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East Sussex
County Council

Annual Report of the Director of Public Heath 2013/14

Delivering Healthy Lives, Healthy People, the East Sussex Health and Wellbeing Strategy

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Foreword

The first of April 2013 saw the successful completion of the transfer of Public Health Services from the Primary Care Trusts to the County Council, and the Health and Wellbeing Board, established in shadow form in 2011, take on its full statutory powers and duties.

The Health and Wellbeing Board has developed its first Health and Wellbeing Strategy – *Healthy Lives, Healthy People, The East Sussex Health and Wellbeing Strategy 2013-2016* – which aims to protect and improve people's health and wellbeing and reduce inequalities. The Strategy sets out the seven key priorities for improvement over the next three years:

1. The best possible start for all babies and young children
2. Safe, resilient and secure parenting for all children and young people
3. Enabling people of all ages to live healthy lives and have healthy lifestyles
4. Preventing and reducing falls, accidents and injuries
5. Enabling people to manage and maintain their mental health and wellbeing
6. Supporting those with special educational needs, disabilities and long term conditions
7. High quality and choice of end of life care

These priorities are areas where the Board can make a real difference and the strategy sets out how this will be achieved through the commissioning of services, joint working and collective action.

This report presents the results from a series of rapid evidence and literature reviews aligned to the seven priority areas. It has been produced to inform delivery of the strategy action plan and aims to provide a robust basis for decision making, building on work already undertaken in East Sussex.

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Chapter 1: Introduction

The Director of Public Health is required by statute to prepare and publish an annual report. This year’s report provides the evidence to help commissioners identify the interventions that will deliver the priorities which have been agreed in the Health and Wellbeing Board’s Health and Wellbeing Strategy for 2013-2016 “Healthy Lives, Healthy People”.

The report presents the results from a series of rapid evidence and literature reviews aligned to the seven priority areas identified in Healthy Lives, Healthy People.

Delivery of the priorities in Healthy Lives, Health People will require action by both the health sector and local government. At a time when public sector commissioners face difficult choices about what they can achieve within reducing resources across and competing priorities, it is important that they have the best possible evidence base from which to make decisions. The recommendations in this report will help service commissioners to ensure that they make the best investment of the resources they have available and to weigh the return on that investment against other competing priorities.

For each of the seven priority areas, sub-topics have been identified which are important for delivery. Recommendations from the evidence reviews have been included in the appendices, and the full evidence review reports are included on the East Sussex Joint Strategic Needs Assessment website www.eastsussexjsna.org.uk.

Commissioners responsible for delivering the action plan supporting the implementation of Healthy Lives, Healthy People can use the report to prioritise the key recommendations for implementation. Recommendations should be prioritised where they:

- are not part of current practice;
- highlight the need for practice to change;
- require retraining or the development of new skills;
- require implementation by a broad range of agencies or across a range of settings
- may be viewed as potentially contentious or difficult to implement for other reasons.

To make the recommendations more easily accessible and to aid review of them for prioritisation, a series of booklets have been produced. Each booklet focuses on one of the priority areas in Healthy Lives, Healthy People, and reproduces what is contained in this report for that area, including all the recommendations for that area contained in the appropriate appendix.

Booklet 1: The best possible start for all babies and young children
Booklet 2: Safe, resilient and secure parenting for all children and young people
Booklet 3: Enabling people of all ages to live healthy lives and have healthy lifestyles
Booklet 4: Preventing and reducing falls, accidents and injuries
Booklet 5: Enabling people to manage and maintain their mental health and wellbeing
Booklet 6: Supporting those with special educational needs, disabilities and long term conditions
Booklet 7: High quality and choice of end of life care

The Health and Wellbeing Strategy Action Plan

Healthy Lives, Health People is supported by an action plan setting out high level actions, outcomes, indicators and targets including those aimed at ‘narrowing the gap’ between the best and worst performing areas in the county (Table 1.1).

