has begun to re-design services to improve quality, sustainability and cost effectiveness, using learning and experience from two other key approaches in designing a new model for supporting people's independence at home; Local Area Co-ordination and Buurtzorg.

Whilst neither of these approaches deliver homecare they both contain useful examples of how to improve outcomes for individuals utilising no-cost or low cost solutions, and organisational structures that improve productivity through autonomy, self-management and a reduction in bureaucracy.

Core principles and key characteristics of Community Solutions Teams;

- **Solution focused** – Get a life not a service.
- **Person centred** – A broader conversation not just an assessment.
- **Community based** – Utilising local assets wherever possible.
- **Aspirational** – Supporting a vision of a "Good Life".
- **Preventative** – Professional involvement that is proportionate and targeted - reaching those people in the community for whom information, advice and a little assistance can help manage their situation.
- **Autonomous** – Self-management at a local level.
- **Local** – Knowledge of the person, and of what their community has to offer.
- **Efficient** – Maximum contact time – minimal bureaucracy.
- **Respectful** – Of both those supported and *of those delivering support*.
- **Consistent** – Delivering continuity through small local teams.
- **Outcome based** – Developing trusting relationships not delivering tasks.
- **Strengths not needs** – Building independence not encouraging dependence.

4.7.1 Re-Design of Community Solutions

Although not yet finalised, the teams will need to build upon the lessons of implementing Local Area Co-ordination, and on the success of Buurtzorg. The teams will be small – up to 12 members and self-managing. Building on the Buurtzorg model the emphasis will be on providing coaching to support team development rather than providing a traditional level of hands on management; this should stimulate a learning environment and encourage a sustainable team identity.

One Major advantage of the Buurtzorg model is the small ratio of bureaucracy to front line delivery, in 2013 this stood at 45 staff to 650 teams (some 7,000 nurses), with a back office overhead cost of only 8%. Over time it will be important to try to replicate this and we are designing an overarching back office function to support teams and also to manage the regulatory function. However this will only work at scale and is unnecessary for any initial limited implementation.

The teams will be required to work in very similar ways to that adopted by Local Area Co-ordinators. Taking time to get to know those they are working with through a “good life” conversation, always seeking to maximise no-cost or low cost solutions from within the individuals existing network, if there is one, or utilising community assets. The teams will also be expected to deliver a preventative approach through identifying those at risk but not in crisis locally, and offering support through information, advice and guidance.

The design and detail of how the teams will be selected, deployed and supported is in its early stage at present, more work is being undertaken to finalise these aspects over the next few months.

4.7.2 Potential Implementation:

Ultimately the Community Solutions Teams should include a range of practitioners, including health professionals, to maximise their impact should they prove successful. In time it is hoped that the teams will be in place across Thurrock, however this is a radical departure in terms of how care and support is provided and we need to launch in a controlled way to prove the concept and learn lessons.

Therefore it seems sensible to link this initiative to the development of the Accountable Care Organisation (ACO) in Tilbury. The locus of this in terms of the link to a local primary care and community offer fits well with the proposed model. More discussion is needed to firm up both initiatives but making the link early in the process should enable a combined approach to be developed.

Currently we are delivering 1195 hours of home care within the four wards linked to the ACO. Typically full time care assistants deliver around 24 hours of care therefore we would require around 48 care staff. This fits well into a potential Buurtzorg style of team deployment of 12 members per team. We would therefore require four teams, one for each of the four wards.

5. Delayed Transfers of Care (DTOCS)

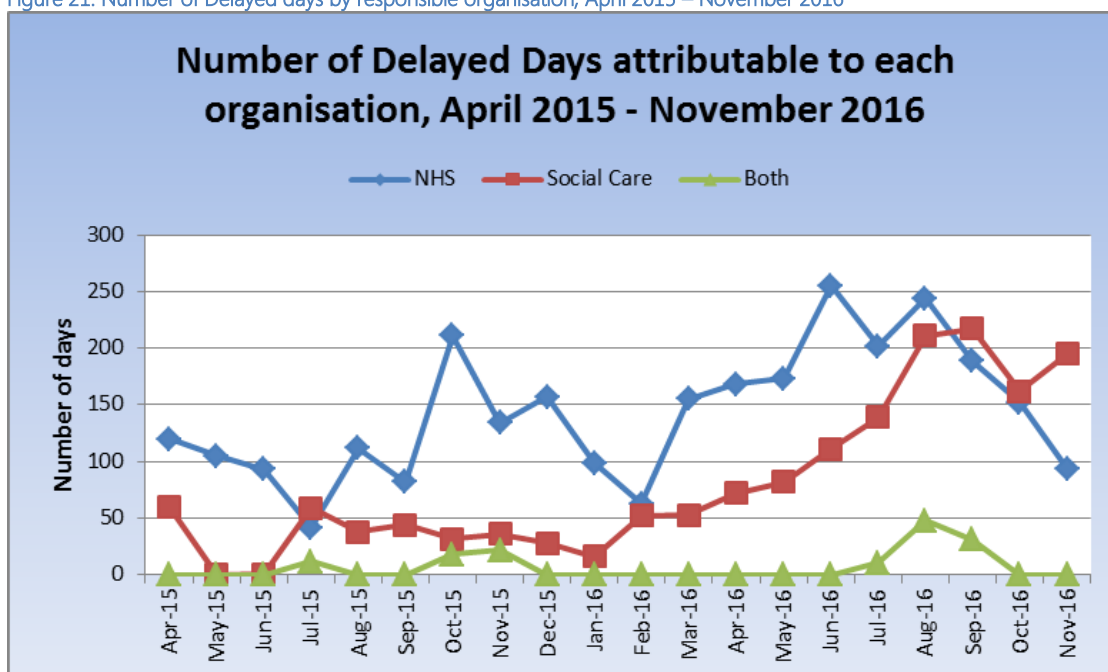
KEY FINDINGS

- DELAYED TRANSFERS OF CARE (DTOCS) HAVE BEEN INCREASING RAPIDLY IN RECENT MONTHS
- DTOCS CAUSED BY LACK OF SOCIAL CARE PROVISION ARE INCREASING RAPIDLY WHILST THOSE CAUSED BY THE NHS ARE FALLING BUT ARE STILL TOO HIGH
- INADEQUATE AND FALLING CAPACITY WITHIN OUR LOCAL ADULT SOCIAL CARE SYSTEM IS EXASPERBATING THE ISSUE OF DTOCS
- FAILURE TO ADDRESS THIS ISSUE IS WASTING SYSTEM RESOURCES, LEADING TO OPERATIONAL UNSUSTAINABILITY AND WASTING SYSTEM RESOURCES
- ADDRESSING THE ISSUE REQUIRES INTEGRATION OF HEALTH AND SOCIAL CARE BUDGETS

Note that the data here is presented for Thurrock as a whole.

In 2015/16, there were 1,844 days of delayed transfers of care for Thurrock residents. However in the subsequent period from April 2016 – November 2016, there have been 2,756 days, which has already exceeded the full year total for 2015/16. Of the 4,600 Delayed Days between April 2015 and November 2016, 2,850 of these were the responsibility of the NHS (62%) – e.g. if a district nurse was required as part of the discharge package, but they were not in place upon the point of discharge, this would be the responsibility of the NHS. 1,608 were the responsibility of Social Care (35%) – e.g. awaiting a nursing home placement, and 142 (3%) the responsibility of both organisations. Whilst at the start of the year, very few Delayed Days were attributable to Social Care, this increased throughout the recording period – particularly after April 2016. This can be seen in the figure below.

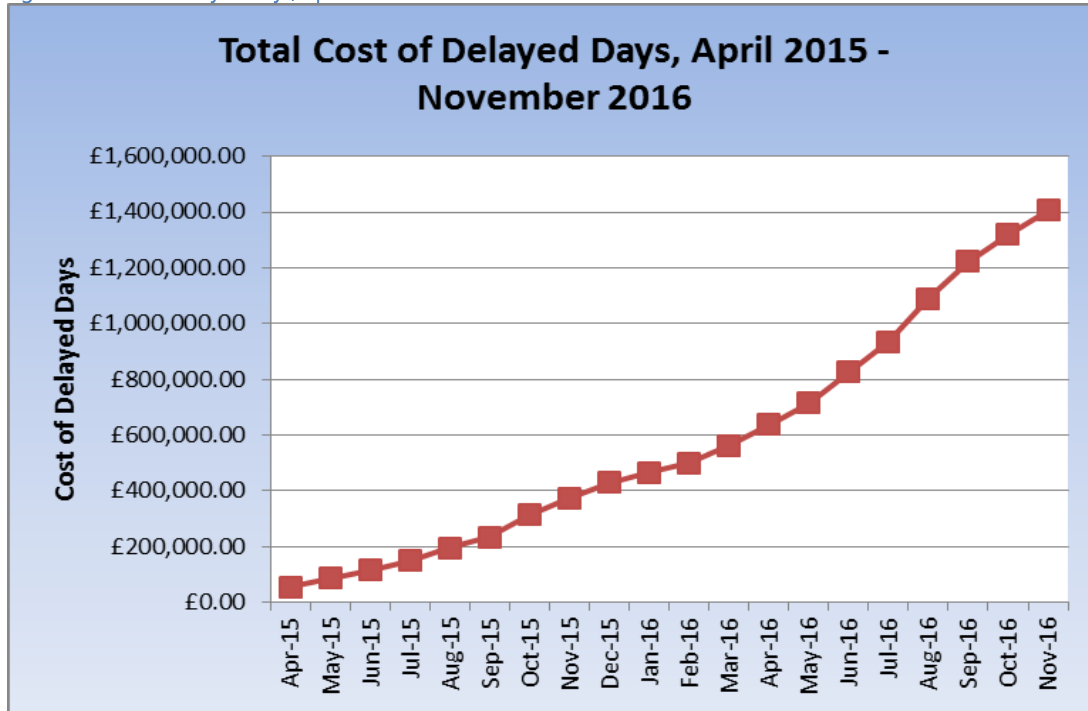
Figure 21: Number of Delayed days by responsible organisation, April 2015 – November 2016



Source: NHS England

Whilst exact costs for these Delayed Days cannot be calculated without viewing individual records, an estimate can be generated. Using an average cost of £306 per excess bed day, it is estimated that the 1,844 delayed days cost £564,264 in 2015-16, and the 2,756 days in April-November 2016 have cost £843,336 - giving a total cost of £1,407,600 for the 20 month period. The cumulative increase can be seen in the figure below.

Figure 22: Cost of Delayed Days, April 2015-November 2016



Source: NHS England and Department of Health

Figure 23 compares the mean weekly cost of a Delayed Transfer of Care compared to other types of Adult Social Care placements.

Figure 23 Mean weekly cost of ASC package types for Tilbury Residents aged 65+

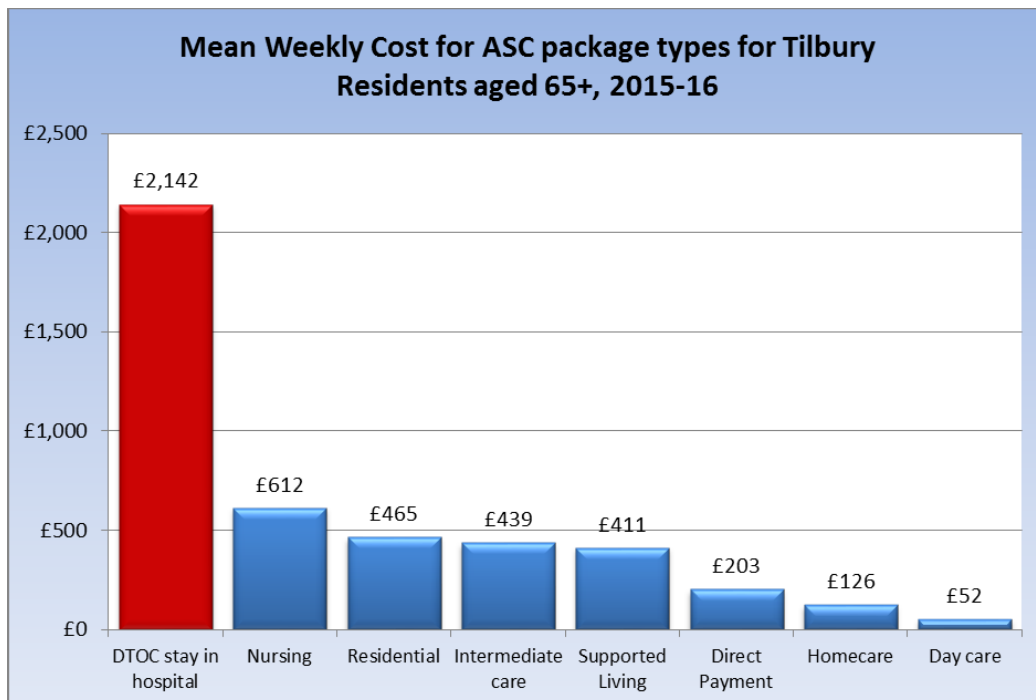
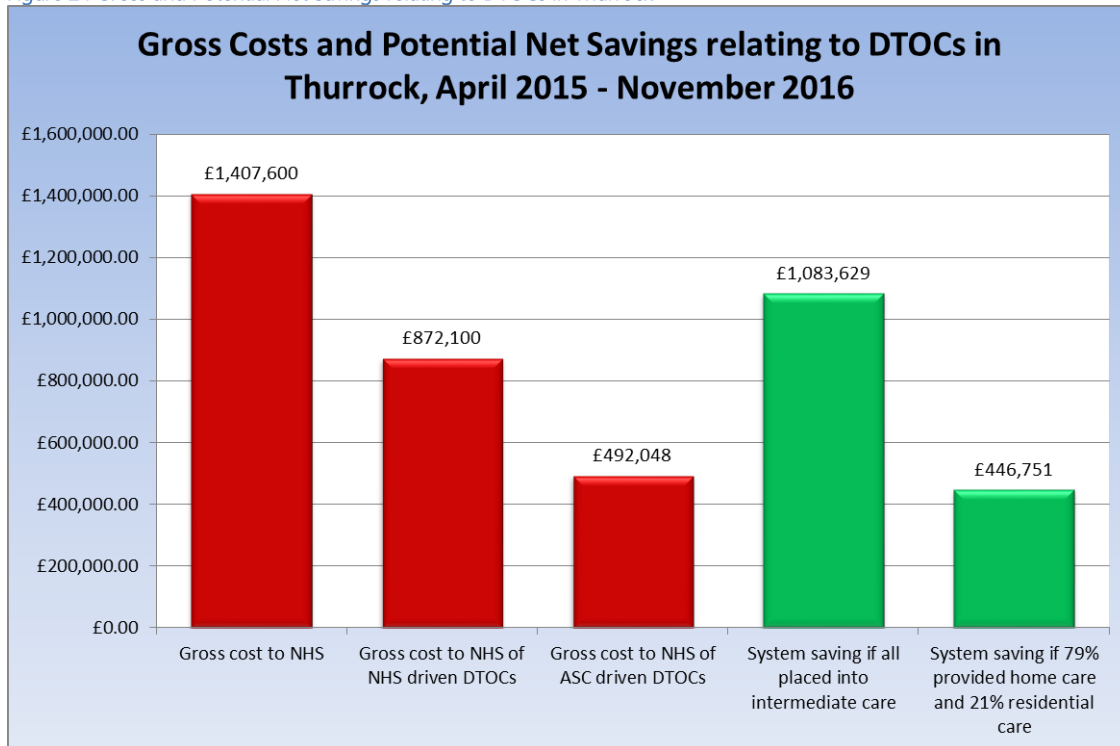


Figure 24 demonstrates the gross costs at potential net savings to the Thurrock Health and Social Care system of DTCs should alternative provision be available.

Figure 24 Gross and Potential Net Savings relating to DTOCs in Thurrock



It is clear that addressing the issue of Delayed Transfers of Care needs to be a System Priority. Whilst Adult Social Care budgets remain detached from those in the wider NHS and are subject to funding reductions as demonstrated in section 1.2.1, the situation is likely to deteriorate further.

Keeping patients in the most expensive part of the system – hospital unnecessarily is bad for patient outcomes, bad for operational sustainability of the system and wastes system resources.

Maintaining separate ASC and NHS budgets held by different sovereign organisations remains a key barrier to solving this issue. It is imperative that we address it by finding mechanisms to integrate these funding streams.

6. Avoidable Emergency Hospital Admissions

Note – some of the data in this section relates to 2014/15 as there were data quality issues with the 2015/16 extract.

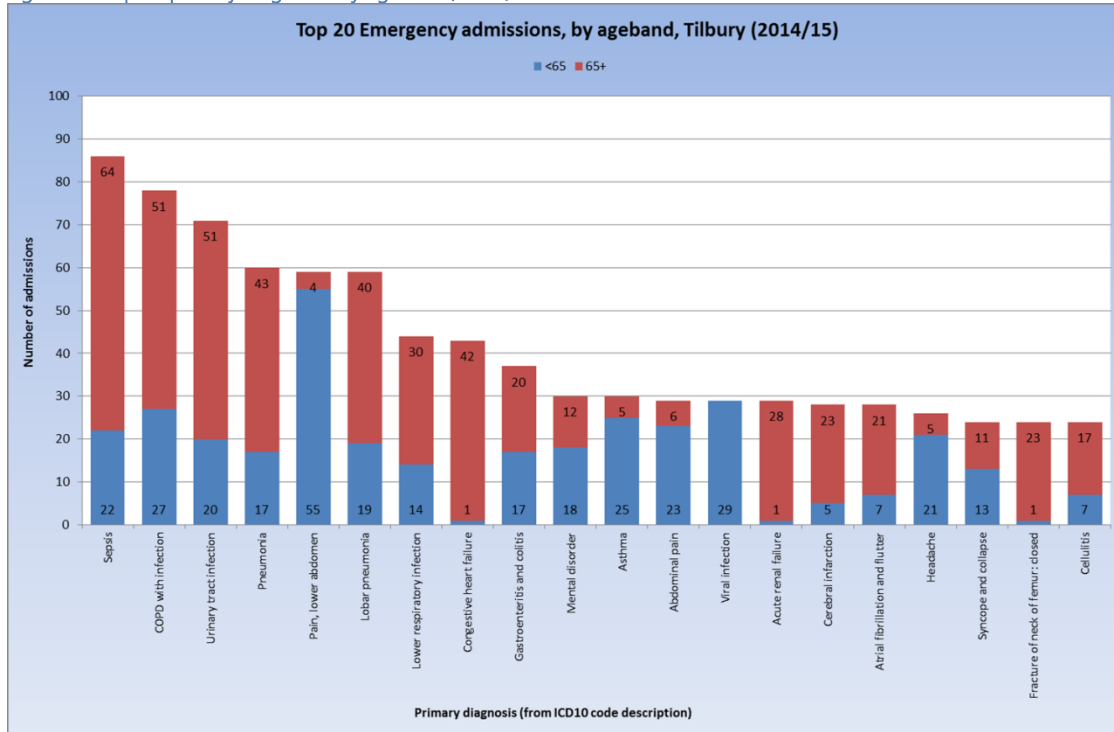
6.1 Unplanned care admissions

KEY MESSAGES

- WHILST SEPSIS IS CODED AS THE MOST COMMON REASON FOR AN UNPLANNED HOSPITAL ADMISSION, RESPIRATORY AND CARDIO VASCULAR DISEASES WHEN COMBINED ACCOUNT FOR THE MOST COMMON REASONS
- RESPIRATORY AND CARDIO-VASCULAR DISEASE IS BOTH HIGHLY PREVENTABLE AT A PRIMARY, SECONDARY AND TERTIARY LEVEL WITHIN THE COMMUNITY
- INVESTING IN PRIMARY PREVENTION WILL REDUCE HOSPITAL ADMISSIONS FOR THESE CONDITIONS IN THE MEDIUM TERM AND IMPROVING CASE FINDING AND CLINICAL MANAGEMENT OF THEM IN PRIMARY AND COMMUNITY CARE WILL REDUCE THEM IN THE SHORT TO MEDIUM TERM

The figure below shows the top 20 reasons for emergency admissions from Tilbury locality patients in 2014/15, grouped for under and over 65 year olds. These were taken from the primary diagnosis field. It can be seen that Sepsis was the main category overall and for those aged 65 years plus, accounting for 86 admissions – 64 of which were to those over 65. COPD with complications and urinary tract infections were the next most common both for all ages and those aged 65 years and over. There are some conditions almost unique to the older population (e.g. congestive heart failure and acute renal failure), and some to the younger age group (e.g. lower abdominal pain and viral infection).

