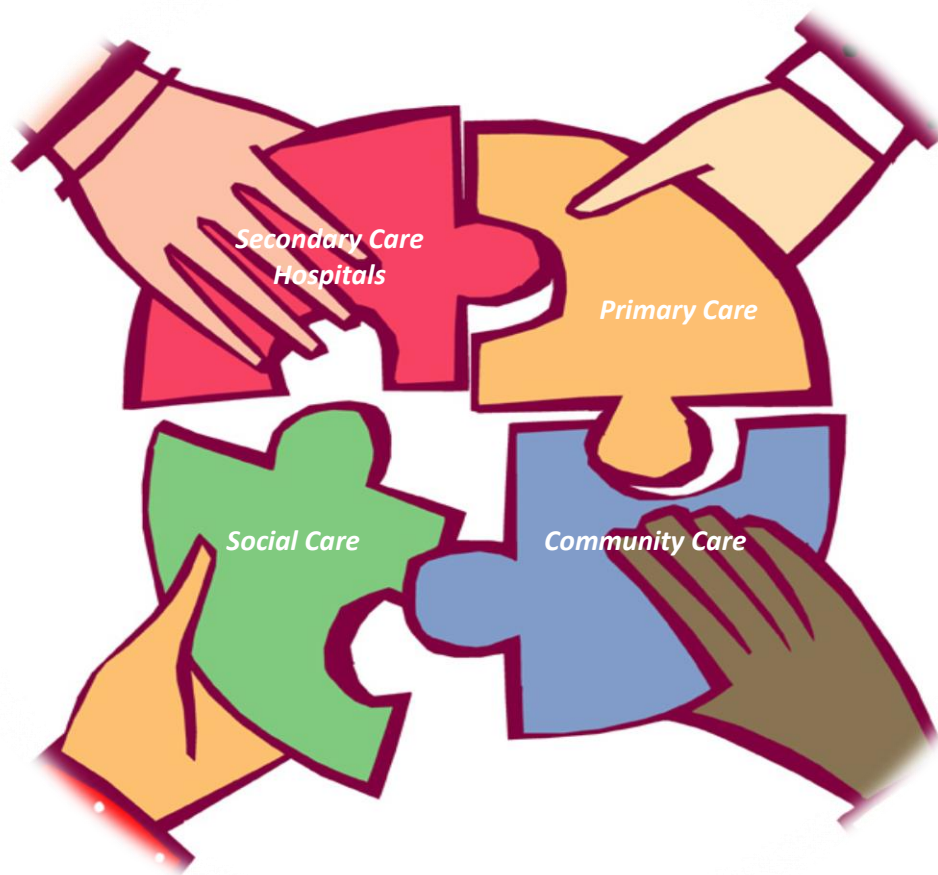


Annual Report of the Director of Public Health: 2016
Executive Summary

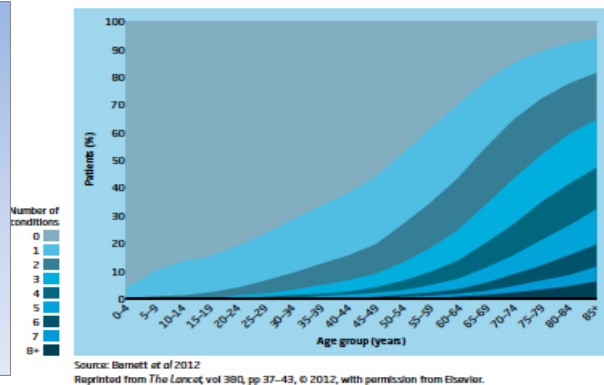
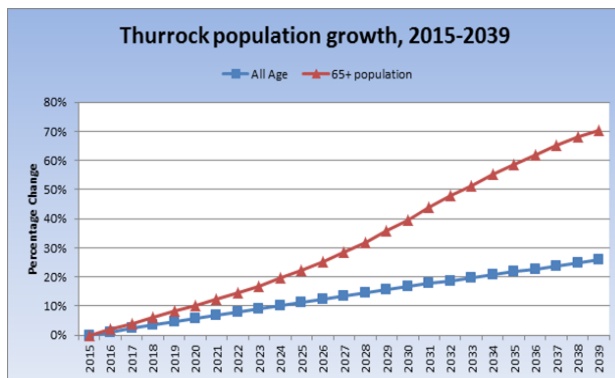
**A Sustainable Health and Social
Care System for Thurrock**



EXECUTIVE SUMMARY OF THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH, 2016

Introduction

As a population, we are living longer but not necessarily healthier lives. The rate of growth in the population aged 65+ locally is increasing at a rate that far exceeds that of the general population (chart 1 below). In addition, older patients are more likely to develop multiple long term conditions (chart 2 below), 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.



