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Report to the London Borough of Merton Healthier Communities and Older People Overview and Scrutiny Panel

Date of Meeting: 12th February 2014

Title of Document: **Report on Long Term Conditions in Merton**	**Purpose of Report:** Requested by the LBM Healthier Communities and Older People Overview and Scrutiny Panel
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Executive Summary: This report has been produced to provide the London Borough of Merton Healthier Communities and Older People Overview and Scrutiny Panel meeting, to be held 12th February, with the information requested regarding Long Term Conditions on Merton.	
Key sections for particular note (paragraph/page), areas of concern etc: N/A	
Recommendation(s): N/A	
Committees which have previously discussed/agreed the report: N/A	
Financial Implications: N/A	
Other Implications: N/A	
Equality Analysis: N/A	
Information Privacy Issues: N/A	
Communication Plan: N/A	

1. Introduction

This report has been produced to provide the London Borough of Merton Healthier Communities and Older People Overview and Scrutiny Panel with the information requested regarding Long Term Conditions.

For the purposes of this paper Mental Health conditions (e.g. Dementia) have not been explicitly addressed.

Although Cancer is not considered a Long Term condition, as it has been identified by Public Health Merton as the main cause of premature death in Merton it is included in this report.

Merton Clinical Commissioning Group is working to enhance the quality of life for people with long-term conditions (in accord with the NHS Constitution) and delivery of this outcome is dependent on alignment with both the Adult Social Care and Public Health Outcomes Frameworks, and requires partnerships with our fellow commissioners of services for Merton's population.

Whilst continuing to commission disease specific services Merton CCG is seeking to provide a person-centred approach to patient care, with the patient, rather than their condition, at the centre of care services. Among the six key delivery areas of the Merton CCG Operating Plan areas (each of which will have a responsible Clinical Director) there are several which will impact on people living with one or more Long Term Conditions, specifically:

- Older and Vulnerable Adults
- Keeping Healthy and Well
- Early Detection and Management

These key areas will be delivered by Merton CCG in partnership with the Local Authority and Public Health (London Borough of Merton). This delivery will be supported at a strategic level by the Better Care Fund (formerly the Integration Transformation fund) and through the Health and Wellbeing Board.

The shift of Public Health to the local authority provides new opportunities to tackle health inequalities and make a real difference to people's lives. The Merton Health and Wellbeing Strategy has been developed to take advantage of the opportunities and takes a broad view of health to address the wider determinants of good health and wellbeing. The Merton Health and Wellbeing Strategy 2013/14 includes as Priority 3 *Enabling people to manage their own health and wellbeing as independently as possible*.

2. Types of LTC in Merton

The following information has been provided by Public Health Merton

Overall for premature deaths (that is deaths in people aged under 75 years of age- many of which are considered preventable), in the period 2009-11 Merton had 1,204 premature deaths which equates to 236 premature deaths per 100,000 population adjusted for various factors, including the age of the population. Out of 150 local authorities this ranked Merton at 29th putting Merton overall in the 'best outcomes' category.

In terms of under-75 mortality rates from all causes, in 2010 Merton had a directly standardized rate of 220.77 per 100,000 population, compared with 272.77 for England and 271.87 for London. This equates to 1157 deaths in Merton from all causes. Compared with other boroughs in South West London, Merton had a mortality rate lower than Croydon and Kingston upon Thames, but higher than Richmond upon Thames, Sutton and Wandsworth. In terms of trend since 2006, compared with London and England, Merton's mortality rates have been consistently lower than both and is decreasing in 2010 more than the rates in London or England.