Table 1.1: The Health and Wellbeing Strategy action plan

OUTCOMES	ACTIONS AND OUTPUTS	OBJECTIVES	STRATEGIC OUTCOME INDICATORS
Priority 1: ALL BABIES AND YOUNG CHILDREN HAVE THE BEST POSSIBLE START IN LIFE			
Babies and young children develop well and are safe and healthy	• Ensure sufficient capacity is identified within midwifery, health visiting and children's centre services to provide high quality targeted support to all vulnerable parents who need it. • Roll out across the county an integrated partnership approach to identifying those who need extra support, and coordinating support with regular meetings between all relevant services in local areas. • Increase breastfeeding support for women in the first five days after birth. • Ensure that all pregnant women who smoke are identified and offered support to give up. • Provide coordinated, personalised specialist support through a "single plan" for parents whose babies have special educational needs or disabilities.	• Fewer referrals to children's social care. • More families with babies given targeted "early help" support. • Further improvement in the proportion of mothers choosing, and able, to breastfeed their babies. • Fewer women smoking in pregnancy. • Improved rates of infant immunisation and vaccination. • More babies and young children with special educational needs or disabilities having a single plan for health, care and education.	1.1 Increase the percentage of children who have been immunised for measles, mumps and rubella (MMR) by age two. Indicator definition: MMR vaccination coverage for one dose (2 year olds). Baselines: (2011/12) England 91.2%; East Sussex 92.0%; Eastbourne 92.5%; Hastings 94.4%; Lewes 90.3%; Rother 91.4%; Wealden 91.4%. Targets by 2016: To achieve the World Health Organisation (WHO) recommended coverage of 95.0% by 2015/16 by achieving 94.0% in 2013/14; 94.5% in 2014/15; 95% in 2015/16 and to reduce the gap at district/borough level from 4.2% in 2011/12 1.2 Improve the level of skills development of the lowest performing children at age 5. Indicator definition: Percentage of children achieving at least 78 points with at least 6 in each of the scales in Personal, Social and Emotional Development and Communication, Language and Literacy of the Early Years Foundation Stage resident-based. Baselines: Academic Year 2011/12: 29.8%. Target by 2016: Reduce percentage point gap between the lowest achieving 20% in the Early Years Foundation stage profile and the rest. Targets to be set following new criteria from the Department for Education.
Priority 2: SAFE, RESILIENT AND SECURE PARENTING FOR ALL CHILDREN AND YOUNG PEOPLE			
Parents are confident, able and supported to nurture their child's development	• Enhance the capacity and leadership of targeted early help services for parents who are struggling. • Ensure quick decisions and actions are taken where it is clear that parents do not have, and cannot develop, the capacity to provide good enough care for their children. • Invest in high quality training for all those who work with vulnerable families and ensure that support is streamlined and coordinated.	• More families given targeted early help support. • Improved rates of immunisation and vaccination. • Reduce the rate of inappropriate referrals to children's social care.	2.1 Fewer children needing a Child Protection Plan (CPP). Indicator definition: Rate per 10,000 (of 0-17 population) of children with a CPP. Baselines: (2011/12) England = 37.8; East Sussex = 65.0 2012/13 outturn to be confirmed. Target by 2016: To reduce the East Sussex rate to 2013/14 = 49.9; 2014/15 = 48.3; 2015/16 = 47.9 2.2 Reduce the number of young people entering the criminal justice system. Indicator definition: The rate of first time entrants to the criminal justice system per 100,000, where first time

OUTCOMES	ACTIONS AND OUTPUTS	OBJECTIVES	STRATEGIC OUTCOME INDICATORS
			entrants are defined as young people (aged 10 – 17) who receive their first substantive outcome (relating to a reprimand, a final warning with or without an intervention, or a court disposal for those who go directly to court without a reprimand or final warning). Baselines: (2011/12) England 712; East Sussex 423. Target by 2016: 2013/14 (381 countywide) = 10% reduction on the 2011/12 East Sussex outturn; 2015/16 = 5% reduction on the 2013/14 East Sussex outturn.
Priority 3: ENABLE PEOPLE OF ALL AGES TO LIVE HEALTHY LIVES AND HAVE HEALTHY LIFESTYLES			
More people will have healthy lifestyles to improve their prospect of a longer, healthier life	• Enhance the alcohol care pathway - from prevention through to recovery and involving a range of health, care and other partners. • Develop and implement a cross-sector multi-agency Tobacco Control Plan. • Develop and implement a cross-sector multi-agency Obesity Prevention Plan. • Enable frontline staff to offer residents brief advice and signposting to relevant services.	• Fewer young people and adults drinking at increasing and higher risk levels. • Lower rates of smoking amongst young people, pregnant women and others in the general population.. • Increase in the proportion of the population achieving the minimum recommended rates of physical activity (all ages) • More people of all ages eating five portions of fruit and vegetables a day. • Reduction in alcohol related crime.	3.1 Reduce rates of mortality from causes considered preventable. Indicator definition: Age-standardised rate of mortality from causes considered preventable per 100,000 population. Baselines: (2010) England average 149; (2010 to 2012) East Sussex average 135.3; Eastbourne 154.0; Hastings 175.6; Lewes 121.4; Rother 133.3; Wealden 112.6. Targets by 2016: 10% reduction between 2010-2012 and 2015-2017 for East Sussex County based on a steady reduction of 2% per year; and by 2015-2017 reduce the gap between Hastings Borough and Wealden District to the gap measured in 2003-2005 (59.5 deaths per 100,000). 3.2 Increase both the percentage offered NHS Health Checks and the take up by those in the eligible population. Indicator definition: Percentage of eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check in the financial year. Baselines: (2011/12) England average 14% offered and 51.2% received; East Sussex average 9.6% offered and 43.5% received. NB. District and Borough level data not available. Targets by 2016: 2013/14 = 10% offered and 50% received; 2014/15 = 20% offered and 50% received 2015/16 = 20% offered, 70% received.