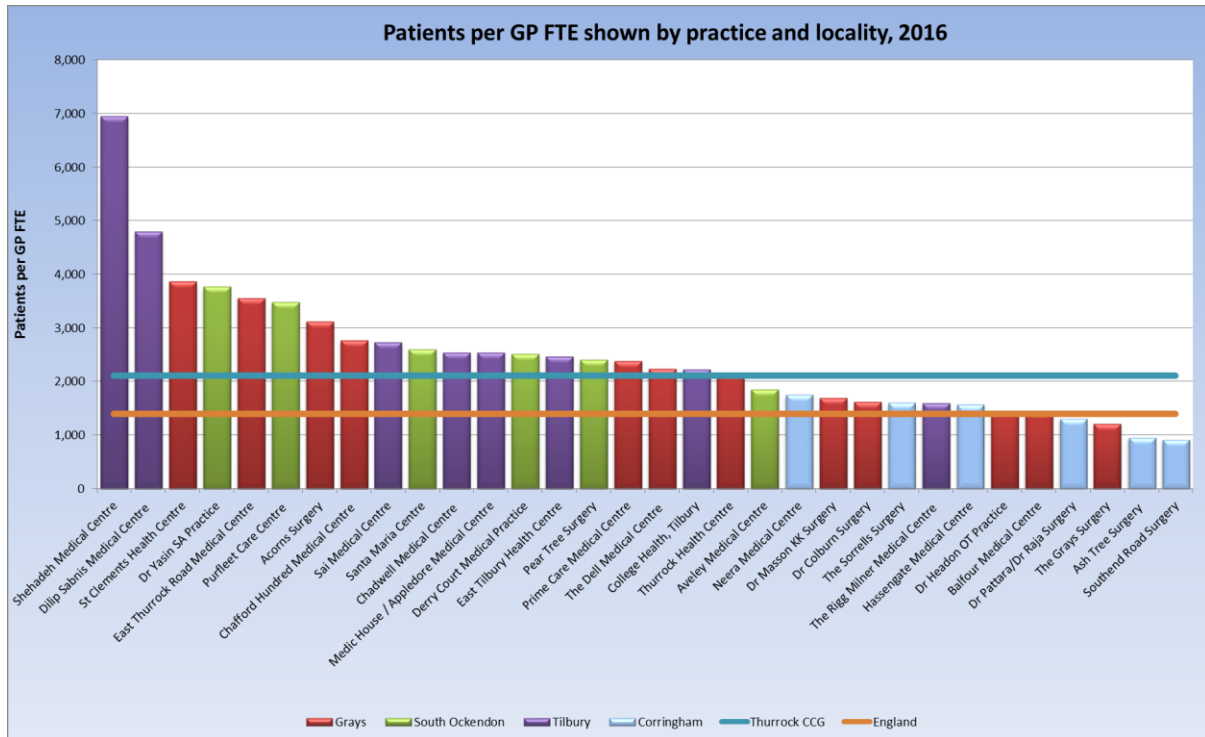
Source: Bennett et al 2012
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Currently approximately 70% of all health and social care funding is now spent on treating and caring for people with long term conditions. Effective demand management to create an operationally and sustainable Adult Health and Social Care System requires a system response. Actions by one organisation alone cannot achieve system sustainability as actions taken in Primary and Community Care influence demand on secondary care, and all three influence demand on Adult Social Care. By setting out the current state of demand on the health and social care system, along with the key influences on activity, this report aims to understand increase understanding of these drivers and provides a list of evidence-based recommendations for effective mechanisms to reduce the growth in demand and ensure the ongoing sustainability of our local health and social care economy. It has been written both to inform local Health and Social Care strategy through the Thurrock Health and Wellbeing Board, and more widely to inform the prevention section of the South and Mid Essex Sustainability and Transformation Plan. Mental Health has been excluded from this report as it is subject to a separate Joint Strategic Needs Assessment ongoing at present.

The report is divided into seven key sections:

1. Primary and Community Care

Section 1 describes a detailed account of what is currently happening in primary and community care with relation to long term condition management. It outlines the inequalities that many Thurrock residents face in accessing a GP or a nurse – Thurrock is the fourth-most under-doctored CCG in the country, and all but five GP practices have a ratio of patients: FTE GPs that is above the England mean. (see figure overleaf).



The *Inverse Care Law* is a significant issue at GP practice level within Thurrock; namely that populations with the greatest health needs are more likely to get the poorest health care. There is a strong positive association between levels of under-doctoring within the Borough and levels of deprivation.

The report also quantifies a rather large expected number of patients with undiagnosed long term conditions such as Stroke, Hypertension, CHD and COPD, which could result in increased unplanned use of hospital and social care services that could have been prevented with earlier detection. This can be seen in the table below.

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

In addition, there is wide variation in the quality of clinical management of long term conditions at GP practice level, with many patients not receiving good quality care. This could include processes such as standard reviews not being undertaken, ineffective blood pressure control, flu vaccinations in vulnerable patients not being undertaken, and lack of onward referrals when identified to be at risk of further deterioration.

The following 12 practices have been identified for further support to improve quality of care across all long term conditions:

- Dr Mukhopadhyay PK PRACT
- Dr Suntharalingam R PRACT
- Chadwell MC
- Sai MC
- Balfour MC
- Aveley MC
- Neera MC
- Pear Tree SURG
- Medic House
- Dr Masson KK SURG
- St Clements HC
- Purfleet Care Centre

Key Recommendations

A. IMPROVE CAPACITY WITHIN PRIMARY CARE

There is an urgent need to address capacity within Primary Care within Thurrock. Levels of under-doctoring and under-nursing are leading to poor quality long term condition management and driving unnecessary emergency hospital admissions and adverse health events for patients, with unnecessary costs.

Thurrock CCG in association with NHS England and Thurrock Council Public Health Team should seek to address this by:

A1) Expediting the building of the four planned Integrated Healthy Living Centres

A2) Working with GP practices to seek to spread best practice in terms of mixed practice workforce models (as set out in section 7 of the main report)

B. IMPROVE CASE FINDING OF UNDIAGNOSED PATIENTS WITH LONG TERM CONDITIONS

There is significant variation between GP practice populations in Thurrock with regard to the percentage of patients with undiagnosed long term conditions. These cohorts of our residents are unaware and not in receipt of potentially life-saving clinical interventions and are at risk of serious adverse health events, preventable hospital admissions and preventable entry into the Adult Social Care System.

Thurrock CCG, in association with the Thurrock Public Health Team and local GP practices should:

B1) Implement a hypertension case finding programme and systematise the measurement of blood pressure across a range of front line providers, both clinical, workplace and community.

