

Annual Report of The Director of Public Health 2016

Executive Summary

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A Sustainable Adult Health and Social Care System for Thurrock



1. Introduction

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 in financial and operational crises. 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 situation can be summed up by figure three; rising and unsustainable demand for emergency care within the most expensive part of our Health and Care system; hospitals. 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 as the management of patients in Primary and Community Care directly influence demand on secondary care, and all three influence demand on Adult Social Care.

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 understand increase understanding of these drivers and provides a list of evidence-based recommendations for effective mechanisms to reduce the growth in demand and ensure the ongoing sustainability of our local health and social care economy.

It has been written both to inform local Health and Social Care strategy through the Thurrock Health and Wellbeing Board, and more widely to inform the prevention section of the South and Mid Essex Sustainability and Transformation Plan.

A copy of the full report is available on the Thurrock Council Website at the following address:

<https://www.thurrock.gov.uk/healthy-living/health-statistics-and-information>

Figure 1

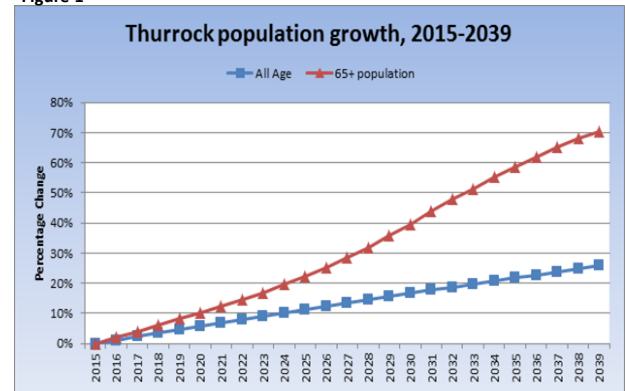


Figure 2

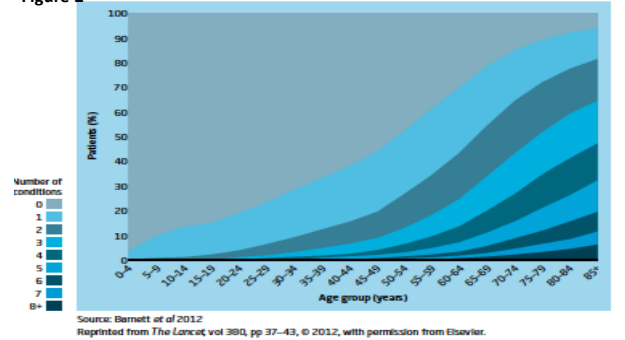
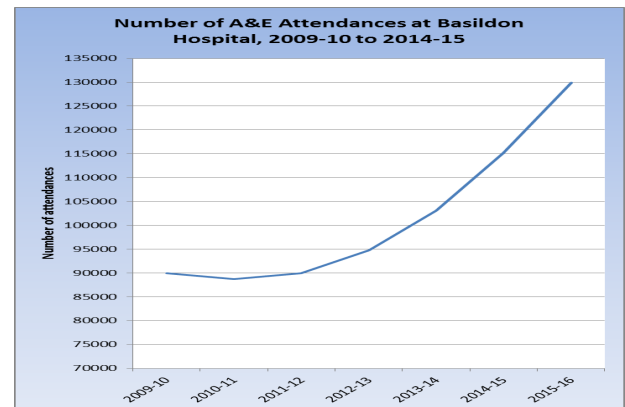


Figure 3



1. Introduction (cont).

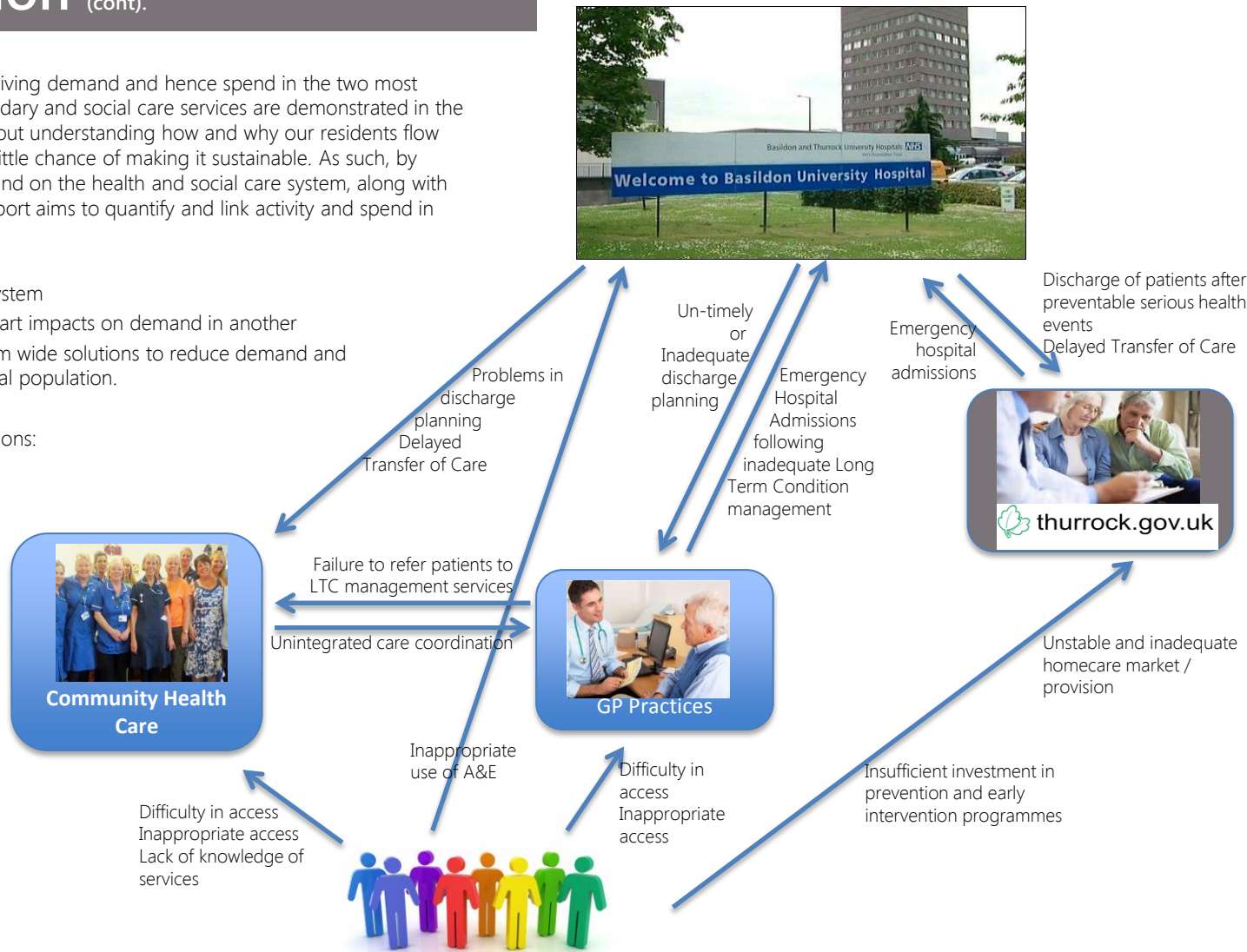
Some of the fundamental reasons driving demand and hence spend in the two most expensive parts of our system; secondary and social care services are demonstrated in the simplified diagram of it below. Without understanding how and why our residents flow through the entire system, we have little chance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

This report is divided into seven sections:

- 1) Primary and Community Care
- 2) A&E Attendances
- 3) Emergency Hospital Admissions
- 4) Delayed Transfers for Care
- 5) Referral to Treatment Pathways
- 6) Adult Social Care
- 7) Self-care and Prevention

The issue of Mental Health, whilst extremely important has been excluded because it is currently subject to a detailed and on-going separate Joint Strategic Needs Assessment Product. We will provide a detailed analyses of our findings in the near future.



2. Improve Primary Care Capacity

Thurrock is chronically under-doctored; in fact the fourth most un-doctored area of England. Figure 4 shows the ratio of Patients per FTE GP, for each GP practice population. The mean ratio of patients per FTE in England is 1,321. In Thurrock it is 2072. However many GP practice populations face ratios significantly greater than this. All but four of our 33 GP practice populations have a greater patient:FTE GPE than England's. In the worst case, this ratio is over five fold the 1:1321 of England's although recent commissioning of a new Provider is addressing this issue.

Furthermore, within the Borough there is strong association between levels of under-doctoring and levels of practice population deprivation. This means that the practice populations likely to be suffering from the greatest levels of ill-health are worst served in terms of numbers of GPs available to care for them. Figure 5 suggests that almost 30% of the variation between levels of under-doctoring between different GP practice populations in Thurrock can be explained by differences in levels of deprivation within those populations.

This is one of the most significant challenges facing our local Health and Social Care system and the population it serves. Approximately 70% of all patient interactions with doctors happen in GP surgeries. GPs also act as 'gatekeepers' to elective care and also are responsible providing clinical management of patients with long term conditions through the QOF (Quality Outcomes Framework). If patients are receiving inadequate care because of levels of under-doctoring, it is highly likely that they will end up in more expensive parts of the H&SC system, particularly as A&E attendances or emergency hospital admissions. Failure to address this issue is both bad for the health of our population, and is wasting money.

Through building multiple regression predictive models that identify and quantify the impact of the factors most likely to lead to an emergency hospital admission we predict that:

- For every one percentage point increase in the availability of GP appointments (as measured by the question "last time you wanted to see/speak to a GP were you able to?" in the GP patient survey) we estimate a reduction in
- 6543 emergency hospital admissions for COPD
- 109 emergency hospital admissions for Heart Failure
- Save the NHS in Thurrock £2.9M

Figure 4

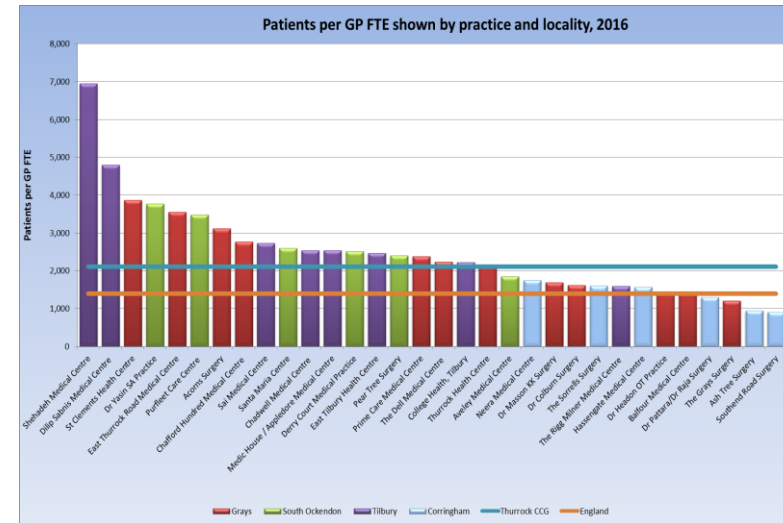
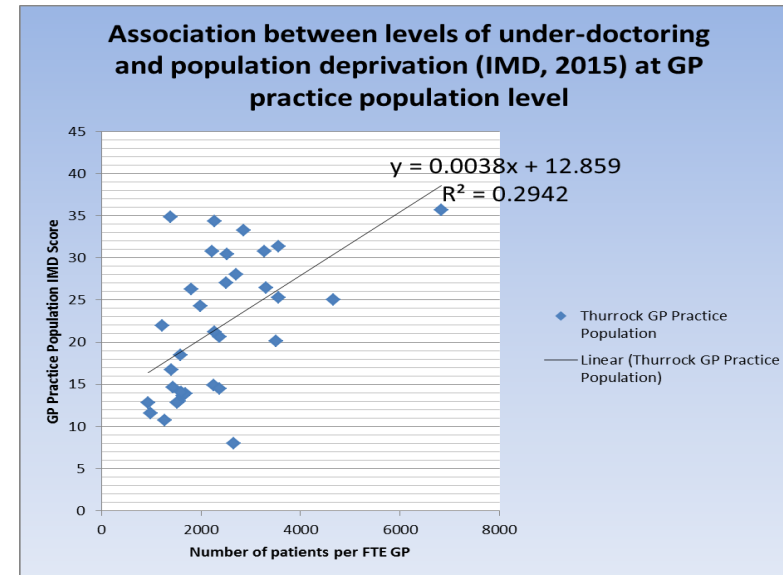


Figure 5



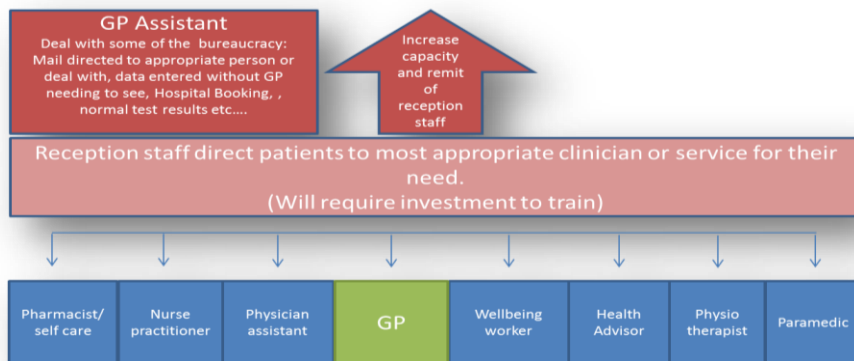
2. Improve Primary Care Capacity

We calculate that in order to bring FTE GP: patient ratios in line with the England average, we require a further 45 GPs in Thurrock. However, given the national shortage of GPs and current difficulties in recruitment, we are operating in a competitive market and it is not feasible to recruit this number to Thurrock quickly. Building the four new proposed Integrated Healthy Living Centres should make Thurrock an attractive place for GPs to work in, however this is a medium term solution.