OUTCOMES	ACTIONS AND OUTPUTS	OBJECTIVES	STRATEGIC OUTCOME INDICATORS
Priority 4: PREVENTING AND REDUCING FALLS, ACCIDENTS AND INJURIES			
Fewer children, young people and older people have preventable falls, accidents or suffer deliberate harm by others or themselves	• Further research and analysis to better understand the causes of falls, accidents and injuries amongst children and young people so that interventions can be targeted at those at greatest risk of harm. • Develop a more integrated, evidence based approach to preventing and reducing falls, accidents and injuries such as coordinated accident prevention activity and campaigns, home safety checks and equipment schemes, and parenting support. • Enhance the falls and bone care pathway with stronger links between community based, primary and secondary care settings and health, care and wider services.	• Fewer children and young people being admitted to hospital for unintentional and deliberate injuries (including falls, accidents, assaults). • Fewer over 65's use secondary care due to a fall. • Fewer over 65's use emergency ambulance services due to a fall. • Fewer over 65's with first or preventable second fractures.	4.1 Reduce emergency hospital admissions amongst children and young people for accidents and injuries. Indicator definition: Crude rate of hospital emergency admissions caused by unintentional and deliberate injuries in children and young people aged 0-17 years, per 10,000 resident population. Baselines: (2010/11) England average 124.3; (2011/12) East Sussex average 121.7; Eastbourne 121.2; Hastings 143.7; Lewes 118.0; Rother 123.4; Wealden 109.6. Target by 2016: 4% reduction for East Sussex between 2011/12 and 2015/16 based on a steady reduction of 1.35% per year. NB: Targets for local areas and/or causes may be proposed following an analysis of research into the causes of falls, accidents and injuries 4.2 Reduce the number of older people admitted to hospital due to falls. Indicator definition: Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population. Baselines: (2010/11) England average 1,642; (2011/12) East Sussex average 1,543; Eastbourne 1,751; Hastings 1,368; Lewes 1,569; Rother 1,358; Wealden 1,605. Target by 2016: 3% reduction in East Sussex between 2011/12 and 2015/16 based on a steady reduction of 1% per year.
Priority 5: ENABLING PEOPLE TO MANAGE AND MAINTAIN THEIR MENTAL HEALTH AND WELLBEING			
People of all ages to experience good mental health and wellbeing, and those with mental health conditions and their carers are able to manage their condition better and maintain their physical health.	• Develop the support pathway for children and young people with emerging mental health needs. • Enhance the mental health care pathway for adults, older people and their carers from prevention through to care planning and recovery with a more personalised approach within all care settings. • Align the mental health care pathway with care pathways for long term conditions and strengthen links with wider services.	• Earlier identification, diagnosis, support and treatment (all ages). • More people (all ages) using community based support. • More people with more severe mental health needs having a comprehensive care plan. • Fewer incidences of self harm and suicide. • Improved physical health for people with mental health support needs. • Better mental health outcomes and quality of life for carers (all ages).	5.1 Improve the experience of NHS mental healthcare for people with mental health conditions. Indicator definition: Percentages of service users responding to survey questionnaires who report being 'satisfied' and/or 'very satisfied' with the mental healthcare services they received, (return rates required being 33%). Baselines: (2012/13) Q3 Hastings and Rother PCT % Satisfied 83%, % Very Satisfied 33%; East Sussex Downs and Weald PCT % Satisfied 84%, % Very Satisfied 39%. Targets by 2016: Satisfied 80%; Very Satisfied 50% (future data will be available at CCG level) 5.2 Report improved outcomes for people with mental health conditions arising from NHS mental healthcare.

