

The Health Needs of East Merton

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Contents

Contents.....	2
Executive summary	4
Introduction	7
Health profile of Merton.....	7
Merton as a whole	7
East and West Merton	9
Summary	15
The leading health problems of East Merton	16
Mortality in East and West Merton	16
Cardiovascular disease.....	18
Cancer	22
Type 2 diabetes.....	24
Respiratory disease.....	25
Summary	26
Current services in East Merton	26
Chronic disease management in East Merton.....	27
Background	27
How can primary care reduce the impact of chronic diseases in East Merton?	27
How are chronic diseases managed by primary care in East Merton?.....	29
Summary	37
Commissioning.....	38
Commissioning background.....	38
<i>Commissioning for Value</i>	38
Summary	40
Evidence from elsewhere.....	41
Improving primary care, including chronic disease management: the Tower Hamlets Primary Care Investment Programme	41
Improving chronic disease management: What is the impact of intermediate care clinics for people with diabetes?.....	44
Reducing need for secondary care: What is the impact of general practitioners with a special interest on primary care services?	45

Managing people with more severe health problems: What is the impact of virtual wards as a means of providing community-based health care?	45
Summary	47
Conclusions	49
Recommendations	50
References	50



Executive summary

This is a review of the health needs of the residents of East Merton. It has been commissioned in connection with the preparation of a business case for a community health facility in the locality.

Merton is more affluent than average for England, with few people affected by severe economic deprivation. Life expectancy is higher than average and health is generally good. The most important threats to public health in Merton are heart disease, stroke, cancer and diabetes. Premature mortality from heart disease and stroke is one of the few health outcomes where Merton as a whole has a higher rate than England.

However, Merton is far from homogenous. The eastern half has a younger, poorer and more ethnically mixed population. The western half is whiter, older and richer. Largely as a result, people in East Merton have worse health and shorter lives.

Most of the excess deaths in East Merton are because of cardiovascular disease and cancer, with larger differences seen in younger people. These large differences in mortality from cardiovascular disease and cancer are not reflected in admission rates, suggesting that the high need for services for the treatment of these two diseases in East Merton, especially below age 75 years, is not matched by the uptake of inpatient hospital services. Diabetes is more common in East Merton than in the west of the Borough. Respiratory disease is also common in Merton, and the performance of the smoking cessation services is poor.

After describing current health services in East Merton, this report sets out the importance of the management of chronic disease in primary care, and points to evidence-based guidance on that subject. It summarises how important chronic diseases are managed in primary care in East Merton practices, compared with elsewhere. Because of lack of time, this report focusses on chronic diseases of later life. It does not cover other important areas of public health such as acute illnesses, children and young people's health and mental health, though other work is in hand about the latter two topics.

Primary care has a critical role in the prevention, prompt diagnosis and management of chronic disease. Many East Merton residents with cardiovascular disease, hypertension, diabetes and chronic obstructive pulmonary disease have not yet been diagnosed. This means that appropriate treatment to improve symptoms and prevent progression is not available to them. There are also large variations between practices in the proportion of registered patients diagnosed with important chronic diseases, suggesting some practices have substantial under-diagnosis.

The primary care management of people with diabetes in Merton is in the bottom quartile for England. There are also indications that some practices have higher than expected rates of admission with chronic obstructive pulmonary disease.

The report then summarises the commissioning background in Merton and the findings of *Commissioning for Value* analyses. It notes that new models of service provision in Merton will involve more care being provided in community settings and less at hospital sites.

Commissioning for Value has indicated areas where Merton CCG's performance and spending compare unfavourably with a group of similar CCGs. The most important of these are mortality from cardiovascular disease and prescribing costs for diabetes and circulatory and respiratory disease.

The report summarises some evidence of potential relevance to decision-making about how to develop primary care in East Merton, especially in the light of the possibility of a new health-care facility in the locality.

Conclusions

East Merton has two crucial opportunities:

- Improving the quality of chronic disease management in primary care is of the greatest importance. Much of this will be achieved by primary health care teams themselves, supported by the CCG, the public health team and others, and should be pursued regardless of changes in the healthcare infrastructure in the locality.
- Transforming how health care is delivered, with less reliance on hospital services and more imaginative and effective use of community-based approaches. This provides people with more accessible care, strengthens collective health resources and reduces the burden on the overstretched acute sector.

This report was prepared to support the business case for a new healthcare facility in East Merton. What role might that play in achieving these two goals?

There are two broad answers to this question:

Firstly, the facility could provide a site for services moving out of secondary care provision or other community facilities locally. As the reconfiguration of services in Merton and surrounding areas gathers pace, this purpose could broaden to complement as well as replace existing services, improving geographical accessibility and drawing services into closer alignment with community and primary care services. The intermediate care diabetes clinic is an example of this.

Secondly, the facility could provide a physical focus for the improvement of primary care services, including chronic disease management. However, the principle changes needed are in the “software” of primary care (for example, leadership, coordination, training, education, motivation, clinical practice guidelines and patient monitoring), rather than the “hardware” (for example buildings, equipment and accommodation).

These two purposes for any new facility are complementary. Imaginative use of the new facility could energise the process of quality improvement, by providing a centre for the initiative and a base for support staff and patients. There may also be value in having a geographically accessible site from which to promote community-wide initiatives to improve health and help residents to make effective use of health care.

Recommendations

1. Merton CCG should take steps to lead improvement in the quality of primary care management of chronic diseases in East Merton. A networking approach to primary care development may be an important way of achieving this.

2. Statutory bodies in Merton should consider the extent to which a new health care facility in East Merton could contribute to health improvement in that locality. Its purpose might include accommodating services moving from elsewhere, housing novel services to complement what exists now, providing the public with an accessible point of contact for a range of local services and acting as a focus for quality improvement initiatives in primary care.
3. The CCG should consider new models of service provision that involve more care being provided in community settings and less at hospital sites. Intermediate care for people with diabetes may be a useful addition to community services in Merton.

Introduction

For some time, there has been interest in the construction of a new community healthcare facility in East Merton. Several sites are being considered and a business case for the required capital is being prepared. The new development should address the health needs of the local population, so Merton's Director of Public Health commissioned this report from PHAST, the Public Health Action Support Team.

The time available for the production of the report was short, so we agreed to focus it on the major long-term health problems that affect the population of East Merton, and to review the evidence pragmatically rather than systematically. The report does not cover other important areas of public health such as acute illnesses, children and young people's health and mental health. There will be a separate report on children's and young people's health, and on mental health.

The aim of the report is to provide a brief review of aspects of the health needs of East Merton's population, and consider how the proposed new health care facility in the locality could best contribute to meeting those needs.

Health profile of Merton

This section of the report summarises the health of Merton's residents, and contrasts the health status of the population of the Borough's east and west halves.

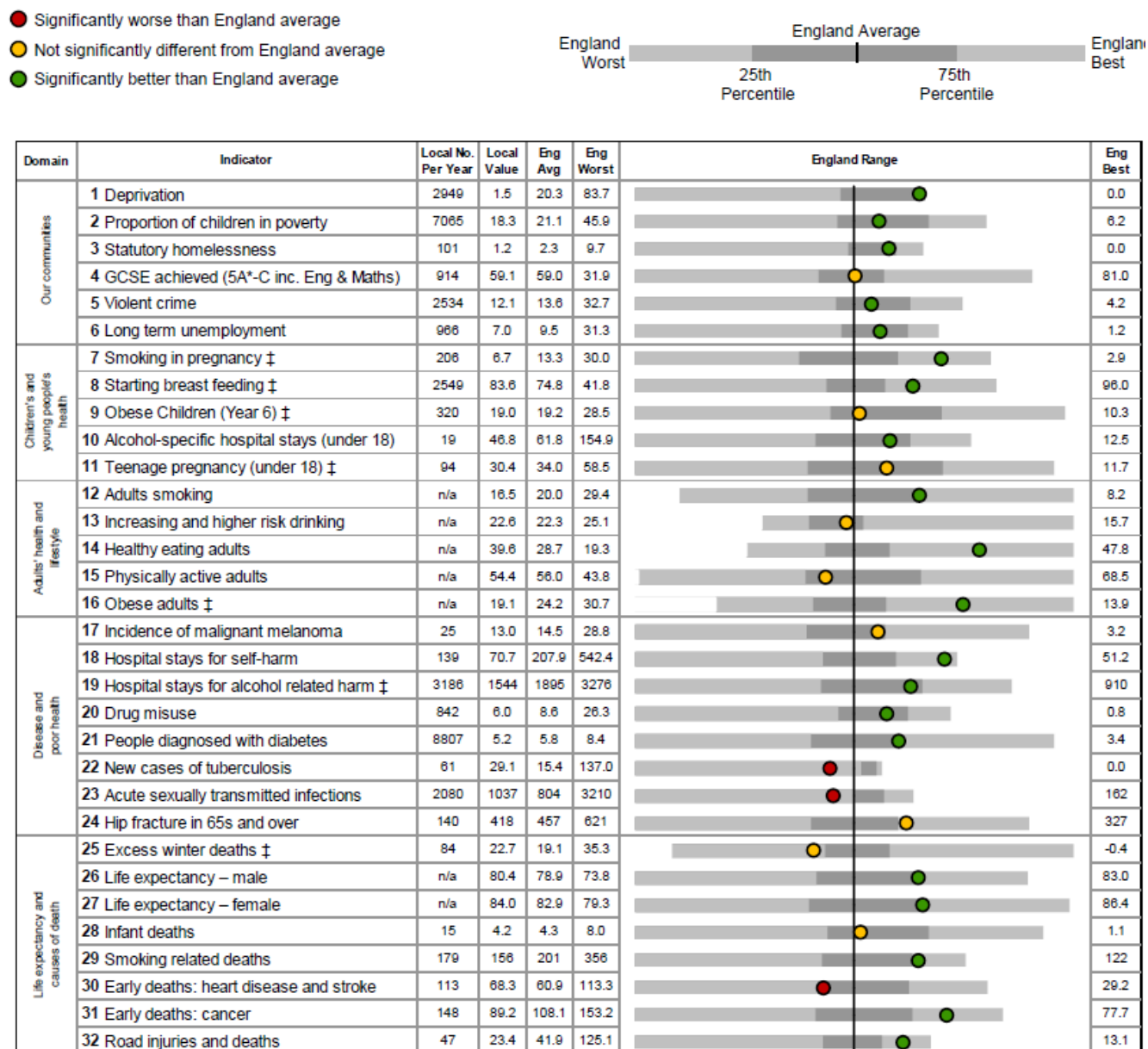
Merton as a whole

The health of people in Merton is generally better than the England average. Deprivation is lower than average: more than 30% of the borough's population live in the most affluent quintile of areas by national standards, while only 2% are in the most deprived quintile. Largely because of the relative lack of deprivation, life expectancy for both men and women is significantly higher than for England as a whole.

On average, male residents of the Borough can expect to live a year and a half longer than average for England, while females can expect to live just over a year longer. Many other measures of health are also significantly better in Merton than elsewhere in England, including lower levels of smoking, higher rates of breast-feeding, healthier eating patterns, less obesity and fewer road injuries (Figure 1).

One of the few measures on which Merton performs worse than England is early deaths from heart disease and stroke.

Figure 1: Health indicators, Merton and England, 2006 to 2012



Source: [Public Health England](http://PublicHealthEngland)

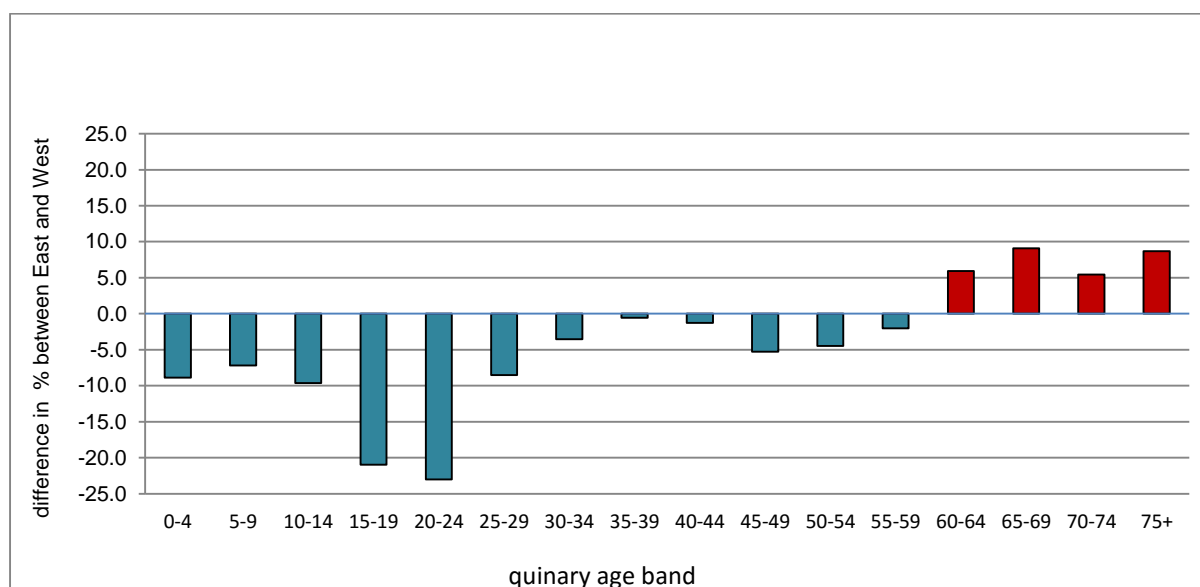
As elsewhere in Britain, long-term, or chronic, diseases are the most important public health problems in Merton. Heart disease, stroke, cancer, diabetes and chronic lung diseases are all common health problems in the Borough and, between them, account for most of the mortality experienced by Merton residents.

East and West Merton¹

Demography

There are important differences in the structure of the population of the two halves of the Borough. Figure 2 shows the differences in the age structures of the Borough's halves. It shows that East Merton's population has a younger age profile, with a larger share of all age-groups under 60 years of age, especially 15 to 24 year olds.

Figure 2: Differences between East and West Merton's population, five year age-bands, 2013



Source: Round 2012 GLA SHLAA population projections

Blue negative figures indicate that there more people in that age-band in East Merton, red positive ones that there are more in West Merton.

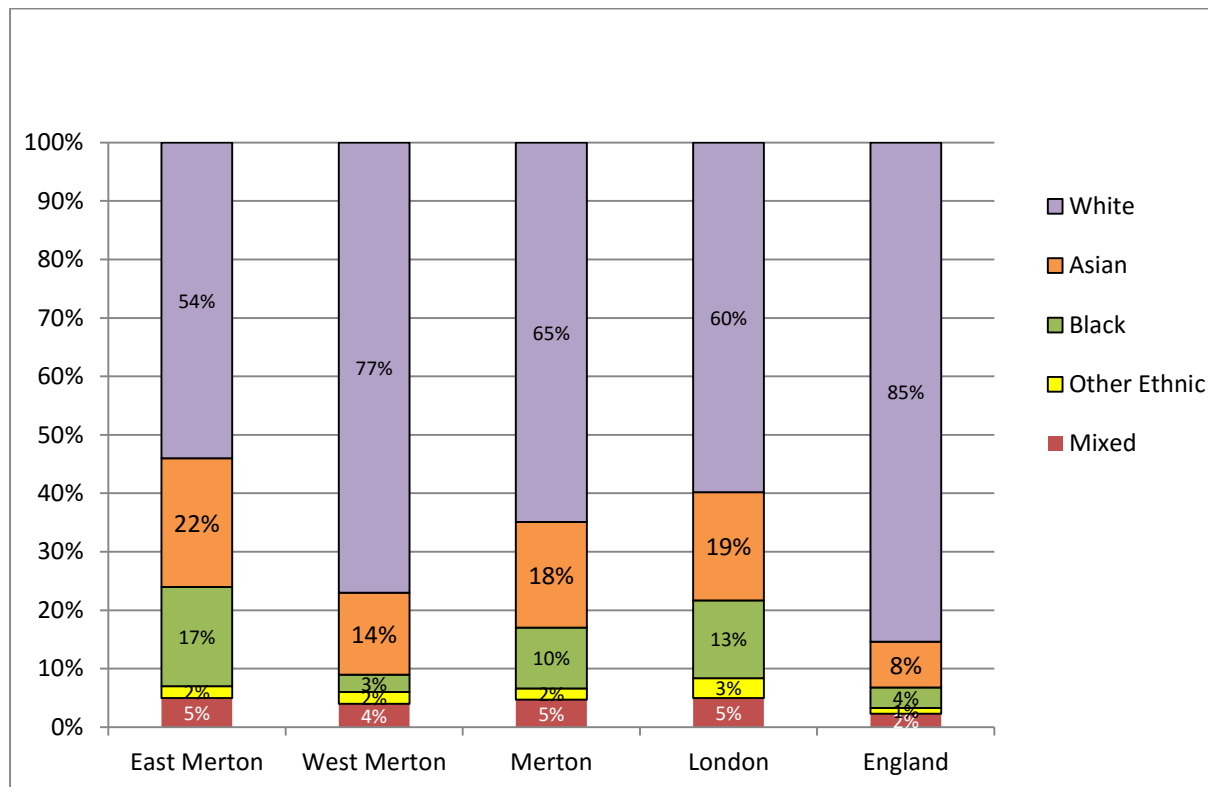
East Merton has a more ethnically diverse population than West Merton (Figure 3). West Merton's population is 77% white, compared with 54% for East Merton; the proportion of the population which is Black is 3% in West Merton and 17% in East Merton. The ethnic composition of East Merton resembles that of London, whereas West Merton has a profile more similar to that of England as a whole.