B2) Increase uptake of the NHS Health Checks programme with better targeting at those most at risk

B3) Commission a Senior Health Checks Programme with a view to increasing case finding of patients with other serious LTCs

B4) Roll out the diabetes secondary prevention programme

Whilst the full list for each heading can be found in the report, some of the main recommendations improving Primary Care Capacity and Long Term Condition Management are:

C. IMPROVE LONG TERM CONDITION MANAGEMENT WITHIN GP PRACTICES AND COMMUNITY SERVICES

There is an unacceptable level of variation between how GP practices manage long term conditions of their patients. There is clear evidence that this is leading to unnecessary adverse health events for patients, avoidable emergency hospital admissions and driving demand in Adult Social Care Budgets. There are also inadequate levels of referral of patients with respiratory disease such as COPD to commissioned community health services such as Pulmonary Rehabilitation and the NELFT Respiratory Team designed to help manage these conditions. This is driving unnecessary cost within the system and poorer outcomes for patients.

Thurrock CCG in association with the Thurrock Public Health Team and GP practices should:

C1) Implement the GP practice Long Term Conditions Management Scorecard as set out in the Health and Wellbeing Strategy

C2) For Stroke patients:

- Improve the clinical management of stroke patients in Primary Care to ensure all Stroke patients have a recorded blood pressure within the previous 12 months and as many as possible have it controlled to 150/90mmHg or less.
- Improve the clinical management of stroke patients in Primary Care to ensure sure that all patients with a previous non-haemorrhagic stroke or history of TIA, have been prescribed an anti-coagulate or anti-platelet agent, unless there is a clinical contra-indication
- Ensure that all patients on the GP practice stroke/TIA register have been offered and are encouraged to have an influenza vaccination. Patients eligible for but who haven't received these interventions can be identified with the support of Public Health System One reports if necessary.

C3) For Hypertensive patients:

- Commission a programme of work to case find patients with undiagnosed hypertension
- Ensure all Hypertensive patients have a recorded blood pressure within the previous 12 months and controlled to 150/90mmHg or less. This can be supported by further analyses undertaken by the Public Health team with regard to hypertensive prescribing and production of bespoke System One reports. It will also be monitored via the future long term conditions scorecard.

C4) For CHD patients:

- Increase the number of patients with CHD who have their blood pressure controlled to 150/90mmHg or less. This can be supported by further analyses undertaken by the Public Health team with regard to hypertensive prescribing and production of bespoke System One reports. It will also be monitored via the future long term conditions scorecard.
- Ensure that all patients with CHD have been offered and encouraged to take an anti-coagulant or anti-platelet therapy in the previous 12 months.
- Ensure that all patients with a history of Myocardial Infarction are treated with ACE-1, ARB (if ACE-1 intolerant), aspirin or an alternative anti-platelet therapy.

C5) For AF patients:

- Ensure that all patients diagnosed with Atrial Fibrillation are regularly assessed for stroke risk using a CHADS2 score assessment tool

- Urgently identify and review all patients with AF who require anti-coagulation or anti-platelet medication and have not been prescribed it. This will be monitored via the future long term conditions scorecard.
- Targeted support to the practices identified to fall within the bottom quartile of practices across England for clinical management of AF (listed within the report).

C6) For patients with respiratory conditions:

- All COPD patients to be reviewed at least once per year and record an FEV1 score.
- All asthma patients to be reviewed once a year including an assessment of asthma control.
- GP practices/NELFT respiratory team to measure and record oxygen saturation value annually for all patients with an MRC score >3
- Increased influenza vaccination coverage in respiratory patients via proactive invitation from GP practices and communications support from Public Health
- Further research into the low referral rates to NELFT community respiratory service and the Pulmonary Rehabilitation service, and support to increase these.

C7) For patients with Diabetes:

- Ensure all patients with diabetes that are not exception reported receive the 10 clinical interventions recommended by NICE. This can be supported by bespoke System One reports created by Public Health if required.
- Public Health to undertake further analyses by way of a 'deep dive' into variation amongst patients receiving these care processes and make more detailed recommendations.
- Encourage uptake of the SWEET Basics course to support self-management amongst newly-diagnosed Diabetes patients.

2. A & E Attendances

Section 2 sets out a picture of A&E activity in Thurrock patients. In 2014/15 there were 59,675 A&E attendances for Thurrock patients, costing almost £6 million. A large proportion of these could hypothetically have had their needs met elsewhere had the facilities been available (42%), or received no significant treatment and therefore perhaps did not need to be there at all (41%). The table below quantifies the numbers of appointments and associated costs, and the excess cost associated with treating these patients in A&E rather than elsewhere – thereby showing the savings to be made by treating these patients in primary or community care.

Category of A&E attendance	Number of A&E Attendances from Thurrock patients (2014/15)	Average cost of A&E attendance per patient	Total cost of treatment in A&E	Estimated cost of the same treatment in a Primary or Community Care setting at £31.50 per patient	NET Excess cost of treating patients in A&E compared to Primary/Community Care
No investigation and no treatment	24,409	£65.62	£1,601,718.58	£768,883.50	£832,835.08
Cat 1 Investigation with Cat 1-2 treatment	7636	£121.22	£925,635.92	£240,534	£685,101.92
TOTALS					£1,517,937.00

Local modelling work found that reducing inappropriate A&E attendances in our own population to rates experienced within the nearby population of Mid Essex CCG would lead to a reduction of 24,074 A & E attendances and a cost saving of £2,696,288.

Key Recommendations

Recommendations included in the report to reduce inappropriate A&E attendances included:

D1) Triage at the front door of A&E is strengthened to deflect this cohort of patients to more appropriate community treatment provision (where available).