*Making Time in General Practice*¹ is a published report that demonstrated that diversifying the workforce skill mix in Primary Care would release significant amounts of GP time and therefore capacity, allowing them to concentrate more time on patients with long term conditions and less time on tasks that could be better undertaken by other types of clinical staff (for example using an in-surgery Pharmacist to undertake medicines reviews, and a Physiotherapist to deal with the one in six appointments where the underlying problem is musculoskeletal).

Figure 6 shows the workforce model proposed in *Making Time in General Practice* and figure 7 shows the our calculations on the impact of this model, should it be introduced in Thurrock on the need for additional GPs to address the situation locally.

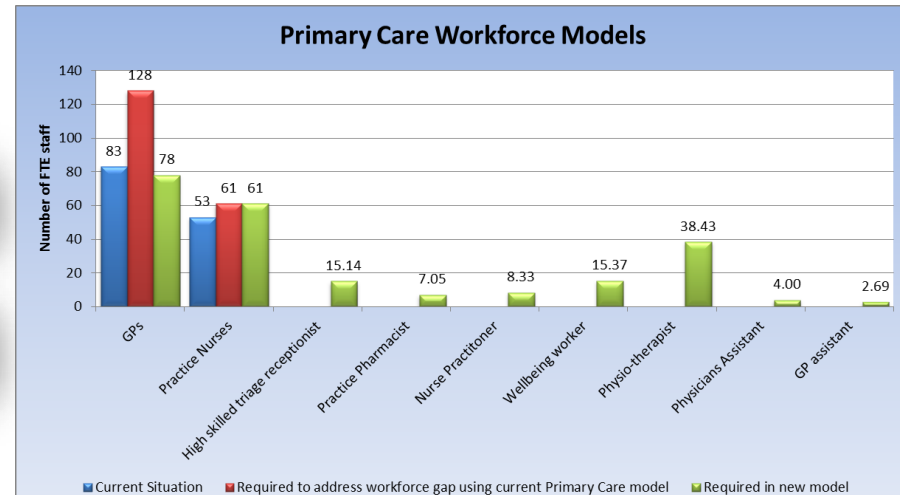
Figure 6



We calculate that to address the issue of under-doctoring in Thurrock we require an additional 2,184 appointments per day. Figure Y demonstrates that by diversifying the skill mix within our GP practice workforce we could release this number of additional appointments without the need to recruit more GPs locally.

Implementing a more diverse workforce skills mix within Primary Care in Thurrock will release an addition 2,184 appointments per day and address the issue of under-doctoring locally.

Figure 7



Recommendations to improve Primary Care Capacity

- Expedite the building of four Integrated Healthy Living Centres that bring Primary, Community and Mental Health Care together with Diagnostics, Hospital Outpatients and Community Hubs, in order to attract the best GPs to Thurrock
- Implement a more diverse skills mix within existing Primary Care provision to free up GP time

¹ Primary Care Foundation and NHS Alliance, Making Time in General Practice, October 2015

3. Prevalence of Long Term Conditions

GP practices are responsible for managing tens of thousands of people with Long Term Conditions in Thurrock. In 2014/15 there were 54,678 cases of long term conditions recorded by GPs, of which there were 23,727 hypertension cases, 9,441 asthma cases and 8,185 Diabetes cases. (Figure 8). The vast majority of long term conditions are highly preventable through lifestyle changes.

There is significant variation between GP practice populations in terms of the prevalence of diagnosed different long term conditions between different populations. This is particularly true of diagnosed rates of Hypertension, CHD and Heart Failure. This could be due to genuine differences in underlying prevalence of these conditions between different practice populations, and/or differences between GP practices' ability to identify and diagnose these conditions in their patients. Detailed analyses of these variations can be found in section 1.2 of the full report.

Figure 9 shows the percentages of patients aged 18+, diagnosed with Asthma, COPD, Diabetes, Coronary Heart Disease, Heart Failure, Hypertension (high blood pressure) and Stroke/TIA at GP practice population level in 2014/15. Prevalences shown in red denote that they are ranked in the top third; in yellow, the middle third; and in green the bottom third of the range within Thurrock for that condition.

Figure 8

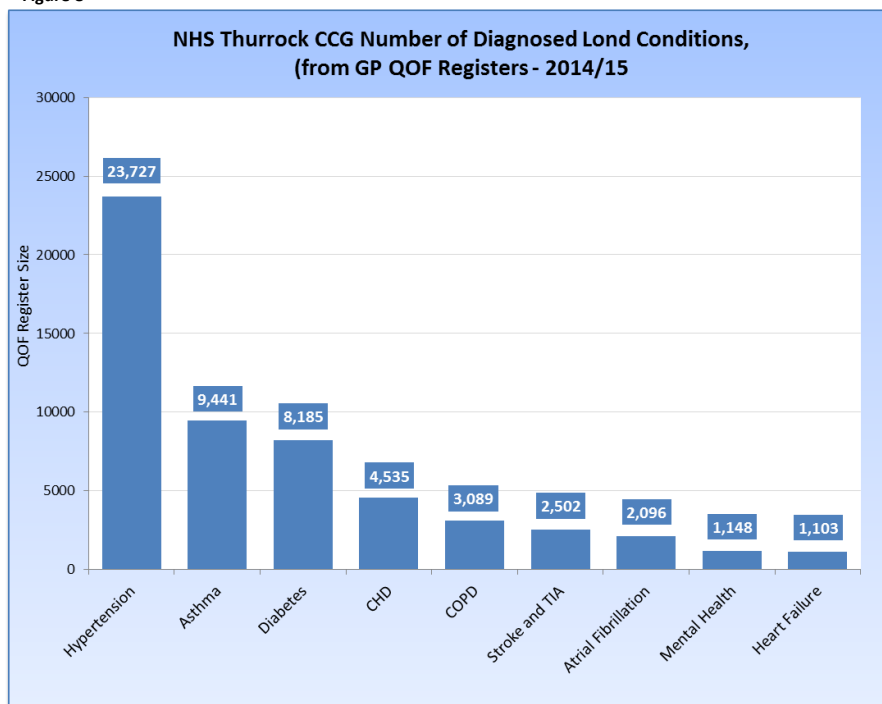


Figure 9

Surgery Name	Asthma	COPD	Diabetes	CHD	Heart Failure	Hypertension	Stroke / TIA
SUNTHARALINGAM R	7.39%	3.20%	9.69%	5.25%	1.32%	18.79%	1.84%
DRS JONES & BYRNE	6.62%	2.18%	7.81%	3.99%	0.70%	16.89%	2.42%
CHADWELL MEDICAL CENTRE	5.76%	2.16%	8.78%	4.76%	1.03%	15.64%	2.44%
STIFFORD CLAYS SURGERY	6.39%	2.81%	6.00%	3.70%	0.82%	14.81%	1.99%
DEVARAJA V C & PARTNER	5.78%	2.07%	6.79%	3.43%	0.71%	21.92%	1.95%
MUKHOPADHYAY SURGERY	5.64%	2.41%	7.40%	2.66%	0.64%	18.85%	1.88%
PEARTREE W HORNDON SURGERIES	5.62%	3.27%	6.78%	3.12%	0.87%	17.45%	1.61%
DESHPANDE A M & PARTNER	4.97%	1.69%	7.52%	2.85%	0.79%	21.19%	1.98%
SHEHADEH MEDICAL CENTRE	6.04%	2.55%	6.91%	2.81%	1.09%	15.44%	1.60%
KK MASSON AND DR H MASSON	5.02%	1.76%	7.08%	4.33%	0.84%	17.40%	1.58%
DR M ROY & PARTNERS	6.16%	1.56%	7.25%	4.11%	0.74%	25.51%	1.31%
DELL MEDICAL CENTRE	6.09%	1.76%	5.95%	3.69%	0.67%	13.29%	2.40%
CHEUNG K K	5.78%	1.89%	5.54%	3.73%	0.61%	19.17%	2.25%
BALFOUR MEDICAL CENTRE	4.45%	1.90%	7.29%	2.99%	0.66%	19.92%	2.08%
AVELEY MEDICAL CENTRE	5.53%	2.45%	6.88%	3.28%	0.70%	14.12%	1.80%
APPLEDORE AND MEDIC HOUSE	5.59%	1.87%	7.02%	3.00%	0.75%	14.14%	1.39%
HORNDON-ON-THE-HILL SURGERY	5.58%	1.86%	5.29%	3.06%	1.74%	16.65%	1.94%
HASSENGATE MEDICAL CENTRE	7.40%	1.68%	6.26%	2.87%	0.59%	13.89%	1.82%
HEALTH CENTRE DARENTH LANE	5.80%	3.31%	6.56%	2.68%	0.47%	13.83%	1.30%
ORSETT SURGERY	5.83%	1.32%	5.43%	2.70%	0.67%	13.80%	1.56%
ETC MEDICAL SERVICES	6.15%	1.11%	6.25%	2.15%	0.58%	14.93%	1.52%
OKOIH & PARTNER	6.69%	2.33%	5.07%	2.02%	0.82%	10.62%	1.27%
DILIP SABNIS MEDICAL CENTRE	5.10%	2.06%	6.15%	2.88%	0.50%	14.98%	1.62%
KADIM PRIMECARE MEDICAL CENTRE	5.67%	1.32%	6.73%	2.81%	0.26%	18.67%	1.19%
BELLWORTHY S V	4.19%	1.84%	6.98%	1.72%	0.35%	16.77%	0.67%
JOSEPH L & PARTNER	4.14%	1.48%	6.04%	2.48%	0.57%	13.19%	1.38%
EAST THURROCK MEDICAL	4.90%	1.66%	6.04%	2.51%	0.58%	12.94%	1.15%
ABELA T & PARTNERS	5.60%	0.72%	4.58%	1.33%	0.41%	9.89%	0.69%
DR PATEL P J PRACTICE	2.37%	1.10%	5.47%	1.55%	0.17%	7.74%	0.72%
THURROCK HEALTH CENTRE	4.45%	0.78%	4.08%	0.84%	0.24%	6.37%	0.68%
PURFLEET CARE CENTRE	4.09%	1.07%	4.87%	1.16%	0.25%	9.68%	0.49%
ST CLEMENTS HEALTH CENTRE	4.56%	0.89%	5.03%	1.24%	0.30%	8.99%	0.49%
ACORNIS MEDICAL CENTRE	3.54%	0.70%	3.23%	0.61%	0.06%	5.63%	0.42%

4. Find the missing thousands

Thousands of people in Thurrock are living with long term health conditions in that are yet to be 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 and treat people to prevent their conditions progressing and their health deteriorating.

Public Health England commissioned Imperial College to develop estimates of the true prevalence of disease at practice level. Statistical models have been developed to determine estimates of the prevalence expected diseases for a number of long term conditions based on specific population demographic and other characteristics of different GP practice populations, based on the best academic published evidence.

These 'expected prevalence' figures include patients that are both diagnosed and known to the practice and undiagnosed and not known nor receiving treatment for their long term condition. Estimates have been produced for 2016 for Stroke, CHD, Peripheral Artery Disease (PAD), Depression, Chronic Obstructive Pulmonary Disease (COPD) and Hypertension (high blood pressure). Estimates for Diabetes were released at CCG level by the National Cardiovascular Intelligence Network.

Figure 10 below shows the recorded (known as the observed prevalence) and expected prevalence for each condition except for PAD, and an estimate of the additional number of patients that are likely to have a condition that is undiagnosed by applying the estimated figure to the Thurrock population. The table does not display the difference for Depression, as this will be presented in a separate Mental Health JSNA document.