Figure 25: Top 20 primary diagnoses by age band, 2014/15



Source: Mede Analytics

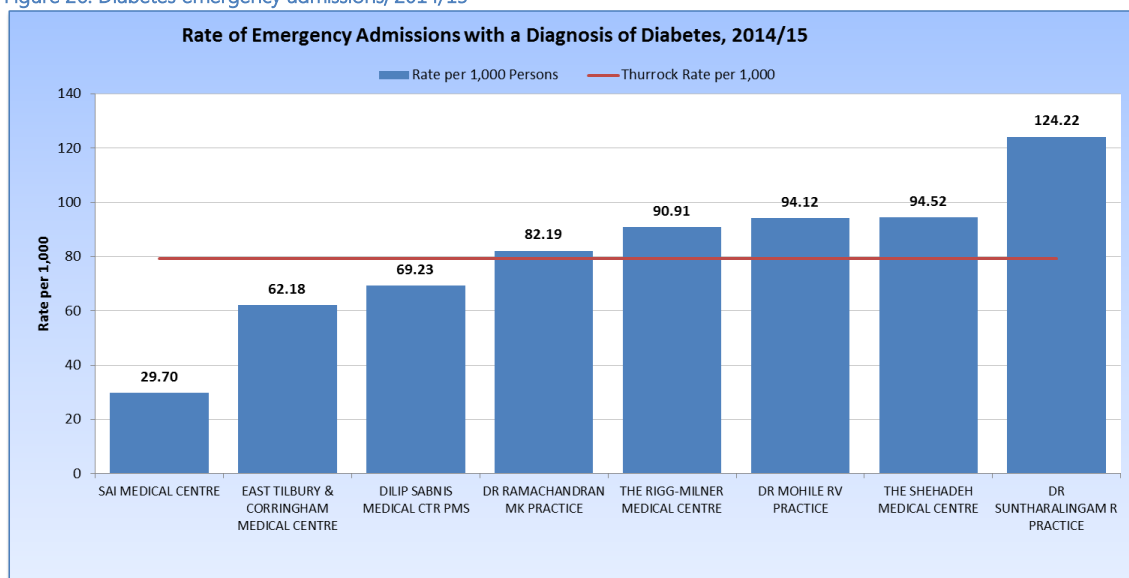
6.2 Emergency Hospital Admissions due to Long Term Conditions

KEY MESSAGES:

- THERE IS SIGNIFICANT VARIATION IN RATE OF HOSPITAL ADMISSION PER 50 PATIENTS ON GP PRACTICE DIABETES AND COPD REGISTERS ALTHOUGH THE REASONS FOR THIS ARE UNCLEAR.
- POSSIBLE EXPLANATIONS COULD INCLUDE VARIATION IN CASE FINDING AND/OR MULTIPLE ADMISSIONS BY INDIVIDUAL PATIENTS WHICH CANNOT CURRENTLY BE CAPTURED BY THE DATA AVAILABLE

The data in the charts below show the rates of emergency admissions for key long term conditions that occurred for Tilbury patients in 2014/15. These have been calculated using inclusion of the condition in either the primary, secondary or tertiary diagnosis columns, as rates per 1,000 patients on each QOF long term condition register. What they show is a large amount of variation at practice level. The first figure below shows the rate for Diabetes, and it can be seen that five of the eight practices had higher admission rates than the Thurrock average (79.4). **Some care needs to be taken in interpreting these data, as they do not control for the fact that an individual patient may be admitted on many occasions.** One the Thurrock Integrated Data Solution is implemented we will be able to track individual patient flows and hence provide more accurate analysis.

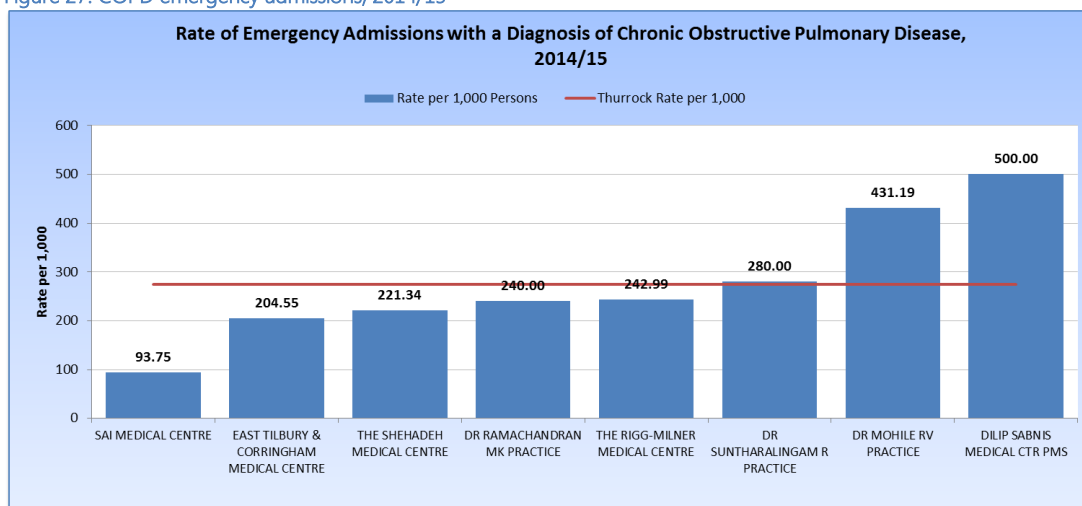
Figure 26: Diabetes emergency admissions, 2014/15



Source: SUS/QOF/ Thurrock Public Health Team Analysis

This figure shows emergency admissions for COPD, and again, the practice-level variation can be seen, with Dilip Sabnis patients being admitted at a rate more than five times above that of Sai Medical Centre (500 per 1,000 patients with COPD, compared to 93.75 per 1,000). Again, the same caveat in bold above applies to these data.

Figure 27: COPD emergency admissions, 2014/15



Source: SUS/QOF/ PH Team Analysis

Admissions per practice for other LTCs can be found in the appendix.

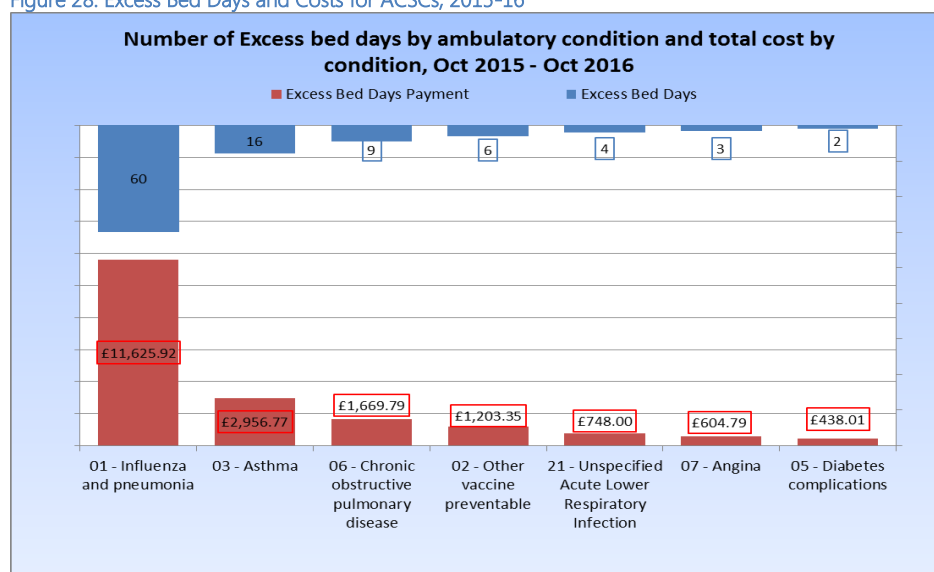
6.3 Hospital admissions due to Ambulatory Care Sensitive Conditions (ACSCs)

KEY FINDING:

- THERE WERE 453 ADMISSIONS FROM TILBURY PATIENTS IN 2015-16 DUE TO CONDITIONS THAT WERE AMENABLE TO EFFECTIVE HEALTHCARE. ACSC ADMISSIONS HAD AN EXCESS COST OF £19K IN 2015-16 AND 100 EXCESS BED DAYS

Ambulatory Care Sensitive conditions are conditions for which effective management and treatment should limit emergency admission to hospital. In 2015/2016 there were 453 coded admissions for Ambulatory Care Sensitive Admissions (£1.2M) from patients registered to Tilbury practices, these account for roughly 5% of all emergency admissions. These admissions caused 100 excess bed days and meant the excess cost was approximately £19K in total (see figure below). It can be seen that the condition with the highest number and cost of excess bed days was influenza and pneumonia, and that the second and third-highest costs were also due to respiratory conditions.

Figure 28: Excess Bed Days and Costs for ACSCs, 2015-16



Source: Hospital Episode Statistics

6.4 Rapid Response Assessment Service

KEY MESSAGE:

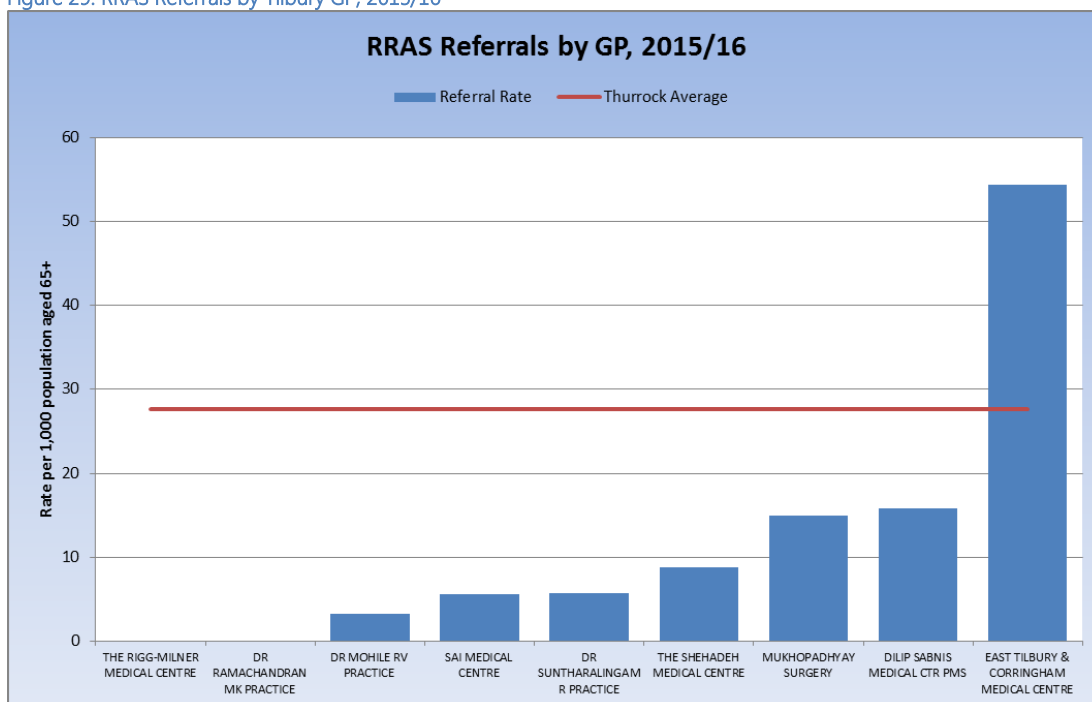
- RRAS IS A SERVICE THAT AIMS TO PREVENT AVOIDABLE HOSPITAL AND CARE ADMISSIONS. REFERRAL RATES FROM TILBURY PRACTICES TO RRAS ARE LOW, YET HOSPITAL ADMISSIONS ARE HIGH SUGGESTING RRAS IS BEING UNDER USED.

The Rapid Response Assessment Service is provided by NELFT and aims to provide rapid assessment and intervention to prevent residents entering either hospital or Adult Social Care Services unnecessarily.

In 2015/16 a total of 53 referrals were received from Tilbury GPs. Converting this to a rate per 1,000 patients aged 65+ (as the main users of the RRAS service); this generates a rate of 9.71 per 1,000. This is lower than the Thurrock average rate of 27.7 per 1,000.

Breaking this down by GP, there were two GPs (Rigg Milner and Dr Ramachandran) which did not refer any patients. The referral rate for East Tilbury HC was double the Thurrock average and much higher than the rest of the Tilbury locality GPs, at 54.3 per 1,000 patients.

Figure 29: RRAS Referrals by Tilbury GP, 2015/16



Source: Thurrock Council

6.5 Mental Health Activity

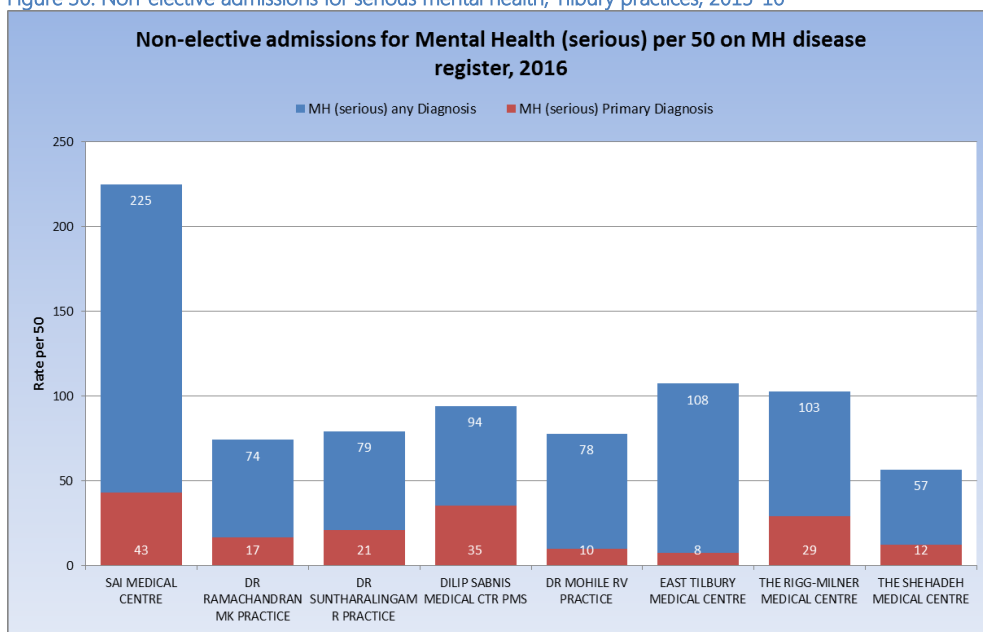
KEY MESSAGE:

- THERE IS CONSIDERABLE VARIATION IN RATE OF HOSPITAL ADMISSIONS FOR SERIOUS MENTAL HEALTH PER 50 PATIENTS ON GP PRACTICE SMI REGISTERS. THE REASONS FOR THIS ARE UNCLEAR BUT INADEQUATE CASE FINDING BY GP PRACTICES MAY BE ONE EXPLANATION.

6.5.1 Emergency Hospital Admissions due to Mental Ill-health

Figure 30 depicts non-elective admissions for mental health conditions as a rate per 50 of those on the QOF mental health register. It is interesting to note that Sai Medical Centre has the 2nd lowest prevalence of depression (7%) in Tilbury and the 3rd lowest prevalence of Serious Mental Illness (0.8%), yet it has rates of mental health admissions much higher than any other practice. This might be reflected in the excess of 61 admissions for patients with a MH condition.

Figure 30: Non-elective admissions for serious mental health, Tilbury practices, 2015-16



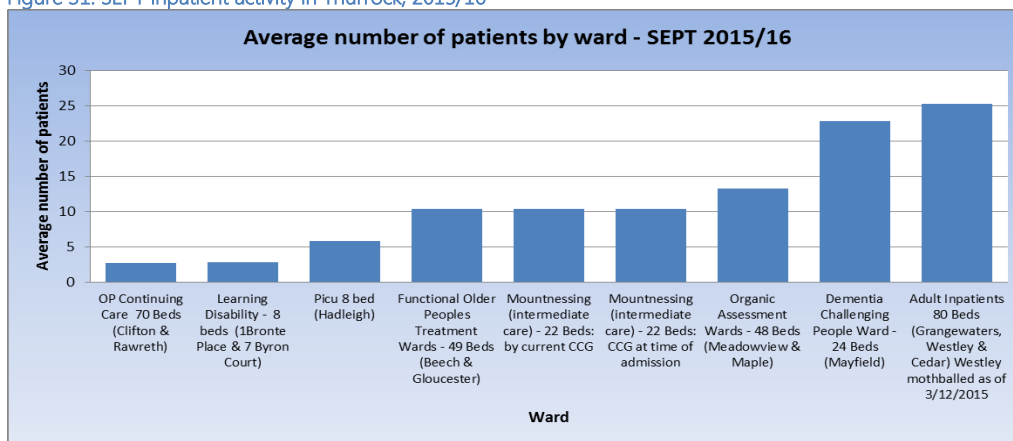
Source: Hospital Episode Statistics

6.5.2 SEPT inpatient activity

Note that the data here is presented for Thurrock as a whole.

SEPT has inpatient provision for Thurrock residents based across a wide area – i.e. they may not be placed near to their home. The figure below shows the average number of patients by the ward provision, and it can be seen that whilst Thurrock might not on average have filled a large proportion of their OP Continuing Care beds (2.7 out of 70); the Dementia Ward at Mayfield which has 24 beds had an average of 22.8 patients admitted.

Figure 31: SEPT inpatient activity in Thurrock, 2015/16



Data on the outcomes of patients who access SEPT treatment is currently being gathered.

7. Long Term Conditions Management

KEY FINDINGS:

- WHEN COMPARED TO COMPARABLE PRACTICES, MANY TILBURY PRACTICES ARE NOT MANAGING CERTAIN LONG TERM CONDITIONS PARTICULARLY WELL. THIS IS PUTTING SOME PATIENTS AT RISK OF SERIOUS HEALTH EVENTS AND DRIVING AVOIDABLE UNPLANNED CARE HOSPITAL ADMISSIONS
- THERE APPEAR TO BE VERY HIGH LEVELS OF EXCEPTION REPORTING IN SOME PRACTICES.
- CONTROL OF HYPERTENSION IS INADEQUATE IN A CONSIDERABLE COHORT OF PATIENTS WITH CARDIOVASCULAR DISEASE AND DIABETES
- CONTROL OF HbA1c NEEDS TO BE IMPROVED FOR A CONSIDERABLE COHORT OF PATIENTS WITH DIABETES AND THERE IS A NEED TO INCREASE REFERRAL OF NEWLY DIAGNOSED PATIENTS TO STRUCTURED EDUCATIONAL PROGRAMMES
- UPTAKE OF FLU VACCINATION IN PATIENTS WITH LTCs NEEDS TO BE INCREASED
- IMPLEMENTING A STRETCHED QOF PROGRAMME MAY BE HIGHLY COST EFFECTIVE IN TERMS OF CVD AND COPD CLINICAL MANAGEMENT

7.1 Introduction

In 1948 when the NHS was founded, almost half of the population died before their 65th birthday. In 2015 this figure dropped to 18%. However, although living longer, our population are increasingly doing so with long term conditions. Spend on patients with long-term conditions accounts for over 70% of the entire NHS budget. Effective management of long term conditions is absolutely vital in order to prevent patients' health, wellbeing and independence from deteriorating and to prevent them being admitted to hospital or requiring social care packages.

7.2 Management of Long Term Conditions in General Practice

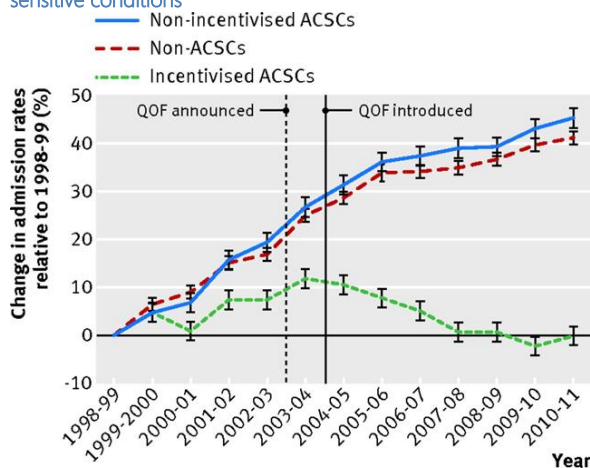
QOF records certain quality of care information on how patients who are diagnosed with diseases are treated by GP surgeries. It was set up as an incentive system and GP practices get paid for the percentage of their "diseased population" that they offer certain tests, medication reviews and treatments for. The indicators are based on evidence of good quality care for the conditions including National Institute of Health and Care Excellence (NICE) recommendations

There has been much debate over recent years whether QOF actually achieves good outcomes for patients in terms of reducing the risk of major events requiring hospitalisation. However a study published in the BMJ this year showed that nationally the introduction of QOF was in fact associated with a decrease in emergency admissions for these incentivised conditions. They also state that:

"Contemporaneous health service changes seem unlikely to have caused the sharp change in the trajectory of incentivised ACSC admissions immediately after the introduction of the Quality and Outcomes Framework. The decrease seems larger than would be expected from the changes in the process measures that were incentivised, suggesting that the pay for performance scheme may have had impacts on quality of care beyond the directly incentivised activities."ⁱⁱ

Figure 32 shows the findings from their research.

