

APPENDIX 1


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




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

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Tilbury Integrated Healthy Living Centre Needs Assessment

A Thurrock Joint Strategic Needs Assessment (JSNA) Product

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November 2015

Annual Report of The Director of Public Health | 2016


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Annual Report of the Director of Public Health: 2016

A Sustainable Health and Social Care System for Thurrock



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

February 2017

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

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



- Inadequate understanding of patient/client flow between constituent parts of the system. STP has the wrong approach**

The money and the patients are in the wrong place

- Avoidable hospital admissions
- Avoidable delays in hospital discharges
- A&E and ambulance “misuse”

Inadequate capacity leads to inadequate quality in Primary Care, Community Care and ASC and keeps the money and the people in the wrong place

- Find the missing thousands
- Treat the missing hundreds
- Increase Primary, Community and ASC capacity

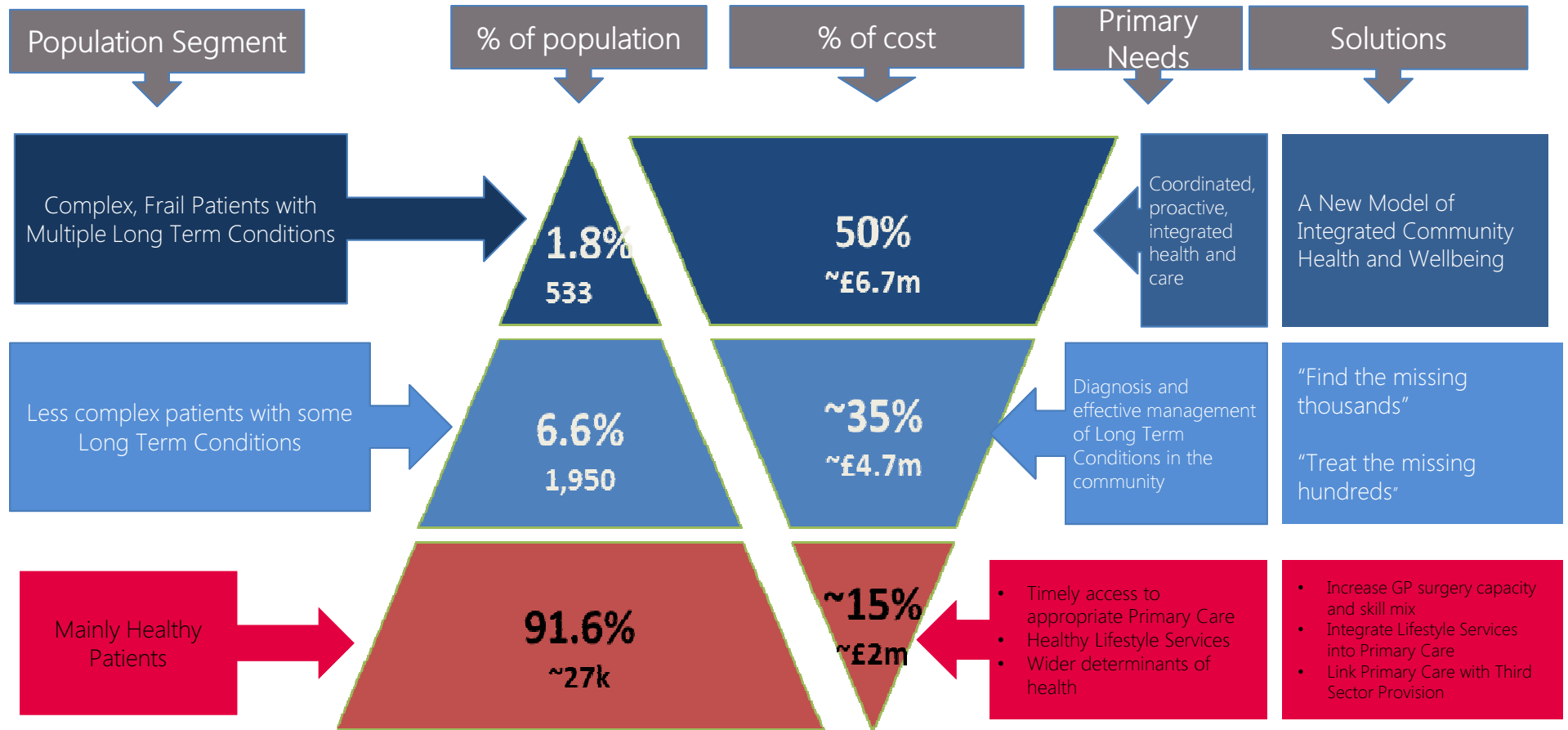
Solve the capacity/quality issue and the money will follow