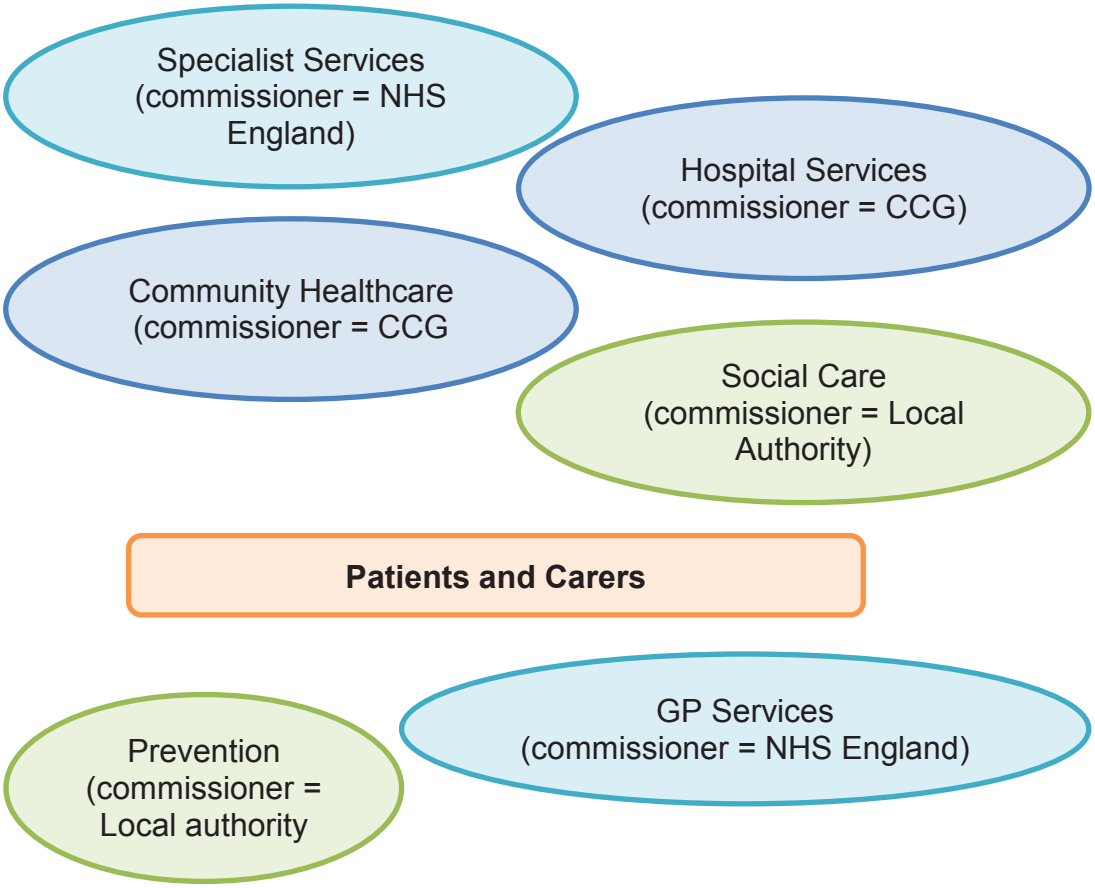
Breaking down the mortality by causes of death, the top three causes of death in those under 75 years of age were (in order of frequency from most to least common) cancers, circulatory disease and accidents and injuries- which accounted for 70% of all deaths in Merton.

Main long term conditions of interest in Merton are:

- **Respiratory Diseases**: deaths from Respiratory Diseases have declined, but there are wide variations in hospital admissions by area. This needs to be studied in more depth.
- **Circulatory Disease**: Under 75s death rate from Circulatory Disease (including Stroke) is higher than England and although the overall trend is downward there was a slight upturn in the last period and it is still the second biggest cause of premature death. The rate of stroke for under 75s increased for both men and women in the last period, although the overall trend is also downwards (2008-10).
- **Diabetes**: Diabetes recorded in primary care is 5.3% for the CCG overall, but ranges from 2% to nearly 10% by Practice. Comparing modelled to recorded prevalence of Diabetes suggests a proportion remains undiagnosed.
- **Cancer**: rates of deaths from Cancer in people aged under 75 have reduced, particularly for females, however it is still the main cause of premature death and inequalities remain with a higher rates of deaths in the eastern wards.

3. Services offered to support people with LTC

There are a range of services to support people living with long term conditions provided by and commissioned by a number of organisations, as shown below:.



The majority of care for someone with a long term condition will be provided by his or her GP; this care is commissioned by NHS England.

Other health services for this group of people are commissioned predominantly by the Clinical Commissioning Group. In addition to the clinical services provided by local hospitals Merton CCG has continued the work of Sutton and Merton PCT to commission services which can be accessed in the community (including, in the case of people who are housebound, in the patient's place of residence). These services, providing both treatment and, where appropriate, rehabilitation include:

- A specialist community respiratory service enabling people with Chronic Obstructive Pulmonary Disease (COPD) and other respiratory conditions to access care and rehabilitation services provided by a range of professionals including Specialist Nurses, Physiotherapists and Occupational Therapists.
- A specialist community diabetes service enabling people with diabetes to access care provided by a range of healthcare professionals including Specialist Nurses, Dieticians and Podiatrists. This is a consultant led

service providing, in community locations, a high level of care suitable for all but the most complex patients (who may need hospital based care services).

Merton CCG commissions a range of other community based specialist nursing services and other rehabilitative services including:

- Specialist Heart Failure Nurses
- a Parkinsons Disease Nurse
- a Specialist HIV Nurse
- neurological rehabilitation services following Stroke
- Speech and Language Therapy Services for people with both neurological and non-neurological conditions.

In addition to providing clinical advice and treatment, and rehabilitation services, the majority of the above services are commissioned to provide education for people to help them to understand and, where possible, manage their own condition and retain their independence and quality of life.