Figure 32 Effect of a national primary care pay for performance scheme on emergency hospital admissions for ambulatory care sensitive conditions



We can therefore use QOF scores as a proxy for quality of care for patients with Long-Term Conditions. We have chosen a sub-set of these indicators that are used by CQC to assess quality to give an indication of this.

We have constructed a QOF performance modelling tool which analyses the performance of the eight GP practices in Tilbury on 43 QOF indicators that consider how effective GP practices are diagnosing and managing the following 12 long term conditions:

- Hypertension
- Heart Failure
- Diabetes
- Asthma
- Depression
- Osteoporosis
- Coronary Heart Disease
- Stroke/TIA
- COPD
- Dementia
- Serious Mental Ill-health
- Rheumatoid Arthritis

For each QOF indicator within long term condition domain the modeller charts the number of patients at practice level that have received and/or been successfully treated against the indicator (shown in green), and the number who have been 'exception reported' (shown in blue). Patients who are 'exception reported' are removed from the cohort of patients relating to the indicator for the purposes of calculating incentive payments against QOF performance. QOF allows practices to 'exception report' patients only if they meet one of the following eight criteria shown in the box below:

- Acceptable Reasons for Exception Reporting a Patient in QOF**
- 1) The patient has been invited and failed to attend the surgery to receive the intervention, on at least three occasions within the financial year.
 - 2) It would not be appropriate to review the chronic disease parameter in the patient because of particular circumstances for example, the patient in terminally ill or extremely frail.
 - 3) The patient has been diagnosed with the condition or registered with the surgery within the last three months.
 - 4) The patient is on the maximum tolerated dose of a medication specified by QOF but still remains sub-optimal in terms of clinical outcome
 - 5) Prescribing the medication specified by QOF would be inappropriate because the medication is contraindicated with other medications that the patient is being prescribed or the patient has a previous history of being unable to tolerate the medication
 - 6) The patient refuses to agree to the investigation on treatment. (informed dissent)
 - 7) The patient has a supervening condition which makes treatment of their condition inappropriate through the QOF indicator inappropriate e.g. reducing cholesterol in patients with liver disease
 - 8) Where an investigative service or secondary care service specified by the QOF intervention is unavailable.

For each indicator, QOF specifies a 'maximum performance threshold' in terms of the percentage of patients within the cohort that received the intervention. GP practices do not receive further funding should they continue to treat additional patients requiring the intervention in the cohort above this performance level. The threshold varies between different indicators and is shown by the dotted red horizontal line on our QOF modeller's output. Treating additional patients above this threshold do QOF provides a maximum payment to GP practices. Practices where the green bar crosses the red horizontal maximum payment threshold have continued to treat patients, even though they received no additional financial compensation from QOF to do so.

The modeller shows the number and percentage of patients for each QOF indicator that fall into two additional groups;

- those that were not successfully treated, not exception reported but where the GP practice was still financially incentivised to treat them (shown in yellow);
- and those that were not successfully treated, and not exception reported, where the practice was not financially incentivised to treat them because they had reached or exceeded the maximum QOF payment performance threshold (shown in red).

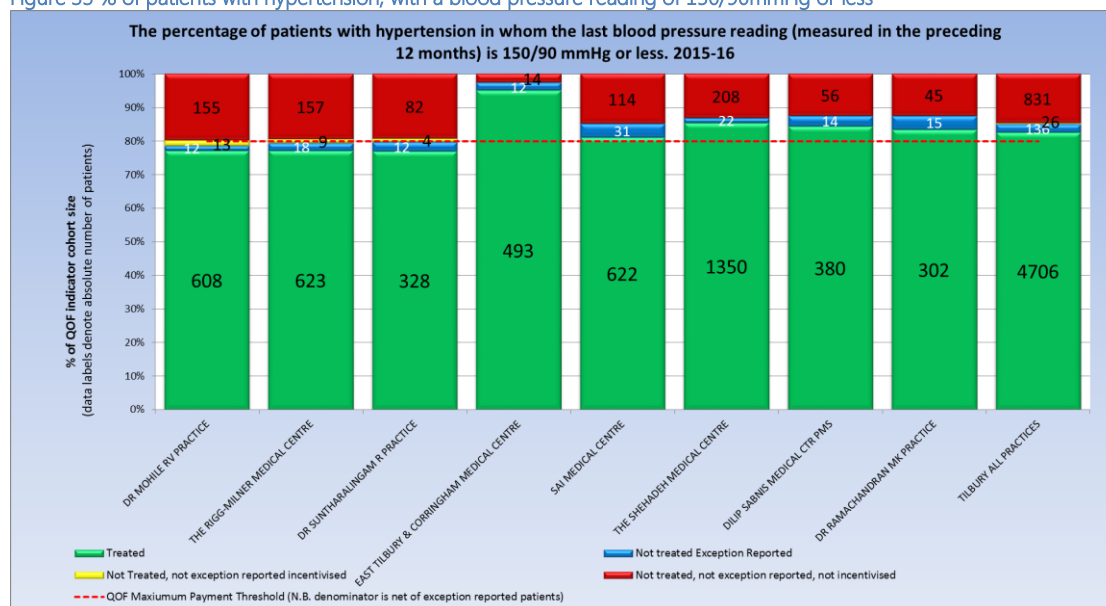
It could be suggested that a practice with a significant number of patients in the 'yellow' category has an operational resource issue, as it is failing to treat patients that it could claim additional funding for. It could also be suggested that patients that fall into the red category may not be being treated because the practice cannot afford to do so financially, as QOF is providing no additional financial incentive for treatment. Implementing further financial incentives may assist practices to treat these patients, although other factors such as lack of workforce may still be an issue.

7.2.1 Management of Hypertension

Hypertension is the most prevalent long term condition in Tilbury. Controlling blood pressure such that it is equal or below 150/90mmHg in patients with a hypertension diagnosis is key to preventing more serious cardiovascular disease and health events such as heart attacks and strokes. We estimate that one in 20 patients with uncontrolled blood pressure will have a stroke in the next three years.

Figure 33 Figure 33 shows the performance at GP practice level and for all GP practices in Tilbury on controlling blood pressure of patients diagnosed with hypertension.

Figure 33 % of patients with hypertension, with a blood pressure reading of 150/90mmHg or less



Source: QOF and Thurrock Public Health Team Modelling

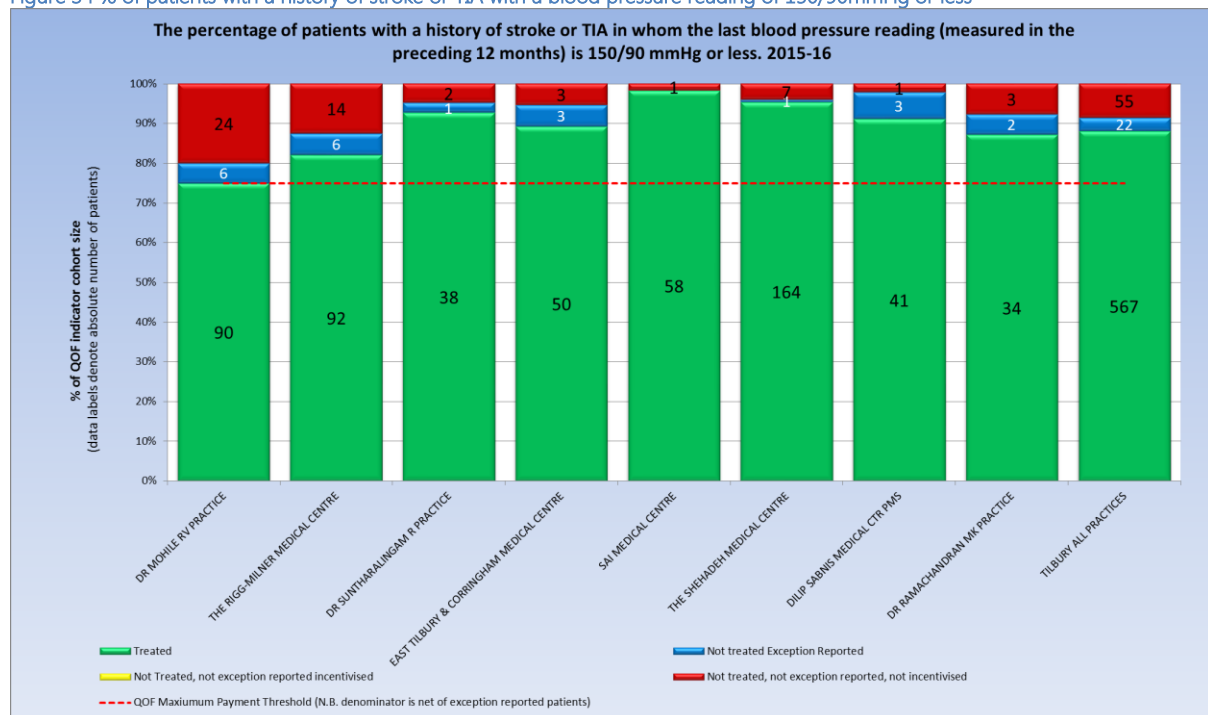
All practices except Rd. Mohile and The Rigg-Milner Medical Centre successfully treated sufficient numbers of patients diagnosed with hypertension to receive maximum QOF payment on this indicator. East Tilbury and Corringham Medical Centre went significantly above the maximum QOF threshold for treatment of high blood pressure. In total 4706 patients in Tilbury on the QOF Hypertension register had their blood pressure controlled to or below 150/90mmHg in 2015-16, however 993 patients with a hypertension diagnosis had uncontrolled high blood pressure. Of these 857 (86.3%) were not exception reported.

QOF only incentivises GPs in Tilbury to treat an additional 26 patients, leaving 831 (83.6%) untreated, not exception reported and with no financial incentive for GP practices to treat them. We predict that 171 of these patients will have a stroke in the next three years, costing the NHS £626,031 and Adult Social Care £960,165.

Implementing a 'stretched QOF' that incentivised GPs in Tilbury to treat or exception report every patient on their hypertension register would cost an additional £3,708

Figure 34 shows the performance of Tilbury GP practices in controlling high blood pressure in those patients who have a history of stroke or TIA.

Figure 34 % of patients with a history of stroke or TIA with a blood pressure reading of 150/90mmHg or less



Source: QOF and Thurrock Public Health Team Modelling

All GP practices in Tilbury successfully controlled the blood pressure of at least 70% of their patients who had a history of stroke/TIA (the maximum QOF payment threshold). However a total of 55 patients with a history of stroke/TIA did not have their blood pressure controlled and were not exception reported. Practices would have received no additional QOF funding had they treated these patients successfully, despite the fact that they are at a very high risk of having a further stroke or TIA.

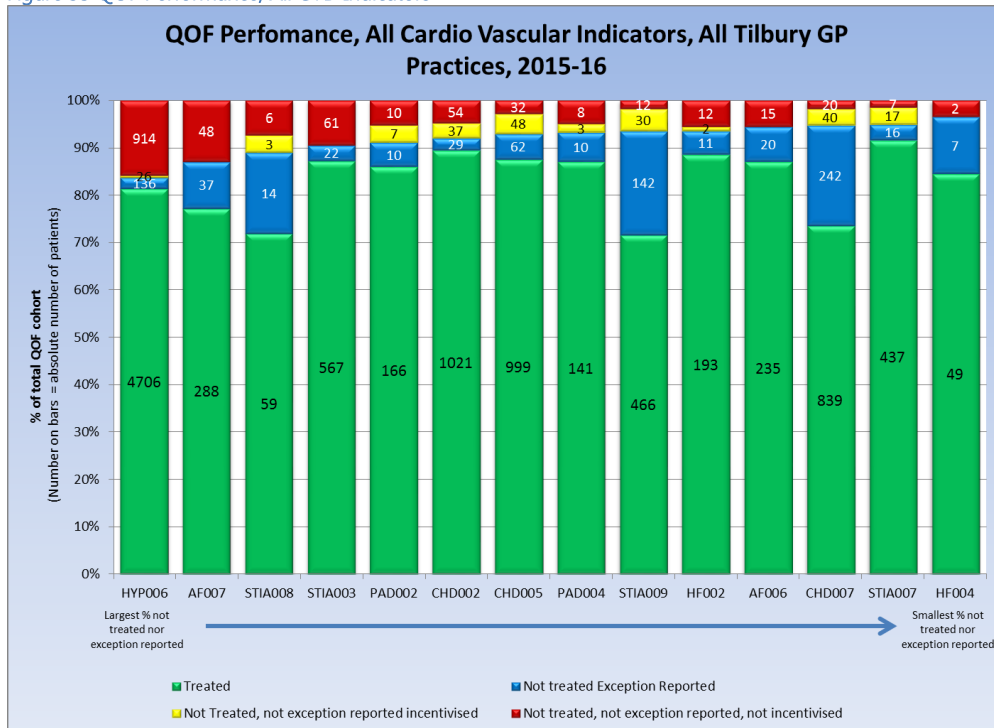
7.2.2 Management of all Cardio-Vascular Disease

QOF states that the following interventions should be carried out in GP practices for patients with Cardio-vascular disease

QOF Code	QOF Indicator
Patients on Hypertension Register	
HYP006	The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
Patients on Coronary Heart Disease Register	
CHD002	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
CHD005	The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken
CHD007	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March
Patients on the Heart Failure Disease Register	
HF002	The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register
HF004	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for Heart failure
Patients on the Atrial Fibrillation Disease Register	
AF006	% patients with AF in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)
AF007	In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy
Patients on the Peripheral Artery Disease Register	
PAD002	The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
PAD004	The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken
Patients on the Stroke/TIA Disease Register	
STIA008	The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded stroke or the first TIA
STIA003	The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
STIA007	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an antiplatelet agent, or an anti-coagulant is being taken
STIA009	The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March

Figure 35 shows the collective performance of all Tilbury GP practices on each QOF indicator in the Cardio Vascular Group in 2015-16 in terms of percentage of the total QOF cohort for each indicator treated; exception reported; not treated and not exception reported but incentivised; and not treated, not exception reported and not incentivised.

Figure 35 QOF Performance, All CVD Indicators

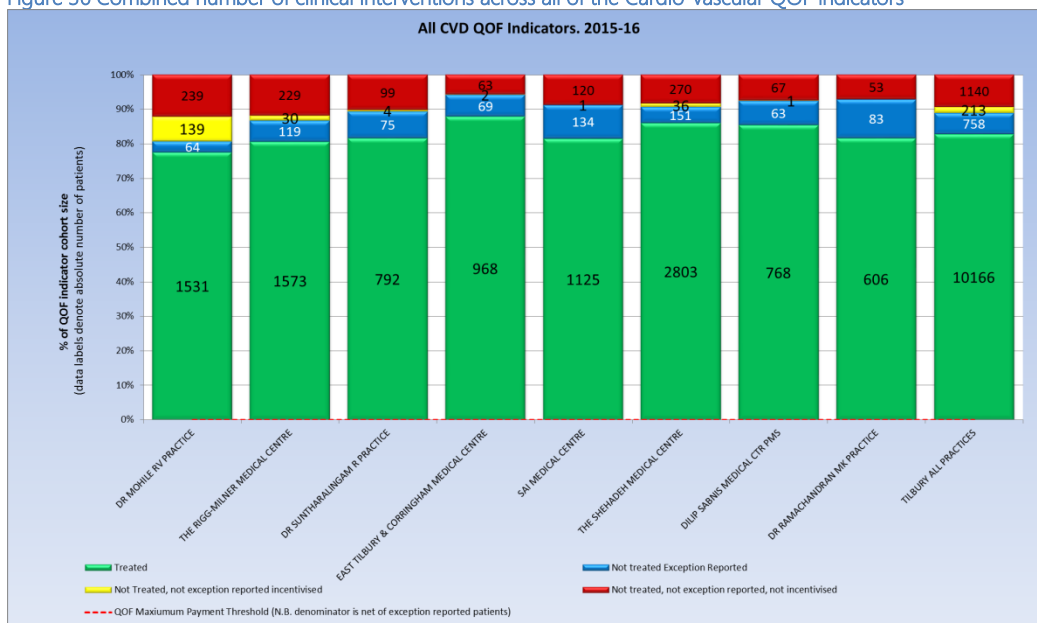


Source: QOF and Thurrock Public Health Team Modelling

HYP006 (discussed in 7.1.1), CHD002 (control of blood pressure in those with CHD), CHD005 (prescription of anti-platelet therapy to patients with CHD), STIA003 (control of blood pressure in patients with a stroke/TIA history) and CHD007 (flu immunisation) have both the largest numbers and percentages of patients of their QOF cohorts that did not receive the treatment/intervention nor were exception reported.

Figure 36 shows the combined number of clinical interventions across all of the Cardio-vascular QOF indicators delivered to patients, exception reported, not delivered and not exception reported but incentivised; and not delivered, not exception reported and not incentivised for each GP practice in Tilbury.

Figure 36 Combined number of clinical interventions across all of the Cardio-vascular QOF indicators



Source: QOF and Thurrock Public Health Team Modelling

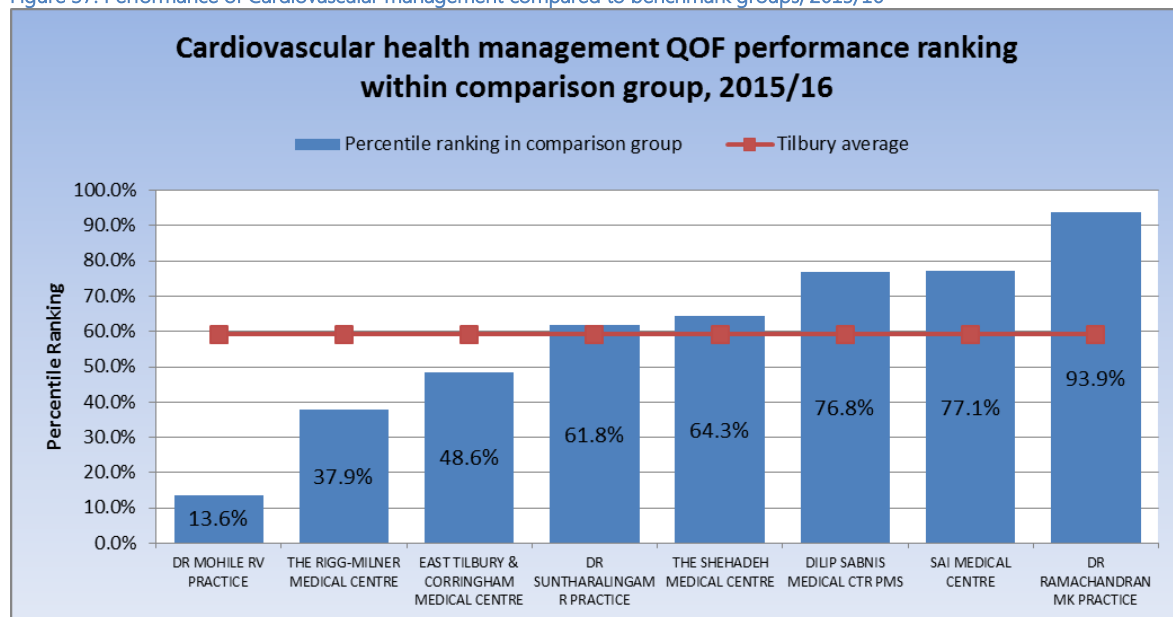
In total 2111 clinical interventions relating to the management of cardio-vascular disease were not delivered to Tilbury patients on cardiovascular disease QOF registers. Of those, only 758 (35.9%) were because the patient had been exception reported. The low percentage of patients that were not treated when QOF incentive was available may suggest that a stretched QOF for cardio-vascular disease may be an effective mechanism to improve the clinical management of these patient cohorts.

