The Case for Change: A New Model of Care for Tilbury and Chadwell

Author:

Ian Wake
Director of Public Health

September 2017

Acknowledgements

The author would like to thank and acknowledge the following colleagues whose ideas, content, statistical analysis and input have all assisted in the creation of this *Case for Change* document.

- Emma Sanford, Strategic Lead - Healthcare Public Health, Thurrock Council
- Maria Payne, Senior Public Health Programme Manager - Health Informatics, Thurrock Council
- Funmi Worrell, Strategic Lead Public Health, Thurrock Council
- Monica Scrobotovici, Healthcare Public Health Improvement Manager, Thurrock Council
- Jo Pitt, Healthcare Public Health Improvement Manager, Thurrock Council
- Les Billingham, Assistant Director of Adult Social Care, Thurrock Council
- Tania Sitch, Integrated Care Director, Thurrock Council and North East London Foundation NHS Trust
- Jeanette Hucey, Director of Transformation, NHS Thurrock Clinical Commissioning Group
- Sharon Hogarth, Area Operations Manager, College Health Ltd.

1. Introduction and Background (1/3)

This document sets out a case for change for A New Models of Care in Tilbury and Chadwell. It has been developed in consultation with key stakeholders including Essex Partnership University NHS Foundation Trust (EPUT), Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH), North East London NHS Foundation Trust (NELFT), NHS Thurrock Clinical Commissioning Group (TCCCG), local GP surgeries and Thurrock Council's Adult Social Care and Public Health Teams.

This document follows the production of a detailed needs assessment for the area of Tilbury and Chadwell which can be by clicking the link at the bottom of this page.

The programme of work stemmed from the publication of the Annual Report of the Director of Public Health (2016) which set out the current state of demand on the local health and social care system, along with the key influences on activity. This report aimed to understand the increasing demand on local health and care services and provided a list of evidence-based recommendations to reduce current unsustainable growth.

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 faces significant financial and operational challenge. There is currently a £59.4M financial deficit across the three hospitals within south and Mid Essex and our Sustainability and Transformation Plan (STP) footprint is forecasting a £99.6M system deficit. Thurrock Council is predicting an £16.6M 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.

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

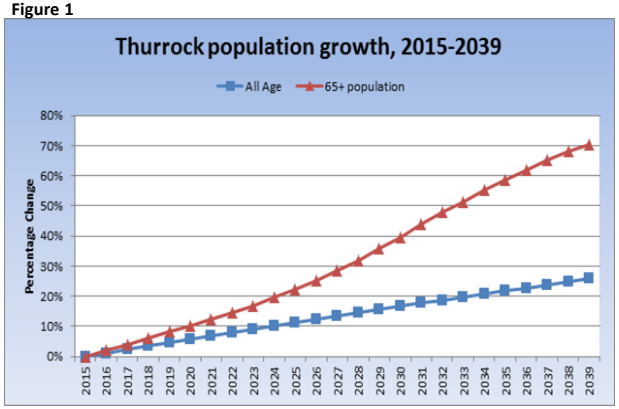
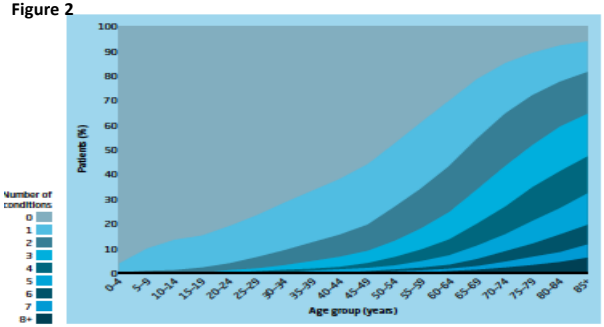
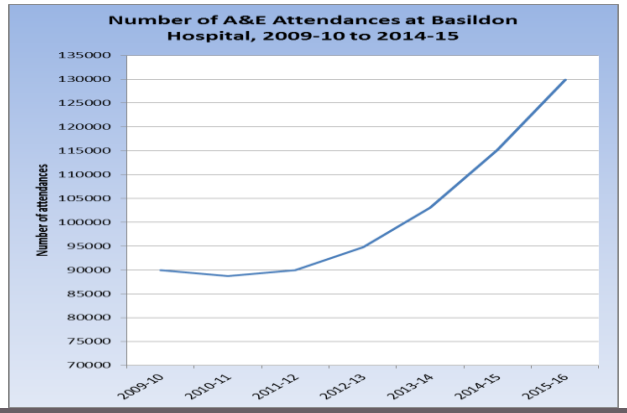


Figure 2



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

Figure 3



1. Introduction and Background (2/3)

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 (figure 4). 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, the APHR 2016 quantified and linked 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.

Following publication of the APHR 2016, EPUT, BTUH, NELFT, TCCG and Thurrock Council decided to collaborate in order to pilot a New Model of Care (NMC) in Tilbury and Chadwell; one of the four localities within Thurrock.

The aim of the NMC is to act as a pilot to demonstrate proof of concept, that if investment and quality and capacity of Primary, Community and Mental Health care is improved, and a single lead provider ensures that all out of hospital services are integrated, that we will have a positive impact on reducing demand on the two most expensive parts of our local health and care economy; acute hospital services and residential care services.

This will then release funding for re-investment in similar models across the rest of the Borough and beyond.

Figure 4

Problems in discharge planning Delayed Transfer of Care

Un-timely or Inadequate discharge planning

Emergency Hospital Admissions following inadequate Long Term Condition management

Emergency hospital admissions

Discharge of patients after preventable serious health events Delayed Transfer of Care

Failure to refer patients to LTC management services

Unintegrated care coordination

Unstable and inadequate homecare market / provision

Inappropriate use of A&E

Difficulty in access Inappropriate access

Difficulty in access Inappropriate access Lack of knowledge of services

Insufficient investment in prevention and early intervention programmes

1. Introduction and Background (3/3)

Tilbury and Chadwell, the place

Figure 5

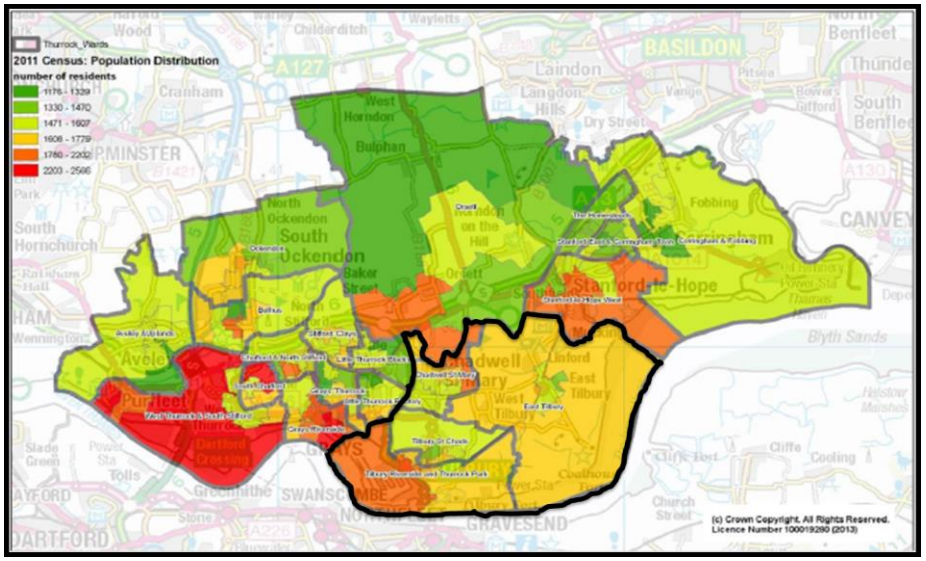
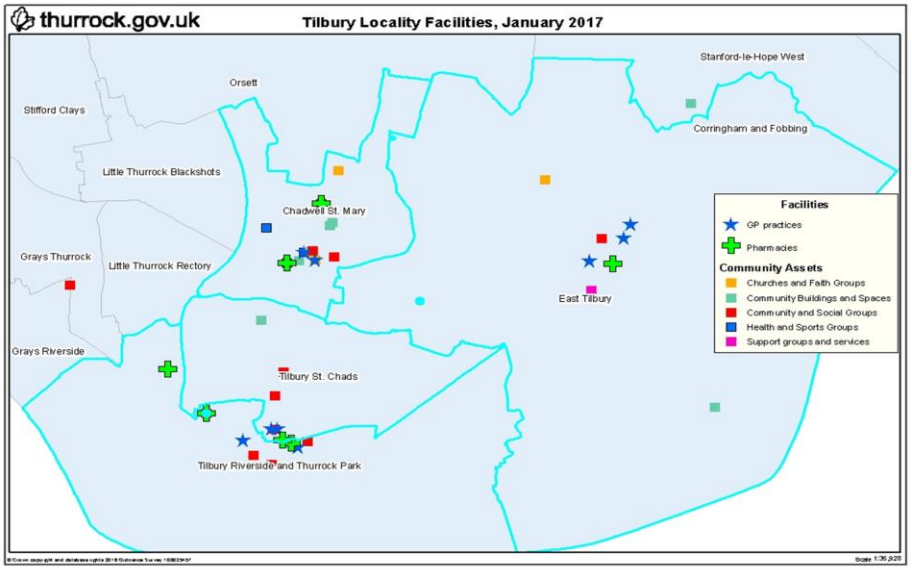


Figure 6



The locality of Tilbury and Chadwell is shown in the thick black line in figure 5. It comprises the four wards of Tilbury St. Chads; Tilbury Riverside and Thurrock Park; Chadwell St. Mary and East Tilbury.

The area is served by a number of GP practices: four surgeries run by College Health Ltd (Thurrock Medical Centre, The Shehadeh Medical Centre (Tilbury), East Tilbury Medical Centre; Chadwell Medical Centre); and four independent GP surgeries (Sai Medical Centre, Rigg Milner, Dilip Sabnis and Dr. Ramachandren's surgery).

The locality also has nine community pharmacies, a community hub and a variety of community and social groups. (Figure 6)

Examples of key assets within the locality include:

- Two Community Hubs, one in Chadwell and one in Tilbury. Both host a variety of activities such as the Credit Union, IT classes, and Local Area Coordinators
- Active Tilbury – funded through Sport England.
- Park Run – open to all Thurrock but situated on Orsett Heath – near Chadwell
- Nature Reserve, Coalhouse and Tilbury Forts providing outdoor opportunities
- Arts Centre offering Dementia walks etc.

The locality has a total population of approximately 35,000 people, although this is predicted to increase by almost 68% within the next 13 years through a combination of natural population growth and Thurrock Council's plan to encourage the building of 10,000 new homes within the locality. Thurrock Council also a comprehensive regeneration plan for Tilbury Town Centre including provision of a new Integrated Medical Centre.

Major employers include The Port of Tilbury. Amazon plan to create 3500 new jobs in a new Citation and Fulfilment Centre currently under construction.

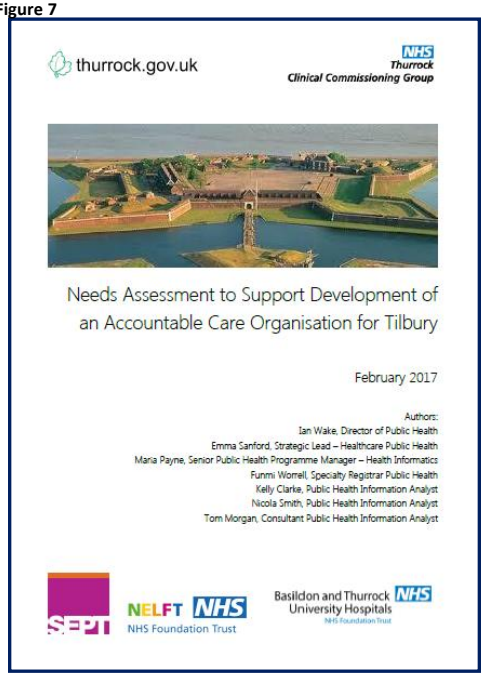
Chapter 2:

A whole system's understanding, a whole system's approach

2. A whole system understanding, a whole system approach (1/2)

The first stage the programme to develop this Overarching Case for Change was to undertake a detailed needs assessment of the locality of Tilbury and Chadwell. (Figure 7) This was published in February 2017. It aimed to address the issue that a detailed understanding of patient/client flow between different constituent services within the local health and care system is fundamental to building a programme of work that reduces demand on secondary acute NHS and residential care services. A full copy of the document can be accessed by clicking the hyperlink below figure 7.

Figure 7



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

The detailed analyses contained within the needs assessment can be summarised in five high level conclusions below and overleaf:

1. Too much money and too many patients are in the most expensive parts of the system:
   - There were 453 potentially avoidable emergency hospital admissions for ambulatory care-sensitive conditions in 2015/16 costing £19,000.
   - There were 1,844 delayed days for delayed transfers of care in 2015/16, with a net wastage of £2.31M, had adequate NHS community services been available (Thurrock wide figures). This has increased since the publication of this needs assessment.
   - 77% of A&E attendances were for issues that needed "advice only and no treatment", or the most minor for of investigation and treatment, and could potentially been treated in Primary Care. The net wastage to the system in treating this cohort of patients in 2015/16 was £0.5M
2. Inadequate quality and capacity in Primary Care, Community Care and ASC keeps the money and the people in the wrong place
   - Tilbury is one of the most "under-GP'd" and "under-practice nurse'd" localities in England
   - Thousands of patients with long term conditions have not been diagnosed, and so are not being treated, putting them at high risk of serious health events and emergency hospital admissions
   - For those patients who have received a diagnosis of a long term condition, many are receiving inadequate care within the community. In 2015/16, 4575, 2011 and 893 NICE recommended clinical interventions for patients diagnosed with diabetes; cardio-vascular disease; and COPD were not delivered putting them at increased risk of serious health events and emergency hospital admissions
3. Solve the capacity and quality issues highlighted in (2), and the money will follow is reduced hospital and ASC costs
4. Solving the capacity and quality issue highlighted in (2) requires integrating the system (and the money)
   - There needs to be further integration between ASC and Health. The organisational sovereignty of budgets creates perverse incentives not to address issues such as delayed discharges.
   - The interface between GP surgeries and Community Services needs to be improved. Too few patients on GP Long term condition registers are not being treated by Long Term Condition Management Services commissioned from NELFT
   - Primary Prevention needs to be "ramped up" and integrated into the day job of all front line health and care staff, rather than being commissioned separately by the Public Health Team.
   - Mental and Physical Health Services operate largely in silos and need to be integrated
   - Self care and the third sector sit largely completely outside clinical care pathways
5. We require a period of "double running" (non-recurrent investment) to solve the problem.
   - We cannot simply decommission services provided by BTUH and ASC whilst we invest in prevention and early intervention programmes, and address the issue of capacity and capability within Primary Care

2. A whole system's understanding, a whole system's approach (2/2)

The aim of the New Model of Care is to move from the current fragmented system of individual services (figure 8), to one single integrated community care offer wrapped around a network of world class primary care GP surgeries, with the resident at its heart (figure 9). Our New Model of Care will have four high level aims, shown in box 1.

BOX 1: Aims of the New Model of Care

1. Reduce the number of unplanned hospital admissions
2. Reduce the number of A&E attendances for conditions that could have been treated elsewhere within the community
3. Reduce the number of Delayed Transfers of Care
4. Keep people as independent as possible for as long as possible, and reduce/prevent/delay entry into care and support services

These will be achieved by delivering the key objectives shown in box 2. These aims and objectives make up an agreed "investment framework" for our Better Care Fund.

BOX 2: Key objectives of the New Model of Care

1. Significantly increase the capacity and quality of Primary Care provision and reduce variation in current provision
2. Significantly increase the diagnosis rates of those with un-diagnosed long term conditions (case finding).
3. Significantly improve the care of patients with Long Term Conditions within the community
4. Empower individuals and communities to take responsibility for their own health and wellbeing
5. Transform the way community health and care services are delivered including making care more flexible, holistic and person-centred, and to reduce duplication and improve outcomes.
6. Harness, and empower the resident, community and third sector as equal partners in health and wellbeing
7. Address wider determinants of health and wellbeing including housing, the environment and employment
8. Improve the mental health and emotional wellbeing of the population
9. Bringing health and care services and resources together in order to reduce duplication, improve efficiency and provide a better response such that people get the right solution at the right place and the right time;
10. Deliver a single live, shared care record.

Figure 8: The current fragmented system

Figure 9: The new ACP

Chapter 3:

A new set of values, a new way of working

3. A new set of values, a new way of working (1/3)

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

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

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

A new approach to health and care that integrates both philosophies in a flexible and appropriate way around the person is highly desirable, but this also requires front line health and care staff who may have worked have worked purely to one model for decades, to break down historical professional hegemony and embrace new ways of seeing the world. We do not under-estimate the challenge of changing organisational and professional cultures in order to achieve this.

As such we have developed an are currently consulting on some high level principles that all partners in our new ACP will sign up to, grouped under three main headings (box 3) and defined what success will look like and how this will be different to the current approach. (box 4 overleaf)

Box 3: Our Values

Partnership with you and your community

- We will listen to you and help you identify what your own needs are
- We will focus on supporting you to achieve the outcomes and solutions that you define
- We will treat you as an equal partner in your health
- We will work "with you", not "do to" you
- We will help you to access the community assets available within your local area and not simply focus on our own health services
- Responsibility for maintaining and improving your health and wellbeing is shared with you and with your neighbourhood;

Proactive prevention

- Our starting point will always be to help you remain as healthy and independent as possible
- We will prevent, reduce and delay you from requiring a social care and health service by intervening as early as possible

Integrated accessible services

- When you do need a health or care service, we will seek to integrate care around you, not require you to access lots of different services
- We will provide you with a single named accountable person who coordinates your care
- With your permission, our care providers will talk to each other so that you should only have to "tell your story" once.

3. A new set of values, a new way of working (2/3)

We have also defined what "success looks like", in terms of the proposed new way of working for our ACP. This is again group under three key headings, set out in box 4

Box 4: What does success look like?

A strong, connected community

- You are less isolated and have the opportunity to be well connected where you live;
- You are able to get the majority of the support you need from within your neighbourhood and as a result you access health and care services less frequently;
- You are enabled to live a healthy and happy life.

Shared responsibility

- You take responsibility for staying as healthy as possible
- We all use health and care resources appropriately and responsibly

Holistic, flexible and proactive care, provided locally

- Our health and care system treats you as an individual and does not define you by your illness or condition;
- You can get the support and care you need at the right place and the right time;
- By bringing health and social care services and resources together we will reduce duplication, improve efficiency and provide a better response
- We act before you reach crisis point and reduce the number of times you need emergency health or care services

3. A new set of values, a new way of working: Beryl's stories (3/3)

What would happen now

Beryl is an 81 year old woman living in Chadwell who has recently become widowed. Simon, her son lives in the Newcastle and sees his mum three times a year. Alice, her daughter lives in North America and is only able to keep in contact via telephone which is difficult given Beryl's hearing loss.

Beryl has lived in the same house for forty years. It is the home in which she raised her family and where she lived with her husband until he died nine months ago. The house has three bedrooms and a large garden which she can no longer maintain. The home is draughty and the heating system is too expensive to run for more than a few hours a day. However the house contains all of her happiest memories and is home. Beryl knows that her house is not manageable anymore and makes her life much more difficult. She feels there is nowhere she would want to move to and so cannot contemplate moving. Beryl has become almost totally isolated since her husband died. She has a reasonable income as he left her well provided for but has lost all interest in mixing with people. As a consequence of her isolation Beryl feels very low, and there are many days when she feels like there is little reason to carry on. As a consequence of this feeling, Beryl has continued to use the sleeping tablets prescribed following her husband's death, she has continued to take these on repeat prescription as she feels that they help to take the edge off of her loneliness.

Two months ago Beryl accidently doubled up on her dose. This led to her falling down the stairs late at night and not being able to get help until the morning. Beryl had broken her hip and suffered other cuts and bruises. After a period in hospital Beryl was discharged home with a package of re-ablement. Beryl was unsure what this meant but now understood that this was care and support for her in her own home that would assist her to regain her independence. The service she received was very good but despite everyone's best efforts Beryl was unable to improve to the same level of independence she enjoyed previously. Beryl now receives a home care package to assist her in her personal care needs and to prompt her medication use. Beryl is now on much more medication than before and gets confused about what she needs to take and when. The longer term prognosis for Beryl would seem to lead inevitably to a period of decline and ultimately to residential or nursing care

What should happen in the future

Beryl watched a new HAPPI housing scheme – Grove Park being built and she and her husband talked about selling their house and using their capital to buy a new equity share home. They recognised that the heating bills would be much lower and there would be fewer worries if they moved to purpose built, attractive housing. Beryl had also joined the Chadwell choir which had been set up by U3A volunteers at the new Chadwell Community Hub – just five minutes down the road from her home. Her husband has been active in the steering group of the community hub and had set up a reading club. A local volunteer has set them up on Skype so they can maintain contact with family in the UK and abroad.

When her husband and prime carer died suddenly, Beryl was contacted by someone who was based at the Chadwell hub and who was called "Initial Support". They explained that their team worked with people who were identified as possibly in need of some help and advice to ensure that their quality of life and independence was being maintained. In Beryl's case the referral had come from the practice nurse in her GP surgery. The worker arranged to visit Beryl in her home and was able to provide her with a few aids that would assist in daily living tasks, and some minor adaptations to her house that would help to prevent Beryl from falling. Also the worker reviewed Beryl's medication and was able to provide good advice about the possible detrimental impact of using the sleeping tablet she had been prescribed for too long. The worker also provided a medication dispensing system that ensured it was very difficult for Beryl to take too many tablets. Finally the worker referred Beryl to a "community Connector" who was a volunteer working in the local community who had established excellent links with a wide number of local groups and networks with whom Beryl could become involved if she wanted. Through the community connector, Beryl felt able to discuss her concerns about continuing to live in her family home in the longer term and how she might get help to move into Grove Park. When she was ready, a local community interest company – 'People Movers' helped Beryl with all the practical arrangements for down-sizing to her new home. With the community support she has in place, the lovely new home and new friends she has made at Grove Park, Beryl's use of medication has reduced as her health has improved. The family who moved into Beryl's house come to visit her, bringing home-made jams made from the fruit trees that Beryl and her husband planted when they were first married. Beryl in turn, helps their daughter with her French homework. The people mover company – set up with the advice of Thurrock CVS found a good home for some of Beryl's surplus furniture.

Grove Park, in tandem with our new Community service hub and our local volunteer services will mean that Beryl's life in older age, after the death of her husband can still be a quality life where health and independence are encouraged. Beryl has just taken over the role of management secretary for the group running the day to day management and maintenance of the scheme. This means that the scheme benefits from her administrative and managerial skills she has from her previous career as the school secretary.

4. Segmenting the Population

Figure 10: Percentage of population and cost of Hospital Services use. (A&E, Outpatients and Inpatients)

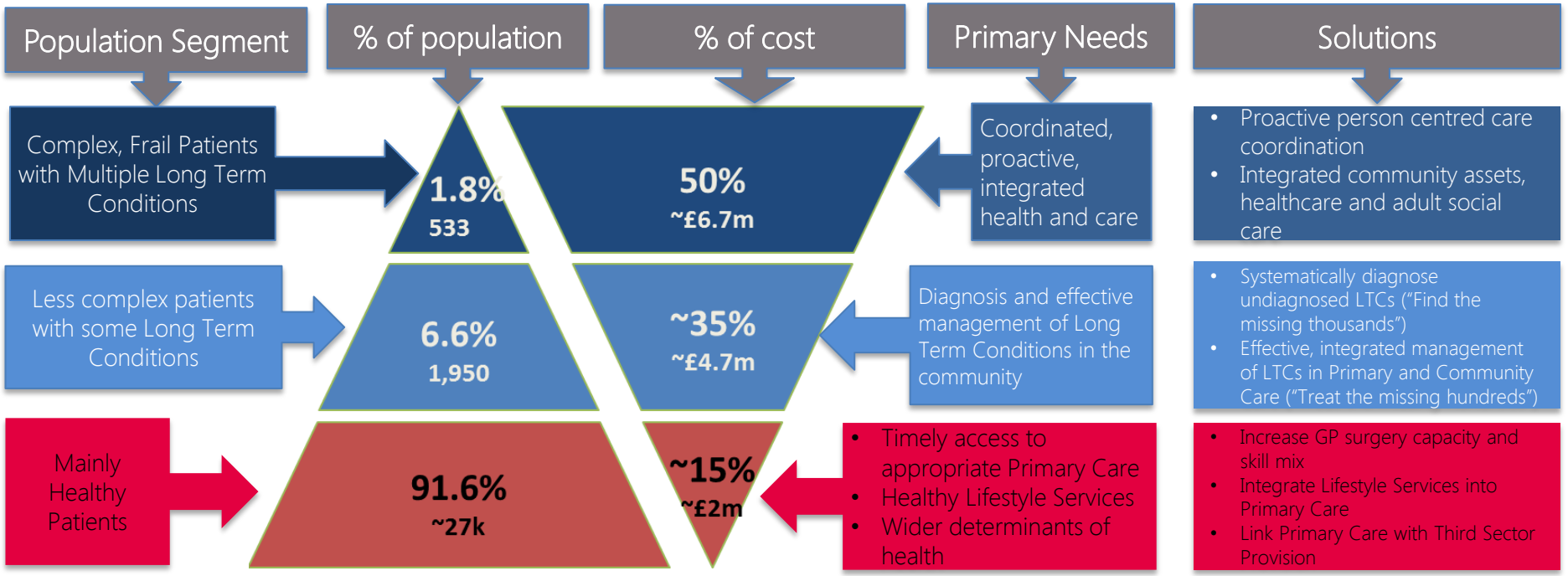


Figure 10 above shows the healthcare (A&E, out patient and in-patient) costs of different segments of the population. 50% of all spend on hospital services is generated by only 1.8% of the population. These residents are likely to be older people with multiple complex needs who are likely to have experienced a number of hospital admissions. There main need in the community is likely to centre around proactive health and social care, with a single named professional responsible for coordinating all of their care needs. The main purpose of such a service needs to be to maximise independence, keep them as well as possible, reduce the number of unplanned hospital admissions and delay entry into residential care.

A further 35% of health care costs is generated from only a further 6.6% of the population. These are likely to be patients with some long term conditions that may or may not have been diagnosed. If not properly managed within Primary and Community Care, they are at risk of more serious health events such as heart attacks and strokes, and are likely to move up into the 'Complex Frail' category. Their main need is to have their long term conditions effectively diagnosed and managed within Primary/Community Care.