Figure 10

Long Term Condition	Recorded Prevalence (i.e. people already diagnosed)	Estimated Prevalence	Additional Number of Undiagnosed Patients based on the estimated prevalence
Stroke (2016)	1.51%	3.70%	3,540
Hypertension (2016)	14.08%	20.95%	10,983
CHD (2016)	2.78%	7.58%	7,521
COPD (2016)	1.8%	2.22%	642
Diabetes (2016)	6.3% (17+)	7.9% (16+)	2,109

There is significant variation between different GP practice populations across Thurrock in terms of the ratio of diagnosed and un-diagnosed patients with different Long Term Conditions. Figures 11 and 12 show the numbers of patients diagnosed (observed patients – blue part of the bar) and estimated not to have been diagnosed (orange part of the bar) with Coronary Heart Disease and Hypertension respectively, for each GP practice population in Thurrock. Detailed analyses of this issue can be found in section 1.2.3 of the main report.

Figure 11

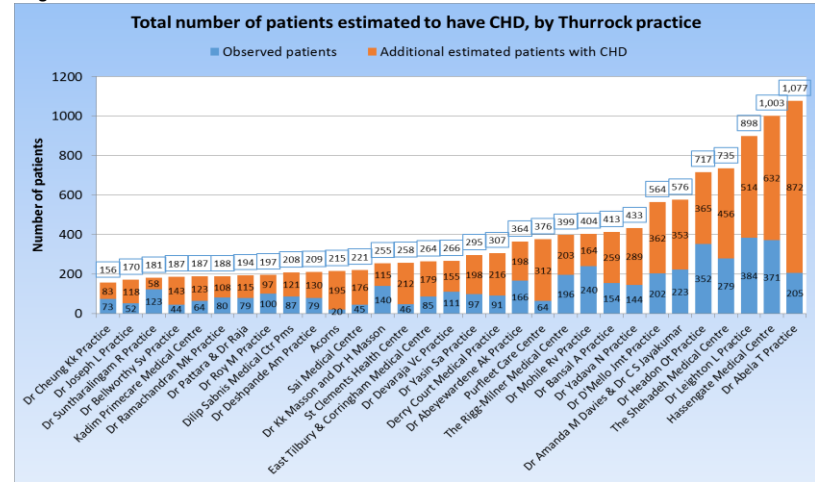
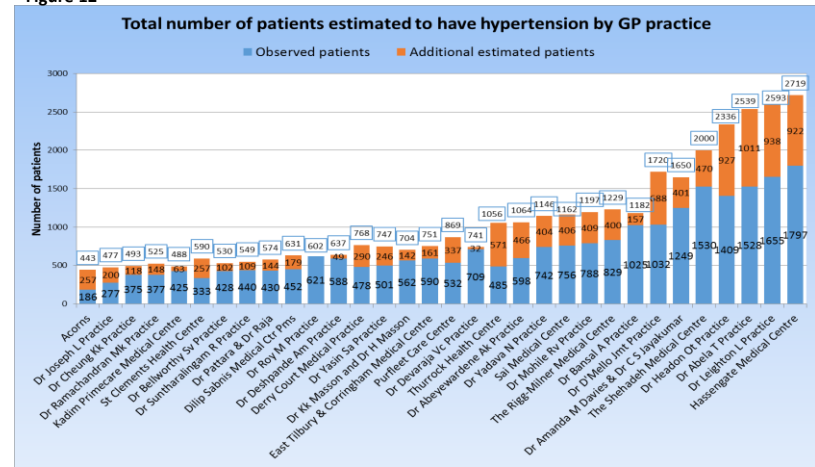


Figure 12



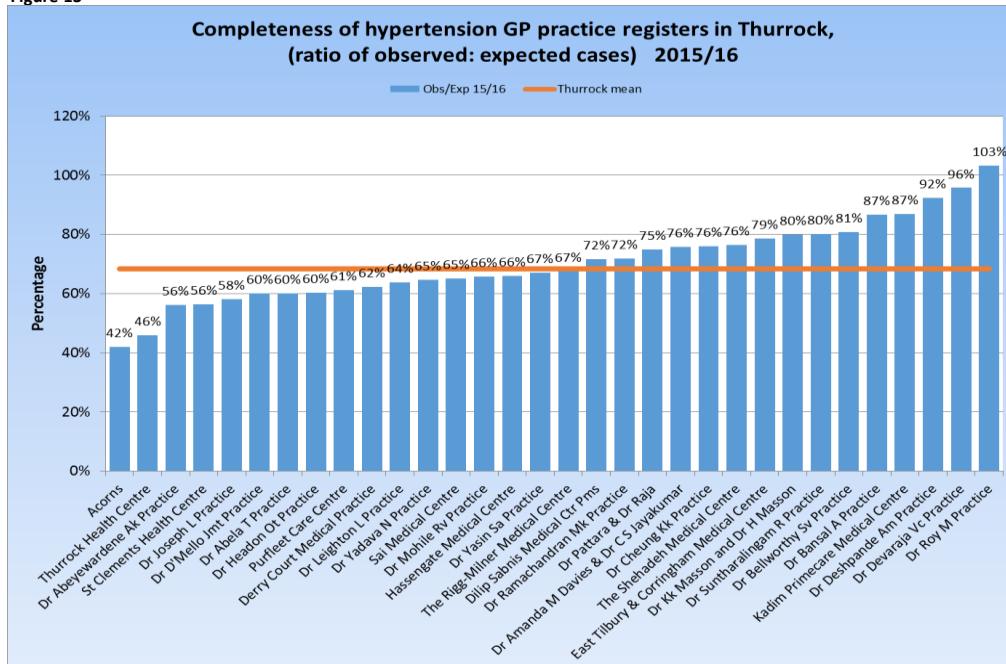
4. Find the missing thousands (cont.)

If we divide the number of patients diagnosed with a specific long term condition, by the total number of patients estimated to have that condition (diagnosed and undiagnosed) at GP practice population level, we can estimate how 'complete' a GP practice long term condition register is. If for example, the *observed* or diagnosed number of patients with high blood pressure divided by the estimated (*expected*) total number of patients in a practice population with high blood pressure = 0.87, then we can say that the practice's high blood pressure (or hypertension register) is 87% complete, and that there are still 13% of patients with high blood pressure within the practice. population that remain undiagnosed and hence untreated.

Figure 13 shows the completeness of GP practice hypertension registers within Thurrock. On average, hypertension registers in Thurrock are 68% complete, suggesting that 32% of people with hypertension remain undiagnosed. There is significant variation between levels of effective case finding between different GP practice populations for high blood pressure. The ratios diagnosed and undiagnosed stroke/TIA and CHD patients are even more significant. We estimate that 59.7% of patients with stroke/TIA, and 63.1% of patients CHD respectively have not been diagnosed and so will not be receiving treatment.

Improving the case finding of high blood pressure and treating it effectively is a potential simple and effective 'quick win'.

Figure 13



Failing to diagnose and treat people with high blood pressure and other cardio vascular disease puts them at significant additional risk of very serious cardio-vascular events including heart attacks and strokes which are also expensive to treat.

There are similar estimates of the completeness of Coronary Heart Disease, Atrial Fibrillation and COPD registers in the main report. Our analyses and modelling suggests the following:

For every 1% more complete we make our hypertension registers, we prevent 65 strokes over 3 years

Increasing completeness of hypertension registers by just 10% would save the NHS £2.38M in stroke treatment costs

...and reduce demand on Adult Social Care residential budgets by £3.65M. As such *case-finding* is potentially very cost effective.

One in every 20 people with untreated high blood pressure will have a stroke in the next three years

One in every two people with untreated Atrial Fibrillation will have a stroke in the next three years

Things that would improve *case finding* of Long Term Conditions:

- Spread best clinical practice of high performing GP surgeries to all.
- "Systematise" case finding activity such as blood pressure monitoring into the work of all front line clinicians/clinical services and within community and other non-clinical front line staff
- Increase the uptake of NHS Health Checks and improve their targeting at those most at risk
- Commission a "Senior Health Checks" programme in Thurrock
- Roll out the diabetes secondary prevention programme to identify those most at risk of developing diabetes
- Undertake social marketing research and implement a communications campaign based on its findings to increase knowledge and demand within our residents

5. Treat the missing hundreds

Once diagnosed with a Long-Term-Condition, effective clinical management of patients is absolutely vital in order to reduce the risk of their, wellbeing and independence deteriorating and to prevent them being admitted to hospital or requiring social care packages.

The management of Long Term Conditions must be seen as the responsibility of three parties; Primary Care Services, Community Care Services and crucially by patients themselves. The quality of clinical management of patients' conditions will be reflected in the Quality Outcomes Framework (QOF) – especially amongst those indicators relating to clinical markers.

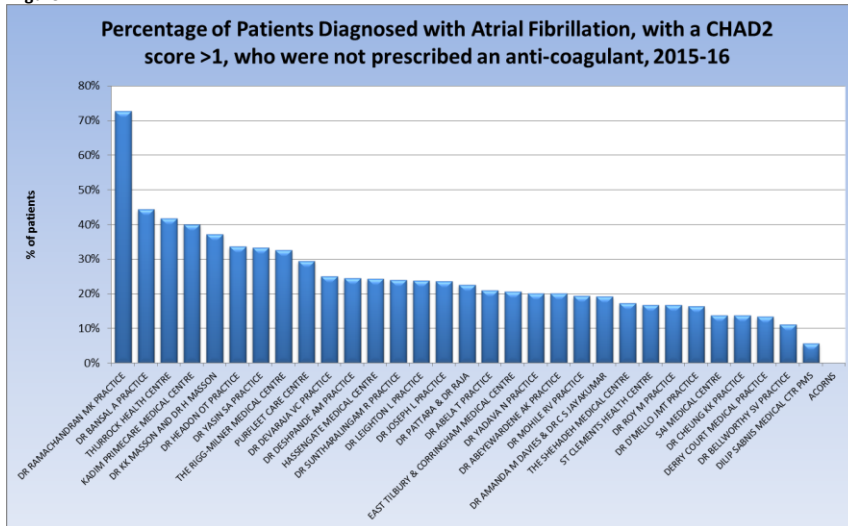
QOF records contain quality of care information on how patients who are diagnosed with diseases are treated in primary care. It was set up as an incentive system and GP practices get paid for the percentage of their "diseased population" that they offer certain tests, medication reviews and treatments for. The indicators are based on evidence of good quality care for the conditions and there is clear evidence that GP practices that score highly on QOF indicators relating to certain long term conditions have a lower emergency hospital admissions rate amongst patients with those long term conditions.

Analyses of QOF indicators in Thurrock suggests that there is considerable variation between GP practices. The reasons behind this may not always be clear and could include variation in levels of under-doctoring; differences in clinical practice within GP surgeries; referral or access to NHS community services and differences in how different GP practice populations self-care.

What is clear, is that there is an urgent need to further understand and address variation in management of long term health conditions within the community and to drive up performance. This will both improve public health and save money.

Sections 1.4 of the main Annual Health Report provides detailed analyses of the variation in management of hypertension, stroke/TIA, COPD, Atrial Fibrillation, Heart Failure and Diabetes. The Thurrock Public Health Team have produced a series of 'multiple regression analyses models that identify and quantify the impact of the interventions in Primary and Community Care most likely to prevent emergency hospital admissions, and as such keep patients well and deliver Health and Social Care system savings. These are discussed in detail in section 3.2 of the main report, which also provides a detailed list of recommendations and the financial and clinical opportunities that can be realised from their implementation. A few examples are provided in this Executive Summary.

Figure 14



QOF recommends that every patient diagnosed with Atrial Fibrillation should have a regular vascular risk assessment, known as a CHAD₂ which assesses their risk of having a stroke. The National Institute of Clinical Excellence (NICE) recommends that those with a CHAD₂ score of 1 or greater should be prescribed an anti-coagulant which will significantly reduce their stroke risk. Figure 14 shows the percentage of patients diagnosed with AF and with a CHAD₂ score >1 who were not prescribed an anti-coagulant in 2014-15. In total there were 421 patients.