The work of these teams is supported by other specialists such as podiatrists, dieticians and physiotherapists, and other services such as Telehealth which will enable some people with conditions such as Heart Failure or COPD to safely monitor and manage their conditions themselves.

These services are all intended to deliver patient-centred care and in support of this patient-centred approach the CCG is delivering an Expert Patient Education programme for people with Long Term Conditions. The Expert Patient Programme is an education programme which recognises that many of the issues and problems encountered by people with a long term condition are the same, regardless of the condition. The programme is a series of courses run by local accredited trainers who themselves have one or more long term condition. These courses provide people with advice on how they can best manage the problems associated with living with a long term condition (including feelings of isolation and loneliness) and also how best to access health services.

In fact, Merton CCG recognises the necessity of addressing the needs of the many people who are now living with more than one long term condition. This is reflected in the Merton Health and Wellbeing Strategy 2013/14 Priority 3, *Enabling people to manage their own health and wellbeing as independently as possible* (further details of which are included further in this document) and in the deployment of the *Better Care Fund* (formerly the *Integration Transformation* fund), which supports the integration of Health and Social Care services.

4. What is being done to increase the diagnosis in the borough

Early diagnosis of long term condition can be critical to the successful management of the condition, and therefore to quality of life. In the early stages of disease, however, people often do not experience symptoms and therefore do not present themselves to a healthcare professional.

A significant contributory factor to encouraging people to visit their GP early enough is through targeted screening programmes such as the NHS Health Checks programme currently managed by Public Health Merton (this is discussed further in this report).

In addition, publicly available data on number of cases of disease that probably exist in the borough (the expected prevalence) can be used to identify where/in what condition there may be significant numbers of undiagnosed patients, and targeted activity can be supported to increase levels of diagnosis.

For example, publicly available data suggests a significant 'gap' between the expected COPD prevalence and the reported COPD prevalence in Merton. Merton CCG therefore decided to support Practices to report the number of people on their Practice COPD register and, more importantly, to proactively screen those patients at risk of COPD (such as smokers) in order to increase the level of diagnosis of the condition. As a result of this programme a number of people have been diagnosed with COPD at an early stage enabling effective management of their condition.

In recognition of the importance of early diagnosis in effective cancer care Merton CCG will be taking on a Macmillan GP (with the additional support of the Public Health Merton) with the specific objectives of improving levels of screening uptake and early diagnosis, in addition to developing the quality of cancer care in Merton..

Finally, the development of the Nelson Local Care Centre is allowing the CCG to put in place improved access to diagnostic services enabling a patient to be seen swiftly. This will streamline the process of identifying if a patient has a long term condition, and also improve access to appropriate advice and treatment.

Merton CCG is also meeting with key stakeholders to ensure that we have a model of care for East Merton focussed on early detection and intervention. We are currently planning to take the update on this work to the March Health and Wellbeing Board.

5. Costs of Long Term Conditions

Due to the mixed commissioner and provider landscape it is extremely difficult to quantify spend for Long Term Conditions. As a result Programme Budgeting, a well-established technique for assessing investment in programmes of care rather than services, is widely used across the health economy.

Public Health England combine the Programme Budgeting data with overall indicators of health outcome (where available) in a *Spend and Outcome Tool* to produce a *SPOT* factsheet presenting CCGs with their position (in comparison the national average) and providing an analysis of the impact of their expenditure, enabling easy identification of those areas which require priority attention.

The most recent SPOT factsheet for Merton CCG (2011/12) is attached as Appendix 1. This report has been analysed by Public Health Merton who have provided the following information in relation to Long Term Conditions:

- **Circulatory Disease**: Higher Spend and Worse Outcomes.
- **Diabetes**: Lower Spend and Worse Outcomes (based on Endocrinal, nutritional and metabolic Programme Budgets – there is no diabetes specific Programme Budget).
- **Cancer**: Lower Spend and Better Outcomes
- **Respiratory Diseases**: Higher Spend and Better Outcomes.

A further report provided by Public Health Merton, showing expenditure per head of population for the last 2 years for which data is available (2010/11 and 2011/12), is attached as Appendix 2.

It should be noted that all Public Health data pre-dates the formation of CCGs and is therefore derived from NHS Sutton and Merton (PCT) data apportioned for Merton.

6. Current challenges within this area and how they are being addressed.

People with long term conditions are intensive users of health and social care services. This has major implications for resources in a time of significant financial pressure. It also means there is a greater need than ever for effective community based services and preventative services. Achieving the highest possible standards of care within increasingly scarce resources is a key priority for Merton.