¹ For the purposes of this report, the Borough's wards are divided as follows:

East Merton comprises Abbey, Colliers Wood, Cricket Green, Figge's Marsh, Graveney, Lavender Fields, Longthornton, Pollards Hill, Ravensbury and St Helier. The total population of these wards is about 106,500.

West Merton comprises Cannon Hill, Dundonald, Hillside, Lower Morden, Merton Park, Raynes Park, Trinity, Village, West Barnes and Wimbledon Park. The total population of these wards is about 96,500.

Figure 3: Proportion of population by ethnic group, Merton, London and England, 2011

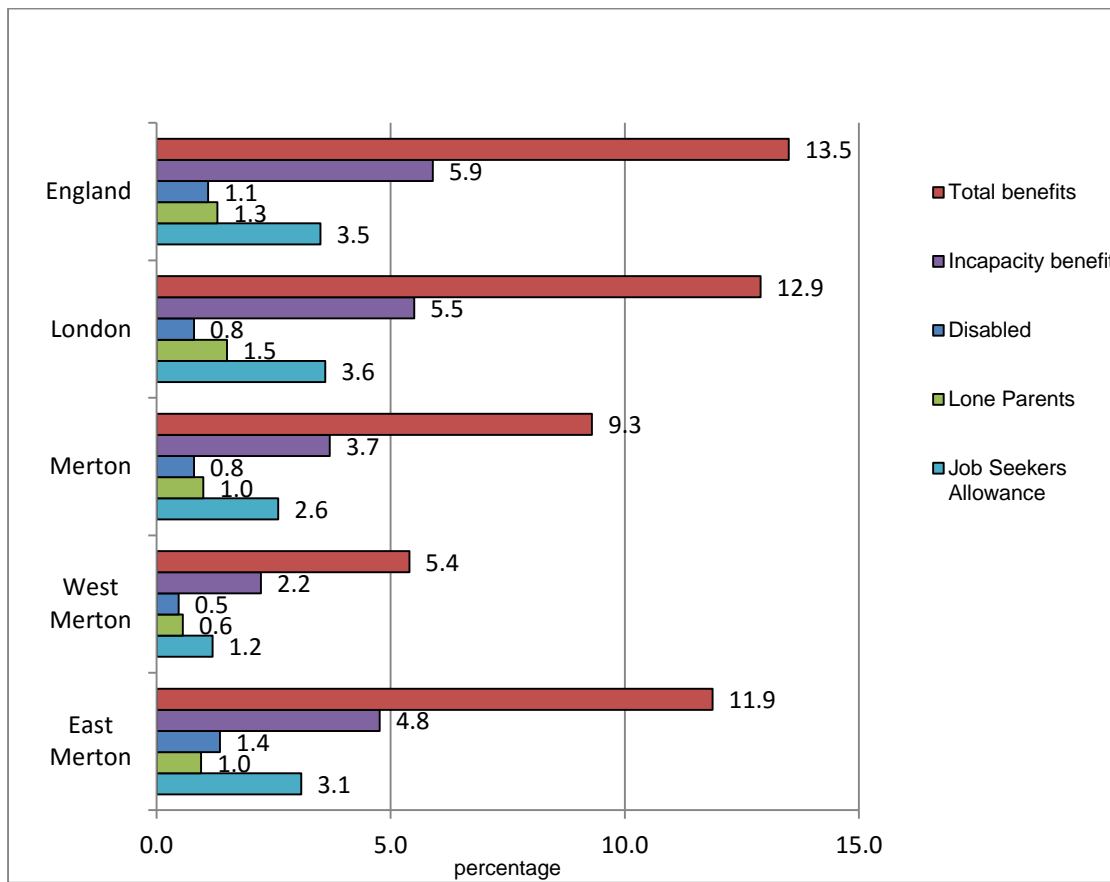


Source: 2011 Census

Economic deprivation

Two sets of statistics illustrate the differences in economic conditions between the two parts of Merton. Figure 4 shows the higher proportion of East Merton residents receiving social security benefits, compared with West Merton. More than twice as many East Merton residents receive these benefits, with the differences especially large for disability benefit and job seekers' allowance.

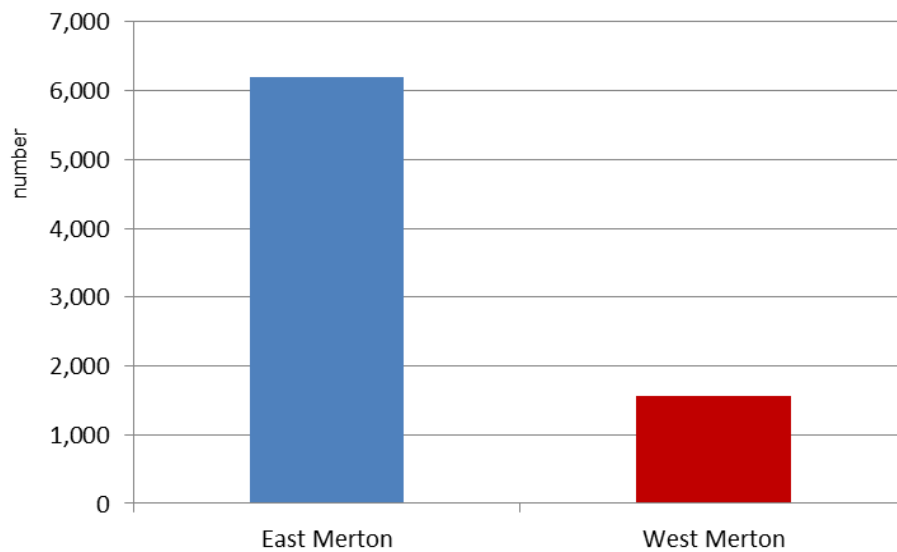
Figure 4: Labour market statistics, East and West Merton, May 2013



Source: NOMIS Labour market reports, Office for National Statistics

About four times more children live in poverty in East Merton than in the West (Figure 5).

Figure 5: Number of people under 16 living in poverty, East and West Merton, 2010



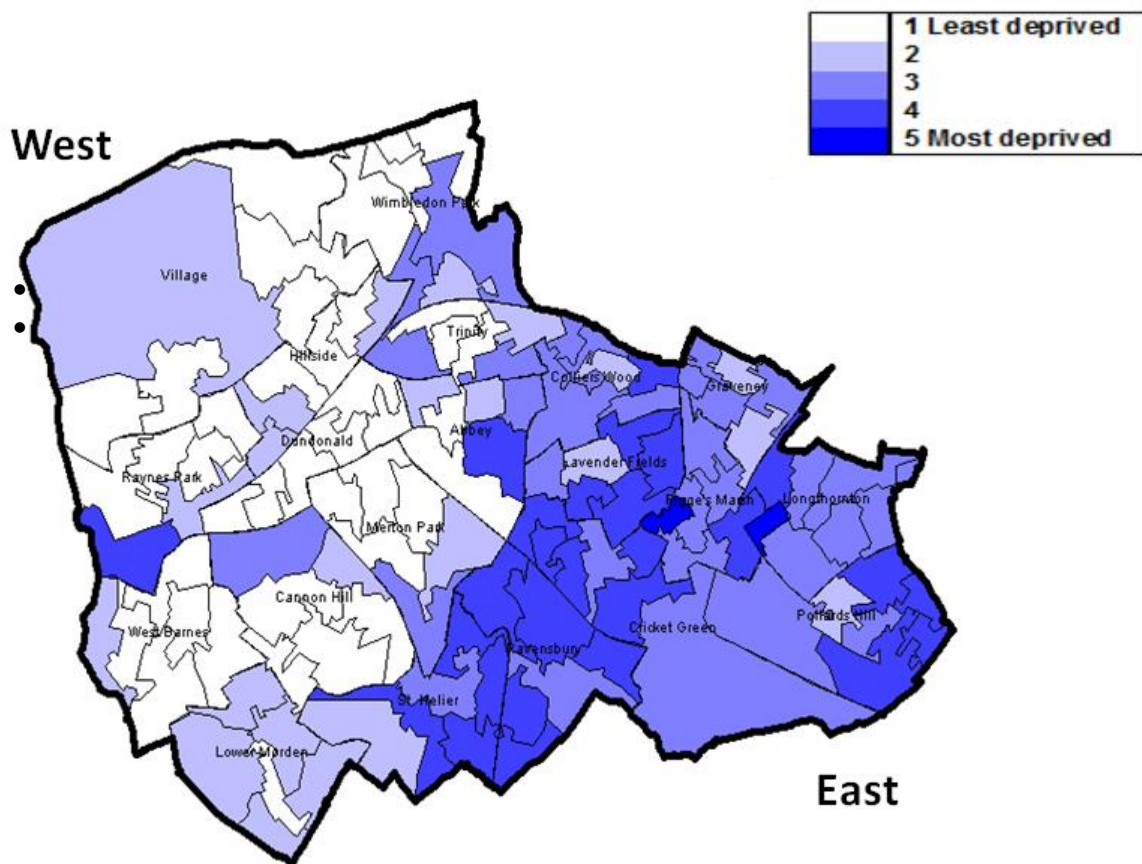
Source: Health Needs Assessment toolkit

Health status

The overall health status of Merton's residents is better than average for England, but the figures are averages and do not convey the differences in health within the Borough. These are stark; males in the most affluent tenth of the Borough can look forward to a life expectancy 5.9 years longer than those in the least deprived tenth, while the difference for female residents is 5.3 years.

In Figure 6, parts of the Borough which are in the most deprived quintile for England are shown in dark blue with lighter blue for more affluent areas and white for the most affluent quintile. With some exceptions, such as Raynes Park and Wimbledon Park, the most deprived areas in Merton are in the eastern part of the Borough, and the affluent areas in the west.

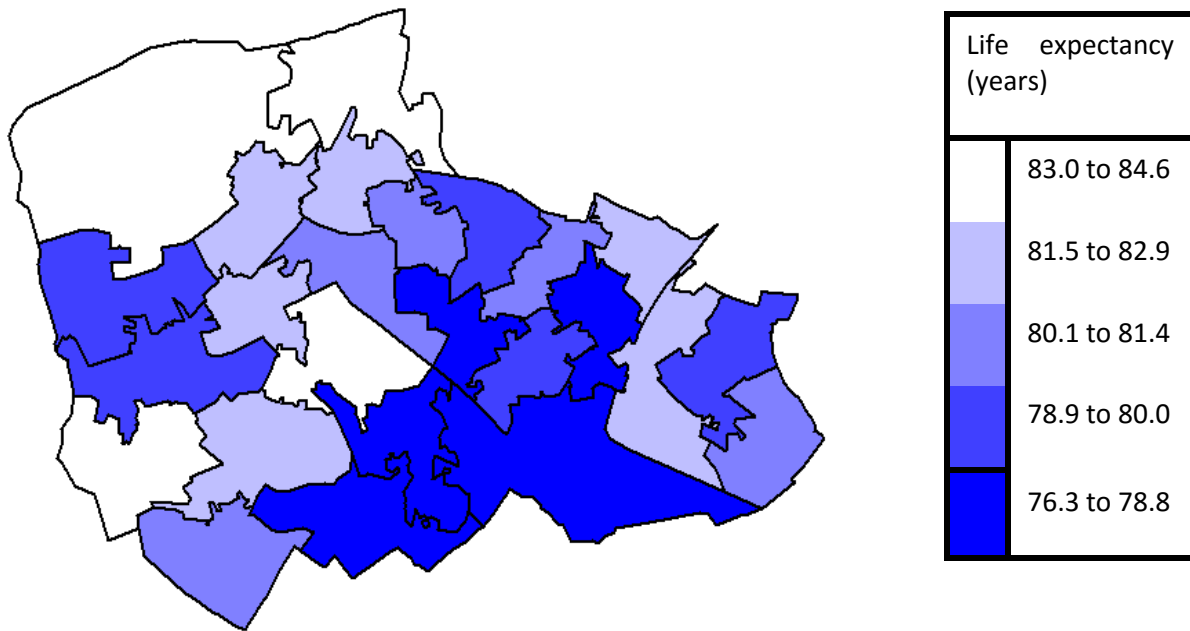
Figure 6: Index of Multiple Deprivation, Merton lower super output area by national quintiles, 2010



Source: [Department of Communities and Local Government](#)

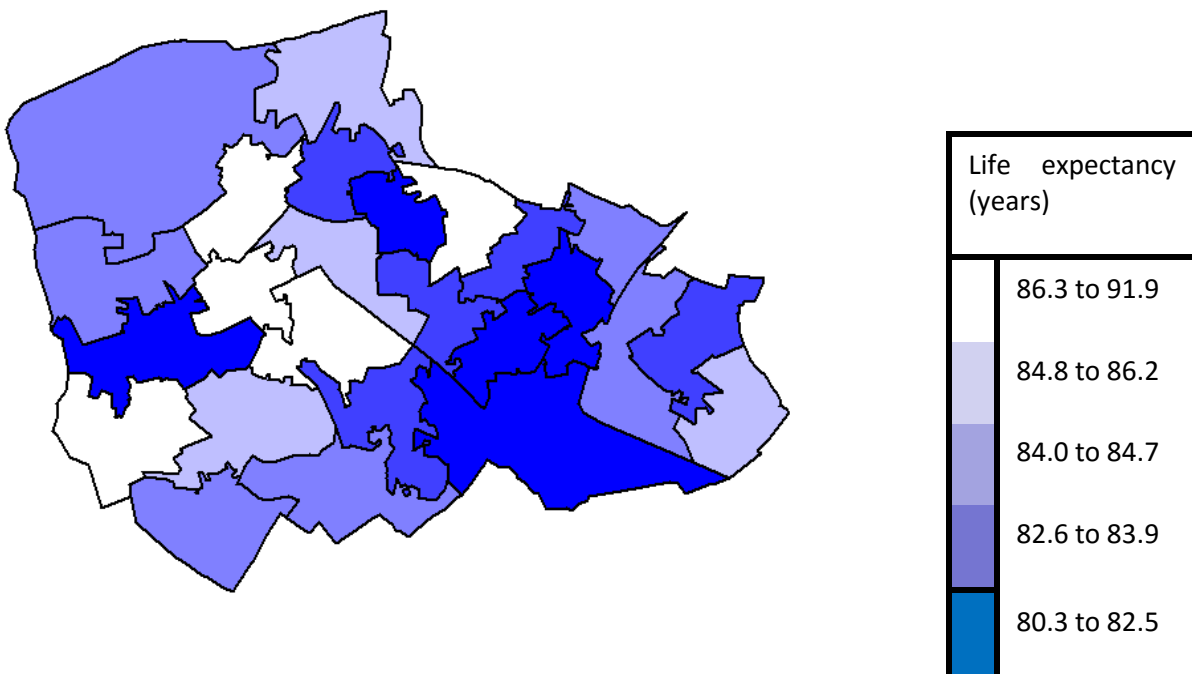
In general, people who live in conditions of socio-economic deprivation experience worse health and have shorter lives than those in more affluent areas. Data from Merton reflect this; Figure 7 shows male life expectancy in different parts of the Borough, and Figure 8 female life expectancy. In both cases, the darker areas, with shorter life expectancy, are concentrated in East Merton. On average, residents of East Merton can expect to live about three years less than those in West Merton; if the death rates in the east of the borough fell to those in the west, there would be 113 fewer deaths in the east each year.

