

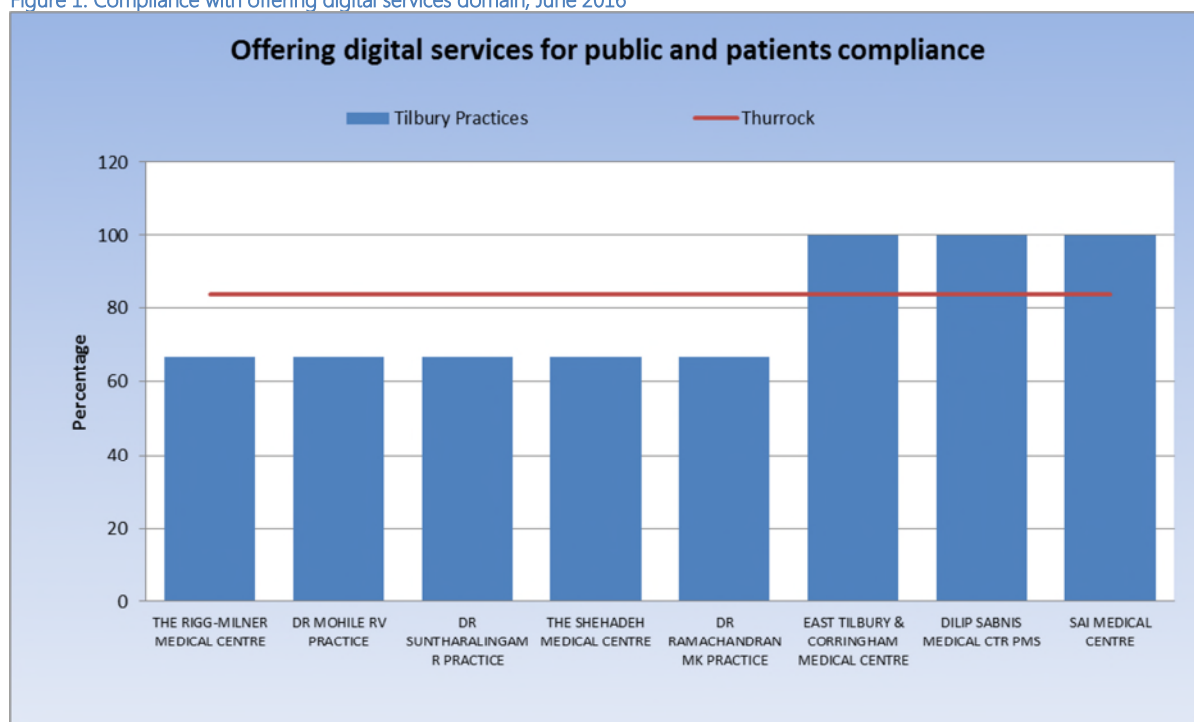
# Supplementary Data Pack: Needs Assessment to support the Development of an Accountable Care Organisation for Tilbury

The purpose of this pack is as a reference for the main document. The main document refers to figures and tables contained within the supplementary pack, these are all contained here. Section numbers are consistent with the main document.

This pack may contain explanations of analyses conducted but does not contain any interpretations or conclusions. These can all be found in the main document.

## SECTION 3 : TILBURY THE PLACE

Figure 1: Compliance with offering digital services domain, June 2016



Source: Primary Care Web Tool

#### Explanation 1: description of roles in pharmacy

**Pharmacists** advise both professionals and patients in the use of drugs and medicines and prepare and dispense prescription medication. They also act as health advisors to the public and have wider skills in areas such as undertaking Medicine Use Reviews, screening services and treating minor ailments. They are accountable for the financial management and are legally accountable for any dispensing errors.

**Dispensing technicians** work under the supervision of a pharmacist. They can assemble medicines for prescriptions, supply medicines to patients (whether on prescription or over the counter) and give advice/information. They can also supervise other pharmaceutical staff. They must be registered with the General Pharmaceutical Council.

**Dispensing assistants** can supply over the counter medicines and give advice/information. They can also support the preparation, dispensing and sale of prescriptions, as well as assisting with stock control, ordering and re-stocking of the dispensary.

**Medicines Counter Assistants** offer advice on common ailments and can sell over the counter medicines.

## SECTION 4: ADULT SOCIAL CARE

### Local Area Coordination

Further details about the age bands of the Tilbury locality residents supported by LACs: their service usage (as a proportion of Thurrock), their presenting issues, and level of support received.

Table 1: Number of residents per Age Band, per LAC area, 2015

Age Bands	Chadwell St Mary / Orsett / Bulphan	East Tilbury	Tilbury
18-35 years	14	7	9
36-55 years	13	11	16
56-75 years	19	9	17
76+ years	20	9	12
Not Specified	2	17	9
Total	68	53	63

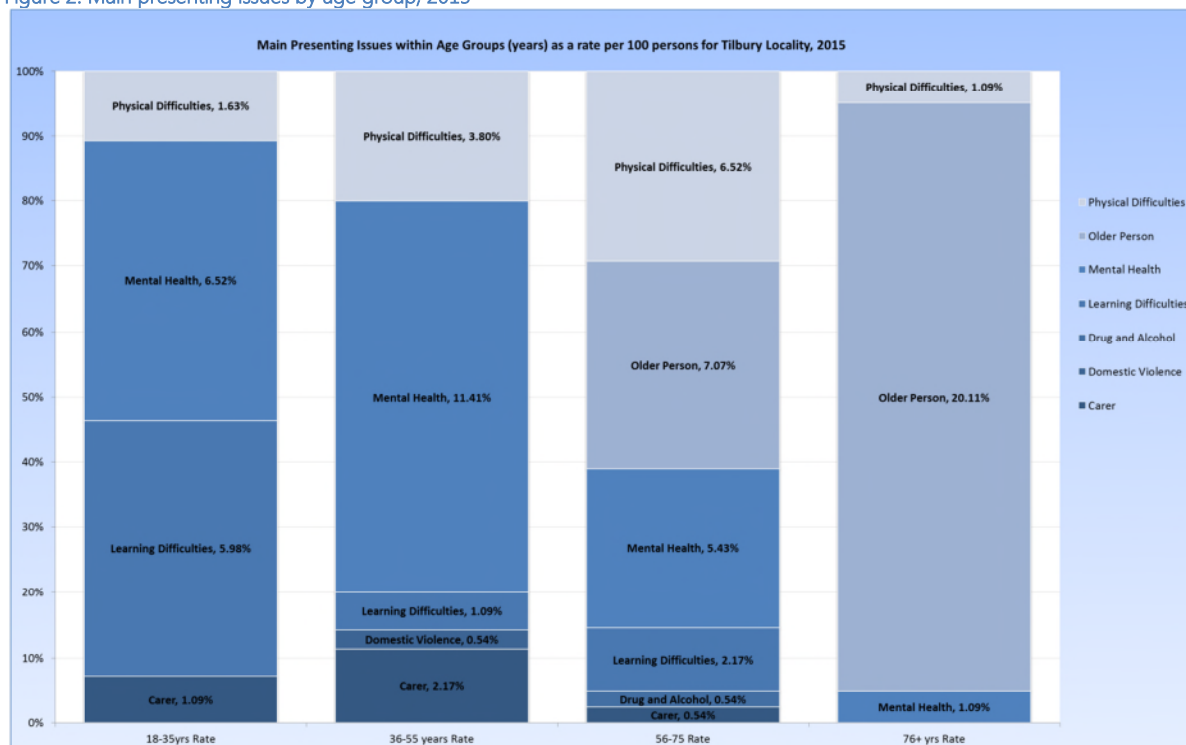
Source: Thurrock Council

Table 2: Service usage and proportion presenting as an Older Person, 2015

Locality/Ward	Persons Total	Locality Usage (%)	% of Locality who presented as a Older Person
Chadwell St Mary/Orsett/Bulphan	68	11.56%	38%
Tilbury	63	10.71%	29%
East Tilbury	53	9.01%	19%

Source: Thurrock Council 2015

Figure 2: Main presenting issues by age group, 2015



Source: Thurrock Council 2015

Note: Older Person is the data recording term for a person that has been referred/contacted the LAC Service due to Social Isolation, Day Care enquiries, Supporting others in their Community, wish to Volunteer and/or looking for local Clubs/Activities instead of funded Day Care over the age of 55yrs+.

Explanation 2: Levels of support offered by LAC service

The LAC Service has two levels of support available, these are:

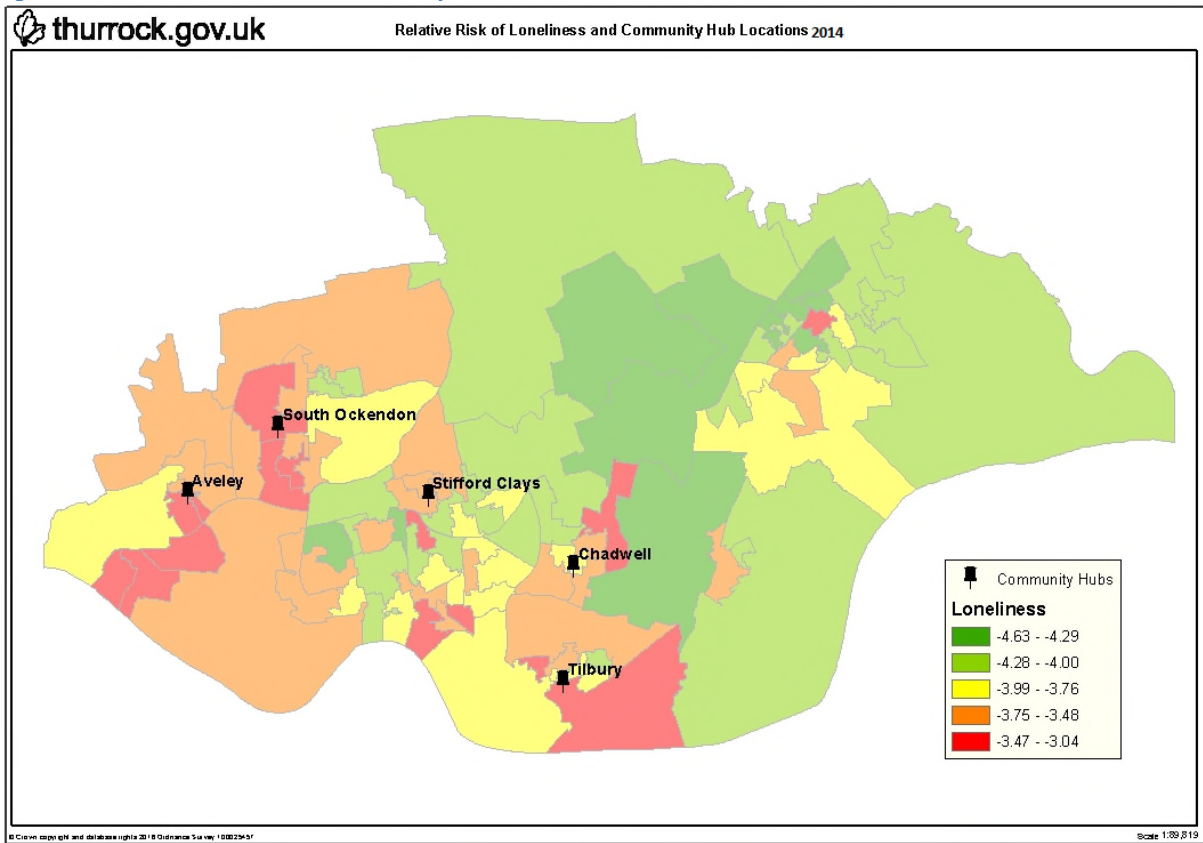
- ✓ Level 1 Support is the provision of information and/or limited support, information and advice is given and no further support is needed at that time, connections made.
- ✓ Level 2 Support is a longer term relationship supporting people (children and adults); who are vulnerable due to physical, intellectual, cognitive and/or sensory disability, mental health needs, age or frailty and require sustained assistance.

Table 3: Level of support received, 2015

LAC Level and Service Required - 2015	
Level 1	122
Information	51
Advice	41
Connections	30
Level 2	62
Total of Level 1 / 2	184

Source: Thurrock Council 2015

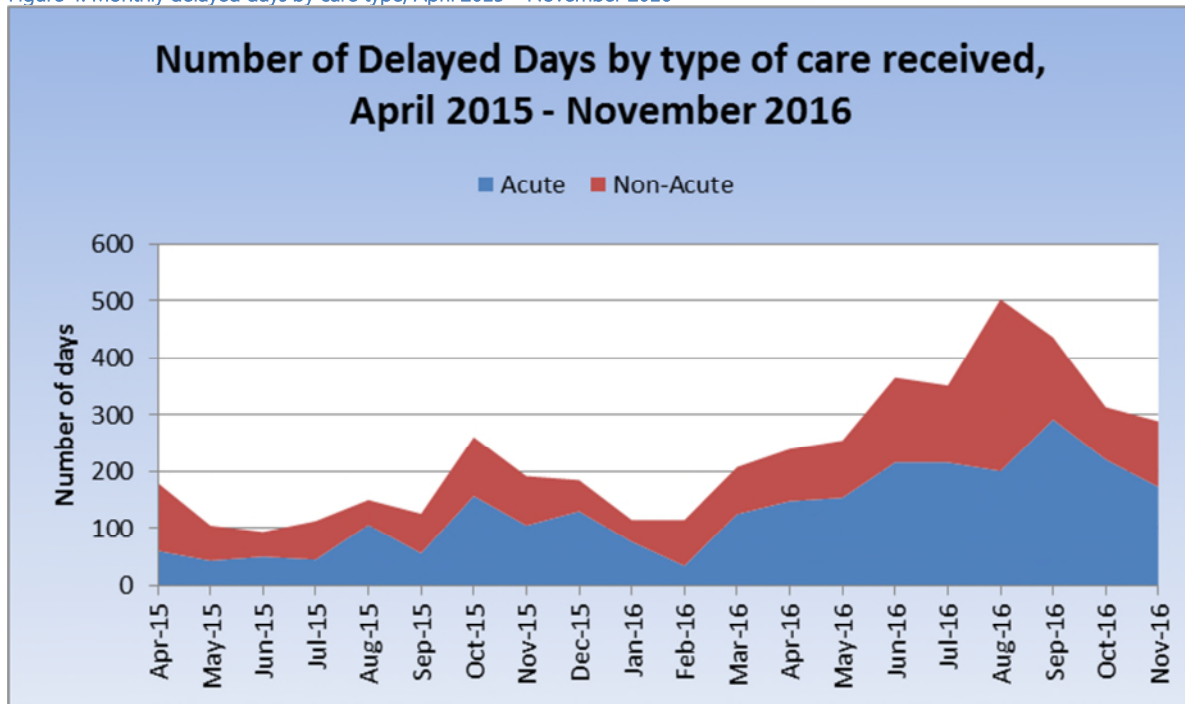
Figure 3: Relative risk of loneliness and community hub locations



Source: Age UK / Thurrock Council

## SECTION 5: DELAYED TRANSFERS OF CARE

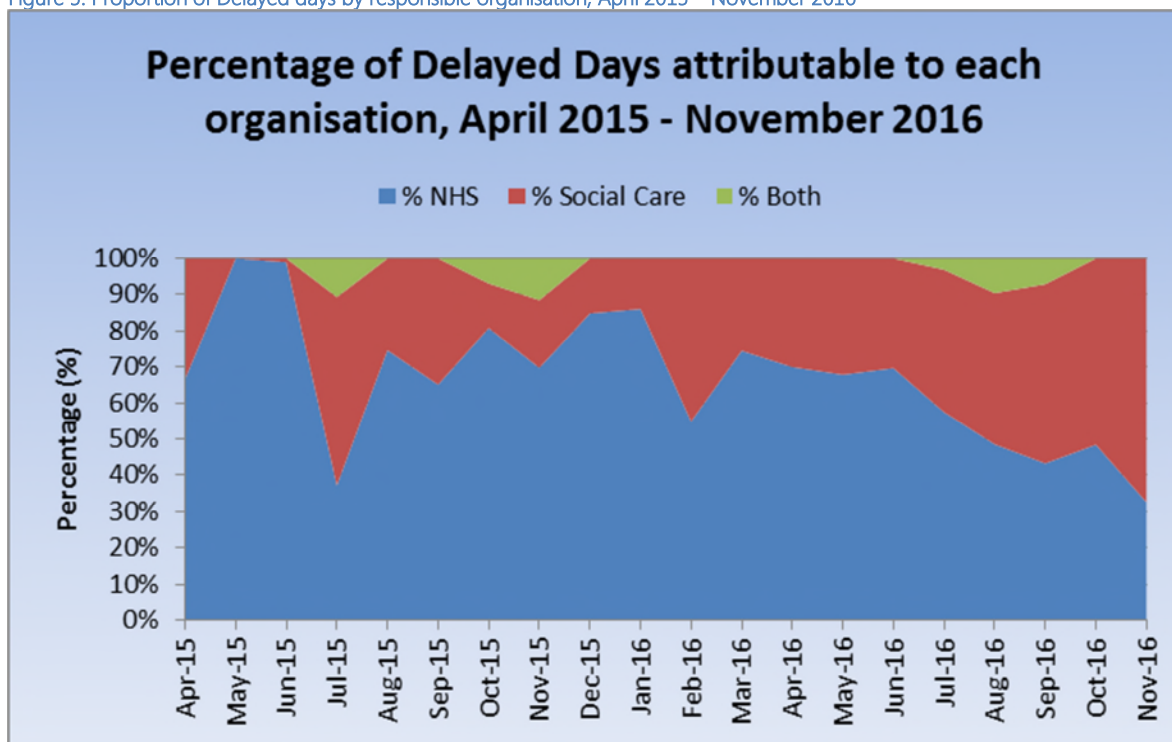
Figure 4: Monthly delayed days by care type, April 2015 – November 2016