Life expectancy is increasing and the number of older people in Merton is projected to increase, so the number of people with long term conditions is rising and particularly people having two or more conditions. At any age long

term conditions can have a significant impact on a person's ability to work and live a full life and stay connected to the community and those who matter to them.

The multiplicity of commissioners of services for patients (and in particular for patients living with a long term condition) can present a challenge to delivering the necessary patient centre care. In addition to the GP services commissioned by NHS England there are a number of specialist services which are commissioned at a 'centrally' (e.g. regular retinal screening for people with diabetes).

Furthermore, in addition to complex health needs this group of patients may also have social care needs which are met by services commissioned by the Borough rather than by the CCG.

To ensure that all of the issues facing people with long term conditions are addressed in a comprehensive manner the Health and Wellbeing Board has identified as one of its' key strategies *Enabling people to manage their own health and wellbeing as independently as possible*. This strategy aims to improve the quality of life for people living with health conditions and to help them to live in their own homes as long as possible, through helping people to manage their own health and wellbeing as independently as possible.

There are a number of initiatives being taken forward under this priority area including:

- Implementation of a new pathway for direct access to reablement services for people with LTCs
- Implementation of a multi-disciplinary model of case management and risk stratification for people with LTCs
- The Ageing Well Programme launched in April 2013 focusing on support services for carers provided by Carers Support Merton such as Neighbourhood peer support groups/networks; Self-financed activities for carers as respite; Carry on caring workshops; Emotional Support and Coaching.
- Introduction of systematic arrangements for analysis of Practice feedback collected Practice Participation Groups

7. What preventative work is being done on LTC

The following information has been provided by Public Health Merton

The main public health activities on prevention of long term conditions are:

- NHS Health Checks: This is run from 25 GP practices in Merton and 3 community pharmacies, with a high uptake. In total in the year 2013-14 till date (quarters 1-3) 4689 Merton residents have undergone an NHS Health Check. The NHS Health Checks programme is directed at adults from the ages of 40-74 years, and each year 20% of the eligible population are invited for a check. New contracts have been developed and are being signed between individual GP surgeries and the LBM, as the programme has transferred from the erstwhile PCT to Public Health Merton in LBM. A new approach is being adopted of providing a universal service with a targeted element towards those most at risk. A system is under development to enable such targeting, and support call and recall and data management and make the process more streamlined for GP surgeries

- Smoking cessation, healthy weight management and physical activity- through the LiveWell programme funded by Public Health Merton

- Health Champions: community volunteers are being recruited and trained to promote health living and support LiveWell in all its health promotion activities

- Development of an adult health book- to support health champions and other healthcare professionals to inform and engage target populations in Merton on various health issues including long term conditions

- Tiers 2 & 3 services for obesity and weight management

- Alcohol prevention- a number of services are being designed to address the whole spectrum of alcohol related challenges from preventing the harms from excess alcohol intake right through to the management of the resulting long term conditions. This includes training on brief advise, designing and disseminating scratch-cards as a health promotion tool, and the development of an alcohol strategy for Merton

- Promoting workplace wellbeing- Public Health Merton is in the process of trying to sign-up LBM to the GLA Workplace Wellbeing Charter

- Training of front-line staff- this is being done with Merton fire-fighters and LBM library services, so that they are able to provide brief advice on smoking cessation and sign-post to LiveWell and other health services as relevant

- Good neighbours project (pilot) in partnership with MVSC to create neighbourhood networks with the initial focus on addressing loneliness and isolation in elderly residents as well as other residents who might be affected/ at risk.

- Additional work is being developed to address health issues in the elderly residents in Merton, in partnership with local agencies (i.e. Age UK Merton, Ageing Well Programme) with a particular emphasis on East Merton, through evidence based and culturally competent services.

- Inequalities work to address the prevalent variances in health outcomes for long term conditions across the borough.

- In addition a GP lead for long term conditions is being funded by Public Health Merton and this post will work with the Public Health lead to develop a long terms condition strategy and action plan.

Public Health England

RightCare

NHS England

Spend and outcome factsheet 2011/12
NHS Merton CCG

Introduction

Programme budgeting is a well-established technique for assessing investment in health programmes rather than services. All Primary Care Trusts (PCT) in England have submitted a programme budget return since 2003/4. All CCG financial figures are based on the above PCT returns.

NHS England has commissioned PHE Knowledge and Intelligence Team (Northern and Yorkshire) to produce a factsheet for each Clinical Commissioning Group (CCG) in England. This factsheet presents an overview of spend and outcomes for NHS Merton CCG. The factsheet presents:

- A diagram that categorises each programme into four quadrants in terms of spend and outcome to allow easy identification of those areas that require priority attention by the CCG.
- A spine chart that shows variation in spend and outcomes compared to similar CCGs, the Strategic Health Authority (SHA) and England, and allows instant visual identification of programmes which may benefit from further review.
- A bar chart which shows spend by programme compared with CCGs in the same Office of National Statistics (ONS) cluster.