7.2.3 Benchmarking GP Performance on Cardio-Vascular Disease Management

GP surgeries provide clinical care to practice populations with significantly varying demographic characteristics in terms of variables such as age, deprivation and morbidity. As such benchmarking them against each other, or a Thurrock or England mean does not necessarily give a fair or accurate picture of a practice's success at managing a cohort of patients with a particular Long Term Condition. In order to control for such practice population differences, for each Tilbury GP practice population, the Thurrock Public Health Team have identified the 20 most similar GP practice populations in England in terms of age and deprivation demographic characteristics. Benchmarking against these 20 practice population groups provides a much more accurate comparator.

Figure 37 depicts the overall management of cardiovascular health, with each GP practice ranked within a personalized benchmark group of 20 similar practices. This shows that, for patients who are neither receiving the intervention nor exception reported, whilst practices such as Dr. Ramachandran are performing well within their benchmark group [only 6.1% of practices are performing better as he is above 93.9% of his comparator group], practices such as Dr. Mohile are not performing as well [86.4% of his benchmarked practices are performing better]. Tilbury locality as a whole is ranked better than 59.24% of practices. Further information on this can be found in the appendix ***

Figure 37: Performance of Cardiovascular management compared to benchmark groups, 2015/16



Source: QOF and Public Health Intelligence Team

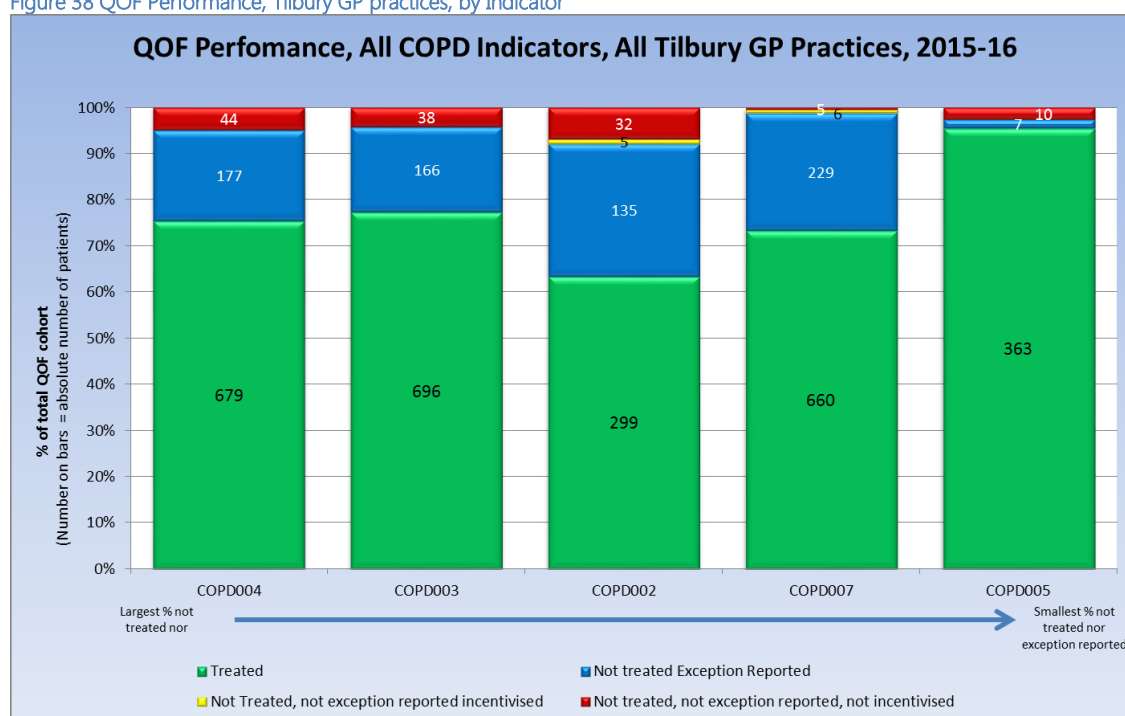
7.2.4 Management of COPD

QOF states that the following interventions should be carried out in GP practices for patients with COPD.

QOF Code	QOF Indicator
COPD002	The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register
COPD003	The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months
COPD004	The percentage of patients with COPD with a record of FEV1 in the preceding 12 months
COPD005	The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥ 3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months
COPD007	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March

Figure 38 shows the collective performance of all Tilbury GP practices on each QOF indicator in the COPD in 2015-16 in terms of percentage and number of patients in the total QOF cohort for each indicator treated; exception reported; not treated and not exception reported but incentivised; and not treated, not exception reported and not incentivised.

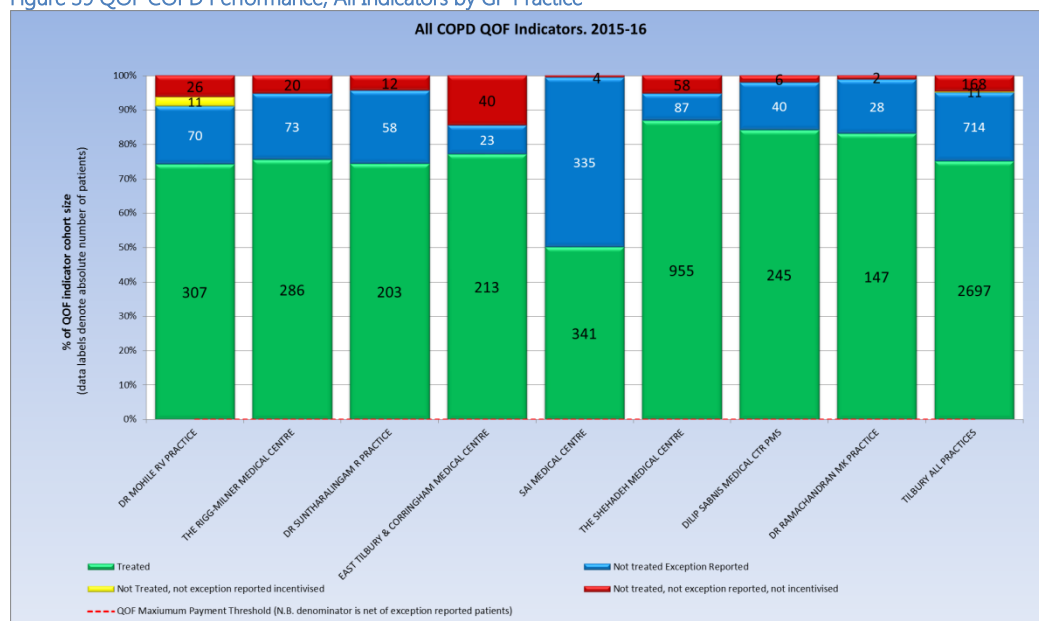
Figure 38 QOF Performance, Tilbury GP practices, by Indicator



COPD004 (recording of an FEV1 in the previous 12 months) and COPD003 (review of patient in the last 12 months including recording of an MRC score) have both the largest numbers and percentages of patients of their QOF cohorts that did not receive the treatment/intervention nor were exception reported. COPD002 (confirmation of diagnosis by post bronchodilator spirometry) and COPD007 (flu immunisation) both have high levels of exception reporting.

Figure 39 shows the combined number of clinical interventions across all of the COPD QOF indicators delivered to patients, exception reported, not delivered and not exception reported but incentivised; and not delivered, not exception reported and not incentivised for each GP practice in Tilbury.

Figure 39 QOF COPD Performance, All Indicators by GP Practice

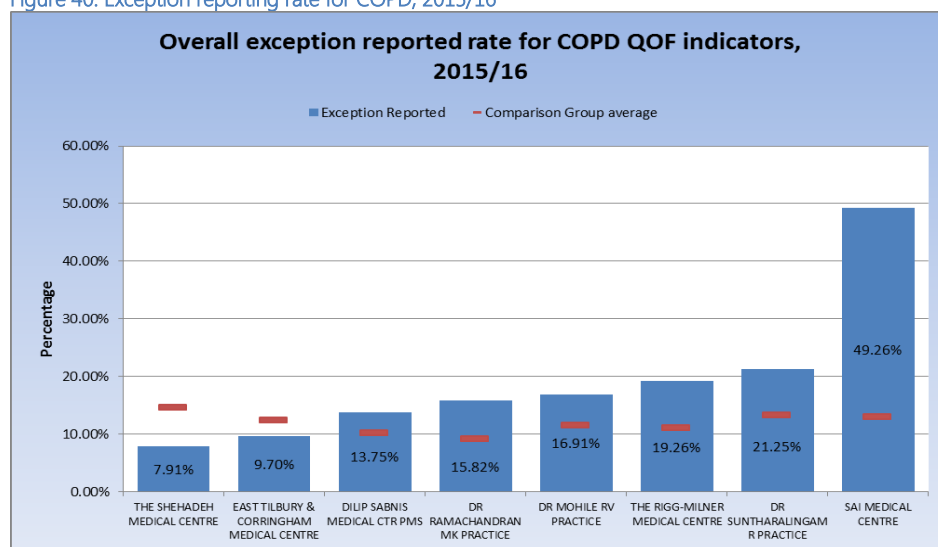


In total 893 clinical interventions relating to the management of COPD were not delivered to Tilbury patients on COPD disease QOF registers in 2015-16. Of those 714 (80%) were because the patient had been exception reported. Sai Medical Centre had a particular high level of exception reporting. Almost half of clinical interventions were not delivered because the patient had been exception reported. The low levels of patients not treated whilst still being incentivised would suggest that a stretched QOF for COPD may be an effective way improving the clinical management of COPD.

7.2.5 Benchmarking GP Performance on COPD Management

Figure 40 shows variation in exception reporting across the COPD indicators, with each practice compared to the average of their England GP practice population group (methodology described in Section 7.2.3). It can be seen that whilst the Shehadeh Medical Centre has an exception rate of nearly half its comparator group (7.91% compared to 14.56%), practices such as Sai Medical Centre have high levels of exception reporting (49.26% compared to 13.00%) against their comparator group. Further information on this can be found in the appendix ***

Figure 40: Exception reporting rate for COPD, 2015/16



Source: QOF and Public Health Intelligence Team

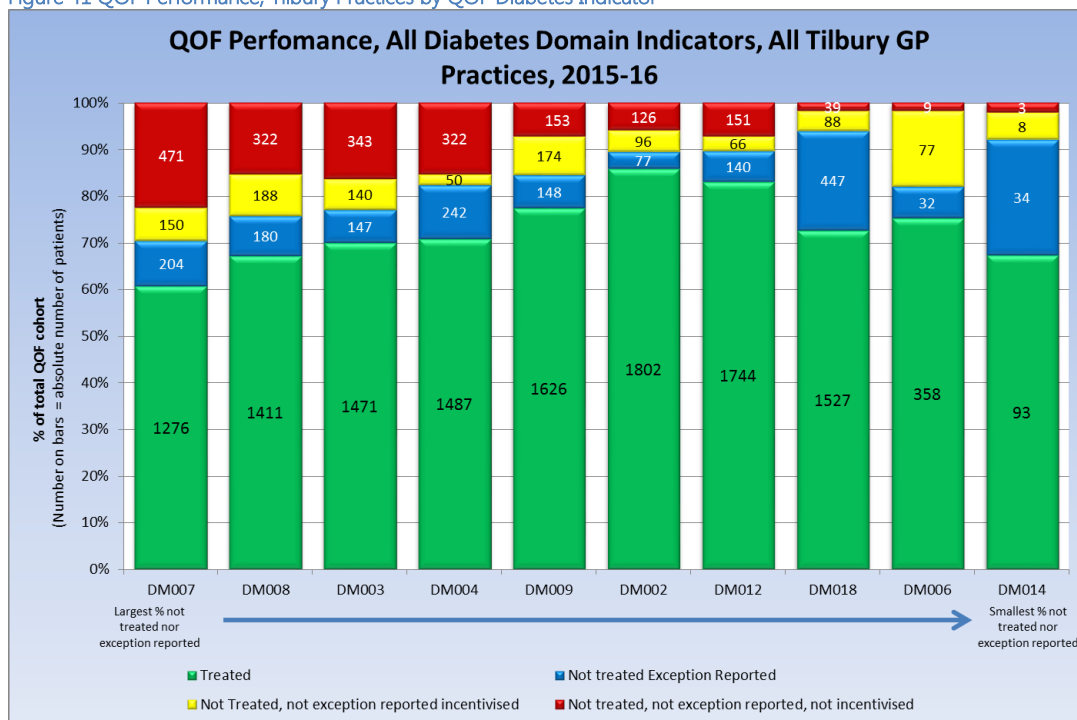
7.2.6 Management of Diabetes

QOF states that the following interventions should be carried out in GP practices for patients with diabetes.

QOF Code	QOF Indicator
DM002	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less
DM003	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less
DM004	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less
DM006	The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)
DM007	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months
DM008	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months
DM009	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months
DM012	% diabetes patients, with a record of a foot examination and risk classification: within the preceding 12 months
DM014	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register
DM018	The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March

Figure 41 shows the collective performance of all Tilbury GP practices on each QOF indicator in the Diabetes domain in 2015-16 in terms of percentage and number of patients within the total QOF cohort for each indicator treated; exception reported; not treated and not exception reported but incentivised; and not treated, not exception reported and not incentivised.

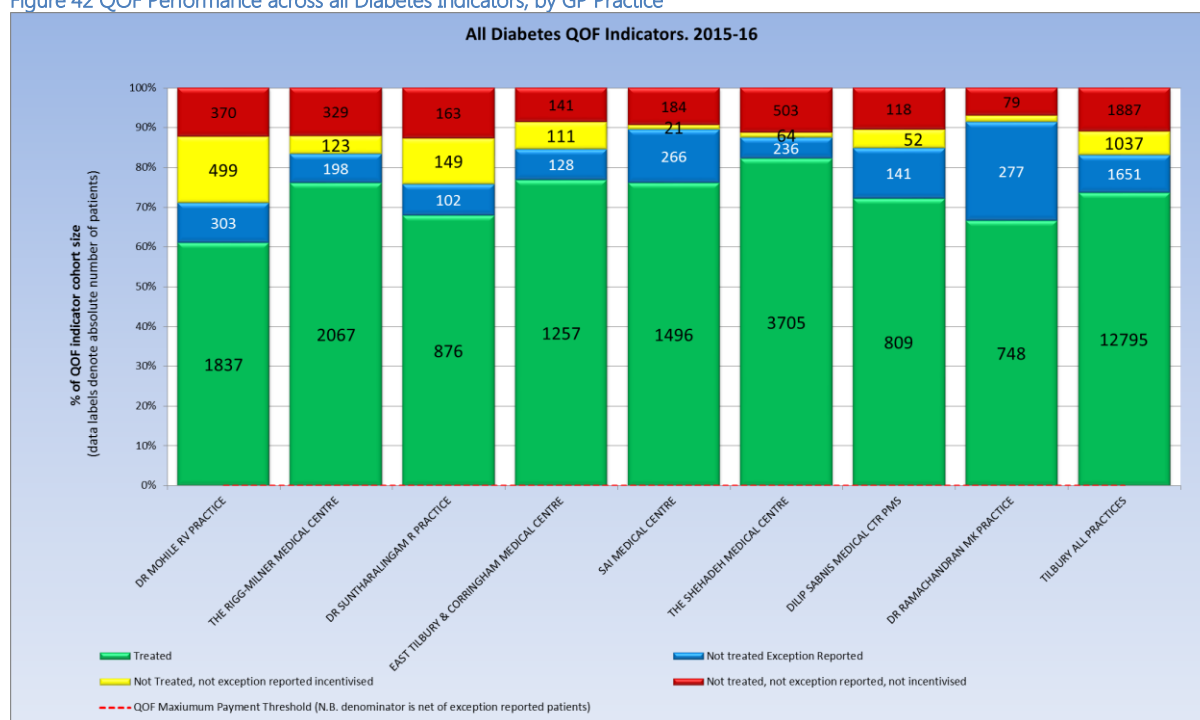
Figure 41 QOF Performance, Tilbury Practices by QOF Diabetes Indicator



DM007 and DM008 (control of HbA1c), and DM003 (control of high blood pressure) have the largest percentages and absolute numbers of patients within their QOF cohorts that did not receive the treatment/intervention nor were exception reported. There is a high percentage of exception reporting on DM018 (flu vaccination) and DM014 (newly diagnosed patients who have been referred to a structured education programme within nine months of diagnosis).

Figure 42 shows the combined number of clinical interventions across all of the Diabetes QOF indicators delivered to patients, exception reported, not delivered and not exception reported but incentivised; and not delivered, not exception reported and not incentivised for each GP practice in Tilbury.

Figure 42 QOF Performance across all Diabetes Indicators, by GP Practice



In total 4575 clinical interventions relating to the management of diabetes were not delivered to Tilbury patients on diabetes disease QOF registers in 2015-16. Of those only 1651 (35.5%) were because the patient had been exception reported. Dr. Mohile's and Dr. Suntharalingam's GP practices had higher percentages of patients that remained untreated despite QOF incentive payments being available. Dr. Ramachandran's practice had a higher level of exception reporting compared to other GP surgeries in Tilbury. These data suggest that operational capacity in terms of diabetes clinical management is an issue for all GP practices in Tilbury to some extent.

7.2.7 Conclusions: Long Term Conditions Management in General Practice

- There are significant numbers of patients on the Hypertension, CHD, Stroke and Diabetes Registers with blood pressure that is uncontrolled. Programmes to address this will significantly reduce the risk of serious health events and unplanned hospital admissions.^{1 2 3 4}
- Control of HbA1c for patients with diabetes needs to be improved for a significant cohort of patients in Tilbury.⁵

¹ NICE CG127. Hypertension: clinical management of primary hypertension in adults. 2011. <http://publications.nice.org.uk/hypertension-cg127>

² Collins et al. Lancet 1990; 335: 827-38

³ PROGRESS collaborative group. Lancet. 2001; 358: 1033-41

⁴ NICE 2010 menu ID NM01

⁵ . <http://guidance.nice.org.uk/CG87> <http://guidance.nice.org.uk/CG15>

- There is a need to increase referral of patients newly diagnosed with diabetes to structured education programmes. There is good evidence that patients who have a good understanding of their long term conditions are able to self-care more effectively and have both better outcomes and a lower usage of clinical services.⁶
- Flu vaccination uptake needs to be improved. Evidence suggests that vaccination that protects patients with LTCs against flu against can prevent serious health complications.⁷
- 2015-16 QOF performance data suggests that operational capacity to improve the clinical management of patients with diabetes within GP practices needs to be improved
- Exception rate reporting Sai Medical Centre and for COPD and CVD patients, and at Ramachandran's surgery for CVD patients is high and warrants further investigation
- Operational capacity at Dr. Mohile's practice for CVD clinical management needs to be improved
- Implementing a stretched QOF may be highly cost effective in terms of CVD and COPD clinical management

7.3 Interface between GP Surgeries and Community LTC management services

KEY FINDING:

- LONG TERM CONDITION MANAGEMENT OF TILBURY PATIENTS BY GP SURGERIES AND COMMUNITY SERVICES IS NOT SUFFICIENTLY INTEGRATED AND AS SUCH PATIENTS DON'T ALWAYS ACCESS SERVICES DESIGNED TO HELP THEM MANAGE THEIR LONG TERM CONDITIONS

A variety of community based Long Term Condition Management services are commissioned by NHS Thurrock CCG and provided by NELFT (or in the case of IAPT services, Inclusion Thurrock), to assist GP practices to manage patients with long term conditions. These include services to manage patients with COPD, Diabetes, Stroke, Heart Failure and Depression. However referral rates of patients into these services from General Practices is both variable and lower than could be considered optimum. Three examples are given below, and more detailed analyses provided in Appendix ***

7.3.1 Referral of Patients with COPD into the Community Respiratory Service provided by NELFT.

NELFT provide an Integrated Respiratory Service which provides proactive chronic disease management services with support for patients and carers, to enable self-management and provide access to a specialist review and advice. Pulmonary Rehabilitation is one component of this service which patients can access if they are assessed to have an MRC score of 3 or greater. In 2015-16, NELFT received 90 referrals for Pulmonary Rehabilitation from Tilbury practices. However, auditing the GP registers for COPD indicated there were 424 patients who had a new MRC score of 3 or greater recorded in 2015-16 in Tilbury practices who would therefore be eligible for a referral to, and would benefit from a Pulmonary Rehabilitation Programme.