Source: NHS England

Note: Acute vs non-acute categorised based on the care the patient was receiving (acute care generally being shorter term, often in response to an emergency or short term illness, and non-acute being non-emergency – such as an outpatients clinic)

Figure 5: Proportion of Delayed days by responsible organisation, April 2015 – November 2016



Source: NHS England Table 4: Delayed days and reason, April 2015 – November 2016

Reason for delay	Number of Delayed Days	Proportion of all Delayed Days
Waiting further NHS non-acute care	1,531	33.28%
Completion of assessment	598	13.00%
Patient or family choice	581	12.63%
Awaiting care package in own home	556	12.09%
Awaiting nursing home placement or availability	496	10.78%
Awaiting residential home placement or availability	431	9.37%
Public funding	176	3.83%
Awaiting community equipment and adaptations	119	2.59%
Disputes	111	2.41%
Housing - Patients not covered by NHS and Community Care Act	1	0.02%
All Reasons	4,600	100.00%

Source: NHS England

### Explanation 3: Anecdotal evidence for reasons for the increase in DTOC to Adult Social Care

The Hospital Social Work Team (HSWT) and the Service Manager for Adult Social Care have stated that the main reasons for the increase in delayed days attributable to Adult Social Care are:

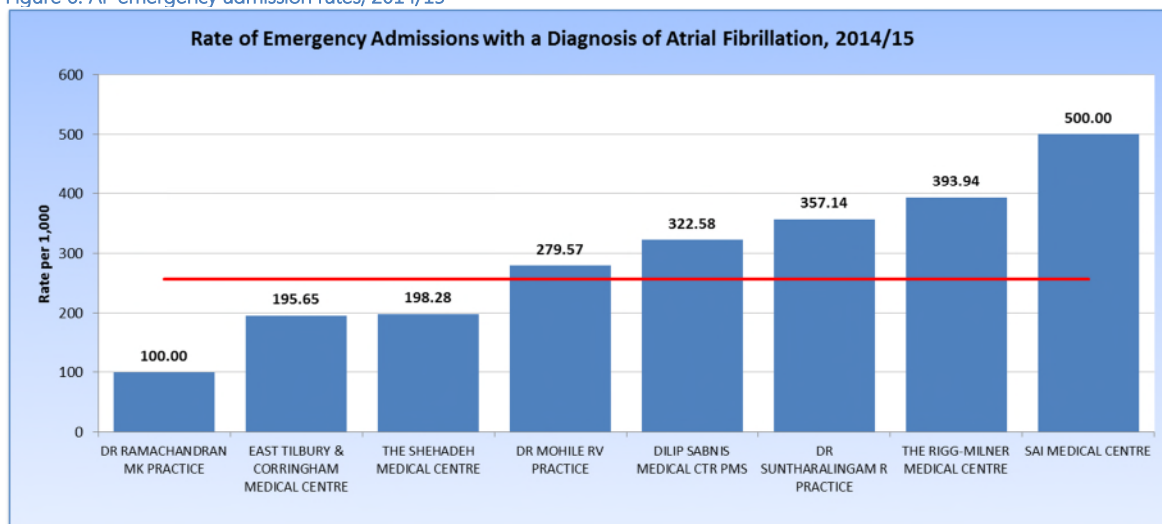
- Lack of care provision residential/nursing care placements and home care resulting in a waiting list for care
- Increase in demand
- Some delays in OT equipment provision
- Some delays in assessments being carried out due to being given minimal notice (48hrs).
- Some delays in the discharge of mental health patients due to awaiting Section 1117 panels.

## SECTION 6: AVOIDABLE EMERGENCY HOSPITAL ADMISSIONS

### LTC Admissions

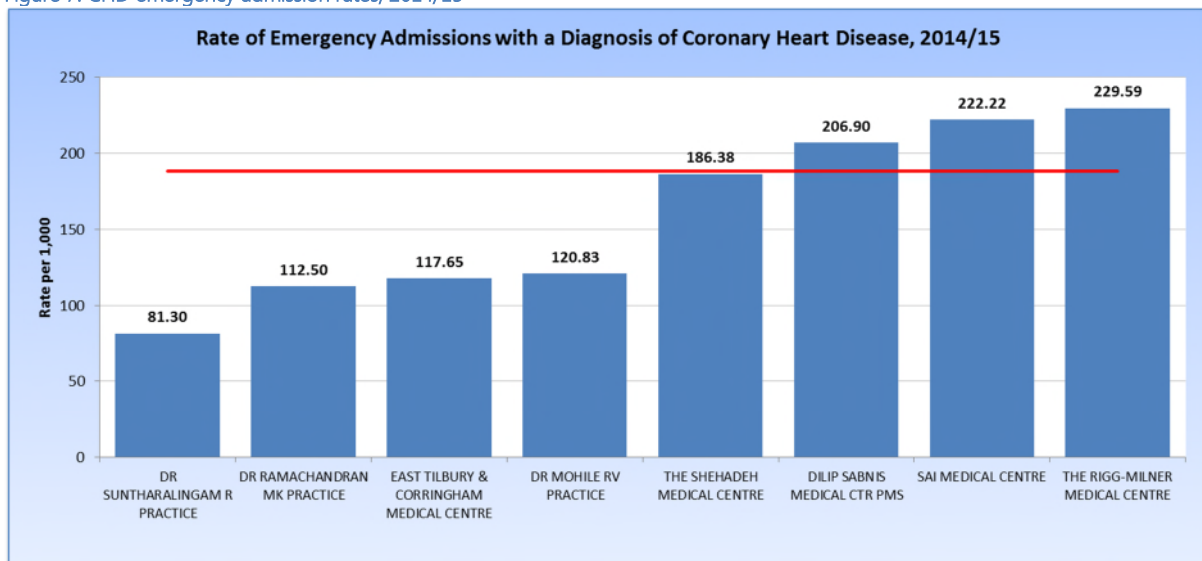
The charts below show practice variation in admission rates for atrial fibrillation, coronary heart disease, heart failure and stroke/TIA. As with those in the main report for COPD and Diabetes, these were calculated as rates per 1,000 patients on those disease registers.

Figure 6: AF emergency admission rates, 2014/15



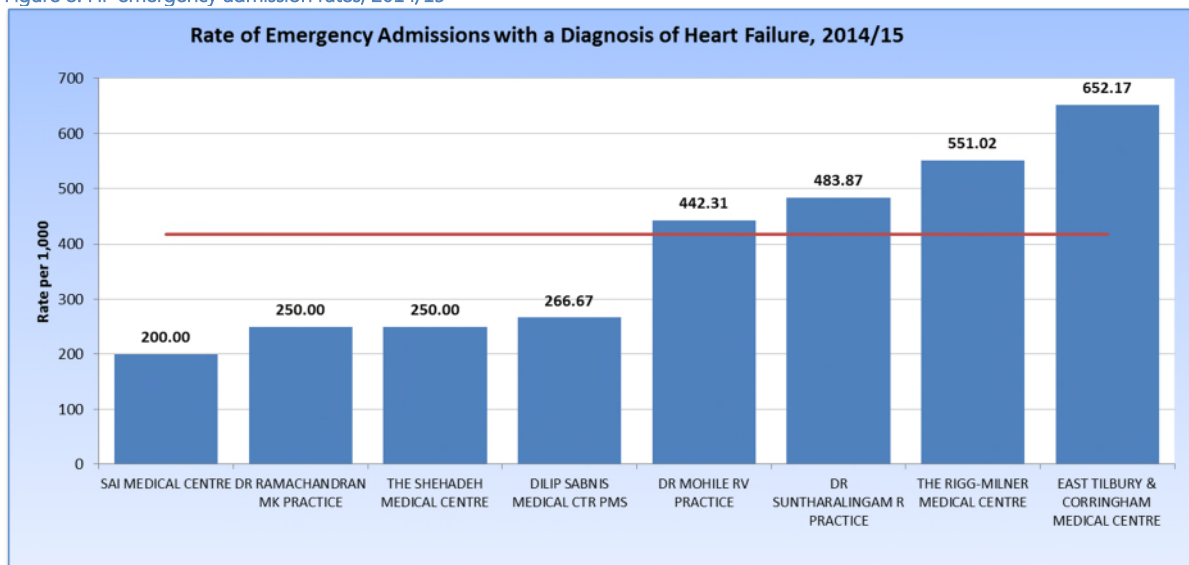
Source: Mede Analytics

Figure 7: CHD emergency admission rates, 2014/15



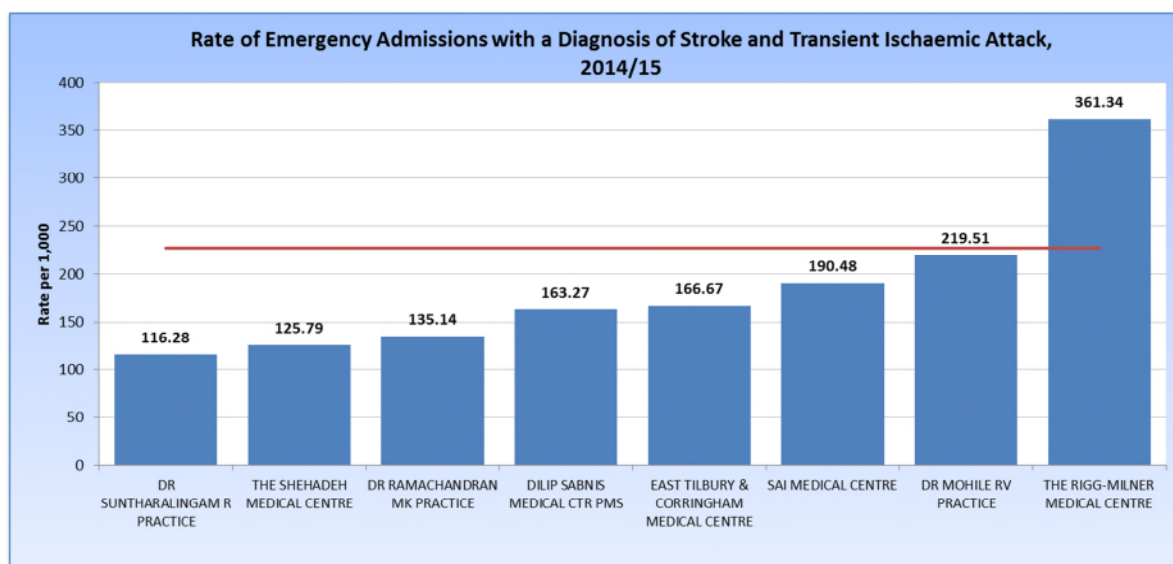
Source: Mede Analytics

Figure 8: HF emergency admission rates, 2014/15



Source: Mede Analytics

Figure 9: Stroke/TIA emergency admission rates, 2014/15



Source: Mede Analytics

### ACSC Conditions

The table below shows information on the number of ACSC admissions - categorising those which are coded, the excess bed days, their cost and length of stay. The excess bed days and cost information is shown in the main report.

Table 5: Spells, Episodes, Excess bed days and Length of stay for Ambulatory Sensitive Care admissions

Ambulatory Sensitive Care	No. of Spells	Episode Count	Excess Bed Days	Excess Bed Days Payment	Total LOS	Duration of Spell	Total Cost
NONE ASC Emergency Admissions	8,656	9,713	3,102	£484,565	21,439	19,567	£11,276,668
All ASC Emergency Admissions	453	699	100	19,247	3,151	3,103	1,188,999
01 - Influenza and pneumonia	118	210	60	£11,626	1,345	1,316	£413,191
02 - Other vaccine preventable	7	12	6	£1,203	80	80	£21,031
03 - Asthma	19	24	16	£2,957	59	57	£24,245
04 - Congestive heart failure	1	2	0	£0	18	18	£3,352
05 - Diabetes complications	42	74	2	£438	425	425	£192,351
06 - Chronic obstructive pulmonary disease	83	134	9	£1,670	439	429	£195,238
07 - Angina	17	26	3	£605	40	40	£13,038
08 - Iron deficiency anaemia	5	6	0	£0	41	41	£7,525
09 - Hypertension	6	7	0	£0	8	8	£9,202
11 - Dehydration and gastroenteritis	5	7	0	£0	22	22	£8,107
12 - Pyelonephritis	8	9	0	£0	34	34	£16,383
13 - Perforated/bleeding ulcer	6	9	0	£0	30	30	£17,569
14 - Cellulitis	15	23	0	£0	85	85	£29,726
15 - Pelvic inflammatory disease	1	1	0	£0	0	0	£854
16 - Ear, nose and throat infections	30	30	0	£0	25	25	£17,500
17 - Dental conditions	4	4	0	£0	3	3	£2,854
18 - Convulsions and epilepsy	22	26	0	£0	53	46	£24,148
19 - Gangrene	11	14	0	£0	127	127	£80,264
21 - Unspecified Acute Lower Respiratory Infection	53	81	4	£748	317	317	£112,421
<b>Total: All</b>	<b>9,109</b>	<b>10,412</b>	<b>3,202</b>	<b>£503,812</b>	<b>24,590</b>	<b>22,670</b>	<b>£12,466,667</b>

Source: Hospital Episode Statistics/Mede Analytics

## SECTION 7: LONG TERM CONDITIONS MANAGEMENT

### NELFT

The section below provides more information about the heart failure service, the stroke hub and integrated respiratory service, and also contains further information on referrals.



## Heart Failure

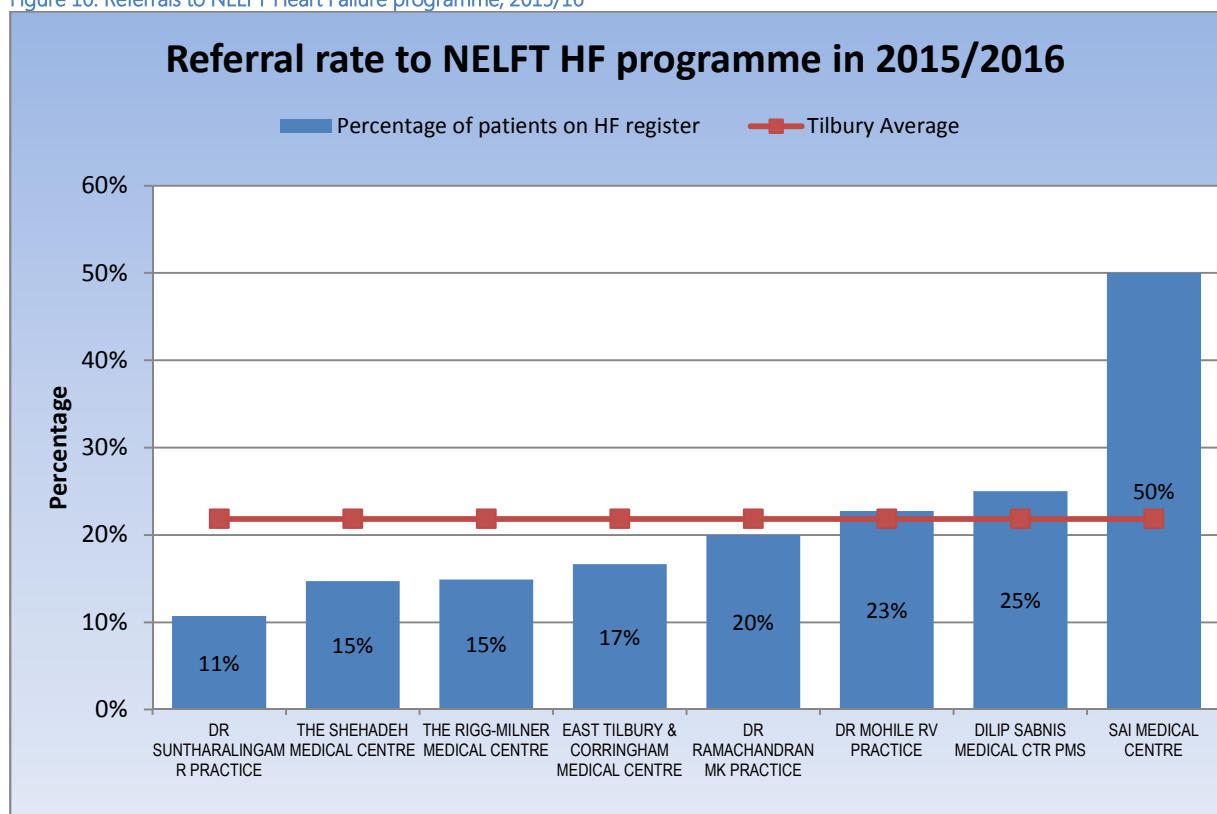
The Community Heart Failure Service provides a patient centred, community based, specialist nursing, education and therapy service for patients with diagnosed Chronic Heart Failure defined by an Ejection Fraction of less than 45%, across South West Essex. The service delivers direct care to patients to assist with maximising disease control and to prevent or minimise deterioration through comprehensive specialist assessment and condition management. In addition the service provides support, resources and education to patients, and health/social care practitioners to enable the delivery of proactive, community based personalised care.