Solving the quality issue requires integrating the system (and the money)

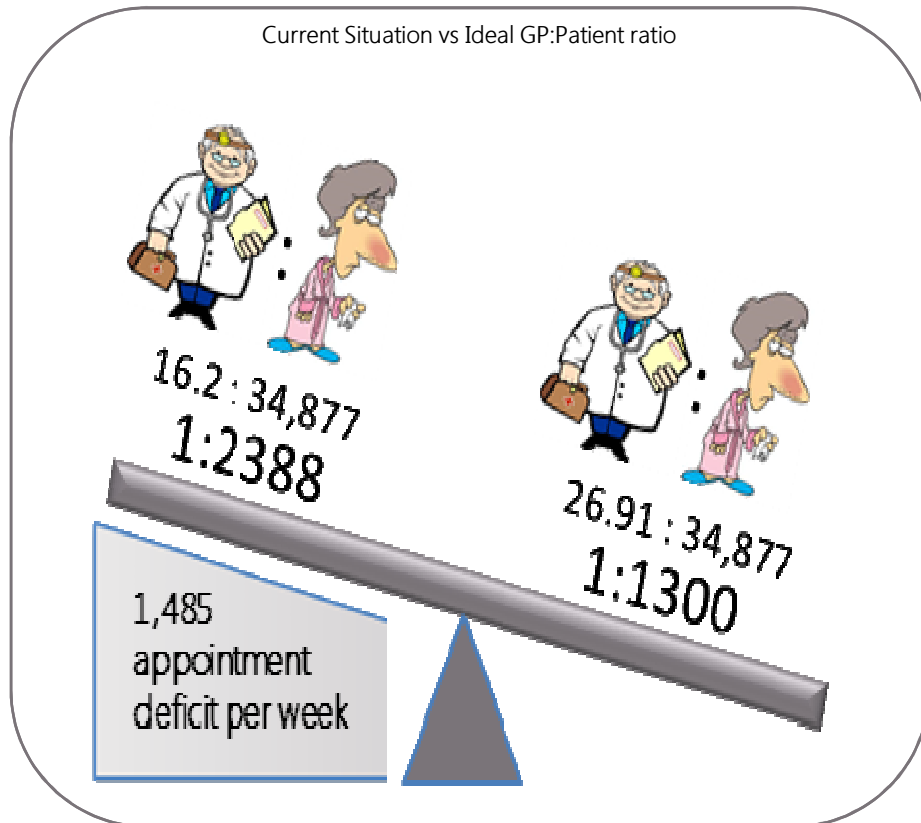
- Integrate ASC and Health
- Interface between GP surgeries and Community Services needs to be improved
- Interface between GP surgeries and Mental Health needs to improve
- Integrate Public Health Services
- Integrate self care and community capacity