OUTCOMES	ACTIONS AND OUTPUTS	OBJECTIVES	STRATEGIC OUTCOME INDICATORS
			Indicator definition: TBC – using 'Health of the Nation Outcome Scores', reports are being developed that will enable periodic review of outcomes for all adults receiving NHS mental healthcare (working age adults and older peoples services). Although details will not be available until early 2013/14, with baselines available 3-6 months afterwards, the ability to report on improvements and clinical outcomes on a large scale and over the next 2-3 years makes this measure sufficiently important to merit inclusion in this action plan. Baselines: New measure from 2013/14. Targets by 2016: To be determined during 2013/14.
Priority 6: SUPPORTING THOSE WITH SPECIAL EDUCATIONAL NEEDS, DISABILITIES AND LONG TERM CONDITIONS			
Those with Special Educational Needs (SEN), disabilities and long term conditions have a better quality of life and longer life expectancy	• Develop a more person centred, coordinated approach to supporting the health and wellbeing of those with SEN, physical and learning disabilities, their parents and carers. • More children have a coordinated support plan for health, social care and education and personal budgets. • Develop an integrated 'whole system' approach to long term conditions with earlier diagnosis, care planning and joined up support for patients and carers. • Integrate mental health support into primary care and chronic disease management care pathways. • Roll out multi-disciplinary Neighbourhood Support Teams across the county.	• Earlier diagnosis and provision of personalised care in the community or at home. • More people feel supported to manage their condition better. • Better health outcomes for those with SEN, disabilities and long term conditions (all ages). • Better quality of life for those with SEN, disabilities and long term conditions (all ages). • Better physical health outcomes and quality of life for carers (all ages).	6.1 Improve measurable outcomes for children and young people with SEN and Disability. Indicator definition: The number of children and young people who have a personal budget attached to their Education, Health and Care Plan. Baselines: This is a new measure. Targets by 2016: 2013/14 = 60. Future targets to be set following 2013/14 outturn. 6.2 Increase the take up of health checks for people with learning disabilities. Indicator definition: Percentage of patients on a Learning Disability register in East Sussex GP practices who have received a health check within the financial year. Baselines: 2012/13 at Q3 England average 65%; East Sussex average 47.8%. Targets by 2016: to meet the England average (currently 65%). Targets to be revised upwards to match the national average if this increases. 6.3 Reduce the time that people with long term conditions spend in hospital. Indicator definition: 6.3.1 The proportion of people with ambulatory care sensitive conditions admitted to hospital as an emergency and; 6.3.2 The number of days between admission and discharge.

OUTCOMES	ACTIONS AND OUTPUTS	OBJECTIVES	STRATEGIC OUTCOME INDICATORS
			Baselines: 6.3.1 (2010/11) Number of admissions: East Sussex 4,996; Eastbourne 1,064; Hastings 1,006; Lewes 846; Rother 889; Wealden 1,191. 6.3.2 (2010/11) Number of bed-days: East Sussex 6,759; Eastbourne 5,731; Hastings 5,026; Lewes 5,026; Rother 5,690; Wealden 7,203. Targets by 2016: 20% reduction in number of admissions and 20% reduction in number of days between admission and discharge.
Priority 7: HIGH QUALITY AND CHOICE OF END OF LIFE CARE			
More people who are approaching the end of life being cared for and dying in their preferred place of care and death and to receive the highest standards of end of life care in any setting	• Roll out the delivery of the end of life care pathway (from advanced care planning to bereavement support) throughout all public, private, and voluntary and community sector health and care providers. • Continue end of life care training and workforce development for health and care staff and volunteers working in community, health and care settings.	• More people identified as approaching end of life have an advanced care plan. • Fewer people identified as approaching end of life dying in hospital. • Staff providing end of life care in community, health and care settings meet the national end of life care core competencies and occupational standards.	7.1 More people identified as approaching end of life are cared for and die in their usual place of residence. Indicator definition: 7.1.1 Deaths at usual place of residence divided by all deaths (usual residence includes home, care homes - Local Authority and non-Local Authority - and religious establishments). [This is an interim indicator as it does not provide information about patient choice and quality of care. When an Electronic Palliative Care Coordination System (EPaCCS) (7.1.2 below) is in place, preferences of care can be recorded as part of the national information standard ISB 158]. 7.1.2 Proportion of population served by GPs and Out Of Hours services that have access to information about people approaching end of life on EPaCCS or other coordination system. Baseline: 7.1.1 (2012/13 at Quarter 1) England average 42.9%; East Sussex Downs and Weald PCT area 47.3%; Hastings and Rother PCT area 42.3% plus 5% to account for the above national average deaths in hospices in the area. 7.1.2 2013/14 = zero% (this is a new initiative to be launched during 2013/14). Target by 2016: 7.1.1 Increase by 1% each year reaching 50.3% at Quarter 4 2015/16 for both EHS CCG and HWLH CCG, and 45.3% in H&R CCG. 7.1.2 2013/14 Identify a system and host for EPaCCS by Q4; 2014/15 = 40% EOLC patient data uploaded to EPaCCS; 2015/16 = 75%.

OUTCOMES	ACTIONS AND OUTPUTS	OBJECTIVES	STRATEGIC OUTCOME INDICATORS
			NB: Targets for EHS and HWLH CCGs are the same based on historical 2012 PCT data. CCG level data will be available from 2014. 7.2 Improve the experience of care for people at the end of their lives . Indicator definition: Work is underway with providers to identify and develop mechanisms, within available resources and capacity, to record carers’ and families’ experience of end of life care. Once this is completed baselines and targets can be established. Whilst reporting would not commence until 2014/15, people’s experience of end of life care will be impacted by strategic actions to roll out the end of life care pathway and to develop the workforce making this measure relevant for inclusion in this action plan. Baseline: This is a new measure. Target by 2016: TBC during 2013/14.