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. However individual outcomes include: provision of personalised care closer to home, contribution to an improvement in the self-management by patients and their carers and contribution towards a reduction in emergency admissions to acute hospitals, the number of A&E Attendances and the number of readmissions.

Referral made on discharge from secondary care which may impact the number of referrals from GPs.

The figure below shows the referrals to the Heart Failure programme as a proportion of those on the Heart Failure QOF register. Whilst it is acknowledged that not all patients on the Heart Failure register would be eligible for a referral to NELFT (e.g. if they are not new diagnoses), this provides a picture of the variation at GP level in referral activity. It should be noted that when NELFT HF referrals were compared to new diagnoses of HF, the number of referrals was higher in many cases than the new patients, which could be if the carers also received referrals to the service.

Figure 10: Referrals to NELFT Heart Failure programme, 2015/16



Source: NELFT and QOF

## Stroke

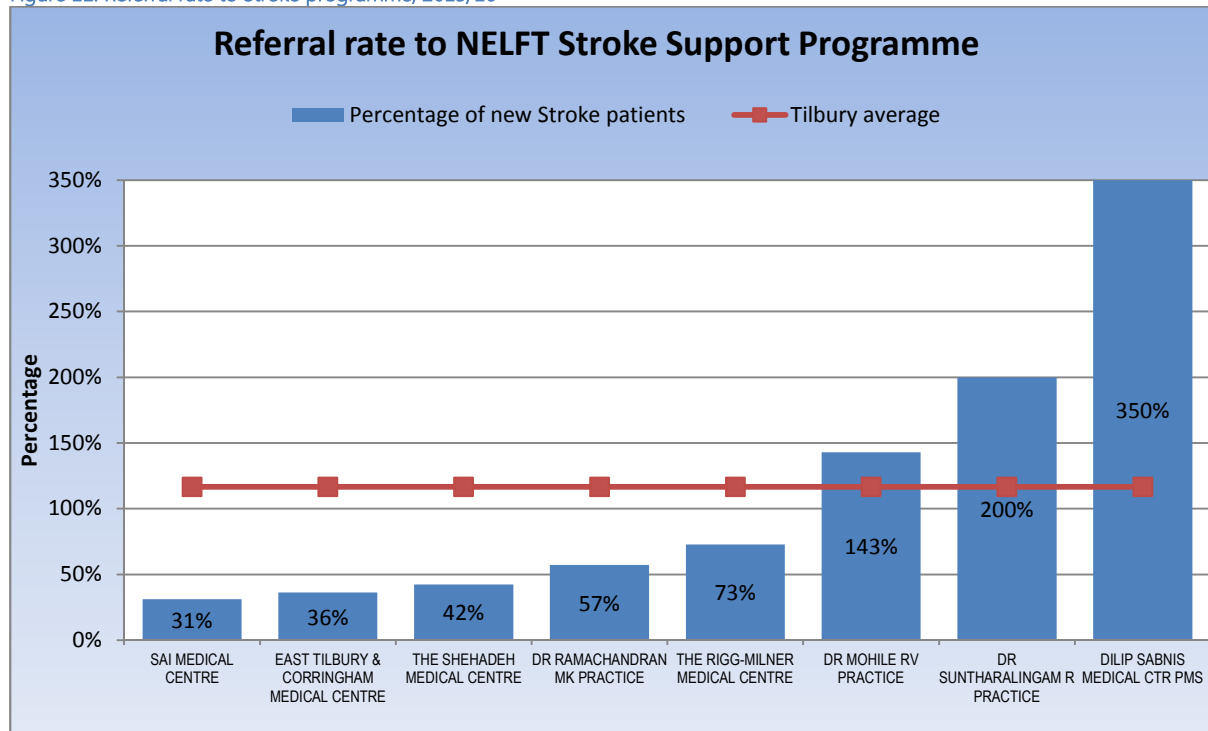
The stroke hub is mostly a programme which helps newly diagnosed patients to transition into community services. It consists of two main services, early supported discharge and the stroke rehabilitation unit. Early supported discharge

service is a comprehensive stroke skilled multidisciplinary team who manage patients at their place of residence and who are able to provide rehabilitation of similar intensity to that of a stroke unit.

The rate of patients referred to the NELFT Stroke services is calculated against the new number of stroke patients on the register in 2015/2016. The high percentage (100%+) of patients referred to NELFT Stroke programme could be because **not only patients are referred to the programme? Only newly diagnosed patients accepted.**

What should be looked more into is the low percentage of patients referred by some practices. One explanation could be the fact that the patients have to meet some criteria in order to be accepted in the programme: to be medically stable, to have adequate cognitive abilities, to be safe to return home and have a Barthel score higher than 50.

Figure 11: Referral rate to Stroke programme, 2015/16



Source: NELFT and QOF

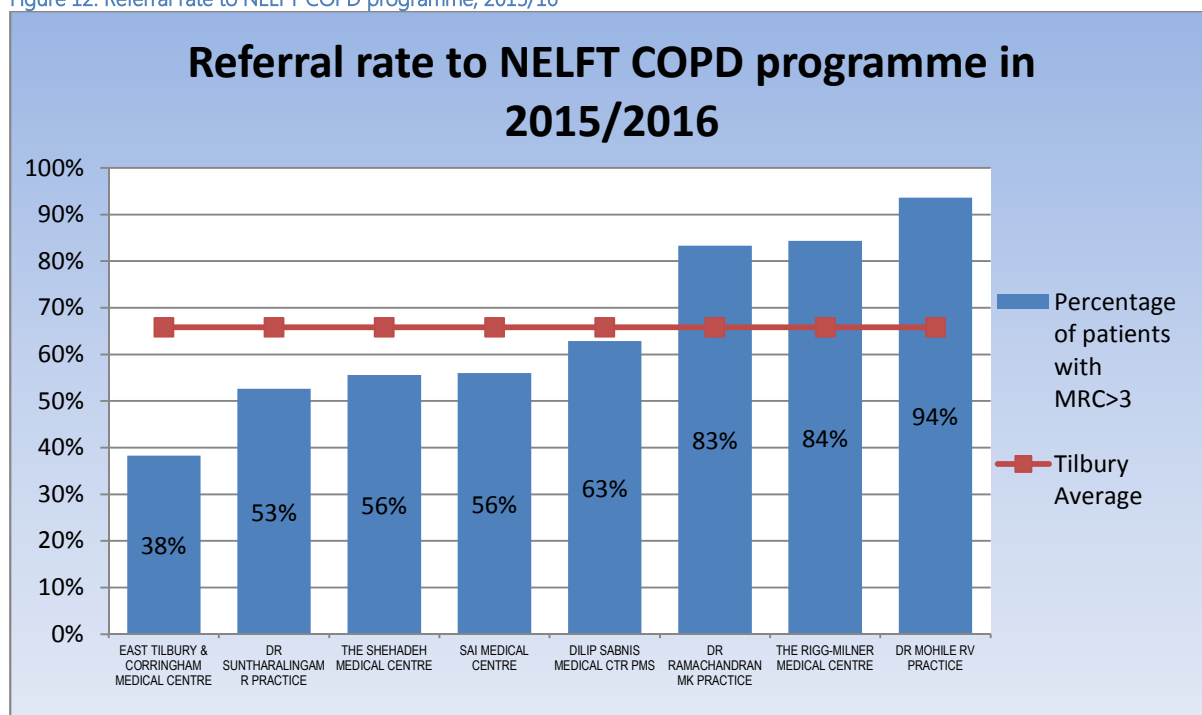
An acknowledged gap by NELFT is a service for AF patients.

### Respiratory Service

This Integrated Respiratory Service offers support to patients with respiratory diseases, particularly COPD, and their carers. Attendants receive clinical input and advice, and are helped to better adjust their treatment and understand their condition. As mentioned in the report, it includes pulmonary rehabilitation and home oxygen assessment. The treatment of people with COPD/Respiratory conditions is evidence-based and managed via a structured pathway approach for all patients with an MRC score of three or above. The anticipated health outcomes of the service include an improvement in patients, relatives and carer's quality of life, improved support for patients with long term conditions, a reduction in related hospital admissions and readmissions and a reduction in related outpatient activity. Whilst the chart in the main document highlighted the rate of those being referred to the pulmonary rehabilitation element of the respiratory programme, this chart shows the referral rate for any aspect of the COPD programme.

\*\*Questionable denominator here, as it uses the QOF COPD005 denominator, and unclear if this is number of COPD patients with MRC over 3, I thought it was all patients...\*\*

Figure 12: Referral rate to NELFT COPD programme, 2015/16



The percentage of patients with an MRC score higher than 3 who were referred to NELFT COPD Support programme during 2015/2016 in Tilbury was 65.8%. This means 134 patients with COPD who were reviewed during fiscal year 15/16 and had an MRC > 3 did not receive any additional support to manage their disease. East Tilbury Medical Centre has the lowest percent of patients referred to NELFT COPD programme.

Post-completion of each programme, NELFT ask participants to complete a 5 x 5 feedback questionnaire – consisting of five simple questions. Below shows the responses received to two of those questions per programme, and it can be seen that almost all programme attendees were happy with the service they received and would recommend it to others.

Table 6: NELFT feedback, 2016

NELFT programme	Question - How likely are you to recommend this service			Question - Did the service meet your expectations		
	Extremely likely	Likely	Neither likely nor unlikely	Yes	Yes, sometimes	No
Diabetes	7	-	1	8	1	-
Chronic Obstructive Pulmonary Disease	12	3	-	14	1	-
Heart Failure	10	5	-	15	-	-
Health Improvement	11	4	-	14	-	1
Stroke	7	6	2	15	-	-

Source: NELFT

## IAPT use

Further information on the ethnicity and disability status of those referred into IAPT services is shown below. It should be noted that this information is only available for Thurrock, and conclusions should be drawn as to whether the Tilbury data would reflect the same characteristics.

**Table 7: Ethnicity of those referred into IAPT services, April to September 2016**

Ethnicity	Percentage
White	90
Black / African / Caribbean / Black British	4
Asian / Asian British	2
Mixed / Multiple Ethnic Group	2
Other Ethnic Group	1
Not Stated / #NA	1
Total	100

Source: IAPT data from TCCG, 2016

The table above shows us that 90% of those referred into IAPT services are White British or other White groups, compared to 86% of the general population of Thurrock being White.

The second largest group to be referred are those of Black African ethnicity, 4%, compared to 8% of the population of Thurrock being Black. There were 2% of those in mixed ethnic groups referred into the services and the group with the smallest referral proportion was the Asian/Asian British ethnic group, 2%, compared to 4% of the population being Asian.

This suggests that those in minority groups are under-represented in IAPT services.

**Table 8: Disability Status of those accessing IAPT, April-September 2016**

Disability	Proportion
None	85%
Mobility and Gross Motor	4%
Memory or ability to concentrate, learn or understand (Learning Disability)	3%
Other	3%
Sight	1%
Hearing	1%
Behaviour and Emotional	1%
Speech	1%
Progressive Conditions and Physical Health (such as HIV, cancer, multiple sclerosis, fits etc)	0%
Manual Dexterity	0%
Personal, Self-Care and Continence	0%
Total	100%

Source: IAPT data from TCCG, 2016

Of those referred into IAPT services, the vast majority (85%) were reported to have no disability. This is an interesting finding because evidence shows that those with a disability are more likely to have a mental health disorder. Therefore,

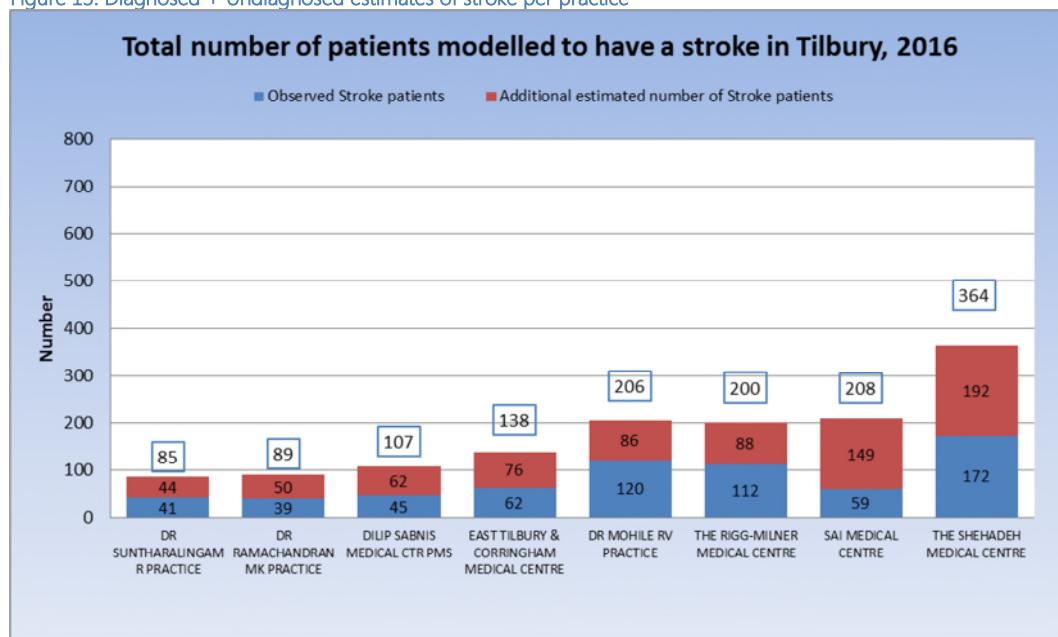
it suggests that those with disabilities are under-represented in IAPT services. More work might need to be done to identify those with disabilities who also have a mental health condition.

### 1.1.1 SECTION 8: EARLY IDENTIFICATION OF LONG TERM CONDITIONS

#### Case finding

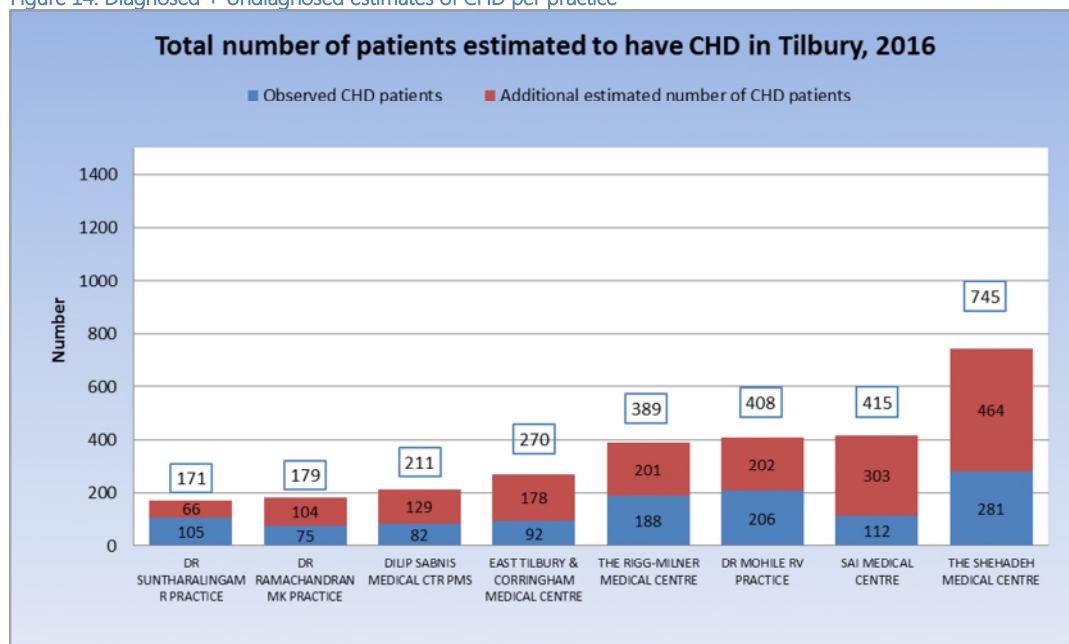
The figures below show the total numbers of patients estimated to have stroke, CHD, hypertension, COPD and Depression per practice, highlighting those who have already been observed and those still undiagnosed.