Figure 7: Life expectancy, males, Merton, 2006 to 2010



Source: Public Health Observatories JSNA dataset, March 2012

Figure 8: Life expectancy, females, Merton, 2006 to 2010



Source: Public Health Observatories JSNA dataset, March 2012

Summary

Merton is more affluent than average for England, with few people affected by severe economic deprivation. Life expectancy is higher than average and health is generally good. The most important threats to public health in Merton are heart disease, stroke, cancer and diabetes. Premature mortality from heart disease and stroke is one of the few health outcomes where Merton as a whole has a higher rate than England.

Merton is however far from homogenous. The eastern half has a younger, poorer and more ethnically mixed population. The western half is whiter, older and richer. Largely as a result, people in East Merton have worse health and shorter lives.

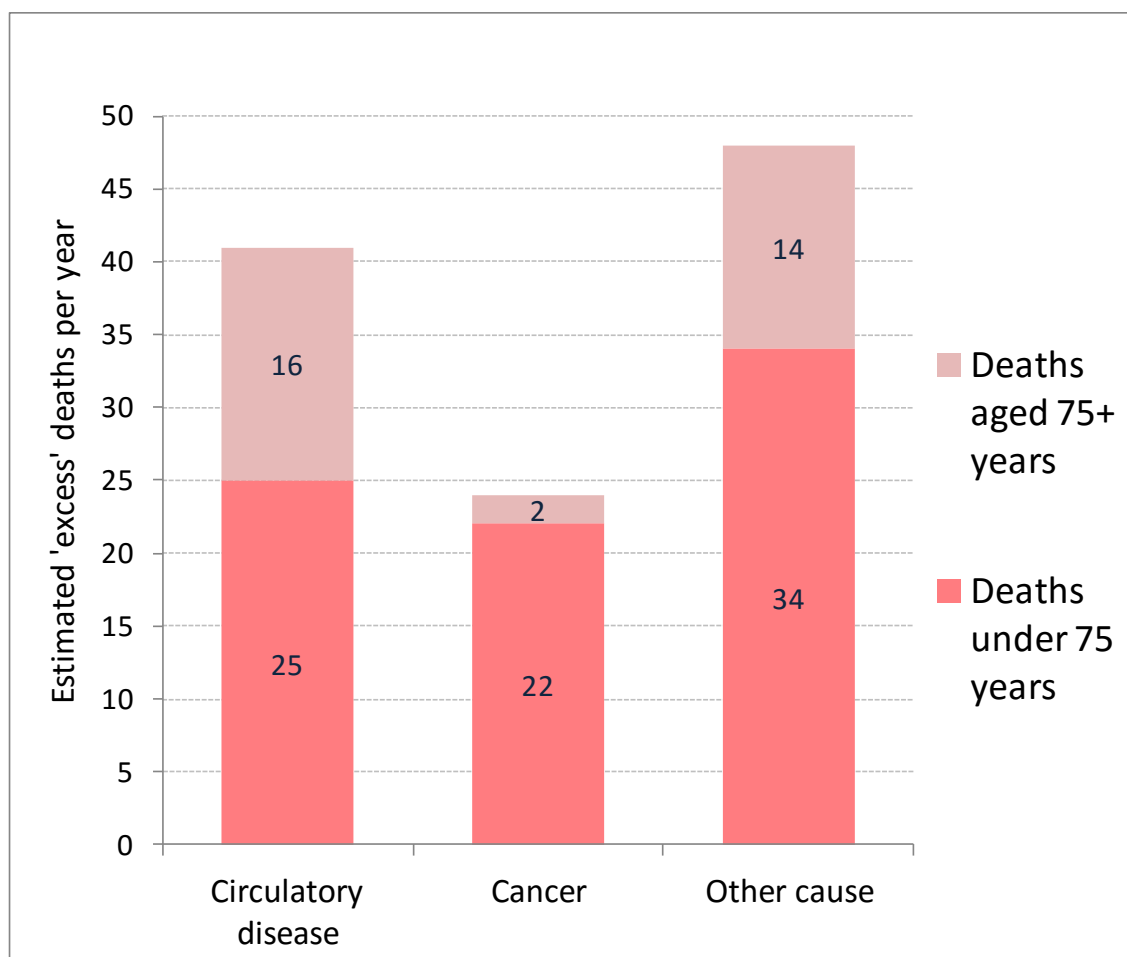
The leading health problems of East Merton

This section of the report describes the most critical health problems facing the population of East Merton. As far as possible, it uses analyses prepared for this report comparing East Merton with the West of the Borough, London and England. Where necessary, analyses of the whole of the Borough are used as well.

Mortality in East and West Merton

What are the main causes of the differences in mortality between East and West Merton? Figure 9 shows the number of excess deaths in East Merton attributable to some leading causes of mortality and in different age groups. It shows that about 41 (or 36%) of the excess deaths each year are due to cardiovascular causes (coronary heart disease, stroke and allied disorders), and about 24 (21%) are due to cancer.

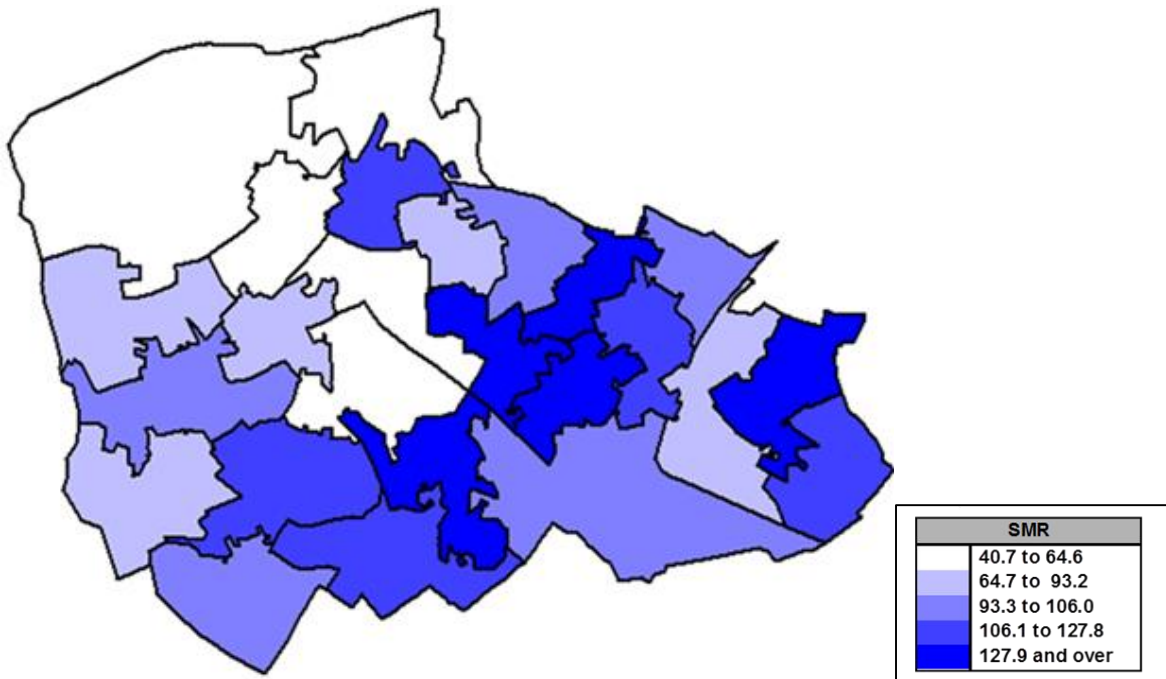
Figure 9: Numbers of annual excess deaths, East Merton compared with West Merton, by cause, 2006 to 2010



Source: Public Health Observatories JSNA dataset, March 2012

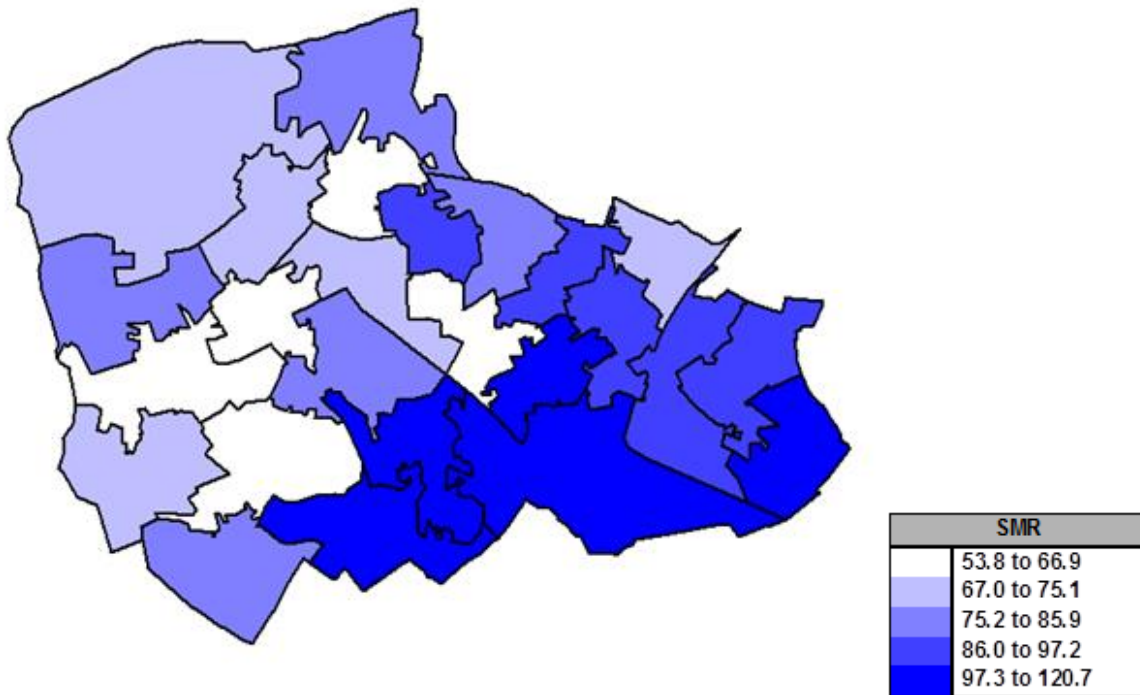
Mortality before 75 years of age from these two conditions is strikingly different in the two halves of Merton (Figures 10 and 11).

Figure 10: Mortality from cardiovascular diseases under 75 years, Merton, 2006 to 2010



Source: Public Health Observatories JSNA dataset, March 2012

Figure 11: Mortality from cancer under 75 years, Merton, 2006 to 2010

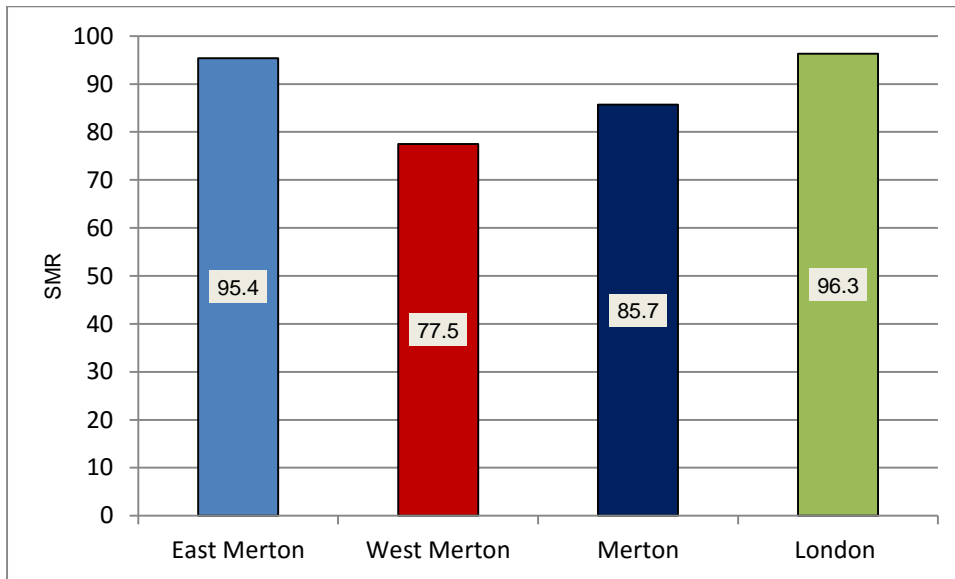


Source: Public Health Observatories JSNA dataset, March 2012

Cardiovascular disease

As shown in Figure 9 above, cardiovascular disease is the largest contributor to the differences in mortality between East and West Merton. This is also illustrated by Figure 12, which indicates that, after adjustment for age, East Merton's mortality from these diseases is similar to that of London and nearly a quarter higher than that of West Merton.

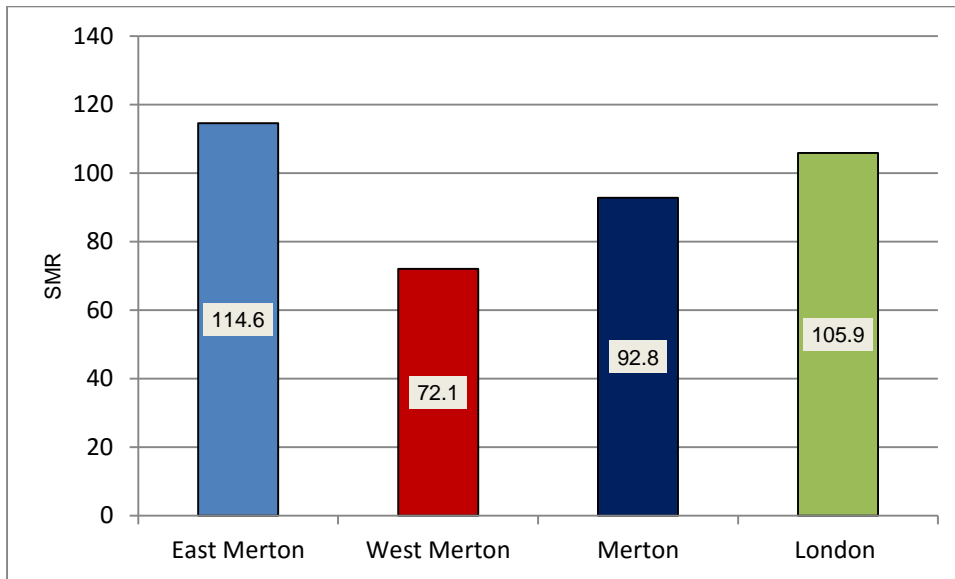
Figure 12: Standardised mortality ratios (SMR) for cardiovascular diseases, all ages, Merton and London compared to England (100), 2006 to 2010



Source: Health Needs Assessment toolkit

The differences for those dying before the age of 75 years are even starker – East Merton’s mortality is higher than that of England and London, whereas West Merton’s mortality in this age group is lower relative to those comparators than it is in all age-groups (Figure 13). This corroborates Figure 1, which showed premature mortality from heart disease and stroke to be one of the few public health outcomes where Merton as a whole has a higher rate than England.