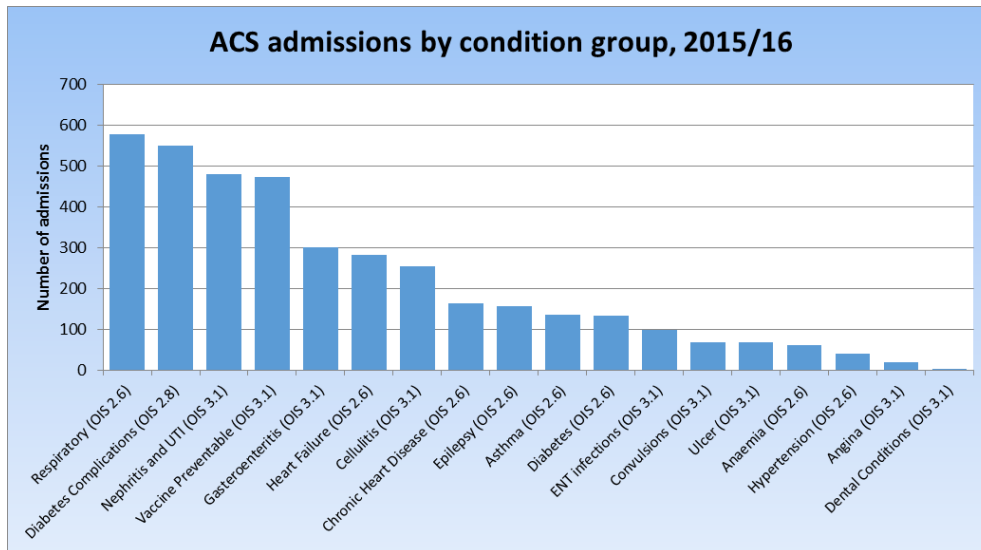
D2) Further investigate practice at Mid-Essex CCG, where inappropriate A&E attendances are significantly lower and implement findings locally if applicable.

D3) Undertake further analyses of the interface between A&E and the Essex Ambulance Service with a view to understanding and recommending appropriate actions to prevent inappropriate A&E conveyances by ambulance.

D4) Developing a 'systems wide response' and associated business case to reinvest excess secondary care costs in community and Primary Care capacity

3. Emergency Admissions

Section 3 looks at emergency admissions, particularly for chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions. These are known as Ambulatory Care Sensitive conditions, and examples include COPD, Diabetes and Heart Failure.



In 2015/16 there were 3,869 of these admissions, with the most common conditions being respiratory, diabetes complications, nephritis and urinary tract infections, and vaccine-preventable. This can be seen in this figure:

We have built four multiple regression statistical models for Respiratory Conditions, Stroke, Hypertension and Coronary Heart Disease/Heart Failure, that identify the key variables that increase the likelihood of emergency hospital admissions for these conditions, and quantify the impact of each variable. Addressing these variables (the underlying causes that are most likely to lead to an emergency hospital admission for respiratory conditions, strokes, high blood pressure and CHD/HF will reduce unnecessary hospital admissions, improve public health and save money.

Key Recommendations

Inadequate Primary Care capacity and variable long term condition management within the community is driving significant unnecessary demand and cost in terms of avoidable hospital admissions and entry into the Adult Social Care system. Implementing the recommendations in sections 1 to 4 of the report will reduce this. In addition to these previous recommendations, we recommend:

E1) Developing a 'systems wide response' and associated business case to reinvest excess secondary care costs relating to avoidable hospital admissions in tertiary primary and community prevention programmes.

E2) For ambulatory care sensitive conditions generally, we recommend:

- Further investigation at the GP practices with the highest admission rates [Purfleet Care Centre, Thurrock Health Centre, Chadwell Medical Centre and Dr Devaraja]

- Further analyses by the Public Health team and inclusion of outputs within the future Primary Care Long Term Condition Scorecard
- Encouragement of sharing of best practice with regard to clinical management of ambulatory care sensitive conditions.

E3) To reduce Stroke admissions:

- Redesign and procurement of a healthy lifestyle service
- Support for a whole system approach to reduce obesity prevalence
- Support more patients with effective blood pressure control (e.g. via further analyses and the creation of bespoke SystemOne reports by the Public Health team, or the sharing of best practice between clinicians)

E4) To reduce COPD admissions

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

E6) To reduce Coronary Heart Disease/Heart Failure admissions:

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

4. Delayed Transfers of Care

Section 4 looks at delayed transfers of care, which occur when an adult inpatient in hospital is ready to go home or move to a less acute stage of care but is prevented from doing so. These are problematic as they reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients. Of the 1,844 Delayed Days in Thurrock in 2015/16, 1,373 (74.46%) of these were coded as the responsibility of the NHS and 419 (22.72%) were the responsibility of Social Care. The table overleaf shows the reasons coded by the number of delayed days, and it can be seen that awaiting further NHS non-acute care accounts for a third of all delayed days.

Reason for delay	Number of Delayed Days	Proportion of all Delayed Days
Waiting further NHS non-acute care	614	33.30%
Completion of assessment	410	22.23%
Patient or family choice	213	11.55%
Awaiting nursing home placement or availability	172	9.33%
Awaiting residential home placement or availability	134	7.27%
Public funding	119	6.45%
Awaiting community equipment and adaptations	78	4.23%
Disputes	69	3.74%
Awaiting care package in own home	35	1.90%
Housing - Patients not covered by NHS and Community Care Act	0	0.00%
All Reasons	1,844	100.00%