Figure 13: Diagnosed + Undiagnosed estimates of stroke per practice



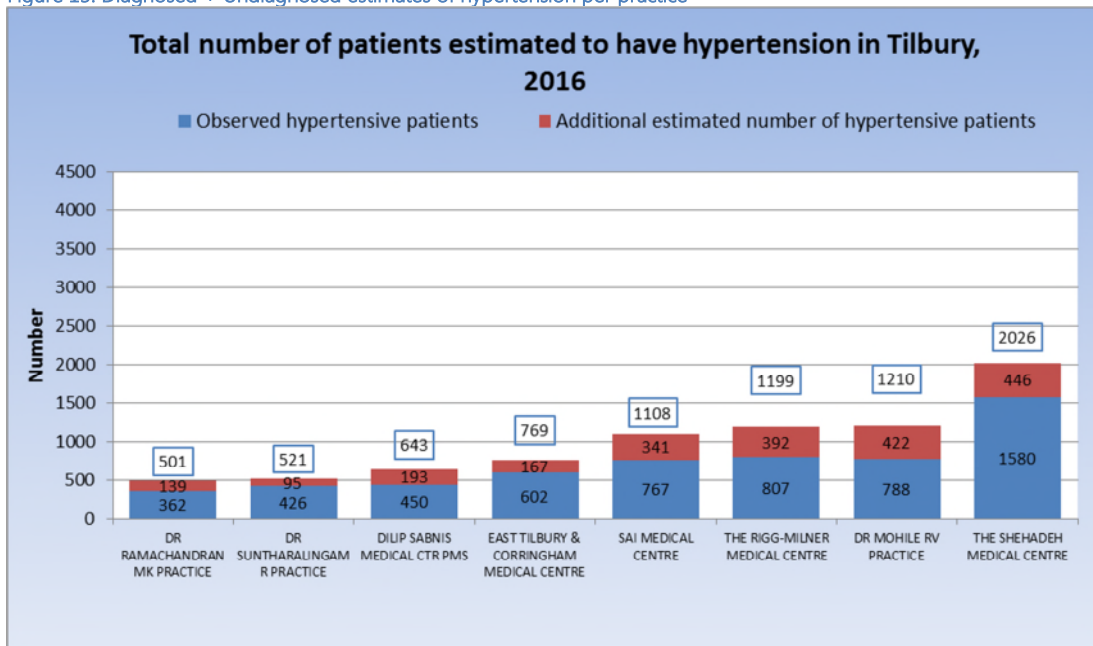
Sources = QOF register 2015/16 and PHE estimates 2016

Figure 14: Diagnosed + Undiagnosed estimates of CHD per practice



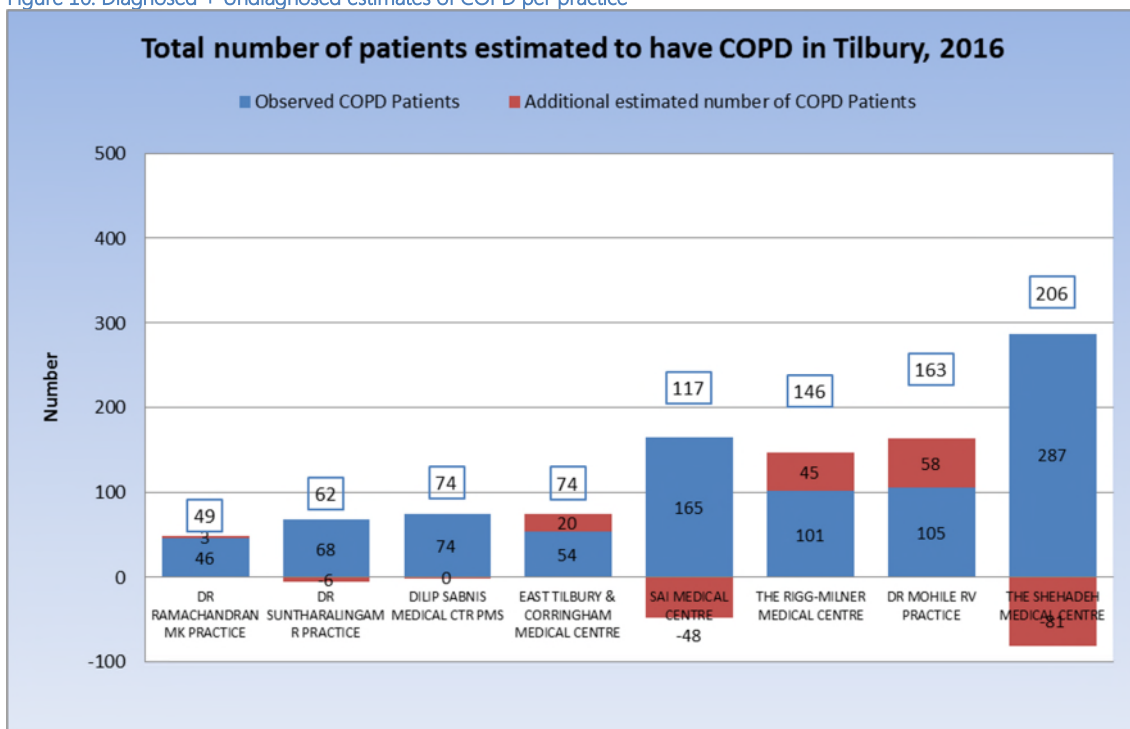
Sources = QOF register 2015/16 and PHE estimates 2016

Figure 15: Diagnosed + Undiagnosed estimates of hypertension per practice



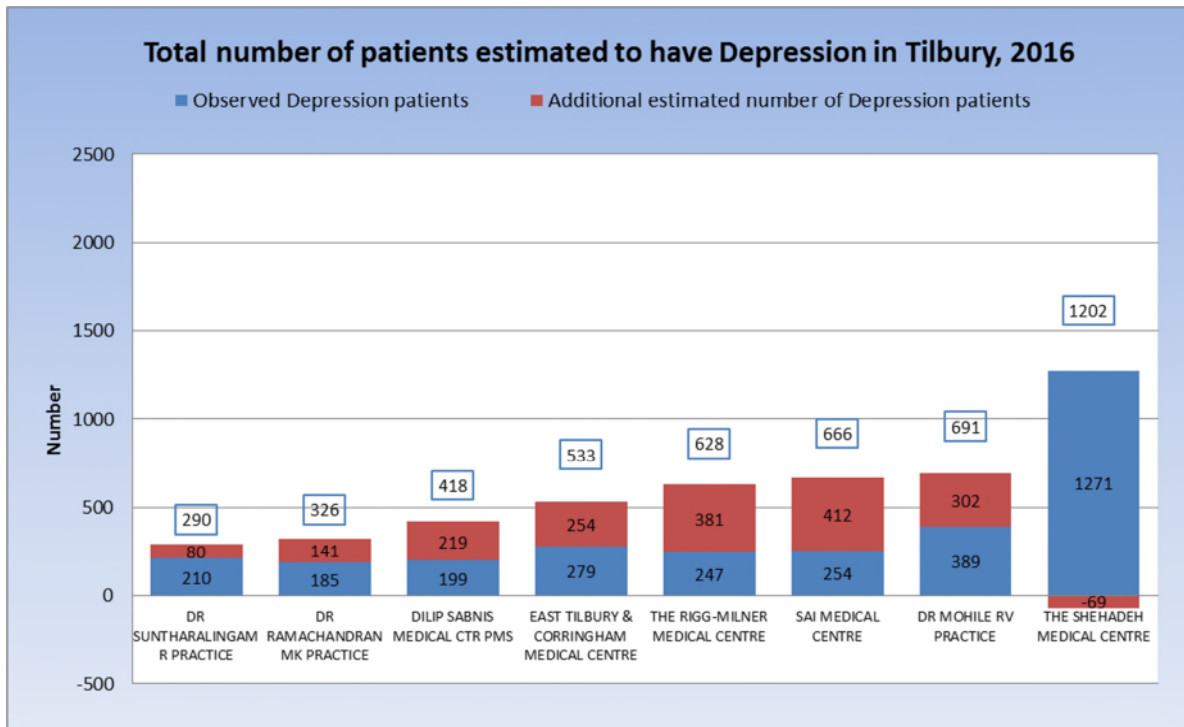
Sources = QOF register 2015/16 and PHE estimates 2016

Figure 16: Diagnosed + Undiagnosed estimates of COPD per practice



Sources = QOF register 2015/16 and PHE estimates 2016

Figure 17: Diagnosed + Undiagnosed estimates of Depression per practice

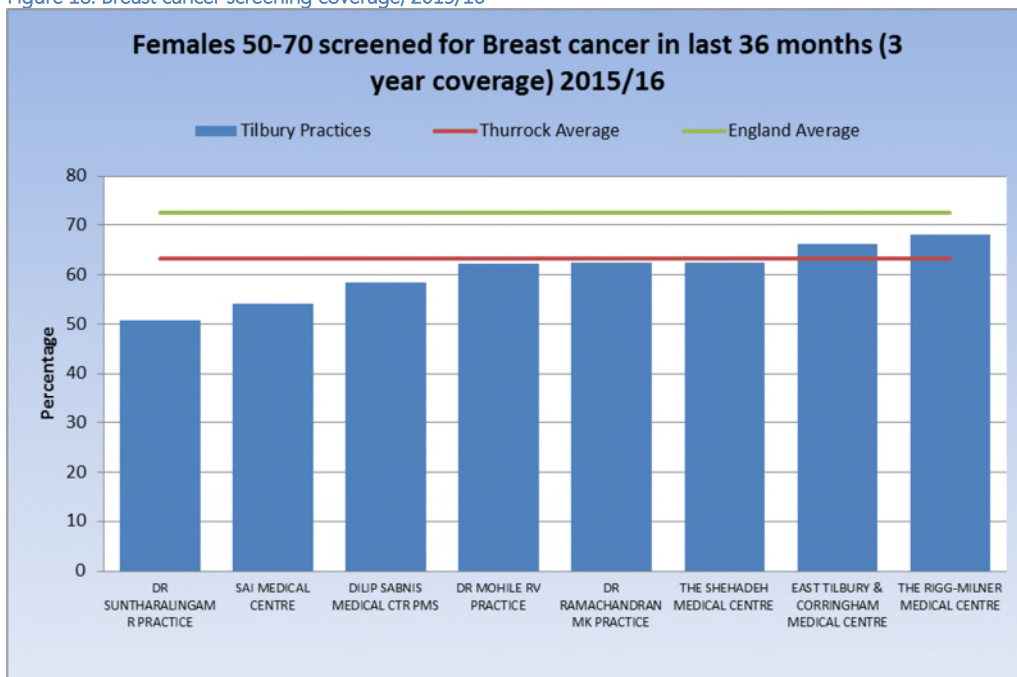


Sources = QOF register 2015/16 and PHE estimates 2016

### Cancer Screening

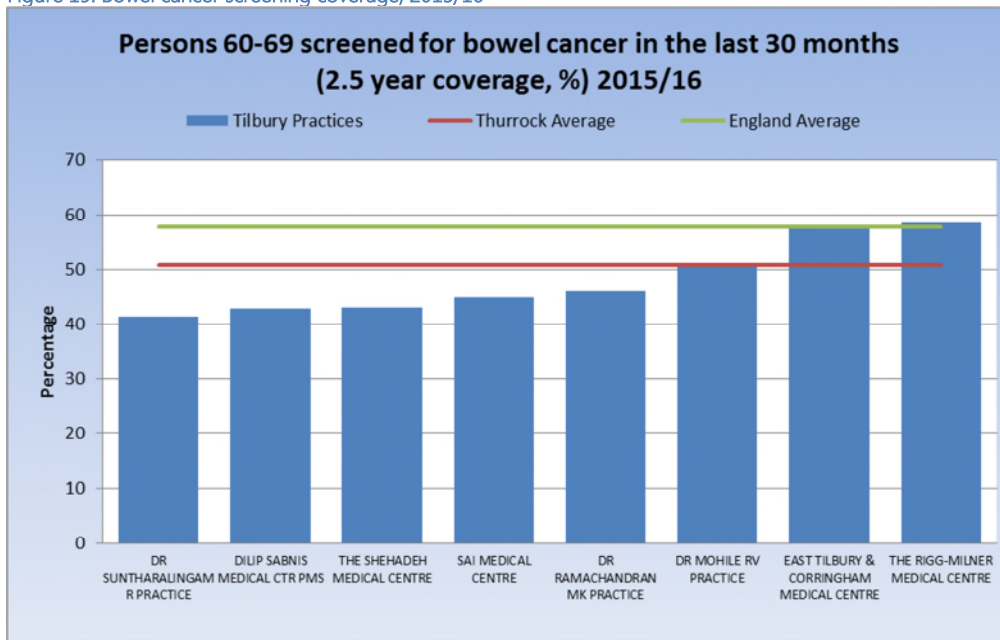
When analysing practice-level cancer screening data, it can be seen that for both breast and bowel cancer screening, coverage is higher in the East Tilbury practices (Rigg Milner and East Tilbury Health Centre) than the Tilbury and Chadwell practices. For breast cancer, coverage ranges from 50.8% in Dr Suntharalingham to 68.2% in Rigg Milner [the Thurrock mean is 63.4%]. For bowel cancer, coverage ranges from 41.4% in Dr Suntharalingham to 58.6% in Rigg Milner [the Thurrock mean is 50.9%].

Figure 18: Breast cancer screening coverage, 2015/16



Source: Public Health England

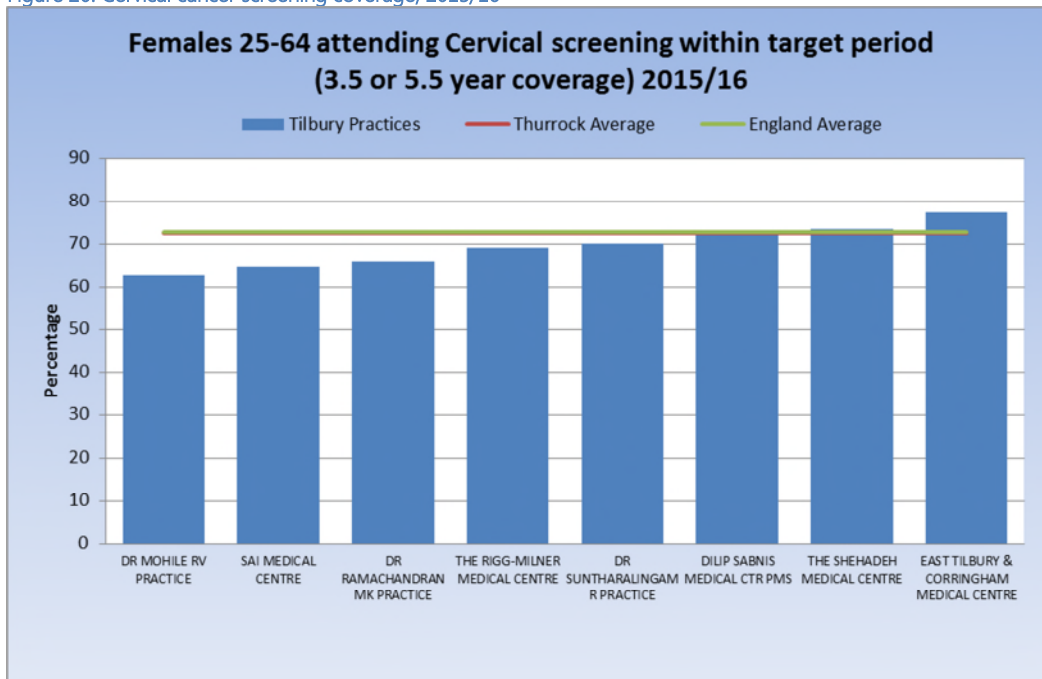
Figure 19: Bowel cancer screening coverage, 2015/16



Source: Public Health England

For cervical screening, whilst coverage still varies within Tilbury locality, many of the practices are much closer to the national and Thurrock averages. Dr Mohile has the lowest coverage (62.6%) and East Tilbury HC has the highest coverage (77.2%). The Thurrock mean is 72.6%.