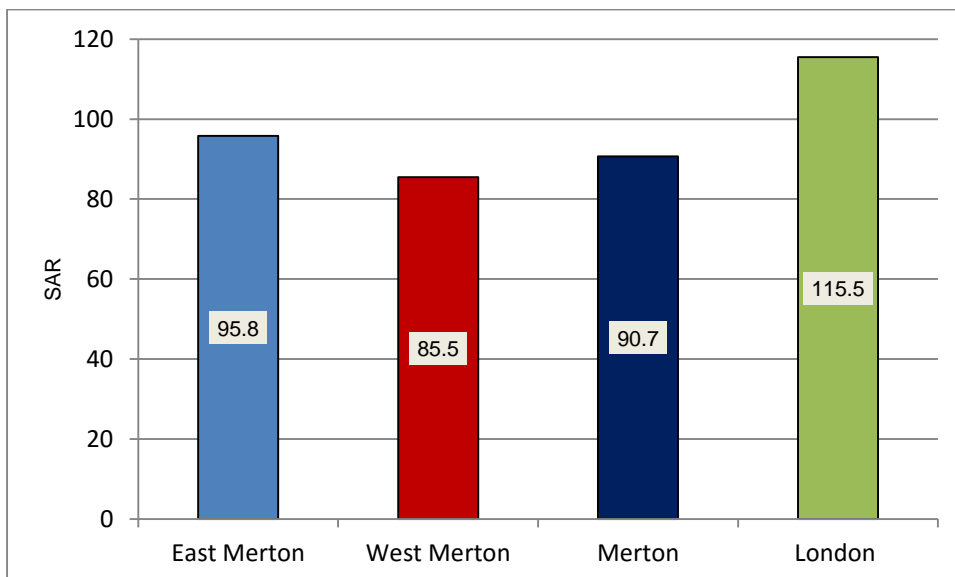
Figure 13: Standardised mortality ratios (SMR) for cardiovascular diseases, under 75 year olds, Merton and London compared to England (100), 2006 to 2010



Source: Health Needs Assessment toolkit

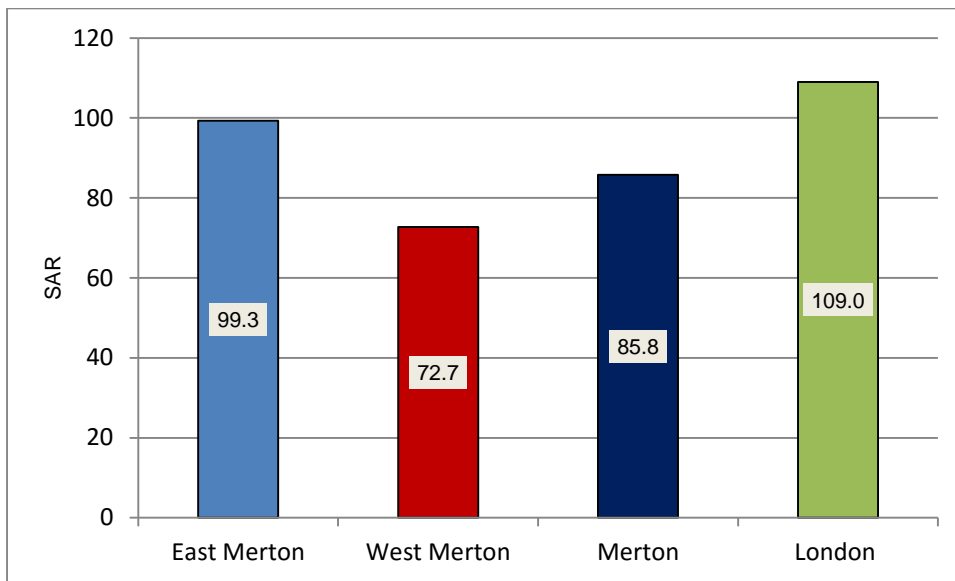
The differences in hospital admissions for cardiovascular disorders do not show such large differences between the two halves of the Borough. Figure 14 shows smaller differences in rates of admission than would be expected from the mortality data shown in Figure 12. The results in those under 75 are even more striking, with the high mortality rates not reflected in admissions (Figure 15).

Figure 14: Standardised admission ratios (SAR) for cardiovascular diseases, all ages, Merton and London compared to England (100), 2006 to 2010



Source: Health Needs Assessment toolkit

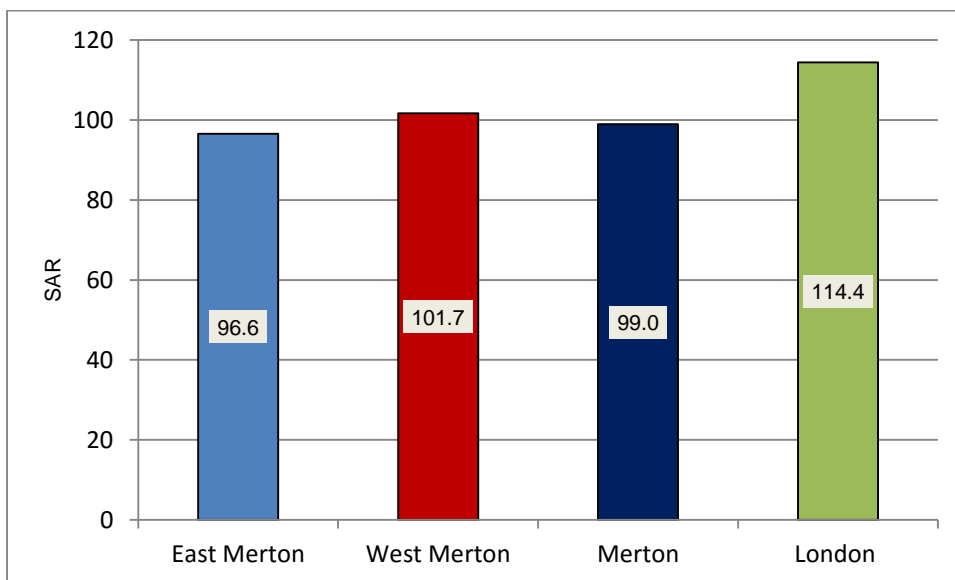
Figure 15: Standardised admission ratios (SAR) for cardiovascular diseases, under 75 year olds, Merton and London compared to England (100), 2006 to 2010



Source: Health Needs Assessment toolkit

For coronary heart disease, the most common cardiovascular disorder, admission rates are lower in East Merton than in West Merton (Figure 16). This is despite a much higher standardised mortality ratio in the East of the Borough (87) compared with the West (69).

Figure 16: Standardised admission ratios (SAR) for coronary heart disease, all ages, Merton and London compared to England (100), 2006 to 2010



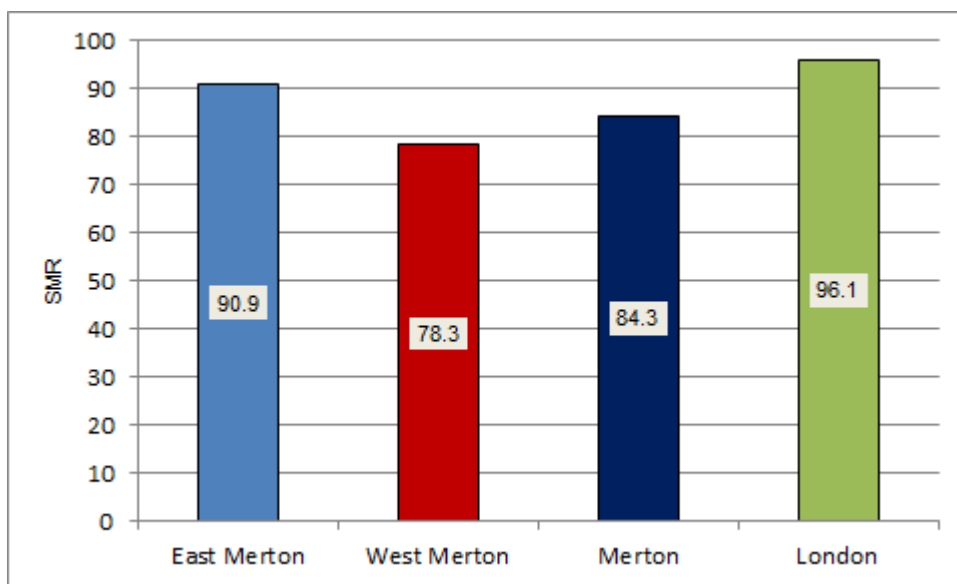
Source: Health Needs Assessment toolkit

These results suggest that East Merton's population has high need for services for the treatment of cardiovascular disorders, especially below age 75 years, but that these needs are not matched by the utilisation of inpatient hospital services.

Cancer

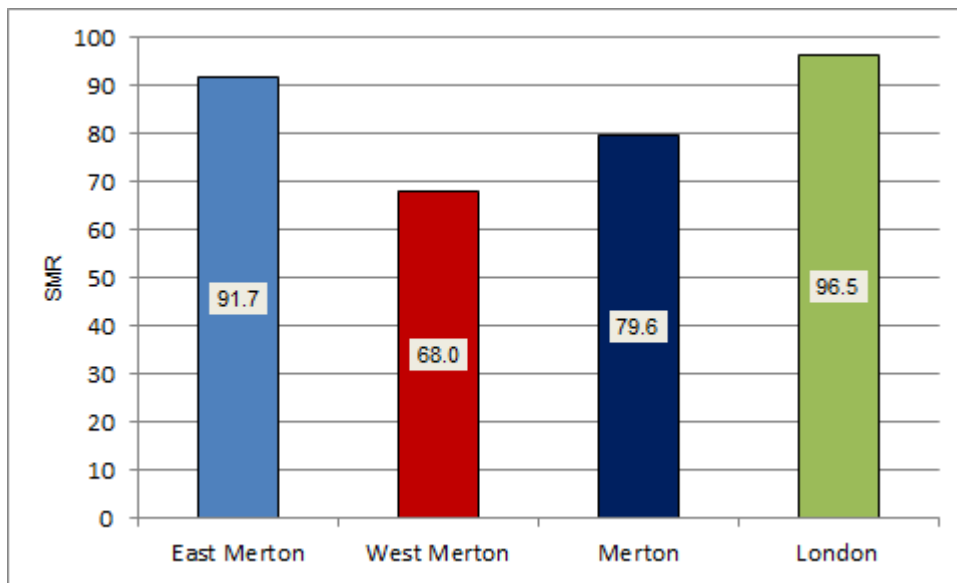
Analysis of cancer data indicates similar trends. Mortality is substantially higher in East Merton than in the West of the Borough (Figure 17), especially in people under 75 years (Figure 18). However, the difference in admission rates is smaller (Figure 19), indicating that the needs of people in East Merton may not be met as fully as those in the West.

Figure 17: Standardised mortality ratios (SMR) for cancer, all ages, Merton and London compared to England (100), 2006 to 2010



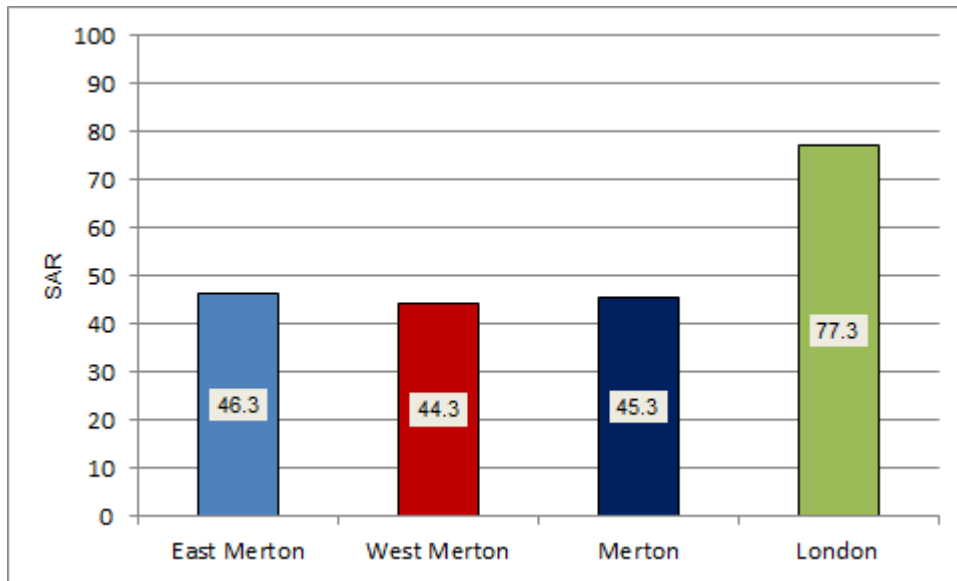
Source: Health Needs Assessment toolkit

Figure 18: Standardised mortality ratios (SMR) for cancer, under 75 year olds, Merton and London compared to England (100), 2006 to 2010



Source: Health Needs Assessment toolkit

Figure 19: Standardised admission ratios (SAR) for cancer, all ages, Merton and London compared to England (100), 2006 to 2010



Source: Health Needs Assessment toolkit

Type 2 diabetes

Diabetes is a common problem in Merton. In 2011/12, 5.3% of Merton's population aged 17 years and older were diagnosed with diabetes, and there were an estimated further 1.9% with undiagnosed diabetes. People with type 2 diabetes, the commonest variety, often also have raised blood pressure and abnormal levels of cholesterol in their bloodstream. These abnormalities, often occurring in sedentary obese people, together produce a particularly dangerous mixture of risk factors, leading to especially high rates of coronary heart disease and stroke. Other complications of diabetes include kidney failure, eye disease and circulatory and neurological problems in the foot and leg. These complications, coupled with the high prevalence of diabetes, mean that the disease is an important public health problem. It is also becoming more common, largely because of the increasing prevalence of obesity.

Diabetes is more common in people of lower socio-economic status and those from ethnic minorities. We would therefore expect it to be diagnosed more often in East Merton residents, and this is borne out by data from general practices there. The average prevalence in the thirteen East Merton practices² is 6.9%, compared with 4.3% in the thirteen practices³ in the West of the Borough.

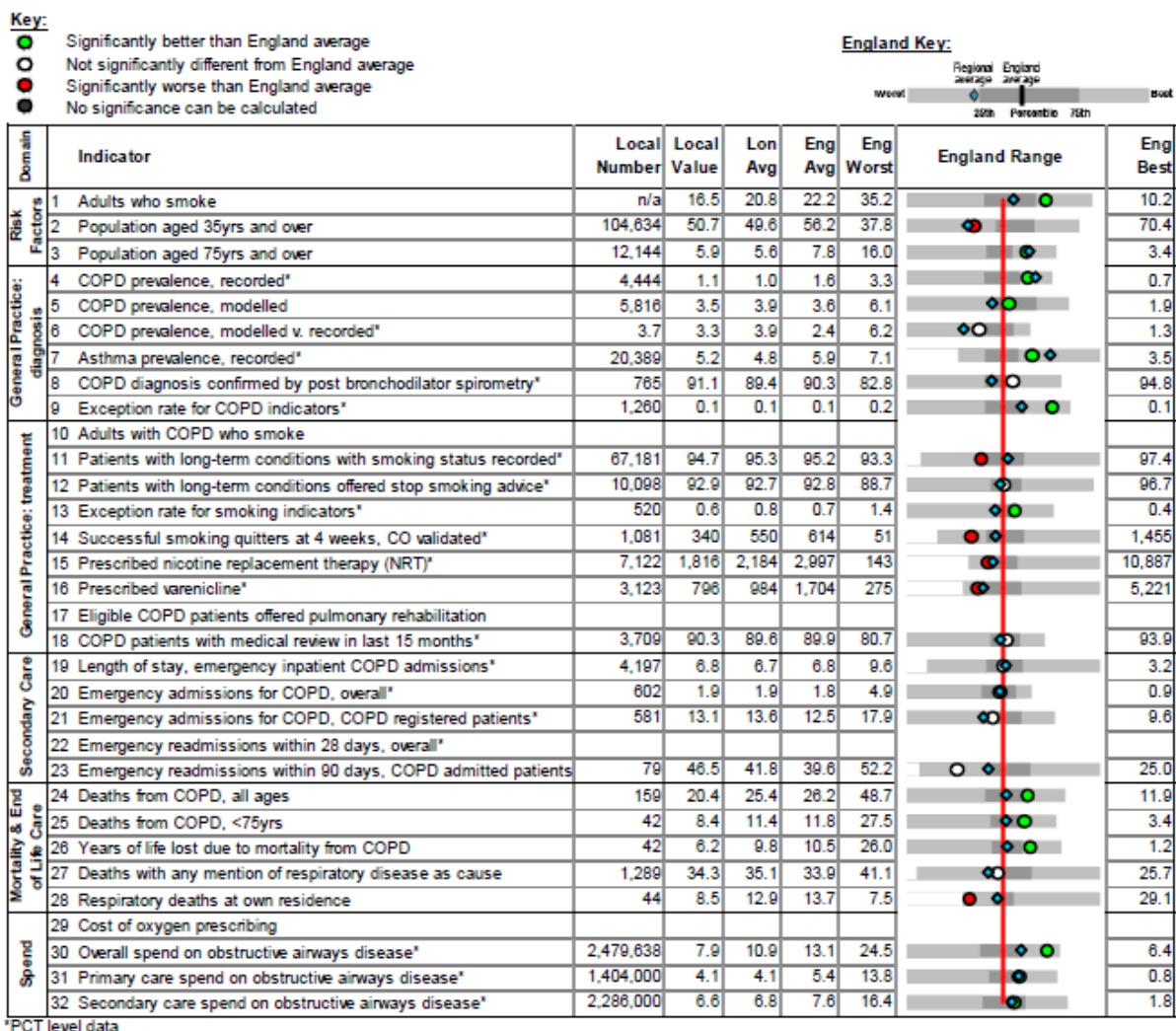
² Central Medical Centre, Colliers Wood Surgery, Cricket Green Medical Practice, Figges Marsh Surgery, The Wilson Health Centre, Graham Road Surgery, Merton Medical Practice, Riverhouse Medical Practice, Rowans Surgery, Tamworth House Medical Centre, The Mitcham Medical Centre, Wandle Road Surgery and Wide Way Surgery.