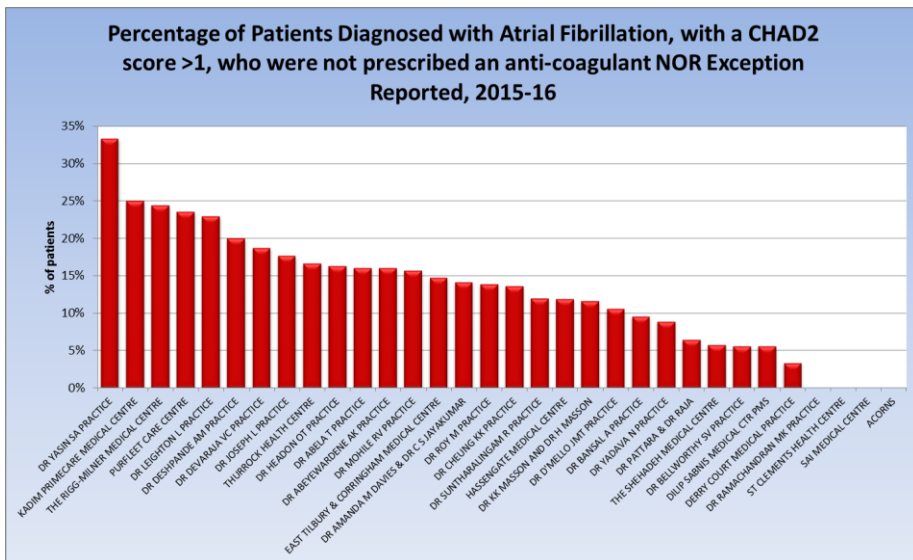
In 2015/16 there were 421 patients in Thurrock with a diagnosis of AF who were assessed at being at high risk of a stroke but were not prescribed an anti-coagulant to reduce their risk. We predict that half of these – 211 people will have a stroke within the next three years.

QOF allows GP practices to 'exception report' patients, removing them from the cohort of patients against which a practice's performance is then assessed. For example, a patient may be exception reported if they fail to attend three invitations to attend the surgery for an appointment for a review of their long term condition, if they actively refuse the intervention (in this example, prescription of an anti-coagulant), or if they have another condition or on other medication that may make delivering the intervention dangerous to their health. As such, it is reasonable to consider excluding patients that have exception reported before considering a GP practice's success in delivering a clinical intervention recommended by QOF.

Figure 15 (overleaf) shows the percentage of patients diagnosed with Atrial Fibrillation, with a CHAD₂ score >1, who were not prescribed an anti-coagulant **nor exception reported**. In 2014/15. In total there were 247 patients in this category in Thurrock, 50% of whom we predict will have a stroke within the next three years.

5. Treat the missing hundreds^(2/3)

Figure 15



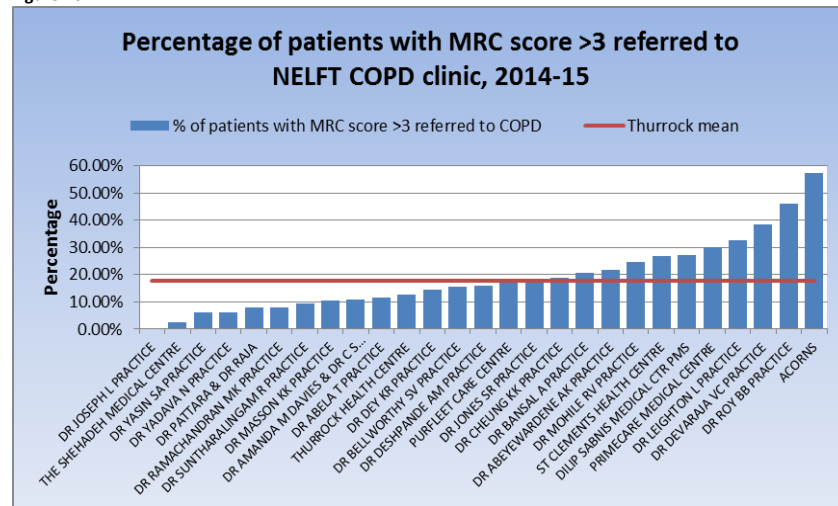
Although 247 patients with Atrial Fibrillation and at high risk of a stroke were neither prescribed an anti-coagulant, nor exception reported, all but Dr. Yasin's practice received the maximum financial reward of 12 QOF points on this indicator. This is because the 2015-16 QOF provides maximum reward if 70% of patients in this cohort receive the intervention. As such, there is no financial incentive for GP practices to ensure the remaining 30% of patients are prescribed an anti-coagulant.

This is clearly a failure of the current contractual system with GP practices. Introducing a 'stretched QOF' that incentivised GP practices to achieve up to 100% would address this failure, and potentially prevent strokes, save lives and save money.

In 2015/16 there were 247 patients in Thurrock with a diagnosis of AF who were assessed at being at high risk of a stroke but were not prescribed an anti-coagulant to reduce their risk nor exception reported.

Under the current QOF rules, GP practices are not financially incentivised to treat 245 of these high risk stroke patients

Figure 16



The Community Respiratory Team is provided by The North East London Foundation Trust (NELFT) to assist in the clinical management of patients with COPD that as progressed to a clinically serious level (denoted by an MRC score >3). The team is commissioned to provide Pulmonary Rehabilitation that has been shown to reduce likelihood of emergency hospital admissions for COPD, and to facilitate rapid discharge back into the community following a hospital admission. Previous analyses has suggested that 28% of the variation in COPD emergency hospital admissions between different GP practice populations can be explained by differences in referral rates of their COPD patients with an MRC score >3 into the NELFT Community Respiratory Team.

Figure 16 shows the percentage of this cohort of patients referred to the NELFT community respiratory team in 2014-15. Overall the referral rate in Thurrock was 17.51%. There is however significant variation between different GP practices. Dr. Shehadeh who has a relatively large practice list size and number of eligible COPD patients only referred four patients (2.26%). Improving referral rates of patients into the NELFT community respiratory team is likely to prevent COPD hospital admissions and keep patients healthier and more independent for longer.

In 2014-15, 1,075 patients with COPD were eligible for Pulmonary Rehabilitation but were not referred by their GP practice.

5. Treat the missing hundreds^(3/3)

Whilst the main report identifies many examples of GP practices providing excellent long term condition management care to patients, there are clearly some practices that are in need of support. Figure 17 below shows the GP practices whose performance on the 34 QOF Long Term Condition Management Indicators we examined, most commonly fell into the bottom quartile of performance

Figure 17

GP Practice	Number of times this practice appeared in bottom quartile of performance (out of 34)
Dr Mukhopadhyay PK PRACT	28
Dr Suntharalingam R PRACT	24
Chadwell MC	20
Sai MC	18
Balfour MC	16
Aveley MC	15
Neera MC	15
Pear Tree SURG	14
Medic House	13
Dr Masson KK SURG	12
St Clements HC	12
Purfleet Care Centre	10

Two new Public Health Programme Manager posts have been recruited to work as part of NHS Thurrock CCG's Primary Care Development team, as a practical resource to support Primary Care clinicians better manage patients with long term conditions and embed best clinical practice into all GP surgeries across Thurrock.

Using analyses within the main report, we will work in collaboration with GP practices to implement a Long Term Conditions Management Scorecard with the QOF metrics that impact most on emergency hospital admissions in order to facilitate sharing of best clinical practice amongst surgeries

Recommendations to improve the management of long term conditions in Primary Care

- Implement the new workforce model discussed in section 2 in order to increase capacity within GP practices to manage patients with Long Term Health Conditions
- Implement a 'Stretched QOF' programme to financially incentivise and compensate GP practices to provide clinical interventions to 100% of patients that require and desire them
- Assist GP practices to identify patients with Long Term Conditions in need of review by producing SystemOne reports that can be run by the Practice Manager
- Provide additional resource to GP practices through the two new Public Health in Primary Care Programme Managers
- Implement the proposed Long Term Condition Management GP score card with a view to facilitating sharing of best practice between GP surgeries
- Embed 'self care' and patient education programmes into long term condition management clinical pathways with greater use of third sector support groups such as Thurrock 'Breathe Easy'
- Increase referral rates of patients with long term conditions such as COPD and Diabetes into NHS Community Services Teams commissioned to assist GP surgeries manage their care

6. Reduce preventable emergency hospital admissions (1/2)

'Ambulatory Care Sensitive' (ACS) health conditions, are chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions. Examples would include COPD, Diabetes and Heart Failure. Their clinical management was discussed in the previous section.

In 2015/16 there were 3,869 admissions deemed as ACS. This was a reduction from the numbers seen in the previous two years (4549 and 3949 in 2013/14 and 2014/15 respectively). When viewing these admissions by GP practice, there is considerable variation. (Figure 18).

Analyses of the most common conditions deemed to be ACS (figure 19), show that the top two were due to Respiratory and Diabetes complications, underlining the importance of improving capacity and capability of Primary and Community Care to manage these effectively

Figure 18

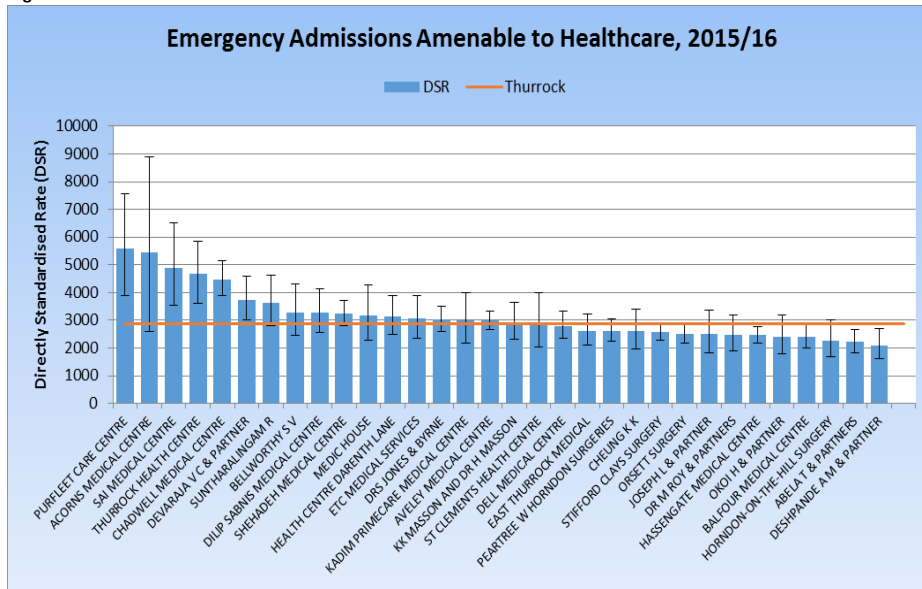
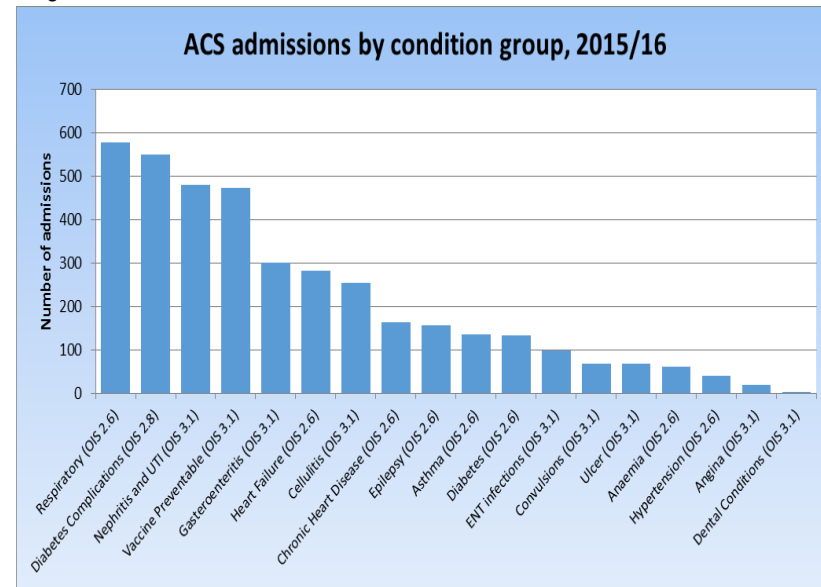


Figure 19



In 2015/16 there were 3,869 hospital admissions deemed as ACS.