Figure 20: Cervical cancer screening coverage, 2015/16



Source: Public Health England

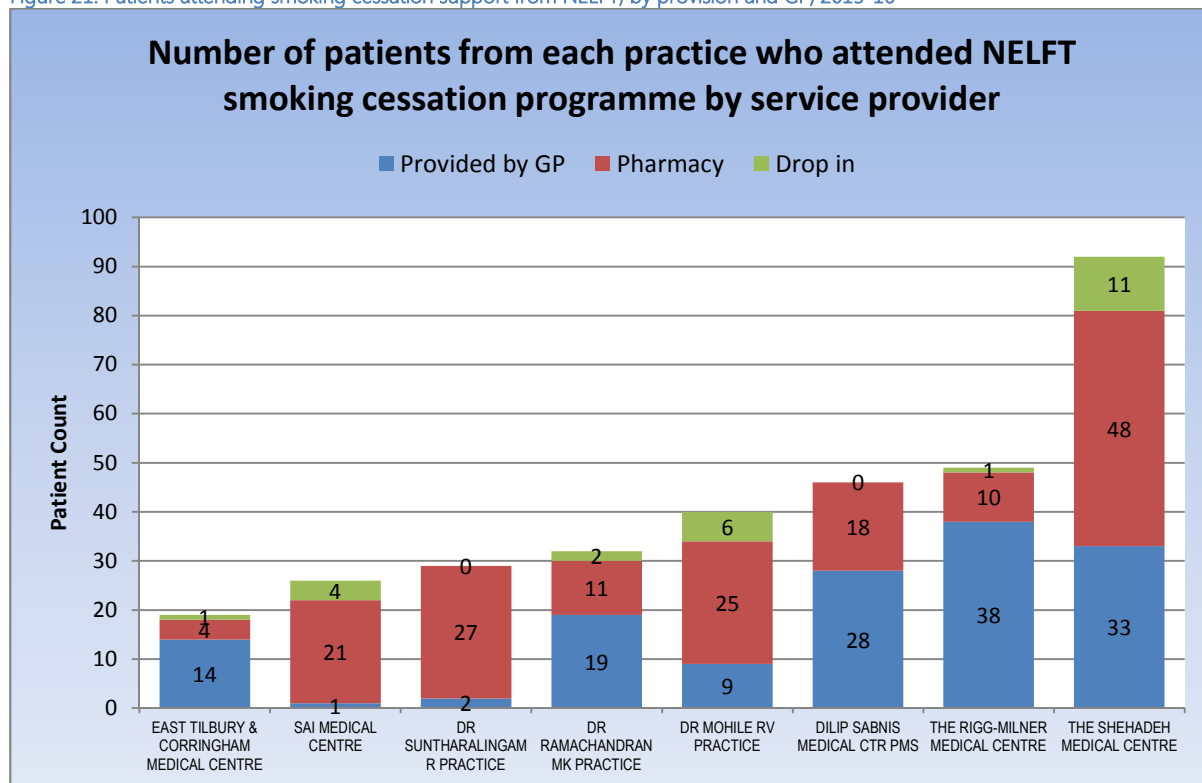
### Public Health Commissioned Services

This section contains further information on smoking, and data on obesity and substance misuse.



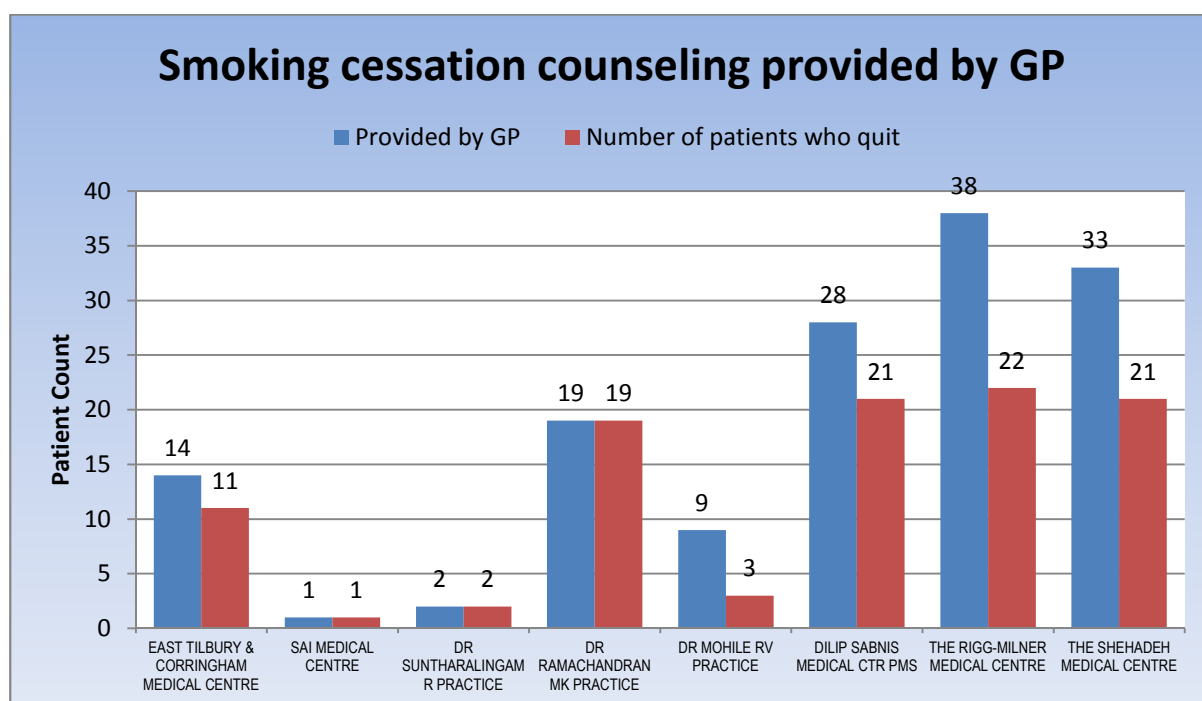
There were a total of 333 patients accessing the smoking cessation services commissioned by NELFT in 2015/16. 144 were supported by their GP, 164 by the pharmacy and 25 by the drop in clinic. This can be seen in the figure below.

Figure 21: Patients attending smoking cessation support from NELFT, by provision and GP, 2015-16



Source: NELFT

From those 144 serviced by their GP, it is recorded that 100 quit smoking, 29 didn't quit, and with the rest it was not followed up.

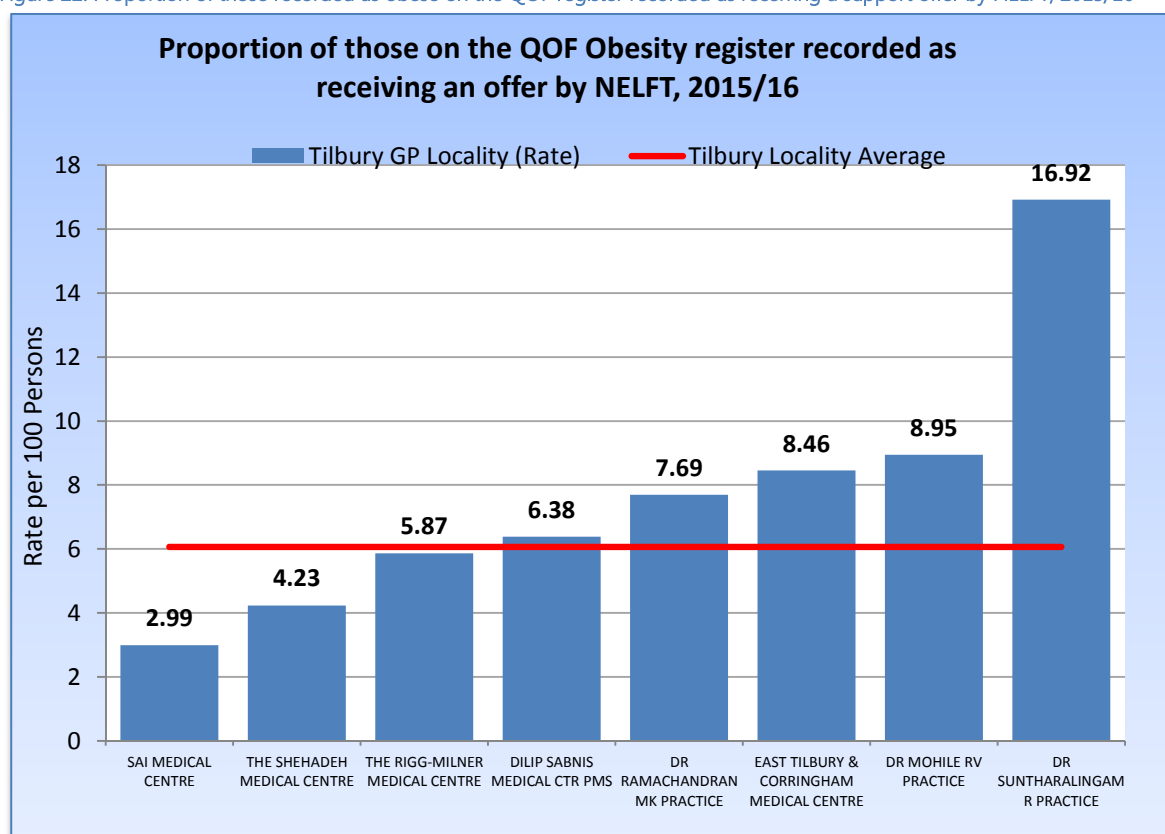


Source: NELFT

There are 4 weight management programmes available to patients from Tilbury who have a BMI higher than 30. Three of them are community based programmes, Tai Chi for Health, KSL, and Nutrition Advice for Health, and NELFT. The community based programmes have limited resources and a limited number of patients attending their classes. Tai Chi for health had 38 patients attending weight management classes last year, with 17 successfully completing, none of them referred by their GP. Similarly, KSL and Nutrition Advice for Health had 10 and 15 patients attending from Tilbury respectively, all self-referred.

During the fiscal year 2015-2016 there were only 54 patients registered with a Tilbury practice referred by their GP to NELFT weight management programme, from a total of 173 referrals. The other sources of referral are community specialist nurses, other health professionals, Vitality, SEPT and self-referrals. In Tilbury, an average of 6.05% of patients on the Obesity registers accessed the NELFT weight management programme in 2015/2016, with less than one third of these patients being directly referred by their GP. The percentage of patients accessing the weight management programme varies across practices from 2.99% to 16.92% of patients on the obesity register. This means 6 out of 100 obese patients registered with a Tilbury practice accessed support services offered by NELFT, with Sai Medical Centre recording the lowest rate of 2.99% (3 out of 100 obese patients).

Figure 22: Proportion of those recorded as obese on the QOF register recorded as receiving a support offer by NELFT, 2015/16



Source: NELFT and QOF

## Substance Misuse

AddAction is the single point of contact for substance misuse, offering a wide range of alcohol and drug treatments services. Referrals in the addiction programme are not mandatory and can only be made with patients' consent. They use Nebula, a case management system, rather than a clinical system such as SystmOne and all the referrals are manually input into the program.

From a total of 89 patients entering the treatment programme in 2015-2016, 11 patients are still active in the treatment. A high percentage of patients referred for treatment, 83.3%, were referred by their GP, and only 6 patients were referred by other sources: 3 were self-referrals, 2 Social Services referrals and 1 coming from the Criminal Justice System.

The table below shows referrals by GP:

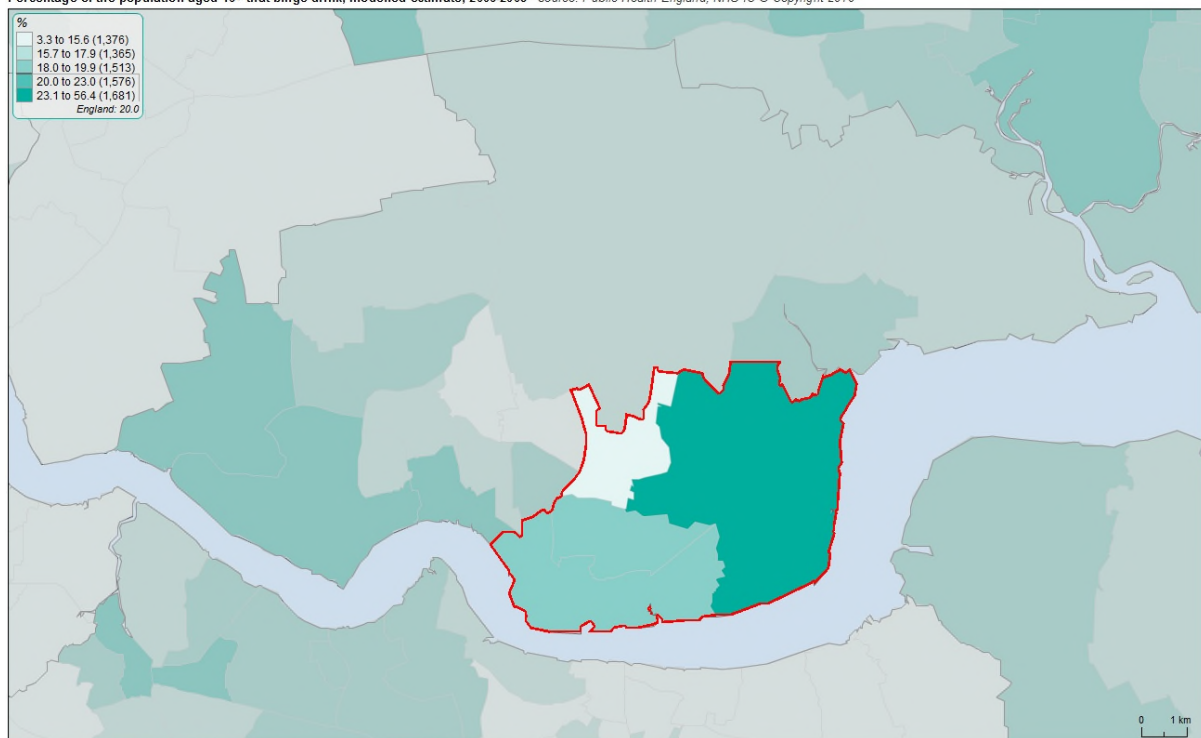
GP	Number of referrals to Addaction
The Rigg-Milner Medical Centre	6
Dr Mohile RV Practice	23
Dr Suntharalingham R Practice	5
The Shehadeh Medical Centre	26
Dr Ramachandran MK Practice	10
East Tilbury & Corringham Medical Centre	0
Dilip Sabnis Medical Centre PMS	7
Sai Medical Centre	7

Source: Addaction

Estimates of binge drinking activity at ward level have been produced by Public Health England. They estimate that approximately 18.5% of adults aged 16+ in the locality area are likely to binge drink. Whilst this is below the national average of 20%, it could still be as many as 5,300 residents (calculated using July 2016 population data for the locality population aged 16+). Even though not all of these residents would access a service, it still indicates that there could be a large amount of unmet need in the area.

**Figure 23: Binge Drinking estimates by ward**

Percentage of the population aged 16+ that binge drink, modelled estimate, 2006-2008 - source: Public Health England, NHS IC © Copyright 2010



©PHE - © Crown copyright and database rights 2016. Ordnance Survey 100016969 - ONS © Crown Copyright 2016 - Ward (2015 boundaries)

Source: Local Health

## 1.1.2 SECTION 9: AVOIDABLE A&E ATTENDANCES

The information below gives more detailed information about the 13,399 A&E attendances from patients registered to practices in Tilbury.