Key facts

- NHS Merton CCG's highest spend areas, excluding programme 23 (Other), are £185 per head per year on Mental Health, £138 on Circulation and £111 on Musculoskeletal.
- NHS Merton CCG has no outlier outcomes, but in the area(s): Disorders of Blood, Maternity , Neonates, the CCG has outlier(s) on spend.

CCGs can use the Department of Health's programme budgeting spreadsheet to explore spend further by programme and sub programme.

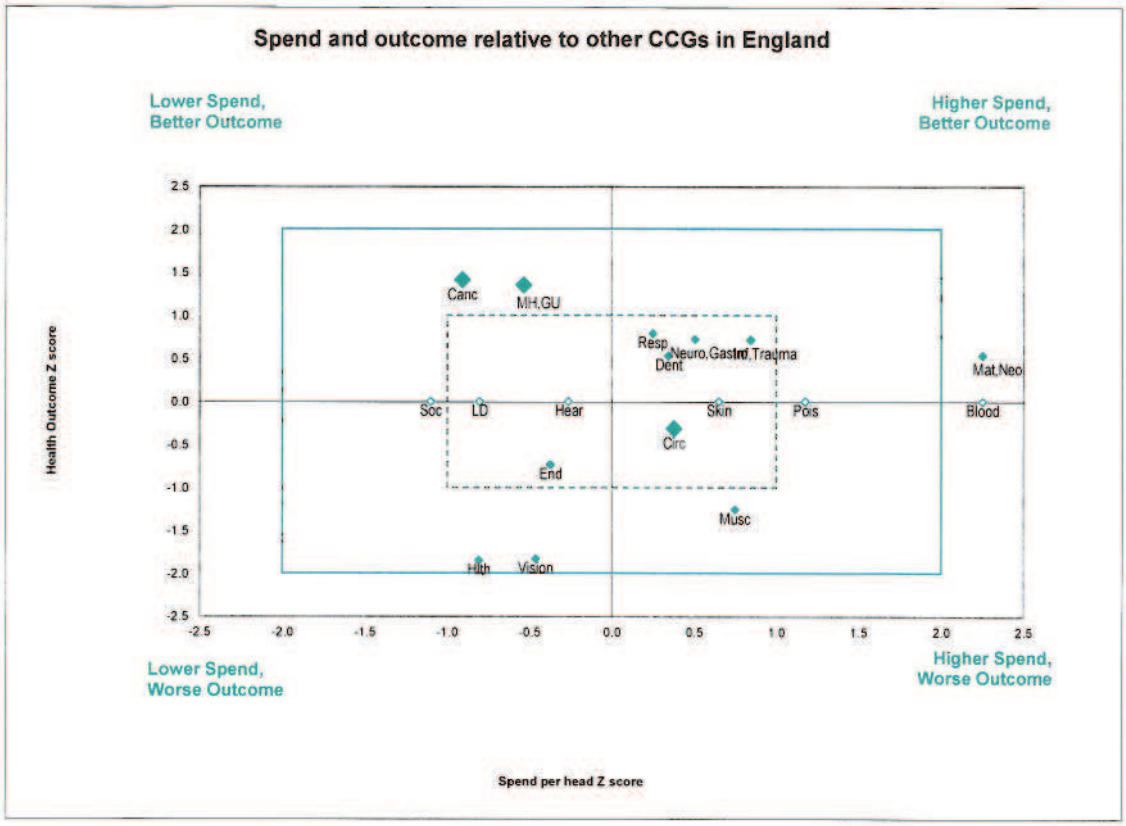
This factsheet and a Spend and Outcome Tool can be found on the PHE KIT (N&Y) website.

Public Health England

RightCare

NHS England

NHS Merton CCG 2011/12



◇ No outcome indicators readily available
◆ Outcome indicators available

Programme Area Abbreviations

Infectious Diseases	Inf	Hearing	Hear	Disorders of Blood	Blood
Cancers & Tumours	Canc	Circulation	Circ	Maternity	Mat
Respiratory System	Resp	Mental Health	MH	Neonates	Neo
Endocrine, Nutritional & Metabolic	End	Dental	Dent	Neurological	Neuro
Genito Urinary System	GU	GI System	Gastro	Healthy Individuals	Hlth
Learning Disabilities	LD	Musculoskeletal	Musc	Social Care Needs	Soc
Adverse effects & poisoning	Pois	Trauma & Injuries	Trauma		

Interpreting the chart:

Each dot represents a programme budget category. The three largest spending programmes nationally (Mental Health, Circulatory Diseases and Cancer) are represented by larger dots.