The vast majority of the population (91.6%) account for only 15% of hospital healthcare costs. This population is likely to consist of mainly healthy patients who have acute illnesses. There main experience of the healthcare service will be in Primary Care and their main concerns are likely to be timely access to a GP or other healthcare professional to assist with acute illness. They may visit A&E inappropriately if they are unable to access these services in a timely way. In addition, they may benefit from and wish to access lifestyle modification services such as stop smoking or weight management or services that help address the wider determinants of health such as housing advice, debt or employment issues.

The remainder of this New Model of Care *Case for Change* is divided into three chapters, each of which focus on solutions required to address the primary needs of each of the above three segments. We recognise that residents may not fit neatly into one segment, and may have needs that span all three. We also recognise that individuals may move between segments during their lifespan. The separation of our proposed initiatives into three chapters is simply a neat way to categorise different types of initiative.

Chapter 5:

Enhance the capacity and capability of Primary Care

Mainly Healthy Patients

91.6%
~27k

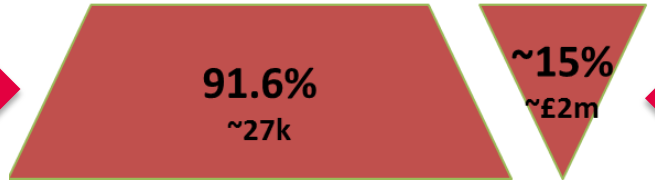
~15%
~£2m

- Timely access to appropriate Primary Care
- Healthy Lifestyle Services
- Wider determinants of health

- Increase GP surgery capacity and skill mix
- Integrate Lifestyle Services into Primary Care
- Link Primary Care with Third Sector Provision

5. Enhancing the capacity and capability of Primary Care

Mainly Healthy Patients



- Timely access to appropriate Primary Care
- Healthy Lifestyle Services
- Wider determinants of health

- Increase GP surgery capacity and skill mix
- Integrate Lifestyle Services into Primary Care
- Link Primary Care with Third Sector Provision

5.1 Introduction

This chapter explores the issue of enhancing the capacity and capability of Primary Care in Tilbury and Chadwell. High quality primary care services that are easily accessible are key to both population health and system sustainability. Over 90% of the population will visit their GP each year and over 95% will use a pharmacy, making Primary Care the most frequently accessed element within the local health and care system.

5.2 GP Under-doctoring in Tilbury and Chadwell: The Current Capacity Gap

Thurrock is one of the most under GP'd and under Practice Nurse'd area of England, and Tilbury has the worst ratio of Full Time GPs and Practice Nurses: Registered Patients in Thurrock. All of the practices in Tilbury and Chadwell have a greater than ideal number of patients per permanent WTE GP. The picture does look slightly different when we include locums in the figures, however this does not provide any continuity of care and is an expensive way to "prop up" capacity. Figure 11 shows the FTE:weighted patient ratio for each surgery in Tilbury, together with the 2014 national average ratio of 1:1321.

This current situation translates into fewer available GP appointments per head of population depending on the average length of appointment offered. GP appointment length is amongst the shortest in Europe often meaning that GPs can only deal with a single issue in one appointment. Demand on GP surgeries nationally is increasing at a rate that is not sustainable, and which has not kept pace with increases in either funding or workforce. Analysis of 30 million patient contacts from 177 practices[1] found that consultations grew by more than 15 per cent between 2010/11 and 2014/15. Over the same period, the GP workforce grew by 4.75 per cent and the practice nurse workforce by 2.85 per cent.

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 12 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.

Multiple Regression Analyses models produced by the Thurrock Healthcare Public Health Team for the 2016 Annual Report of The Director of Public Health, demonstrated that Improving access to Primary Care services provided from GP Surgeries has the potential to prevent serious adverse health events and avoid unnecessary secondary care admissions and costs. For Thurrock as a whole, 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 11

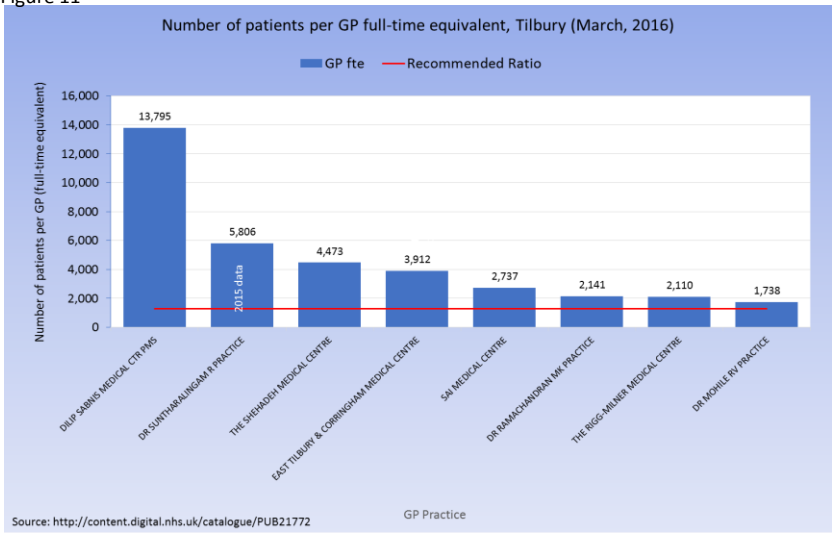
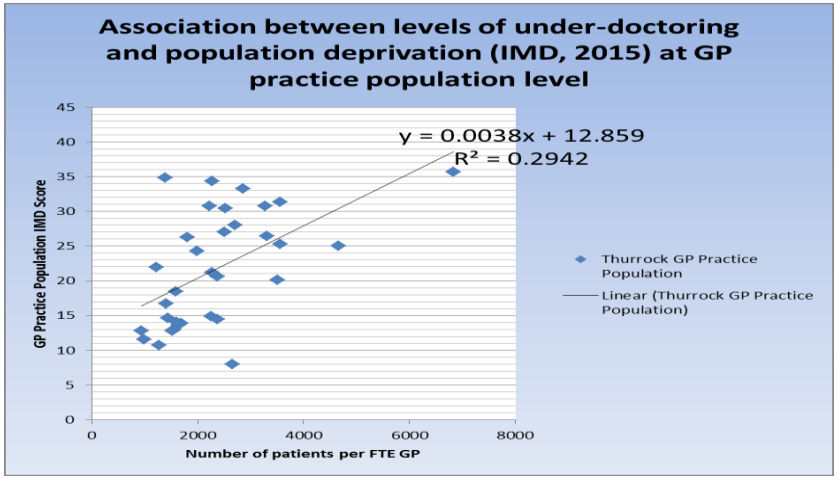


Figure 12



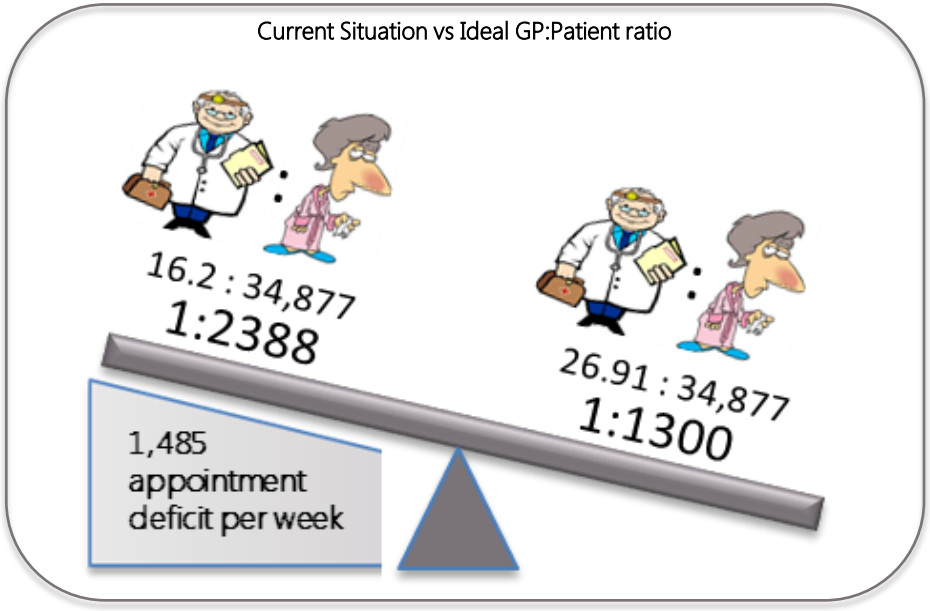
5. Enhancing the capacity and capability of Primary Care (2/X)

GP Under-doctoring in Tilbury and Chadwell: The Current Capacity Gap (cont.)

There are currently 16.2 FTE GPs in Tilbury and Chadwell, giving a FTE GP to patient ratio of 1:2388. We calculate that in order to bring FTE GP: patient ratios in line with the 1FTE GP per 1300 patient ratio (approximately in-line with the 2014 England mean ratio) set out in the ACP Needs Assessment , we require a further 10.71WTE GPs in Tilbury and Chadwell. Under new APMS contract rules, we calculate that each additional FTE delivers 138.72 appointments per week. The current lack of these GPs in Tilbury and Chadwell leaves an appointment deficit of 1486 appointments per week (shown in figure 13).

Lack of timely access to Primary Care in Tilbury and Chadwell is a significant concern for residents and a pressing problem both in terms of population health terms and system sustainability. Residents who are unable to get an appointment in their surgery risk delays in treatment for health conditions and are more likely to access A&E for more minor clinical issues that should be dealt with in the community. (Box 5). 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 Medical Centres should make Thurrock an attractive place for GPs to work in and assist in recruiting new GPs, however this is a medium term solution.

Figure 13



Box 5: Financial Impact of Inadequate Primary Care Access

In 2015/16:

- 77% of A&E attendances from Tilbury and Chadwell residents were for clinical issues that could have been dealt with in the community
- This resulted in **£950,000** of net excess cost to our local health system

[2] Primary Care Foundation and NHS Alliance, Making Time in General Practice, October 2015

5. Enhancing the capacity and capability of Primary Care (2/X)

5.3 Why the historical model of General Practice is broken

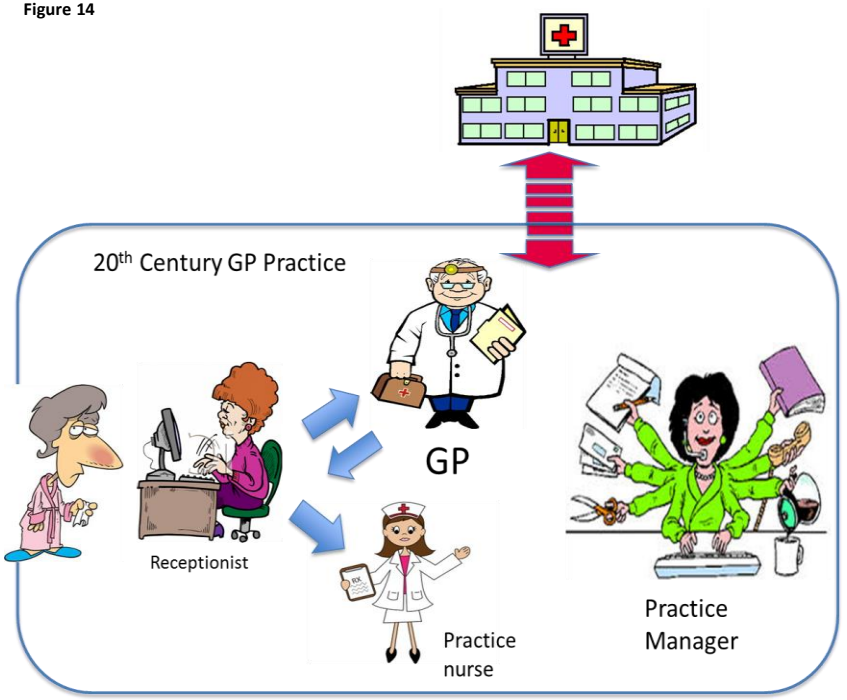
Although increasing GP numbers may help ease the burden on overstretched surgeries, research suggests that the historical model of General Practice, little changed from before the inception of the NHS itself is no-longer fit for the 21st century.

Figure 14 shows a simplified model of a traditional GP practice. In order to access the GP the patient books an appointment either in the surgery or via telephone with the receptionist. Most (if not all) patients see the GP first, who may decide to pass care on to a practice nurse, if the practice has one within the surgery. This may necessitate booking further appointments via the receptionist. There is a back office administrative function run by the practice manager who is responsible for multiple administrative tasks from opening and directing post, chasing test results or out patient appointments from hospital or community health providers, organising call-recall systems to invite patients with long term conditions to attend surgery for clinical interventions, managing practice income and accounts, often through multiple payment mechanisms with different commissioners, keeping practice HR policies up to date and line managing other administrative tasks. The traditional surgery has generally consisted of small teams and the model is replicated many times within a given locality.

The model is no-longer fit for purpose in the 21st century against a backdrop of rising patient demand, an ageing population, advances in treatment and patients living with multiple long term conditions.. Key problems identified in *Making Time in General Practice*[1] (a published report based in a comprehensive national survey of issues faced by GPs and their surgeries' workforce) and by a recent report by *The Kings Fund*[2] and in the ACP needs assessment include:

- A lack of triage. Patients are allocated time with the GP in the order that they present to the receptionist, and clinical need of the patient is not generally taken into account in prioritising appointments as the receptionist lacks the clinical skills to triage effectively.
- Patients generally all see the GP first who then makes onward referral to either the practice nurse or other hospital specialist. This is not efficient if the GP is not the most appropriate person to deal with the patient's clinical need
- The GP may spend time undertaking tasks that could be completed more efficiently by another professional, for example medication reviews that could be undertaken by a pharmacist, seeing patients with low level acute illnesses that could be dealt with by a prescribing nurse; triaging post that could be done by a highly skilled physician's assistant, or dealing with patients with an underlying need that is not clinical for example housing or debt issues, bereavement or loneliness.
- Appointment times are generally ten minutes meaning only one issue can be dealt with in each appointment. This may not meet the needs of today's patients who are living with multiple long-term conditions
- The relatively small size of the surgery team makes its level of resilience low, and risks service disruption due to absence. It also reduces opportunities for peer support and learning between clinicians, sharing best clinical practice, and risks care being reactive rather than proactive.

Figure 14



- Practice nursing support is generally low and not undertaken at scale. Nurses in different practices may have different skill sets leading to a non-uniform offer to patients between different practices.
- Administration tasks such as call-recall systems, HR or clinical governance policies or contracting that could be done more efficiently at scale are duplicated multiple times across different surgeries. This is inefficient and expensive.
- Patients are referred on to other services for clinical procedures that could be provided in Primary Care if there was greater capacity. Examples include common diagnostic tests, MSK services and long term conditions management e.g. COPD, diabetes management, IAPT and health improvement services.
- The interface between the surgery and hospital is often poor. GPs and Practice managers complain about discharge summaries being incomplete or late, and patients being sent back to surgery when out-patient appointment services have failed.

[1] Primary Care Foundation and NHS Alliance, Making Time in General Practice, October 2015.
[2] Understanding Pressures in General Practice. Kings Fund, 2015

5. Enhancing the capacity and capability of Primary Care (2/X)

Large numbers of GP Appointments are Potentially Avoidable

Making Time in General Practice conducted research in 50 GP surgeries covering 5,000 consultations and concluded that overall, 27% of GP appointments were judged by respondents to have been potentially avoidable, with changes to the system around them. The results of the research are shown in figure X. The most common potentially avoidable consultations were amendable to action by the practice, often with the support of the CCG. The biggest categories were:

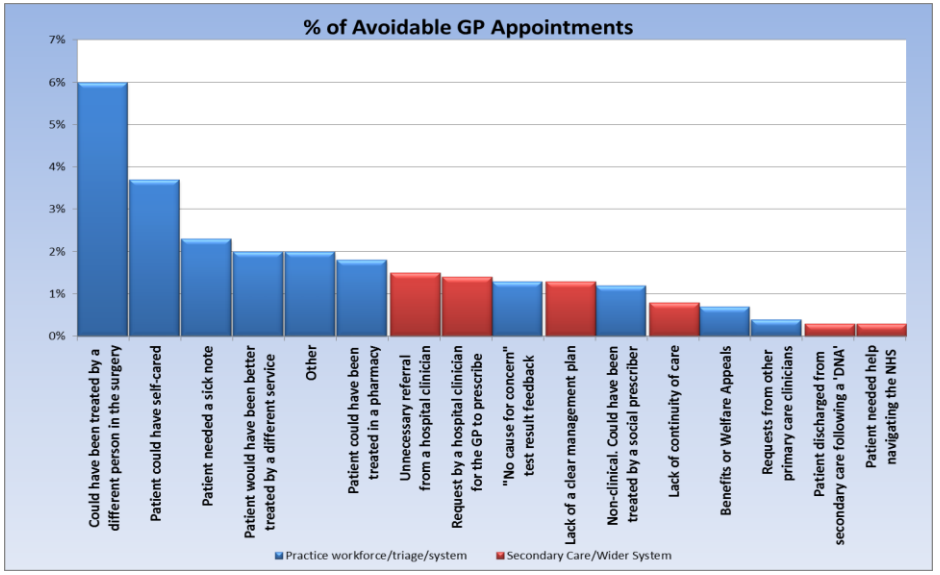
- Where the patient would have been better served by being directed to someone else in the wider primary care team, either within the practice, in the pharmacy or a so-called 'wellbeing worker' (e.g. care navigator, peer coach, health trainer or befriender). Together, these three, which could be improved by more effective triage or signposting system, together with a more diverse practice workforce and integrated support services, accounted for 16% of GP appointments.

- An additional 1% of appointments were to inform a patient that their test result was normal and no further action was needed. These could potentially be avoided if an IT solution or other system that allowed patients to access test results was implemented or communicated test results to patients was implemented at practice level.

- Demand created by hospitals accounted for a total of 4.5% of appointments. The largest category, creating 2.5% of appointment, comprised problems with outpatient booking (either a lapse in the outpatient booking process, such as failure to send a follow-up appointment), or a patient failing to attend an appointment, necessitating an entirely new GP referral. The other, creating 2%, was the result of hospital staff instructing the patient to contact the GP for a prescription or other intervention which was part of their hospital care.

- A further 1% of appointments would not have been necessary if continuity of care or a clear management plan had been established. This could be solved by more integrated working between health and care professionals

Figure 15



5. Enhancing the capacity and capability of Primary Care (2/X)

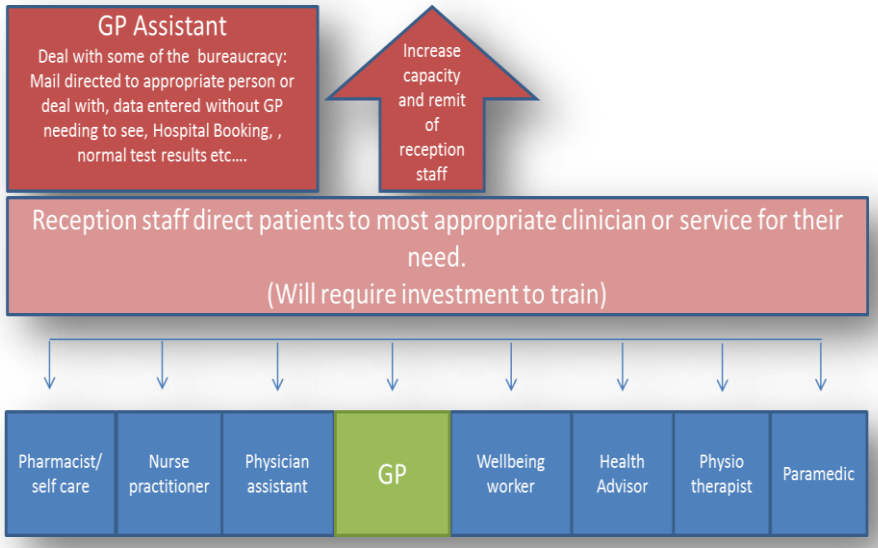
5.4 Increasing the Clinical Skill Mix within GP Surgeries

We calculate that in order to bring FTE GP: patient ratios in line with the England average, we require a further 12.88WTE GPs in Tilbury and Chadwell. 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[2] demonstrates 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. Figure X shows the original workforce model proposed in *Making Time in General Practice*.

We will invest the "£3 per head" Primary Care funding for Thurrock in Tilbury and Chadwell Surgeries as part of our ACP programme in order to deliver a diversified mixed skill clinical workforce, based on the model shown in figure X. This in turn will free up GP time to care for the most complex patients, and release additional clinical appointments for residents, addressing the problems of under-doctoring and inadequate timely access to surgery appointments.

Figure 16



Nurse Practitioner

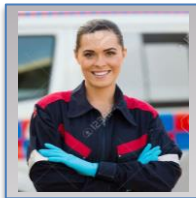
Highly qualified nurse practitioners with the skills and qualifications to prescribe are able to see and treat many patients who in a traditional surgery would require a GP appointment, for example patients with less complex conditions, for example those who need antibiotics for acute infections

Practice Based Pharmacist

With increasing number of patients living with multiple long term conditions, GPs are increasingly required to undertake complex medication reviews. These could be done by a surgery based pharmacist, often in a fraction of the time. One in two patients take their medication incorrectly. The pharmacist can help address this through medication compliance reviews

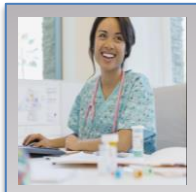
Physiotherapist

One in six GP consultations is for a musculo-skeletal problem. Basing physiotherapists in GP surgeries allows this cohort of patients to be treated directly without the need to necessarily see a GP for onward referral to a hospital or community based physiotherapy service.



Paramedic

Successfully piloted in some areas of the UK, including College Health in Medway, a paramedic can be used to undertake emergency home visits to assess and treat patients, calling upon GP or other clinical support only when necessary. They have also been used in systematic outreach to care homes and have shown to significantly cut avoidable hospital admissions.



Physicians Assistant

A Physician's Assistant (or Associate) is a new clinical role in the NHS. Their role includes the ability to diagnose, interpret data, devise care management plans and prescribe. They work alongside GPs and nurses in the treatment and management of a wide range of patients, come with a generic clinical skill set but can be trained by the surgery to specialise in key areas of need, for example sexual health.

Wellbeing Worker

The ACP Needs Assessment showed low referral of patients with poor lifestyles into health improvement services such as stop smoking, NHS Health Checks or sexual health clinics. These services have traditionally been commissioned and often remotely from GP surgeries. Placing health improvement at the heart of Primary Care will help address this, and make it easier for residents to make positive lifestyle changes

5. Enhancing the capacity and capability of Primary Care (2/X)

By implementing new models of working in Primary Care as set out in Making Time in General Practice and through other research, we calculate that we could release an additional 1495 number of GP appointments per day in Tilbury and Chadwell.

This has the potential to bridge this deficit in current number of appointment offered as shown in the boxes below. Figure 17 shows that with the current ratio of 1 FTE GP to 2,388 patients in Tilbury and Chadwell, the population faces a shortage of 1,485 appointments per week compared to what would be available if we met the ideal ratio of 1 FTE GP to 1300 patients.

Conversely, figure 18 shows the potential impact of implementing a new model of General Practice from modelling undertaken by the Healthcare Public Health Team by implementing a new model of General Practice for Tilbury and Chadwell, designed by the Healthcare Public Health Team based on the principles set out in *Making Time in General Practice*. We calculate that the new model would release 1,495 GP appointments per week (figure 18), closing the deficit shown in figure 17 without the need to recruit the additional 10.71 WTE GPs. Indeed the new model actually performs slightly better in terms of increasing capacity within General Practice compared to recruiting additional GPs to deliver the 1:1300 FTE GP:weighted patient ratio, delivering an additional 10 appointments per week (figure 19)

Figure 17

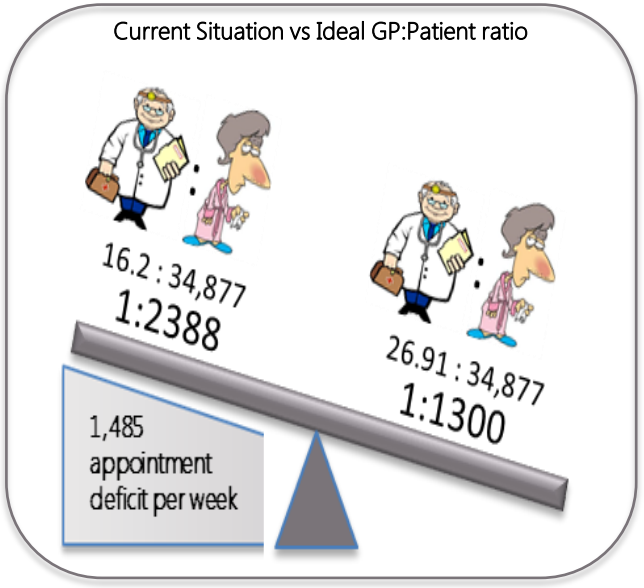


Figure 18

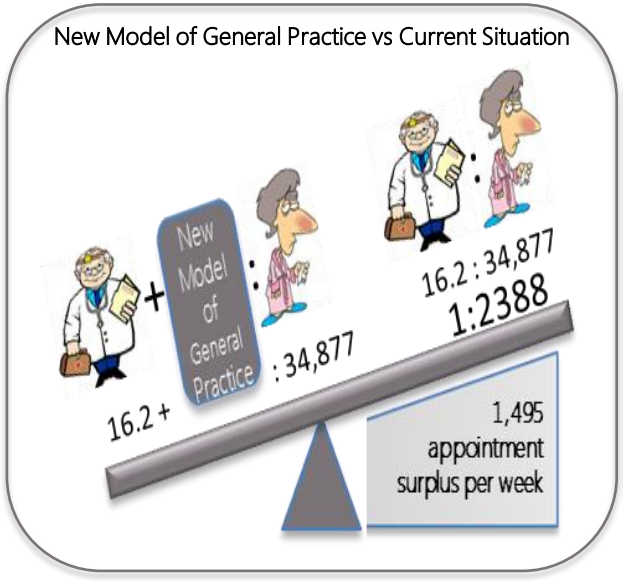
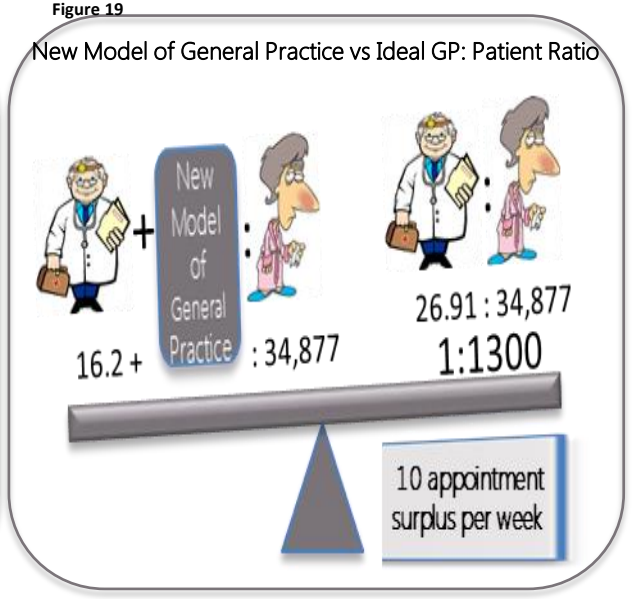


Figure 19



5. Enhancing the capacity and capability of Primary Care (2/X)

5.4 Increasing the skill mix within GP Practices (cont.)

Table 1 shows the costs of implementing the mixed skill work force in GP surgeries in Tilbury and Chadwell, and Box 6 shows the assumptions that underpin the modelling undertaken by Thurrock's Health and Social Care Public Health Team in relation to the number of additional appointments released (shown on the previous page).