### *Minor Investigations and treatments*

Looking at investigations in the lower level HRG categories, it can be seen that the most common investigations include Haematology, X-ray, Clotting studies and Blood Gases. Table 9 below shows the number of treatments that occurred over the 12 month period by the time of day (In or Out of normal Primary Care operating hours). [This is shown in the chart in the main report]

Table 9: Number of attendances in the lower HRG categories by Investigation and time of day

	In Practice Hours	Out of Practice Hours
None	3,598	1,453
Haematology	1,178	891
X-ray plain film	1,012	584
Clotting studies	261	162
Arterial/capillary blood gas	222	190
Other	191	91
Urinalysis	97	65
NONE	80	43
Biochemistry	72	43
Cardiac enzymes	25	20
Bacteriology	22	14
Blood culture	16	2
Electrocardiogram	12	3
Pregnancy test	3	4
Cross match blood/group and save serum for later cross match	4	2
Toxicology		2
Serology	1	1
Refraction, orthoptic tests and computerised visual fields	1	1
Histology	1	
Immunology	1	

Source: Hospital Episode Statistics

Table 10 shows the number of treatments that occurred over the 12 month period by the time of day (In or Out of normal Primary Care operating hours). The most common treatments include advice/none, Observations/ecg, prescription medications. [This is shown in a chart in the main report]

Table 10 Number of attendances in the lower HRG categories by treatment and time of day

	Out of Practice Hours	In Practice Hours
Guidance/advice only	1,248	1,946
None (consider guidance/advice option)	1,241	1,603

NONE	156	1,908
Observation/electrocardiogram, pulse oximetry/head injury/trends	220	357
Prescription\medicines prepared to take away	151	259
Recording vital signs	142	154
Other (consider alternatives)	91	136
Intravenous cannula	83	131
Medication administered	94	88
Bandage/support	25	33
Sling/collar cuff/broad arm sling	15	27
Wound closure, other	23	17
Recall/x-ray review	15	23
Wound cleaning	17	19
Dressing	12	17
Loan of walking aid (crutches)	6	19
Fracture review	6	13
Dressing/wound review	7	10
Splint	5	11
Plaster of Paris	2	10
Infusion fluids	7	4
Burns review	3	2
Anaesthesia		3
Tetanus	1	2
Sutures		2
Nasal airway	1	1
Epistaxis control		1
Cooling - control body temperature		1

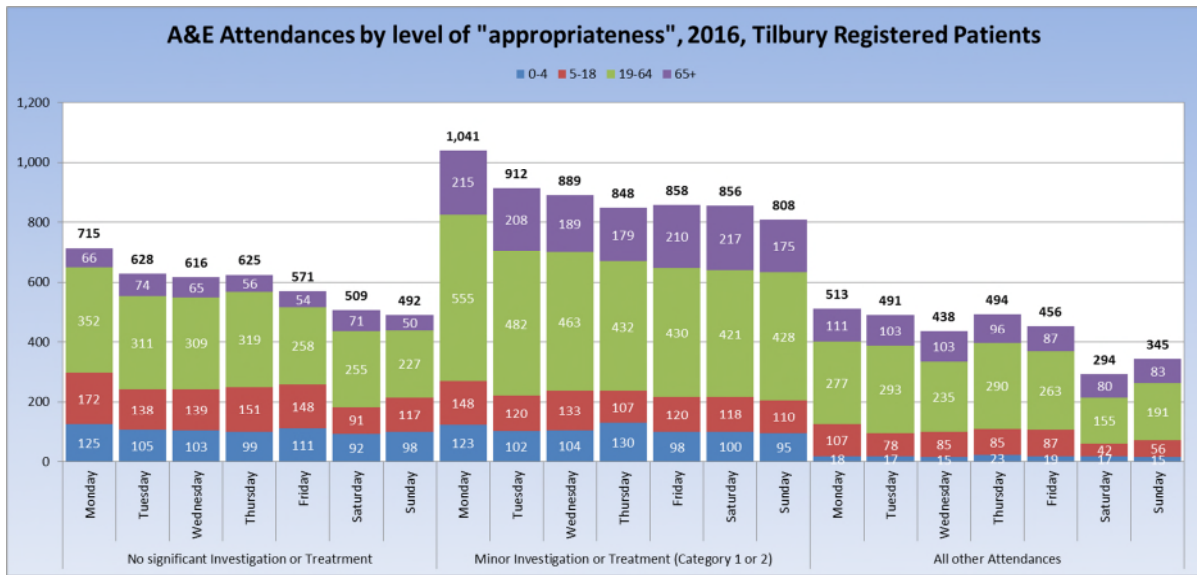
Source: Hospital Episode Statistics

### ***Day of the Week and Age***

Figure 24 shows that the largest amount of activity is taken investigating and treating minor activity. For all activity groups Monday is the busiest day and attendance levels fall throughout the week.

The largest group of users are the 19 to 64 year olds followed by the 65+ (It is worth noting that this group consists of the largest proportion of the population so this would be expected, the purpose of this analysis is to look at who is attending.)

Figure 24 A&E attendances by HRG category and Day of the week

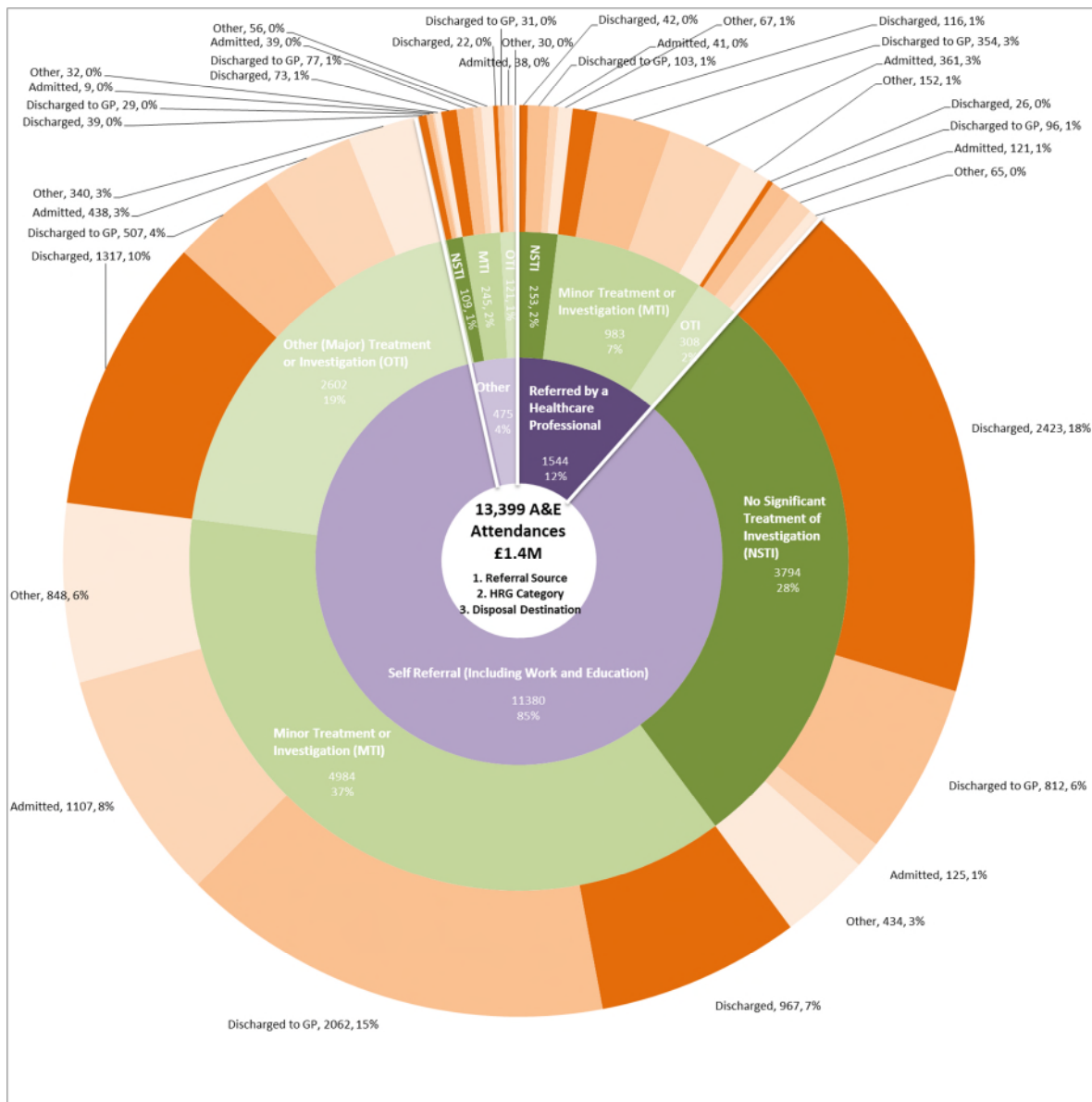


Source: Hospital Episode Statistics

### Referrals and Disposals

By the far the largest group are self referrals (Including those sent by workplace and Education organisations) these make up 85% of all attendances (11,380 , £1.2M). 3,794 (33%) of these require no significant treatment or investigation (£246K) and of those 2,423 (64%) were discharged requiring no further follow-up (£159K) and 812 (21%) were discharged to follow-up with their GP (£52K). [Figure 25] 12% (1,544) of the attendees were referred by a healthcare professional. The largest proportion of these (63%) required some minor investigation or treatment. (983, £123K). 36% (553) of those who were referred by a healthcare professional were discharged to their GP (£68K), most of whom had either no or minor investigations and treatments during their time in A&E (457, £50.5K). [Figure 25] Financial opportunity – tighten referral pathways from other parts of the health and social care system = £123K).

Figure 25: Referrals, HRG categories and Disposal of Tilbury A&E attendees



Source: Hospital Episode Statistics

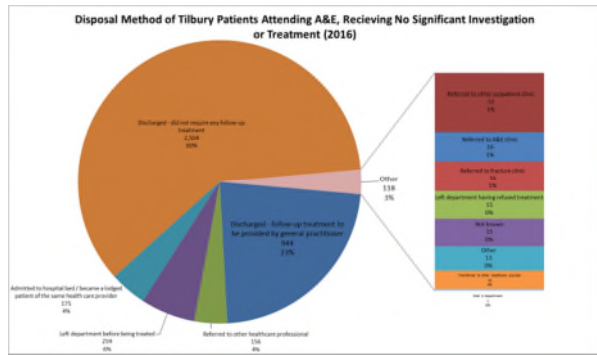


Figure 26

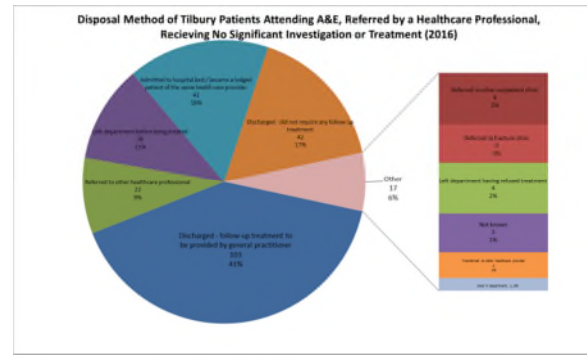


Figure 29

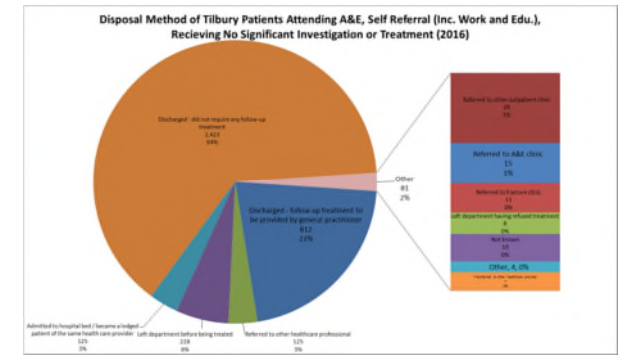


Figure 32

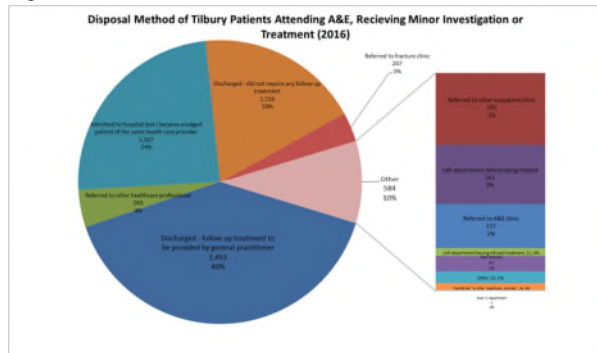


Figure 27

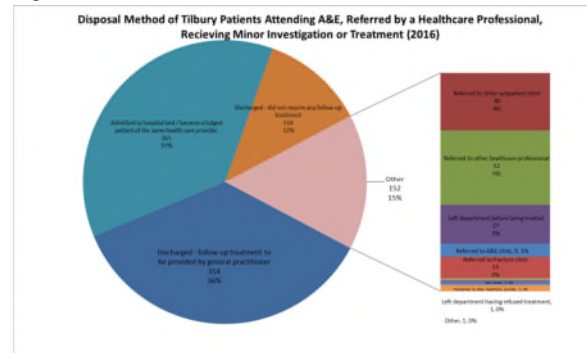


Figure 30

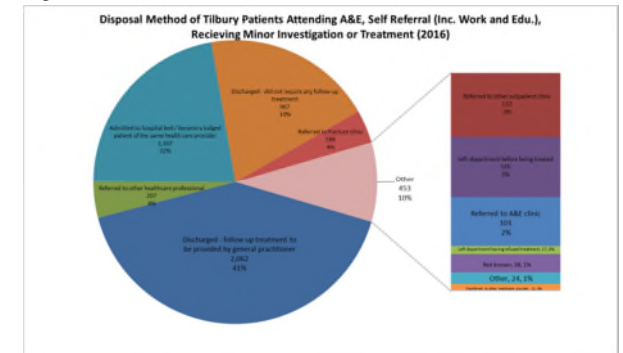


Figure 33

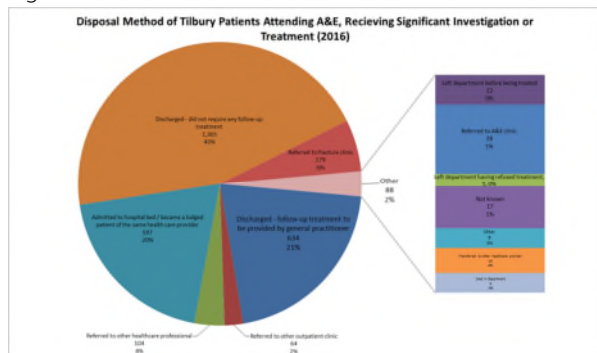


Figure 28

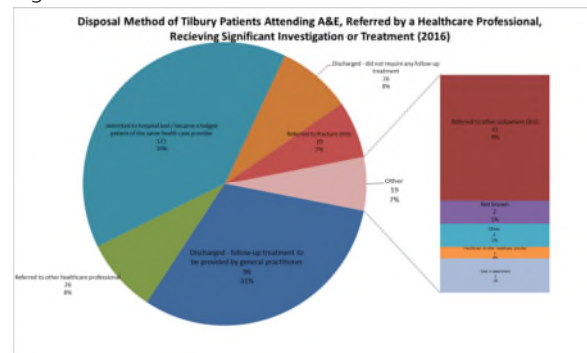


Figure 31

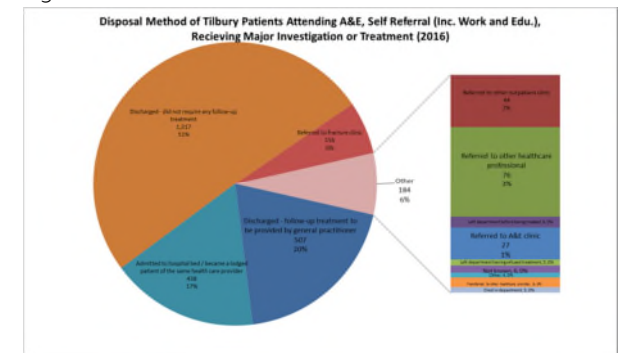


Figure 34



The pie charts above demonstrate the differences in the proportion of patients being discharged, admitted and discharged to GP depending on the referral source (Self or Healthcare professional) and severity of investigation or treatment. (See Orange and blue segments). The orange segments (discharged with no follow up) are much larger for the patients who self referred and the admitted section (lighter blue) is much larger for those who were referred by a healthcare professional.