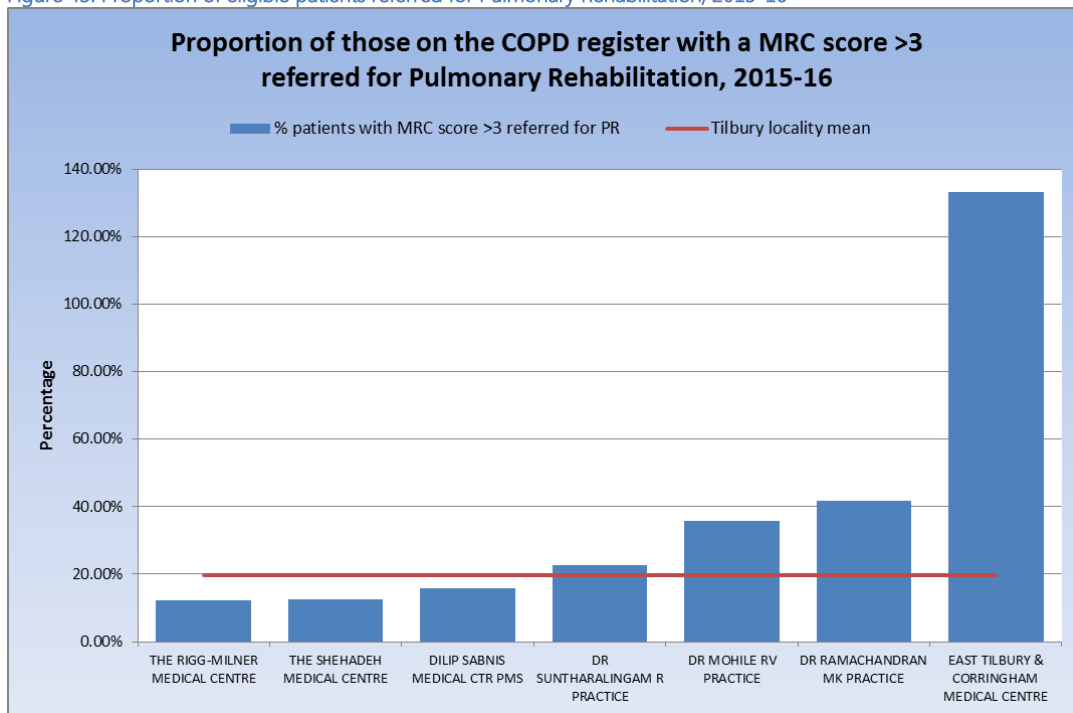
Figure 43 shows the percentage of patients on each Tilbury GP practice COPD register eligible for a referral into the Pulmonary Rehabilitation service that were referred in 2015-16. There is significant variation in referral rates between the eight GP practices, with a mean referral rate of 20% of eligible patients. The reasons for both the low overall referral rate and the variation are unclear. Possible explanations could include poor clinical practice in Primary Care; difficulty in accessing the service by patients; a refusal by patients to accept an offer of referral; a high DNA rate by referred patients; or inadequate capacity within the commissioned service.

⁶ NICE 2011 menuID:NM27

⁷ <https://www.gov.uk/government/publications/flu-immunisation-programme-2014-to-2015>

It can however be concluded that the interface between GP practices, patients with COPD and the Community Respiratory Team is not working at a level to deliver optimum population health outcomes for patients with clinically advanced COPD, putting them at increased risk of unplanned hospital attendances and admissions.

Figure 43: Proportion of eligible patients referred for Pulmonary Rehabilitation, 2015-16



Source: SystmOne and NELFT

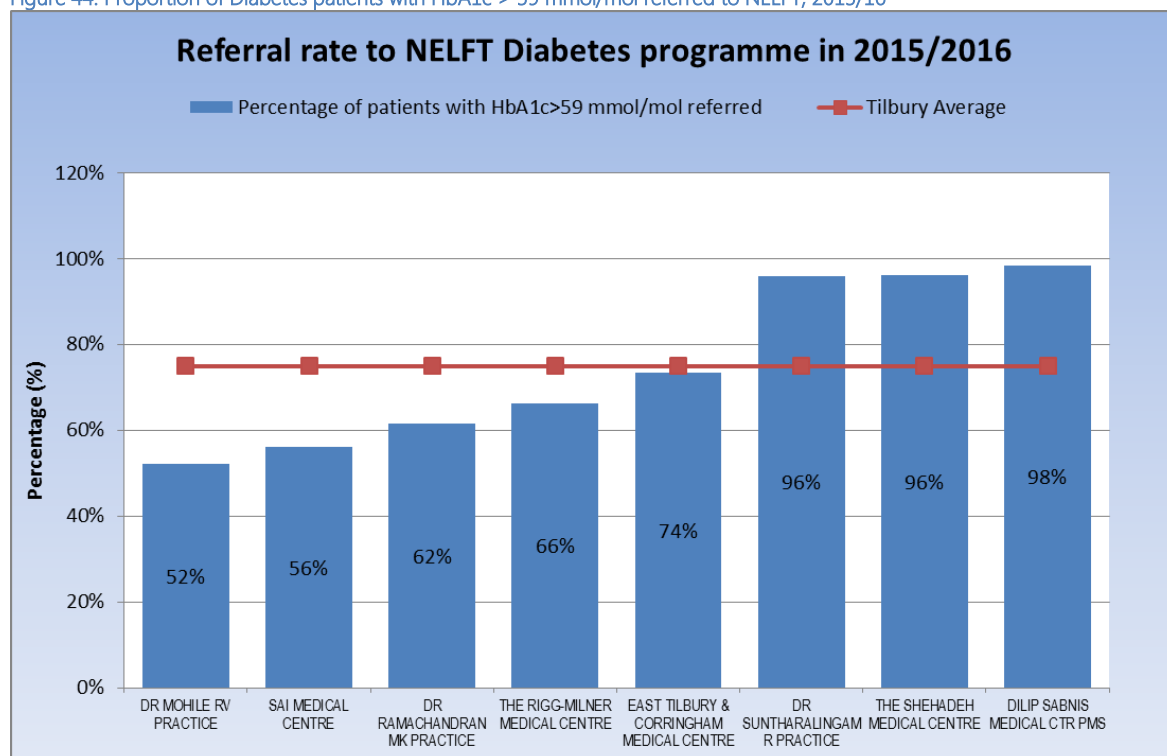
7.3.2 Referral of Patients with Diabetes into the Community Diabetes Service

NELFT offers expert advice, support and education around medication, diet and lifestyle for patients with Diabetes Type I and Type II. They use an individual approach, offering personal plans of care and goals for each patient. This support service contributes towards reducing health inequalities for people living with diabetes, improve patient experience, improve outcomes through reducing complications that arise from poor control and support end of life care associated with the management of diabetes. The overall outcome for the service is to enhance a patient's quality of life, improve their physical health and optimise their social and psychological well-being and reduce acute admissions.

Patients with diabetes meet the referral criteria for the Community Diabetes Service if they have an HbA1c level above 59mmol/mol on at least two maximised oral diabetes medications

In Tilbury locality the average referral rate of the patients with diabetes (and HbA1c higher than 59 mmol/mol) to the NELFT Diabetes Support programme in 2015/2016 was 75%. Again, there is a high variation across practices, with Dr. Suntharalingam, the Shehadeh Medical Centre and Dilip Sabnis Medical Centre referring more than 96% of their patients with uncontrolled blood glucose levels, while Dr. Mohile's Practice referred only 52% of them. This means 73 of Dr. Mohile's patients had uncontrolled levels of blood glucose and weren't referred to any diabetes programmes for support. **In total, 216 patients from Tilbury had higher levels of HbA1c than recommended in 2015/2016 and weren't referred to the Community Diabetes Service.** This suggests that integration between this service and some GP practices in Tilbury needs to be improved and that some patients with diabetes at increased risk of more serious complications are not getting the best possible clinical management of their condition.

Figure 44: Proportion of Diabetes patients with HbA1c > 59 mmol/mol referred to NELFT, 2015/16



Source: NELFT and QOF

Further analyses of this issue can be found in Supplementary Data Pack.

7.3.3 Interface between GP Surgeries and IAPT

KEY FINDINGS

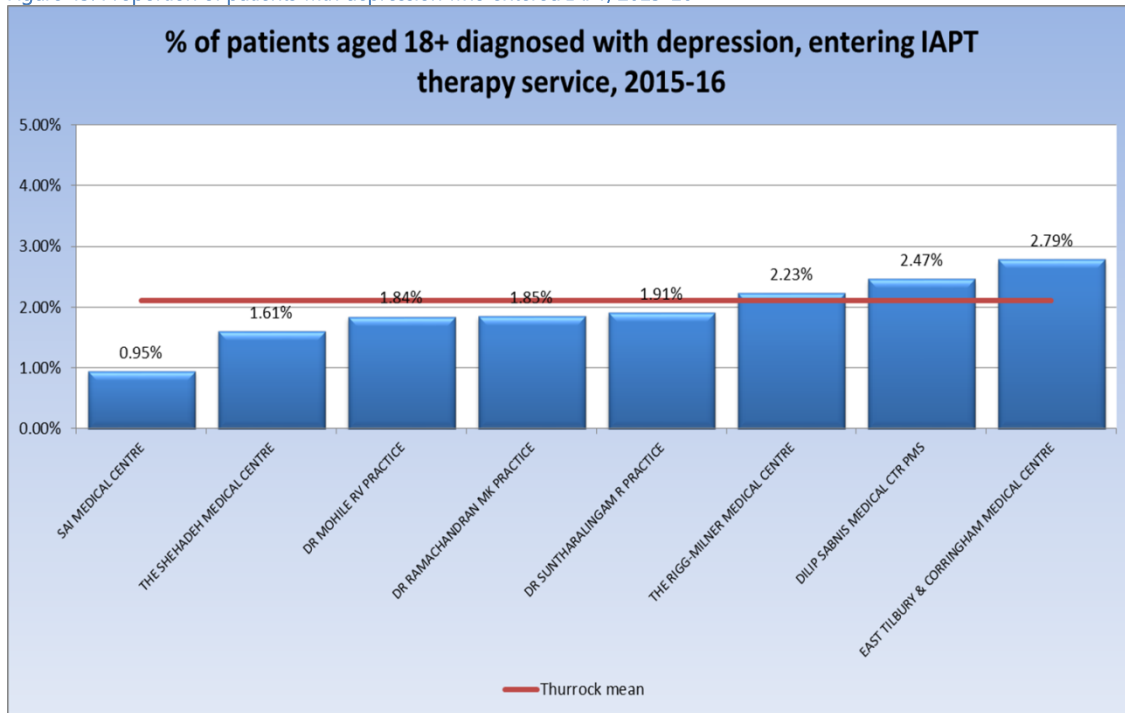
- RATE OF ACCESS TO IAPT SERVICES PROVIDED IN 2015-16 BY PATIENTS IN TILBURY WITH A DIAGNOSIS OF DEPRESSION WAS VERY LOW ALTHOUGH THESE DATA MAY NOT REFLECT THE CURRENT SITUATION.
- FURTHER ANALYSIS OF 2016-17 DATA SHOULD BE UNDERTAKEN ONCE AVAILABLE TO ASCERTAIN ACCESS TO AND EFFECTIVENESS OF IAPT SERVICES

Section 3.3.2 highlighted the high prevalence of both diagnosed and undiagnosed depression in Tilbury. IAPT (Increasing Access to Psychological Therapies) is a service that since April 2016 has provided by Inclusion Thurrock. The provider offers a range of talking therapies and a Recovery College to treat patients with depression. **The data within this report relates to the previous financial year, prior to the current service being provided and therefore should not be considered to necessarily reflect the current situation, as the previous provider did not provide IAPT services from locations in Tilbury.**

In 2015-16, 520 patients from the Tilbury practices entered IAPT. Using the number of patients registered to have depression as a denominator,

Figure 45 demonstrates that a very small proportion of patients who could benefit from accessing the service did so in 2015-16 and that the rate of access varies considerable between different GP practice populations with a diagnosis of depression.

Figure 45: Proportion of patients with depression who entered IAPT, 2015-16



Source: QOF and IAPT

Within the locality, it appears that East Tilbury & Corringham Medical Centre had the highest proportion of Depression patients entering IAPT (2.79%) and Sai Medical Centre and the lowest (0.95%).

Like Pulmonary Rehabilitation, the reasons for this are unclear and could include reluctance from patients to access the services on offer; difficulty by patients in accessing the service; lack of awareness of the service; a poor previous experience by patients of accessing a talking therapy service; or low referral rates by GP practices. It is worth noting that patients can both self-refer to IAPT, or be referred by their GP following diagnosis of depression or anxiety.

8. Early Identification of Long Term Conditions

8.1 Case Finding of Patients with undiagnosed Long Term Conditions (LTCs)

KEY FINDINGS

- THERE ARE A SIGNIFICANT NUMBER OF PEOPLE IN TILBURY WITH UNDIAGNOSED STROKE, HYPERTENSION, CHD AND DEPRESSION WHO WILL NOT BE RECEIVING TREATMENT AND WILL BE AT INCREASED RISK OF SERIOUS HEALTH EVENTS
- PATIENTS WITH EXISTING DIAGNOSED PHYSICAL LTCs ARE AT MUCH GREATER RISK OF HAVING DEPRESSION AND AS SUCH SCREENING OF PATIENTS ON EXISTING QOF DISEASE REGISTERS FOR DEPRESSION IS IMPORTANT
- CASE FINDING AND TREATING THESE COHORT OF PATIENTS IS HIGHLY COST EFFECTIVE AND WILL MAKE THE HEALTH AND SOCIAL CARE SYSTEM BOTH OPERATIONALLY AND FINANCIALLY MORE SUSTAINABLE, AND IMPROVE PUBLIC HEALTH
- THERE IS VARIATION BETWEEN DIFFERENT PRACTICE POPULATIONS IN TILBURY ACROSS ALL LTCs

Whilst there are a large number of patients diagnosed with long term conditions in Tilbury, it can also be demonstrated that there are significant numbers of people with long term conditions who have not yet been diagnosed. Identifying patients with long term health conditions who are unaware that they have them is an absolutely key Public Health priority, if we are going to intervene early with excellent clinical management to prevent chronic diseases progressing and patients' health deteriorating. Using the *expected prevalence* figures developed by Imperial College London and referenced in the 2016 Annual Public Health Report, it can be seen in the table below that for the majority of conditions, there appear to be a number of undiagnosed patients for stroke, hypertension, CHD and depression. It is interesting to note that Tilbury practices as a whole appear to be diagnosing more cases of COPD than the modelled estimate, resulting in an 'over-diagnosis' of nine patients across the locality. This is not in line with the rest of the borough, with the Thurrock-wide analyses in the Annual Public Health Report estimating an additional 642 COPD patients yet to be diagnosed.

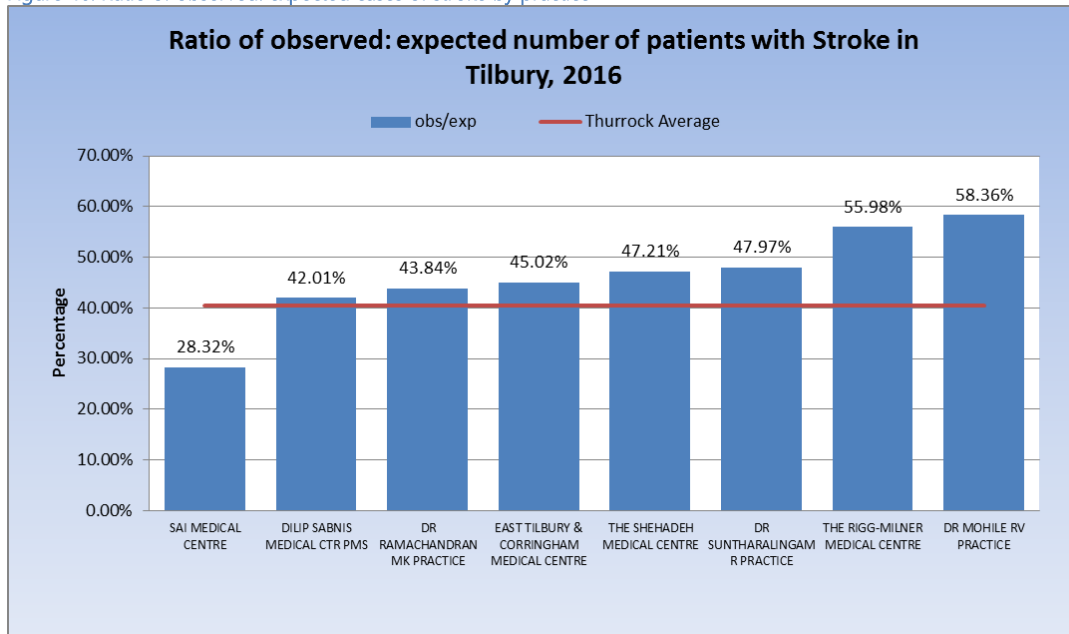
Table 8: Observed and Expected patient numbers, Tilbury locality

Condition	Observed number of patients	Total estimated number of patients	Additional Number of Undiagnosed Patients based on the estimated prevalence
Stroke (2016)	650	1,398	748
Hypertension (2016)	5,782	7,977	2,195
CHD (2016)	1,141	2,790	1,649
COPD (2016)	900	891	-9
Depression(2016)	3,034	4,754	1,720

Source: QOF register 2015/16 and PHE estimates 2016

The figures below show the ratio between those who have been diagnosed and are receiving clinical management and treatment for their Long Term Condition, and those who have not been diagnosed and will therefore not be receiving treatment. This ratio is also known as the "Completeness of the Disease Register". Figure 46 shows Stroke patients by GP practice, and it can be seen that, this is lowest in Sai Medical Centre (28.32%) This stroke register can therefore be said to be highly incomplete. The Thurrock ratio of observed: expected patients is 40.37% - meaning that there is a large gap between the diagnosed and likely undiagnosed stroke patients of the borough.

Figure 46: Ratio of observed: expected cases of stroke by practice

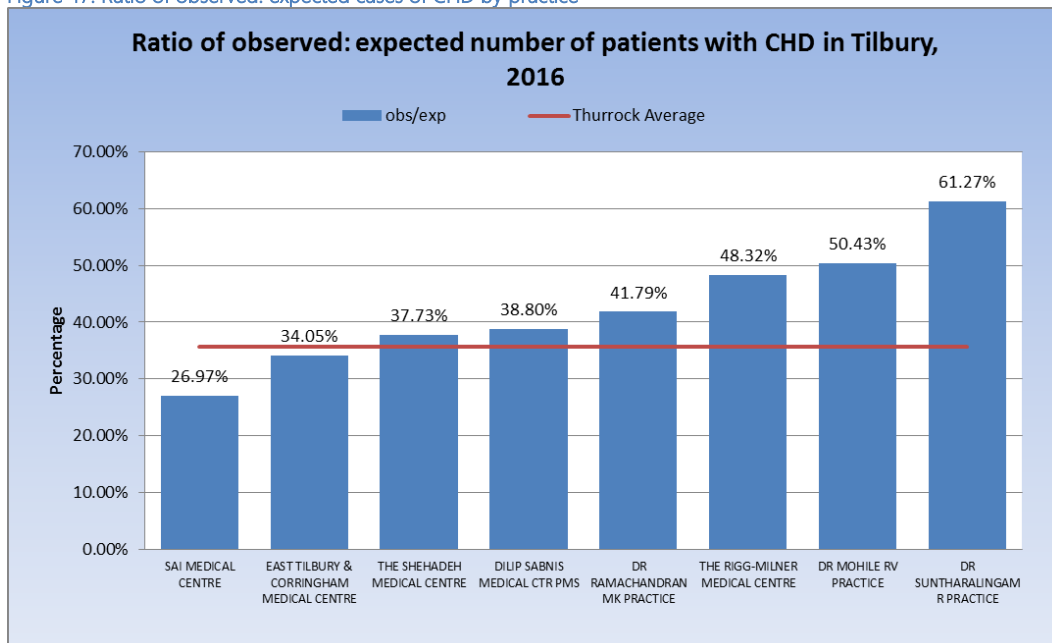


Sources = QOF register 2015/16 and PHE estimates 2016

Patients who have had a stroke or TIA are ten times more likely to have another stroke compared to someone of the same age without a history of a stroke. It is therefore extremely important to diagnose and clinically manage patients with undiagnosed stroke/TIA.

Figure 47 shows the ratio between observed and expected numbers of patients with CHD, and it is again Sai Medical Centre which has observed/diagnosed the lowest proportion of expected patients in Tilbury. The Thurrock ratio of observed: expected patients is 36.89% - meaning that there is a large gap between the diagnosed and likely undiagnosed CHD patients of the borough.