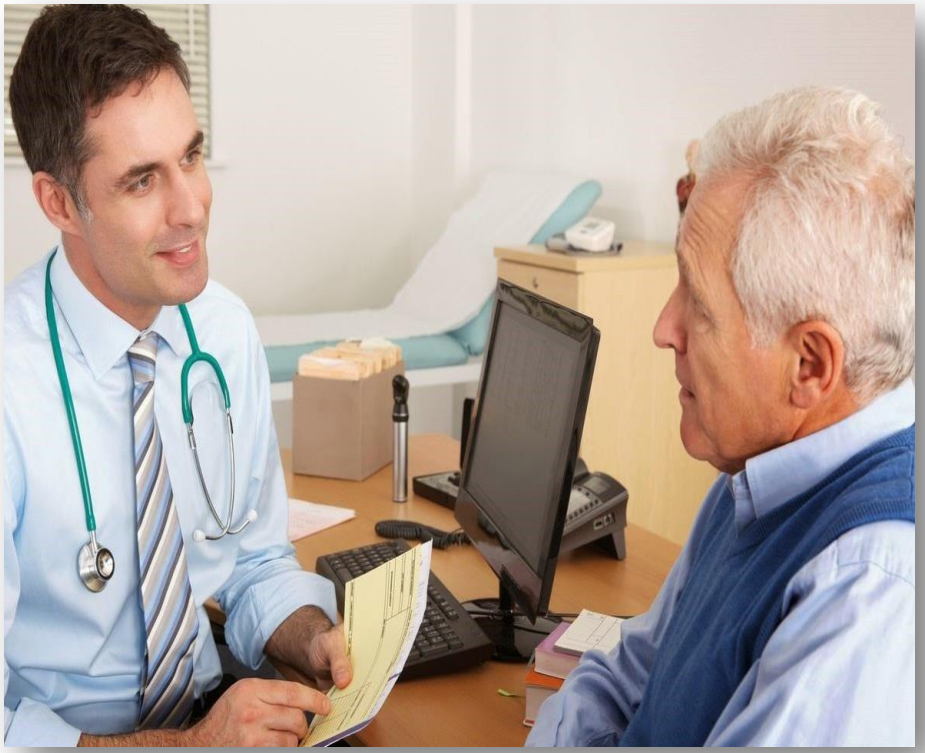
The new model will be funded through investment of Primary Care Transformation Funds that are attached to the Government's General Practice Five Year Forward View Strategy.

Table 1

Staff Group	Current FTE	NEW Model FTE	Aditional FTE required	Salary / AFC Band	Total Estimated Cost
GPs	16.2	16.2	0	N/A	£0
Nurse Practitioner	5.5	5.5	0	AFC 7	£0
Advanced Nurse Practitioner	7.1	8.5	1.4	AFC 8	£82,522
Physio Therapist	0	8	8	AFC 6-7	£337,033
Well-being worker	1	3	2	AFC 4	£53,178
Admin/Receptionists	34.4	34.4	0	AFC 3	£0
Physician Assistant (DPC)	3	4.8	1.8	AFC 6-7	£33,703
GP Assistant (Administrative)	0	3	3	AFC4	£82,103
Practice Based Pharmacist	1	2	1	N/A	£0
Health Advisor and health care assistant (FTE)	3.1	4.1	1	AFC 4	£27,368
Social Prescriber	0.2	2	1.8	£13.74/hr	£61,518
Total	71.5	91.5	20		£620,552

Box 6: Assumptions

1. We do not wish to reduce the number of GPs in the area under any new model. There is a shortage and we should at least maintain current levels.
2. The ideal number of GPs in Tilbury would result in a ration of patients to GP of 13,00:1 and for nurses 2765:1.
3. These results in a shortage that cannot be filled by GPs and nurses either physically or financially
4. The shortfall can be filled by other members of a mixed skill workforce
5. All WTE patient facing staff can spend 410 minutes per day with patients
6. Appointment lengths for GPs, Nurses, Pharmacists, and Nurse Practitioners are on average 10 minutes.
7. Appointment length for a wellbeing worker is on average 30 minutes
8. Appointment length for a physio-therapist is on average 15 minutes
9. A physician assistant can deal with 40 patients per day
10. The ratio of patients to GP assistants should be 5000:1 – this can save each GP 40 minutes per day
11. A receptionist has some kind of interaction with all of the patients dealt with by patient facing staff and each interaction lasts on average 3 minutes. (With on-line booking and touch screen check in this can be reduced).
12. Increase in Social Prescribers is based on the opinion of CVS.
13. Some manual alterations to admin/reception support and GP assistants have been made to reflect expert opinions.
14. Hourly rate of staff are as follows: GP
15. 30% on costs have been included but no employment costs are calculated. e.g. training.



Key Action

We will implement a new mixed skill workforce model within GP surgeries within Tilbury and Chadwell to release an additional 1495 appointments per week to residents, address the current levels of under-doctoring and improve access to clinical care within surgeries for our residents

5. Enhancing the capacity and capability of Primary Care (2/X)

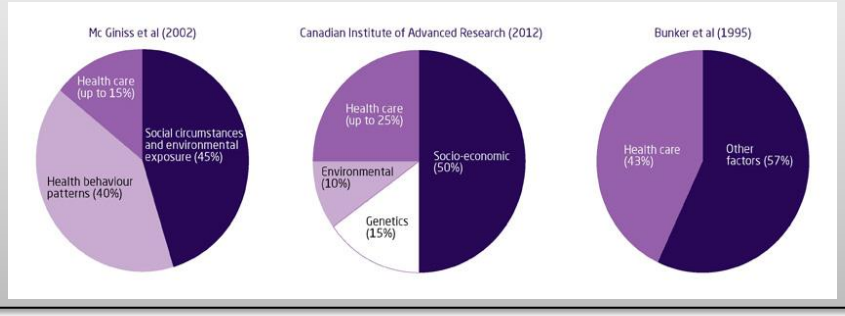
5.5 A Partnership with Patients and Community to address wider determinants of health

Traditional bio-medical models of medicine have placed the clinician in the role of 'expert' and the resident in the role of 'patient', too often being the passive recipient of care following a diagnosis. However a number of international studies suggest that in the most effective health systems world wide, there is are much more equal and partnership based relationship with the care receiver being empowered to both make choices and take responsibility for their own health, wellbeing and care.

Intuitively, this more modern approach feels correct. A strong body of research now exists showing that social and environmental factors; potentially within the control of the individual but largely outside of the scope of traditional clinical practice can have a major impact on health and wellbeing.

A recent systematic review that considered 218 published studies involving almost four million people concluded that loneliness and social isolation was more dangerous to health than obesity, and that those who were socially isolated were at a 50% increased risk of early death compared to those with strong social networks [4]. Professor Michael Marmot's report into Health Inequalities in England showed the significant impact that factors such as education, income, employment and housing can have on health [5], and a number of studies suggest that these 'wider determinants of health' have a greater impact on health and wellbeing than clinical health services. (Box X).

Box 7: Influences on Health



Residents of Tilbury and Chadwell are disproportionally affected by social and environmental factors that impact negatively on health outcomes. Two of the four wards covered by the ACP have a significantly greater proportion of overcrowded households than Thurrock or England (figure 20), and three have a greater proportion of residents with no formal qualifications

Addressing these wider determinants of health in order to break inter-generational embedded health inequalities is key to improving the health and wellbeing of Tilbury residents. However, for too long, statutory services that address wider determinants of health and wellbeing have been delivered in isolation to local health and care services. The ACP will address this by strengthening links between Primary Care and statutory services that address wider determinants of health including our *Brighter Futures* Children and Families Service, Employment, Debt and Housing Advice and seek to co-locate delivery of these services within the ACP, and ultimately within the new Integrated Medical Centre for Tilbury and Chadwell.

Figure 20

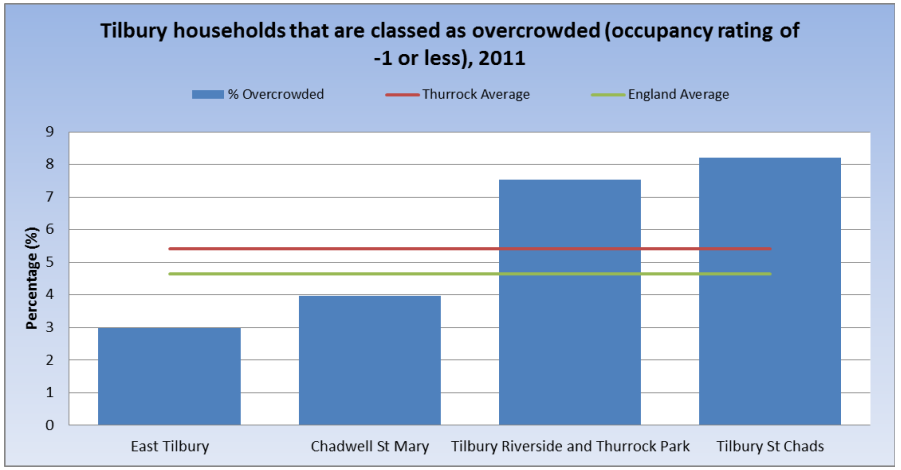
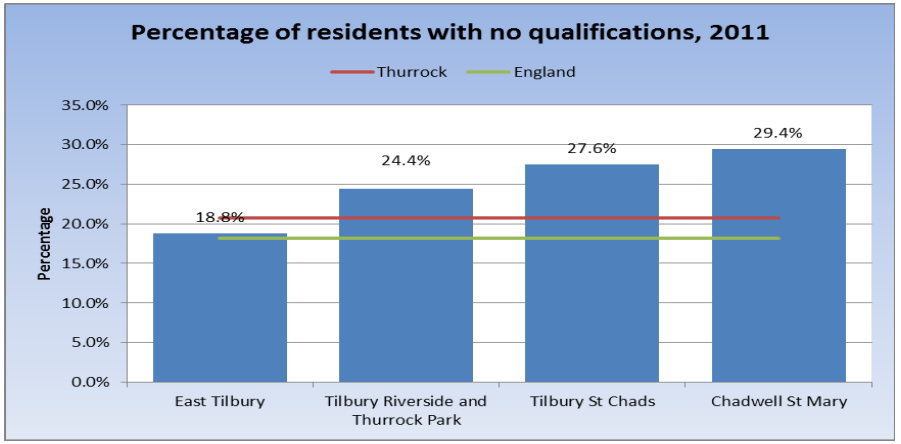


Figure 21



5. Enhancing the capacity and capability of Primary Care (2/X)

5.5 A Partnership with Patients and Community to address wider determinants of health (cont)

Thurrock has a proud tradition and strong story to tell relating to our community and third sector provision with over 500 community and voluntary organisations aligned to an active Council for Voluntary Services (CVS). This estimate includes registered organisations, such as charities, social enterprises and co-operatives, voluntary organisations, community/neighbourhood groups, informal interest groups and faith groups. Our *Stronger Together* and *Living Well in Thurrock Programmes* are recognised models of best practice. In terms of paid staff, based on the average number of FTE paid staff employed by respondents to the State of the Sector survey across Thurrock, it is estimated that the 500 organisations employed 1,315 FTE paid staff in 2014/15. There are also an estimated 7,429 volunteers, representing 4.6% of Thurrock's total population as are our Local Area Coordinators.

A *Community Hub* operates in Tilbury. Priorities for the hub are determined by residents but include:

- Support and advice for residents to self-serve for information, both via face-to-face and web-based support
- Increasing volunteering opportunities
- Hosting groups to encourage cohesion and reduce isolation such as craft groups
- Hosting groups to improve health and wellbeing (e.g. fitness classes)
- Facilitating meeting opportunities for residents with public sector staff (e.g. Local Area Coordinators)
- Community gardens

Community feedback to date has been very positive with residents, ward councillors and professionals providing good comments back to the Stronger Together partnership who oversee the Hubs programme, however historically this provision has been divorced from Primary Care commissioning. Our new ACP will address these issues by placing the individual, community and third sector at the heart of Primary Care.

5.5.1 Social Prescribing

One mechanism to achieve this will be through 'social prescribing' which is currently being piloted in some GP practices in Tilbury, East Tilbury, Aveley and Purfleet.

Individuals sometimes lack the confidence to discuss issues at the root of their anxiety and with GP's time pressure; social prescribing allows an individual time to discuss what matters in their life.

Social prescribing compliments other services; local area coordinators, community solutions, housing or the third sector, by finding out what matters to them rather than what's the matter, social prescribing is able to signpost or refer to the relevant person, without the individual ping-ponging around the system and connecting all agencies together.

There is emerging evidence that social prescribing can lead to a range of positive health and well-being outcomes. Studies have pointed to improvements in areas such as quality of life and emotional wellbeing, mental and general wellbeing, and levels of depression and anxiety. Social prescribing schemes may also lead to a reduction in the use of NHS services. A study of a scheme in Rotherham (a liaison service helping patients access support from more than 20 voluntary and community sector organisations), showed that for more than 8 in 10 patients referred to the scheme who were followed up three to four months later, there were reductions in NHS use in terms of accident and emergency (A&E) attendance, outpatient appointments and inpatient admissions. An evaluation of social prescribing in Shropshire suggested that it reduced GP consultations by 48% and A&E attendances by 33% in the cohort of patients accessing the programme.

The aim of the programme is to empower individuals to improve their own health and wellbeing and social welfare by connecting them to non-clinical and community support programmes to address social and wider determinants of health and wellbeing such as loneliness, debt, housing issues, employment or bereavement. A consultation with a social prescribing programme begins with a detailed discussion between the Social Prescriber and the resident which starts with the question "what does a good life mean to you?" The social prescriber and resident then formulate a joint action plan to achieve goals based on this answer.

5. Enhancing the capacity and capability of Primary Care (2/X)

5.5.1 Social Prescribing (cont).

The Social Prescribing programme will:

- build self-resilience amongst adult patients assisting them to better manage their holistic wellbeing
- reduce demand on primary care services, particularly from patients that could be better supported by other local services
- empower GPs and other clinical staff with a practical mechanism to assist patients who access their surgery with non-clinical issues. (National research suggests that patients with issues that have an underlying problem that is non-clinical can account for up to 20% of all GP appointments).

We will roll out social prescribing at scale across the ACP locality in order to link community sector capacity with GP surgeries and empower patients to address social causes of ill-health. In our new model of care, patients will be able to access a social prescriber either directly through the triage system at the 'front door' of their surgery or following a referral from a member of their surgery's clinical team.

The full Social Prescribing Business case can be accessed here:

5.5.2 Empowering Patients : Patient Participation Groups

From April 2016 it has been a contractual requirement for all GP practices in England to form a Patient Participation Group (PPG) during the year and make reasonable efforts to it to be representative of the practice population. PPGs can play a key role in assisting GP practices to improve patient care including

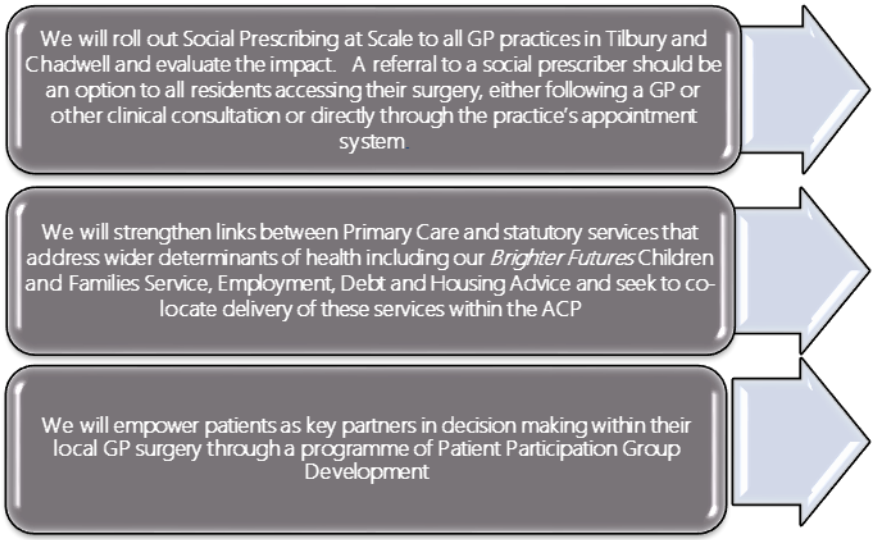
- Advising the practice on the patient perspective
- Providing a mechanism for patients to make positive suggestions about the practice and how it can improve
- Encouraging and organising health promotion activities within the practice and amongst the wider population it serves
- Communicating with the wider patient body
- Running volunteer services and support groups to support patients and the services of the practice
- Influencing the work of the practice or the wider NHS to improve commissioning
- Fundraising to improve services provided by the practice

We will deliver a new programme Patient Participation at GP practice level. Healthwatch will help support practices to set up a PPG where one currently doesn't exist, including engaging and recruiting patients, and will deliver a training programme including a free resource pack to those PPGs that are already operating. The training programme will increase the understanding and confidence of PPG members on issues such as PPG roles and responsibilities. Members of the Thurrock Public Health Team will support the delivery of the training programme by providing GP Practice population specific profiles that identify the main health needs of the practice population. The accompanying resource pack has been developed by Thurrock Healthwatch based on a model of best practice from the National Patients' Association

5.5.3 Measuring Success: GP Patient Satisfaction Survey

The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The survey is sent out to over a million people randomly selected across the UK within two waves and the results show how people feel about their GP practice and help's GP surgeries understand where they can improve. It includes topics such as making appointments; waiting times; perception of care; opening hours and out-of –hours services.

Response rate to the survey has historically been low for Tilbury and Chadwell (average of 31% of surveys returned). We increase the survey sample size for Tilbury and Chadwell and work with PPGs and patients to increase response rate as a further mechanism to evaluate patient satisfaction with our new model of Primary Care. The full business case for this programme can be accessed here.



5. Enhancing the capacity and capability of Primary Care (2/X)

5.6 Embedding Healthy Lifestyle Services within Primary Care and the wider Health and Care System

The Tilbury and Chadwell ACO Needs Assessment identified that residents in Tilbury and Chadwell are more likely than those in Thurrock and England to engage in health damaging behaviour such as poor diet, low levels of physical activity, smoking and being overweight. This increases the risk in the overall population of serious health events including cardio vascular disease and cancer and increases the overall level of morbidity within the population. Healthy lifestyle services are commissioned by Public Health and in 2016/17 were provided by North East London Foundation Trust (NELFT), who also sub-contracted some delivery of services, e.g. smoking cessation support directly to some GP surgeries and pharmacies.

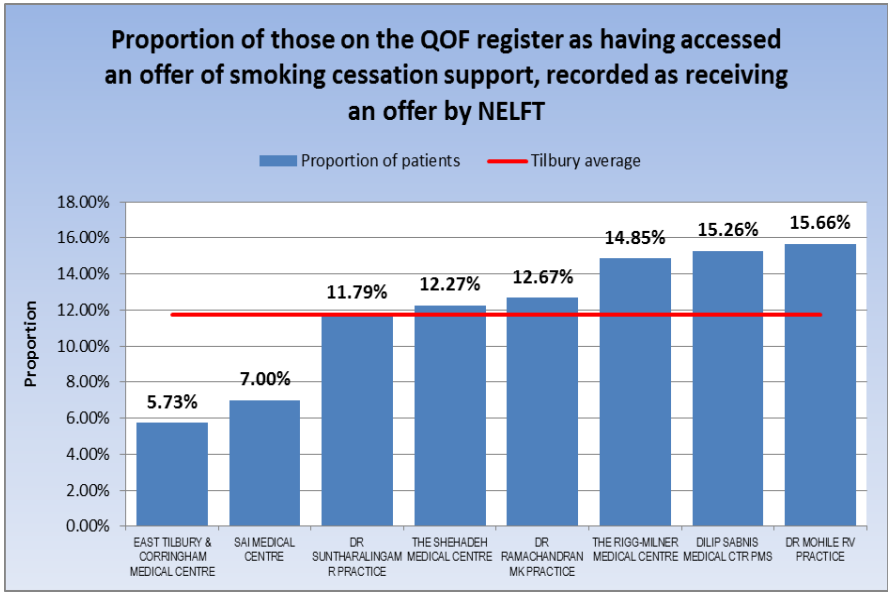
Ensuring these services are as accessible as possible to Tilbury and Chadwell residents who wish to make improvements in their lifestyle is key in terms of improving the overall health of the population and the needs assessment identified that there is still much opportunity for improvement. For example, the Quality Outcomes Framework (QOF) records the number of patients aged 15 or over who are current smokers and have a record of an offer of support and treatment within the preceding 24 months (QOF indicator SMK004). In 2015/16, this totalled 5,677 for all Tilbury and Chadwell practices. Data from the NELFT provided Healthy Lifestyle service found there to be 333 patients accessing smoking cessation support in 2015/16 – doubling this number to provide an estimate of those accessing support in the preceding 24 month period would still only give 666 patients – accounting for just 11.7% of the number on the QOF register. This variation by practice can be seen in Figure 22. East Tilbury Health Centre has the lowest proportion of their QOF patients receiving smoking cessation support by NELFT (5.73%) and Dr Mohile the highest (15.66%) – see figure below.

The finding that only 11.7% of those on the QOF register recorded as having an offer of support or treatment appeared to be supported by NELFT suggests there is variation in the support offered to patients, as quantifying this means that as many as 5,011 smokers may qualify for this support but be receiving something different.

In 2017/18, a new provider of Healthy Lifestyle Services was commissioned but failed to deliver satisfactory performance, and the Public Health Team is in the process of terminating the contract and bringing the service back "in house" as a holding measure whilst future options are explored. This providers an opportunity to reconfigure the service to better embed it within GP surgeries, pharmacies and the wider health and care system including hospitals.

We propose to locate healthy lifestyle "wellbeing workers" from the current provider directly within the enhanced Primary Care Team as a further resource for practices to use to work with patients who wish to make lifestyle improvements such as a stop smoking quit attempt.

Figure 22



We will also explore more effective ways of directly contracting with surgeries who with to offer healthy lifestyle services as providers including creating one contract with each surgery that covers all lifestyle programmes, with payments made on agreed population outcomes, reducing the administrative burden on surgeries. We will use the new MedeAnalytics system (see page ***) to help surgeries better identify and target patients with poor lifestyles, and provide direct marketing to them with regard to available support to help them make changes.

We will work with Basildon Hospital to embed healthy lifestyle programmes into clinical care pathways, targeting support to patients with early onset diseases causes by poor lifestyles, for example COPD and cardio-vascular disease.

Key Actions

- We embed Healthy Lifestyle Services directly within GP surgeries by locating "Wellbeing Workers" within the Enhanced Primary Care Team.
- We will consult with surgeries who want to contract with Public Health to provider Healthy Lifestyle Services about implementing a administration light single contract for all services
- We will work with Basildon Hospital to embed healthy lifestyle programmes into clinical care pathways, targeting support to patients with early onset disease caused by poor lifestyles.

5. Enhancing the capacity and capability of Primary Care (2/X)

5.7 Effective Front Door Triage

The mixed skill practice workforce model described previously requires effective 'front door' triage in order for it to work most effectively; The new model network model surgeries require an efficient system to direct the patient accessing a surgery to the most appropriate person or service within the ACP. The exact design of the triage system is a matter for the surgeries themselves, but one potential model may include a shared appointment booking system within the ACP/Surgery Management Hub.

Models that have worked well in other pilots throughout the country include:

5.7.1 Telephone Triage and Consultation by a GP

Use of the telephone for consultations is growing rapidly in general practice. Some practices have been offering this kind of consultation for ten years or more, but interest has grown significantly since about 2012. From a starting point of treating phone contacts as brief triage encounters, practices are increasingly recognising the feasibility and value of fully addressing the patient's need in a single phone contact where appropriate

This model works on the basis that the most experienced clinician in the workforce is best able to make the clinical judgement necessary to triage effectively, and that 60-70% of consultations can be handled entirely on the phone in an average to 4-6 minutes.

Where face-to-face consultation is required, a GP is usefully able to determine this within the first two minutes of the telephone call.

Where piloted, this approach has been shown to improve access, especially for carers and people in full time work, and reduces DNAs by up to 80%.