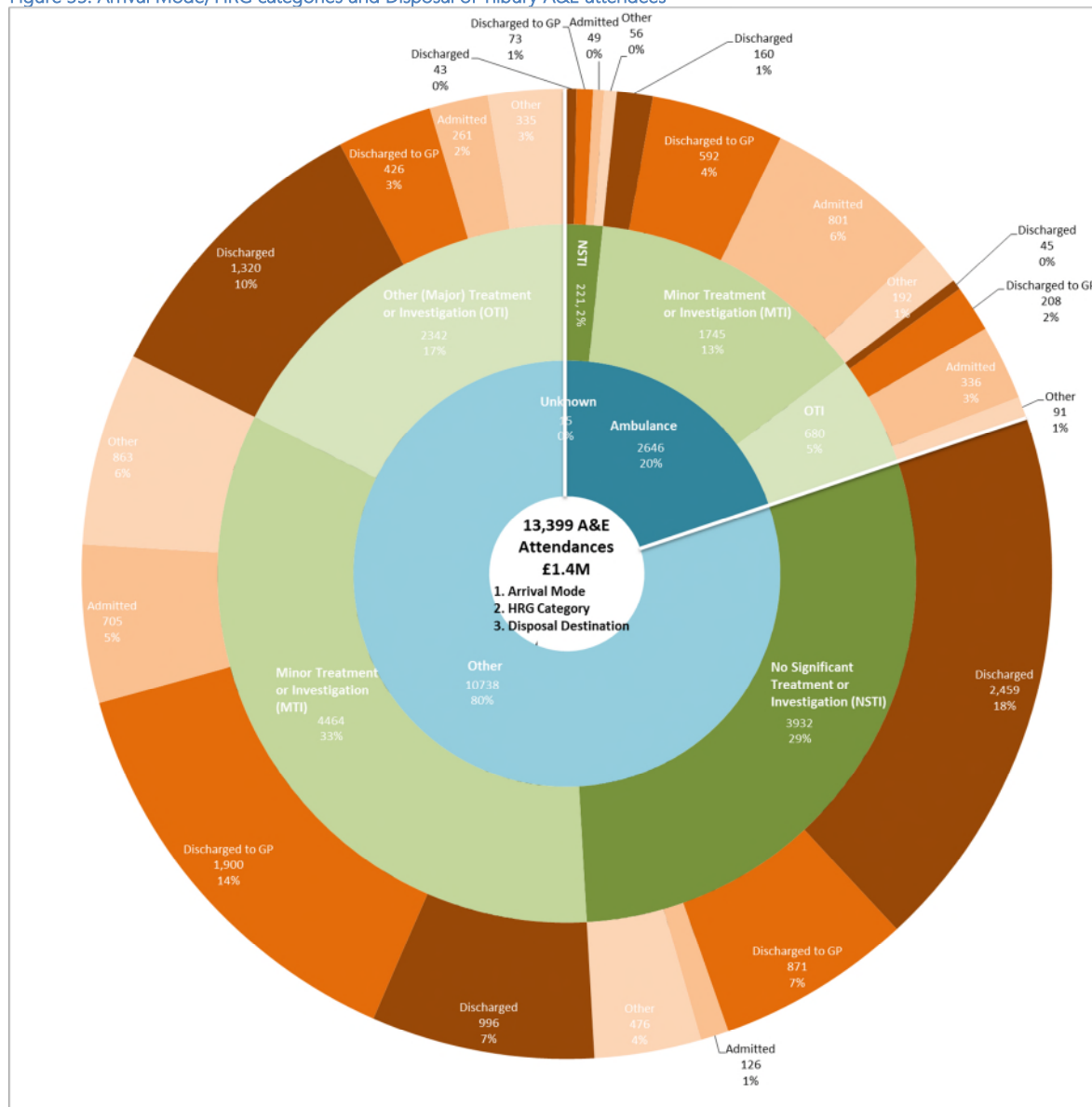
Financial opportunity – improve patients self referral activity in line with a health professional and so reducing those who are discharged with no significant treatment = £162K (2,172 attendances)

### Mode of arrival and Disposals

Around 20% (2,646) of low level HRG attendances arrive in A&E in an ambulance. 1,745 (65%) of these received only minor investigations and treatments and a further 221 (8%) received no significant intervention or treatment. 665 (34%) of those who arrived in ambulance and only received low level to no investigations or treatments were discharged from A&E for GP follow up and an additional 203 (10%) were discharged with no further follow up required. [Figure 35]

Financial opportunity – improve triage on ambulance use with an aim to reduce the number of attendances who receive minor investigations and treatments and are then discharged to primary care or home. Savings of up to £224K.

Figure 35: Arrival Mode, HRG categories and Disposal of Tilbury A&E attendees



Source: Hospital Episode Statistics

#### ***4 hours plus in A&E***

During busier periods (daytime) a smaller percentage of people are in A&E for longer than four hours. This is probably due to the staffing mix and availability of disciplines to call on in the hospital as well as numbers being lower in the evening and perhaps more unpredictable. [

Figure 36]

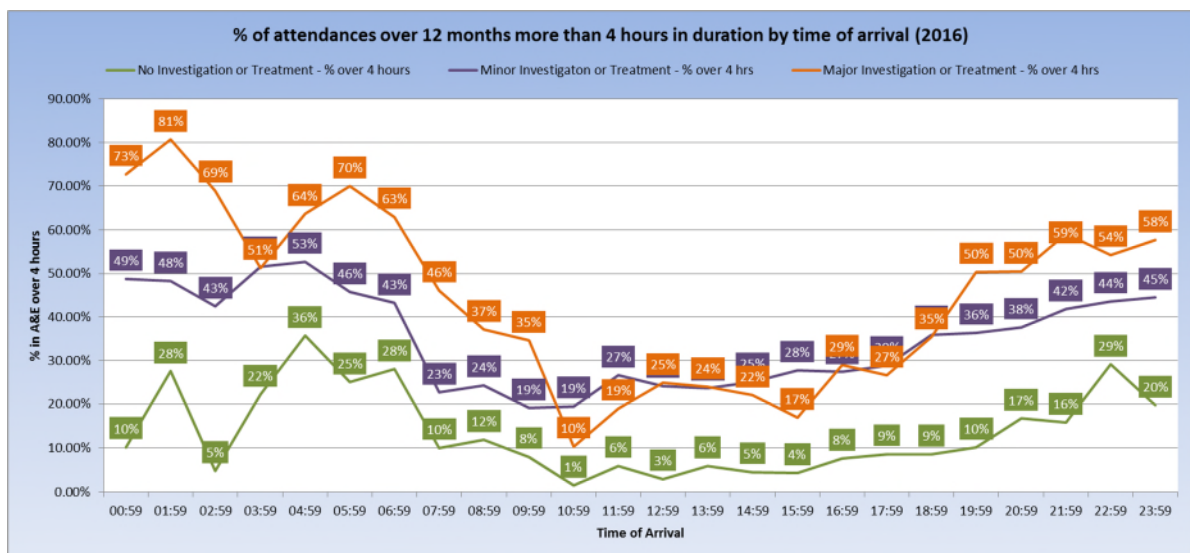
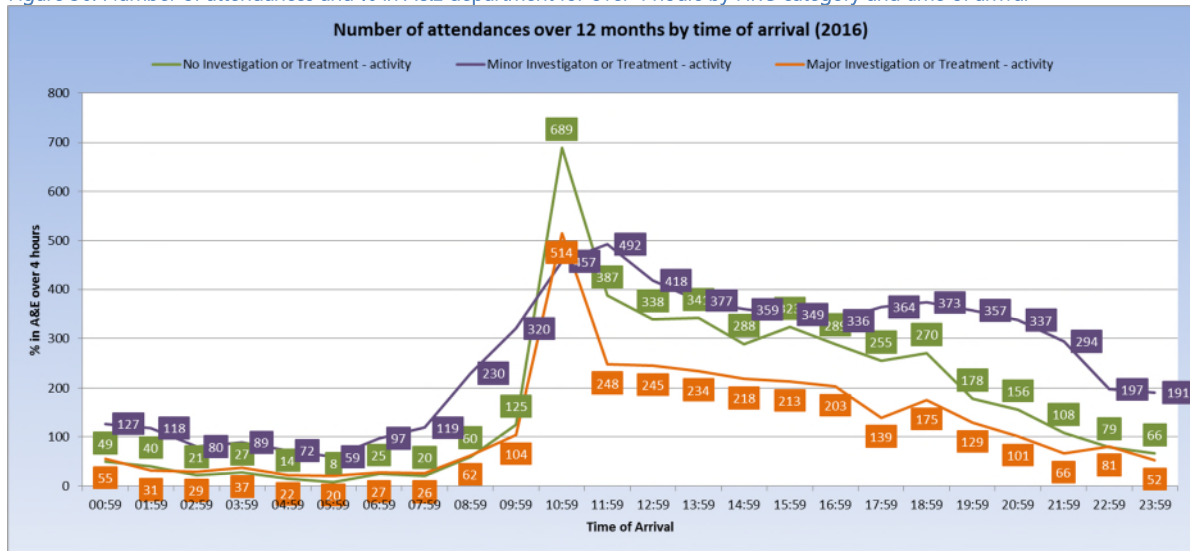
It is concerning, however, that those requiring more major investigations and treatments have a higher probability of being in A&E for longer than 4 hours in the night than those of a lesser severity. This is the reverse of the daytime. Those requiring no significant Investigation or Treatment have a relatively low probability of being in the department for longer than 4 hours.<sup>1</sup> [

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<sup>1</sup> Note – when we get IDS look at time to triage, time to treatment, Time to admission/discharge.

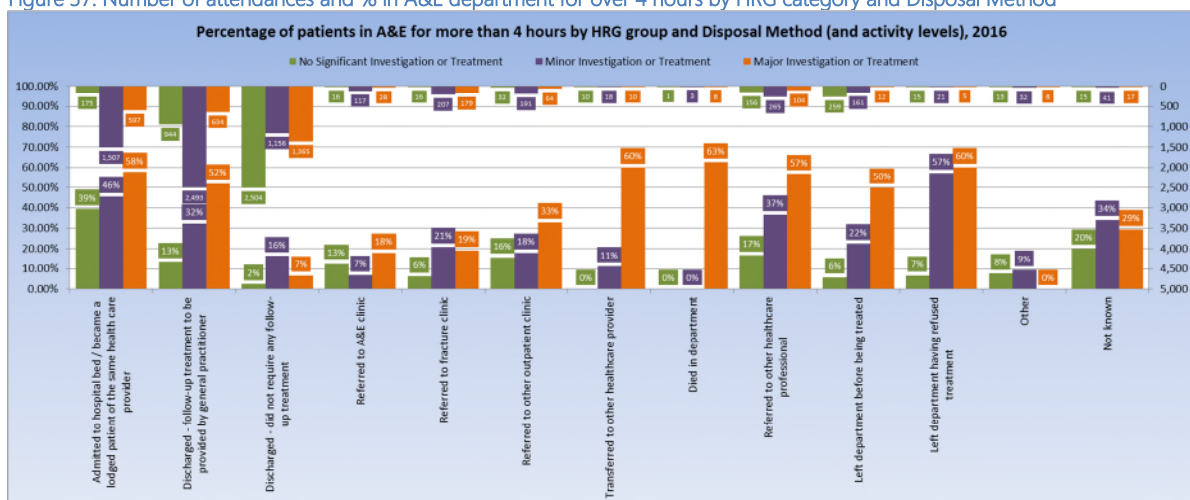
Figure 36]

Figure 36: Number of attendances and % in A&E department for over 4 hours by HRG category and time of arrival



Source: Hospital Episode Statistics

Figure 37: Number of attendances and % in A&E department for over 4 hours by HRG category and Disposal Method



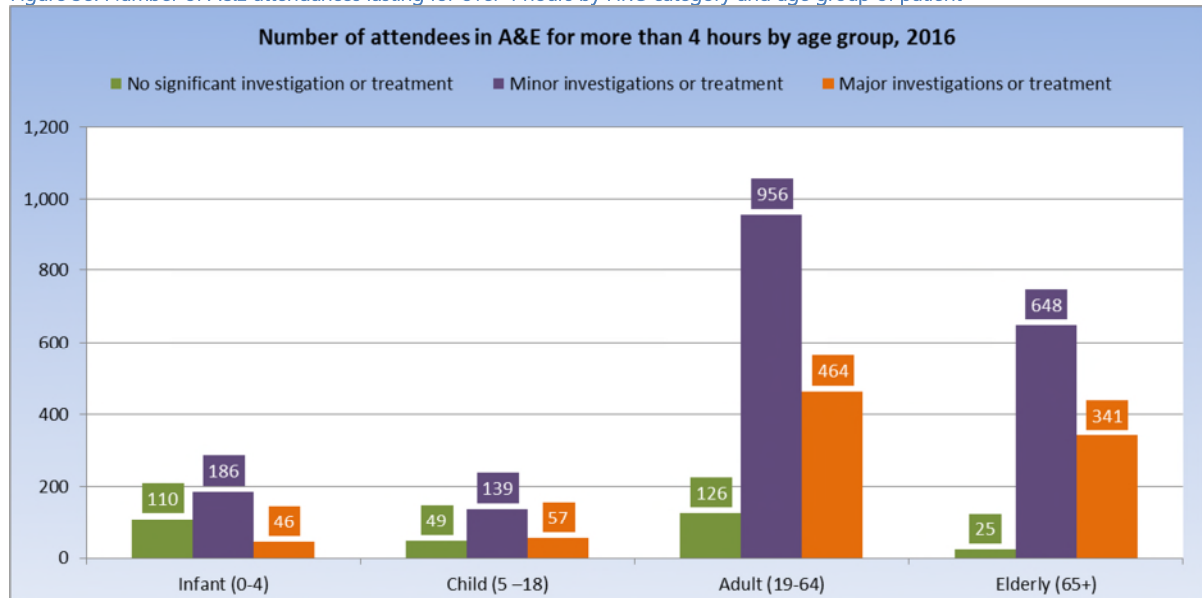
Source: Hospital Episode Statistics

Approx. 60% of those requiring minor/major investigations or treatments but who leave before treatment have been in A&E for longer than 4 hours before they leave.[Figure 37]

Research question: Do they leave because of the waiting? Do they return as a Frequent Flier?

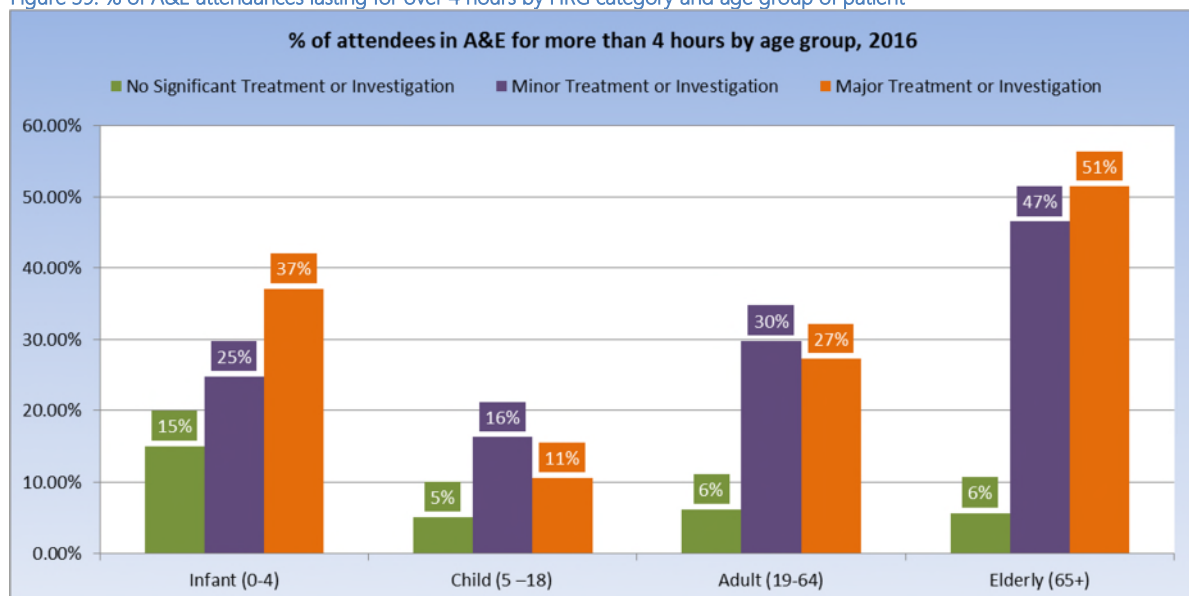
It appears that the more complicated and voluminous cases have a higher chance of being in A&E longer than 4 hours this is as to be expected. [Figure 37]

Figure 38: Number of A&E attendances lasting for over 4 hours by HRG category and age group of patient



Source: Hospital Episode Statistics

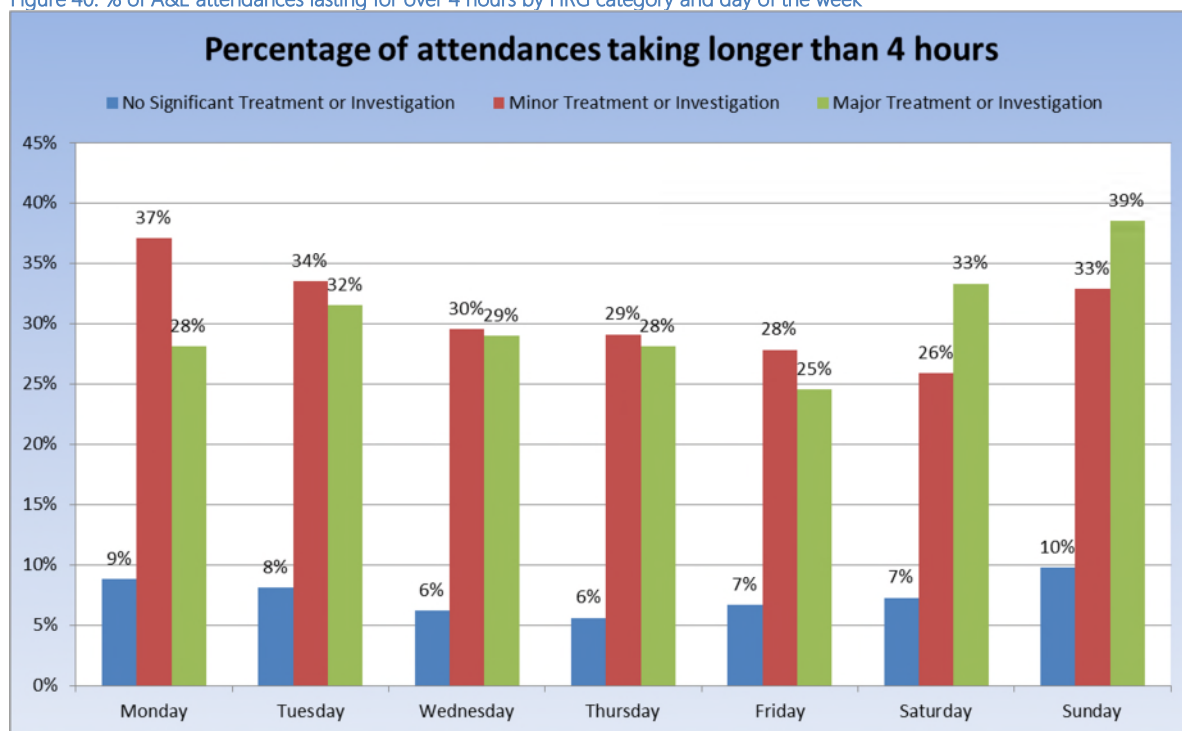
Figure 39: % of A&E attendances lasting for over 4 hours by HRG category and age group of patient



Source: Hospital Episode Statistics

Mostly patients who require no investigation or treatment are discharged within 4 hours, however, there are large proportions of those requiring Investigations and treatments or admissions who are in the A&E department for more than 4 hours. This is especially the case for the elderly attendees. [Figure 38 and Figure 39].