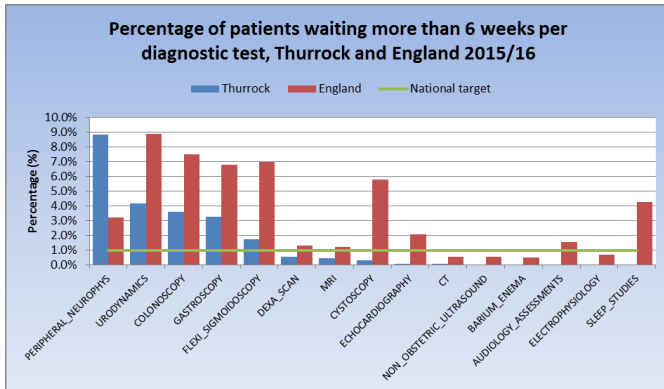
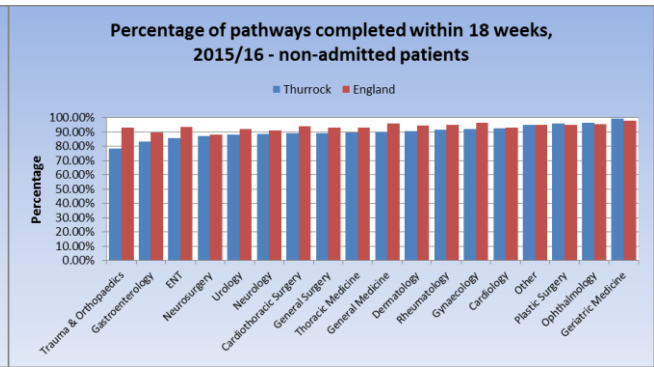
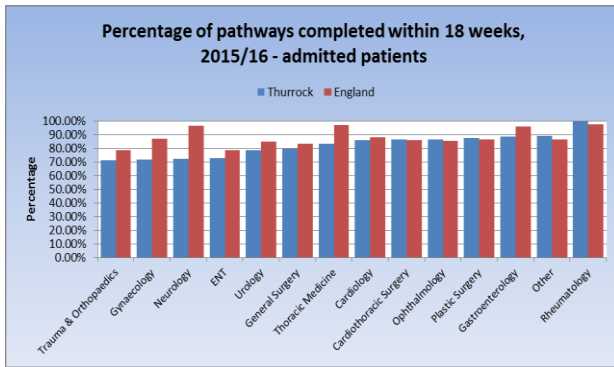
Key Recommendations

The main recommendations listed to reduce/eliminate delayed transfers of care in Thurrock include:

- F1) Further research by Public Health, Thurrock CCG and Basildon Hospital to ascertain the factors behind the large number of delayed days due to improving access to non-acute NHS care
- F2) Further research by Public Health and Thurrock CCG to ascertain the factors behind the large number of delayed days due to late completion of assessments
- F3) Investigation and piloting of a rapid discharge service to place social care resource in the hospital, and the development of a comprehensive step down facility to provide capacity to assess and provide intermediate rehab. Both of these projects would improve local capacity of residential and nursing home placements.
- F4) Developing a 'systems wide response' and associated business case to reinvest excess secondary care costs in preventative activity that keeps older people healthy and well and thereby reducing future demand on social care services.

5. Referral to Treatment Care Pathways

Section 5 looks at referral to treatment pathways. The standard set by the NHS constitution outlines that NHS Consultant led treatment should commence within a maximum of 18 weeks from GP referral for non-urgent conditions. The percentage of pathways completed within the 18 week target varies in Thurrock by pathway for both admitted and non-admitted patients. In particular patients on trauma and orthopaedics, gynaecology (admitted patients), gastroenterology (non-admitted patients) neurology and ENT pathways have lower proportions of pathways completed within 18 weeks. This can be seen in the figures below.



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

Key Recommendations

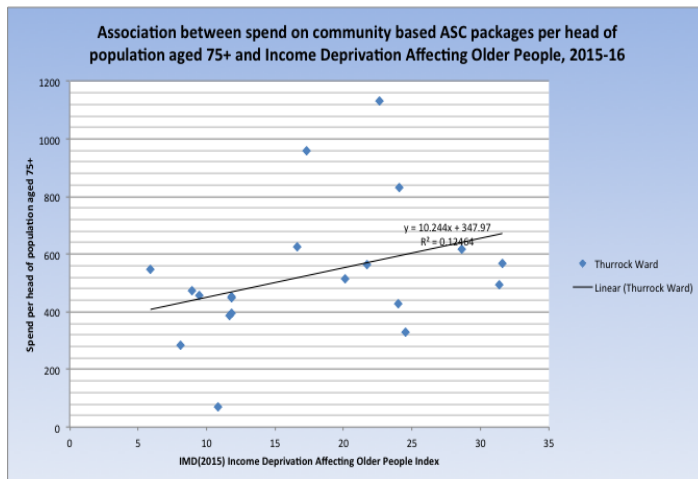
The main recommendations listed to improve efficiency in referral to treatment pathways include:

G1) Further research by Public Health in conjunction with Thurrock CCG and Basildon Hospital to better understand the efficiency and cost effectiveness of elective care and access to diagnostics. This research should include analyses of workforce data and outpatient clinic data

G2) Continued work at STP foot print level to rationalise and simplify clinical care pathways such that patients are not required to access diagnostics and treatment at multiple hospital sites.