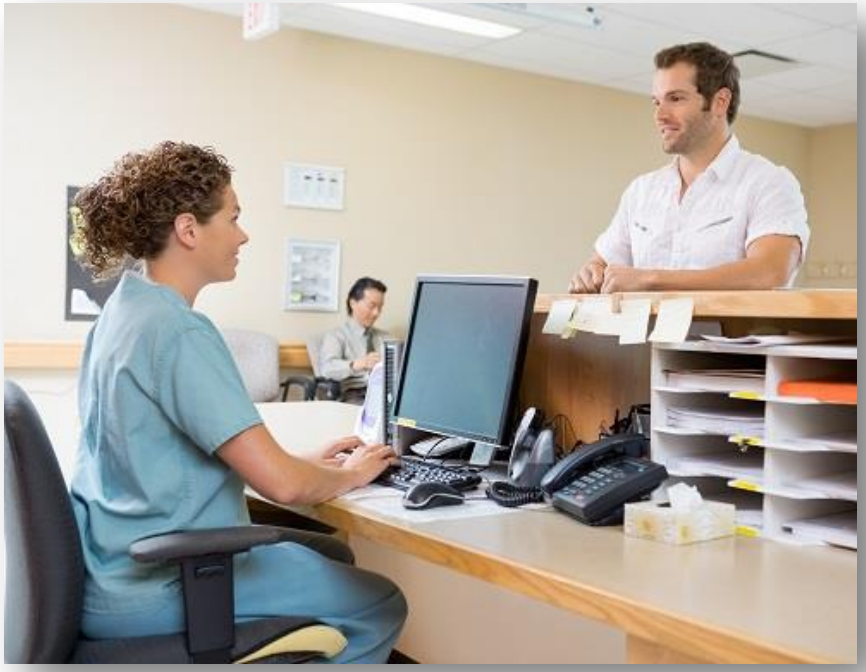
Implementation of the programme works best when actual demand is measured across the time of day and day of week and the supply of appointments is adjusted accordingly (for example increasing the supply of appointments on a Monday morning).

5.7.2 Highly trained reception staff

Training reception staff to connect the patient with the most appropriate service rather than simply book everyone in to see the GP first has been shown to be effective in pilots across the country.

Receptionists are trained to ascertain the patient's needs including "red flags" for medical emergencies. Directories of all available services (including services outside of the practice) are developed and the receptionist has access to these in order to aid decision making.

Receptionists are also encouraged to ask lots of questions, and trained in asking the patient about his/her needs.



One of the key barriers to implementation may be patient expectation and the acceptability of the approach to patients. This can be overcome through a systematic communications programme with patients that stresses the benefits to both them in terms of being directed to the person most appropriate to meet their needs, and also to the GP, in allowing them to focus on issues that only they can deal with. Use of the Patient Participation Group and patient news letters have been shown to assist implementation.

When trialled in West Wakefield, 960 GP hours were saved across six surgeries caring for 64,000 patients, in the first 10 months of the new triage system.

Highly trained triage reception staff have been shown to reduce GP appointments at over 1000 per annum for a 10,000 list size practice.

Other benefits have included faster access to the correct service for patients and increased staff satisfaction; receptionists feel that they're doing a better job for patients and making a larger contribution to their surgery.

5. Enhancing the capacity and capability of Primary Care (2/X)

5.7 Effective Front Door Triage (cont.)

5.7.3 E-Consultations (WebGP)

WebGP is an e-consultation system that integrates within the surgery's website. When a patient clicks on the WebGP icon they have a number of options including:

- Finding out more about their symptoms, a particular condition and treatment including access to written and video self help content
- Sign posting from the symptom checker to other more appropriate services including pharmacy and self care
- Requesting a repeat prescription
- Requesting a call back from a nurse
- Completing an "e-consult" form where they can fill out details of their symptoms on-line and have them reviewed by a clinician in the surgery who can then issue a prescription remotely, undertake a telephone consultation or call the patient in for a face-to-face consultation.

The main benefits of the system to patients are that they can gain reassurance about their symptoms/condition without having to make a GP appointment, or can take time to describe their symptoms accurately in writing, rather than have to do this face to face in a short GP consultation.

Where implemented, evaluation of the system demonstrates the following impacts:

- 91% of patients are 'extremely satisfied'.

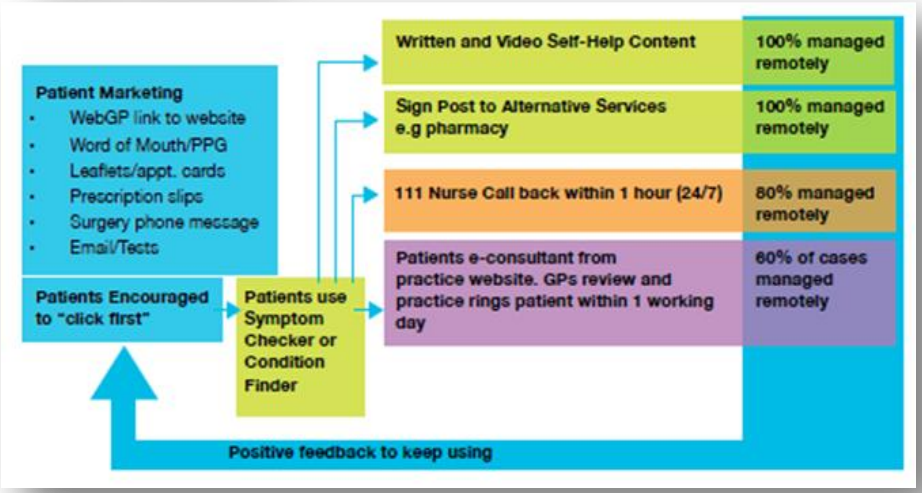
- 90% of users don't contact the practice:
    - 60% use the 'symptom checker' / self help alone
    - 20% visit the pharmacy
    - 10% request a 111 nurse call back

- 10% of users have an 'online consultation' of whom:
    - 40% are dealt with by a GP remotely, in an average of 2.9 minutes
    - 20% receive a telephone consultation by a GP
    - 40% have a face to face appointment with a member of the surgery's clinical team

Evaluation has also suggested that the e-consultation is particularly welcomed by patients who may feel uncomfortable talking about certain conditions and is most widely used by those suffering from depression or other mental ill-health. There is also some evidence that it may reduce A&E attendances.

We have obtained funding to make WebGP available free of charge to all surgeries within the ACP. We will work with surgery staff through the Tilbury and Chadwell GP practice network to reach agreement on the best model of front door triage for the network and look to base this within the Surgery Management Hub.

Web GP Patient Flows



A full copy of the E-Consult business case can be accessed here:

Key Actions

We will work the GP surgeries to develop and implement a shared front door triage system for the Tilbury and Chadwell ACP surgery network.to capitalise on the mixed skill workforce model in Primary Care

We will support surgeries to implement WebGP

5. Enhancing the capacity and capability of Primary Care (2/X)

5.8 Building Surgery Resilience

The 20th Century GP practice lacks resilience because of its small size and low numbers of staff. GPs are often working in isolation and large numbers of different types of practice administration falls to one person. Recent history in Tilbury has demonstrated the issues caused for population health when small practices fail. Delivering Primary Care working 'at scale' was identified as a key priority in the GP Five Year Forward View. Networks of GP practices can bring the following benefits to both practices' workforce and ultimately to patients:

Resilience:

- Pooling of staff including nurses, reception staff, clerical staff and sessional GPs increases an individual practice's resilience to staff leave and also allows more comprehensive services to be offered to patients
- Overflow support is available at the busiest times including phone consultations and home visiting

Economies of Scale:

- Purchasing of indemnity, supplies and utilities becomes cheaper allowing more investment in frontline services
- Key back office functions can be shared or done once for all surgeries in the network including policies and procedures, procurement, managing correspondence and ICT support
- Specialist functions that benefit all surgeries can be developed including HR, Finance, Clinical Governance and Business Intelligence.

Systems Partnerships

- Planning of workforce; infrastructure development; service reconfiguration; and public health can be done once at scale
- Provision and integration of a wide range of additional services including community pharmacy, optometry, social care, housing, welfare and the third sector can be integrated into the network

Increased Skill Mix

- A wide range of complementary clinical front line roles can be incorporated into the practice network's workforce including pharmacists, specialist nurses, physiotherapists, mental health therapists and paramedics.
- Similarly wellbeing worker roles can be incorporated including social workers, care navigators, health trainers and coaches and welfare advisors

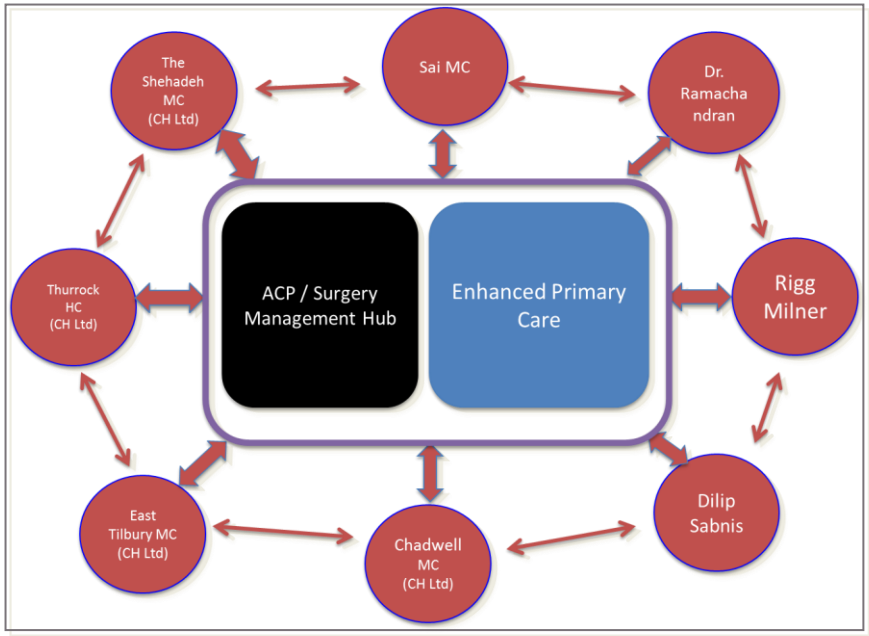
Innovation and Improvement

- Evidence scoping such as population health analytics and evidence based literature reviews can be undertaken at skill to ensure that the workforce is kept up to date with continuous professional development, and that the network is responding to the needs of the population it serves
- Analytics such as priority setting, benchmarking of performance and real time measurement can be incorporated into the work of the network

Staff Development

- A wider network of primary care workforce provides much greater opportunities for shared learning, CPD and career development including mentoring.

Figure 23



The ACP will implement a network model of surgeries in Tilbury and Chadwell to realise the benefits described in the first column (figure 23) Whilst the final form of the network is yet to be agreed by the surgeries involved, good progress has been made to date with all GP practices signing an Memorandum of Understanding setting out how they will collaborate together. Ultimately this paves the way for the model shown in figure A where administrative functions including appointments booking, call-recall of patients and all GP practice administration could be undertaken by a shared Surgery Management Hub, and the wider clinical and non-clinical patient facing staff could we shared in an 'Enhanced Primary Care Function'.

Key Action

We will implement a new network based model of Primary Care in Tilbury and Chadwell in order to build resilience amongst current surgeries and realise the benefits to both the workforce and residents of delivering Primary Care 'at scale'.

5. Enhancing the capacity and capability of Primary Care (2/X)

5.9 Reducing the Administrative Burden on Clinicians

Making Time in General Practice concluded that administration and bureaucracy were major burdens on surgeries. The chief sources of bureaucracy in general practice were:

- Getting paid
- Processing information from hospitals and other providers
- Keeping up to date with changes
- Reporting other information

Getting Paid

This was by far the biggest administrative burden facing general practice, with 45% of surgeries surveyed highlighting it as an issue. Practice income is now derived from a complex and diverse list of sources including the weighted capitation of the practice list size, performance on the Quality and Outcomes Framework and income from a wide range of individual contracts including AQPs (Any Qualified Provider) with Clinical Commissioning Groups for services such as phlebotomy, Directly Enhanced Services with the DH, and Public Health contracts both with Public Health England for screening and immunisation and with local authorities for lifestyle services such as stop smoking and NHS Health Checks.

Processing information from hospitals and other providers

This was rated as the next biggest administrative burden, almost en par with 'getting paid'. Surgeries report that processing discharge letters, chasing test results and coordinating outpatient or elective hospital appointments has increased substantially in recent years in line with an ageing population . The interface between hospital and surgery was reported as often inadequate both in terms of the administration processes (for example discharge letters were often late, or posted and emailed requiring the surgery the cross reference), and in terms of clinical content; GPs complained that hospital Consultants were too remote or that the content of discharge summaries detailed what had happened to a patient in hospital but failed to provide information on what clinical care needed to be on-going after discharge. Many surgeries also complained of having to deal with patients requiring re-referral to hospital outpatient clinics because appointments had been arranged at very short notice and/or times that they could not attend.

Keeping up to date with changes

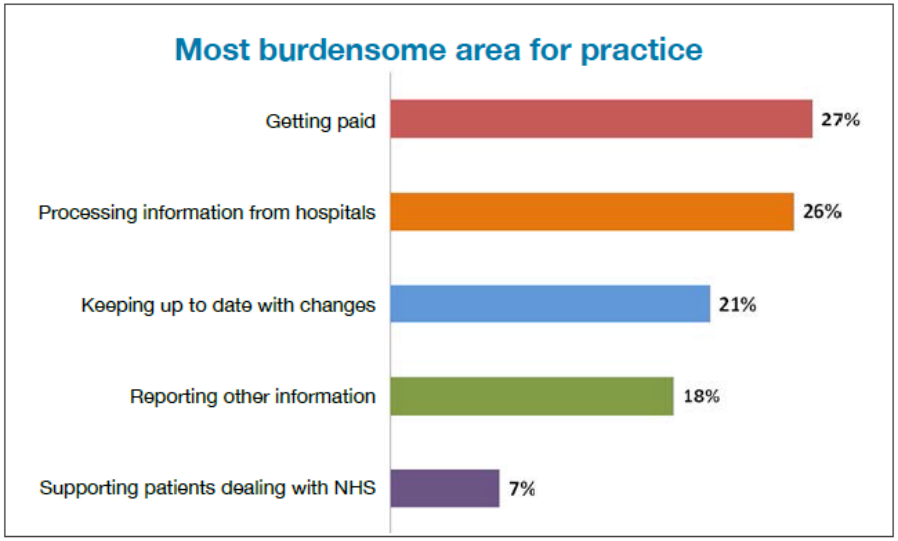
Keeping up to date with incoming information from commissioners and other bodies, particularly at a national level, was also a significant area of burden for practices. Managers reported that this was particularly problematic when later trying to retrieve information sent by email, letter or bulletin.

Reporting other information

The fourth most burdensome issue was reporting for contract monitoring or regulation. Here, surgeries cited frustration caused by multiple requests for similar information, sometimes from different teams in the same organisation (particularly NHS England), often at very short notice (eg 24 or 48 hours), and often formulated in ways which differed from how the information was stored. NHS England and CQC were described as frequently asking for information about the same aspect of the practice, but in different ways, at different times, and in a series of requests rather than a single one.

Supporting patients dealing with the NHS

Finally, supporting patients to navigate the health and care system was also cited by 7% of surgeries surveyed an area where practice workload is increasing.



Source: Making Time in General Practice[2]

At Scale Administration

Creating a centralised 'back office' Surgery Administration and Management Hub as discussed on page X will go some way to relieving the current bureaucratic burden being experienced by our surgeries by allowing administrative tasks to be done once and at scale for all surgeries within the Tilbury and Chadwell network. We will also explore with surgeries, how to better use information technology to streamline contract reporting and payment mechanisms for local contracts, for example by implementing systems to directly extract performance data from SystmOne.

The GP Assistant

Much of the administration that in the 20th Century GP Practice model has been the responsibility of the GP, can be dealt with by GP Assistants. These are new highly trained administrators who are skilled in reading, coding and actioning incoming clinical correspondence according to a standard protocol, for example following up late test results or discharge summaries from a hospital Their aim is to triage administration such that only that which is critical is dealt with by the GP. Where piloted, the following impacts have been observed:

- GPs typically save 30-60 minutes per day (e.g. mean of 45min in Brighton)
- With training and a standard protocol, safety is very good (e.g. zero adverse events in 15,000 letters, Brighton)
- Coding improves.
- Staff satisfaction improves: enhanced role and greater contribution to the practice.

We will provide funding to the Tilbury and Chadwell Surgery Network to pilot new GP Assistant roles in order to reduce the administrative burden on front line clinical staff, releasing them to deliver more patient care.

5. Enhancing the capacity and capability of Primary Care (2/X)

5.9 Reducing the Administrative Burden on Clinicians

Improving communication between surgeries and hospital

One of the strongest themes to come out of the national research in *Making Time in General Practice* is the unnecessary extra workload created by the lack of clear systems and processes for practices and their local hospitals to communicate with each other and their shared patients. We will work with the BTUH/Southend/Mid Essex tri-hospital network and our local surgery network to address this through developing consistent guidelines creating opportunities for clinicians to cut through all the unnecessary rules that get in the way of rapid and effective treatment of patients and lead to so many repeat consultations to chase up basic administrative tasks.

Specifically we will seek to implement:

- The ability for patients who don't attend a hospital appointment to rebook within two weeks without having to return to the GP
- A system for GPs to discuss a case with a hospital specialist and for hospital clinicians to speak to GPs within hours rather than days
- A standardised discharge letter with agreed clinical information structured and presented in a consistent way, electronically transferred to the patient's surgery within 24 hours of discharge
- Informal education networks that allow GPs to build better relationships with Hospital Clinicians and promote informal communication.

Case Study: Improving Discharge Summaries

Brighton and Hove CCG and Brighton and Sussex University Hospitals have developed a process to improve the transfer documentation sent by hospital to GPs. An important element of this is a specially designed form, which is based on published standards for handover documentation.

The form, designed to be completed by junior doctors as part of discharge processes, includes a text box entitled "clinical narrative" which asks the discharging clinician to tell the story of the admission, encouraging them to do so in a way that might be easily understood. Patients themselves receive a printed copy at discharge, aiming to reinforce the importance of making the narrative readable. The documentation also includes the list of medications on which a patient has been discharged as well as specific boxes to document any medications that have been discontinued and any changes made to dosages, flagging up those factors most important for a GP to have quick sight of.

The overall appearance and design of this summary is based on graphic design principles to enhance the impact of key messages on the clinicians completing and reviewing it. Attention was given to the coding so that as much as possible can be auto completed.

The introduction of this new form was accompanied by training for the junior doctors who would be using it, and this was backed up by a period of audit, where summaries were reviewed by consultants for quality prior to being sent, The form is emailed at the point of discharge, so is received in a timely fashion by the GP practice, delivering seamless transfer of care. This form has led to much improved transfer communication between hospital and surgeries.

Key Actions

- We will work with the Tilbury and Chadwell surgery network to create a shared administration 'hub' to undertake administration once at scale
- We will pilot GP Assistants in Tilbury and Chadwell to reduce the administrative burden on front line clinical staff, releasing them to deliver more patient care.
- We will implement the ability for patients to re-book outpatient appointments without the need to return to their surgery.
- We will agree standardised discharge information protocols from hospital to surgery
- We will improve communication between primary and secondary care clinicians through formal and informal networks.

5. Enhancing the capacity and capability of Primary Care (2/X)

5.10 Developing the role of Community Pharmacy

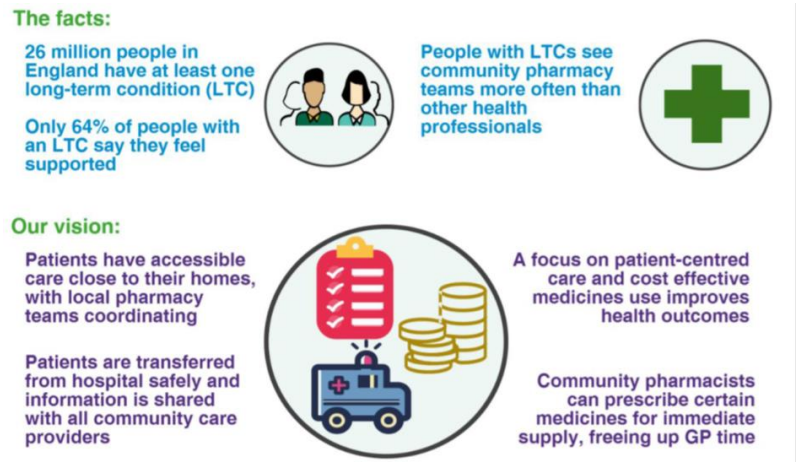
Community Pharmacy Forward View: A vision for future pharmacy care

Community pharmacies are the nation's most accessible healthcare providers: around 90% of the population live within 20 minutes walking distance of a pharmacy, and pharmacy services are available without an appointment. With even greater access in the most deprived areas, the community pharmacy network bucks the inverse care law, and is an invaluable resource in the fight against widening health inequalities. The diversity of the mixed market offers people choice in when, where and how they access primary healthcare services and this helps to promote and maintain quality. Community pharmacy teams have contact with large numbers of people, including those who may not regularly use other health services, and the ability to convey health messages, support self-care and provide advice opportunistically to 1.6 million people every day.

*The Community Pharmacy Forward View was published by PSNC and Pharmacy Voice, with the support of the Royal Pharmaceutical Society's English Pharmacy Board (2016).

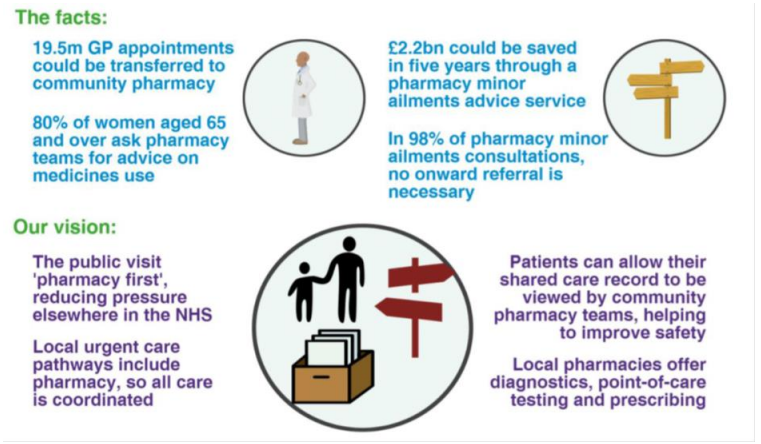
Community pharmacy has developed its Forward View setting out how it can develop, and it is looking to collaborate with all health and social care commissioners to develop services in three core areas:

1.Supporting people to manage their long-term conditions:



2. Offering a first port of call for healthcare advice and treatment

3. Becoming neighbourhood health and wellbeing hubs:



Key Actions

We will work with community pharmacy colleagues to help them realise the opportunities in the Community Pharmacy Froward View in Thurrock

We will improve communication between community pharmacy and wider health and social care organisations in order to optimise the health of the population

5. Enhancing the capacity and capability of Primary Care (X/X)

5.10 Developing the role of Community Pharmacy (cont.)

Community Pharmacy Forward View: A vision for future pharmacy care

Objectives with the Community Pharmacy Forward View are to:

- Demonstrate understanding of the aspirations of Government, the public and patients for health and healthcare in England, and set out a clear, shared vision for how community pharmacy can help deliver them
- Demonstrate the commitment to working as an integrated part of the NHS and wider public health system, and to help deliver improvements in quality, efficiency and outcomes
- Develop and share credible and constructive ideas for the medium to long term that will enable these improvements to be achieved while maintaining a thriving community pharmacy network that continues to generate wider economic and social value
- Show commitment to working together with Government and with other partners to develop and implement tangible plans for turning these ideas into reality, and seek a similar commitment in return constructively, as part of this partnership, to achieve the desired future

What will this look and feel like for people using community pharmacies in future?

- Whenever someone visits a community pharmacy for help with a minor injury or ailment, an urgent problem with their medicines or a query about an immediate health concern, they will be dealt with quickly by courteous and knowledgeable staff, will be listened to carefully, and will receive a personalised response.
- All community pharmacies will feel like professional healthcare environments. When people seek self-care advice, information or treatment from a community pharmacist or member of their team they are able to discuss this in an appropriate, private setting.
- People will be able to access 'pharmacy first' services via a variety of routes, including online as well as face-to-face.
- People can give community pharmacists and pharmacy technicians permission to both review and add information to their personal health record, so that advice and treatment they receive for urgent care takes into account their general health, any underlying conditions and medicines use.
- Community pharmacists and their teams will help people spot and address any patterns in when and how they access urgent care – for example, the recurrence of a minor condition which might need further investigation or regularly running out of medicines which might need to be managed differently.
- If someone visits a community pharmacy following referral from another service provider (e.g. NHS 111, their GP or A&E) the pharmacy will be expecting them when they arrive, and will have relevant information about why they are attending.
- After any self care consultation with a community pharmacist, people will understand the advice they have been given and how to use any products they have been supplied, feel confident on how to manage their condition and well informed on when and how to seek further help if necessary.
- When people do need to see another healthcare professional or service after speaking to a community pharmacist, because their condition is more serious or less clear-cut than they
- thought, organising this from the pharmacy will be quick and straightforward. Community pharmacists and their teams will be able to refer and book people directly into other services, fast-tracking them if they believe this is necessary.

Embracing change and addressing primary care workforce issues

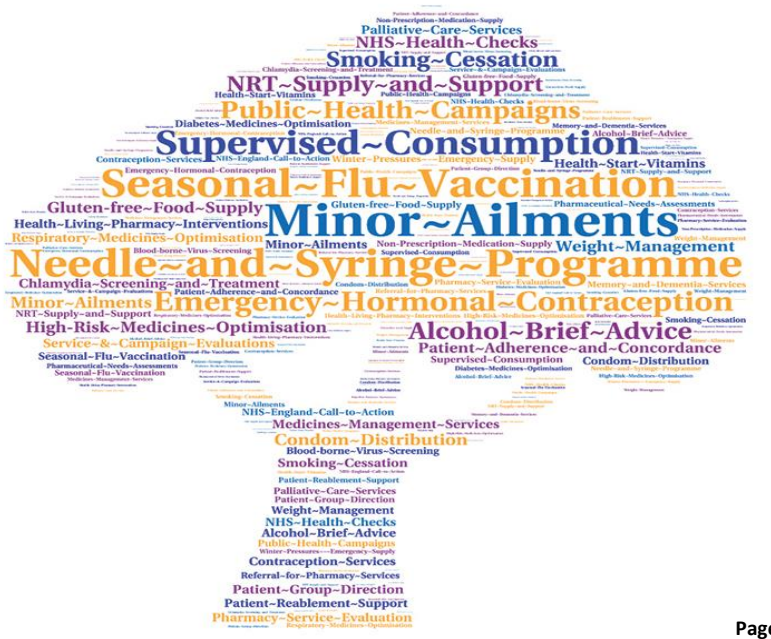
- As the NHS and society as a whole change over time, new approaches to delivering primary healthcare and supplying medicines will undoubtedly evolve. Right now, the community pharmacy network provides the vehicle that can deliver much of what the health system needs, in particular to address the workforce and capacity pressures in other parts of the primary care system.

Case studies

Long-term conditions: The Community Pharmacy Future (CPF) project helps people with long-term conditions to use their medicines effectively, improves their skills and confidence in managing their health, and enhances overall quality of life.