These potentially avoidable admissions cost the NHS £11.6M

6. Reduce preventable emergency hospital admissions (2/2)

Preventable emergency hospital admissions are a symptom of inadequate capacity and missed opportunity to intervene in the management of long term conditions within Primary and Community Care, together with at times inadequate self-care by patients themselves. Implementing the recommendations in sections 2 to 5 of the report will address this. From the modelling work we have undertaken to identify the main drivers of preventable emergency hospital admissions across the Mid and South Essex STP area, we have concluded:

Reducing smoking prevalence by 1% in patients with LTCs prevents 107 respiratory admissions per year

For every 20 patients with untreated high blood pressure we estimate one will have a stroke in the next three years

For every five patients with high blood pressure that we treat successfully such that their blood pressure reduces to $\leq 150/90$ mmHg, we will prevent one having a stroke in the next three years

For every 10 patients diagnosed with Heart Failure that we treat with classes of drug known as ACEs and ARBs that help lower their blood pressure we will prevent one emergency hospital admission in the next three years

There were 772 emergency admissions for falls in 2015/16 costing the CCG £2.6M and ASC £363K

Recommendations to reduce preventable emergency hospital admissions

Develop a 'systems wide response' and associated business case to reinvest excess secondary care costs relating to avoidable hospital admissions in tertiary primary and community prevention programmes. This will require an element of 'pump priming funding'

For ambulatory care sensitive conditions generally, we recommend:

- Further investigation at the GP practices with the highest admission rates
- Further analyses by the Public Health team and inclusion of outputs within the future Primary Care Long Term Condition Scorecard
- Facilitate sharing of best practice with regard to clinical management of ambulatory care sensitive conditions

To reduce Stroke admissions:

- Redesign and procurement of a healthy lifestyle service with a focus on those patients with Long Term Conditions
- Support for a whole system approach to reduce obesity prevalence
- Implement a Hypertension case-finding and Clinical Management Improvement Programme

To reduce COPD admissions

- Reduce smoking prevalence via the production of a new Tobacco Control Strategy
- Reduce the number of people exposed to poor air quality via the production of a new Air Quality and Health Strategy
- Refocus and target smoking cessation support towards those newly-diagnosed with long term conditions.

To reduce Coronary Heart Disease/Heart Failure admissions:

- Redesign and procurement of a healthy lifestyle service focus on those patients with Long Term Conditions
- Support for a whole system approach to reduce obesity prevalence
- Treat more Heart Failure patients with effective medication, with support from the Public Health team via further analyses and the creation of bespoke System One reports
- Support more patients with effective blood pressure control (e.g. via further analyses and the creation of bespoke SystemOne reports by the Public Health team, or the sharing of best practice between clinicians)

Implement a falls prevention service within referral clinical care pathways from the Ambulance Service and Tele-care provider

7. Reduce avoidable A&E attendances

Figure 20

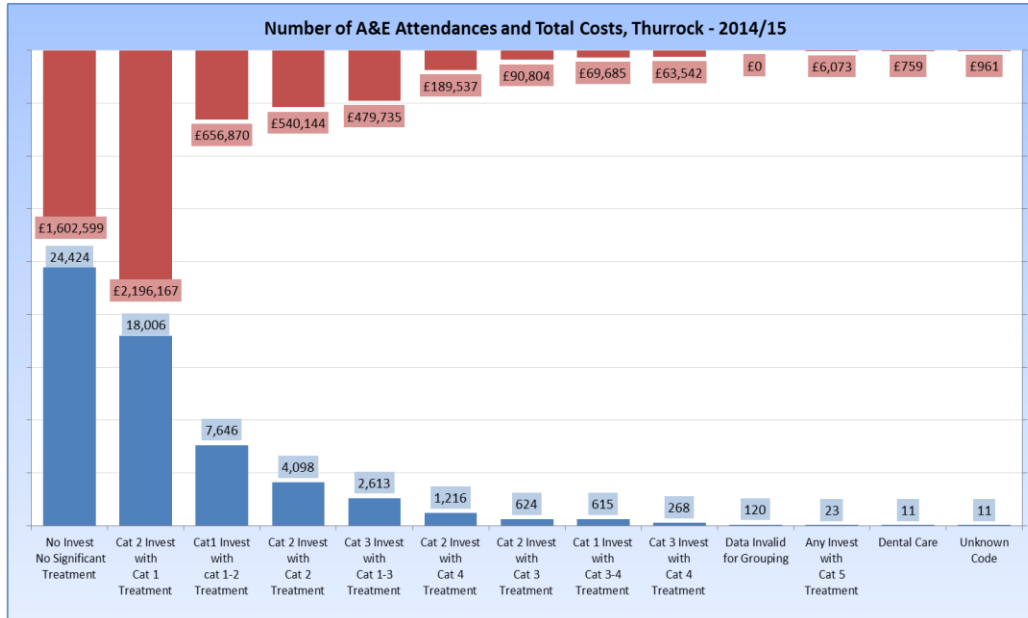
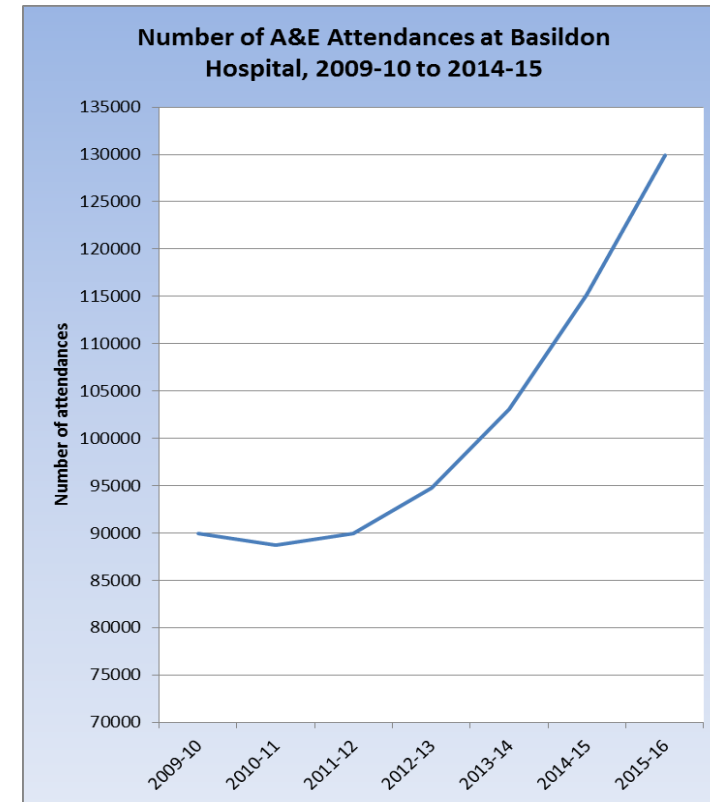


Figure 21



A&E attendances both locally and nationally are increasing at an unsustainable rate, both financially (as it costs more to treat patients with less serious clinical conditions in A&E) than in other community settings, and operationally, as treating with minor illnesses in A&E divert staff resource away from those who are genuine emergencies. Figure 21 shows the exponential growth in numbers of patients attending A&E at Basildon Hospital over the last seven years .

Whilst there are undoubtedly occasions where A&E is the most appropriate place for a patient to access care, we conclude that the vast majority A&E attendances are inappropriate and that A&E is often accessed by patients who have suffered neither an accident, nor have a medical emergency.

We have classified two levels of inappropriate attendances. The first are those who received no significant investigation or treatment. We feel that the vast majority of these attendances did not require medical attention at all. The second is those who received low level interventions and/or treatments. (as defined as a 'category 1 investigation with cat 1-2 treatment' or a 'category 2 investigation with category 1 treatment' within Hospital Episode Statistics (HES) data). Examples of a Category 1 investigation include blood tests or urinalysis, and a category 1-2 treatment, e.g. a wound dressing change). Previous analyses has lead us to the conclusion that a significant amount of this activity could be seen and dealt with in a primary care setting if facilities and capacity were available. (Figure 20)

7. Reduce avoidable A&E attendances (2/3)

Of the 59,675 attendances in 2014/15 24,424 (41%) fell into the first of these categories; that is that they did not require medical attention at all. These A&E attendances cost a total of £1.6M (an average of £65.62 per attendance). (figure 20 on previous page). Almost 2.5% of these (608) used an ambulance to get to A&E.

Of the 59,675 attendances in 2014/15 25,652 (42%) fell into the second of these categories. That is that they could have been seen and treated elsewhere had facilities been available, these cost a total of £2.8M (an average of £111.22 per attendance). (figure 18 on previous page) Incredibly, 27% of these (6,991) used an ambulance to get to A&E.

83% of all A&E attendances needed no medical investigation or treatment, or the most minor category of medical investigation and treatment.

27% of these attendances were conveyed to A&E by ambulance

Treating these patients in Primary / Community Care would deliver £1.57M NET savings in Thurrock alone.

Figure 22, shows ambulance conveyances to A&E by treatment and investigation category and age. Inappropriate ambulance conveyances (defined by patients requiring no treatment or investigation or the most minor treatment/ investigation) fall sharply as patient age increases. Most inappropriate conveyances were used to convey patients aged 0 to 5 category, followed by those aged 5 to 19.

Figure 23 shows variation in the rate of inappropriate A&E attendances by GP practice population in Thurrock. In order to explore this further, we built a multiple regression analysis model to investigate the impact of various potential variables that may influence variation of inappropriate A&E attendances across the South and Mid Essex STP area. This analysis identified two key variables; distance of the GP practice population from A&E, and CCG from which services were commissioned. Mid Essex had significantly lower levels of inappropriate A&E attendances compared to other CCG areas suggesting that triage and deflection of inappropriate A&E attendances at Broomfield Hospital was more robust than elsewhere.

Figure 22

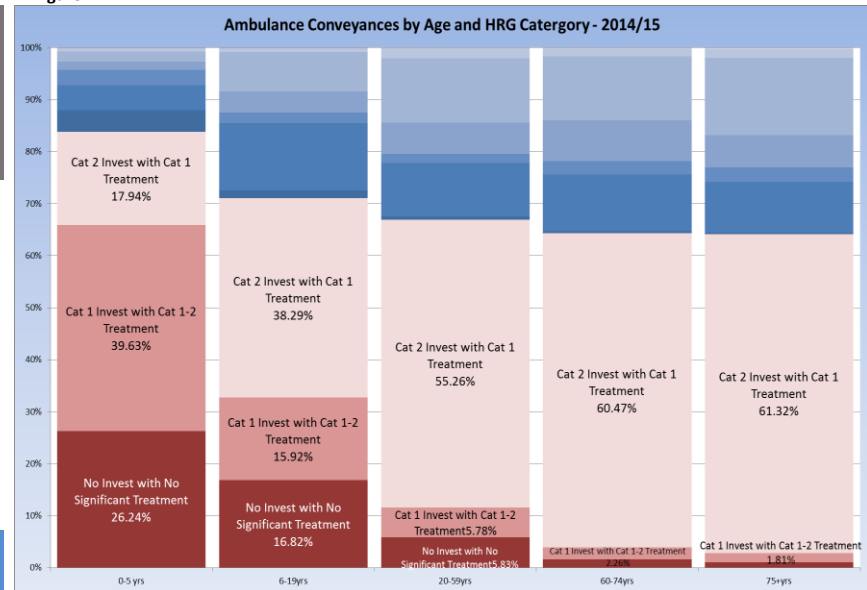
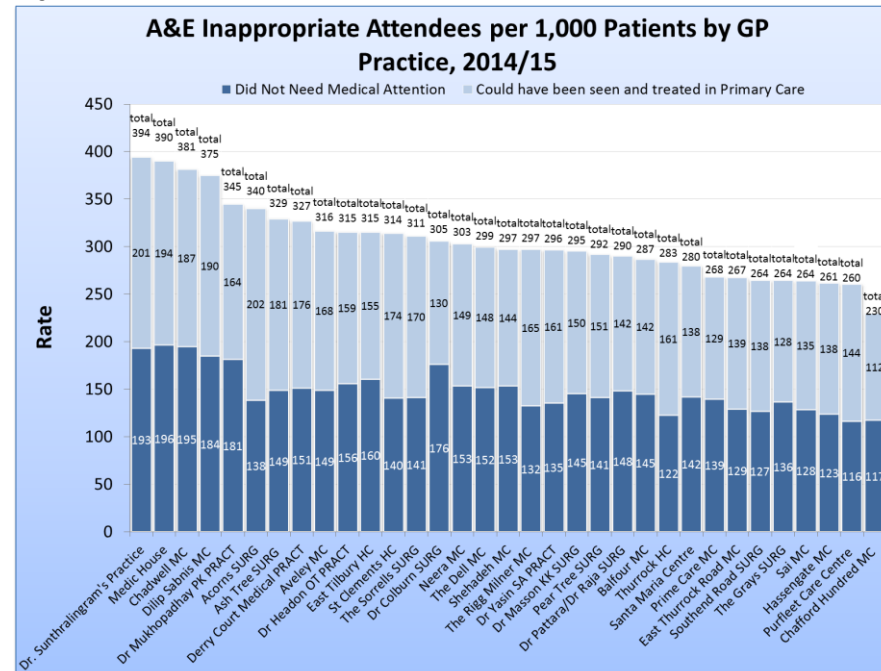


Figure 23



7. Reduce avoidable A&E attendances (3/3)

From our modelling we concluded that

Over a three year period, reducing the rate of inappropriate A&E attendances from Thurrock patients in-line with those from Mid Essex CCG, would lead to a reduction of 24,074 attendances.