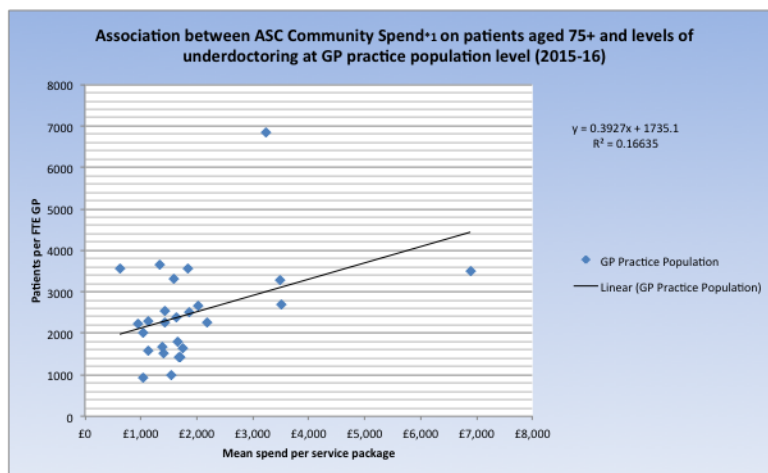
6. Adult Social Care

Section 6 outlines the current picture of social care activity and costs. Spend on *Community ASC* packages varies between different ward populations, with the wards of Grays Thurrock, Stifford Clays, Stanford East and Corringham and Chadwell St. Mary's appearing to have the greatest overall demand, but a larger proportion of their population may be over 65.



Approximately 12.5% of the variation in spend per head of population aged 75+ between wards can be explained by levels of income deprivation. Whilst association between two variables does not necessarily demonstrate one causes another, a reasonable hypothesis could be that differences in levels of morbidity between different ward populations (strongly associated to deprivation) are leading to increased social care needs in more deprived areas.

As such, this demonstrates that there are Social Care Inequalities in addition to Health Inequalities between different wards populations in Thurrock.



Approximately 16.6% of the variation in spend per head of population aged 75+ can be explained by levels of under-doctoring at GP practice level. As with the previous association, this does not necessarily imply that under-doctoring causes increased rates of ASC spend. This can be seen in this figure:

Almost one third of all adult social care clients begin to receive their social care packages as a result of a hospital discharge, equating to 954 clients for 2015/16 (when extrapolating to include those with no referral source recorded). Spend on these packages equated to £1,840,266. In total, there were a total of 11,910 of emergency hospital admissions in 2015/16. As such, based on these figures:

- For every 1% reduction in emergency hospital figures, this has the potential to reduce the additional number of clients requiring a new ASC package by 119
- In turn this has the potential to save ASC £18,402 in the year the client starts the package, although cumulative savings will be substantially more

Muscular Skeletal problems (Arthritis, Osteoporosis and MSK [other]) are the most common clinical diagnosis recorded as a long term physical health condition. In addition, a significant proportion of their clinical conditions diagnosed before entry to adult social care are preventable and controllable – such as hypertension, Coronary Heart Disease, Chronic Kidney Disease, Falls, high Cholesterol, Atrial Fibrillation, Stroke and COPD.

Key Recommendations

The main recommendations listed to reduce demand in adult social care include:

H1) Effective targeting of direct prevention and early intervention programmes at those aged 60+, and particularly those in the wards of Grays Thurrock, Stifford Clays, Stanford East and Corringham Town, and Chadwell St. Mary

H2) Further research by Public Health in conjunction with Adult Social Care to ascertain the apparent variation in need for adult social care identified at both ward and GP practice level

H3) Review the effectiveness of commissioned musculoskeletal services

H4) Improvements to frontline adult social care data recording practices

H5) Continued implementation of preventative services outlined in the report aimed at keeping older people healthy and well

H7) Implement the proposed programmes to support clients with LD within the community including Shared Lives; Medina Road Supported Living and Sheltered Housing Support

H8) Implement depression screening in adult social care clients

7. Self-care/Prevention/Primary Care/Social Care

Section 7 outlines a number of evidence-based opportunities within the realms of promoting patients to self-care, and wider prevention in the community, primary care and social care. One significant area for opportunities lies with obesity prevention, as it is known that increasing obesity prevalence is associated with higher prevalence of a number of long term conditions. The table below quantifies the estimated additional treatment costs associated with obesity as a co-morbidity up to 2021 if there are no major changes to obesity or future long term condition prevalence.

Condition	Average treatment cost per person	Average treatment cost per obese person	Additional number of obese patients between 2016 and 2021	Additional projected health costs between 2016 and 2021 due to obesity as a co-morbidity
Stroke	£23,315 (acute & rehab care)	£30,309.50 (acute & rehab care)	240	£1,678,680 (acute & rehab care)
CHD	£4,956 (Coronary Artery Bypass Graft)	£6,442.80 (Coronary Artery Bypass Graft)	664	£987,235.20 (Coronary Artery Bypass Graft)
	£427 (Cardiac Rehab episode)	£555.10 (Cardiac Rehab episode)		£85,058.40 (Cardiac Rehab episode)
	£20 (ACE inhibitors per year)	£26 (ACE inhibitors per year)		£3,984 (ACE inhibitors per year)
Diabetes	£1,800-£2,500 per year (inpatient only)	£2,340-£3,250 per year (inpatient only)	1,404	£758,160-£1,053,000 per year (inpatient only)
Hypertension	£69 per year	£89.70 per year	4,297	£88,947.90 per year

There is a vision in Thurrock to tackle obesity in a “whole-systems” approach and develop a borough whose environment encourages and promotes people who live and work in the area to be physically active, to socialise and meet, and to maintain independence and have a good quality of life.