The Structure of this Report

The report outlines the approach taken to review the literature and evidence and takes each of the priority areas in turn, identifying the sub-topics that are important for delivery. It presents some of the key facts and figures for the priority area and then identifies evidence based recommendations for implementation.

The Department of Health published the Public Health Outcomes Framework for England in July 2012, setting out desired outcomes for public health and how they should be measured. Where there are Public Health Outcome Framework indicators relevant to the priority area, they have been included together with how East Sussex compares to England for the indicator(s).

All recommendations from the evidence reviews have been included in Appendicies 1-7, and the full evidence review reports for each of the priority areas are included on the East Sussex Joint Strategic Needs Assessment website www.eastsussexjsna.org.uk

Chapter 2: Evidence based commissioning

2.1 The approach – identifying the evidence

Within each of the seven priority areas of the Health and Wellbeing Strategy several sub-topics were identified as important for delivery. These were reviewed for evidence to support health and social care interventions and services.

The evidence reviews:

- Focused on systematic reviews and meta-analyses, but where there was a lack of evidence, randomised controlled trials were also included.
- Provide a summary of clear and concise evidence statements based on the 5-10 most recent and relevant systematic reviews or meta analyses.
- Identify the most important and relevant messages supported by the scientific literature.

Table 2.1: The seven priority areas and their sub-topics for the overall literature review

	Priority area	Sub-topic	
1	The best possible start for all babies and young children	a.	Interventions to support smoking cessation during pregnancy
		b.	Interventions to support breastfeeding initiation and continuation
		c.	Interventions to support parents of babies with special educational needs/disabilities
		d.	Interventions to improve rates of infant immunisation and vaccination
		e.	Interventions to achieve healthy weight during childhood (addressing obese and underweight children)
2	Safe, resilient and secure parenting for all children and young people	a.	Interventions to support parents who are struggling
		b.	Quality training as an intervention for those who work with vulnerable families
		c.	Effective parenting interventions to support children/young people
		d.	Interventions to reduce the number of young people entering the criminal justice system
		e.	Interventions to improve outcomes for children in families supported by social care services
3	Enabling people of all ages to live healthy lives and have healthy lifestyles	a.	Interventions to reduce the number of young people/adults drinking alcohol at a high risk level
		b.	Interventions to lower rates of smoking amongst young people/adults
		c.	Interventions to support primary prevention of smoking in children/young adults
		d.	Interventions to support people to change behaviour (all ages)
		e.	Interventions to promote physical activity (all ages)
		f.	Interventions to promote healthy eating (all ages)
4	Preventing and reducing falls, accidents and injuries	a.	Interventions to prevent falls, accidents and injuries amongst children and young people
		b.	Interventions to prevent falls, accidents and injuries (adults)
		c.	Interventions to prevent falls, accidents and injuries (elderly)
		d.	Integration of services to manage falls, accidents and injuries (elderly)
		e.	Interventions to prevent road traffic injuries

5	Enabling people to manage and maintain their mental health and wellbeing	a.	Interventions to promote early identification, diagnosis, support and treatment of mental health conditions (all ages)
		b.	Interventions to promote community based mental health services and support (all ages)
		c.	Interventions to promote utilisation of comprehensive care plans for people with severe mental health needs (all ages)
		d.	Interventions to reduce the incidents of self-harm and suicide (all ages)
		e.	Interventions to improve the physical health of people with mental health conditions (all ages)
		f.	Interventions to promote better mental health outcomes and quality of life for carers (all ages)
6	Supporting those with special educational needs, disabilities and long term conditions	a.	Interventions to support person centred care in the community for people with special educational needs
		b.	Interventions to support person centred care in the community for people with disabilities
		c.	Interventions to support person centred care in the community for people with long term conditions
		d.	Interventions to support self-management for people with long term conditions
		e.	Interventions to promote better physical health outcomes and quality of life for carers (all ages)
		f.	Integrated services as an intervention to avoid inappropriate attendance at A&E/admissions/bed days
7	High quality and choice of end of life care	a.	Interventions to increase the number of people identified as approaching end of life
		b.	Interventions to increase the number of people identified as approaching end of life with advanced care plans
		c.	Interventions to promote the number of people dying in their preferred place of care and reduce the number dying in hospital
		d.	Interventions to promote end of life care staff training
		e.	Interventions to support people who are bereaved

Evidence was classified based on the Scottish Intercollegiate Guidelines Network (SIGN) methodology. These reviews did not include a full systematic assessment of study quality (Table 2.2). Perceived levels of bias and probabilities of causal relationships were scored based on an assessment of each source’s methodology; scorings were indicative rather than definitive.