- We require a period of double running to solve the problem**

Population segmentation and new care models



5. Enhancing the capacity and capability of Primary Care



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



5. Enhancing the capacity and capability of Primary Care



Nurse Practitioner



Practice Based Pharmacist



Physiotherapist



Paramedic

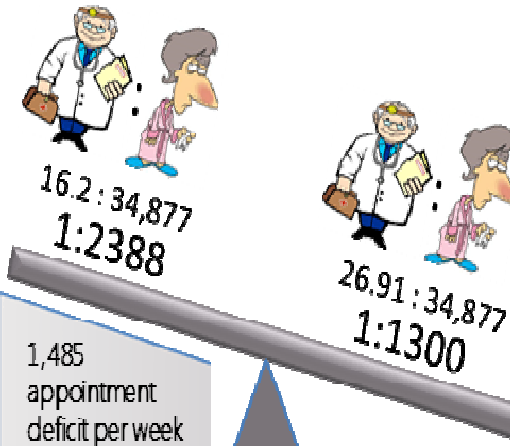


Physicians Assistant

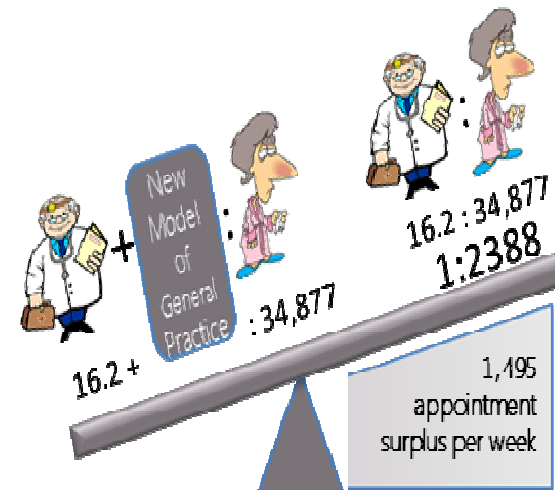


Wellbeing Worker

Current Situation vs Ideal GP:Patient ratio

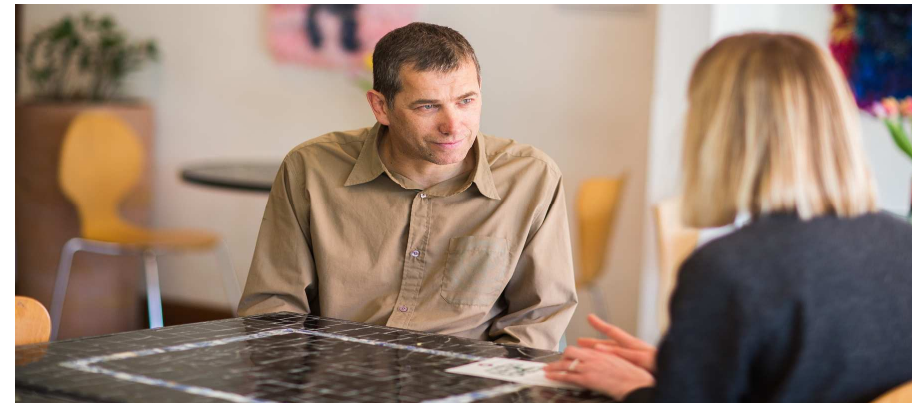


New Model of General Practice vs Current Situation



Enhancing the capability and capacity of Primary Care

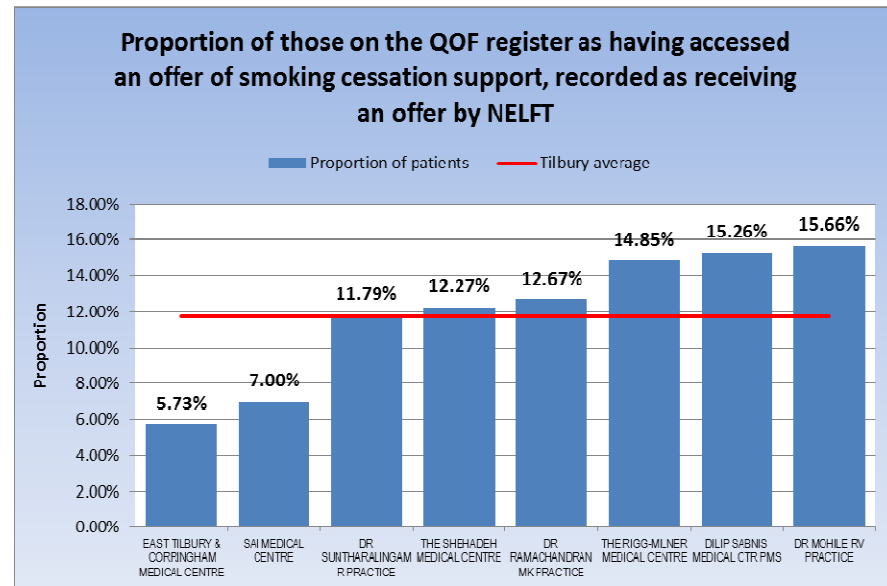
- Social Prescribing
- Strengthen Patient Participation Groups
- Increase coverage of the GP Satisfaction Survey
- Integrate Public Health Wellbeing Services