The outcome measures on the chart have been chosen because they are reasonably representative of the programme as a whole. This means that for some programmes no outcome data is available.

The source data for the outcome measures shown on the chart can be found in the Spend and Outcome Tool.

A programme lying outside the solid +/- 2 z scores box, may indicate the need to investigate further. If the programme lies to the left or right of the box, the spend may need reviewing, and if it lies outside the top or bottom of the box, the outcome may need reviewing. Programmes outside the box at the corners may need a review of both spend and outcome.

Programmes lying outside the dotted/thin +/- 1 z score box may also warrant further exploration.

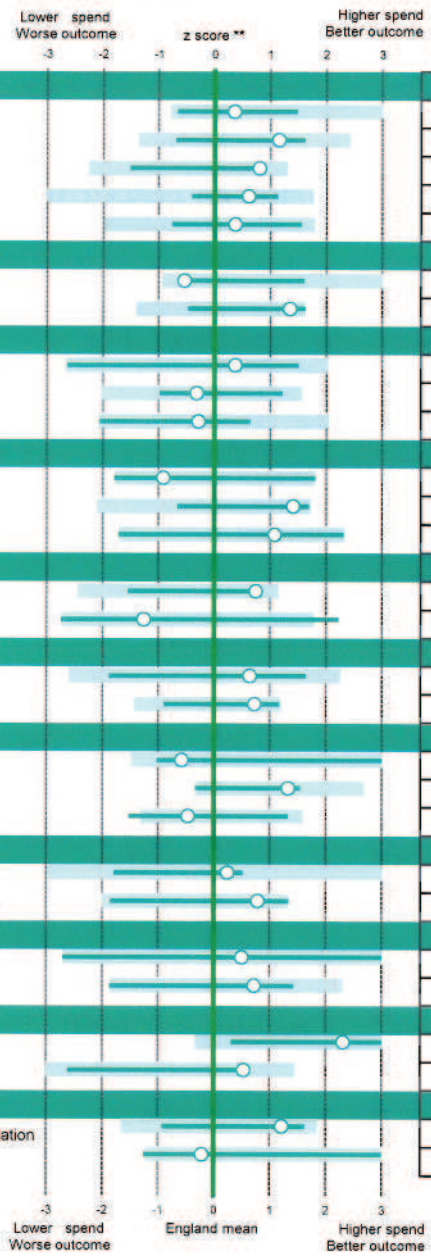
Z score:

A z score essentially measures the distance of a value from the mean (average) in units of standard deviations. A positive z score indicates that the value is above the mean, whereas a negative z score indicates that the value is below the mean. A z score below -2 or above +2 may indicate the need to investigate further.

Public Health England

NHS Merton CCG
London Suburbs
London SHA

NHS England



	CCG 10/11	CCG 11/12	2011/12 values ONS Cluster	SHA	England	Notes
Overall						
Overall spend per weighted head of population	£1,876	£1,787	£1,813	£1,868	£1,755	1
All age all cause mortality	490	468	509	511	537	8
Deprivation - Index of Multiple Deprivation 2010	15	15	23	25	22	7
Slope Index of Inequality in Life Expectancy (males)	7.1	7.1	7.6	7.6	8.8	5
Slope Index of Inequality in Life Expectancy (females)	5.1	5.1	4.9	4.8	5.9	5
Mental Health						
Mental Health spend per weighted head of population	£188	£185	£219	£255	£212	1
Mortality from suicide and undetermined injury, DSR*†	4.9	5.4	6.7	7.0	8.0	8
Circulation						
Circulation spend per weighted head of population	£140	£138	£132	£127	£131	1
Mortality from circulatory diseases, DSR*, under 75 years	76	70	64	65	63	8
Patients with CHD whose last blood pressure < 150/90	89%	90%	89%	89%	90%	4
Cancers and Tumours						
Cancer spend per weighted head of population	£117	£88	£94	£97	£105	1
Mortality from all cancers, DSR*, under 75 years	95	90	100	104	109	8
% cancer patients receiving treatment within 2 months	91%	91%	89%	88%	86%	3
Musculoskeletal system						
Musculoskeletal spend per weighted head of population	£106	£111	£88	£84	£98	1
PROMs* EQ-5D Hips Health Gain	0.45	0.36	0.40	0.39	0.41	6
Gastrointestinal Disease						
Gastrointestinal spend per weighted head of population	£96	£94	£85	£84	£87	1
Mortality from gastrointestinal disease	16	15	17	19	19	8
Genitourinary system						
Genitourinary spend per weighted head of population	£97	£82	£96	£97	£88	1
Genitourinary deaths within 30 days of admissions, ISR*	2540	2079	2273	2063	2722	6
% CRF* with hypertension on ACE*/ARB* therapy	91%	88%	90%	90%	90%	4
Respiratory Disease						
Respiratory spend per weighted head of population	£87	£86	£80	£80	£84	1
Mortality from Bronchitis, Emphysema & COPD*, DSR*, u75	7	8	10	11	11	8
Neurological Disease						
Neurological spend per weighted head of population	£76	£87	£78	£72	£81	1
Mortality from epilepsy, DSR*, under 75 years†	0.7	1.1	1.5	1.4	1.5	8
Maternity						
Maternity spend per weighted head of population	£109	£110	£102	£97	£68	1
% Low birth weights	6.7%	6.7%	8.1%	7.8%	7.3%	2
Other						
Primary Care GMS*/PMS* spend per weighted head of population	£159	£168	£149	£153	£149	1
Miscellaneous spend per weighted head of population	£142	£150	£197	£194	£160	1