Table 2.2: Study Quality Classification

1++	High quality meta-analyses, systematic reviews of Randomised Controlled Trials (RCTs), or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias
1-	Meta-analyses, systematic reviews, or RCTs with a high risk of bias
2++	High quality systematic reviews of case control or cohort studies High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2+	Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2-	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3	Non-analytic studies, e.g. case reports, case series
4	Expert opinion

The recommendations for each topic were classified using a system based on the overall quality of the evidence. Recommendations graded ‘A’ are based on the highest quality evidence and those graded ‘D’ the lowest (Table 2.3).

Table 2.3: Recommendation Strength Classification

A	At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
B	A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 1++ or 1+
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 2++
D	Evidence level 3 or 4; or extrapolated evidence from studies rated as 2+

2.2 Commissioning prioritisation

This report aims to provide commissioners and multi-agency partnerships with a checklist against which commissioning plans and strategies can be compared to ensure they are based on current best evidence.

It is acknowledged that the evidence reviews include some interventions that are well established within local services. However, it is recommended that commissioners and multi-agency partnerships review the full list of recommendations against strategies and then develop a process for prioritising and building recommendations into work plans using the following criteria to identify interventions which:

- are not part of current practice;
- highlight the need for practice to change;
- require retraining or the development of new skills;
- require implementation by a broad range of agencies or across a range of settings;
- may be viewed as potentially contentious or difficult to implement for other reasons.

The best possible start for all babies and young children

Chapter 3: The best possible start for all babies and young children

Focus on

3.1 Interventions to support smoking cessation during pregnancy
3.2 Interventions to support breastfeeding initiation and continuation
3.3 Interventions to support parents of babies with special educational needs/disabilities
3.4 Interventions to improve rates of infant immunisation and vaccination
3.5 Interventions to achieve healthy weight during childhood (addressing obese & underweight children)

Public Health Outcome Framework indicators relevant to this key area and their East Sussex rating in comparison to the England Average, November 2013

	Public Health Outcome Indicator	Comparison to England
2.01	Low birth weight of term babies	Significantly better
2.02	Breastfeeding	
ii	prevalence at 6-8 weeks after birth	Better
2.06	Excess weight in 4-5 and 10-11 year olds	
i	4-5 year olds	Better
ii	10-11 year olds	Significantly better
3.03	Population vaccination coverage	
iii	Diphtheria/Polio/Haemophilus influenzae type B (1 year old)	Better
iii	Diphtheria/Polio/Haemophilus influenzae type B (2 years old)	Worse
iv	Meningitis C	Better
v	Pneumococcal Conjugate Vaccine	Better
vi	Haemophilus influenzae type B/Meningitis C booster (5 years)	Significantly worse
vi	Haemophilus influenzae type B/Meningitis C booster (2 years old)	Better
vii	Pneumococcal Conjugate Vaccine booster	Worse
viii	Measles Mumps Rubella for one dose (2 years old)	Worse
ix	Measles Mumps Rubella for one dose (5 years old)	Worse
x	Measles Mumps Rubella for two doses (5 years old)	Sigignificantly worse

3.1 Key facts and figures: smoking in pregnancy

Smoking during pregnancy increases the risk of infant mortality by an estimated 40%. Around a third of all perinatal deaths in the UK are thought to be caused by smoking. Passive exposure to tobacco smoke, both before and after birth, also has a substantial impact on the risks of a range of foetal and childhood health problems. Smoking during pregnancy is strongly associated with younger age and lower socioeconomic status. It is the single most modifiable risk factor for adverse outcomes in pregnancy.[1]