These 'excess' A&E attendances cost NHS Thurrock CCG an additional £2.7M

Treating these 'excess' A&E attendances in Primary / Community Care settings would save the NHS system in Thurrock approximately £2M over three years.

That for every one mile further a way a GP surgery is from A&E, a reduction of six inappropriate A&E attendances per 1000 patients would be expected from that practice population.

Social Marketing Research on inappropriate A&E attendances at Basildon Hospital, commissioned by Public Health in 2014 concluded that the primary reasons for inappropriate attendances were:

- Belief or desire of the patient that they needed to be seen immediately
- Dissatisfaction with their GP surgery in terms of waiting time or relationship with its clinicians
- Belief that they would likely be referred to hospital by their GP and so wished to "cut out the middle man".

It also concluded that there was little that could be done in terms of patient education that would reduce demand on inappropriate A&E attendance and that improving the capacity and capability of Primary and Community Care facilities in conjunction with a robust "triage and deflect" system at the front door of A&E where patients with minor clinical conditions were refused entry and sign posted to treatment more appropriate clinical settings was the only intervention likely to prevent A&E misuse.

It would be interesting to compare triage policies at Broomfield Hospital with those at the two other A&Es in the STP area to ascertain if there are differences that would explain the significantly lower rate of inappropriate A&E attendances from patients living in the Mid Essex locality.

Our findings suggest that a significant amount of money is being spent unnecessarily treating a large cohort of patients with minor ailments in Accident and Emergency. Improving the capacity and capability of Primary Care Services locally whilst developing more robust triage at the door of A&E to deflect this cohort of patients back to Primary Care will improve both the financial and operational sustainability of our local health economy. However, a level of 'pump priming' resource is required to achieve this.

Recommendations to Reduce Avoidable A&E Attendances

- Develop a 'systems wide response' and associated business case to re-invest excess secondary care costs associated with treating patients with minor clinical conditions into community and Primary Care capacity and capability
- Significantly increase Primary / Community Care Capacity in Thurrock including better skills mix of staff with GP surgeries, improved diagnostics as set out in section 2 of this report
- Expedite building of the four Integrated Healthy Living Centres for Purfleet, Tilbury, Grays and Corringham
- Investigate commissioning/provider strategy at Mid Essex CCG to ascertain why rates of A&E usage from this population is so significantly lower than other areas in the STP foot print and implement findings locally if applicable.
- Improve front door triage at A&E at Basildon Hospital to assess and deflect patients with minor conditions from being able to accessing A&E services
- Undertake further analyses of the interface between A&E and the Essex Ambulance Service with a view to understanding and recommending appropriate actions to prevent inappropriate A&E conveyances by ambulance

8. Improve Referral to Treatment Pathways

Referral to treatment pathways are the system by which a GP refers a patient for planned care delivered within a hospital setting (sometimes referred to as 'elective care'. The standard set by the NHS constitution outlines that NHS Consultant led treatment should commence within a maximum of 18 weeks from GP referral for non-urgent conditions.

The percentage of pathways completed within the 18 week target varies in Thurrock by pathway type for both admitted (figure 24) and non-admitted patients (figure 25). In particular patients on trauma and orthopaedics, gynaecology (admitted patients), gastroenterology (non-admitted patients) neurology and ENT pathways have lower proportions of pathways completed within 18 weeks.

Patients awaiting a diagnostic test are meant to receive this within six weeks. If not met, this could contribute to a delayed referral to treatment pathway. The national standard is for less than 1% of patients to wait more than 6 weeks for a test, and it can be seen from figure 26 that a large proportion of patients are waiting more than 6 weeks both locally and nationally – particularly for peripheral neurophysiological tests (e.g. a nerve conduction test), urodynamics, colonoscopies and gastroscopies.

Recommendations to Improve Referral to Treatment Pathways

- Public Health in conjunction with Thurrock CCG, Basildon Hospital and the two other District General Hospitals in our STP foot print should undertake further research to better understand the efficiency and cost effectiveness of elective care and its relationship to access to diagnostics. This research should include analyses of workforce data and outpatient clinic data
- Work should continue at STP foot print level to rationalise and simplify clinical care pathways such that patients are not required to access diagnostics and treatment at multiple hospital sites.

Figure 24

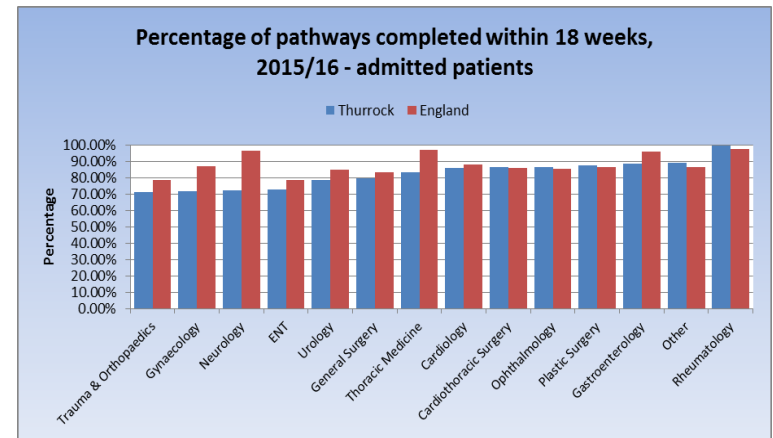


Figure 25

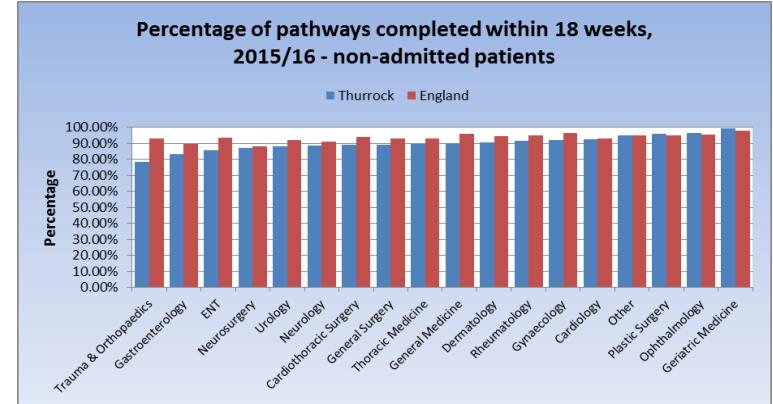
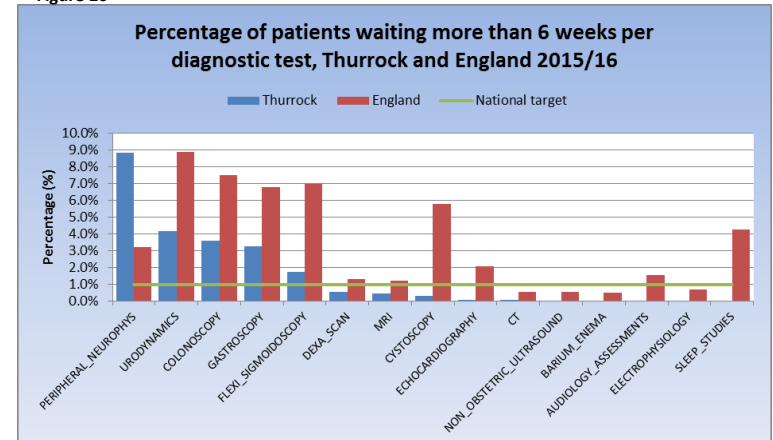


Figure 26



9. Reduce Delayed Transfers of Care

Delayed Transfers of Care (DToCs) occur when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so because the required health or social care services are unavailable.

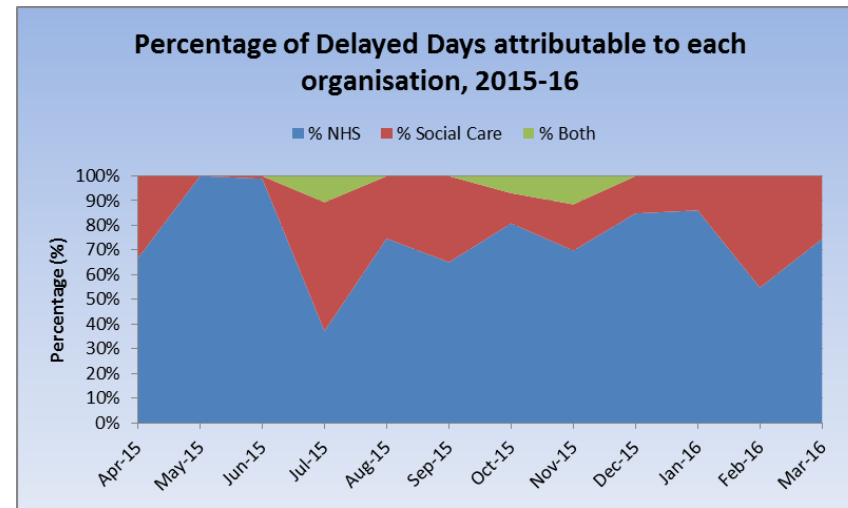
DToCs are problematic because they reduce the number of hospital beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients. Of the 1,844 Delayed Days in Thurrock in 2015/16, 1,373 (74.46%) of these were coded as the responsibility of the NHS and 419 (22.72%) were the responsibility of Social Care. Figure 27 shows the reasons for DToCs in Thurrock, coded by the number of delayed days, and it can be seen that awaiting further NHS non-acute care accounts for a third of all delayed days although this could include delays in Continuing Health Care (CHC) provision as opposed to NHS Intermediate or 'step down' care.

Whilst at the start of the year, almost all Delayed Days were due to the NHS, this proportion reduced throughout the year (figure 28). This suggests that lack of capacity within Adult Social Care provision is driving unnecessary cost within the Health and Social Care System locally

Figure 27

Reason for delay	Number of Delayed Days	Proportion of all Delayed Days
Waiting further NHS non-acute care	614	33.30%
Completion of assessment	410	22.23%
Patient or family choice	213	11.55%
Awaiting nursing home placement or availability	172	9.33%
Awaiting residential home placement or availability	134	7.27%
Public funding	119	6.45%
Awaiting community equipment and adaptations	78	4.23%
Disputes	69	3.74%
Awaiting care package in own home	35	1.90%
All Reasons	1,844	100.00%

Figure 28



Working on an average figure of £400 per day per patient to remain in a hospital bed, Delayed Transfers of Care of Thurrock patients cost the NHS £737,600 in 2015-16

Recommendations to Reduce Delayed Transfers of Care

- Public Health to undertake further research to ascertain the factors behind the large number of delayed days due to improving access to non-acute NHS care and late completeness of assessments
- Investigate and pilot a rapid discharge service to place social care resource in the hospital, and the development of a comprehensive step down facility to provide capacity to assess and provide intermediate rehabilitation. Both of these projects would improve local capacity of residential and nursing home placements.
- Developing a 'systems wide response' and associated business case to reinvest excess secondary care costs in preventative activity that keeps older people healthy and well and thereby reducing future demand on social care services, and in better Adult Social Homecare Provision

10. Adult Social Care

As discussed in the Introduction (section 1), rising spend in Adult Social Care is largely a product of failures to intervene earlier in a client's life, together with the fact as a society, we are living longer but not necessarily healthier lives.

Figure 30 shows the mean Adult Social Care Spend on Community Social Care Packages by different GP practice populations aged 75+. There is over a seven fold difference between the practice population with the highest and lowest spend, although the reasons for this are unclear. However, the main report demonstrates some clear associations between differences in community factors and primary care capacity, and rising cost in delivering Adult Social Care.

Figure 31 plots the mean spend on Adult Social Care Community based packages for older people per head of population aged 75+ in each ward in Thurrock against the level of income deprivation faced by older people within each ward (a good proxy indicator for levels of morbidity). It shows a positive association. Roughly 12.5% of the variation in Adult Social Care Community Spend per head of population aged 75+ at ward level can be explained by differences in income inequality. As such, it could be claimed that there are Social Care inequalities as well as health inequalities between different ward populations of older people in Thurrock, as those who are poorest are most likely to require more complex adult social care community packages.

Figure 32 demonstrates that approximately 16.6% of the variation in spend per head of population aged 75+ can also be explained by levels of under-doctoring at GP practice level. However some care should be taken in interpreting these results as association doesn't necessarily imply causality.