Would you like to be more involved in your GP surgery?

**Ask about joining the
Patient Participation Group**

Speak to your
practice receptionist
for more
information.



5. Enhancing the capacity and capability of Primary Care

Effective Front Door Triage

Telephone Triage and Consultation by a GP

- Most experienced clinician is triaging
- Up to 70% of consultations handled by phone in 4-6 minutes
- Need for face to face consultation determined within 2 minutes
- Improved access and reduced DNAs by up to 80%

Highly trained reception staff

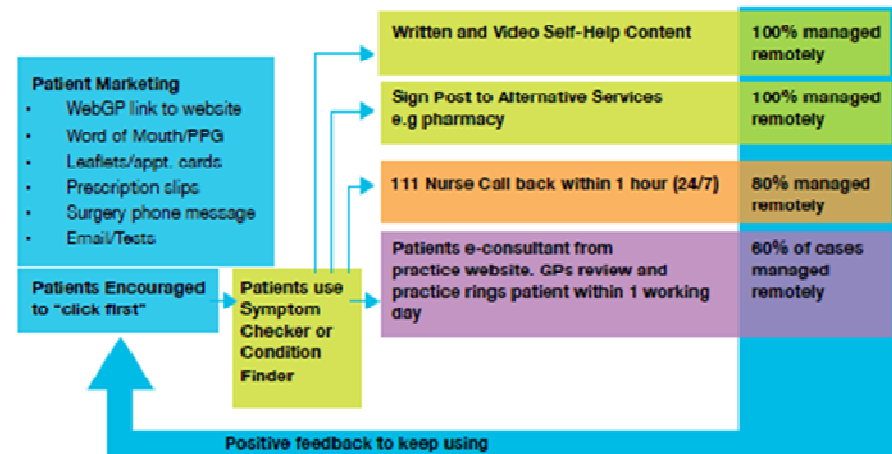
- Reduced GP appointment demand by 10%
- Improved patient and staff satisfaction

Web-GP

- 90% of users don't contact the practice
 - 60% use symptom checker
 - 20% visit pharmacy
 - 10% request a 111 nurse call back
- 10% of users have an online consultation
 - 40% are dealt with by a GP remotely – average of 2.9 minutes
 - 20% receive a telephone consultation
 - 40% have a face to face appointment with a member of the surgery's clinical team
- 14% stated that they would have gone to A&E



Web GP Patient Flows



6. Find the missing thousands, treat the missing hundreds

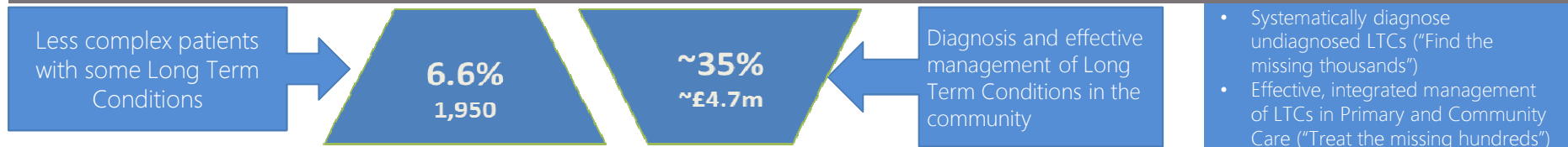


Table 2

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

- Finding and treating 100 undiagnosed residents with high blood pressure prevents 10 strokes over three years
- 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.