³ Alexandra Surgery, Cannon Hill Lane Medical Practice, Francis Grove Surgery, Freeman Practice, Grand Drive Surgery, James O'Riordan Medical Centre, Morden Hall Medical Centre, Pepys Road Practice Centre, Princes Road Surgery, Stonecut Surgery, The Church Lane Practice, The Vineyard Hill Road Surgery and the Wimbledon Village Practice.

Respiratory disease

The most common respiratory diseases in Merton are asthma and chronic obstructive pulmonary disease. Asthma is commoner, with a recorded prevalence⁴ from Quality and Outcomes Framework data in Merton of 20,400, compared with 4,500 for chronic obstructive pulmonary disease. Figure 20 provides further information about respiratory disease in Merton. It shows that the outcomes of the smoking cessation service are poor, with a rate of successful validated quitters significantly lower than elsewhere. The information was not available broken down by ward or practice, but both diseases are more common in people of lower socio-economic status, and so will be more prevalent in East Merton.

Figure 20: Respiratory disease in Merton



Source: London Health Programmes

⁴ This report uses this term to refer to prevalence calculated from primary care Quality and Outcomes Framework records – this is also referred to as the observed prevalence. This is contrasted with the prevalence estimated or modelled from the application of the results of epidemiological surveys to each practice's registered population.

Summary

People in East Merton die younger than those in the West of the Borough. Most of the excess deaths are because of cardiovascular disease and cancer, with larger differences seen in younger people. The large differences in mortality from cardiovascular disease and cancer are not reflected in admission rates, suggesting that the high need for services for the treatment of cardiovascular disorders in East Merton, especially below age 75 years, is not reflected in the utilisation of inpatient hospital services. Diabetes is more common in East Merton than in the west of the Borough because of the deprivation and ethnic composition of the population there. Respiratory disease is also common in Merton, and the performance of the smoking cessation services is poor.

Current services in East Merton

There are thirteen general practices in East Merton: Central Medical Centre, Colliers Wood Surgery, Cricket Green Medical Practice, Figges Marsh Surgery, Wilson Health Centre, Graham Road Surgery, Merton Medical Practice, Riverhouse Medical Practice, Rowans Surgery, Tamworth House Medical Centre, The Mitcham Medical Centre, Wandle Road Surgery and Wide Way Surgery. The Wilson Health Centre is also a walk-in centre for patients not registered with the practice.

Community services are provided at the Wilson Hospital. They include an older people's assessment service, out-patient physiotherapy, other therapy clinics and a community mental health service. In many cases, patients are referred to these community services by their general practitioner; some are also available on referral by a consultant, or as part of a package of care provided by specialists.

St George's Hospital, St Helier Hospital and Kingston Hospital are the main providers of district hospital services for Merton residents. All three provide diagnostic and treatment services for people with diabetes, cancer, cardiovascular and respiratory disease. St George's Hospital is a tertiary hospital with a greater range of specialist services.

Chronic disease management in East Merton

This section of the report describes the importance of the management of chronic disease in primary care, and points to evidence-based guidance on that subject. It goes on to summarise information on how important chronic diseases are managed in primary care in East Merton practices, compared with West Merton, the Borough as a whole and London.

Background

We have seen that coronary heart disease, diabetes, cancer and chronic obstructive pulmonary disease are the most important threats to the health of the people of East Merton. These diseases have three important characteristics in common:

- They are more frequent in poorer people.
- They can be prevented. All are related to lifestyle factors such as smoking, obesity, lack of physical activity, an unhealthy diet and excessive alcohol consumption.
- Primary care has a key role in preventing and treating them
 - Coronary heart disease can be prevented by lifestyle advice in primary care, smoking cessation and the treatment of raised blood cholesterol and high blood pressure.
 - Diabetes can be prevented by weight management and physical activity. It is also usually diagnosed in primary care; because prompt diagnosis and treatment prevents complications, this is particularly important. The management of diabetes and the early recognition of complications are also key roles of primary health care teams.
 - The risk of cancer can be reduced by smoking cessation, weight management, physical activity and cervical and bowel cancer screening, all of which can be provided via primary care.
 - Chronic obstructive pulmonary disease can also be prevented by smoking cessation, which also improves the prognosis of established disease. The diagnosis is usually made in primary care.

This means that important ways to improve the health of local people are to

- reduce inequalities in health
- support improvements in lifestyle
- improve the detection and treatment of these conditions.

How can primary care reduce the impact of chronic diseases in East Merton?

Cardiovascular disease

There is a large amount of guidance from the National Institute of Health and Care Excellence (NICE) on the prevention and treatment of cardiovascular disease. It includes [guidance on preventing the uptake of smoking by children and young people](#) and on [promoting physical activity](#), through to the management of clinical conditions such as [raised blood lipids](#), [chronic heart failure](#) and [hypertension](#).

Diabetes

NICE has issued guidance on [preventing type 2 diabetes: population and community-level interventions](#), [preventing type 2 diabetes: risk identification and interventions for individuals at high risk](#) and [the management of type 2 diabetes](#).

NICE guidance on [risk identification and interventions for individuals at high risk of type 2 diabetes](#) made recommendations including

- Risk assessment and identification
- Matching interventions to risk
- Lifestyle-change programmes.

NICE guidance on [the management of type 2 diabetes](#) made recommendations including

- Offering structured education to every person and/or their carer at and around the time of diagnosis, with annual reinforcement and review
- Providing individualised and on-going nutritional advice from a healthcare professional with specific expertise and competencies in nutrition
- Setting a glycated haemoglobin target
- Offering lifestyle interventions and medication to help achieve and maintain the glycated haemoglobin target level, lipid levels and blood pressure.

Chronic obstructive pulmonary disease

NICE has [published guidance on the management of chronic obstructive pulmonary disease in adults in primary and secondary care](#). Among the key priorities are early diagnosis, pulmonary rehabilitation and managing exacerbations. NICE's [Quality Standard for chronic obstructive pulmonary disease](#) describes high quality care, with associated measures.

The Department of Health has published an [Outcomes Strategy for chronic obstructive pulmonary disease and asthma](#) and an NHS [Companion Document](#) to support the NHS in improving outcomes for people with chronic obstructive pulmonary disease.

The Outcomes Strategy recognises the need to move away from the largely reactive episodic care based in hospitals to a systematic, pro-active and patient-centred approach. This should be rooted in the primary care setting but underpinned by a multi-disciplinary approach to the management of chronic obstructive pulmonary disease. There is also a [chronic obstructive pulmonary disease toolkit for commissioning](#), which covers improving diagnosis, pulmonary rehabilitation, managing acute exacerbations and home oxygen assessment and review services.

Cancer

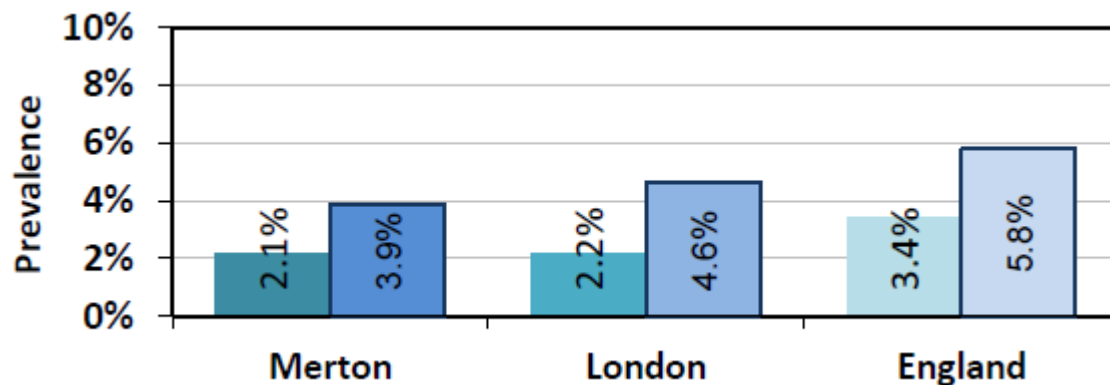
As cancer is not one disease, there is a range of best practice evidence for management of different cancers. Guidance is available from NICE on, for example, [lung cancer](#) and [colorectal cancer](#).

How are chronic diseases managed by primary care in East Merton?

Cardiovascular disease

Figure 21 shows the prevalence on coronary heart disease recorded by practices in Merton, London and England, compared with the prevalence expected on the basis of epidemiological surveys. It shows that only 53% of the patients with coronary heart disease in Merton have been diagnosed and recorded with the diagnosis by their general practitioner. This is slightly better than the result for London (48%) but worse than that for England (59%).

Figure 21: Observed and modelled prevalences of coronary heart disease, Merton, London and England, 2011/2012



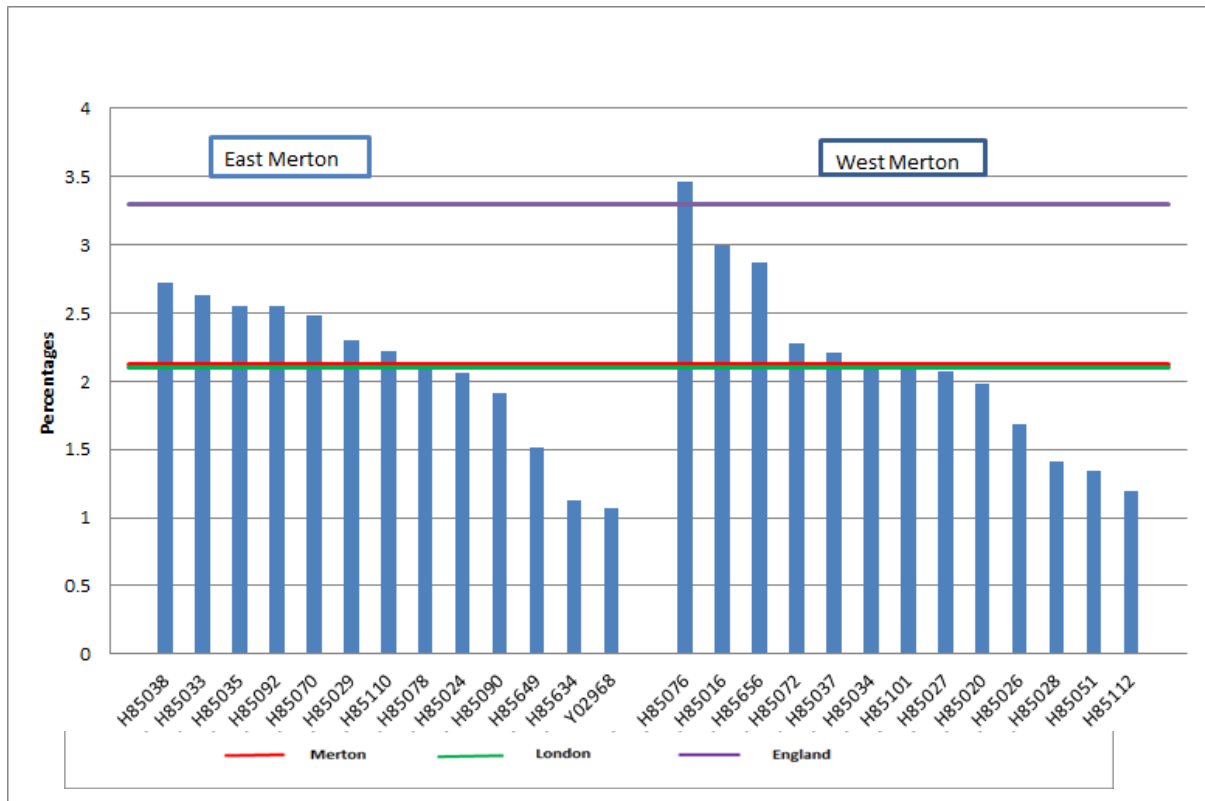
Source: Public Health England

Figure 22 shows the reported prevalence of coronary heart disease in Merton practices. Several important findings emerge from Figure 22:

- There are substantial differences in the recorded prevalence of coronary heart disease in Merton practices. The highest recorded prevalence is one patient in twenty-eight, the lowest is one in ninety-three. These prevalences are unstandardised – in other words they have not been adjusted for differences in the age and sex composition of different practices, so some variation is to be expected. Practices serving a younger population would naturally have a lower prevalence of most long-term conditions. However, the average ages of practices' registered populations do not vary substantially enough to explain the low prevalences reported by some practices. It is likely that these practices are not diagnosing, or not accurately recording, the presence of coronary heart disease in their registered patients. The average ratio of recorded to expected coronary heart disease prevalence is higher in West Merton practices (0.77) than in East Merton (0.74).
- Coronary heart disease is more common in socio-economically deprived people, so we would expect to find a higher reported prevalence in East Merton. In fact, the opposite is seen, with the average prevalence in West Merton (2.13%) slightly exceeding that in East Merton practices (2.09%). This suggests that under-diagnosis and under-recording of coronary heart disease is more common in practices serving East Merton residents, exacerbating the health disadvantages that they already experience.

- These results are against a background in which only half of Merton residents with coronary heart disease are diagnosed (Figure 21), so even practices with higher recorded prevalences are likely to have a substantial number of undiagnosed or unrecorded patients with the disease.

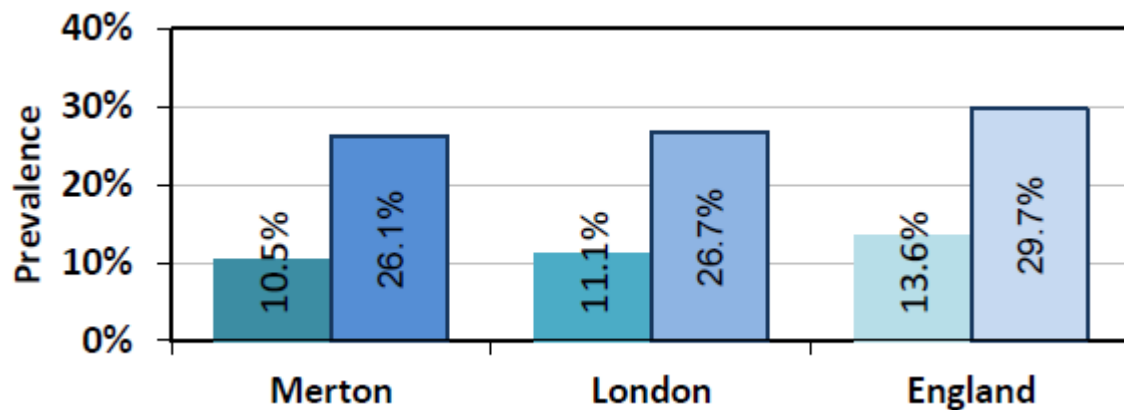
Figure 22: Recorded prevalence of coronary heart disease, Merton general practices, by part of borough, 2012/13



Source: Quality and Outcomes Framework

Figure 23 shows the extent of likely under-diagnosis of hypertension in Merton. Forty percent of patients with the condition have been diagnosed, compared with 46% in England and 42% in London.