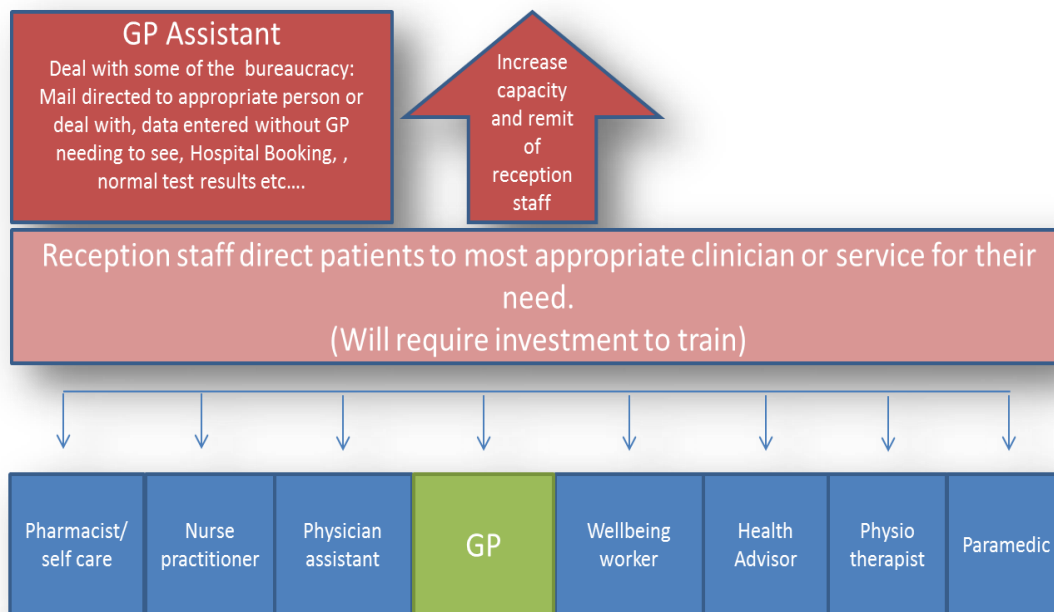


Other preventative approaches outlined in the report as being effective include:

- The Well Homes programme – having completed 241 assessments to those in poor quality private housing between August-April 2016, the estimated savings to the NHS alone are £418,314
- Various initiatives resulting in earlier identification of long term conditions such as the NHS Health Check and cancer screening – increasing uptake of bowel, breast and cervical cancer screening can reduce treatment costs from later diagnosis and increase the number of patients surviving 1 year post-diagnosis
- Falls prevention – the return on investment for the newly-commissioned programme is expected to be between £1.88 and £3.79 for every £1 we spend.
- Supporting community approaches to self-care – increasing use of the community hubs, rolling out a social prescribing pilot, Local Area Coordination and Timebanking are some examples of current local activity that is likely to have a positive impact on community health. In 2015/16 there were over 11,000 Timebanking exchanges, which involved Thurrock residents giving and receiving their time and skills to others on a voluntary basis.

The report also details a suggested revised staffing model for primary care, in order to contend with projected future demand. This could result in **up to 2,186 additional appointments per day** across the borough, and could surround GPs in primary care with other appropriately-qualified staff to manage some

of their workload and maximise GP time spent on clinical issues. It would also reduce the number of GPs required in the future to close the deficit already experienced.



There are a number of digital investments into health and social care detailed in the report, including the Council's Quickheart program – the most popular pages appearing to relate to *Living at Home* (2471 views between January 2015-September 2016), and promoting patients to use online services to book or amend their GP appointments, as Thurrock has a lower proportion of patients enabled to book online than the national average (9.98% compared to 15.3% as of June 2016).

There is also evidence that falls prevention, Integrated Continence services, Depression screening , strengthening Community Capacity and Sign Posting, Interface Geriatrics, services for carers, re-ablement, using social workers in A&E and assistive technology are all effective for reducing demands to Social Care.

Key Recommendations

Whilst there are a number of recommendations relating to each of the preventative opportunities outlined, they can loosely be grouped into the below:

- Continue to invest in community approaches to promote disease prevention
- Continue to invest in improving poor quality housing via the Well Homes programme
- Public Health to complete a Whole Systems Obesity Needs Assessment to best outline the most effective approaches to reducing the impacts from high obesity prevalence
- Improvements to detection rates of diseases – such as the proposed hypertension detection program and NHS Health Checks
- Improvements to management of long term conditions – a number of specific recommendations relating to this have been outlined in sections 1 and 3 above
- Increasing access to primary care via the revised staffing model outlined above
- Continued sharing of best practice amongst practices as it develops

SUMMARY OF FINANCIAL OPPORTUNITIES

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

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

A breakdown of the projects/recommendations that could lead to delivery of these financial opportunities are given in Appendix A. **The authors accept that further business cases now need to be developed in order to ascertain associated levels of required investment to deliver savings, and best methods of delivery.**

APPENDIX A: FINANCIAL OPPORTUNITIES BY PROJECT:

Desired Outcome	Interventions	Investor of costs	Recipient of savings	Financial Opportunity
<p>Improve Detection of Hypertension. Detect 5,000 patients over 3 years.</p> <p>Prevent 33 strokes per year.</p>	<p>Hypertension detection programme funded under BCF</p> <p>Long Term Condition Management Scorecard</p>	Better Care Funding	NHS Social Care	<p>Savings of: £361K over 3 years to the NHS (A&E, Admission, and Ambulance only)</p> <p>£395K over 3 years (Social Care – over 3 years) [section 3.3]</p>
<p>Prevent patients from becoming Hypertensive. Mitigate against the additional 3,694 additional Hypertensive patients we are expected to have by 2021 due to rising levels of Obesity.</p> <p>Prevent 61 strokes per year.</p>	Halt rise of obesity	CCG / Public Health (prevention) /Council	NHS Social Care	<p>Savings of: £667K over 3 years to the NHS (A&E, Admission, and Ambulance only)</p> <p>£730K over 3 years (Social Care – over 3 years) [section 3.3]</p>
<p>Improve assessment and treatment with appropriate drug therapies AF patients with a CHADS2 score of 1:</p> <p>7 patients not exception reported. Prevent 0.86 strokes per year</p> <p>19 patients who are exception reported. Prevent 2.3 strokes per year.</p>	<p>Long Term Conditions Scorecard</p> <p>Health care Public Health Improvement manager posts</p>	No costs	NHS Social Care	<p>Savings of: £31K over 3 years to the NHS (A&E, Admission, and Ambulance only)</p> <p>£34K over 3 years (Social Care – over 3 years) [section 3.3]</p>
<p>Improve availability of GP appointments so that 0.01% more people rate it as positive in all practices:</p> <p>Prevent 158 admissions for CHD and HF per year</p> <p>Prevent 58 admissions for respiratory conditions per year</p>	<p>New mixed staffing model</p> <p>Digital services</p> <p>Increase means of self-care (community Hubs, pharmacies)</p>	CCG / Public Health (prevention)	NHS Social Care	<p>CHD HF Savings of: £2.2M over 3 years (to NHS - £4,614 per admission)</p> <p>Respiratory Savings of: £389K (to NHS - £2,233 per admission)</p>
<p>Treat more patients who have HF with LVD with ACE or ARB</p> <p>9 patients not exception reported. Prevent 0.63 admissions for CHD and HF per year</p>	<p>Long Term Conditions Scorecard</p> <p>Health care Public Health Improvement manager posts</p>	No Costs	NHS Social Care	<p>Savings of: £8.7 - £31K over 3 years (to NHS - £4,614 per admission)</p> <p>Unable to quantify savings for Social Care.</p>