**** z scores**

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CCG value
SHA range
ONS Cluster range

Notes

1. Department of Health 2011/12 ‡
2. NCHOD 2009 - 2011 data ‡
3. Healthcare Commission 2009/10 ‡
4. Quality and Outcomes Framework 2011/12
5. SHA and Cluster values are PCT averages
6. HSCIC 2009 - 2010 data ‡
7. Population weighted average of LLSOA IMD 2010
8. PHE KIT (N&Y) 2009 - 2011 data
9. Significant changes were introduced to the programme budgeting data collection methodology in 2010/11. Expenditure in 2010/11 should not be directly compared to expenditure in 2009/10. CCG mortality DSRs have been calculated using a methodology which assigns a geography to a CCG. These rates are subject to change either through further refinement to the methodology used or through changes to the CCG configuration. The metadata is available from PHE KIT (N&Y).

‡ CCG values based on PCT values

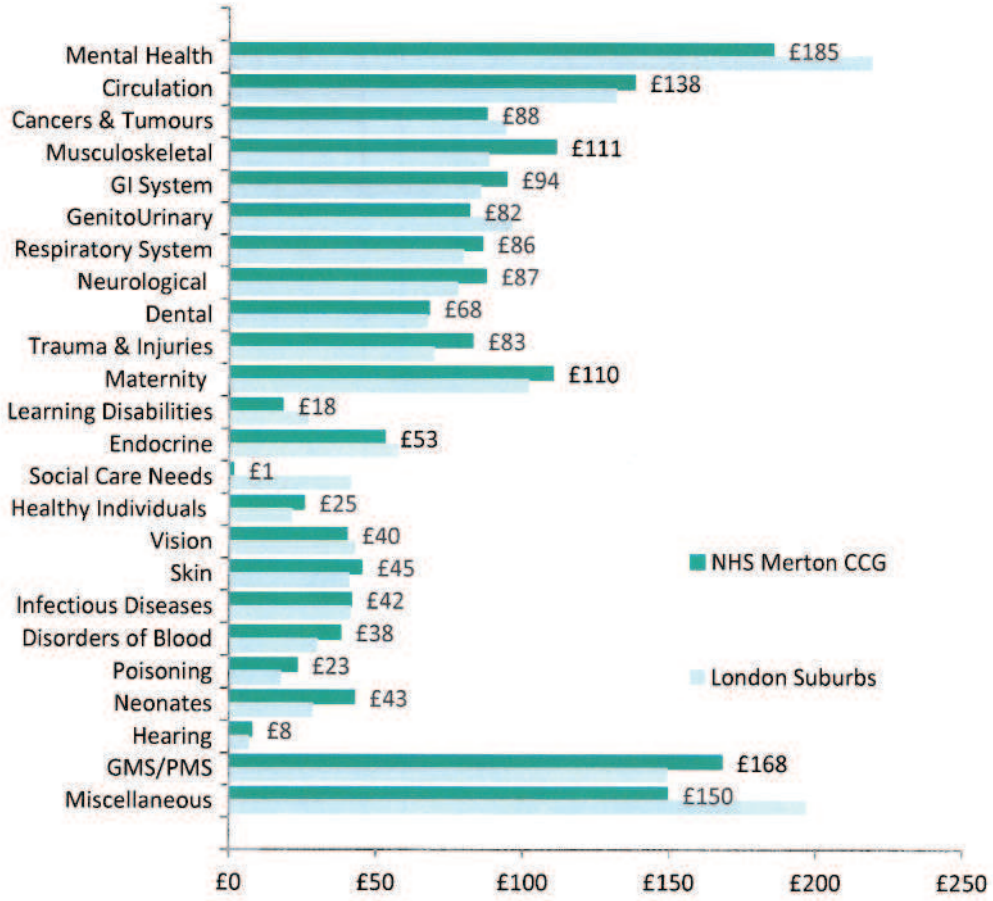
ONS Cluster

Clusters are used to group local authorities (LA) together according to key characteristics common to the population in that grouping. The Office of National Statistics derive these groupings, known as clusters, from census data. CCG values have been derived from LA values.