Figure 40: % of A&E attendances lasting for over 4 hours by HRG category and day of the week



Source: Hospital Episode Statistics

Figure 40 shows that the probability of being in the A&E department for over 4 hours varies for minor and major investigations and treatments but less so for those who require no investigation or treatment. A higher percentage of those attending at either end of the week will be in the department for over 4 hours than those attending mid-week.

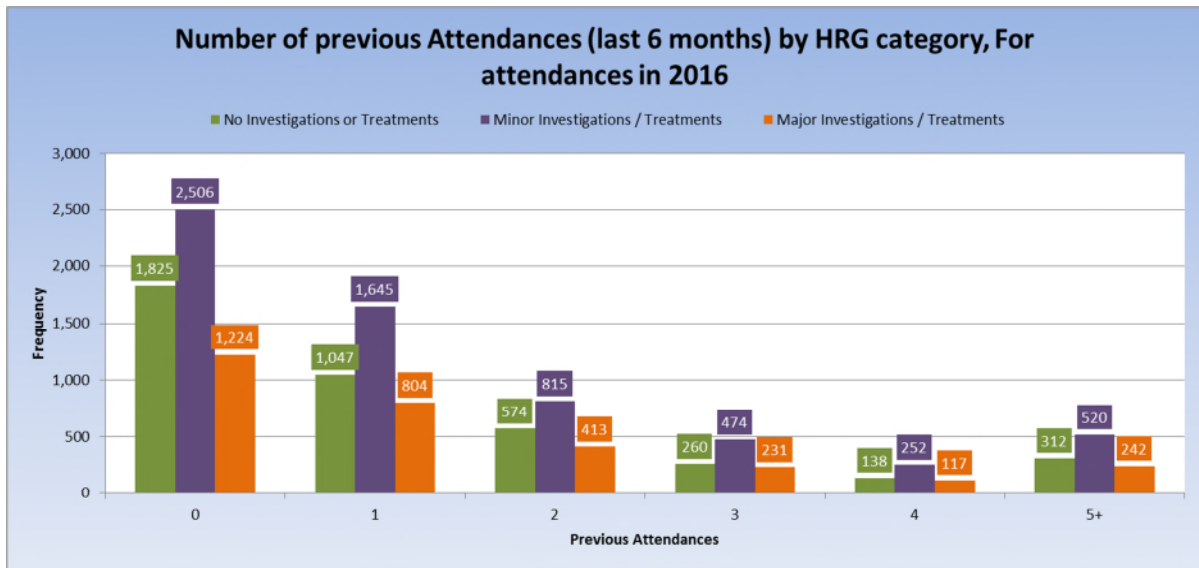
### Frequent Attenders

Figure 41 shows the number of attendances in 2016 by HRG category by the number of previous attendances over the previous 6 months.

For example; in the last 12 months there were 1,047 attendances (which resulted in no Investigations or Treatment) where the patient had had 1 previous A&E attendance in the last 6 months (where the previous attendance had any HRG or disposal recorded).

The highest frequency of previous attendances occurs in the Minor Investigation or Treatment group followed by those in the No Investigation or Treatment group. Further investigation would be required to ascertain whether this is "worried well" phenomena or those who are worried because their previous attendance(s) was one of a serious nature.

Figure 41: Frequency of previous attendances by HRG category and number of previous attendances.



Source: Hospital Episode Statistics

### 1.1.3 SECTION 10: PRIMARY CARE DEVELOPMENT

The charts below show the amount of patients per each type of staff in the Tilbury practices to a “benchmark” and to the England average. The Benchmark group has been developed by our Health Care Public Health team; each practice has its own comparator group, the comparator group consists of itself and 19 other practices, nationally with very close population characteristics to the practice (IMD, Register size and age distribution). Although there are differences between practices we can see that generally in Tilbury there are much greater numbers of patients per staff group than there are for appropriate comparators and the England average. [Charts for patients: FTE GP and patients: FTE nurse are in the main report]

Figure 42: Patients per GP (headcount)

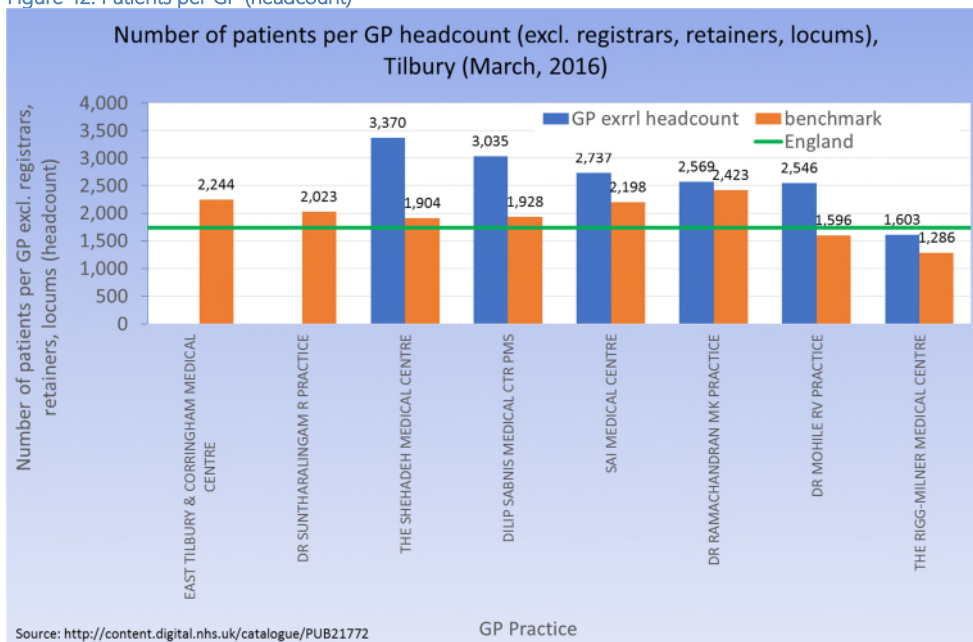


Figure 43: Patients per Nurse (headcount)



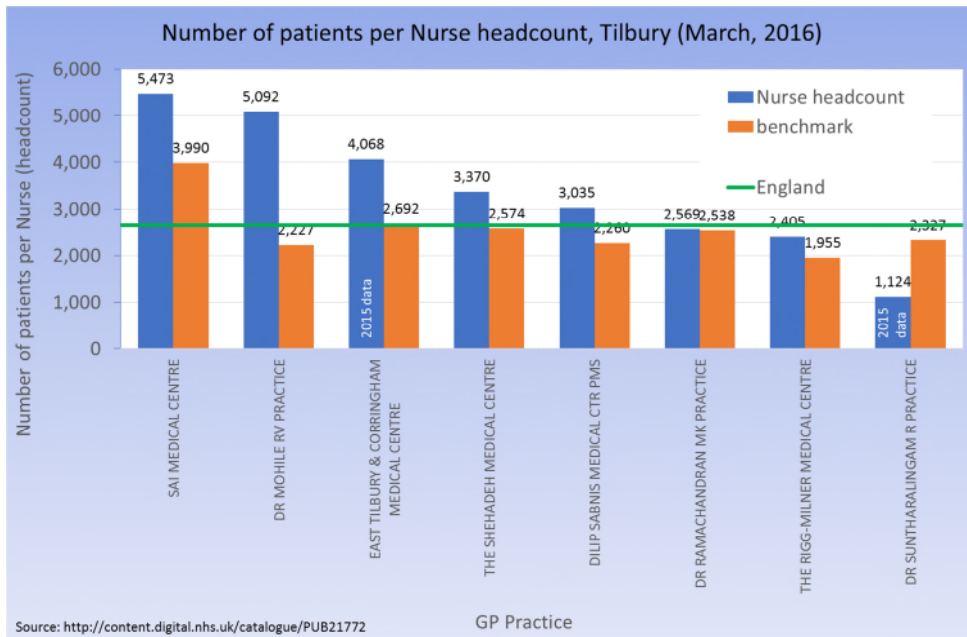


Figure 44: Patients per other Direct Patient Care professional (Headcount)

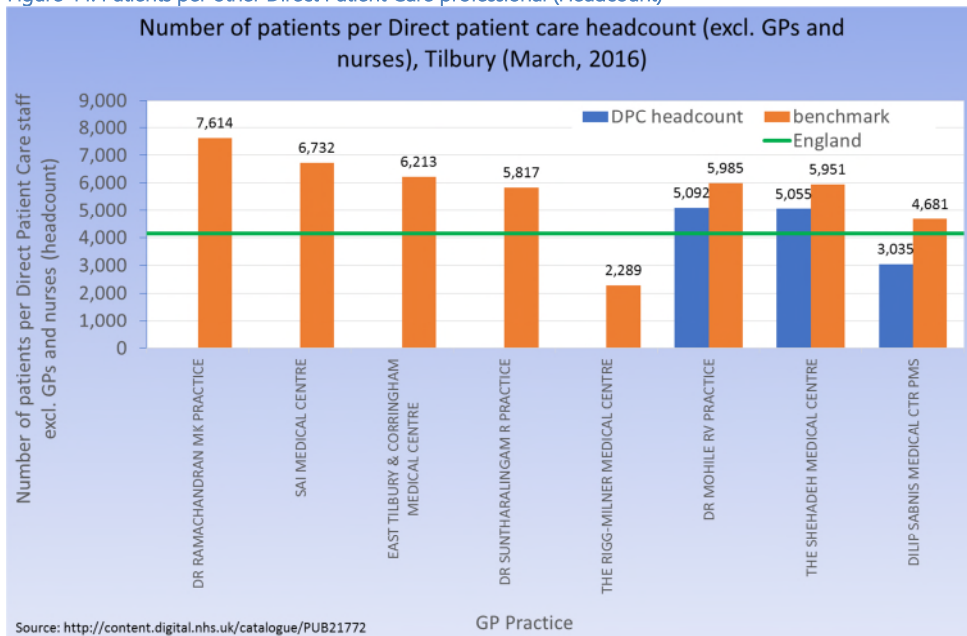


Figure 45: Patients per other Direct Patient Care professional (FTE)

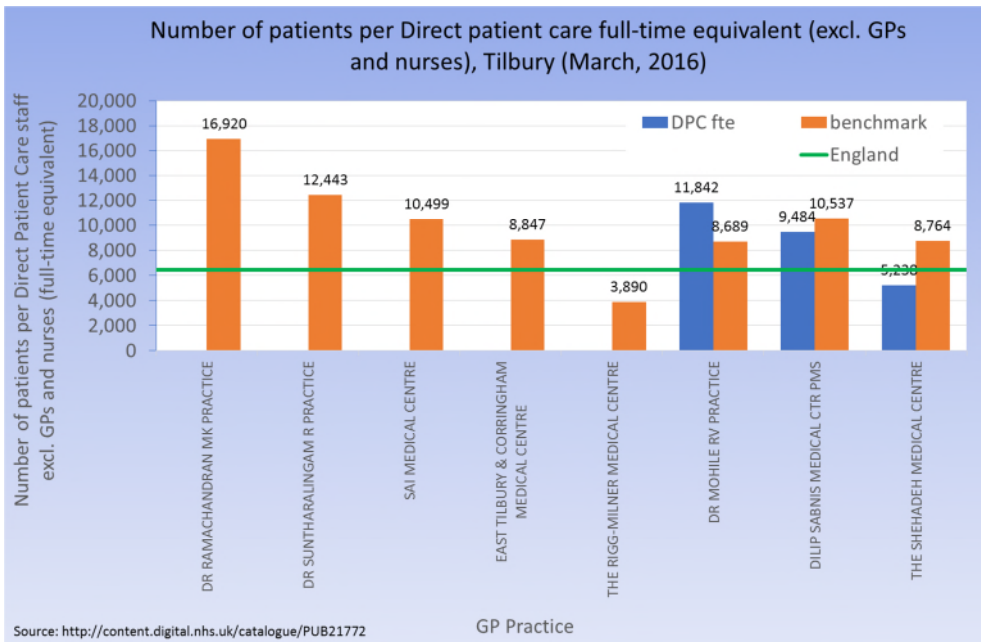


Figure 46: Patients per administrator (headcount)

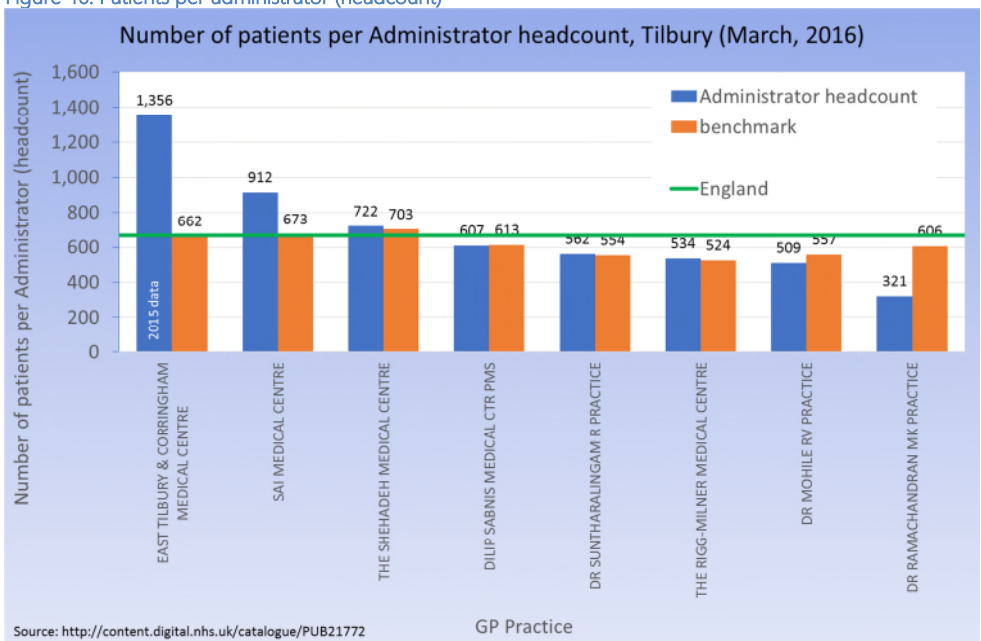


Figure 47: Patients per administrator (FTE)

Number of patients per Administrator full-time equivalent, Tilbury (March, 2016)