The first port of call: Devon's Pharmacy First scheme offers people walk-in consultations with a healthcare professional, close to their home and outside GP surgery opening hours. This scheme involved 134 community pharmacists and led to a reduction of 7000 GP appointments, 2600 out of hours consultations and 360 A&E attendances.

Health and wellbeing hub: The Priory Pharmacy makes a positive difference in the lives of people in its community, by being proactive about the opportunities for improving health outcomes.



Chapter 6: *Find the missing thousands, Treat the missing hundreds*

Improving Case Finding and management of Long Term Conditions

Less complex patients with some Long Term Conditions

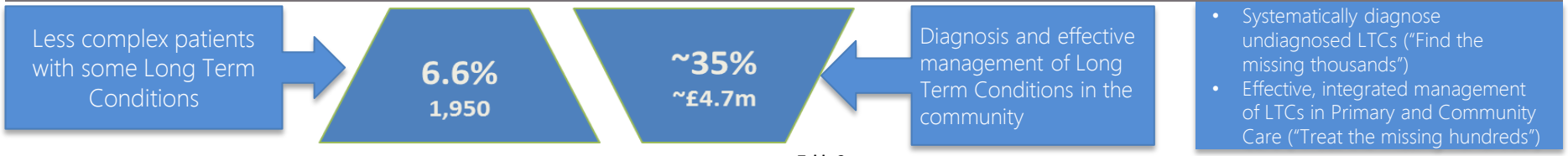
6.6%
1,950

~35%
~£4.7m

Diagnosis and effective management of Long Term Conditions in the community

- Systematically diagnose undiagnosed LTCs ("Find the missing thousands")
- Effective, integrated management of LTCs in Primary and Community Care ("Treat the missing hundreds")

6. Find the missing thousands, treat the missing hundreds



6.1 Introduction

This chapter explores the action most relevant to the segment of the population of Tilbury and Chadwell living with long term conditions.

As a population, we are living longer but not necessarily healthier lives. Increasingly many people are living with one or more long term physical or mental health conditions. More than 15 million people in England (30% of the population) have one or more long term-health conditions.[6] This includes people with a range of conditions that can be managed but often not cured, such as diabetes, high blood pressure (hypertension), other cardio-vascular disease such as Coronary Heart Disease (CHD) or Heart Failure (HF), and respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD) or Asthma.

The Tilbury and Chadwell ACO Needs Assessment Chadwell, demonstrated that there are significant numbers of people with long term conditions that have been both diagnosed and remain undiagnosed. have not yet been diagnosed. Identifying patients with long term health conditions who are unaware that they have them *("find the missing thousands"*), is an absolutely key priority for our New Model of Care, if we are going to intervene early with excellent clinical management to prevent chronic diseases progressing and patients' health deteriorating. Ensuring that once diagnosed, ALL patients with specific long term conditions receive the absolutely best evidence based treatment ("treat the missing hundreds") is equally important for the same reason. Promptly diagnosing and managing long term conditions is both good for population health and highly cost effective in terms of health and care system sustainability; for example, it is both better for the individual and health system to diagnose and manage high blood pressure than care for a patient once they have had a stroke caused by untreated hypertension (see box A)

Detailed estimates of the numbers of people with long term conditions "the expected number", numbers of people with diagnosed long term conditions (the "observed" number) and undiagnosed common long term conditions (the difference between "the expected" and "the observed") at GP practice population level are detailed in the ACO Needs Assessment document. A summary of these results is shown in table 2. It shows that the most common long term condition is Tilbury and Chadwell is hypertension, followed by depression and that these two conditions also have the greatest number of undiagnosed patients. COPD is the third most common long term condition, but our figures suggest that under-diagnosis of COPD is not an issue. However, although slightly less common, a significant number (1,649 patients) have undiagnosed Coronary Heart Disease (CHD).

Table 2

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

6.2 Finding the missing thousands

6.2.1 Improve Performance of NHS Health Check Programme

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

National evidence shows that the detection of disease is significantly more frequent among NHS Health Check attendees compared to non-attendees for:

- Chronic kidney disease.
- Familial hypercholesterolemia.
- Hypertension.
- Peripheral vascular disease.
- Type 2 diabetes.

As such, the NHS Health Checks programme is a key mechanism to *find the missing thousands*.

Local Authorities have a statutory duty to commission the NHS Health Checks programme from the Public Health Grant. Historically in Thurrock the programme has been delivered by GP practices and a central provider. Uptake of NHS Health Checks (i.e. the proportion of residents who are invited for a health check who receive one) is variable across practice populations in Tilbury and Chadwell, with an average ratio of those receiving checks: being invited of only one in two. (figure 24 overleaf)

Box 8

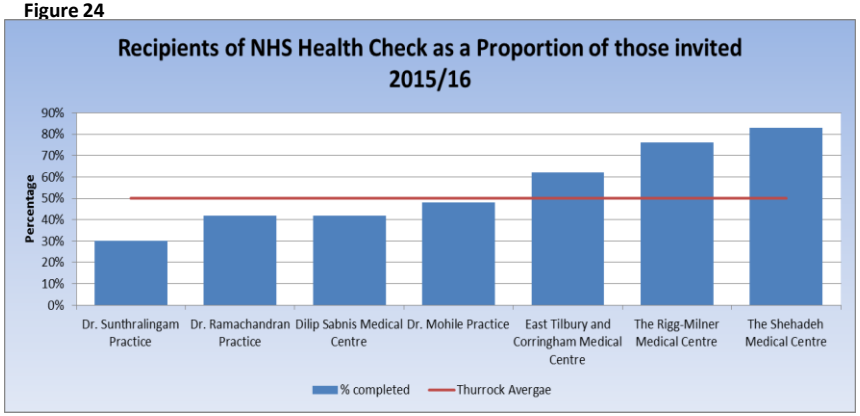
Multiple Regression Analysis Modelling by the Thurrock Public Health Team , reported in the 2016 Annual Public Health report allows us to estimate that in Tilbury practices, for each 10 0people with hypertension, that were previously un-diagnosed, who we identify we can prevent 10 stroke sover a 3 year period. We estimate that this would save the NHS £38,000 and Adult Social care £44,000 over three years. Furthermore if we were then able to treat these 100 patients effectively so that their Blood Pressure were maintained below 150/90 a further 2 strokes would be prevented producing further savings of £7,270 to the NHS and £8,420 to Adult Social Care.

This equates to 270 avoidable strokes in Tilbury every 3 years and a total avoidable cost of £1.8M making identification of hypertension extremely cost effective.

6. Find the missing thousands, treat the missing hundreds

6.2.1 Improve Performance of NHS Health Check Programme continued

Figure 24



We will improve the diagnosis or undiagnosed cardio-vascular disease through improving the performance of the NHS Health checks programme, by targeting it more effectively to those with the highest cardio-vascular risk. Key actions to achieve this will include:

- Developing new SystmOne reports that prioritise invitations to those with the greatest CVD risk-scores via application of the QRISK2 algorithm.
- Undertaking social marketing research with the target cohort to better understand the most effective invitation messages for different population segments within the target cohort and revising invitation letters in response to the findings

Over a three year period, we will aim to achieve an additional 282 hypertension, 120 CHD and 66 Diabetes diagnoses through this programme as a result of the new approach. We estimate that this will prevent 35 stroke admissions, and save the local health and care system £277k in reduced unplanned hospital admissions and adult social care packages (using the assumption on the previous slide). It is also expected that the earlier treatment of the CHD patients will result in 131 prevented admissions, and save the health system £605k over the three year period.

The full business case for this initiative can be accessed here:.

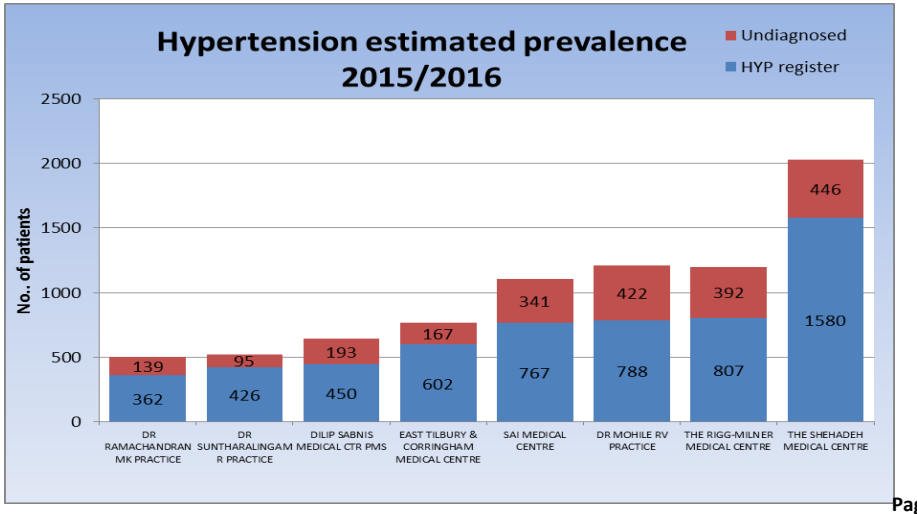
6.2.2 Improve Hypertension and Atrial Fibrillation Case Finding

The purpose of this project is to respond to the low case finding rates in Tilbury and Chadwell. The use of local assets, such as pharmacies and community hubs, will increase the access to high-quality services in safe environments. Additionally, capitalising on the already established contact with the local residents in general practice, a patient self-testing programme will be developed with blood pressure machines in the waiting area.

This project aims to increase the rate of people living with hypertension who are aware of their condition, and will thus increase the number of people properly managing their condition and receiving the appropriate care in a safe environment. As best practice recommends, people tested for high blood pressure will also be tested for irregular pulse.

The Tilbury and Chadwell locality has a higher prevalence of Hypertensive and Atrial fibrillation (AF) patients than the borough and England. Public Health England estimates show the average prevalence of HYP in Tilbury is 21.5% compared to 14.1% in Thurrock and 13.8% in England. With a detection rate of 73%, almost 2,200 patients from Tilbury have hypertension and not aware of it (Figure 25). Based on local statistical models, one out of five undiagnosed and untreated patients will develop a stroke in the next three years. (Annual Report of The Director of Public Health, Thurrock Council, 2016)

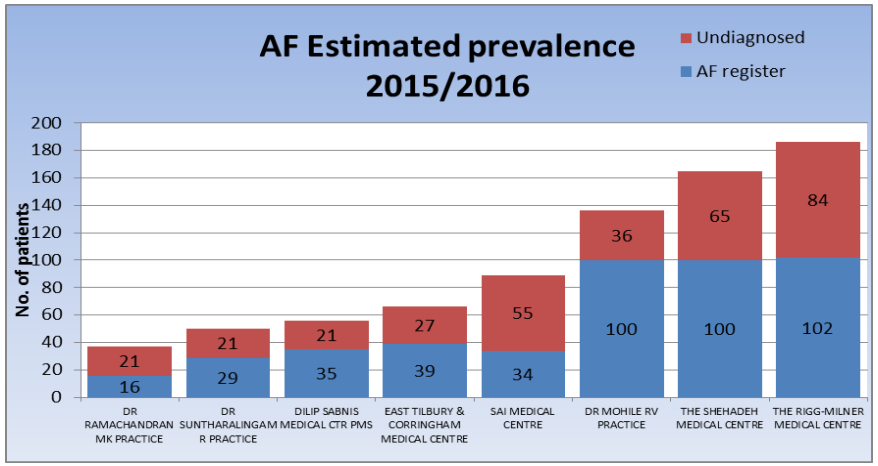
Figure 25



6. Find the missing thousands, treat the missing hundreds

6.2.2 Hypertension and Atrial Fibrillation Case Finding continued

Figure 26



Similarly, with a prevalence of 2.12% and an even lower detection rate of 56%, there are 330 patients with AF who are not diagnosed and not treated in Tilbury. (Figure 26). If not treated in the next three years with the appropriate anti-coagulant, we predict that 1 in 2 patients will suffer a stroke. The money saved by the NHS and social care over a 3 year period following a single patient having a stroke has previously been estimated as £3,644 and £4,221, respectively.

Aims and objectives of programme

- Improve the access to hypertension and atrial fibrillation (AF) screening services;
- Lower the gap between estimated and diagnosed cases of hypertension and AF;
- Increase the number of people living with hypertension or AF who understand their condition and receive the appropriate medication;
- Reduced complications associated with uncontrolled hypertension or AF;
- Reduce pressure on secondary and social care;
- Reduce costs associated with preventable strokes.

In order to effectively address the health inequalities and variation in outcomes while accounting for the under doctoring and under nursing in this area, the "Tackling high blood pressure" report form Public Health England recommends a series of key approaches:

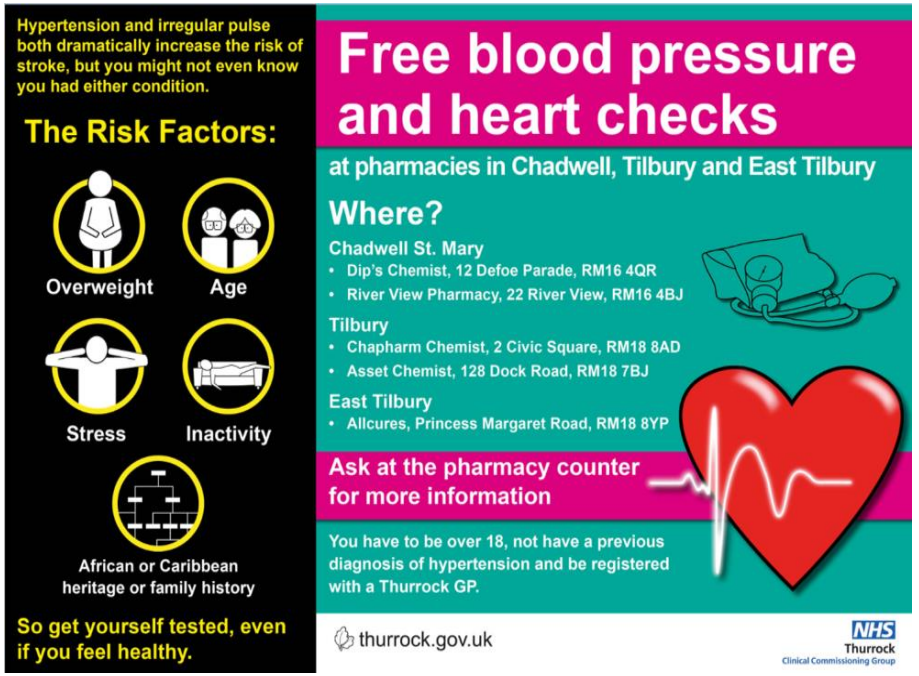
- pro-active provision of testing for high-risk and deprived groups of all ages through outreach testing beyond general practice, particularly through pharmacy
- more frequent opportunistic testing in primary care, achieved through using wider staff (nurses, pharmacy etc.), and integrating testing into the management of long term conditions
- targeting high-risk and deprived groups, particularly through general practice records audit and outreach testing"
- improving take-up of the NHS Health Check, a systematic testing and risk assessment offer for 40-74 year olds

Based on these recommendations and our local assets map, the hypertension and AF detection programme will be structured in three separate work-streams:

- Pharmacy detection,
- Community detection and
- General practice detection.

Pharmacy detection

One of the solutions to the GP and nurse shortage in primary care is the use of other community resources available. According to the 'Tackling high blood pressure' report the use of local pharmacies is particularly useful for reaching patients who might be less engaged in the health system, such as younger men, low income households and those in deprived areas.



The pharmacy detection programme is a 6-month pilot currently taking place in 5 local pharmacies in Tilbury and Chadwell. The pharmacist or the healthcare assistant will invite their clients to have their blood pressure checked based on their risk profile. However, it isn't necessary that the resident is asked by the pharmacy staff, anyone who is registered with a Thurrock GP can ask the pharmacy staff to check their blood pressure and pulse if they wish so. If the results are positive on 3 separate occasions, to rule out any false positives, the resident will be referred to their GP for further investigations and treatment. If proven to be cost-effective, the programme will be funded for a minimum of 3 years.

6. Find the missing thousands, treat the missing hundreds

6.2.2 Hypertension and Atrial Fibrillation Case Finding continued

Community detection

For those who prefer a more private setting and wish to self-test, we equipped the Tilbury Community hub with a blood pressure and pulse regularity machine to be used by local residents at their convenience. This is a person-centred approach in partnership with the local volunteer sector which also aims at empowering the local residents to take responsibility of their own health and well-being. In order to use the equipment, individuals will have to sign a disclaimer and provide some anonymous information for statistical purposes. The volunteers in the hub were trained to guide individuals in the process if needed.

If the results are positive on separate occasions, residents are encouraged to initially have their blood pressure values validated in a pharmacy, and, if confirmed, go to their GP for treatment. This way we prevent a high volume of residents making appointments with the GP.

The programme started on the 11th of September and, if successful, will be replicated in all Thurrock hubs.

General practice

Even though the general practice is the most common place for disease testing, because of the limited resources available, the current trend is to move away from it as much as possible, especially for such services that can be provided by other community partners. However, the surgery is a great resource itself for reaching people who are already engaged in the healthcare system and holds invaluable health-related information for each registered patient.

To free some of the clinical staff time and make a better use of the non-clinical staff members we will use self-test machines close to the waiting area where patients waiting for their appointment can test themselves. Each clinic will name a non-clinical hypertension champion to lead on this project and aid patients in the testing process. We will also construct SystmOne reports that highlight patients with high blood pressure readings but who are not on the surgery Hypertension register

Through the above programmes we aim to screen one patient per day per facility (pharmacy, community hub or general practice) and to detect between 532 and 904 hypertensive patients and 62 to 107 AF patients during a period of 3 years. Table 3 illustrates the maximum expected returns to the NHS and to ASC as a result of this number of people being detected and well managed, thus an approximate number of 234 strokes being prevented from happening

Table 3

	Patients detected	Stroked avoided	3-year NHS saving	3-year ASC saving	Total savings
HYP	904	113	£413,670	£476,556	£890,226
AF	107	121	£444,105	£511,618	£955,723
Total AF & HYP	1,011	234	£857,776	£988,174	£1,845,949

Each programme is a pilot and set to run for a different amounts of time. The table below gives the maximum cost of each pilot for the duration of the pilot and if the pilot was successful for a 3 year period:

	Period of Pilot (months)	Cost of pilot (including treatment)	Estimated 3 year cost (including treatment)
Pharmacy detection	6	£10,434	£55,106
Community detection	12	£2,293	£6,578
General practice	12	£41,064	£75,992
Total cost		£53,791	£137,676

If all of the pilots are considered successful and run for the full 3 year period in Tilbury and Chadwell, and detection levels were as described in table 1 then the return on investment would be 12. However actual ROIs will be calculated as part of the evaluation for each project.

The full business case for this initiative can be accessed here:.
https://edrms.thurrock.gov.uk/id:A2669648/document/versions/latest

Key Actions

- We will develop new SystmOne reports that prioritise Health Check invitations to those with the greatest CVD risk-scores via application of the QRISK2 algorithm.
- We will undertake social marketing research with the target cohort to better understand the most effective invitation messages for different population segments within the target cohort and revise Health Check invitation letters in response to the findings
- We will implement a Hypertension case finding programme in Pharmacies, General Practice and our Community Hubs
- We will assist GP practices to case find patients with undiagnosed hypertension by constructing SystmOne reports that highlight to surgeries patients with high blood pressure who are not on the Hypertension QOF register

6. Find the missing thousands, treat the missing hundreds

Diabetes Case Finding
Improve Diabetes Case Finding

It is estimated that 2,238 people within Tilbury currently have diabetes both diagnosed and undiagnosed. The number of observed cases of diabetes in 2015-16 within Tilbury was 2,101, this equated to a prevalence of 7.4% compared to the England average of 6.6%. Based on the estimated prevalence of 7.9% it suggests that there are 137 individuals currently walking around undiagnosed. This is a modest estimate as with an increase in obesity projected for future years, it is expected there will be an increase in diabetes rising to 2,853 total cases by 2026 [7].

In 2012, NICE called for those working in dentistry to be involved in the identification of risk factors for diabetes due to the strong correlation with periodontitis [8]. This was further supported within a joint consensus report published in 2013 by the European Federation of Periodontology and American Academy of Periodontology [9] to identify undiagnosed diabetes within dentistry with the use of chair side blood tests [10].

The project aims to increase the detection rate of people living with Diabetes (Type 2) who are asymptomatic and are at risk of serious health implications if undiagnosed, such as stroke, sight loss, heart attacks, kidney failure, lower limb amputations and even death. Pre-diabetic range will also be considered and referred into the National Diabetes Programme for healthy lifestyle advice. It is intended that the project will increase the number of people receiving the appropriate care and treatment to manage their condition at an earlier stage leading to better health outcomes, whilst reducing costs of complications due to late diagnosis.

The early detection of diabetes will result in better management of the condition, reducing the risk of further serious life limiting or life changing illness. A&E attendances and emergency admissions for Diabetes and Diabetes related conditions should be reduced, and referrals into the National Pre-Diabetes programme should result in fewer patients becoming diabetic reducing the overall prevalence in the long term.

Initially this pilot is not a Tilbury Pilot but does include some of the areas within Tilbury. We have targeted areas across Thurrock which are estimated to have the highest numbers of un-diagnosed Diabetes Patients based on what is recorded on practice QOF registers. Using the business case for this pilot we have estimated how much it would cost to role out the Dentistry phase across the Tilbury ACP footprint area over 1 year. (Table X)

The role out of this programme in the three dentistry practices in Tilbury would cost an estimated total of £9,938. We expect that over a year it would be possible to test around 1,000 people and assuming a prevalence in the undiagnosed population of 1.3% (7.9%-6.6%) we would diagnose around 13 people per year. Diabetes .co.uk estimate the cost of treating complications of diabetes to be up to £2,500 per patient. By identifying 13 patients and treating them effectively so as to avoid these complications there is a total opportunity to avoid £32.5K costs to the NHS, plus any additional costs required to support patients after these complications (eg. Limb amputations etc...).

There is also the opportunity to identify patients with values in the pre-diabetic range. These patients can then be referred for intensive lifestyle interventions under our NDPP in order to reduce / delay the risk of developing Diabetes in the future. We currently do not have a reasonable estimate of how many this would be. We will populate this figure following the initial pilot.

Associated GP Locality	Reasoning
Chadwell St Mary (Dilip Sabnis surgery)	High recorded obesity prevalence, low levels of physical activity & high smoking prevalence
Tilbury (Tilbury Health Centre)	low levels of physical activity, low uptake of Health Checks (meaning they are not diagnosing through this mechanism), high smoking prevalence, and high rates of emergency admissions for Diabetes (indicating that there could be an issue with identification and management)
Tilbury (Dr Shehadeh)	High recorded obesity prevalence, high smoking prevalence and low levels of physical activity.
Grays (Dr Shehadeh)	Statistically similar to Tilbury branch, but with a higher ethnically diverse population which puts them at a disproportionate risk of the disease.
Chafford (Dr Abela)	Low levels of observed diabetes but high ethnically minority population which puts them at a disproportionate risk of the disease.
Grays (Acorns)	Low levels of observed diabetes, high smoking prevalence but high ethnically minority population which puts them at a disproportionate risk of the disease.

	Cost	Expected tests	Expected diagnoses	Expected Pre-Diabetic Diagnoses	Cost of complications for non-controlled Diabetes, NHS, per year
Dentisty	£9,156.00	800	10.4		£26,000.00
Mobile unit	£782.00	200	2.6		£6,500.00
Total	£9,938.00	£1,000.00	13.00	Unknown	£32,500.00

Key Actions

We will produce an acceptable SLA for dentists to sign up to deliver HbA1c, chair side, point of care testing in individuals wuth early onset gum disease or who are considered high risk using a questionnaire administered in the waiting area.

We will implement HbA1c testing in the new PHE mobile dental unit for those who fall outside of traditional services such as the travelling community, homeless, those with disabilities or those with additional needs.

6. Find the missing thousands, treat the missing hundreds

6.2.4 Depression case finding

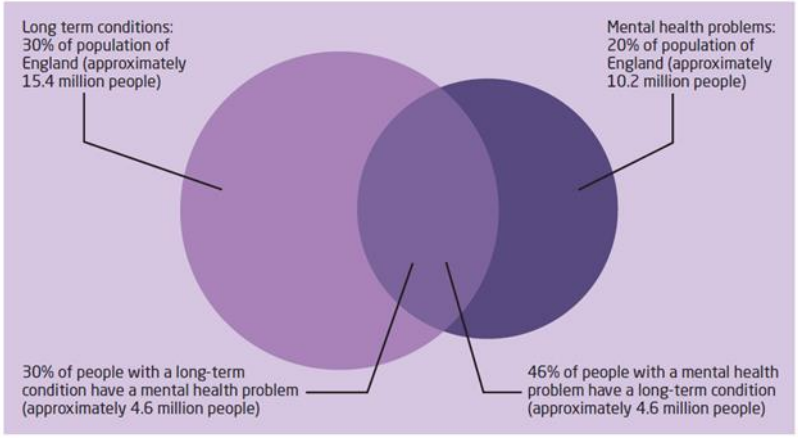
Figure 27 shows that over half (51%) of social care users self-report feelings of moderate to severe anxiety or depression in Thurrock.

Figure 27 Depression and anxiety among social care users: % people who use services who report that they feel moderately or extremely anxious or depressed (2013/14

Area	Value	Lower CI	Upper CI
England	52.8	-	-
East of England region	53.2	-	-
Bedford	53.8	-	-
Cambridgeshire	48.6	-	-
Central Bedfordshire	51.8	-	-
Essex	57.0	-	-
Hertfordshire	51.6	-	-
Luton	53.6	-	-
Norfolk	60.3	-	-
Peterborough	55.3	-	-
Southend-on-Sea	48.4	-	-
Suffolk	48.8	-	-
Thurrock	51.1	-	-

Source: Adult Social Care Survey

The relationship between Long Term Conditions s and Mental Ill Health



A patient with a physical long term condition (LTC) without depression is estimated to cost the NHS £1,760 a year less than a patient with both a long term condition and co-morbid depression (£3,910 vs £5,670). Early identification and subsequent management of depression would delay and reduce higher level interventions later on. The potential saving, if only 100 (approx. one third) of those newly identified LTC/depressed patients are better managed and clinical depression averted, is £176,000.