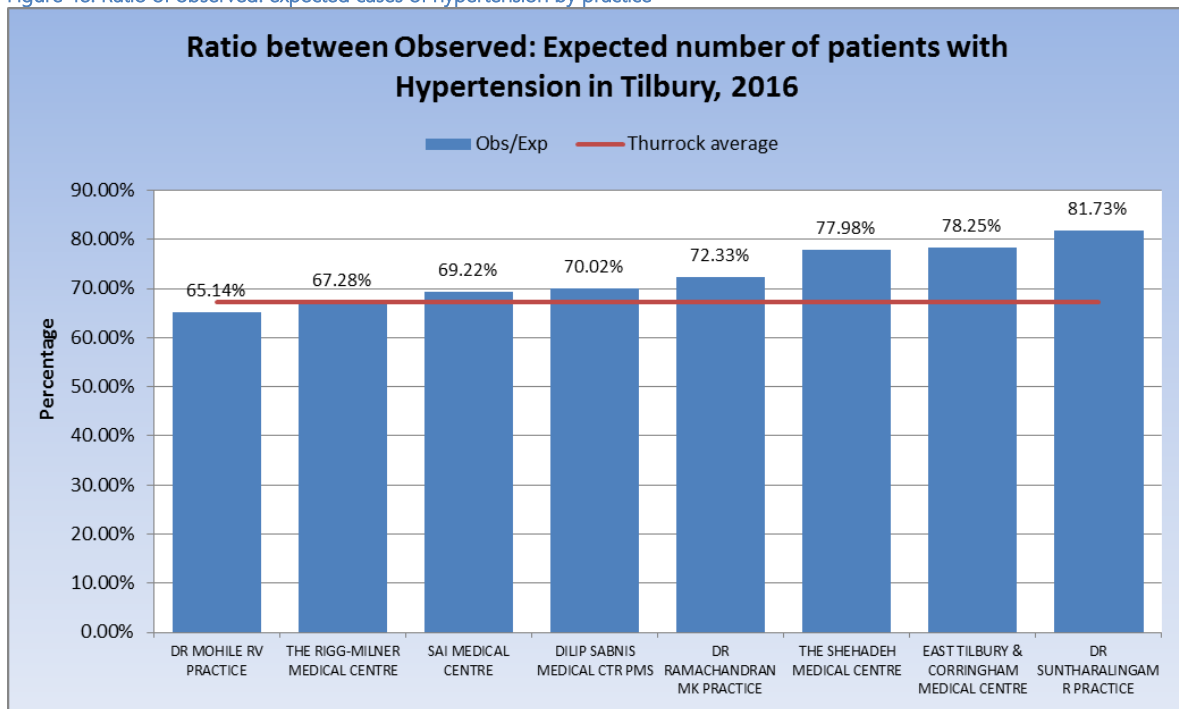
Figure 47: Ratio of observed: expected cases of CHD by practice



Sources = QOF register 2015/16 and PHE estimates 2016

Figure 48 shows observed: expected hypertension patients by GP, and it can be seen that Dr Mohile has the lowest ratio in Tilbury. And as with CHD above, Dr Suntharalingham appears to be case finding at a fairly high rate. The majority of Tilbury practices appear to be case-finding at a similar rate to the Thurrock average of 68.34%.

Figure 48: Ratio of observed: expected cases of hypertension by practice

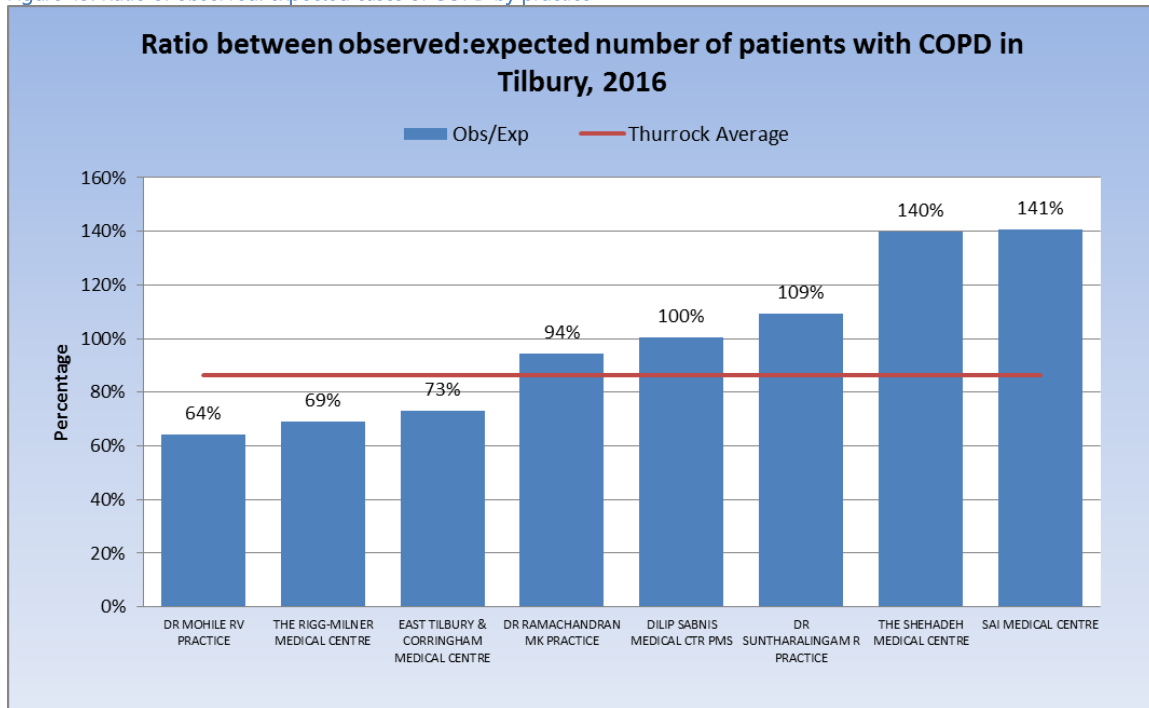


Sources = QOF register 2015/16 and PHE estimates 2016

Multiple Regression Analysis Modelling by the Thurrock Public Health Team concluded that 1 in 20 patients with undiagnosed hypertension will have a stroke within the next three years. For Tilbury, this equates to 110 preventable strokes over the next three years which would save the NHS £403K and Adult Social Care £618K. Identifying and treating patients with high blood pressure is therefore both highly cost effective and will significantly reduce stroke risk.

Error! Not a valid bookmark self-reference. shows observed: expected COPD patients by GP, and it can be seen that of the 8 Tilbury practices, four have diagnosed the modelled number or greater number of patients, with Dr Shehadeh and Sai Medical Centre having ratios of 140% and 141% respectively. This may suggest variation in clinical practice in terms of diagnosis of COPD.

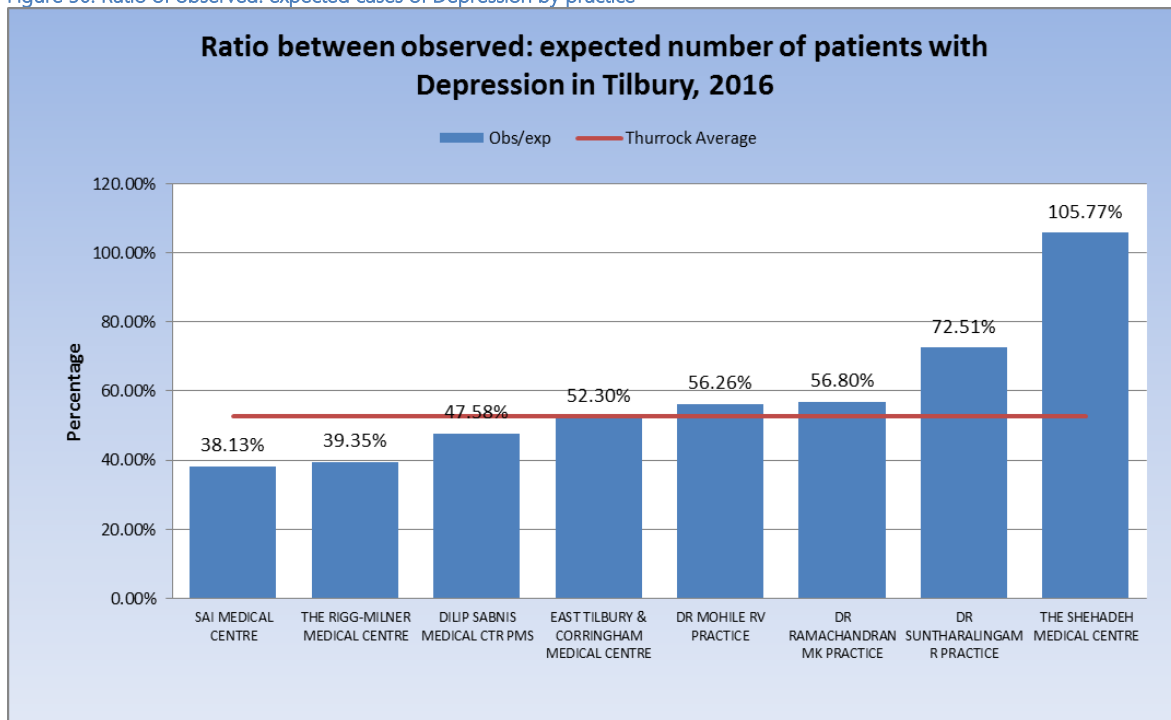
Figure 49: Ratio of observed: expected cases of COPD by practice



Sources = QOF register 2015/16 and PHE estimates 2016

Figure 50 shows observed: expected Depression patients by GP, and it can be seen that this ranges quite broadly within Tilbury – Sai Medical Centre has a ratio of 38.13% whilst Dr Shehadeh has a ratio of 105.77%.

Figure 50: Ratio of observed: expected cases of Depression by practice



Sources = QOF register 2015/16 and PHE estimates 2016

The Kings Fund estimate that 46% of people with depression also have one or more other physical long term conditions.⁸ Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including significantly poorer clinical outcomes, increased morbidity and mortality, a lower quality of life and reduced ability to manage physical symptoms effectively. This in turn has a significant negative impact on system sustainability due to higher usage and cost of health and social care services.

Increased treatment costs of physical LTCs for patients with co-morbid depression and anxiety range from 35% to 168% depending on the long-term condition studied. It is therefore vital to identify and treat patients with undiagnosed depression, both in public health terms and as a way of reducing financial and operational demand on the local health and care system.

8.2 Health Checks

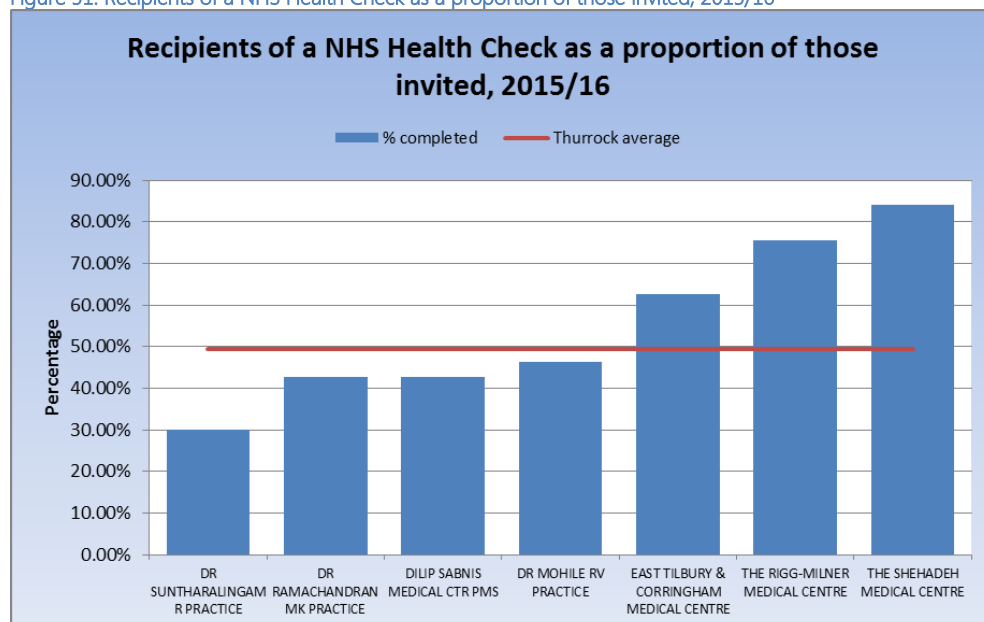
KEY FINDING:

- WE NEED TO PROMOTE HEALTH CHECK UPTAKE IN CERTAIN PRACTICES AS AN OPPORTUNITY TO INCREASE DIAGNOSES OF LTCS

NHS Health Checks are offered for those aged 40-74 years inclusive without a pre-existing long term condition. The aim of the programme is both to identify patients with undiagnosed LTCs and those with lifestyle or clinical biomarkers that put them at increased risk of developing a LTC in the future.

The outcomes of Health Checks at Tilbury level is largely unknown, as the most robust data recording centres around the national targets which concentrate on invites and uptake. Data taken from SystmOne covers the majority of practices in Tilbury locality – with the exception of Sai Medical Centre who does not use this system. Almost half of those across Thurrock invited for a Health Check in 2015/16 attended (49.38%). When looking at the data for the seven Tilbury practices, this varies from 30.00% (Dr Suntharalingham) to 83.98% (The Shehadeh Medical Centre).

Figure 51: Recipients of a NHS Health Check as a proportion of those invited, 2015/16



Source: SystmOne

As one of the only non-cancer systematic case finding programmes for LTCs it is imperative that we increase the uptake of Health Checks in Tilbury.

⁸ Naylor et. Al.

8.3 Cancer Screening

KEY FINDING:

- SCREENING RATES FOR BREAST AND BOWEL CANCERS ARE BELOW THE NATIONAL AVERAGE, AND THERE IS WIDE VARIATION AT PRACTICE LEVEL IN TILBURY.

Cancer screening coverage for breast and bowel cancers is significantly lower in Thurrock than the national average. Within Tilbury, the average is slightly worse again, although there is a large amount of practice-level variation (see figures x-x in appendix). The table below shows average coverage for the three main screening programmes in Tilbury, Thurrock and England.

Table 9: Cancer Screening Coverage in Tilbury, Thurrock and England, 2015/16

Cancer Screening Programme	Breast	Bowel	Cervical
Tilbury locality average	60.6%	48.2%	69.4%
Thurrock average	63.4%	50.9%	72.6%
England average	72.5%	57.8%	72.8%

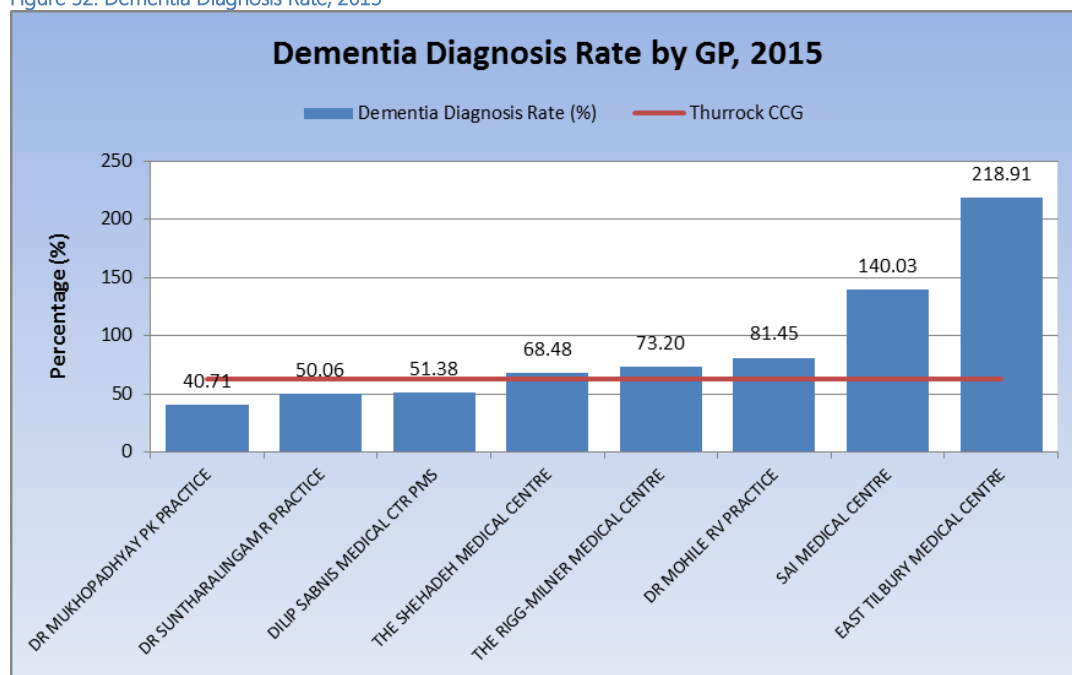
8.4 Dementia Diagnosis and Support

KEY FINDING:

- CASE FINDING OF DEMENTIA IN TILBURY APPEARS TO BE VARIED, WITH SOME PRACTICES DIAGNOSING MORE THAN THE ESTIMATED NUMBER.

Identification of dementia appears to range quite significantly within the Tilbury locality area. As with section 8.1 above, comparing actual diagnoses to expected figures generates practice-level variation, with three of the Tilbury practices appearing to diagnose around half of the expected number of patients, and two practices (Sai Medical Centre and East Tilbury Medical Centre) appearing to diagnose more patients than expected (140.03% and 218.91% respectively).

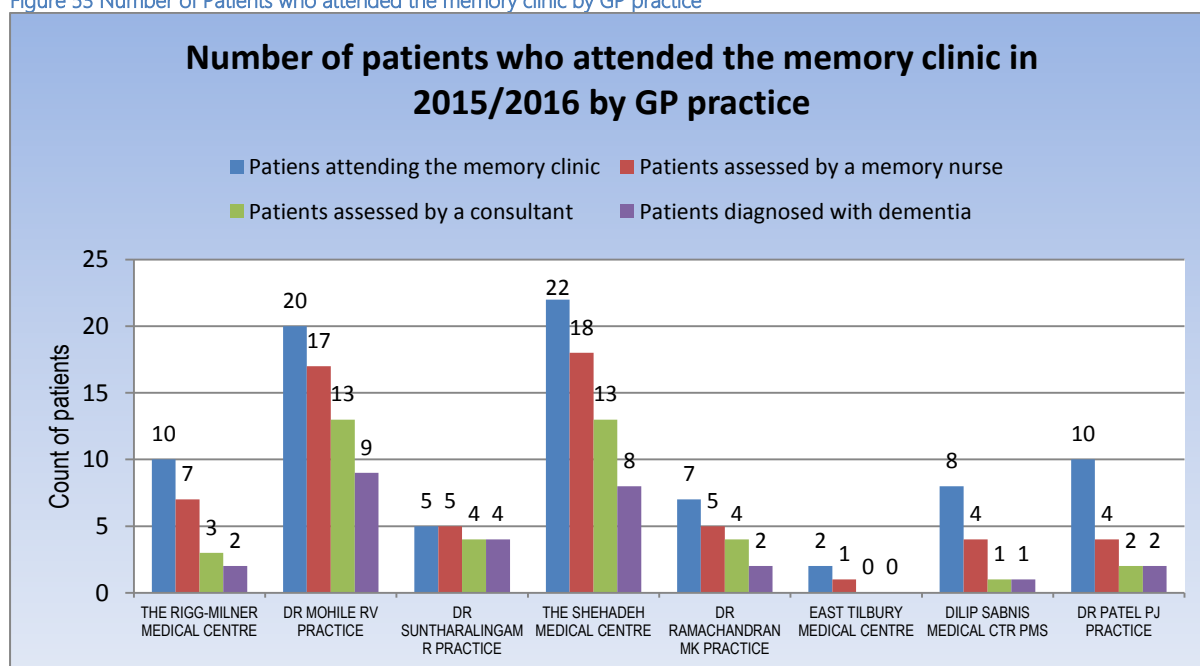
Figure 52: Dementia Diagnosis Rate, 2015



Source: Primary Care Web Tool

Patients identified with memory problems can be referred by the GP to the memory clinic to further be assessed. The clinic sees any patient with a wide range of memory problems, from mild loss of memory to dementia. After the assessment, patients are referred to appropriate services. Patients with a severe dementia diagnosis will be referred to their GP, while the rest of the patients with cognitive problems will be referred to a memory nurse or consultant for further tests. Those diagnosed with dementia are further referred to Alzheimer’s Society support programme. It is estimated that about half of the referrals to the memory clinic come from the primary care field, and usually from those few champions in the area. Records from the fiscal year 2015-2016 show all the referrals in the dementia programme for Tilbury patients came from consultants, none of them coming from a primary care clinic.

Figure 53 Number of Patients who attended the memory clinic by GP practice



Source: Thurrock CCG

During the fiscal year 2015-2016, a total of 84 patients registered with a practice from Tilbury presented at the memory clinic. After triage and appropriate assessments done by a memory nurse or consultant, 28 patients were diagnosed with dementia.