Desired Outcome	Interventions	Investor of costs	Recipient of savings	Financial Opportunity
Prevention of COPD cases. Prevent 100 cases of COPD and prevent 0.3 hospital admissions per year.	Smoking Prevention Smoking Cessation Obesity Prevention	Public Health (prevention)		Respiratory Savings of: £1,764K over 3 years (to NHS - £1,960 per admission)
To avoid 33 emergency admission for respiratory conditions per year Reduce the prevalence of smoking in patients with Long Term Condition patients by 9 percentage points	Smoking Cessation targeted at those with early on-set smoking related disease	Public Health (prevention)	NHS Social Care	Savings of: £194K over 3 years (NHS)
Commission an Integrated Falls Prevention Programme for Older People	Falls prevention	Better Care Funding	NHS Social Care	ASC savings: at least £2.6M Acute Hospital Savings: at least £10M Over 3 years
Reduce the number of A&E attendances requiring no investigation or treatment.	Mitigate the impact of closeness and convenience by introducing local services Educate parents through health visitors when to use A&E Consider training parents in first aid/self-care Consider an Ambulance Triage	NHS	NHS	Reduce A&E attendances by 294 per year saving the NHS £19K per year £57K over 3 years
Reduce inappropriate attendances to be in line with Mid Essex	Review Mid Essex triage system and consider implementation in Thurrock Educate parents through health visitors when to use A&E Consider an Ambulance Triage	NHS	NHS	Reduce A&E attendances by 8,000 per year saving the NHS £900K per year £2.7M over 3 years
Increase patients with Long Term Conditions' knowledge on how best to self-care	Self-care	PH Existing Community Capacity	NHS Social Care	For a cost of £400 per patient, average net saving of £1,800 per patient per year

Desired Outcome	Interventions	Investor of costs	Recipient of savings	Financial Opportunity
Social Prescribing	Community management of care	PH CVS? CCG?	NHS Social Care	After five years, a return on investment of £3.38 per £1 spent.
Well Homes	Keeping people well at home	Public Health Private Housing Service	NHS Wider society Social Care	Completing 400 assessments a year is calculated to result in £1,676,815 savings to society [£694,297.10 to NHS] Over 3 years: Wider Society: £2.9M NHS: 2.1M
Increase early diagnosis of breast cancer in line with the East of England average.	Cancer screening	NHS England / Public Health	NHS Social Care	Improving early diagnosis by 6% could save £58,243 in cancer treatment costs, or a three year total of £189K
Increase early diagnosis of cervical cancer in line with the East of England average.	Cancer screening	NHS England / Public Health	NHS Social Care	Improving early diagnosis by 6% could save £3,775.20 in cancer treatment costs, or a three year total of £12K
Increase early diagnosis of bowel cancer in line with the East of England average.	Cancer screening	NHS England / Public Health	NHS Social Care	Improving early diagnosis by 6% is calculated to save £26,374 in cancer treatment costs, or a three year total of £81K
Reduce the future number of long term conditions patients who are also obese.	Obesity Prevention – targeted weight management initiatives, tier II/III	Public Health CCG	NHS Social Care	The additional projected costs of LTC + obese calculated to be: Stroke £5M CHD coronary artery bypass grafts £3M. Diabetes inpatient £2.3M - £3.2M Hypertension management £267K Over 3 years. These are all on top of their existing LTC management costs.
Increase uptake of the programme from 56% to 66%.	NHS Health Checks	Public Health	NHS Social Care	The increase in uptake by 10 percentage points would result in 57 additional Quality Adjusted Life Years over the course of a lifetime.
Achieve the target of 500 patients referred onto the service.	National Diabetes Prevention Program	CCG	NHS Social Care	NHS Savings: £27K ASC Savings: £1,232 Over 3 years NET

Desired Outcome	Interventions	Investor of costs	Recipient of savings	Financial Opportunity
Enabling a patient to self-refer to a physiotherapist.	Physiotherapy in Primary Care	CCG	NHS Social Care	Estimated savings of up to £44,959.20 in hip and £76,705.20 in knee osteoarthritis patients.
Maintaining effective cholesterol control in patients with Diabetes and CHD.	Management of hypertensive patients	CCG	NHS Social Care	Three year savings from: Strokes and heart attacks avoided: £256K (NHS) strokes avoided: £36K (Social Care) The above come from treating an additional 493 Diabetes and 241 CHD patients.
Continued investment into the RRAS	Rapid Response Assessment Service	NHS Social Care	NHS Social Care	ASC Packages avoided: £524,081 per week (Social Care) Over three years - £81M Opportunities not calculated for NHS