We will improve the diagnosis of common mental health disorders (depression and anxiety) through improving the screening for depression via social care and primary care colleagues by targeting those with the highest risk (those aged 65+ with at least one LTC. Key actions to achieve this will include:

- Developing new SystmOne reports that identify those with LTCs
- Embedding depression screening in LTC clinics in primary and community care
- Embedding depression screening into the work of front line Adult Social Care staff

Table 4. Modelled data on the numbers of those affected by LTCs and mental health problems in Thurrock and Tilbury

	Thurrock (nearest 100)	Tilbury (nearest 100)
Population (all age)	173,400	38,246
Long-term condition (30%)	52,000	11,500
Mental health problem (20%)	34,700	7,600
30% of people with a LTC also have a MH problem	15,600	3,400
46% of people with a MH problem also have a LTC	16,000	3,500

A full copy of the Depression Screening business case can be accessed here:

Key Actions

We will develop new SystmOne reports that highlight to surgeries those patients with long term conditions who have not been screened for depression

We will embed screening of clients with depression into the work of staff treating those with physical long term condition and front line adult social care staff

6. Find the missing thousands, treat the missing hundreds

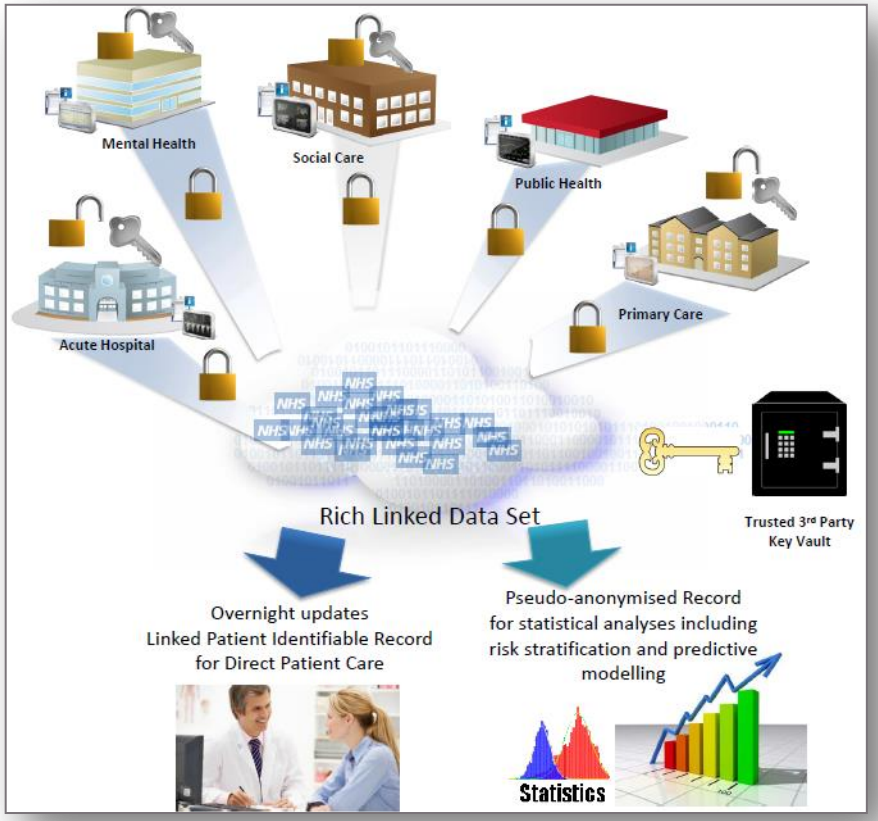
6.2.5 Systematic Case Finding of undiagnosed Long Term Conditions by interrogating GP Surgery Clinical Systems

Since the inception of the NHS, patient medical records have been held by their GP in their surgery. Historically, medical records were paper based, but more recently these have been moved onto electronic clinical record storage and management software, or which there are a number of differing types. The majority (88%) of Thurrock GP surgeries use the same software; *SystmOne,* which is also used by North East London Foundation Trust (NELFT) for NHS community services. However, four of our surgeries use different software databases for patient medical record management.

The move from paper to electronic databases for medical record storage presents opportunities for systematic interrogation of these systems in order to assist front line clinical staff identify key cohorts of patients that either have an undiagnosed long term condition or are diagnosed but whose conditional management could be improved. By linking medical records at patient level to health records held in adult social care and/or hospital enhances these opportunities further. For example, a patient who attends A&E with severe respiratory symptoms and is diagnosed at the hospital as having likely COPD, can be flagged electronically to their GP practice and placed on the surgery's COPD patient register if hospital and surgery records can be linked. Similarly, electronic interrogation of a GP surgery's clinical database can identify all patients who have had a series of high blood pressure readings or may even be being prescribed anti-hypertension medication, but are not recorded on the GP practice hypertension register, and therefore may not be in receipt of the systematic care management for their condition.

Historically, a lack of time, resources and in some cases IT skills within the 20th Century model of GP surgeries have prevented such systematic approaches to case finding of patients with long term conditions being implemented. Similarly Information Governance (IG) restrictions and a lack of connectivity between hospital, social care, community care and primary care electronic patient record databases have acted as further barriers to delivering proactive, case-finding and integrated care.

Figure 28



Mede/Analytics

An Integrated Data Solution: MedeAnalytics

MedeAnalytics is a cloud based analytics platform that aggregates and links patient records from a range of different clinical systems and providers including GP surgeries, hospital, adult social care, mental health and NHS community providers creating a single shared patient record linked on NHS number.

Figure 28 sows how MedeAnalytics operates. A third party trusted key is used to pseudo-anonymise patient records from different organisations and databases across the health and care system. These individual pseudo-anonymised data sets are then sent to MedeAnalytics, who link them on pseudo-anonymised NHS number to create a 'data lake' of linked health and care records at patient/client level. These can be analysed by Public Health in their pseudo-anonymised form to create tools that predict risks or outcomes in specific patient cohorts. For example, groups of undiagnosed patients with specific long term conditions can be identified as discussed above. These can then be sent back to the patients' GP surgery who can use their unique identifier to reverse the pseudo-anonymisation and identify patients that they can review.

Key Actions

We will procure and implement the MedeAnalytics IDS across Tilbury and Chadwell

We will assist surgeries to "find the missing thousands" by constructing and running automated reports through MedeAnalytics/SystmOne that identify patients who have risk factors or are on medication for specific long term conditions but have not been added the surgery's Long Term Condition Disease Register

6. Find the missing thousands, treat the missing hundreds

6.3 Treat the missing hundreds: Improving the Management of Long Term Conditions in Primary and Community Care

The ACO needs assessment identified the challenge of inadequate clinical management of patients diagnosed with long term conditions in both primary and community care. Most patients diagnosed with a Long Term Condition are managed by their GP surgery under the Quality Outcomes Framework (QOF) which specifies a series of clinical management interventions that should take place each year of patients recorded on specific long term conditions disease registers. QOF rewards practices through payments based on the percentage of patients with a specific long term condition who meet the criteria for the intervention who actually receive it. However, QOF only rewards practices up to a maximum payment threshold (usually between 70% and 80% of all eligible patients in the cohort receiving the intervention), meaning that surgeries receive no additional payment for treating the remaining 20% to 30% of the eligible cohort (depending on the QOF indicator/intervention). This quirk in national commissioning in effect leaves significant numbers of patients with long term conditions untreated and therefore inadequately managed, placing at the at significant unnecessary risk of serious adverse health events and avoidable hospital admissions.

In addition, GPs can 'exception report' patients, removing them from the cohort eligible for treatment and hence the denominator used to calculate practice performance to reach the maximum payment threshold, if they meet certain criteria, for example refusing the clinical intervention, failing to respond to three invitations to attend surgery or if the intervention is contraindicated because of another diagnosis a patient may have or medication that they are prescribed. However, the needs assessment identified significant variation in rates of exception reporting on different indicators between surgeries. The reasons for this are unclear, and could be explained by populations with differing levels of morbidity, differing levels of willingness to agree to take recommended prescribed drugs, or differing abilities to access the surgery when appointments are offered. However, high levels of exception reporting are unfavourable in population health terms, leaving significant numbers of patients with long term conditions potentially under-treated and inadequately managed within the community.

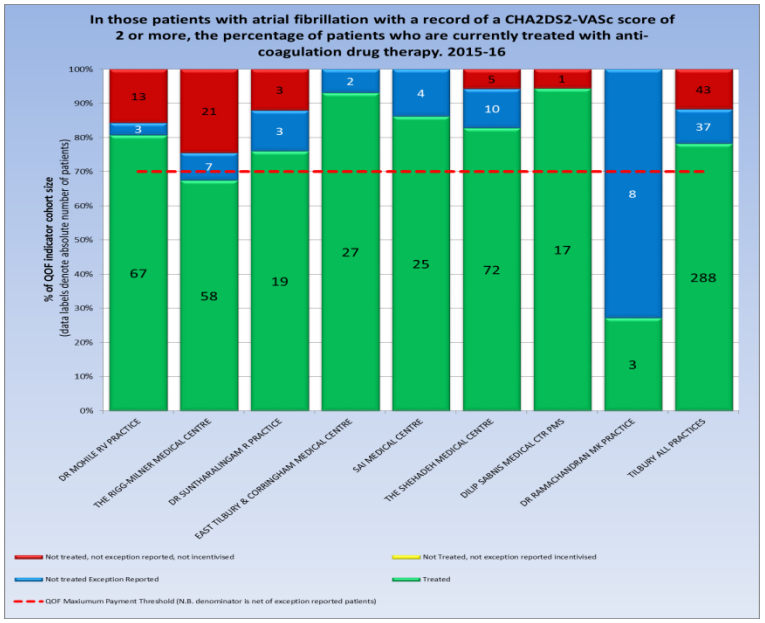
An example of the impact of the payment threshold and exception reporting is shown in figure 29, taken from the ACO Needs Assessment. National Institute of Health and Care Excellence (NICE) guidance states that those patients diagnosed with Atrial Fibrillation who have a CHADS2-VASc score of 2 or more should be treated with anti-coagulation drug therapy to reduce the risk of a stroke. Figure 29 shows performance on this indicator in 2015-16 across surgeries in Tilbury and Chadwell. However, because of the maximum QOF payment threshold of 70% (shown by the red dotted line in figure 29), QOF provides no funding to GP surgeries to treat 30% of patients in this cohort.

The green parts of each surgery bar show the numbers and % of the cohort successfully receiving this intervention; the blue parts the number and % who were exception reported and; the red parts the number and % that were neither exception reported nor treated. The negative impact, both on patient health and cost to our local health care system is shown in box one.

We will take urgent action to address a national commissioning directive that make no sense in either health nor financial terms. We will do so by implementing a local "stretched QOF" local commissioning framework across all key cardio-vascular, respiratory, diabetes, mental health and musculo-skeletal related QOF indicators, that abolishes the 'maximum QOF payment threshold' and provides adequate funding for GP surgeries to provide appropriate clinical interventions to **100%** of all patients on long term condition registers who require NICE approved clinical interventions.

We will also use the new MedeAnalytics Integrated Data Solution to run automatic reports on GP clinical databases that flag to surgeries, any patient that requires a QOF based intervention who has yet to receive one. We will work with the network of surgeries in Tilbury and Chadwell to offer a single, centralised patient 'call-recall' system that will manage the appointments and booking patients with long term conditions who need such interventions, on behalf of surgeries as part of the new Clinical Management Hub.

Figure 29



Box 9: The Perverse Impact of the QOF system on Patients with Atrial Fibrillation and the Health and Care System in Tilbury and Chadwell

- **80** patients with Atrial Fibrillation and a CHAD2 score >1 are not anti-coagulated
- **43** (60%) of these are not exception reported
- **Surgeries receive no funding** to treat any of them
- Providing additional **funding to** surgeries to **treat** these untreated **43 patients (**by raising the QOF threshold from 70% to 100%) would cost **£2,121**
- Left untreated, our modelling demonstrates that **50%** of these patients (22 Tilbury and Chadwell residents) **will have a stroke in the next three years**
- **The initial cost to the NHS** of treating **22 strokes is £84,202**, and the **cost to** Adult **Social Care is £129,145**

6. Find the missing thousands, treat the missing hundreds

6.3.1 Implementation of the "Stretched QOF"

Evidence from the BMJ indicates that the introduction of QOF for the management on some Ambulatory Care Sensitive Conditions (ACSC) was associated in the reduction of emergency admissions for these conditions (Figure 30).

It is expected that by increasing the number of patients with long term conditions treated under QOF, this programme would result in a number of outcomes, including:

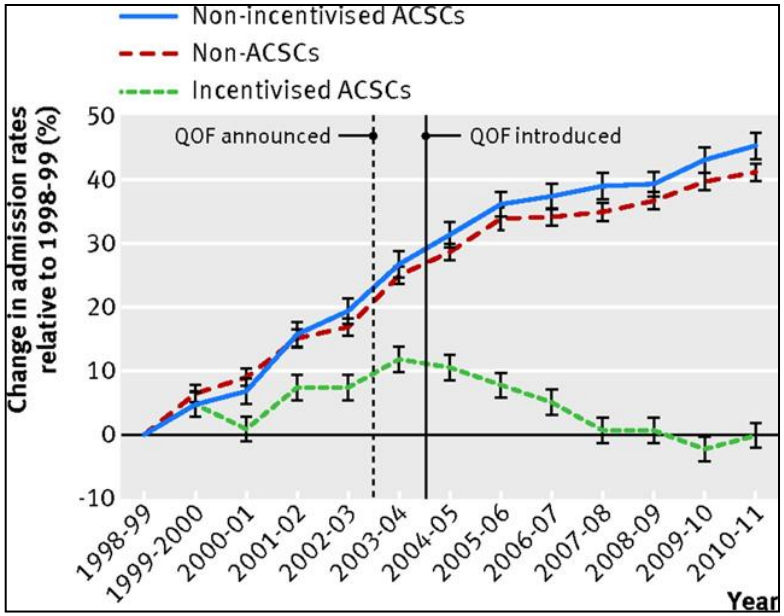
- Better management of patients with long term conditions
- Patients who are happier with their care
- Fewer serious adverse health events such as strokes, heart attacks, COPD exacerbations and serious complications from diabetes
- Reduction in avoidable emergency hospital admission rates because of complications resulting from badly managed long term conditions
- Reduction in avoidable demand for adult social care packages
- Significant system cost savings

The implementation costs are shown in the table 5 below, and will be funded as part of the joint Thurrock CCG/Council Better Care Fund:

Table 5

	Cost to achieve 100% on All indicators based on current detection rates	Proposed Increase in Detection Rates	Cost to achieve 100% on All indicators based increased detection rates	Proposed Increase in Detection Rates	Cost to achieve 100% on All indicators based increased detection rates
Hyp	£4,635.14	10%	£5,274.62	20%	£5,914.09
CHD	£1,471.00	5%	£1,638.00	10%	£1,806.00
AF	£3,815.43	0%	£3,815.43	0%	£3,815.43
HF	£4,786.00	0%	£4,786.00	0%	£4,786.00
PAD	£311.35	0%	£311.35	0%	£311.35
STIA	£1,981.50	0%	£1,981.50	0%	£1,981.50
DM	£10,800.40	5%	£11,180.98	10%	£11,450.63
COPD	£5,735.28	0%	£5,735.28	0%	£5,735.28
Asthma	£10,366.64	0%	£10,366.64	0%	£10,366.64
Dementia	£13,902.99	0%	£13,902.99	0%	£13,902.99
Mental Health	£2,455.66	0%	£2,455.66	0%	£2,455.66
Depression	£1,908.25	0%	£1,908.25	0%	£1,908.25
Oesteoporosis	£1,752.31	0%	£1,752.31	0%	£1,752.31
Rhumatoid Arthritis	£583.89	0%	£583.89	0%	£583.89
Total	£64,505.84		£65,692.90		£66,770.02

Figure 30



We can calculate potential outcomes and returns for three of the QOF indicators by using the Long Term Condition models produced for the 2016 APHR. These are detailed in table 6 (next page). We predict that implementing a Stretched QOF will save the Health and Social care system at least £640K based on only three QOF indicators to avoid CVD events. We are unfortunately unable to estimate this further for other conditions and indicators but it is logical to assume that additional saving

Key Action

We will implement a Stretched QOF programme for all surgeries in Tilbury and Chadwell on Long Term Conditions Indicators to ensure funding is available for practices to treat 100% of patients on QOF disease registers

6. Find the missing thousands, treat the missing hundreds:

6.3.1 Implementation of the "Stretched QOF" (cont.)

Table 6

	Min additional cases treated	Maximum additional cases treated	Assumptions for range	Outcomes	Returns estimated	Potential Savings
The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	893	1170	Excluding exception reporting and no detection increase to including exception reporting and 10% increase in detection	18-23 strokes avoided over 3 years	NHS - Stroke Avoidance Adult Social Care - Stroke Avoidance	£65,082 to £85,270 £75,387 to £98,771
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy	48	85	Excluding or Including exceptions	62 - 110 strokes avoided over 3 years	NHS - Stroke Avoidance Adult Social Care - Stroke Avoidance	£227,385 to £402,662 £263,390 to £466,420
In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB	2	9	Excluding or Including exceptions	2.2 - 7.6 fewer non- elective admissions for CHD/HF over 3 years	NHS - admission avoidance	£10,058 to £45,263
Total Measurable Returns					NHS Adult Social Care **Total**	£302,525 to £533,195 £338,777 to £565,191 £641,302 to £1,098,386

6. Find the missing thousands, treat the missing hundreds:

6.3.2 Improving uptake of flu vaccinations amongst high risk groups

Morbidity and mortality attributed to flu is a major cause of harm to individuals, especially vulnerable people, and a key factor in NHS winter pressures. The annual flu immunisation programme helps to reduce GP consultations, unplanned hospital admissions and pressure on A&E and is therefore a critical element of the system-wide approach for delivering robust and resilient health and care services during winter. This project aims to increase the proportion of people vaccinated for flu who are at high risk of ill health or death if not vaccinated.

Various factors help to increase the levels of uptake of flu vaccination including the sending of personalised letters to the population from their GP practice.

The project aims to target two main groups of patients:

1) Those with long term conditions in the clinical risk groups covered by QOF [CHD, Stroke, Diabetes and COPD] where the GP could be incentivised via a 'stretched QOF' [see previous slide - the estimated cost of vaccinating patients in these groups has been included in the 'stretched QOF' programme and is therefore not repeated here.]
2) Those in high risk groups not covered via QOF. Current uptake in Tilbury is particularly low for groups such as carers (26% compared to a national target of 75%) and pregnant women (28% compared to a national target of 55%) – this can be seen in the table 7below.

Table 7

	6m-2yr olds (at risk)	Carers	Pregnant women (all)	Children (aged 2-7)	<65 At-Risk (Chronic Liver Disease)	<65 At-Risk (Asplenia or dysfunction of the spleen)	<65 At-Risk (Chronic Kidney Disease)	<65 At-Risk (Immuno-suppression)
Tilbury Avg (%)	33.0	26.0	28.0	42.5	29.0	35.0	39.0	40.0
National Target (%)	55.0	75.0	55.0	40.0	55.0	55.0	55.0	55.0

It is estimated that we would need to vaccinate 328 patients in these other high-risk groups; and the cost of vaccinating them is estimated to be £3,936 [including the vaccine cost and relevant promotional materials].

It is expected that reducing flu outbreaks will result in:

- Reduced ill health in patients
- Reduced hospital admissions (and therefore bed days and lengths of stay in hospital) - *there were 118 spells for influenza/pneumonia in 2015-16 from Tilbury residents costing £413,191.*

It is hypothesised that a large majority of these could have been prevented if the patient had had the flu vaccination. If we could prevent 80% of these by delivering the flu vaccination, that would result in a cost saving of £330,552.80.

- Reduction in sick leave taken by staff in all parts of the healthcare workforce (it is estimated that approximately 10% of sickness absences are related to flu.)

There will also be savings to Adult Social Care with reduced outbreak response costs (e.g. the additional staff, vaccine costs etc) which cannot be quantified.

A full copy of the Flu Immunisation Business Case can be accessed here:

6. Find the missing thousands, treat the missing hundreds

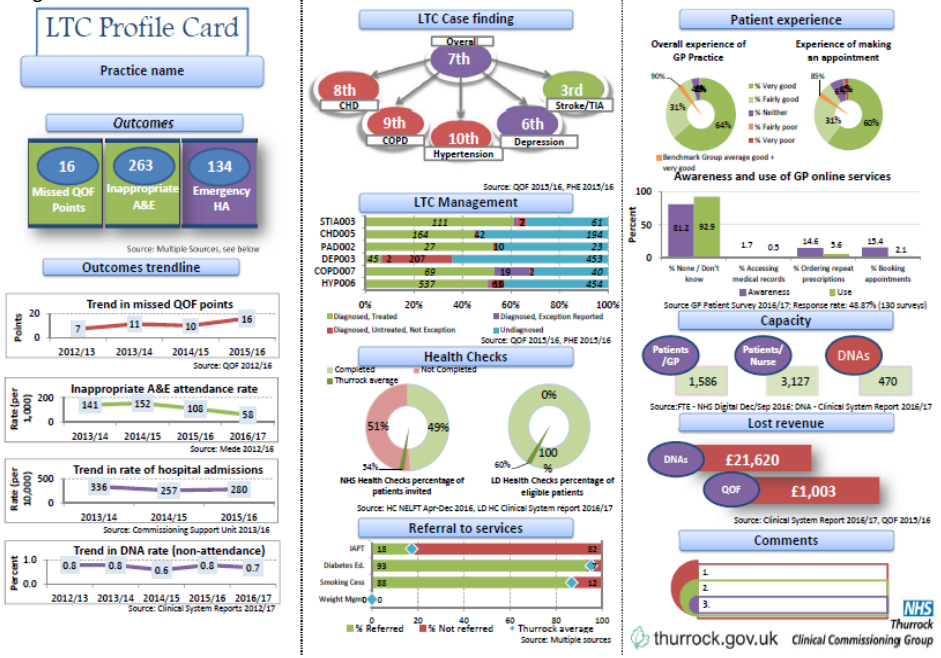
6.3.3 Working to Support Surgeries Deliver World Class Long Terms Condition Case Finding and Management

The Healthcare Public Health Team and Thurrock CCG's Primary Care Improvement Team will continue to work in partnership with GP surgeries to share and embed best practice relating to the diagnosis and management of patients with long term conditions.

We will continue to roll out our Long Term Conditions Profile Card (figure 31) which provides a benchmark of each of our GP surgery's performance relating to both the case finding and management of patients with long term conditions against a cohort of 20 surgeries across England that serve practice populations with demographic characteristics most similar to their own.

We will support our surgery practice managers and clinical teams to develop and implement surgery based action plans, based on the contents of their profile cards, with a view to encouraging a culture of shared learning and continuous quality improvement. At a Tilbury and Chadwell and Thurrock level, we will monitor performance on long term conditions case finding and clinical management over time to ensure that sustained improvements are being made, and we will triangulate this with analysis from MedeAnalytics to ascertain the impact that improved management of long term conditions is having on emergency hospital admissions and demand for adult social care packages, and publish the results.

Figure 31



Key Actions

We will use the new MedeAnalytics Integrated Data Solution to assist surgeries identify patients that need to be reviewed under QOF for their long term conditions management care and reduce avoidable exception reporting

We will work with the network of surgeries in Tilbury and Chadwell to offer a single, centralised patient 'call-recall' system that will manage the appointments and booking patients with long term conditions who need such interventions, on behalf of surgeries as part of the new Clinical Management Hub.

We will continue to roll out the LTC Profile Card and provide support to Practice Managers and Surgery Clinical Teams to develop and implement action plans to improve clinical quality and patient satisfaction

6. Find the missing thousands, treat the missing hundreds

6.3.4 Increasing and Integrating Capacity to Manage Long Term conditions in Primary Care

Figure 32 shows the combined number of clinical interventions across all of the Diabetes QOF indicators delivered to patients, exception reported, not delivered and not exception reported but incentivised; and not delivered, not exception reported and not incentivised for each GP practice in Tilbury.

In total 4575 clinical interventions relating to the management of diabetes were not delivered to Tilbury patients on diabetes disease QOF registers in 2015-16. Of those only 1651 (35.5%) were because the patient had been exception reported. The 'yellow' parts of the bars (relating to a total of 1037) were for interventions that were incentivised through the existing QOF commissioning framework but not delivered. Similar charts are available within the Tilbury ACO needs assessment document for QOF interventions relating the cardio-vascular disease and respiratory disease, and show a similar pattern.

These data suggest that raising the threshold of the maximum level of QOF payment to 100% of eligible patients on all indicators (discussed on the previous page) may not be the entire solution to inadequate disease management of long term conditions in GP practices, as for some indicators, in some surgeries, patients did not receive interventions nor were exception reported, even though financial reward would have been payable under QOF. Rather, where patients are not receiving clinical interventions were funding is available to practices to deliver them, it would suggest that surgeries lack clinical capacity to review and manage patients with long term conditions.

NHS Thurrock CCG commission North East London NHS Foundation Trust (NELFT) to provide community long term conditions management clinics to support GP surgeries manage patients with diabetes, COPD, stroke and Heart Failure. The Tilbury ACO Needs Assessment demonstrated a minority of patients with these conditions, registered at GP practice level were referred to these clinics. Only 25%, 17% and 8% of patients with COPD, Heart Failure and Stroke respectively were referred to the relevant NELFT community commissioned service. (Figure 33). The reasons for this are unclear, but whilst GP practices are failing to deliver 100% of QOF long term conditions management interventions to the cohort of patients eligible to receive them, these relatively low levels of referral suggest cause for concern.

The needs assessment noted that possible causes for low referral rates included the separation of community LTC management services from surgery clinical teams, and the fragmentation of community LTC management into disease specific services. It noted that increasingly, Tilbury and Chadwell residents are living with more than one long term condition but needed to travel to different clinics, run at different times and locations to receive treatment for different long term conditions. This is clearly not the most optimal way to deliver services from a patient experience point of view, and having a single long term conditions management service that could support practices review patients once for all of their long term conditions would be a more optimal way of service delivery.