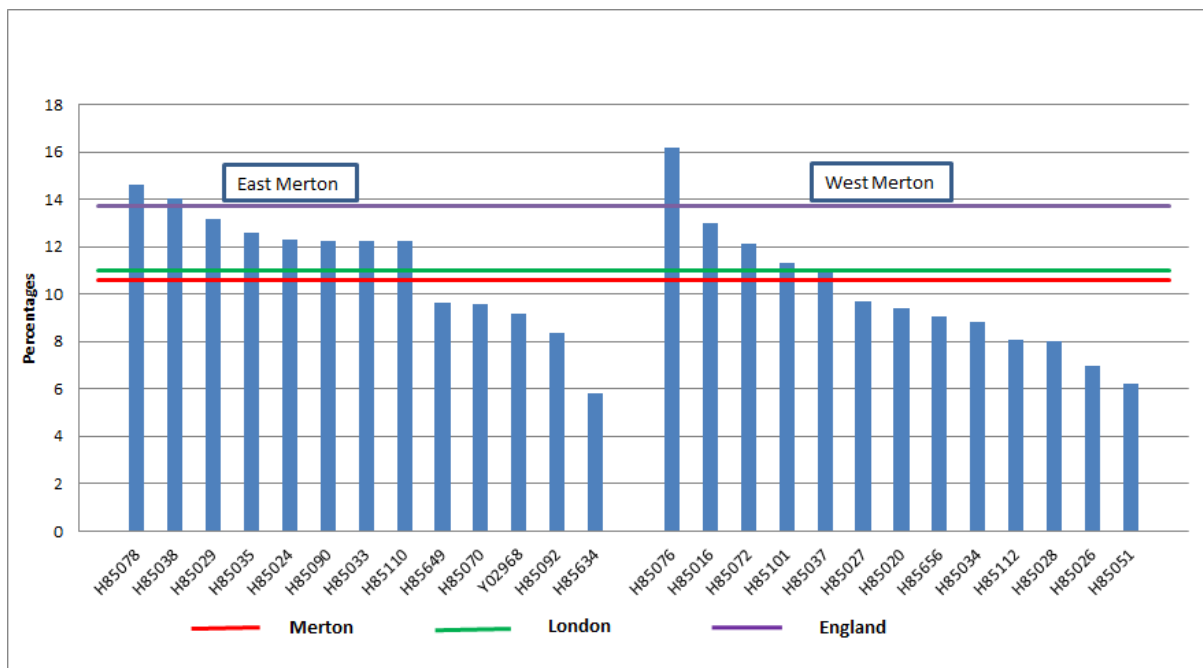
Figure 23: Observed and modelled prevalences of hypertension, Merton, London and England, 2011/2012



Source: Public Health England

Figure 24 shows the reported prevalence of hypertension in people registered with practices in East and West Merton. Here, the pattern seen in coronary heart disease is reversed, with a higher average prevalence of 11.2% in East Merton practices, compared with 10% in those in West Merton. This does not mean that the proportion of patients correctly diagnosed is higher in East Merton – if the true prevalence there is substantially higher because of the deprived, ethnically mixed population, then the extent of under-diagnosis might still be higher there. In any case, the large variation in the recorded prevalence of hypertension indicates that some practices have substantial under-diagnosis. The results are an encouraging indication about overall ascertainment of hypertension in East Merton, but must be seen in the context of the overall under-diagnosis shown in Figure 23.

Figure 24: Recorded prevalence of hypertension, Merton general practices, by part of borough, 2012/13



Source: Quality and Outcomes Framework

Under-diagnosis matters because unless patients' health problems are correctly recognised and recorded, they cannot be offered appropriate care, including treatments which would reduce the risk of future health problems. So patients currently do not receive the treatment and support that they need, including advice and medications to prevent the disease progressing. This leads to avoidable progression of disease with consequent health and social care costs.

We cannot estimate the health improvement from identifying and treating these patients without information on the severity and prognosis of their specific clinical condition; a few of them may in any case be diagnosed and treated but inaccurately recorded in primary care information systems. However, the numbers involved indicate that the impact of more complete diagnosis would be substantial.

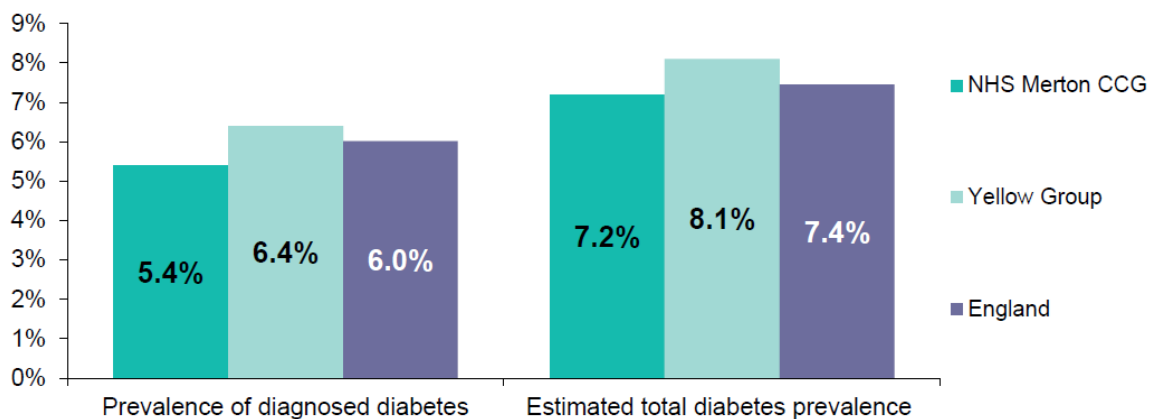
Diabetes

Primary care interventions for diabetes include

- focussed efforts to reduce individuals' risk of developing diabetes
- the investigation of symptoms of diabetes and diagnosis of the disease
- measures to reduce cardiovascular risk in people with diabetes, such as smoking cessation advice, dietary change and treating hypertension and raised blood lipids
- treatment of symptoms and complications of diabetes
- referral of patients with more complex disease.

Figure 25 compares the recorded prevalence of diabetes with what is expected on the basis of epidemiological surveys. In 2012/13, there were 9,425 adults in Merton with diagnosed diabetes and an estimated 2,875 adults with undiagnosed diabetes. The proportion of people with diabetes who had been diagnosed was lower in Merton (75%) than in a group of similar primary care trusts (79%) and in England (81%).

Figure 25: The prevalence of diagnosed diabetes and the estimated total prevalence of diabetes, Merton, yellow group and England, 2012/13

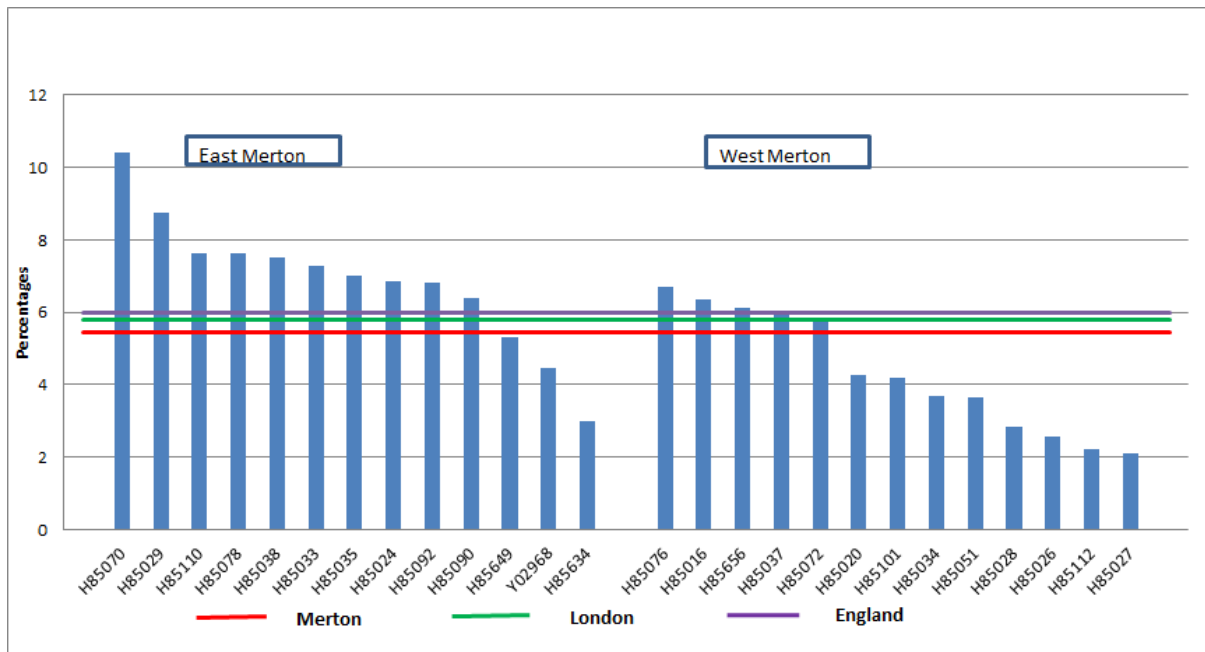


Source: Quality and Outcomes Framework 2012/13 and Diabetes Prevalence Model

The yellow group was a set of similar PCTs with a younger than average age structure, a larger proportion of Black and Asian residents and moderate deprivation levels. Sutton & Merton PCT was a member of the group.

Figure 26 shows the recorded prevalence of diabetes in practices in East and West Merton. As with hypertension, the average recorded prevalence in East Merton is higher (6.9%) than in West Merton (4.3%). The true prevalence of diabetes in East Merton is likely to be substantially higher than in the west of the Borough, because of its deprivation and the higher proportion of ethnic minority residents. So the degree of under-diagnosis may still be greater in East Merton.

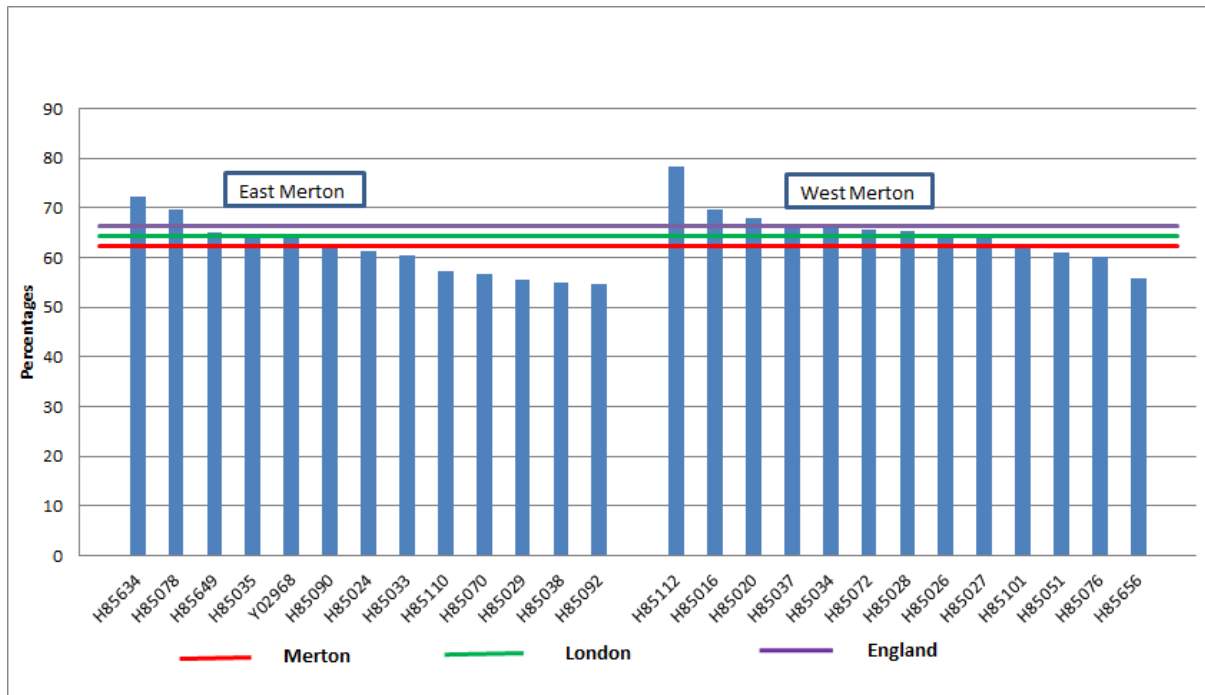
Figure 26: Recorded prevalence of diabetes, Merton general practices, by part of borough, 2012/13



Source: Quality and Outcomes Framework

The quality of diabetes care is of great importance in determining the risk of complications. One important measure of diabetes control is the level of HbA1c in the blood – a higher level indicates worse control and a higher risk of complications. Figure 27 shows the proportion of patients who have had an HbA1c level of no more than 7.5% recorded in the past year. On this measure of control, the performance of West Merton practices was slightly better, with an average of 65.2% of patients meeting this standard of care, compared with 61.5% in the east of the borough.

Figure 27: Proportion of patients with diabetes with a recorded HbA1c no higher than 7.5mmol/l in the past 15 months, Merton general practices, by part of borough, 2012/13



Source: Quality and Outcomes Framework

NICE has specified the care processes that patients with diabetes should receive in order to check the effectiveness of treatment, monitor their risk of cardiovascular disease and detect complications. Figure 28 shows Merton general practices' performance with respect to these measures of quality.

In 2011/12, the most recent available date, only 53% of Merton patients received all care processes recommended by NICE (except eye screening, which is not carried out via primary care). This was in the bottom quartile for England. Although coverage was above 90% for four of the care processes, it was poor in relative terms: Merton was in the bottom quartile of CCGs for cholesterol, smoking, body mass index (a measure of obesity), and serum creatinine and urine albumin (measures of renal function). There is no sign of a rise in the proportion of patients with all care processes in place; indeed, the proportion of patients having all the care processes recommended by NICE fell in the three years to 2011/12. The information was not available for this report broken down by ward or practice.

Figure 28: Proportion of patients with diabetes receiving NICE's recommended care processes (excluding eye screening), Merton CCG and England, 2009/10 to 2011/12

		All diabetes ^a			Type 1			Type 2		
		2009-2010	2010-2011	2011-2012	2009-2010	2010-2011	2011-2012	2009-2010	2010-2011	2011-2012
HbA1c ^b	CCG/LHB	91.0% ■	91.2% ■	91.1% ■	79.3% ■	81.3% ■	81.7% ■	92.5% ■	92.6% ■	92.3% ■
	England & Wales	92.1% ■	92.5% ■	90.3% ■	85.7% ■	86.0% ■	83.0% ■	93.2% ■	93.5% ■	91.3% ■
Blood pressure	CCG/LHB	95.3% ■	94.8% ■	94.4% ■	87.0% ■	86.4% ■	84.7% ■	96.2% ■	95.7% ■	95.3% ■
	England & Wales	95.2% ■	95.0% ■	95.0% ■	88.9% ■	88.7% ■	88.4% ■	96.1% ■	95.9% ■	95.8% ■
Cholesterol	CCG/LHB	89.8% ■	90.3% ■	89.3% ■	71.1% ■	75.4% ■	73.6% ■	91.7% ■	91.9% ■	90.9% ■
	England & Wales	91.7% ■	91.6% ■	90.9% ■	79.1% ■	78.8% ■	77.8% ■	93.2% ■	93.1% ■	92.4% ■
Serum creatinine	CCG/LHB	91.1% ■	91.1% ■	91.4% ■	72.7% ■	77.5% ■	76.9% ■	92.9% ■	92.6% ■	92.8% ■
	England & Wales	92.5% ■	92.5% ■	92.5% ■	81.0% ■	81.2% ■	81.1% ■	93.9% ■	93.8% ■	93.8% ■
Urine albumin ^c	CCG/LHB	70.0% ■	70.3% ■	67.9% ■	51.5% ■	55.1% ■	52.2% ■	72.1% ■	72.1% ■	69.5% ■
	England & Wales	72.3% ■	75.1% ■	76.0% ■	56.2% ■	58.4% ■	59.2% ■	74.3% ■	77.1% ■	77.9% ■
Foot surveillance	CCG/LHB	84.2% ■	85.2% ■	86.2% ■	69.0% ■	71.2% ■	70.9% ■	86.2% ■	87.2% ■	87.9% ■
	England & Wales	84.1% ■	84.3% ■	85.3% ■	71.7% ■	71.5% ■	72.8% ■	85.9% ■	86.1% ■	87.0% ■
BMI	CCG/LHB	90.0% ■	89.4% ■	88.9% ■	80.9% ■	82.0% ■	79.9% ■	91.1% ■	90.3% ■	89.9% ■
	England & Wales	90.1% ■	89.9% ■	90.3% ■	83.6% ■	83.4% ■	83.7% ■	91.1% ■	90.8% ■	91.3% ■
Smoking	CCG/LHB	79.5% ■	75.7% ■	77.1% ■	72.1% ■	68.9% ■	70.0% ■	80.3% ■	76.4% ■	77.8% ■
	England & Wales	86.9% ■	84.8% ■	85.1% ■	80.8% ■	78.6% ■	79.0% ■	87.7% ■	85.7% ■	85.9% ■
Eight care processes ^d	CCG/LHB	54.7% ■	52.6% ■	51.5% ■	37.6% ■	34.0% ■	33.4% ■	56.7% ■	54.8% ■	53.3% ■
	England & Wales	59.4% ■	60.6% ■	60.5% ■	42.4% ■	43.3% ■	43.2% ■	61.6% ■	62.8% ■	62.6% ■

^a All diabetes includes maturity onset diabetes of the young (MODY), other specified diabetes and not specified diabetes.