Figure 29

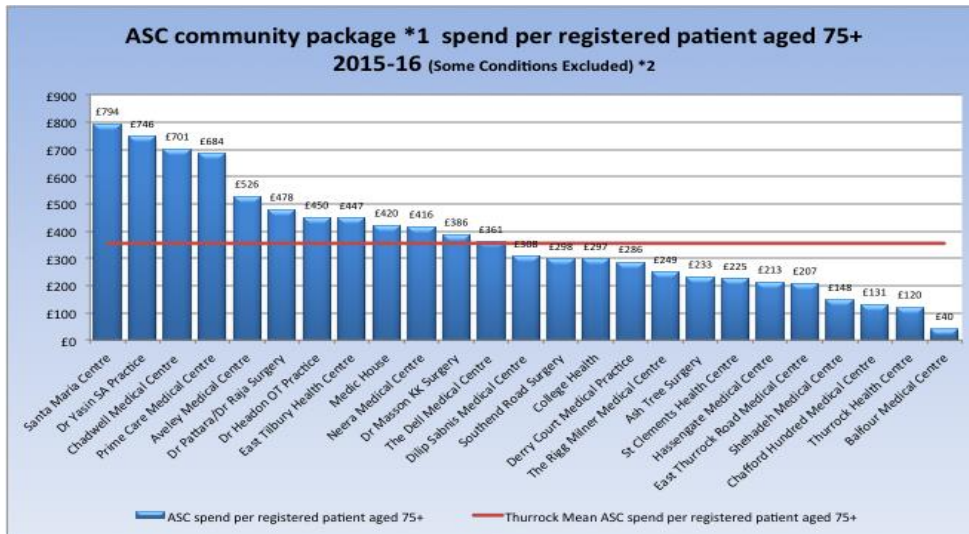


Figure 30

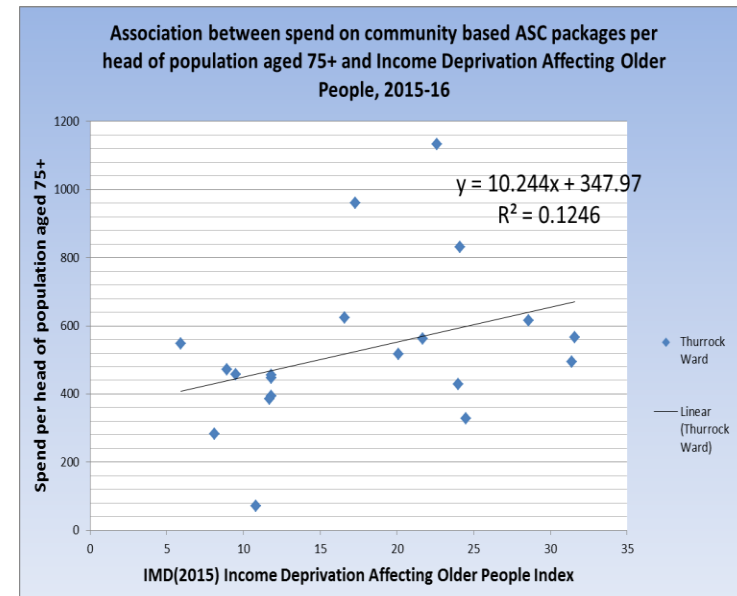
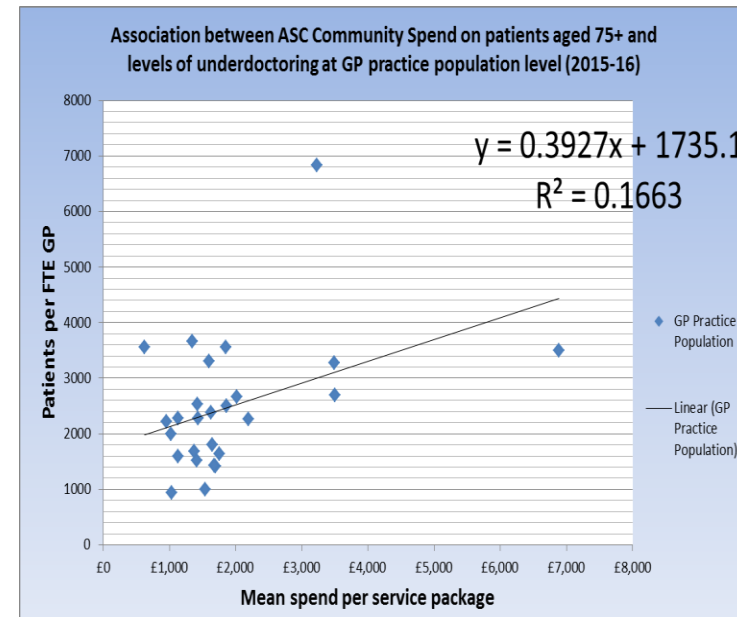


Figure 31

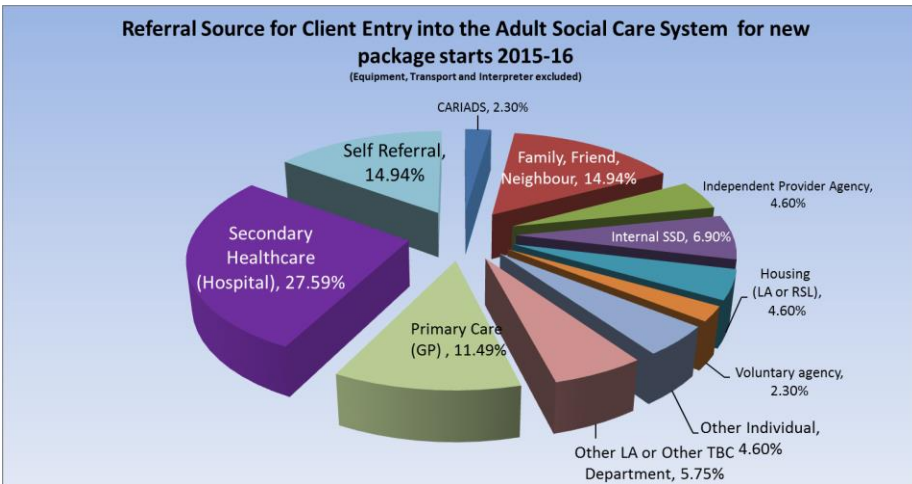


10. Adult Social Care (2/3)

Figure 30 demonstrates the link between secondary care hospital admissions and demand on Adult Social Care. In 2015-16, the most common reason for entry into the Thurrock Council Adult Social Care System was after a hospital admission. Referral from Primary Care was the second most common reason.

We calculate that for every 1% we reduce hospital admission within the Thurrock population we prevent 119 new Adult Social Care Package Starts per annum.

Figure 30



As part of the analyses of Adult Social Care data in preparation for the Annual Public Health Report, we built a Care Package activity-cost modeller which examines the numbers of new, existing and ending types of care package between 2014 and 2016 and their mean cost for all types of care package and different ages of clients. Output from the modeller looking at clients aged 75+ is shown in figures 31,32 which show a pattern common across many types of service package.

Whilst the number of new service packages is reducing from 2014-15 to 2015-16, the mean cost per service package is increasing. This suggests that Prevention and Early Intervention programmes such as Local Area Coordination, Stronger Together and Living Well in Thurrock are having a positive impact in reducing demand for new statutory care packages, but that the acuity of the packages that are provided is increasing. Regrettably the product of these two facts over all packages is an increase in spend.

Figure 31

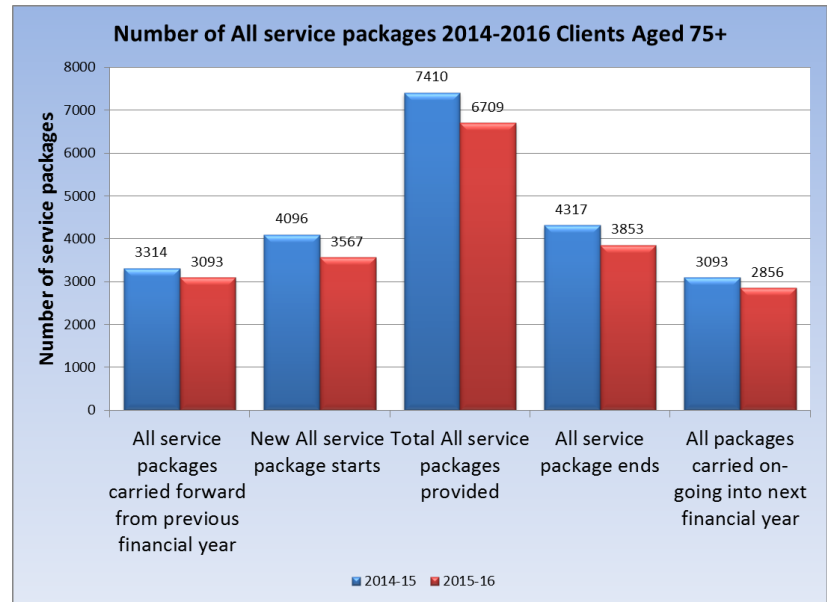
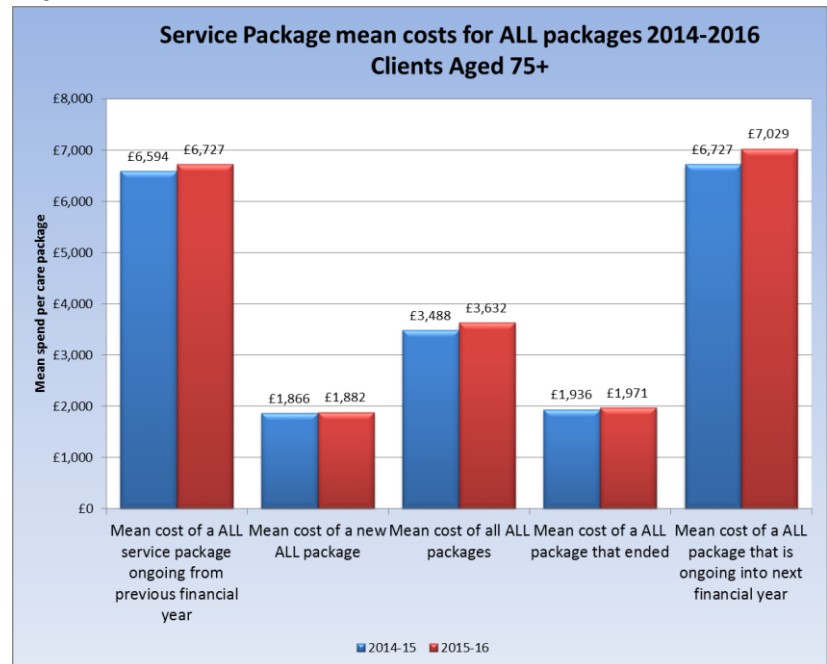


Figure 32



10. Adult Social Care (3/3)

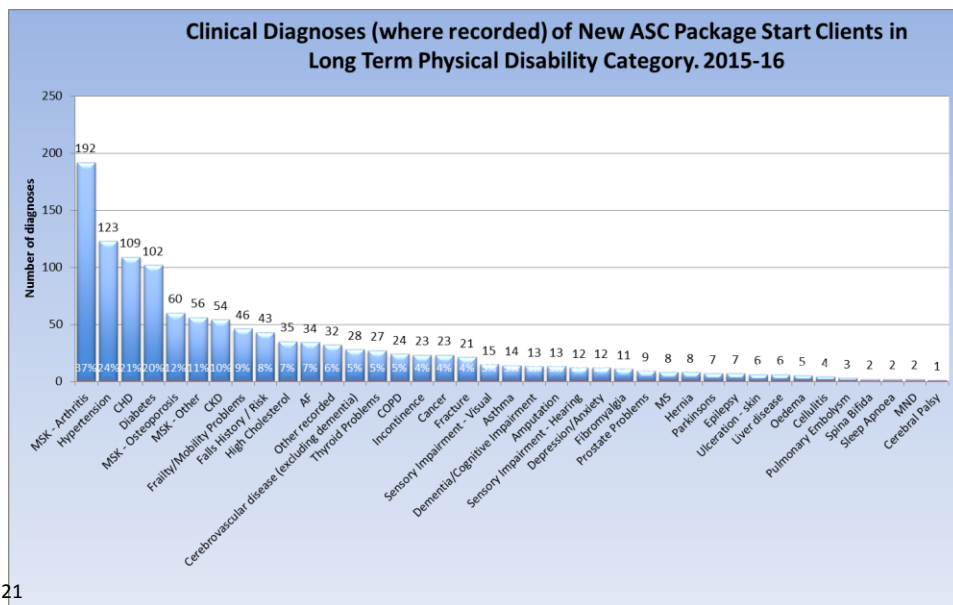
In order to try and further understand the health conditions that precede entry into the local ASC system, further analyses were done on the Other Long Term Physical and Other Long Term Neurological categories (the two most commonly recorded category reasons for a new package start. Recording of clinical conditions was generally poor so the data presented below must be treated with some caution. However, many social care staff 'free text' a description of the health of the client in these two categories. Category analysis was undertaken on the free text 'health details' field and a description of any health condition coded. The results of this analysis are shown in figure X for the Long Term Physical Disability Category.