Figure 32

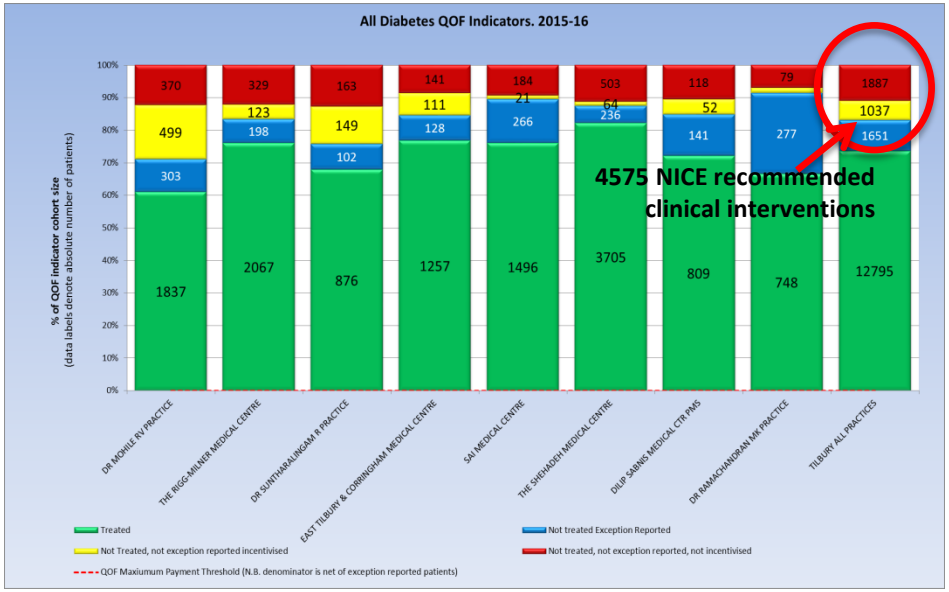
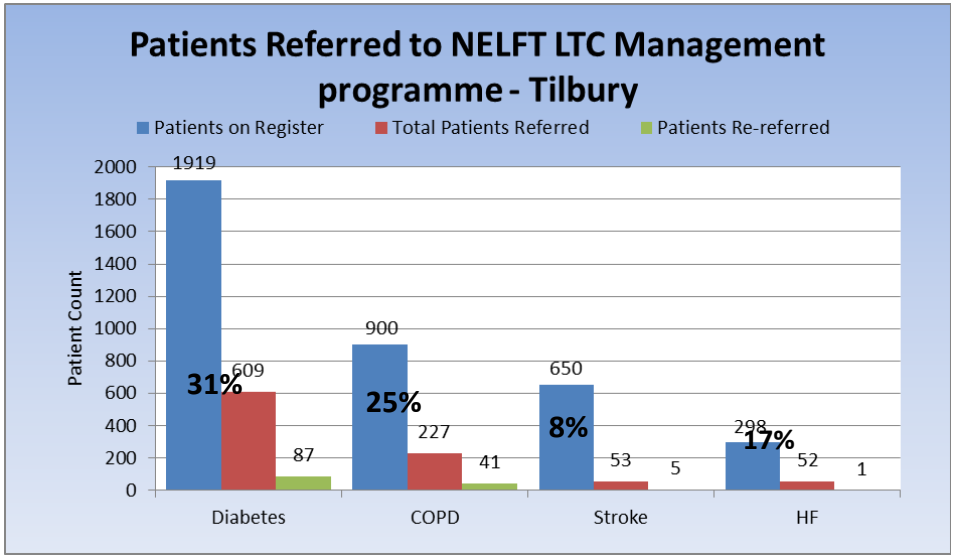


Figure 33



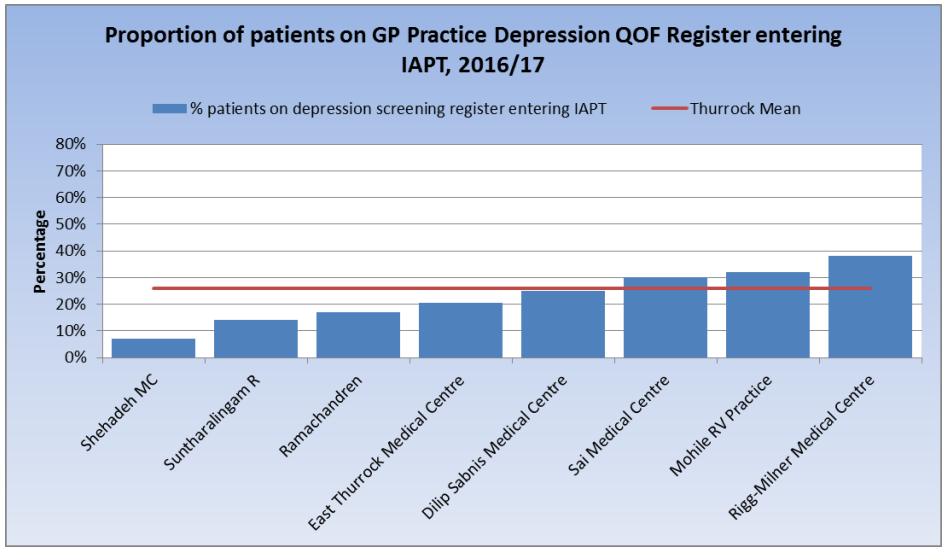
6. Find the missing thousands, treat the missing hundreds

Increasing and Integrating Capacity to Manage Long Term conditions in Primary Care (cont).

Treatment for depression and anxiety is most commonly in Primary Care by GPs. NHS Thurrock CCG also commission Inclusion Thurrock to provide psychological talking therapies – IAPT (Increasing Access to Psychological Therapies), for patients with depression and anxiety.

Like referral to NELFT community LTC management clinics for physical long term health conditions, the proportion of patients on GP surgery depression registers entering IAPT is relatively low (7% to 39%), with half of all surgeries in Tilbury and Chadwell having a lower rate of patients with depression and anxiety entering IAPT than the Thurrock average in 2016/17. (Figure 34)

Figure 34

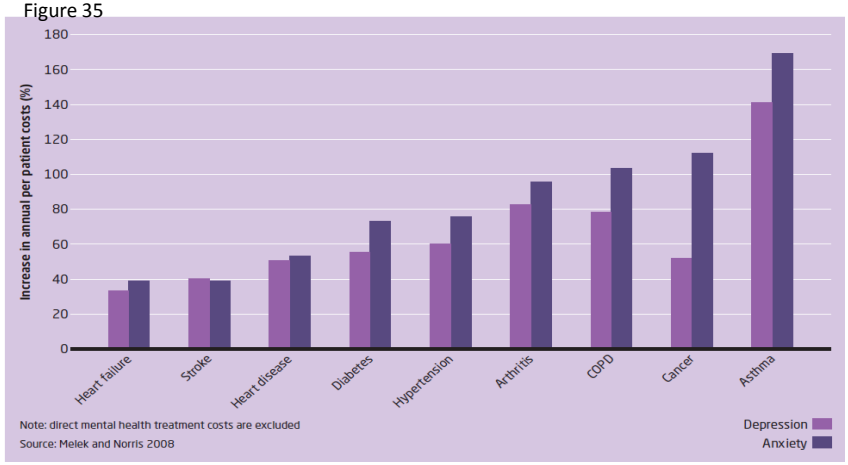


The relationship between physical long term health conditions and common mental health disorders (depression and anxiety) is well established and was discussed on page ***. 30% of people with long term physical health conditions also have co-morbid depression and/or anxiety, and that 46% of people with a mental health disorder, also have a co-morbid physical long term health condition.

Furthermore, patients with long term physical health conditions and comorbid untreated depression and anxiety have been shown to have significantly poorer health outcomes, and significantly greater health service usage and costs. (Figure 35).

We will address these issues by bringing community healthcare capacity for managing mental and physical long term conditions closer to Primary Care, and by integrating it into a single more streamlined service.

Figure 35



We will seek to create a single long terms condition management service within the Enhanced Primary Care Team, shared by the network of GP surgeries in Tilbury and Chadwell. The LTC management service will be able to provide additional support to GP surgeries to manage patients with diabetes, cardio-vascular disease and respiratory disease, rather than requiring referral to disease specific community services, as at present. The new arrangement will strengthen relationships between primary and community care clinicians for the management of patients with long term conditions. It will also allow patients to be seen once, closer to home for all of their long term conditions rather than having to attend different clinics specialising in different long term conditions.

We will integrate current IAPT services provided by *Inclusion Thurrock* within the shared Enhanced Primary Care clinical team, in order to increase the number of patients with diagnosed depression and anxiety entering treatment, and provide a single integrated service offer that treats depression and anxiety alongside physical long term health conditions.

Key Actions

We will integrate current disease specific physical long term conditions clinics into a single integrated LTC management service, based within the shared Enhanced Primary Care clinical team, to strengthen shared care arrangements between Primary and Community Healthcare services and provide a one stop shop for patients

We will integrate IAPT service provision within the Enhanced Primary Care clinical team to increase the number of patients with depression and anxiety entering treatment and to provide a single integrated service that can treat physical and mental ill health.

Chapter 7: *What does a good life look like for you?*

Proactive, Integrated Community Health and Wellbeing

Complex, Frail Patients with Multiple Long Term Conditions

1.8%
533

50%
~£6.7m

Coordinated, proactive, integrated health and care

- Proactive person centred care coordination
- Integrated community assets, healthcare and adult social care

7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing

Complex, Frail Patients with Multiple Long Term Conditions

1.8%
533

50%
~£6.7m

Coordinated, proactive, integrated health and care

- Proactive person centred care coordination
- Integrated community assets, healthcare and adult social care

Introduction

This chapter focuses on the 1.8% of residents that account for 50% of the healthcare spend in Tilbury and Chadwell. Although relatively small in number, this cohort has the greatest level of health and care need and uses a disproportionate amount of health and care resource. Residents represented within this group are likely to have multiple long term conditions, come in contact with NHS community healthcare services, be in receipt of domiciliary home care or other types of adult social care package, and experience admission to hospital or other secondary care services, perhaps multiple times within a year.

However, being in receipt of 50% of the total healthcare resource spent in Tilbury and Chadwell does not necessarily mean that this cohort receives the best possible health and care services. Anecdotal evidence from providers of health and care services suggest that services are often provided in a disjointed, inflexible and inefficient way. In order to demonstrate this, we have selected at random, the records of a client from Thurrock Council's Adult Social Care LAS, receiving domiciliary home care in 2015/16, whom we shall name "Beryl".

Beryl and her likely care in 2015/16

Beryl is an 89 year old woman who lives alone. She has a history of TIAs and has strokes, the last one resulting in her being admitted to Basildon Hospital. She also suffers from several cardio-vascular diseases including high blood pressure (hypertension) and Atrial Fibrillation, both of which are underlying risk factors for her strokes. As a lifelong smoker, she received a diagnosis of COPD ten years ago. She is monitored by her GP and different NELFT community long term conditions clinics for these conditions.

She has also been diagnosed with osteoporosis and has a history of falls and fractures. Her deteriorating long term conditions and her falls have resulted multiple visits to Basildon Hospital both as an outpatient and in terms of emergency A&E attendances. She has been admitted to Basildon Hospital as an inpatient, once due a fall/fracture, and twice because of stroke/TIA over the past 12 months.

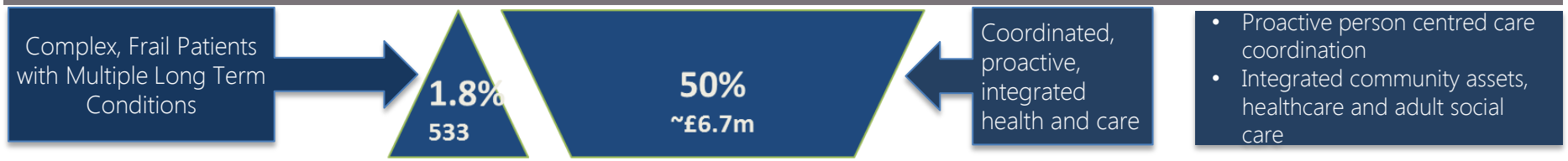
She also has some continence issues and repeated UTIs requiring treatment by her GP and the community continence team.

Following her last stroke, Beryl received some re-ablement at Basildon Hospital and then was assessed by the Hospital Social Work Team as requiring physical home care support, double handed, three times a day in order to meet her personal care needs as she now has impaired mobility. Her last stay in hospital has left her with some acquired pressure ulcers

Beryl is suffering from depression and anxiety because of her deteriorating health and because she feels lonely and isolated. Some mild confusion has been noted by the social work team.

The diagram to the right summarises the needs of Beryl as assessed by the Health and Care system

7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing



Historically, as a result of the way health and care has been commissioned and provided, the following different services would all be contributing to Beryl's care.

GP Surgery
Beryl's GP and surgery will hold Beryl's medical records and will be the first point of contact for Beryl on a day to day basis, and ultimately responsible for coordinating her care, including making referrals to other services that may be able to support her. Her GP surgery would be responsible for prescribing medication to treat infection and vaccinating Beryl against future infection e.g. influenza and pneumococcal infection. In addition, her surgery will be managing her COPD, Atrial Fibrillation, Stroke/TIA and depression through delivery of a series of clinical intervention under QOF.

Hospital
Have treated Beryl in A&E when she has had a COPD exacerbation or fall, as an in-patient following a stroke and fall, and as an outpatient for osteoporosis. Re-ablement was also provided at hospital when Beryl was most un-well following her stroke, as was assessment to determine her adult social care homecare need.

Community Respiratory Team
Beryl may receive further treatment and management for her COPD from the Community Respiratory Team. She is likely to have to access the team at a separate appointment by travelling to their clinic. Long term management of her COPD will be shared with her GP practice who will also undertake clinical management under QOF.

Community Stroke Rehabilitation Service
Beryl will be receiving further treatment and rehabilitation for her stroke from the Community Stroke Rehabilitation Service. The service, led by a specialist team provides specialist neuro-rehabilitation to minimise deterioration of her condition and enable optimum function levels to be reached and maintained. It also provides specialist support, resources and education to Beryl to enable self-management. Beryl is likely to have to access the team at a separate appointment by travelling to their clinic. Long term management of her stroke will be shared with her GP practice who will also undertake clinical management under QOF.

Integrated Community Team (ICT)
Members of the ICT are visiting Beryl at home to provide care following her hospital discharge. Clinical staff are treating her pressure ulcers and providing wound care. They may also undertake some prevention activity such as vaccinating Beryl against flu.

Community Falls Team
Given Beryl's history of falls, she may have been referred to the falls service. This service, provided by the NHS community provider, is responsible for conducting Medication Reviews, Postural stability training, eyesight checks and ensuring a home safety check is undertaken, with a view to reducing the likelihood and risk of Beryl having future falls. Beryl may have to travel to clinics for some of these services or they may be provided within her home.

Occupational Therapy
OTs would visit Beryl at home and assess how her home may need to be adapted in order to maximise independent living and help her to remain at home for as long as possible

IAPT
Beryl may wish to accessing talking therapies for her depression/anxiety. If so, she will need to either self-refer or be referred by her GP to her local IAPT provider, and travel to an appointment to receive the service

Dementia Crisis Support Team
Beryl has been referred to this team by her GP to investigate her memory and mild confusion issues. They are currently undertaking memory diagnostic testing with Beryl.

Domiciliary Home Care
Beryl's needs related to personal home care would were assessed on hospital discharge by the hospital social work team following some re-ablement. They have commissioned a private homecare provider, to provide three visits a day.

Meals on Wheels
Beryl's low level of current physical functioning requires Meals on Wheels to be delivered to her home each day.

MDT (Multi-disciplinary Team)
MDTs are formed of groups of clinicians that are involved in Beryl's care. Their aim is to review the care being provided to patients with complex or multiple needs and act in a proactive way to prevent the patient deteriorating and to better coordinate care. An MDT may or may not meet at Beryl's surgery (as not all surgeries have MDTs). Beryl may or may not be discussed at the MDT depending on the methodology used by her surgery to select patients for review. Whether or not the MDT meets at Beryl's surgery, **it is unlikely that her GP or any other single professional will have timely access to information on all clinical and care interventions provided to Beryl, and also unlikely that all services providing such interventions will be represented at the MDT**.

7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing

Problems with the current way care is provided

Figure 36 shows he current way that care is provided for Beryl. A number of immediate problems with the current system, detailed below:

Task and service focussed not holistic

Care providers are commissioned through, and therefore deliver care as, a series of discrete "tasks" rather than as a single holistic single package that meets all of Beryl's needs. For example different NHS community care staff arrive at Beryl's home to undertake different care tasks, usually centred around different clinical conditions. Similarly adult homecare providers are commissioned to deliver a fixed number of hours or minutes of care for a set number of times each day. with no flexibility relating to how Beryl may be feeling on a particular day or what her needs on that day may be.

Impersonal and Anonymous

Care is provided by multiple individuals from different teams in different organisations entering Beryl's. Beryl is likely to see many different individuals over the course of a week or even day, and these may be subject to change from day to day or week to week. The care providers may not have time to get to know Beryl personal basis or understand anything above her most basic needs of food, personal care and disease management. Further more, Beryl is subject to many visits of different people at differing times of the day making it impossible for her to plan her life outside of these care needs.

Inflexible

Because care is both task focussed and impersonal, the needs of the recipient of care, which may vary on a day to day basis are never taken into account. Similarly, the task focussed nature of how care is commissioned, risks resulting in a 'one size fits all' type of care delivery that meets only the most basic needs of the resident.

Fragmented

Multiple organisations and individuals provide different health and care tasks. Beryl's care is determined by how services are currently organised, not on her needs. Beryl has to travel to multiple care providers to receive different elements of her care. Intelligence about the needs or wants of Beryl is not shared adequately between care providers. Beryl has to "tell her story" many times to many different people. No one care provider (most particularly important, her GP) has adequate or timely access to a single comprehensive record of the all the care Beryl has received, nor has an oversight of all of Beryl's needs. Actions (or lack of them) in one part of the system drive demand and costs in another; for example if Beryl's cardio-vascular disease is poorly managed in the community, Beryl is likely to be admitted to hospital as an emergency.

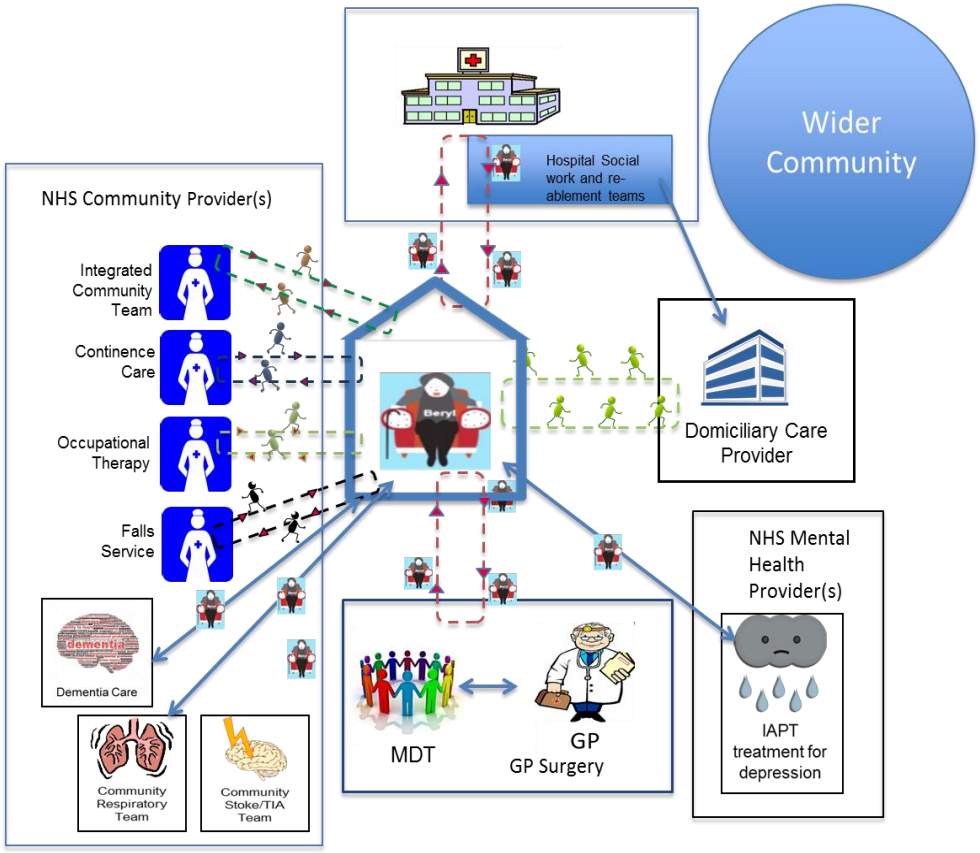
Inefficient

At an organisational level, staff may have to visit many different patients/clients across and beyond the Thurrock boundary, resulting in much time spent travelling between individual residents' homes rather than providing care. At a health and care system's level, multiple visits may be conducted by staff from different organisations to the same clients' home to undertake different tasks, when a single person could undertake all tasks more effectively.

Reactive not preventative

Each care provider delivers a specific intervention in reaction to Beryl's current situation. Insufficient consideration is given to any long term plan for Beryl that focuses on preventing her from deteriorating further. Self care does not feature highly enough in Beryl's long term care plan.

Figure 36



Biomedical and deficit based rather than person centred and asset based

Beryl's needs are determined separately by professionals based on their assessments of what she can't do or what is wrong with her. Care delivery focuses purely on "fixing" or managing Beryl's health and care deficits by doing things "to" Beryl. Beryl is a passive recipient of care. Insufficient consideration is given to Beryl as a person, what life she may want or what makes her happy. Options for Beryl gaining support from her wider community, (to address for example her isolation and loneliness) are widely ignored.

A better way for Beryl

The title for this chapter is taken from an observation made by a leader of one part of our local health care system who rightly suggested that instead of providing health and care services to residents from the starting point of current organisational forms or the deficits of the care recipient as organisations determine them, we should start from the point of view of those receiving services and ask the fundamental question ***"what does a good life look like for you?"***

7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing

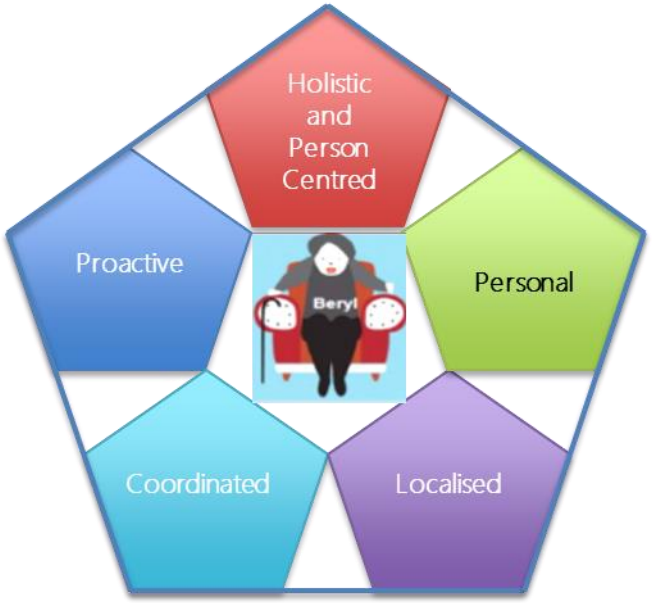
A Better Way for Beryl: Key Principles of a new model of integrated care

Addressing the challenges identified in figure X on the previous page requires fundamental reform of the way that health and care is organised at a local level. To achieve it requires a paradigm shift in thinking of those delivering health and care services, and may present a challenge to current established professional hierarchies. It is likely to require a new relationship between commissioners and providers, and between provider and provider, and potentially an entirely new provider landscape.

Such a level of system transformation will only be successful if there is 'buy in' a new vision for how health and care could be provided, across staff at all levels and throughout all organisations that make up our current health and care system; successful delivery will require co-design between commissioners, providers and residents. As such, this *Case for Change* document does not seek to specify in detail the precise organisational forms of a new health and care system, but sets out some high level principles centred around the needs of the care receiver, for a new model of care. We envisage that the detailed design work for realising this vision will take place in the *Integrated Models of Care* work stream and beyond it.

However, in order to address some of the issues being experienced by Beryl and the thousands like her receiving care in our current system, we propose that any new model of care needs to be based on the following five key principles:

The Five Pillars of a New Model of Care



1. Holistic and Person Centred

Too often, the care in the current system is determined by professionals and specified as a series of tasks. The new model of care needs to shift the focus of organisations from *"doing to"* to *"doing with"*. This requires a new relationship between care provider and care receiver based on empowerment and partnership. Fundamental to this new relationship is the opportunity for the care receiver to consider and specify "what a good life" means to them. It starts with a **single, common, comprehensive and holistic assessment** of their needs as *they* define them. Such an assessment needs to consider the individual in the context of their family, friends and community, rather than simply in the context of the physical functioning of their own body. Issues to be discussed and agreed with the individual in developing a care plan need to include:

- Physical health needs
- Mental and emotional wellbeing
- Functional ability
- Social health, social relationships, hobbies and interests
- Economic factors such as income, benefits and debt
- Educational factors and
- Cultural factors
- Housing
- Self care and empowerment

The single, comprehensive assessment needs to form a **single comprehensive agreed care plan** that all services work in partnership with the care receiver to deliver.

2. Personal

Figure X on page Y demonstrated the sheer number of different individuals that may be entering Beryl's home at any one time to deliver care "tasks". Even within a given category of care (for example domiciliary home care) different individuals may deliver the same type of task at different times. This situation is bad for both care receiver and care provider as there is little chance to form any kind of relationship or shared understanding of needs. From Beryl's point of view, care is provided by anonymous strangers to whom she constantly has to re-tell her "story"; from the care provider's point of view, care is provided "cold" to patients or clients whose needs they have little or no understanding of.

The new model of care needs to **limit the number of different people delivering care** to the resident to the absolute minimum and provide a **consistency in care relationship** between care giver and receiver. This will provide a more rewarding working environment for those providing care, and a more fulfilling and personal care experience for residents. It is also a more efficient way of delivering care as the needs of the resident will be known and understood by the individual or individuals delivering care to them. As such, opportunities for more holistic and preventative care will become available, and monitoring of changes in the health and wellbeing of residents become easier.

Personalised care is **also flexible care**. It represents a shift away from the current situation of delivering care as a set number of specific tasks, determined in advance and delivered in the same way each day, to one that adapts to the changing needs and wishes of the resident from day to day and week to week. It puts **the receiver of care in control** of the care they receive each day, and who provides it.