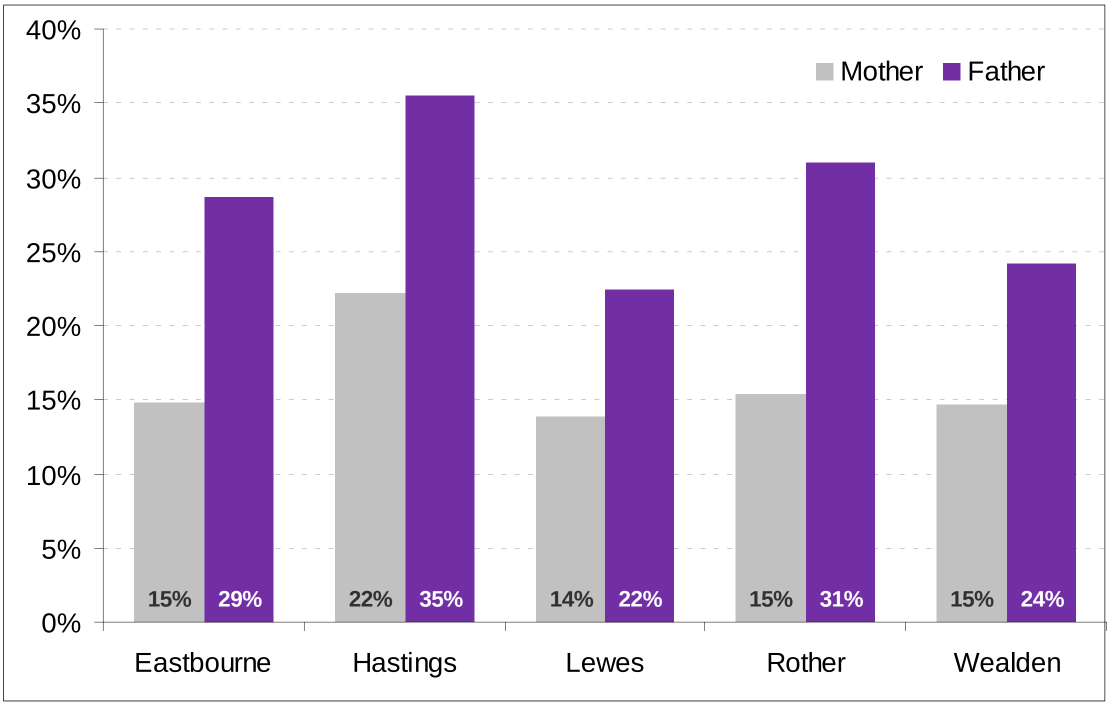
Figure 3.1 Percentage of mothers smoking at booking and time of delivery, by district and borough, 2011/12

Source: East Sussex JSNA, Local Briefing - Maternal Smoking in East Sussex 2011/12, October 2012
www.eastsussexjsna.org.uk/briefings

In East Sussex 18% of women are smoking at the time they book with the midwife at 10-12 weeks of pregnancy; 16% are still smoking at delivery suggesting that only 2% of women give up during pregnancy. Smoking rates are highest in Hastings both at booking (24%) and at the time of delivery (22%). They are lowest at booking in Wealden (14%) and at delivery in Lewes (11%) where more women appear to give up smoking during pregnancy.

At the 6 week health visitor review the smoking status of both parents is identified. Rates range from 14-22% in mothers and 22-35% in fathers. The highest rate for mothers and fathers are in Hastings.

Figure 3.2 Percentage of parents smoking at babies 6 week Health Visitor review, babies born in 2011/12



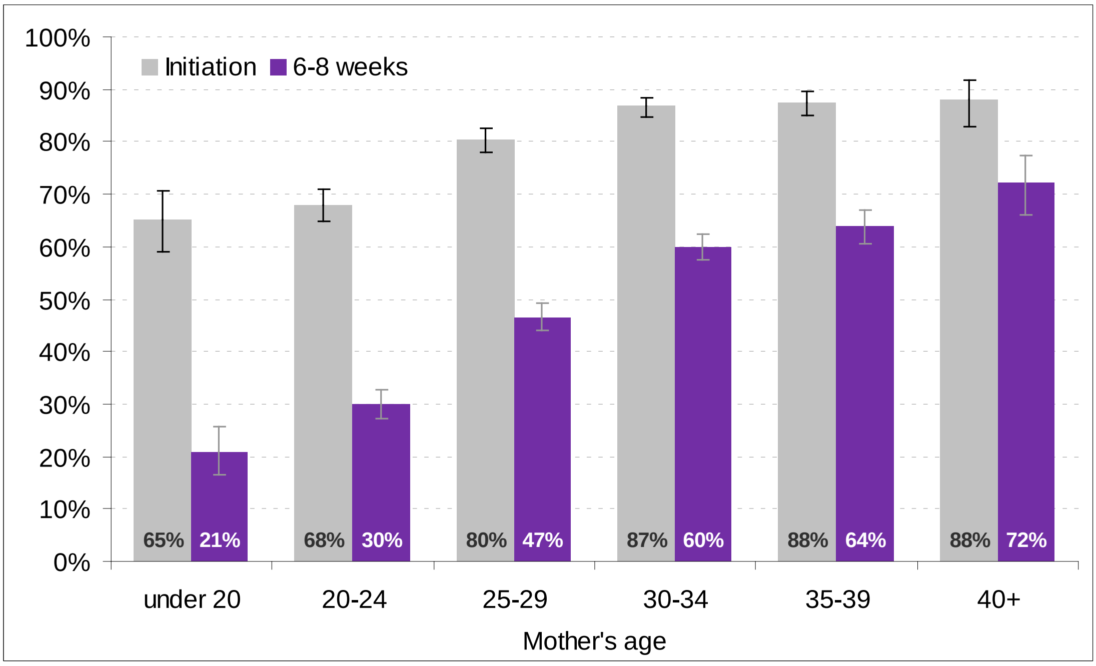
Source: East Sussex JSNA, Local Briefing - Maternal Smoking in East Sussex 2011/12, October 2012
www.eastsussexjsna.org.uk/briefings

There is a clear socioeconomic gradient across East Sussex with smoking rates being highest in the most deprived areas and lowest in the least areas

3.2 Key facts and figures: breastfeeding

Breastfeeding has been shown to benefit infant health in terms of reducing the risk of infection, improving intellectual and motor development, and reducing chronic disease risk as well as benefiting maternal health in the short and long term. There are also additional economic benefits for the family, the NHS, employers and society. There are well-recognised age, education and socio-economic gradients in infant feeding practices with younger women from the lowest educational and socio-economic groups least likely to breastfeed.