It is envisaged that the low number of referrals from primary care may be as a result of the clinic not having an electronic clinical system to receive referrals. Additionally, after the patient presents at the clinic, the nurse practitioner who assesses them might need further information from the primary care office, such as blood test results, meaning further non-automated correspondence. However, it is not thought that the memory clinic could sustain a large increase in referrals at the current time, due to only having 1FTE nurse available to assess all the patients coming in, including secondary care, community and self-referrals; however, they recently received funds to hire 2 more FTEs in the near future.

9. Public Health Commissioned Services

KEY FINDINGS

- PUBLIC HEALTH ISSUES SUCH AS OBESITY, SUBSTANCE MISUSE AND SMOKING ARE PREVALENT IN TILBURY; YET THE REFERRALS TO COMMISSIONED SERVICES ARE FAIRLY LOW.
- REDUCING SMOKING PREVALENCE IN THOSE PATIENTS WITH EXISTING LONG TERM CONDITIONS HAS BEEN DEMONSTRATE TO REDUCE UNPLANNED RESPIRATORY HOSPITAL ADMISSIONS OVER THREE YEARS.
- INTEGRATING DELIVERY OF HEALTH IMPROVEMENT SERVICES INTO THE DAY JOB OF ALL STAFF WITHIN ANY FUTURE HEALTH AND CARE MODEL FOR TILBURY RATHER THAN REFERRING PATIENTS TO DISCRETE SERVICES PROVIDED SEPARATELY COULD HELP ADDRESS THIS SITUATION

9.1 Introduction

Thurrock Council Public Health Team is responsible for commissioning a range of Primary Prevention and Treatment services from the Public Health Grant. These include:

- Tobacco Control and Smoking Cessation
- Drug and Alcohol Treatment Services
- Sexual Health and Contraception Services
- Tier II Obesity prevention and treatment services including weight management and exercise on referral

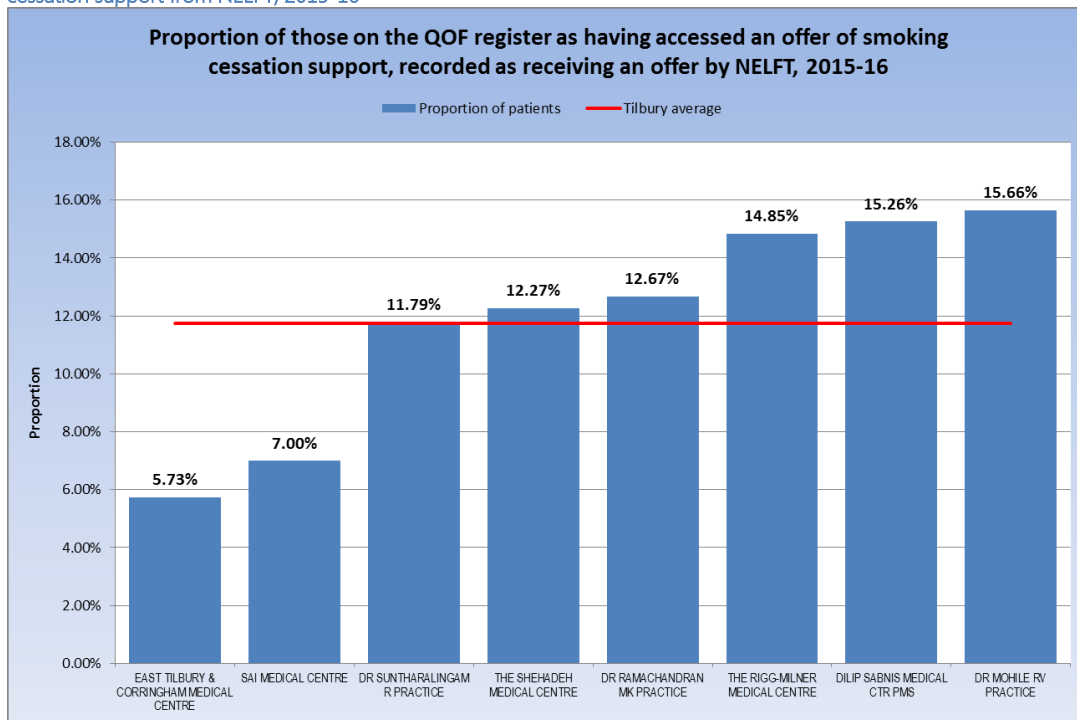
There is a strong evidence base that such services are both effective and cost effective in helping maintain population health and reduce demand on health treatment and social care services.

9.2 Smoking Cessation

The QOF register records the number of patients aged 15 or over who are recorded as current smokers and have a record of an offer of support and treatment within the preceding 24 months (QOF indicator SMK004). In 2015/16, this totalled 5,677 for all Tilbury practices. The NELFT data found there to be 333 patients accessing smoking cessation support in 2015/16 – doubling this number to provide an estimate of those accessing support in the preceding 24 month period would still only give 666 patients – accounting for just 11.7% of the number on the QOF register. This variation by practice can be seen below. East Tilbury Health Centre has the lowest proportion of their QOF patients receiving smoking cessation support by NELFT (5.73%) and Dr Mohile the highest (15.66%) – see figure below. The finding that only 11.7% of those on the QOF register recorded as having an offer of support or treatment appeared to be supported by NELFT suggests there is variation in the support offered to patients, as quantifying this means that as many as 5,011 smokers may qualify for this support but be receiving something different.

Multiple Regression Modelling undertaken by the Public Health Team has demonstrated that for each percentage point smoking prevalence is reduced in those on Long Term Condition QOF disease registers avoids 107 unplanned care hospital admissions for respiratory conditions over three years.

Figure 54: Proportion of those on the QOF register as having received an offer of smoking cessation support, who accessed smoking cessation support from NELFT, 2015-16



Source: QOF and NELFT

9.3 Weight Management and Alcohol Treatment Services

A similar situation can also be seen for obesity – where the numbers referred to the NELFT weight management service are very low compared to those recorded as obese by GPs, and also for alcohol misuse – comparing the referrals to Addaction with surveyed estimates of binge drinking indicates that there could be an unmet need for support. Further detailed analysis is available in the Supplementary Data Pack.

10. Potentially Avoidable A&E Attendances

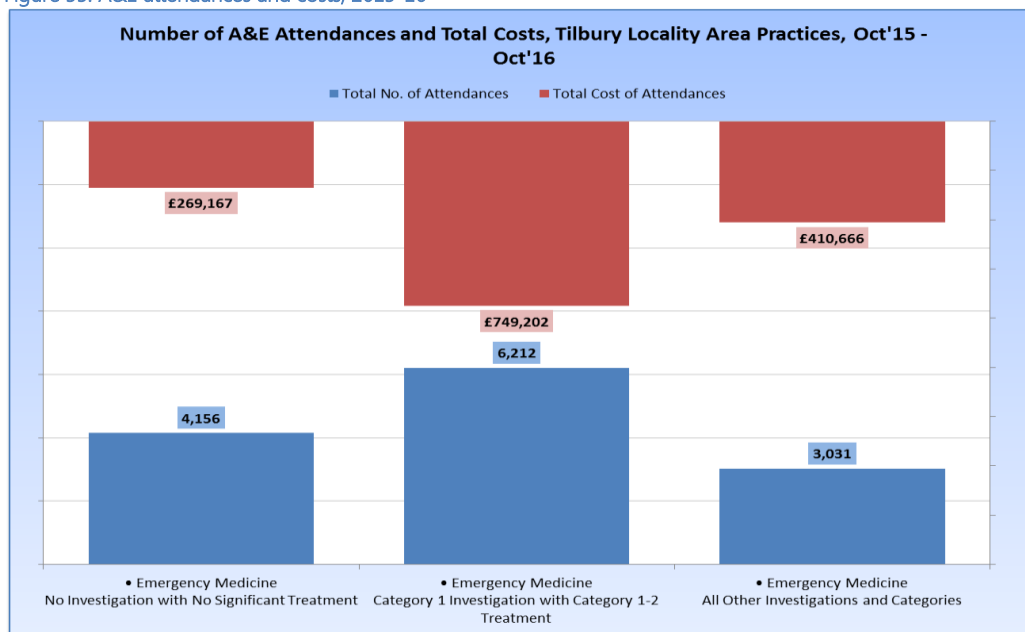
KEY FINDINGS:

- 77% OF THE A&E ATTENDANCES BY TILBURY LOCALITY PATIENTS IN 2015-16 COULD HAVE POSSIBLY BEEN TREATED ELSEWHERE HAD THE FACILITIES AND CAPACITY EXISTED. 31% OF A&E ATTENDANCES (4,156) PATIENTS RECEIVED NO INVESTIGATION OR TREATMENT AND 46% RECEIVED THE MOST MINOR CATEGORY OF CLINICAL INVESTIGATION OR TREATMENT
- THE EXCESS COST TO THE NHS OF THIS COHORT OF PATIENTS WAS AN ADDITIONAL £1,018,369.
- THERE APPEARS TO HAVE BEEN HIGH USAGE OF THE IC24 OUT OF HOURS SERVICE FOR CALLS THAT RECEIVED ADVICE ONLY. IN ADDITION THERE APPEARS TO BE A GOOD LEVEL OF AWARENESS AROUND THIS SERVICE, INDICATING THAT INCREASING UPTAKE OF THIS SERVICE MAY STILL NOT REDUCE INAPPROPRIATE A&E ATTENDANCES

10.1 A&E Attendances by HRG Code

There were 13,399 A&E attendances by Tilbury locality patients in 2015/16. Of these, 10,368 attendances were classified as either *Category 1 investigation with Category 1-2 treatment*, or *No Investigation with no significant treatment* – loosely meaning that either they could possibly have been treated elsewhere had the facilities existed, or they did not need any specialist intervention at all. These accounted for 77% of all Tilbury attendances and cost a total of £1,018,369 (see figure below).

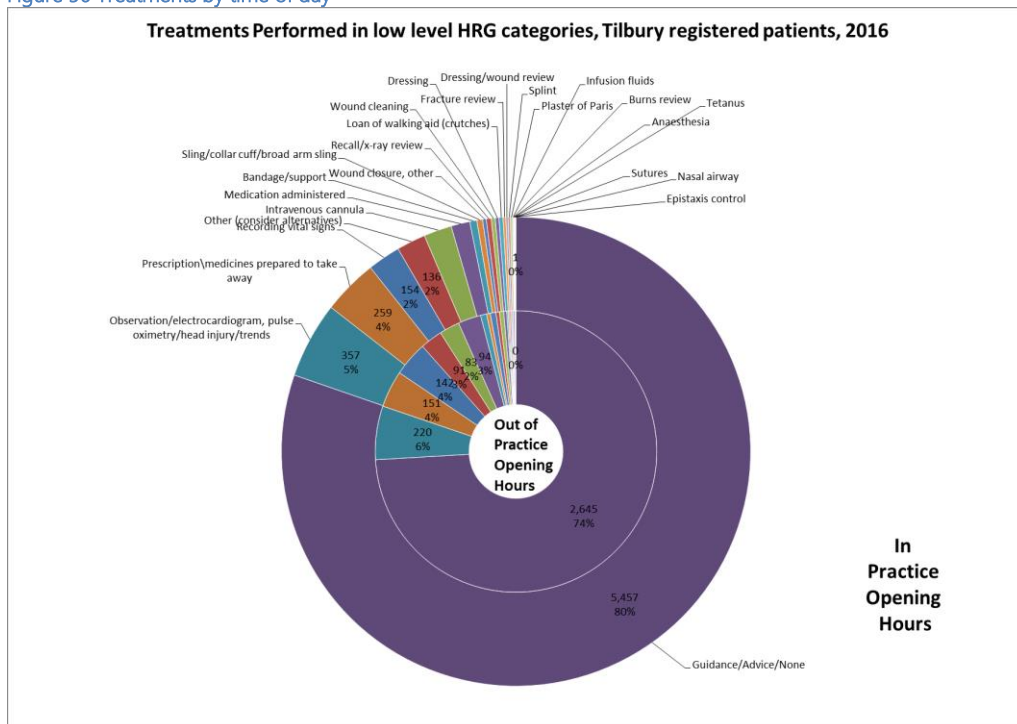
Figure 55: A&E attendances and costs, 2015-16



Source: Hospital Episode Statistics

Simply looking at the lower level HRG categories, it can be seen that a significant proportion of the activity results in no tangible treatment being given other than advice. The proportion of this activity is again higher in the daytime than evening when GP practices are closed.⁹

Figure 56 Treatments by time of day¹⁰



Source: Hospital Episode Statistics

Figure 57 shows that during the daytime a larger proportion of the activity receives no investigation (53%) than out of hours (41%). This is the category of patients who also didn't receive any significant treatment. We believe that the difference which equates to 811 attendees is indicative of patients not being able to get an appointment or not being satisfied with Primary care (if they really thought they needed A&E we would expect this proportion to look similar throughout the day). Other observed differences are mainly due to this and are lost if we manipulate the data to exclude the excess in this column. The excess cost to the NHS of treating these patients in A&E rather than Primary Care was £55,782.

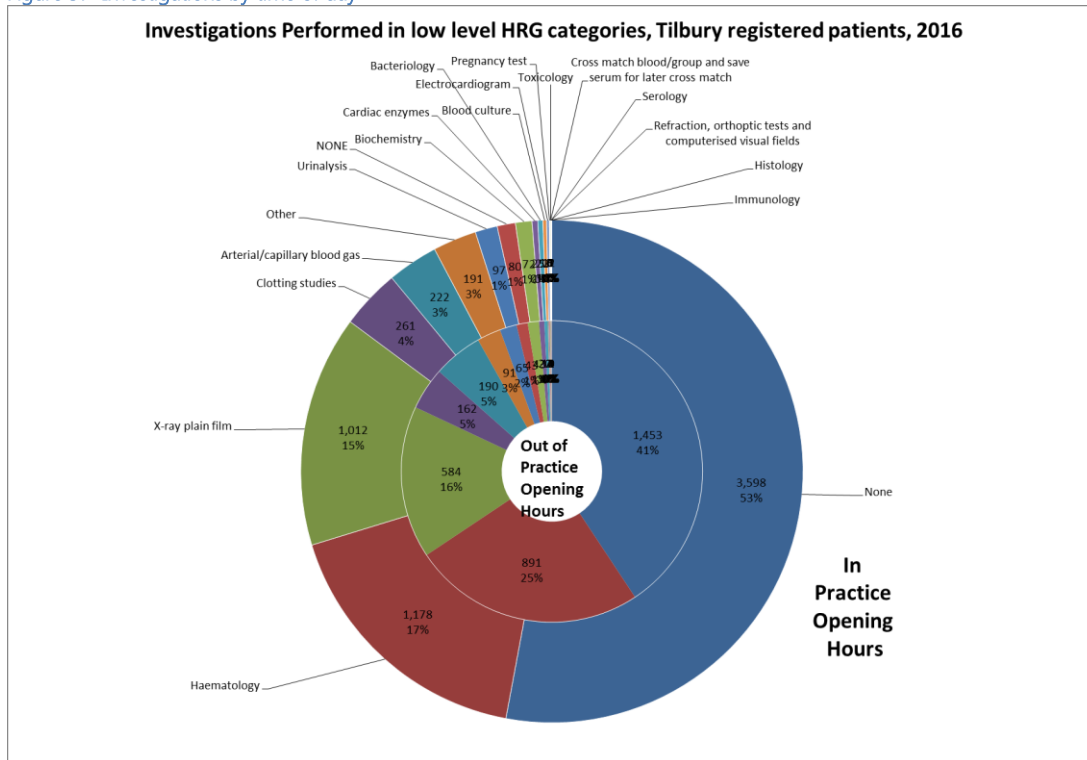
Figure 57 shows the Clinical Investigations performed in low level HRG categories for Tilbury patients attending A&E in 2016 for both in an out of GP practice opening hours.

In total 5051 patients received no clinical investigation at A&E, with the majority of this cohort attending within GP practice opening hours. The next most common clinical investigations formed within GP practice opening hours were Haematology (17%) and X-ray plain film (15%). This suggests considerable demand and scope for such services to be provided within the community.

⁹ No financial opportunity calculated due to overlap with above

¹⁰ Advice and no treatment categories have been combined

Figure 57 Investigations by time of day



Source: Hospital Episode Statistics

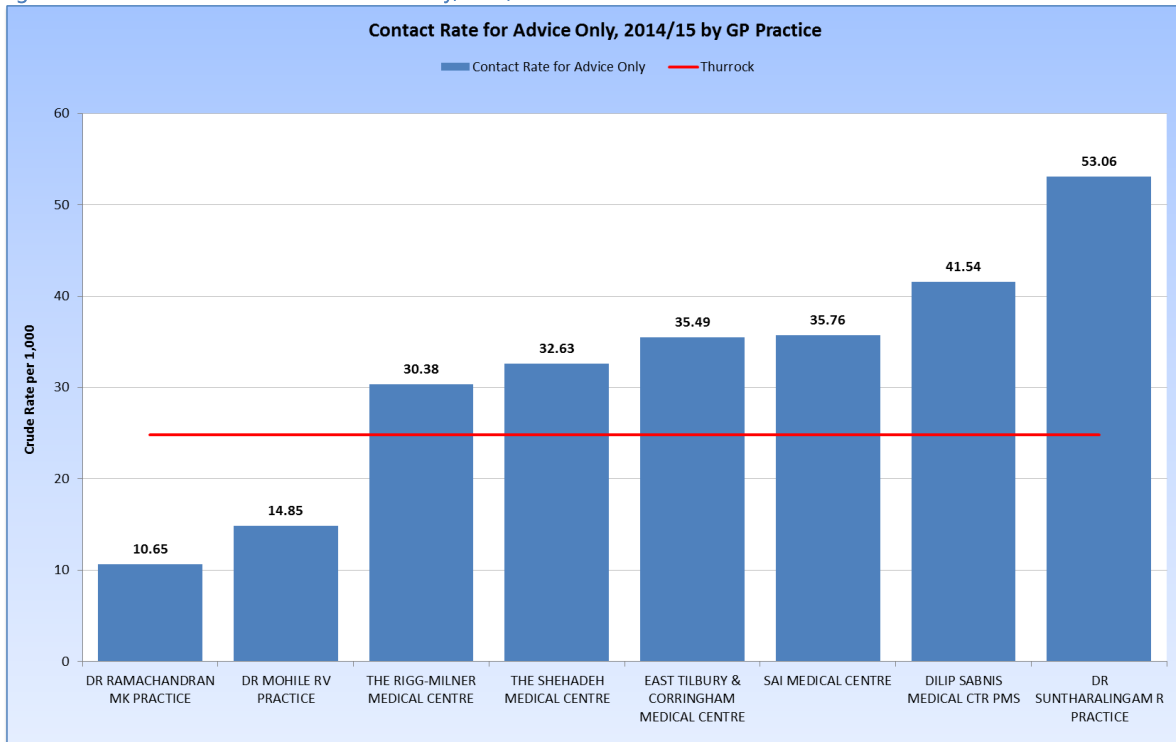
10.2 Out of Hours Primary Care Service

It could be hypothesised that awareness and use of IC24 as an alternative route to access healthcare advice is likely to be low where there is high volumes of out of hours A&E attendances where patients are simply given advice and no treatment, with the assumption they are accessing A&E as they do not know where else to go for advice out of hours.