It is also worth noting that we cannot be sure what impact each clinical diagnosis had on the decision to provide an ASC package to the client. For example a client may have Hypertension, Diabetes and Incontinence, but if the hypertension and diabetes are well controlled, the demand for care may have been a result purely of the incontinence. The issue of data recording will be solved by our newly procured Integrated Data System which will allow us to link pseudo-anonymised hospital and adult social care patient/client records via their NHS number. This will greatly facilitate future understanding of the key clinical conditions that contribute to ASC demand and develop further targeted prevention and early intervention programmes to address this.

Remembering the above caveats, Muscular Skeletal Problems – Arthritis, Osteoporosis and MSK (other) if combined are by far the most common clinical diagnosis recorded in the Long Term Physical 'Other' category. It is highly likely that these conditions are playing at least some part in entry into the ASC system for a significant number of clients. This warrants further investigation particularly in terms of the quality of NHS services commissioned to treat MSK, and in terms of primary, secondary and tertiary MSK prevention initiatives.

It is also worth noting a significant proportion of the diagnoses are for conditions that are largely preventable, and controllable with good clinical management. These include Hypertension, CHD, Diabetes, Chronic Kidney Disease, Falls, High Cholesterol, Atrial Fibrillation and COPD. Improving the case finding and clinical management of these conditions and (in the medium term) investing in Primary Prevention initiatives such to assist people to improve lifestyle behaviour is likely to have a positive impact on reducing demand of ASC conditions.

Figure 33



Recommendations in relation to Adult Social Care

Target provision of direct prevention and early intervention programmes at those aged 60+, and particularly those in the wards of Grays Thurrock, Stifford Clays, Stanford East and Corringham Town, and Chadwell St. Mary where the need is greatest.

Public Health in conjunction with Adult Social Care should undertake further research to ascertain the apparent variation in need for adult social care identified at both ward and GP practice level

Review the effectiveness of commissioned musculoskeletal services

Continue implementation of preventative services such as *Living Well in Thurrock* outlined in main the report aimed at keeping older people healthy and independent

Implement the proposed programmes to support clients with LD within the community including Shared Lives; Medina Road Supported Living and Sheltered Housing Support

Implement depression screening in adult social care clients

11. Summary of Financial Opportunities

The theme that runs through this report is that in order to make our Health and Social Care System Sustainable, we need to find system solutions to invest further upstream in Primary, Secondary and Tertiary Prevention. This requires us overcoming issues of organisational sovereignty that have led in the past to 'financial gaming' and pool resources for the benefit of both the population and the system as a whole. It will also require an element of "double running" or 'pump priming' investment, as it is impossible to cut services in the most expensive part of the system, i.e. hospitals and adult social care until we have invested sufficiently in primary and community care.

A number of financial opportunities have been calculated from embedding the recommendations listed in the main report into practice, or continuing with those already in place such as the Diabetes Prevention Programme. Whilst some cost savings (particularly to Social Care) could not be quantified due to data quality issues, it can be seen from the below that there are a large amount of savings to both Adult Social Care and the NHS to be made over a three year period by investment into preventative activity.

These are gross and not net savings, and will require (in some instances) further investment to realise. However, delivering just 10% of the financial opportunity in Thurrock listed below would go a long way to make our System Sustainable.

	3 year Savings to Adult Social Care	3 year savings to the NHS
Primary Prevention [refers to interventions aimed at the entire population, concerned with preventing disease onset], e.g. smoking cessation programmes. Usual time scale to impact on the system – medium to long: 5 to 20 years	£3,331,232	£19,162,764
Secondary Prevention [refers to interventions aimed at specific cohorts of the population, concerned with early detection of disease or risk factors that may lead to disease, and providing interventions to reduce the risks of further disease progression], e.g. bowel cancer screening. Usual time scale to impact on the system- Short to medium: 3 to 10 years.	£395,000	£3,312,000
Tertiary Prevention [refers to interventions concerned with reducing the consequences of a disease once it has developed], e.g. good clinical management of patients with long term conditions such as diabetes. Usual timescale to impact on the system – short: 0 to 3 years.	£81,070,000	£5,653,992
Total	£84,796,232	£28,128,756

APPENDIX A: Financial Opportunities by Project (1/5)

KEY:

Primary
Prevention

Secondary
Prevention

Tertiary Prevention,
(Long Term Condition Management)

Desired Outcome	Interventions	Investor of costs	Recipient of savings	Financial Opportunity
<p>Improve Detection of Hypertension. Detect 5,000 patients over 3 years.</p> <p>Prevent 33 strokes per year.</p>	<p>Hypertension detection programme funded under BCF</p> <p>Long Term Condition Management Scorecard</p>	Better Care Funding	NHS Social Care	<p>Savings of: £361K over 3 years to the NHS (A&E, Admission, and Ambulance only)</p> <p>£395K over 3 years (Social Care – over 3 years) [section 3.3]</p>
<p>Prevent patients from becoming Hypertensive. Mitigate against the additional 3,694 additional Hypertensive patients we are expected to have by 2021 due to rising levels of Obesity.</p> <p>Prevent 61 strokes per year.</p>	Halt rise of obesity	CCG / Public Health (prevention) /Council	NHS Social Care	<p>Savings of: £667K over 3 years to the NHS (A&E, Admission, and Ambulance only)</p> <p>£730K over 3 years (Social Care – over 3 years) [section 3.3]</p>
<p>Improve assessment and treatment with appropriate drug therapies AF patients with a CHADS2 score of 1:</p> <p>7 patients not exception reported. Prevent 0.86 strokes per year</p> <p>19 patients who are exception reported. Prevent 2.3 strokes per year.</p>	<p>Long Term Conditions Scorecard</p> <p>Health care Public Health Improvement manager posts</p>	No costs	NHS Social Care	<p>Savings of: £31K over 3 years to the NHS (A&E, Admission, and Ambulance only)</p> <p>£34K over 3 years (Social Care – over 3 years) [section 3.3]</p>
<p>Improve availability of GP appointments so that 0.01% more people rate it as positive in all practices:</p> <p>Prevent 158 admissions for CHD and HF per year</p> <p>Prevent 58 admissions for respiratory conditions per year</p>	<p>New mixed staffing model</p> <p>Digital services</p> <p>Increase means of self-care (community Hubs, pharmacies)</p>	CCG / Public Health (prevention)	NHS Social Care	<p>CHD HF Savings of: £2.2M over 3 years (to NHS - £4,614 per admission)</p> <p>Respiratory Savings of: £389K (to NHS - £2,233 per admission)</p>

APPENDIX A: Financial Opportunities by Project (2/5)

KEY:

Primary Prevention

Secondary Prevention

Tertiary Prevention,
(Long Term Condition Management)

Desired Outcome	Interventions	Investor of costs	Recipient of savings	Financial Opportunity
Treat more patients who have HF with LVD with ACE or ARB 9 patients not exception reported. Prevent 0.63 admissions for CHD and HF per year	Long Term Conditions Scorecard Health care Public Health Improvement manager posts	No Costs	NHS Social Care	Savings of: £8.7 - £31K over 3 years (to NHS - £4,614 per admission) Unable to quantify savings for Social Care.
Prevention of COPD cases. Prevent 100 cases of COPD and prevent 0.3 hospital admissions per year.	Smoking Prevention Smoking Cessation Obesity Prevention	Public Health (prevention)		Respiratory Savings of: £1,764K over 3 years (to NHS - £1,960 per admission)
To avoid 33 emergency admission for respiratory conditions per year Reduce the prevalence of smoking in patients with Long Term Condition patients by 9 percentage points	Smoking Cessation targeted at those with early on-set smoking related disease	Public Health (prevention)	NHS Social Care	Savings of: £194K over 3 years (NHS)
Commission an Integrated Falls Prevention Programme for Older People	Falls prevention	Better Care Funding	NHS Social Care	ASC savings: at least £2.6M Acute Hospital Savings: at least £10M Over 3 years
Reduce the number of A&E attendances requiring no investigation or treatment.	Mitigate the impact of closeness and convenience by introducing local services Educate parents through health visitors when to use A&E Consider training parents in first aid/self-care Consider an Ambulance Triage	NHS	NHS	Reduce A&E attendances by 294 per year saving the NHS £19K per year £57K over 3 years

APPENDIX A: Financial Opportunities by Project (3/5)

KEY:

Primary Prevention

Secondary Prevention

Tertiary Prevention,
(Long Term Condition Management)

Desired Outcome	Interventions	Investor of costs	Recipient of savings	Financial Opportunity
Reduce inappropriate attendances to be in line with Mid Essex	Review Mid Essex triage system and consider implementation in Thurrock Educate parents through health visitors when to use A&E Consider an Ambulance Triage	NHS	NHS	Reduce A&E attendances by 8,000 per year saving the NHS £900K per year £2.7M over 3 years
Increase patients with Long Term Conditions' knowledge on how best to self-care	Self-care	PH Existing Community Capacity	NHS Social Care	For a cost of £400 per patient, average net saving of £1,800 per patient per year
Social Prescribing	Community management of care	PH CVS? CCG?	NHS Social Care	After five years, a return on investment of £3.38 per £1 spent.
Well Homes	Keeping people well at home	Public Health Private Housing Service	NHS Wider society Social Care	Completing 400 assessments a year is calculated to result in £1,676,815 savings to society [£694,297.10 to NHS] Over 3 years: Wider Society: £2.9M NHS: 2.1M
Increase early diagnosis of breast cancer in line with the East of England average.	Cancer screening	NHS England / Public Health	NHS Social Care	Improving early diagnosis by 6% could save £58,243 in cancer treatment costs, or a three year total of £189K
Increase early diagnosis of cervical cancer in line with the East of England average.	Cancer screening	NHS England / Public Health	NHS Social Care	Improving early diagnosis by 6% could save £3,775.20 in cancer treatment costs, or a three year total of £12K
Increase early diagnosis of bowel cancer in line with the East of England average.	Cancer screening	NHS England / Public Health	NHS Social Care	Improving early diagnosis by 6% is calculated to save £26,374 in cancer treatment costs, or a three year total of £81K

APPENDIX A: Financial Opportunities by Project (4/5)

KEY:

Primary Prevention

Secondary Prevention

Tertiary Prevention,
(Long Term Condition Management)

Desired Outcome	Interventions	Investor of costs	Recipient of savings	Financial Opportunity
Reduce the future number of long term conditions patients who are also obese.	Obesity Prevention – targeted weight management initiatives, tier II/III	Public Health CCG	NHS Social Care	The additional projected costs of LTC + obese calculated to be: Stroke £5M CHD coronary artery bypass grafts £3M. Diabetes inpatient £2.3M -£3.2M Hypertension management £267K Over 3 years. These are all on top of their existing LTC management costs.
Increase uptake of the programme from 56% to 66%.	NHS Health Checks	Public Health	NHS Social Care	The increase in uptake by 10 percentage points would result in 57 additional Quality Adjusted Life Years over the course of a lifetime.
Achieve the target of 500 patients referred onto the service.	National Diabetes Prevention Program	CCG	NHS Social Care	NHS Savings: £27K ASC Savings: £1,232 Over 3 years NET
Enabling a patient to self-refer to a physiotherapist.	Physiotherapy in Primary Care	CCG	NHS Social Care	Estimated savings of up to £44,959.20 in hip and £76,705.20 in knee osteoarthritis patients.

APPENDIX A: Financial Opportunities by Project (5/5)

KEY:

Primary Prevention

Secondary Prevention

Tertiary Prevention,
(Long Term Condition Management)

Desired Outcome	Interventions	Investor of costs	Recipient of savings	Financial Opportunity
Maintaining effective cholesterol control in patients with Diabetes and CHD.	Management of hypertensive patients	CCG	NHS Social Care	Three year savings from: Strokes and heart attacks avoided: £256K (NHS) strokes avoided: £36K (Social Care) The above come from treating an additional 493 Diabetes and 241 CHD patients.
Continued investment into the RRAS	Rapid Response Assessment Service	NHS Social Care	NHS Social Care	ASC Packages avoided: £524,081 per week (Social Care) Over three years - £81M Opportunities not calculated for NHS