^b For patients under 12 years of age, 'all care processes' is defined as HbA1c only as other care processes are not recommended in the NICE guidelines for this age group.

^c There is a 'health warning' regarding the screening test for early kidney disease (Urine Albumin Creatinine Ratio, UACR) but we believe that this does not concern NHS Merton CCG.

^d The eye screening care process has been removed from this table; therefore 'eight care processes' comprises the eight care processes that are listed above.

■ <70%

■ 70% - 90%

■ >90%

Source: National Diabetes Audit 2011/12

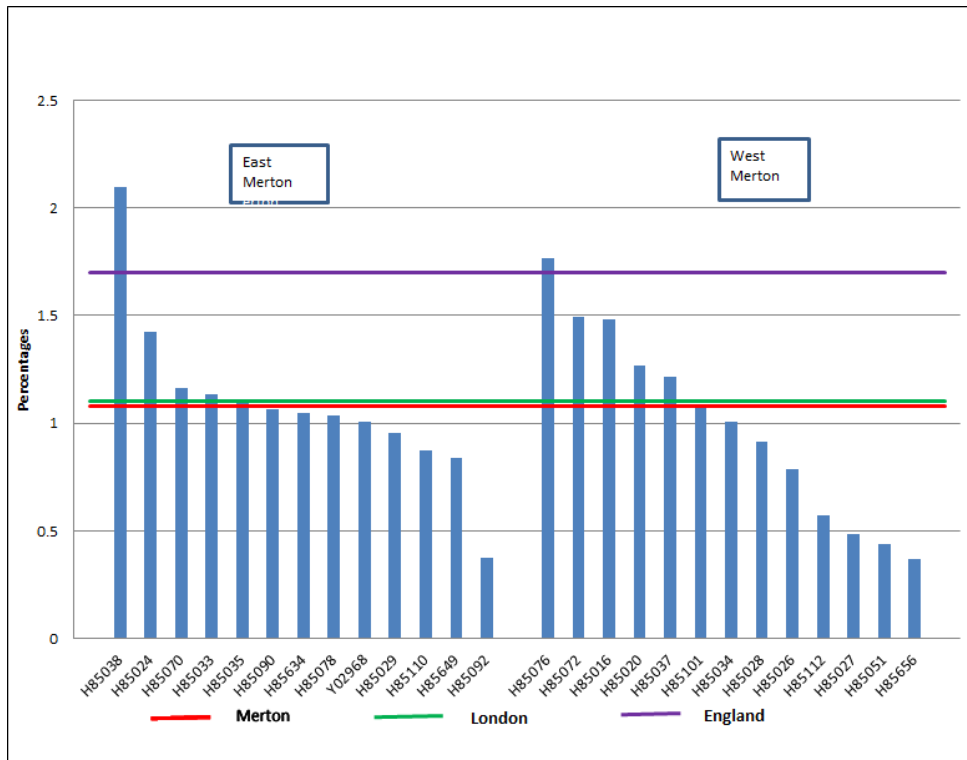
Chronic obstructive pulmonary disease

Figure 29 shows the recorded prevalence of chronic obstructive pulmonary disease in each practice in Merton. Average prevalence is slightly higher in East Merton practices (1.09%) than in West Merton (0.99%). This may reflect in part a higher prevalence of smoking in the deprived half of the borough; the degree of under-diagnosis may still be higher in the East of the Borough than in the West. This may underlie the much higher rates of admission with chronic obstructive pulmonary disease in East Merton (Figure 30). The high rates of admissions from practices without unusually high prevalences

may indicate opportunities to improve management and reduce the incidence of exacerbations of the disease.

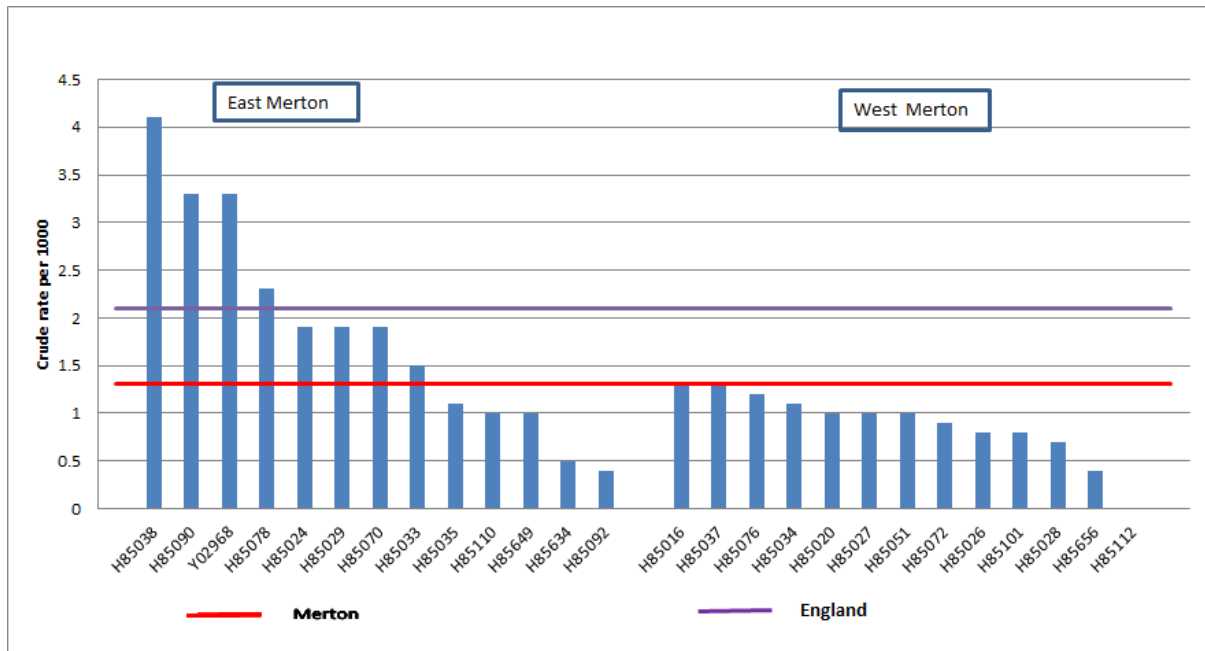
Merton CCG is supporting the *COPD: Know it, Check it* campaign to improve awareness of chronic obstructive pulmonary disease.

Figure 29: Recorded prevalence of chronic obstructive pulmonary disease, Merton general practices, by part of borough, 2012/13



Source: Quality and Outcomes Framework

Figure 30: Admissions with chronic obstructive pulmonary disease, Merton general practices, by part of borough, 2010/11



Source: Quality and Outcomes Framework

For all these indicators, practices can exception-report (that is exclude) patients who, for example, do not attend appointments or in whom the treatment is judged inappropriate. The rates of exception reporting in Merton are lower than average and do not appear higher in either half of the Borough.

Summary

Primary care has a critical role in the prevention, prompt diagnosis and management of chronic disease. Many East Merton residents with cardiovascular disease, hypertension, diabetes and chronic obstructive pulmonary disease have not yet been diagnosed. This means that appropriate treatment to improve symptoms and prevent progression is not available to them. There are also large variations between practices in the proportion of registered patients diagnosed with important chronic diseases, suggesting some practices have substantial under-diagnosis. The rates of exception reporting in Merton are lower than average and do not appear higher in either half of the Borough.

The primary care management of people with diabetes in Merton is in the bottom quartile for England. There are also indications that some practices have higher than expected rates of admission with chronic obstructive pulmonary disease.

Commissioning

This section of the report summarises the commissioning background in Merton and the findings of the Commissioning for Value analyses.

Commissioning background

Merton Clinical Commissioning Group intends to move services out of secondary care into community and primary care settings, in line with the multi-CCG *Better Services, Better Value* programme, and the *Better Healthcare, Closer to Home* programme inherited from NHS Sutton & Merton. The CCG's plans include:

- Models of care closer to or within patients' homes
- Care delivery by locality-based multi-disciplinary teams
- Community-based rapid access to diagnostics, assessment and treatment pathways.

Commissioning for Value

Commissioning for Value is a programme designed to help CCGs improve the value of and outcomes from the services that they commission. It is a collaboration between NHS Right Care, NHS England and Public Health England. It compares each CCG with similar ones to identify areas of spending where lower costs or better outcomes should be achievable, by hypothesising the costs and outcomes if that CCG's performance improved to equal, or exceed, a peer group of similar CCGs. In Merton's case, these were nine other CCGs in Outer London⁵ and North & West Reading CCG. Merton's level of deprivation is close to average for this group.

The main findings from the *Commissioning for Value* analysis for Merton are below. These apply to the whole CCG; no analyses are available at sub-CCG level. On most measures, Merton is not significantly different from the other members of its comparator group. The only exceptions for the chronic diseases covered by this report are

Cardiovascular disease

- Mortality from circulatory diseases before age 75 years: Merton is in the second highest quartile for England, and significantly higher than the comparator group
- The reported prevalence of hypertension as a percentage of the estimated prevalence: Merton is in the lowest quartile for England, but significantly higher than the comparator group
- Spend on non-elective admissions: Merton is in the lowest quartile for England and significantly lower than the comparator group
- Rates of non-elective, and all, secondary care admissions: Merton is in the lowest quartile for England and significantly lower than the comparator group
- The proportion of patients with transient ischaemic attack at higher risk treated within 24 hours: Merton is in the lowest (ie worst) quartile for England and significantly lower than the comparator group.

⁵ Hounslow, Ealing, Sutton, Hillingdon, Richmond, Wandsworth, Kingston, Waltham Forest and Barnet.

Cancer

- Non-elective admissions: Merton is in the second highest quartile for England, and significantly higher than the comparator group
- Females aged 50 to 70 years screened for breast cancer in the previous three years: Merton is in the lowest quartile for England and significantly lower than its comparator group
- Emergency bed-days: Merton is in the highest quartile for England and significantly higher than its comparator group
- Successful smoking quitters at four weeks: Merton is in the lowest (ie worst) quartile for England and significantly lower than its comparator group. It has the second lowest rate in England.

Diabetes

There is no diabetes category in *Commissioning for Value*, but it forms the majority of the endocrine, nutritional and metabolic disease category.

- Spend on primary care prescribing: Merton is in the second highest quartile for England but significantly lower than the comparator group
- Net ingredient cost of prescribing per patient on the QOF diabetes register: Merton is in the second lowest quartile for England but significantly higher than the comparator group
- Observed versus emergency bed-days for diabetes: Merton is in the lowest quartile for England and significantly lower than the comparator group.

Respiratory

- Spend on primary care prescribing: Merton is in the lowest quartile for England but significantly higher than the comparator group.

The *Commissioning for Value* analysis estimated the impact of Merton improving its performance to the average of its comparator group, or more ambitiously to the average of the best five members of that group. This analysis indicated that

- Thirty-four lives could be saved in Merton per year from improving performance in cardiovascular disease
- £62,000 could be saved in elective endocrine, nutritional and metabolic disease admissions
- £174,000 could be saved in non-elective cancer services
- £9,000 could be saved from cancer prescribing
- £422,000 could be saved from endocrine, nutritional and metabolic disease prescribing
- £300,000 could be saved from prescribing for circulatory disease
- £410,000 could be saved from respiratory prescribing.

In nearly all cases, these benefits would result from improving performance to the level of the best five CCGs.

Summary

New models of service provision in Merton will involve more care being provided in community settings and less at hospital sites.

Commissioning for Value has indicated areas where Merton CCG's performance and spending compares unfavourably with a group of similar CCGs. The most important of these are mortality from cardiovascular disease and prescribing costs for diabetes and circulatory and respiratory disease.

Evidence from elsewhere

This section of the report summarises some evidence of potential relevance to decision-making about how to develop primary care in East Merton, especially in the light of the possibility of a new health-care facility in the locality.

There are many potential approaches to meeting the health needs of East Merton residents better, and many potential uses of the proposed new health care facility there. Addressing these uncertainties is not easy to achieve with a highly focused literature search. The need to complete this report rapidly also militated against a comprehensive approach to the literature. In order pragmatically to provide something of value, we focus on three interventions, chosen because they are:

- primary-care or community-based
- intended to address the major health issues discussed above
- interventions which could be provided from a new community health care facility in East Merton.

The questions are:

1. What is the impact of general practitioners with a special interest?
2. What is the impact of intermediate care clinics for people with diabetes?
3. What is the impact of virtual wards as a means of providing community-based health care?

We did not have time to carry out a formal systematic literature search, but here summarise some research findings of relevance. We begin with coverage of the Tower Hamlets Primary Care Investment Programme, which may be of relevance to local policy makers.

Improving primary care, including chronic disease management: the Tower Hamlets Primary Care Investment Programme

The Tower Hamlets Primary Care Investment Programme is one of the largest and most comprehensive development programmes for primary care services in London. Established in 2009, it aimed to develop networks of practices operating in defined areas to deliver enhanced, standardised primary care for health promotion and the management of long term conditions. It aimed to tackle a combination of poor health and an under-resourced primary care service delivering care of variable quality. An additional objective was to reduce use of hospitals, with more services being provided closer to home.

The programme has two components:

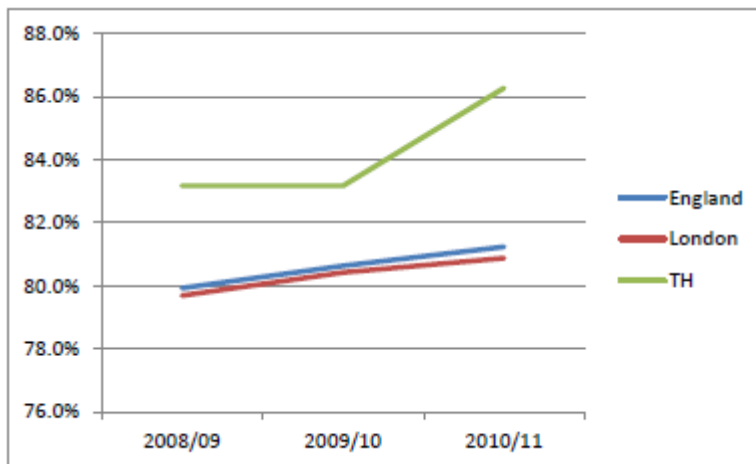
- Eight networks were established, delivering six care packages to 80,000 patients. They each cover 18,000 to 36,000 residents, served by four or five general practices with approximately twenty GPs.

The networks bring practices together to plan and deliver service changes. Each network has a formal governance structure and leadership, with a clinical leader, a network manager and a network coordinator.

- Six care packages, each consisting of a defined set of clinical protocols devised on the basis of evidence and best practice. The protocols describe the precise interventions required for patients, with associated staffing and costs. They address local public health priorities with an emphasis on long-term conditions and health promotion: diabetes, three cardiovascular disease packages (NHS Health Checks, hypertension and secondary prevention), chronic obstructive pulmonary disease and immunisations. Each package also has objectives and performance measures covering clinical outcomes and process, with an emphasis on self-care.