Data from 2014-15 indicates that contact rates to IC24 which received advice only are relatively high in Tilbury, which indicates it could this be the same patients calling repeatedly (see

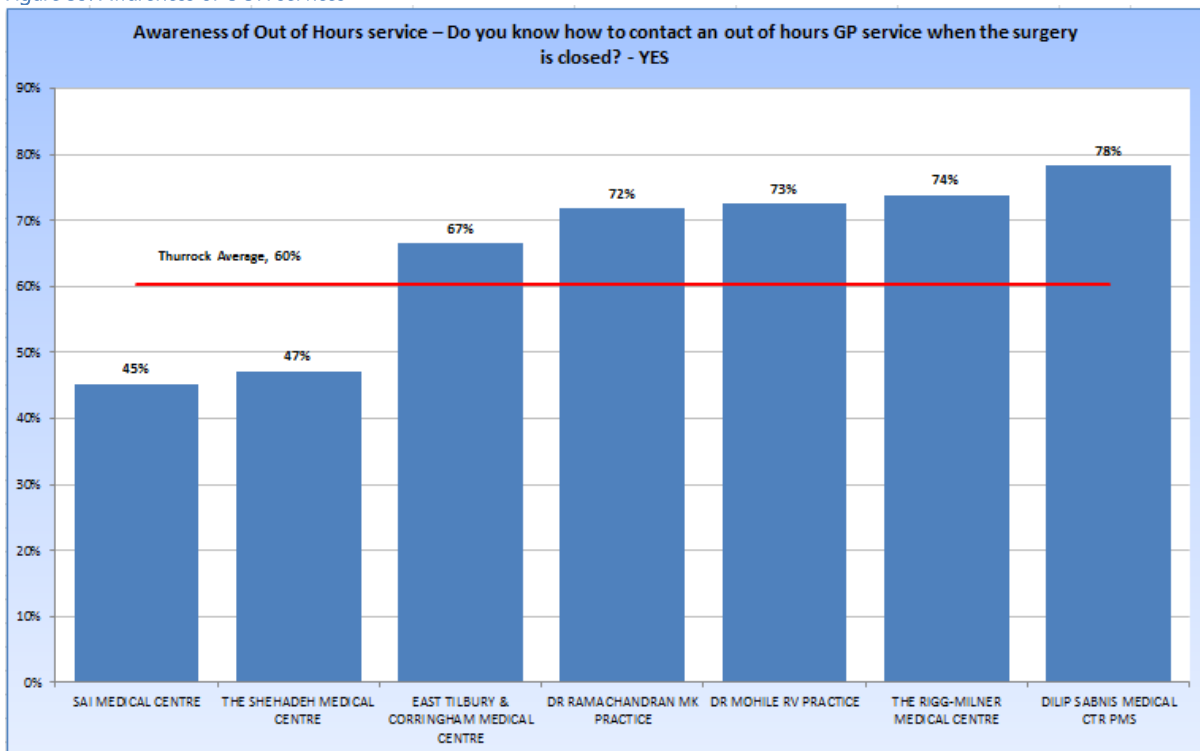
Figure 58). Data from the GP Patient Survey however indicates quite a high awareness of IC24 Out of Hours services (see Figure 59), so it could also be that the contacts are from different patients but that they are also attending A&E and receiving advice/information twice. It should be noted however that the sample size of this survey was fairly low.

Figure 58: OOH Contacts that received advice only, 2014/15



Source: IC24

Figure 59: Awareness of OOH services



Source: GP Patient Survey

11. Primary Care Workforce and Capacity

KEY FINDINGS:

- TILBURY IS SIGNIFICANTLY UNDER DOCTORED AND UNDER NURSED IN TERMS OF PRIMARY CARE
- THE CURRENT SITUATION IS HIGHLY LIKELY TO BE NEGATIVELY IMPACTING ON ABILITY OF GP PRACTICES TO CASE FIND AND CARE FOR PATIENTS WITH LONG TERM CONDITIONS AND CONTRIBUTING TO AVOIDABLE A&E ATTENDANCES AND ADMISSIONS
- IMPLEMENTING A MIXED SKILLED WORKFORCE IN PRIMARY CARE COULD HELP SOLVE THE CURRENT SITUATION

11.1 Primary Care current workforce

Currently it is acknowledged that there is a shortage of GPs and nurses in Thurrock but particularly in Tilbury. When benchmarking staffing levels of GPs excluding registrars, retainers and locums to the comparator group for each Tilbury practice, it can be seen from the figures below that there are a number of practices with patient: GP ratios that are both higher than the England average and the benchmarked averages.

In 2014/15 when the original Tilbury Locality JSNA Needs Assessment Document was produced to support the Integrated Healthy Living Centre project, the mean England ratio of patients per FTE GP was 1321 and in Thurrock it was 2072 making Thurrock the fourth most under GP'd area in England.

Figure 60 shows the situation in March 2016 for Tilbury. Dilip Sabnis has 13,795 patients per full time equivalent GP, and all GP practices had FTE GP:patient ratios significantly above the 1321 England benchmark. **Up to date data for Dr. Suntharalingam's practice was not available at time of production of this report and so 2015 data has been used which may not reflect the current situation.**

Figure 60: Patients per GP (FTE)

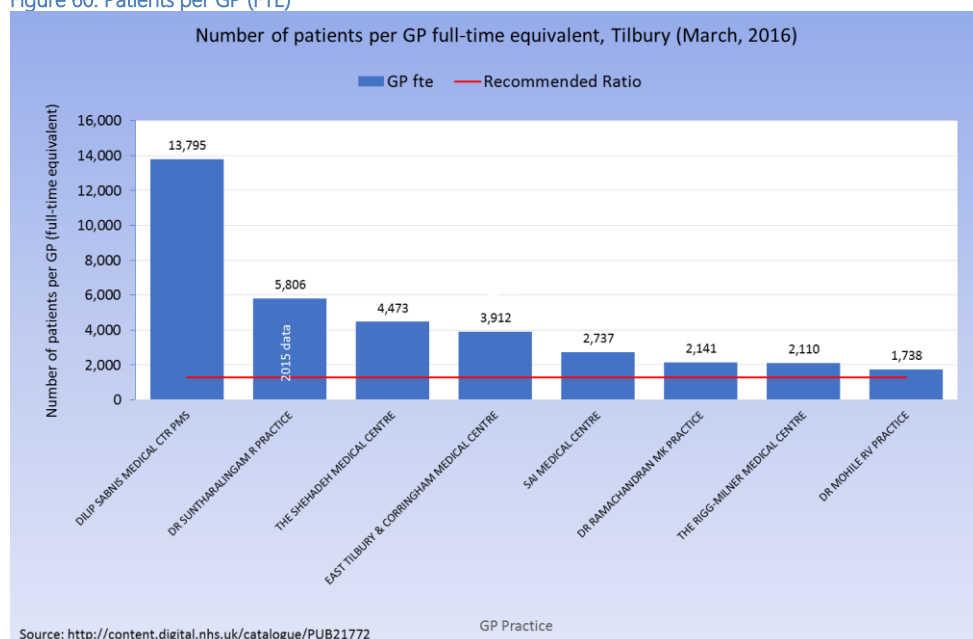
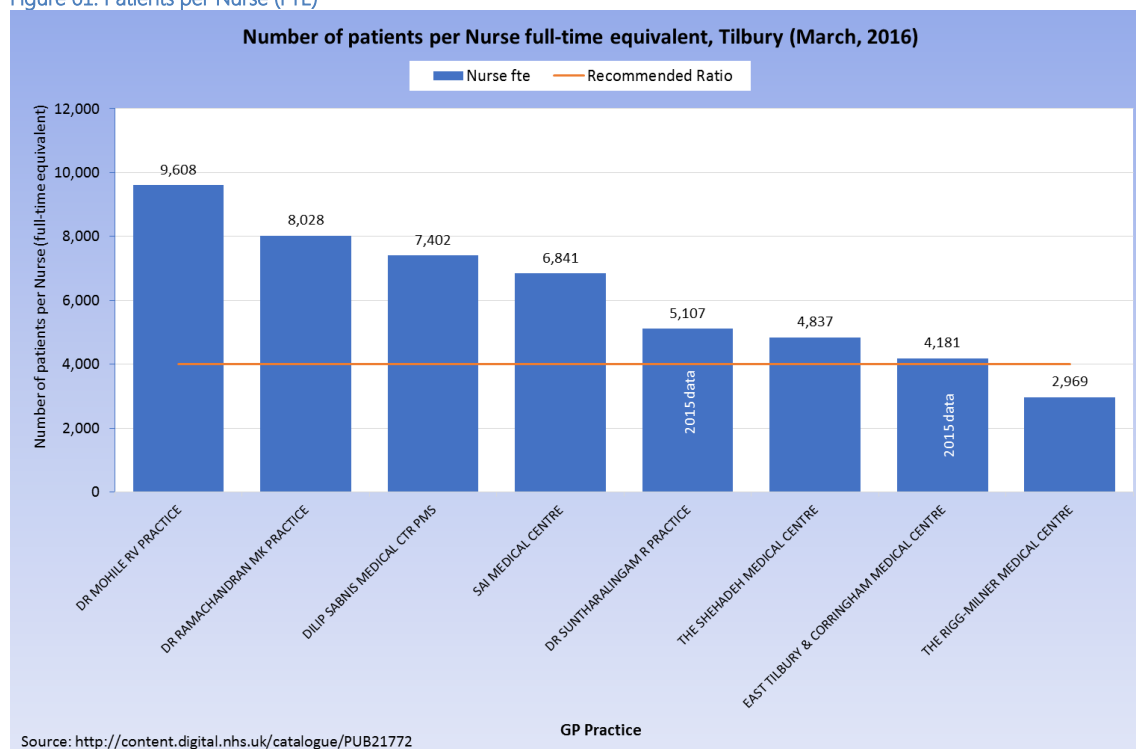


Figure 61 shows the ratio of patients: full time nurse, and it can be seen that, with the exception of Rigg Milner, all practices have a greater ratio than the England mean. Dr Mohile has the largest ratio of patients: FTE nurse (9,608).

Figure 61: Patients per Nurse (FTE)



Under doctoring and under nursing in Primary Care presents a series challenge to the entire health and care system in Tilbury. 90% of all patient interactions within the NHS occur within Primary Care. GPs and Practices nurses that have patient list sizes that are too large are unlikely to be able to provide the proactive long term condition management, case finding and primary prevention highlighted in the previous sections as so important to maintain a population's health and prevent unnecessary hospital admissions. Similarly patients that are unable to access a timely appointment within Primary Care because of competing demand from large list sizes are more likely to access A&E for minor clinical issues. This is both operationally and financially unsustainable, diverting ED staff from treating patients with life threatening conditions and wasting NHS financial resources.

11.2 Primary Care future workforce

In the 2016 Report of the Director of Public Health we made recommendations for a mixed staffing model that would provide an additional 324 appointments per day in Tilbury. Table 10 compares the results from this work to the current situation. Unfortunately we do not have a breakdown of the current situation to the same level of detail as the proposed model but it can be easily seen that we would need an additional:

- 1 practice pharmacist
- 8-11 other DPC staff (depending on what is already in place)
- 4 GPs
- 7 Nurses
- 1 Nurse practitioner

We would need to conduct a thorough review of skill sets of the 36.55 current Admin staff as we are unaware of how this is broken down. It may be that our model has underestimated the need for receptionists/ Admin support, or that there are admin functions that are not covered by our definition.

It is worth noting that the number of FTE GPs in Tilbury has reduced from 19 to 10.57 since our initial analyses.

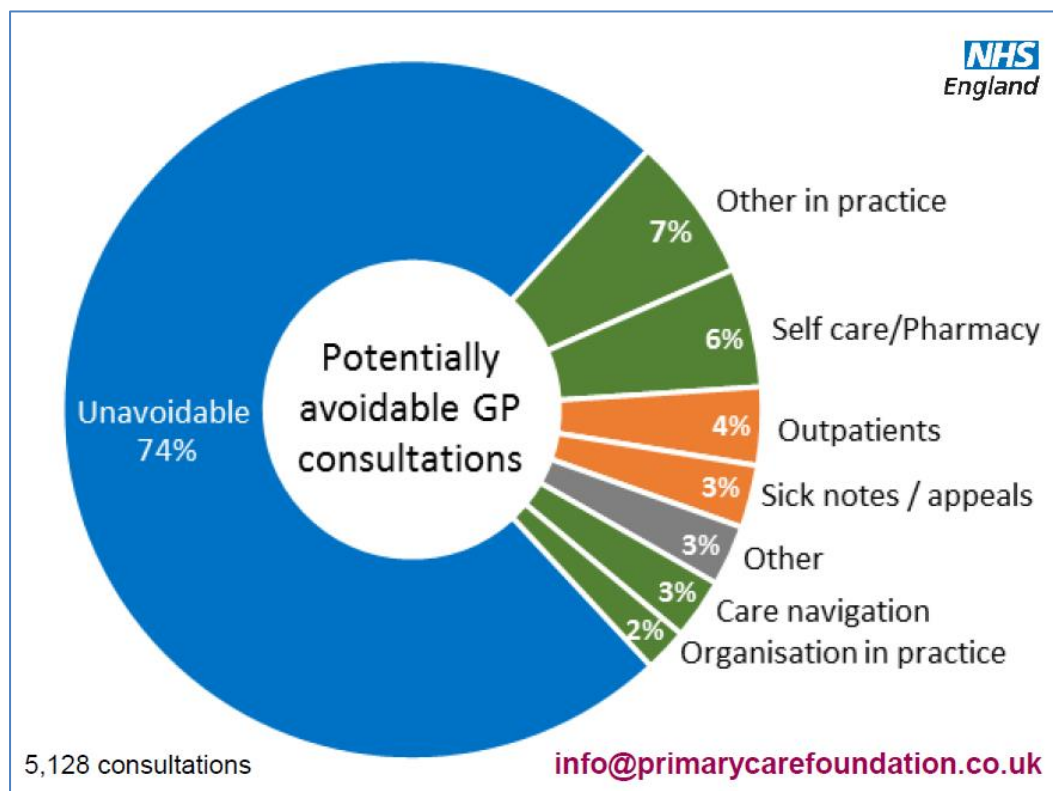
Table 10: Comparison of staffing levels in current General Practice Model to those suggested for a Mixed Staffing Model

	Current Model	Mixed staffing model
GPS (FTE)	10.57	16
Nurses (FTE)	5.77	13
Nurse Practitioner	?	1
Other DPC (FTE)	2.68	
Physio therapist	?	8
Well-being worker	?	3
Admin (FTE)	36.55	
Receptionists	?	3
Physician assistant	?	1
GP assistant	?	1
Pharmacists (FTE)	0	1

Source: Public Health Analyses from "Making Time in Primary Care"

11.3 Making time in Primary Care – other initiatives

The Making Time in General Practice report by NHS Alliance found that around 26% of GP consultations could potentially be dealt with via other avenues. The breakdown of this can be found below:



Source:

The report goes on to recommend 10 key areas of activity to have an impact on redistributing patient care and increasing the number of consultations. Of these, work has begun in some areas (some of which is referenced within this

report) including social prescribing, partnership working and new consultation types – e.g. the trial of eConsult / WebGP. In addition, our work on primary care workforce modelling has outlined the requirements for a redesigned workforce which can take some of the avoidable GP appointments and also lessen the burden of recruiting even more GPs.

10 High Impact Actions

NHS England

- 1: ACTIVE SIGNPOSTING**
- 2: NEW CONSULTATION TYPES**
- 3: REDUCE DNAs**
- 4: DEVELOP THE TEAM**
- 5: PRODUCTIVE WORK FLOWS**
- 6: PERSONAL PRODUCTIVITY**
- 7: PARTNERSHIP WORKING**
- 8: SOCIAL PRESCRIBING**
- 9: SUPPORT SELF CARE**
- 10: DEVELOP QI EXPERTISE**

Innovations from around England that release time for GPs to do more of what only they can do.
bit.ly/gpcapacityforum

#GPforwardview

Source:

11.3.1 Social Prescribing

Social Prescribing involves the empowerment of individuals to improve their health and wellbeing and social welfare by enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-medical services, often provided by the voluntary and community sector. This aims to:

- ✓ Reduce demand on GPs and the NHS
- ✓ Reduce social isolation
- ✓ Improve health outcomes
- ✓ Address health inequalities
- ✓ Improve Community cohesion
- ✓ Increase Patient satisfaction
- ✓ Support those at risk of Unplanned Admissions
- ✓ Divert patients away from medical health services
- ✓ Assist GPs with CQC compliance visits and Public Health Outcomes

A joint scheme with NHS Thurrock's CCG and Thurrock's CVS, the workforce for Thurrock's Social Prescribing Team is equivalent of FTE 1.15 paid staff – two part time Social Prescriber Navigators (17.5hrs per week per employee) and one part time administrator (10hrs per week).

An initial twelve month "pilot scheme" (December 2016) has begun within all GP practices within the Thurrock locality.

12. Conclusions and next steps

This needs assessment demonstrates both the assets and deficits within the Tilbury Health and Social Care system and wider community. The main conclusions and recommendations and conclusions are given in section X at the start of the report.

12.1 Conclusions

In summary, making a demonstrable difference to the health and wellbeing of the population of Tilbury we must recognise and address the following:

1. **The money and the patients are in the wrong place**
 - There are too many avoidable hospital admissions and A&E attendances.
 - Avoidable delays in hospital discharges are both bad for patients and operationally and financially unsustainable for our Health and Social Care system
2. **Inadequate investment, capacity and quality in Primary Care, Community Care and ASC keeps the money and the people in the wrong place**
 - Thousands of patients with Long Term Conditions remain undiagnosed
 - Hundreds of patients with diagnosed long term conditions are not receiving thousands of evidence based clinical interventions that would reduce their risk of serious health events and of avoidable hospital and care admissions.
 - A lack of Primary Care capacity and capability including skill mix is a key cause of the above.
3. **There is an urgent need to integrate both care (and the money) to solve the problem. Care needs to be provided holistically around the person and not commissioned in discrete services to and from which people are referred or fail to be adequately referred**
 - Interface between GP surgeries and Community Services isn't working adequately
 - Primary Prevention (Health Improvement) is not integrated into the day job of front line professionals but commissioned independently by Public Health and provided separately. Again the interface between community long term condition management and services such as smoking cessation isn't effective.
 - Self-care services such as patient education and community support groups sit entirely outside of clinical care pathways.
 - The separation of NHS and Adult Social Care budgets is wasting large amounts of money in delayed transfers of care
4. **There is an urgent need to address the issue of poor mental health**
 - Clinical mental ill health services are separated from clinical physical health services with an inadequate interface between them
 - There is an under diagnosis of depression
 - The data in this report (albeit now out of date) suggests that minimum numbers of patients with diagnosed depression were accessing talking therapies
 - Mental wellbeing and protective factors against poor mental health such as employment, community cohesion and social networks are largely disconnected with NHS mental health services
5. **In order to achieve points 1 to 4, there is a need to 'double run' financially. Solving the problem will need a level of non-recurrent investment in Community Services to deliver savings that will come from reduced demand on hospital services.**

6. **There is a need to bridge differences in organisational and community culture.**
- The NHS works on a medical deficit model that aims to 'fix' illness. Social Care and the third sector work on an asset based empowerment model that starts with the individual and the premises of helping them to help themselves and each other.
 - Both approaches have merit depending on circumstances and there is a need for both to understand the other if truly effective integration is to occur
 - There are a great many community assets in Tilbury, the greatest being the community itself. Creating a new way of working will fail if those assets are not capitalised upon and the community of Tilbury are engaged fully within the new approach.

12.2 Next Steps

The Business Case setting out the new approach for an Accountable Care Organisation in Tilbury needs to consider the following:

12.2.1 Some key potential quick wins for which business cases should be developed

- A programme to improve the case-finding and treatment of patients with hypertension
- A programme to screen patients on QOF Long Term Conditions Management Registers for Depression and treat where appropriate
- Implementation of the new MedeAnalytics Integrated Data Solution at pace to link Primary, Secondary, Community and Social Care records in order to assist GP practices to case find and call/re-call patients with long term conditions in need of review, and to improve referral of patients with COPD, Cardio-Vascular Disease and Diabetes into existing commissioned community long term conditions management programmes
- A workforce skills audit of GP practice staff and implementation of the mixed skills workforce model set out in "Making Time in General Practice"
- Implementation at pace of WebGP and Social Prescribing within General Practice to free up capacity and begin to address under doctoring/nursing
- Implementation of a 'Stretched QOF' for Hypertension and COPD
- Implementation of a programme to significantly increase flu vaccination coverage
- Implementation of a programme to significantly increase the uptake of NHS Health Checks

12.2.2 Fundamental delivery issues that the business case needs to consider

- A new integrated workforce model between GP surgeries, Pharmacies, Community Care, Mental Health Treatment Providers, Health Improvement/Public Health treatment services, and social care staff
- How the capacity and resource of the community and third sector providers can be incorporated into a new way of working such that issues of social wellbeing and wider determinants of health can be addressed
- How best to engage with the residents of Tilbury in co-design of the new model

12.2.3 Finance and Governance

- What does success look like? What outcomes are we trying to achieve and how will we build evaluation into the process from day one.
- What is the total finance currently available and how can it best be pooled
- What additional 'double running' finance may be available and how is it best accessed
- How do the current contractual relationships between providers change, and between commissioners and providers

13. References

- ⁱ Department of Health (2016) – Reference Costs 2015-16. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf [Accessed 20/01/2017]
- ⁱⁱ M J Harisson, M Dusheiko, M Sutton, H, Gravelle, T Doran, M Roland; Effect of a national primary care pay for performance scheme on emergency hospital admissions for ambulatory care sensitive conditions: controlled longitudinal study, BMJ 2014; 349:g6423