† Rates based on small numbers.

***ACE** - Angiotensin converting enzyme inhibitor
***ARB** - Angiotensin receptor blocker
***COPD** - Chronic Obstructive Pulmonary Disease
***CRF** - Chronic Renal Failure
*** DSR** - Directly Standardised Rate per 100,000
***GMS** - General Medical Services contract
***ISR** - Indirectly Standardised Rate per 100,000
***PMS** - Patient Medical Services contract
***PROMs** - Patient Reported Outcome Measures

Spend compared to ONS Cluster



This chart shows spend per head of population for your CCG and ONS cluster.

It also shows GMS/PMS spend on Primary Care (23a), and Miscellaneous spend (23x). Currently Primary Care prescribing is apportioned across programme areas but the spend on primary care staffing is not apportioned. If Miscellaneous spend is large then it may give a less accurate picture of spend on each programme, and CCGs may wish to take steps to reduce the amount of Miscellaneous spend in their programme budget return.

APPENDIX 2.

Public Health England

NHS Merton CCG
London Suburbs
London SHA

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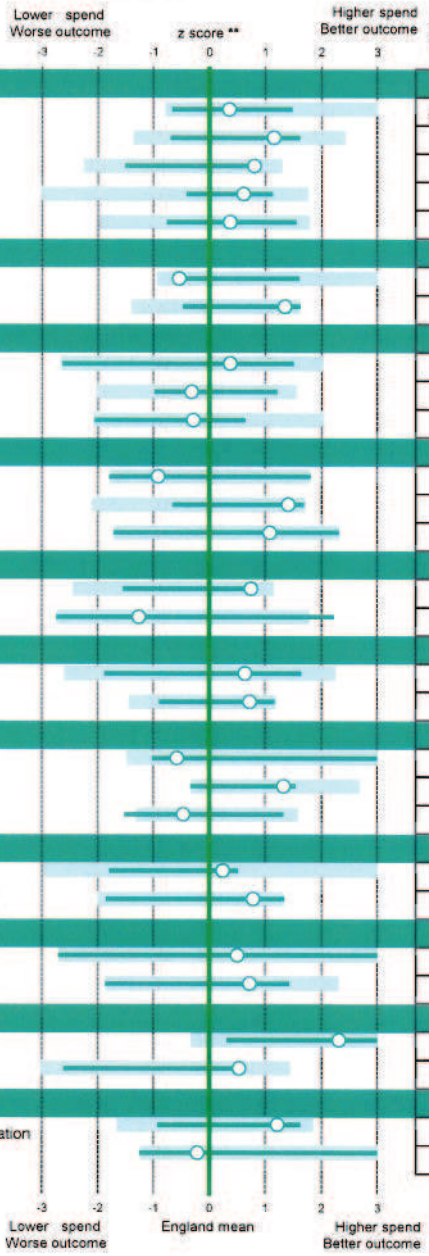

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ONS Cluster range

Notes

1. Department of Health 2011/12 ‡
2. NCHOD 2009 - 2011 data ‡
3. Healthcare Commission 2009/10 ‡
4. Quality and Outcomes Framework 2011/12
5. SHA and Cluster values are PCT averages
6. HSCIC 2009 - 2010 data ‡
7. Population weighted average of LLSOA IMD 2010
8. PHE KIT (N&Y) 2009 - 2011 data
9. Significant changes were introduced to the programme budgeting data collection methodology in 2010/11. Expenditure in 2010/11 should not be directly compared to expenditure in 2009/10. CCG mortality DSRs have been calculated using a methodology which assigns a geography to a CCG. These rates are subject to change either through further refinement to the methodology used or through changes to the CCG configuration. The metadata is available from PHE KIT (N&Y).

‡ CCG values based on PCT values

ONS Cluster

Clusters are used to group local authorities (LA) together according to key characteristics common to the population in that grouping. The Office of National Statistics derive these groupings, known as clusters, from census data. CCG values have been derived from LA values.

† Rates based on small numbers.

***ACE** - Angiotensin converting enzyme inhibitor
***ARB** - Angiotensin receptor blocker
***COPD** - Chronic Obstructive Pulmonary Disease
***CRF** - Chronic Renal Failure
*** DSR** - Directly Standardised Rate per 100,000
***GMS** - General Medical Services contract
***ISR** - Indirectly Standardised Rate per 100,000
***PMS** - Patient Medical Services contract
***PROMs** - Patient Reported Outcome Measures

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