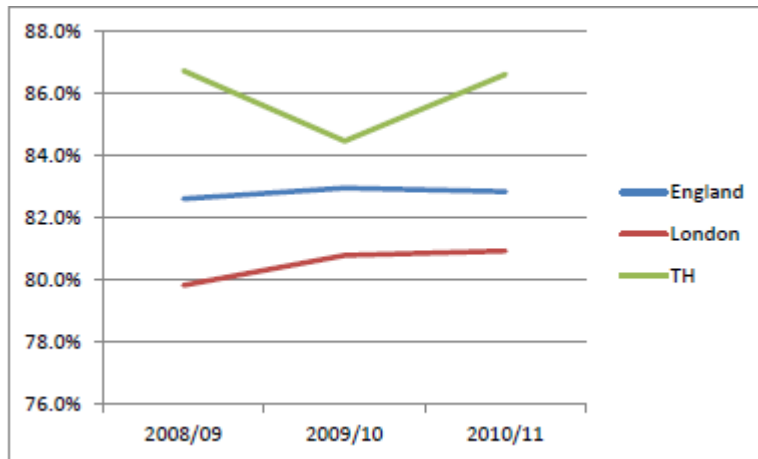
The programme cost £5m in 2011/12. It has apparently been at least partially evaluated, though we were not able to find the primary report of any evaluation. The evaluation concluded that the diabetes programme had delivered benefits for patients, especially those who had not achieved blood pressure and cholesterol targets (Figures 31 and 32). Costs had increased, but emergency admissions had fallen – no further details were provided. Immunisation uptake also improved (Figure 33).

Figure 31: Proportion of diabetic patients with blood pressure less than 145/85 mmHg, Tower Hamlets, London and England, 2008/9 to 2010/11



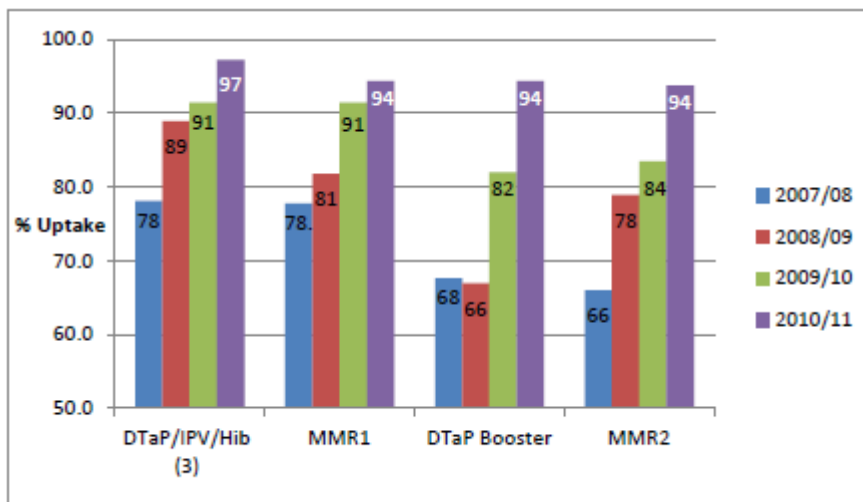
Source: Tower Hamlets Primary Care Investment Programme

Figure 32: Proportion of diabetic patients with cholesterol less than 5mmol/L, Tower Hamlets, London and England, 2008/9 to 2010/11



Source: Tower Hamlets Primary Care Investment Programme

Figure 33: Coverage of childhood immunisations, Tower Hamlets, 2007/ to 2010/11



Source: Tower Hamlets Primary Care Investment Programme

The evaluation indicated that the following factors contributed to success:

- Willingness to share information and standardised systems
- Strong clinical leadership
- Strong governance with fora and committees to promote engagement
- Building strong identities and common objectives
- Engagement with external partners, especially third sector and patients.

Conclusion

Some of the principles from Tower Hamlets about how to improve the quality of chronic disease management in primary care are readily transferable to East Merton. These include

- Establishing clinical leadership
- Developing clinical networks with strong collective commitment to improvement
- Active feedback of data
- Actively addressing barriers to progress.

No firm conclusions about the Tower Hamlets Programme can be drawn without access to the full evaluation reports, but it is a comprehensive, extensive and expensive approach which apparently has important benefits.

Improving chronic disease management: What is the impact of intermediate care clinics for people with diabetes?

Wilson et al carried out a randomised trial comparing the clinical outcomes, costs and views of patients with type 2 diabetes with access to an intermediate care clinic with those with access to conventional hospital services.[1] The intermediate care clinic included a multi-disciplinary team led by a specialist nurse and a diabetologist, who managed patients for a short period to improve diabetic control and then referred them back to their practice. A service similar to this is already in place in Merton, though it is not clear how generally accessible it is.

Only 16% of eligible patients agreed to participate, of whom 40% were lost to follow-up; this introduces bias and severely limits generalisability.

After eighteen months, the proportion of patients whose HbA1c ($\leq 7\%$), blood pressure ($< 140/80$ mmHg) and cholesterol (< 4 mmol/l) were all adequately controlled was 92 (14.3%) of the patients in the intervention practices and 59 (9.3%) of those in the control practices ($P=0.059$). There were no differences between intervention and control groups in psychological stress or perceived continuity of care. In the subset of practices able to provide routine data on achievement of control at baseline and follow-up, there was no difference between control and intervention groups. The average cost of an integrated care consultation was £102. Average general practitioner and practice nurse costs were higher in the intervention group (mean £27 vs £20, $P=0.012$) as were community clinic costs (£1.46 vs £0.49, $P = 0.025$). There was no significant difference in hospital or total healthcare costs.

Professionals saw the service as having two valuable roles: the up-skilling of staff and short-term inputs to patient care. Patients welcomed the service, particularly the extra time given to their care and input from a team that they believed to have additional skills. They felt that their care was coordinated without loss of continuity.

Conclusion

This is an innovation well worth considering in Merton. That said, its local use would need careful evaluation, not least because this trial's reliability is markedly impaired because so few people accepted the invitation to participate.

Reducing need for secondary care: What is the impact of general practitioners with a special interest on primary care services?

General practitioners with a special interest (GPwSIs) are GPs with additional expertise in a specific area of clinical practice. Schemes involving GPwSIs are intended to divert patients with less complex problems to intermediate practitioners, speed up access to specialists and improve convenience for patients.

Rosen et al carried out an evaluation of GPwSIs in four sites, three with dermatology GPwSI services and one with a GPwSI musculoskeletal service.[2] The authors found no significant changes in hospital referral rates following the introduction of GPwSI clinics in any of the sites studied. Incomplete data precluded calculation of new hospital referrals at two sites, while total referrals (to hospital and GPwSI clinics) increased at the three other sites.

The likelihood of referral did not change after the launch of the GPwSI clinics in any of the sites studied. Association between the launch of GPwSI clinics and hospital outpatient waiting times was variable between the sites. Differences in the methods for attributing costs to GPwSI clinics precluded reliable comparison of the costs of GPwSI appointments, and the authors had no data with which to compare the costs of hospital and GPwSI clinics.

Patient satisfaction with both GPwSI and hospital clinics was high with significantly greater satisfaction with GPwSI clinics in some domains.

Conclusion

This evaluation provides no sound reason to introduce GPwSIs.

Managing people with more severe health problems: What is the impact of virtual wards as a means of providing community-based health care?

The term 'virtual ward' or 'virtual community ward' is used to describe a model of care which was developed in Croydon and involves the delivery of highly coordinated preventive health and social care at home to people at high predicted risk of unplanned hospital admission. Risk of hospital admission is identified using a predictive risk modelling tool such as the Patients at Risk of Re-hospitalisation (PARR) tool.

The most important elements of the virtual ward approach are

- using a predictive model to identify individual patients in a population who are at high risk of future unplanned hospital admission
- offering these people a period of intensive, multidisciplinary case management at home using the systems, staffing and daily routines of a hospital ward.

Virtual wards use similar structures and processes to a hospital ward, such as a single point of access, daily ward rounds, notes to document patient progress and a ward administrator. The ward is 'virtual' because there is no physical building and the people receiving care stay in their own homes

throughout. The virtual ward team is multidisciplinary, involving senior and junior nurses, community matrons, pharmacists, physiotherapists and social workers, with access to more specialist community staff when required.

Since the introduction of virtual wards in Croydon in 2006, the term has been adopted elsewhere in the UK, although inevitably the services vary in terms of the type of intervention provided and the patient group/s for which they care. The concept continues to evolve and definitions are slippery.[3]

The virtual ward model of care is one example of a wide range of interventions which involve case management of patients in the community and which aim to prevent or reduce unplanned hospital admissions. Other examples include community matrons, case management, nurse/specialist home visits, chronic disease/long term disease management, integrated care pilots, comprehensive geriatric assessment/home visits, rapid response teams and disease-specific prevention programmes.

Virtual wards and other forms of community-based care differ, in terms of their overall aims and approach, from hospital-at-home services where active treatment is provided by healthcare professionals in a patient's home for a condition that otherwise would require hospital care, either as an alternative to hospital admission or to enable early discharge from hospital. In general, patients cared for by hospital-at-home services are likely to have a higher level of need and will receive care over a shorter period of time than patients cared for 'on' a virtual ward. In practice, there is likely to be some overlap between the different models of care. For example, in the management of patients with an acute exacerbation of a pre-existing condition, which requires more intensive healthcare input over a short period of time, a virtual ward may be able to provide a similar level of care to that of a hospital-at-home service.

In 2011 and 2012, Lewis et al evaluated virtual wards at three NHS sites (Croydon, Devon and Wandsworth).[4] This is the only published evaluation of virtual wards that we found.

Croydon had pioneered the virtual ward concept, but since 2007 the intervention had changed to standard (i.e. one-to-one) case management delivered by a community matron with the support of an administrative assistant. Thereafter, Croydon virtual ward patients did not receive multidisciplinary case management.

The virtual ward in Devon was more firmly rooted in primary care, with a general practitioner championing the development and implementation of the project. A notable feature of the Devon virtual ward was that staff had admitting privileges at a community hospital and had access to the general practice electronic health record. Indeed, to help with the process of integration, an electronic single assessment process and common assessment framework were introduced. However, these assessment systems proved to be too unwieldy for practical use.

A more successful initiative was the virtual ward data exchange, which enabled the sharing of information across organisational boundaries by bringing together data from the acute hospitals, general practitioner systems, out-of-hours providers, the local ambulance trust and social care and community health services. For the first time, it became possible to obtain a whole-system view of each individual patient's data. This system was seen as useful in promoting integration, not least because it allowed whole-system costs to be determined for each member of the population.

The most notable feature of the Wandsworth virtual wards project was the inclusion of a full-time general practitioner as part of the virtual ward team. This new role for general practitioners was

viewed as the primary care equivalent of intensive care doctors in a hospital, in the sense that they dealt with only the most complex patients.

As in Devon, there was a clear general practitioner champion supporting the virtual ward project in Wandsworth. In comparison with the other two study sites, social care staff were more closely involved.

These case studies suggest a number of lessons for policy-makers. First is the importance of involving general practitioners in the design and delivery of innovative models of care: simply obtaining the backing of a general practice-led committee may be insufficient. Second, safeguards, such as key performance indicators, may be helpful in avoiding regression back to old ways of working (e.g. record the number of professions represented at each multidisciplinary team meeting). Third, an assessment of the efficacy of virtual wards in reducing unplanned hospital admissions cannot be made on the pooled results of these three case studies, since the nature of the intervention varies so widely.

In a controlled evaluation, Lewis et al reported no evidence that the virtual wards that they studied reduced mortality, costs, emergency hospital admissions or ambulatory-care sensitive hospital admissions in the first six months of implementation.[5] They did however observe a reduction in elective hospital admissions and outpatient attendances. Most of the patients studied were from Croydon, which no longer followed the multi-disciplinary virtual ward concept as originally intended, making these results of limited value.

Conclusion

It is too early to recommend the virtual ward for East Merton. The concept is attractive but complicated and apparently expensive. Whether it is beneficial is still uncertain.

Summary

An appropriate purpose for a new community-based health care facility in East Merton would be to improve the quality of chronic disease management. This would improve health and quality of life by preventing and managing chronic diseases more effectively, so that fewer patients progress to more advanced disease. It could also cater more effectively for people with greater needs and so reduce the demand for hospital admissions.

The evidence reviewed here provides some indications about how to go about this. An intermediate care diabetes clinic is a useful approach which may be capable of being implemented more extensively than it is at present in East Merton. The Tower Hamlets approach may be unnecessarily intensive for East Merton, but could be replicated in part. Virtual wards and GPwSIs are not supported by the evidence summarised here, though our literature search was not exhaustive.

A full literature search and review of relevant national guidance would be useful. This should also incorporate emergent ideas about the best ways to proactively co-ordinate care and support for people with long-term conditions. The recent King's Fund publication *Delivering better services for people with long-term conditions: Building the house of care* is relevant here.[6] The proposed model encompasses all people with long-term conditions, not just those with a single disease or in high-risk groups, and it assumes an active role for patients, with collaborative personalised care planning at its heart. It emphasises that

- People with long-term conditions play an active part in determining their own care and support needs through personalised care planning.
- Collaborative relationships between patients and professionals, shared decision-making and self-management support are at the heart of service delivery.
- Tackling health inequalities is a central aim, given that people in lower socioeconomic groups are more likely to experience long-term conditions.
- Each individual is engaged in a single, holistic care planning process with a single care plan regardless of how many different long-term conditions they have.
- Individual needs and choices are aggregated to provide a local commissioning plan.
- Self-management support may be provided by community and self-help groups alongside statutory services.

Conclusions

East Merton has two crucial opportunities:

- Improving the quality of chronic disease management in primary care is of the greatest importance. Much of this will be achieved by primary health care teams themselves, supported by the CCG, the public health team and others, and should be pursued regardless of changes in the healthcare infrastructure in the locality.
- Transforming how health care is delivered, with less reliance on hospital services and more imaginative and effective use of community-based approaches. This provides people with more accessible care, strengthens collective health resources and reduces the burden on the overstretched acute sector.

This report was prepared to support the business case for a new healthcare facility in East Merton. What role might that play in achieving these two goals?

There are two broad answers to this question:

Firstly, the facility could provide a site for services moving out of secondary care provision or other community facilities locally. As the reconfiguration of services in Merton and surrounding areas gathers pace, this purpose could broaden to complement as well as replace existing services, improving geographical accessibility and drawing services into closer alignment with community and primary care services. The intermediate care diabetes clinic is an example of this.

Secondly, the facility could provide a physical focus for the improvement of primary care services, including chronic disease management. However, as the Tower Hamlets experience shows, the principle changes needed are in the “software” of primary care (for example, leadership, coordination, training, education, motivation, clinical practice guidelines and patient monitoring), rather than the “hardware” (for example buildings, equipment and accommodation).

These two approaches are complementary. Imaginative use of the new facility could energise the process of quality improvement, by providing a centre for the initiative and a base for support staff and patients. There may also be value in having a geographically accessible site from which to promote community-wide initiatives to improve health and help residents to make effective use of health care.

Other key findings of this report are:

- Although Merton residents are on average fairly prosperous and healthy, the Borough is not homogenous. Those who live in East Merton are less affluent and have substantially worse health.
- Most of the excess deaths are because of cardiovascular disease and cancer, with larger differences seen in younger people.
- The large differences in mortality from cardiovascular disease and cancer are not reflected in admission rates, suggesting that the high need for services for the treatment of cardiovascular disorders in East Merton, especially below age 75 years, is not reflected in the uptake of inpatient hospital services.
- The performance of the smoking cessation service in Merton is poor.

- Many East Merton residents with cardiovascular disease, hypertension, diabetes and chronic obstructive pulmonary disease have not yet been diagnosed. This means that appropriate treatment to improve symptoms and prevent progression is not available to them.
- There are also large variations between practices in the proportion of registered patients diagnosed with important chronic diseases, suggesting some practices have substantial under-diagnosis.
- The primary care management of people with diabetes in Merton is in the bottom quartile for England. There are also indications that some practices have higher than expected rates of admission with chronic obstructive pulmonary disease.
- *Commissioning for Value* has indicated areas where Merton CCG's performance and spending compares unfavourably with a group of similar CCGs. The most important of these are mortality from cardiovascular disease and prescribing costs in diabetes and circulatory and respiratory disease.

Recommendations

1. Merton CCG should take steps to lead improvement in the quality of primary care management of chronic diseases in East Merton. A networking approach to primary care development may be an important way of achieving this.
2. Statutory bodies in Merton should consider the extent to which a new health care facility in East Merton could contribute to health improvement in that locality. Its purpose might include accommodating services moving from elsewhere, housing novel services to complement what exists now, providing the public with an accessible point of contact for a range of local services and acting as a focus for quality improvement initiatives in primary care.
3. The CCG should consider new models of service provision that involve more care being provided in community settings and less at hospital sites. Intermediate care for people with diabetes may be a useful addition to community services in Merton.

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