- NHS Health Checks Programme
- Hypertension and AF Screening Programme
- Diabetes case finding through dentist
- Systematic Depression Screening through LTC clinical and ASC staff
- Use of SystmOne/ Mede-analytics

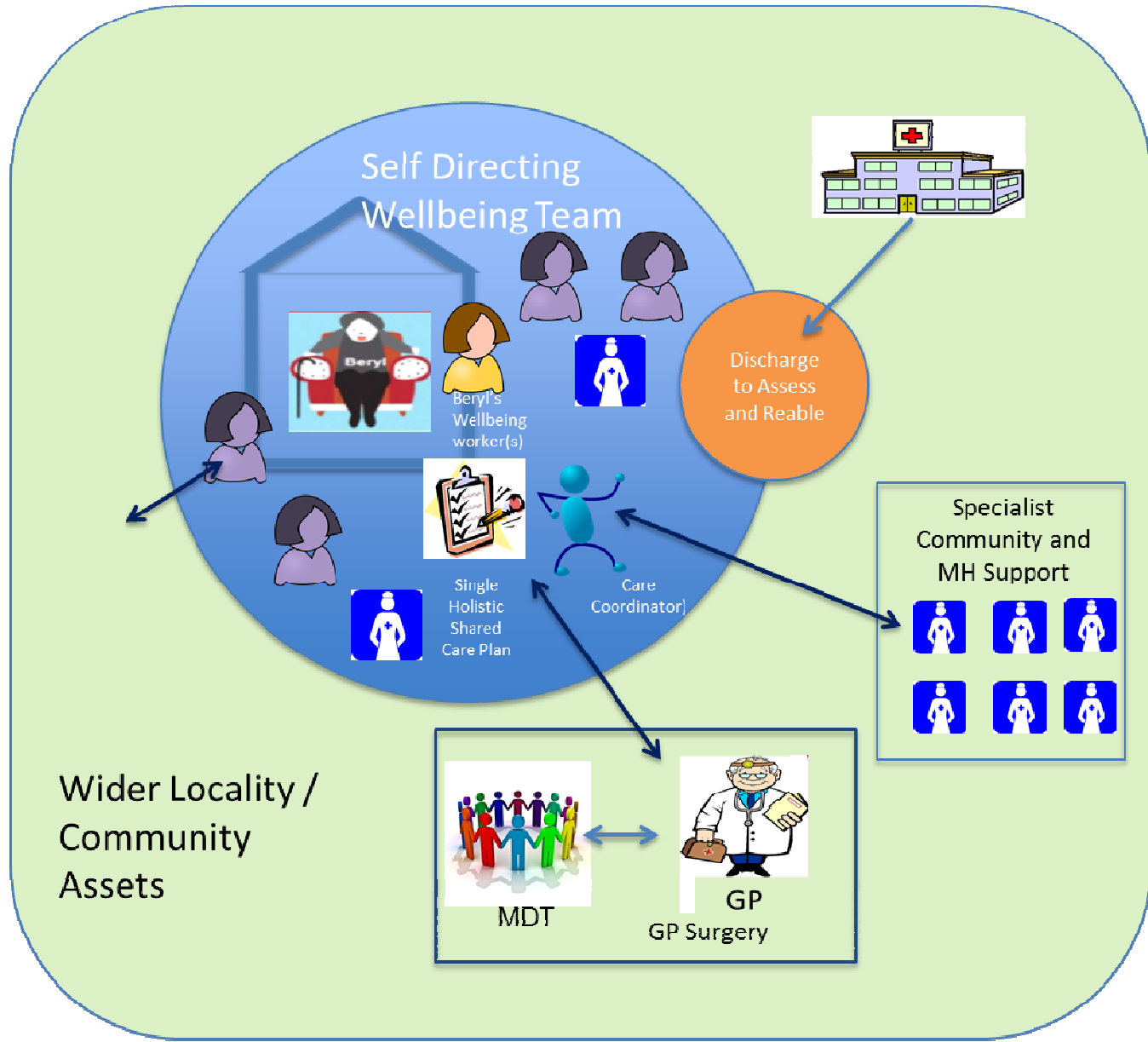