7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing

3. Localised

If personal, flexible and holistic care is to be provided, then care delivery needs to become much more localised. It will simply be impossible to deliver the rationalised number of care givers and flexible approach to care provided above, if care delivery is organised across a single large geographical footprint. The new model of care will require a number of **sub-borough or even sub-locality based wellbeing teams,** with **fewer staff members** in each team, **and each team member up-skilled** to undertake a more diverse range of tasks than at present. For example domiciliary care workers could be trained to undertake clinical bio-marker monitoring or routine clinical tasks such as HCA tasks – BPs, urinalysis, phlebotomy, peak flow for COPD, wound care. Stronger relationship with the GP to save the GP visiting. Current carer relationship with GP doesn't exist.

In order to gain maximum efficiency, we envisage localised wellbeing teams to be more **self-directed and self managing**. We will seeks to **eliminate any unnecessary administrative** burden on front line staff that comes from the current "KPI heavy" commissioner-provider relationship, and release time for resident facing care. Although there are some specialist services where small numbers of patients/clients accessing them require provision only at Borough wide level or above, we will seek to re-design and re-provide services on default locality or sub-locality footprint, unless there are clear reasons why this is not possible.

Localised wellbeing teams are also **holistic** teams. They operate within the context of a **wider knowledge and understanding of the capacity, skills, and assets in their locality**. They will capitalise on these community assets and provide a link between the resident and their community, making it easier for the goals set out in the resident's care plan to be realised.

An example of this approach is shown in this You-Tube Video.

4. Coordinated

Although our new model of care aims to deliver services through small self-directed teams of multi-skilled professionals, we recognise in the case of residents like Beryl, the sheer number of different services they may require make this challenging. However we must move from the current situation of multiple task oriented services working directly with Beryl and in isolation of each other, to a single coordinated approach.

Our New Model of Care will therefore have a **single named accountable 'case manager'** assigned to Beryl and every other resident with complex needs. They will act as **the single point of contact** for Beryl and her GP, and will coordinate the care activities of all other health and care professionals in order to deliver the single care plan agreed with the resident as part of the single holistic assessment process. The case manager will be **responsible for maintaining the single common comprehensive holistic assessment and single agreed care plan, that all care providers will work to.**

The case manager **will "broker" care from all other parts of health and care system** on behalf of the Beryl and will be responsible for keeping her single shared care plan up to date. This new care coordination approach will ensure that activity is not duplicated between different parts of the system, and that everyone involved in delivering Beryl's care is sighted on every other part of it.

The case manager will play an active part in surgery based multi-disciplinary teams

5. Proactive

Our new model of care fundamentally shifts the emphasis of care from being reactive to being proactive. Care delivery moves from individual organisations and professionals completed set tasks specified in advance to one of contributing to achieving the goals set out in a single shared care plan based on a single common holistic assessment which **aims to deliver *the best life possible* as defined by the resident**. This will be achieved by **professionals working as equal partners with the resident** and the wider assets within their community.

We will also deliver proactive care by effective case finding of residents most likely to benefit from this new approach. Too often the current system of care delivery waits until a resident is in crisis or suffers a serious health event and is admitted to hospital, before providing a service. For example, in 2015/16 the most common route of entry to services commissioned or provided by Thurrock Council Adult Social Care was through the Basildon Hospital Social Work Team, following a hospital admission.

By using our new Integrated Data Solution and linked patient/client records from MedeAnalytics (see page 39), we **will develop more effective risk stratisfaction tools that will allow us to identify the characteristics of specific cohorts of residents at greatest risk of adverse health events, and intervene earlier** with our new integrated model of care. We will work with each GP surgery in the Tilbury and Chadwell network to ensure a systematic process of 'case finding' of patients who could benefit from care coordination is implemented using reports produced by the Healthcare Public Health Team in MedeAnalytics. We will also ensure that every GP surgery is supported to have an **effective Multi-disciplinary team** that meets regularly to review patient cohorts deemed to be most at risk and who could most benefit from our new Model of Care.

Our new Integrated Locality Wellbeing Teams will also play a key role in identifying vulnerable residents within their locality or sub-locality as a further mechanism for effective, proactive case finding.

7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing

Community Wellbeing Teams

In order to achieve our vision of the five pillars of care we will implement new sub-locality "wellbeing teams". Whilst the precise make up of these teams is beyond the scope of this document and will be determined by stakeholders in the Integrated Workforce work stream of the New Models of Care programme, as a minimum they will include a new "Wellbeing worker" role who will be trained to undertake the following:

- Replace the domiciliary care provider function and provide personal care to residents
- Undertake monitoring of clinical biomarkers and provide some routine healthcare procedures that a traditional healthcare assistant might currently deliver, for example undertake blood pressure monitoring, wound care, phlebotomy or urinalysis. In doing so, they will provide a key link between homecare and the GP surgery
- Be partly 'outward facing' and have a good understanding of the wider assets within the resident's community, and be responsible for linking the resident into these in order to deliver "a good life", promote self care and maximise opportunities for prevention.

In short, the new "Wellbeing Worker" will combine elements of the traditional domiciliary homecare worker, HCA and social prescriber/Local Area Coordinator.

We envisage wellbeing workers to be matched with residents depending on the needs and wishes of the resident as identified and captured in the single holistic assessment, with a view to developing a longer term one to one relationship with the resident. This will be both rewarding for the resident in terms of consistency of individual assisting them with daily living and for the wellbeing worker who will be able to use their individual skills, interests and talents to enrich the lives of a specific group of residents. The longer term consistent care relationship will also maximise opportunities for monitoring and prevention. The new "Wellbeing worker" role will also give greater status to traditional domiciliary care roles, provide opportunities for training and career development and as such, should result in a more sustainable and stable ASC homecare provision.

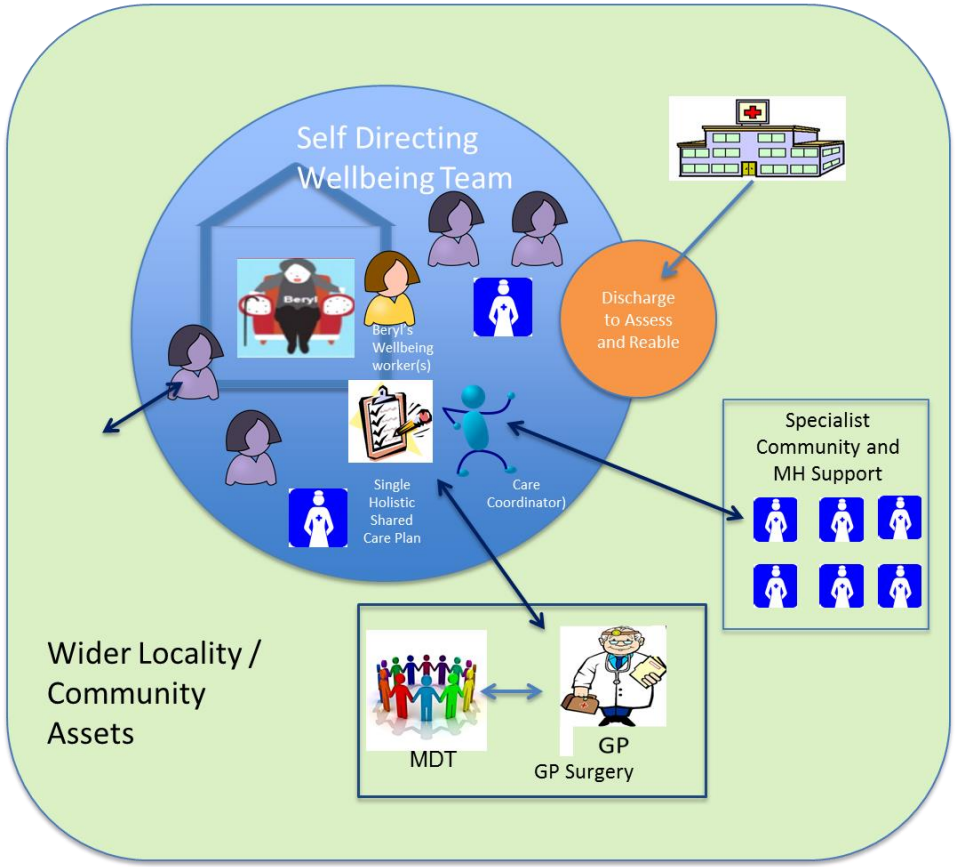
Community Wellbeing Teams may also include other community healthcare or GP surgery clinical team members, together with care coordinators. They will be absolutely critical members of future surgery based Multidisciplinary Teams. The Community Wellbeing Team, through the care coordinator will broker additional specialist clinical care from current providers where necessary to meet the resident's single shared care plan.

Community Wellbeing Teams will be sub-locality focussed and as self-directing as possible in order to maximise direct client contact time, minimise travel and gain the greatest possible understanding of the client in the context of his or her wider community. Evidence from similar models of self-directing teams e.g. Buurtzorg suggest that the team should be no-greater than 12 team members in size.

The Integrated Workforce work stream may also wish to consider adding additional functions into the wellbeing team or working alongside it, including a "discharge to assess" model, where patients are discharged back into the community and re-abled to their maximum ability before their long term single holistic assessment, single shared care plan and on-going community support it agreed.

This new model of care, may look something like figure 37

Figure 37



7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing

Summary and Key Actions

- We will assess all residents' needs once using a single, common, holistic assessment tool in partnership with the resident. The tool will consider and identify the physical, emotional, mental, functional, educational, economic, cultural, housing and self care needs of the resident, in the context of their wider family and community.
- We will develop a single, comprehensive shared care plan based on the assessment that all care providers will work to.

- We will rationalise the number of individuals providing care to the resident to the absolute minimum and up-skill the existing health and care workforce to deliver a wider range of health and care tasks.
- We will concentrate on having fewer people providing longer term care, and focus on developing consistent care relationships
- We will ensure that care is provided in a way that is flexible enough to change to meet the changing needs and wants of the resident on a day to day and week to week basis.

- We will create localised, self-directing community health and wellbeing teams at a sub-locality level to act as the primary interface between the resident and health and care services.
- We will create a new "Wellbeing Worker" role within these teams who will be responsible for providing traditional domiciliary home care, routine clinical monitoring and procedures traditionally undertaken by a Health Care Assistant, and providing a link between the resident and assets and capacity within his or her community
- We will develop a new relationship between commissioners and these teams, based on high level population health outcomes and the absolute minimum level of KPIs and administration

- We will introduce "care coordination" across all current providers of health and care, with a single named accountable professional responsible for brokering care for the resident from the current providers, as determined by their single comprehensive shared care plan, and acting as a single point of contact for the resident and their GP.
- We will ensure effective Multi-Disciplinary Teams operate within each GP surgery within the Tilbury and Chadwell network, and that all key professionals involved in the care of residents are in attendance.

- We will shift the relationship between care provider and receiver from one that reacts to their current health status to one that empowers them to remain well and live the best life possible.
- We will implement proactive "case finding" mechanisms including use of risk stratification tools and systematic clinical and wellbeing worker judgement to identify residents at risk of adverse health events who would most benefit from care coordination, and intervene earlier

Chapter 8: *Making it happen*

Implementing and Evaluating our New Model of Care

8. Implementing and Evaluating our New Model of Care

8.1 Agreed Governance Structure

The Governance Structure shown in figure 38 has been agreed by all key stakeholders and has been set up.

A Thurrock Accountable Care Partnership Executive is meeting regularly and will be responsible for governance in terms finance, performance and future commissioning/provider contractual relationships across Thurrock. A Tilbury and Chadwell New Models of Care Steering Group will take over all responsibility for delivery of the New Model of Care as described within this document and will report to the ACP Executive Group. Terms of reference for this group are currently in development.

Below this, three working groups will be responsible for developing and delivering work programmes relating to the three key chapters in this document (5,6 and 7), and focusing on

- Improving and Enhancing the capacity and capability of Primary Care
- Improving the Diagnosis and Treatment of people with Long Term Conditions (*Find the missing thousands, treat the missing hundreds)*
- Delivering Proactive, Integrated Community Health and Wellbeing

The role of each working group will be to convert the high level "key actions" set out in each chapter into a detailed action plan, and then manage the implementation of that plan, transforming care in Tilbury and Chadwell around the three key topics set out in each chapter. Progress against these action plans will be monitored at the Tilbury and Chadwell Project Steering Group and ultimately the Thurrock ACP Executive

8.2 Evaluating Impact of the New Model of Care

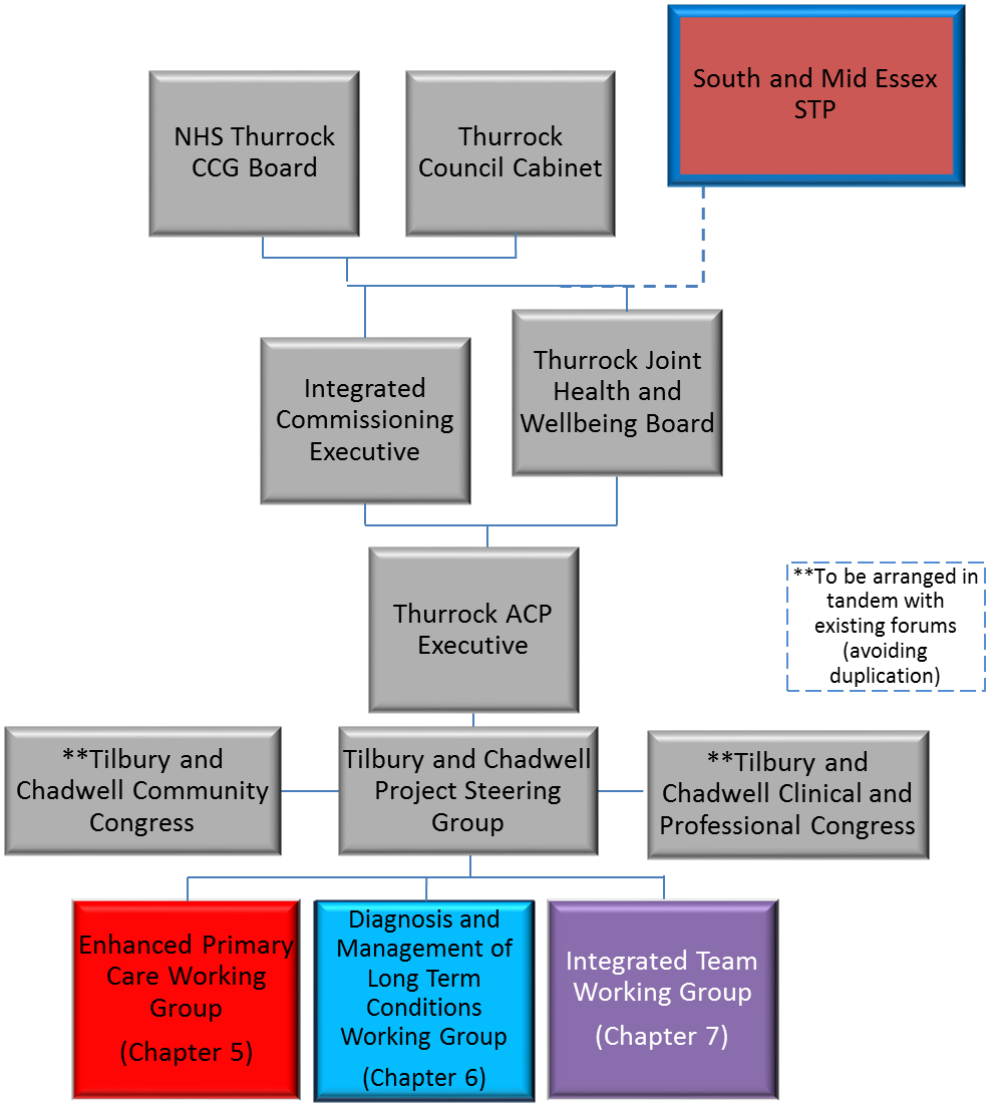
The key purpose of piloting the New Model of Care in Tilbury and Chadwell is to demonstrate "proof of concept", with a view to replicating it across Thurrock (and beyond) if shown to be successful. As such, building robust evaluation into the programme of work both in terms of an initial baseline of health and care activity and outcomes, and the impact of the work programme on that activity and outcomes will be key.

Overall responsibility for evaluation will rest with Thurrock Healthcare Public Health Team, with additional support provided through the Consultant in Public Health from Public Health England (East of England). However agreeing what indicators will be base-lined and measured needs to be one of the first tasks undertaken by each of the three working groups. By implementing the key actions set out in this document, we expect the New Model of Care to demonstrate sustainability in terms of reduced activity and cost in secondary health care (for example through reduced hospital admissions and A&E attendances) and in Adult Social Care (for example through reduced numbers of residents entering residential care). It is therefore essential that activity and cost in the cohorts of residents impacted by the New Model of Care are base-lined and monitored in detail.

We will produce an evaluation framework for the New Model of Care by December 2017 which lists all indicators agreed by the three working groups, together with agreed levels of investment required to implement the key actions, and expected impacts in terms of population health and financial return.

Agreed Governance Structure

Figure 38



8.3 Summary of Key Actions for each working group

The follow sections summarise the proposed key actions for each of the three working groups, as set out in Chapters 5,6 and 7 together with work to date on their potential impacts both in terms of population health and system sustainability. They have been produced as a starting point from which each working group can develop a more detailed action plan and evaluation framework.

8.3.1 Enhance the capacity and capability of Primary Care

Key Action	Investment Required	Investment Source	Impact	Lead(s)
Recruit a mixed skill workforce within a shared Enhanced Primary Care Team in Tilbury and Chadwell including practice based Pharmacists, Physio-therapists, Physicians Assistants, Wellbeing Workers, Nurse Practitioners and social prescribers	£620,552	From "£3 per head" GP Transformation funding	An additional 1495 surgery appointments per week Potential of up to £500K savings from A&E Category 1 and 2 tarrif if increase in Primary Care appointments mitigates against A&E use for non-emergency clinical conditions	GP Partners Area Operations Manager, College Health Ltd, Head of Primary Care, Thurrock CCG
Roll out social prescribing at scale across all GP practices in Tilbury and Chadwell and evaluate impact	£140,000	Better Care Fund	Contributes to the above	Director of Transformation, Thurrock CCG GP Partners Thurrock CVS
Strengthen links between GP surgeries and services that address the wider determinants of health such as housing, debt and employment advise			Contributes to the above	Healthcare Public Health Improvement Managers Relevant Provider service leads
Design and implement a shared "front door" patient triage programme that assess patient need and directs them to the most appropriate member of the Enhanced Primary Care Team without necessarily having to see a GP first		From existing resources	Contributes to the above	GP Partners Area Operations Manager, College Health Head of Primary Care, Thurrock CCG
Implement WebGP		Existing external grant	Contributes to the above	GP Partners Area Operations Manager, College Health Director of Transformation, Thurrock CCG
Implement a new network based model of Primary Care in Tilbury and Chadwell, including shared 'back office' functions, in order to build surgery resilience and realise the benefits to both workforce and residents of delivering Primary Care 'at scale'		From existing resources	Increased surgery resilience Improved economies of scale Systems Partnership working Improved clinical skill mix Improved opportunities for staff development	GP Partners Area Operations Manager, College Health Primary Care Development Team, Thurrock CCG Director of Transformation, Thurrock CCG
Strengthen and develop Patient Participation Groups	£40,000	Public Health Grant		Thurrock Healthwatch Healthcare Public Health Team
Embed Healthy Lifestyle Service workers within shared Enhanced Primary Care Team and ensure systematic offer of smoking cessation service to all patients recorded as smokers	£100,000	Public Health Grant	Reduced prevalence of smoking within population. Increased number of smoking quit attempts	Consultant in Public Health GP Partners Area Operations Manager College Health LTd
Embed Healthy Lifestyle Programmes into Clinical Care Pathways in Community and Secondary Care			Reduced prevalence of smoking within population. Increased number of smoking quit attempts	Consultant in Public Health

8.3 Summary of Key Actions for each working group

8.3.2 Improve the diagnosis and management of long term conditions

Key Action	Investment Required	Investment Source	Impact	Lead(s)
Target NHS Health check invitations to those most likely to be at risk of undiagnosed cardio-vascular disease, through development of SystmOne reports that make use of the QRISK2 algorithm	£39,000	Public Health Grant	An additional 94, 40 and 22 Hypertension, CHD and Diabetes diagnoses respectively Reduction in stroke unplanned care admissions and ASC packages attributable to stroke £650K NHS treatment and ASC costs avoided over three years	Healthcare Public Health Team
Improve the coverage of NHS Health checks through use of social marketing research and tailored invitation letters	As above	Public Health Grant	As above	Consultant in Public Health Healthcare Public Health Managers
Implement a systematic Hypertension Case Finding Programme	£138,000	Public Health Grant Better Care Fund	£1.846M through reduction in Healthcare and ASC costs attributable to stroke	Healthcare Public Health Team
Develop SystmOne reports that highlight patients with long term physical health conditions who have not been screened for depression			Potential up to £3.5M	Healthcare Public Health Team in collaboration with Southend Public Health Team
Embed depression screening into the work of front line staff treating patients with long term conditions and adult social care staff				Healthcare Public Health Team
	£10,000	Public Health Grant	An additional 10 diagnoses of diabetes. Net saving of £26,000 in avoided treatment costs from diabetes complications	Healthcare Public Health Team Local dental practices
Procure and implement the MedeAnalytics Integrated Data Solution, linking Primary, Community, Mental Health, Secondary Care and Adult Social Care records at patient/client level	£110,000	Better Care Fund		Strategic Lead, Healthcare Public Health
Assist surgeries to "find the missing thousands" by constructing and running automated reports through MedeAnalytics/SystmOne that identify patients who have risk factors or are on medication for specific long term conditions but have not been added the surgery's Long Term Condition Disease Register	As above	As above	Increase in undiagnosed hypertension, CHD, AF, HF, TIA and diabetes. Unable to quantify precisely	Healthcare Public Health Team GP Practice Managers GP Partners

8.3.2 Improve the diagnosis and management of long term conditions (continued)

Key Action	Investment Required	Investment Source	Impact	Lead(s)
Implement a Stretched QOF programme for all surgeries in Tilbury and Chadwell on Long Term Conditions Indicators to ensure funding is available for practices to treat 100% of patients on QOF disease registers	£64,770	Better Care Fund	Up to 110 stokes prevented over three years £554,195 NHS Treatment savings £565,191 ASC savings	Strategic Lead, Healthcare Public Health GP Practice Managers GP Partners
Improve the coverage of flu vaccination in at risk groups	£4,000	Better Care Fund	Up to 94 hospital treatment spells related to influenza Up to £330,553 NHS Treatment cost savings	Healthcare Public Health Team GP Practice Clinical Team GP Practice Managers
Identify patients who need to be reviewed under QOF for long term conditions and reduce exception reporting through use of the new Integrated Data Solution (MedeAnalytics)	Existing staff resources		Improved surgery capability to manage patients with existing LTCs	Healthcare Public Health Team GP Practice Managers GP Partners NELFT LTC Clinical Services
Develop a systematic centralised patient call-recall mechanism that automates and manages appointments for patients requiring LTC review	Existing staff resources		Improved surgery capability to manage patients with existing LTCs	Healthcare Public Health Team GP Practice Managers NELFT LTC Clinical Services
Roll out the LTC profile card to support practice managers and the Enhanced Surgery Clinical Teams to develop and implement action plans to imprive clinical quality and patient satisfaction relating to LTC management	Existing staff resources	Public Health Grant	Improved surgery capability to manage patients with existing LTCs	Healthcare Public Health Team Surgery Clinical and Practice Management Team
Integrated the current disease specific physical LTC clinics into a single integrated LTC management service based within the shared Enhanced Primary Care Clinical Team, in order to strengthen arrangements between Primary and Community Health Care and Provide a Single one-stop LTC management service for patients	Existing staff resources plus £100K for additional LTC nursing support	Public Health Grant	Improved surgery capability to manage patients with existing LTCs Reduced numbers of serious health events including strokes, COPD exacerbations Reduced numbers of unplanned care admissions and demand on secondary healthcare and adult social care services	Healthcare Public Health Team Surgery clinical teams GP Practice Managers NELFT LTC Clinical Services
Integrate IAPT service provision within the Enhanced Primary Care clinical team to increase the number of patients with depression and anxiety entering treatment and to provide a single integrated service that can treat physical and mental ill health	Existing staff resources		Improved surgery capability to manage patients with existing LTCs Reduced numbers of serious health events including strokes, COPD exacerbations Reduced numbers of unplanned care admissions and demand on secondary healthcare and adult social care services	Healthcare Public Health Team Surgery clinical teams GP Practice Managers NELFT LTC Clinical Services IAPT

8.3.3 Proactive, Integrated Community Health and Wellbeing

Page X summarises the key actions of this work stream, based upon the proposed "five pillars of care".

It is difficult to quantify the impact in terms of activity and cost accurately of this integrated care coordination approach, but best evidence suggests it can reduce health and care costs by at least 20%. If this were realised in Tilbury and Chadwell it would represent a potential saving of £1.34M in healthcare costs alone.

References

[1] Baird, B. et. al. Understanding pressures in general practice. Kings Fund. May 2016

[2] Primary Care Foundation and NHS Alliance, Making Time in General Practice, October 2015

3 Understanding Pressures in General Practice. Kings Fund, 2015

[4] Session 3328: "Loneliness: A Growing Public Health Threat," Plenary, Saturday, Aug. 5, 3-3:50 p.m. EDT, Room 151A, Street Level, Walter E. Washington Convention Center, 801 Mount Vernon Pl., Washington, D.C.

[5] Marmot M et. al., *Fair Society, Healthy Lives. The Marmot Review.* 2012. Strategic Review of Health Inequalities in England post 2010.

[6] *Ten Things You Need to Know about Long-term Conditions.* Department of Health website. Available at: www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthingsyouneedtoknow/index.htm (accessed on 5 December 2011). Department of Health, 2011.

[7] Director of Public Health et al. Annual Report of the Director of Public Health. A Sustainable Health and Social Care System for Thurrock. s.l. : Thurrock Council, 2016. https://www.thurrock.gov.uk/sites/default/files/assets/documents/annual_health_report_2016.pdf

[8.] NICE (2012) Type 2 diabetes: prevention in people at high risk Public Health Guideline (PH38) https://www.nice.org.uk/guidance/ph38

[9]. European Federation of Periodontology (2012) The EFP Manifesto: Perio and General Health http://www.efp.org/efp-manifesto/manifesto.html

[10.] Chapple et al (2013) Diabetes and periodontal diseases: consensus report of the Joint EFP/AAP Workshop on Periodontitis and Systemic Diseases J Clinical Perio. https://www.ncbi.nlm.nih.gov/pubmed/23631572