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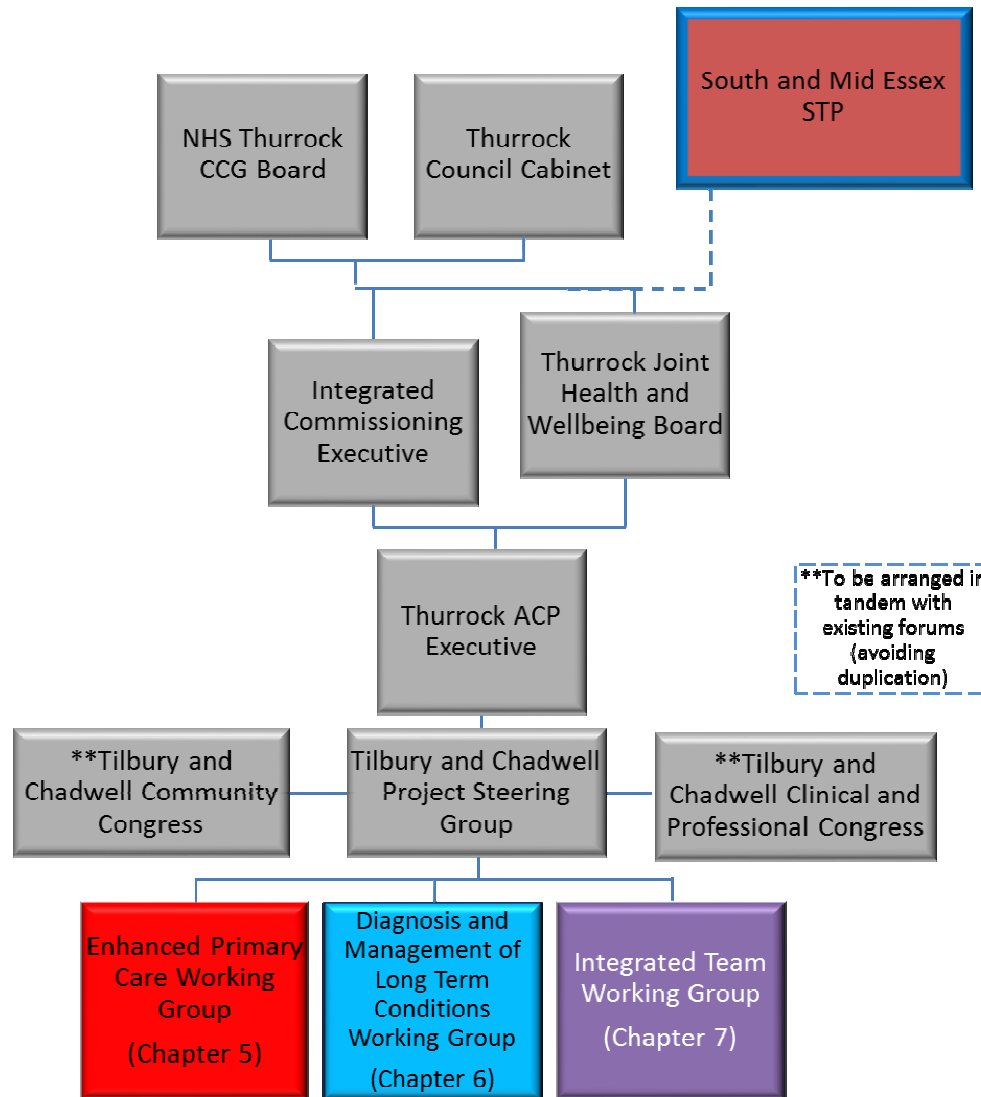
SE2

Edited by Emma with Tilbury relevant modelled figures

Sanford, Emma, 18/09/17

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





- Implementation Planning
- Evaluation
- Commissioning Arrangements