Figure 3.3 Prevalence of breastfeeding initiation and breastfeeding at 6-8 weeks amongst babies of known status by maternal age, 2011/12

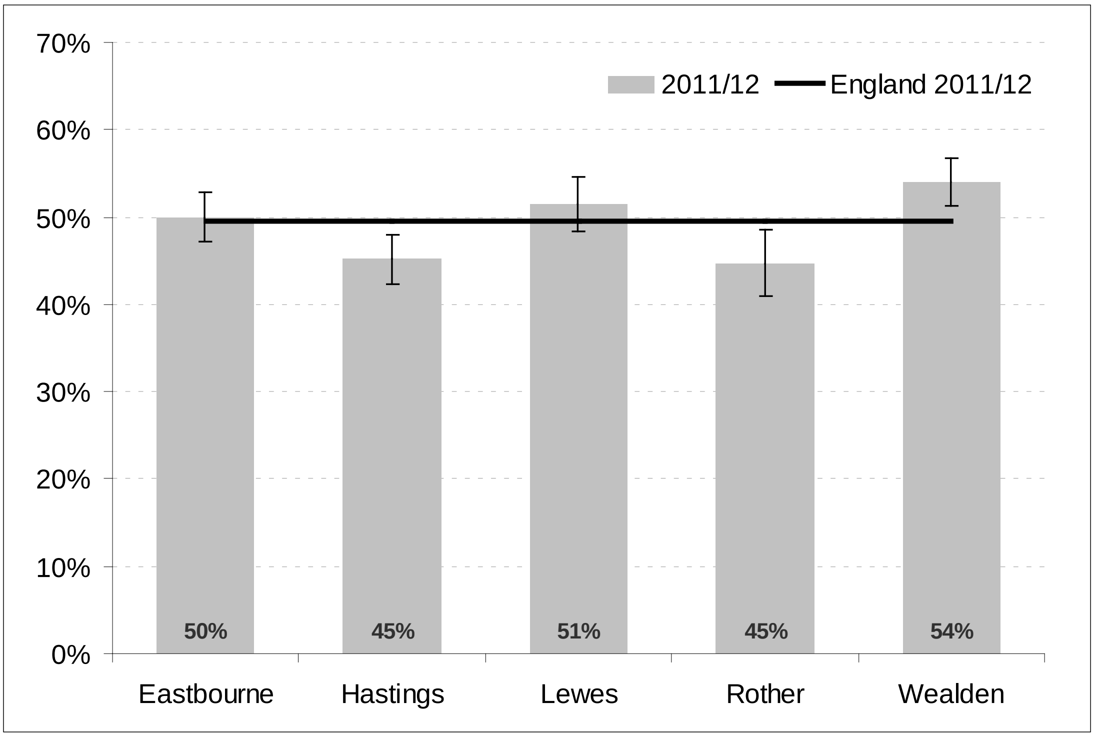


Source: East Sussex JSNA, Local Briefing - Breastfeeding at 6-8 weeks in East Sussex 2011/12, November 2012
www.eastsussexjsna.org.uk/briefings

In East Sussex the breastfeeding initiation rate and the rate at 6-8 weeks increase with the age of the mother with drop off rates being highest for younger women. Over two thirds of mothers aged under 20 who initiated breastfeeding in 2011/12 had stopped by 6-8 weeks, compared to less than half of those aged 25-29 years and around a quarter of those aged 35+ years.

Overall East Sussex breastfeeding rates at 6-8 weeks are in line with the England average with the highest rates being in Wealden and the lowest in Hastings. In both Hastings and Rother rates are significantly below the national average.

Figure 3.4 Percentage of mothers breastfeeding at 6-8 weeks by East Sussex local authorities with 95% confidence intervals, 2011/12



Source: East Sussex JSNA, Local Briefing - Breastfeeding at 6-8 weeks in East Sussex 2011/12, November 2012
www.eastsussexjsna.org.uk/briefings

3.3 Key facts and figures: babies with special educational needs or disabilities

The prevalence of learning disability in England for babies up to 2 years of age is estimated at 39 per 10,000 for girls and 60 per 10,000 for boys. Based on these rates it is estimated that in East Sussex there are 50 children aged 2 years and under (30 boys and 20 girls) with learning disabilities.

Finding out their child has a complex health need and/or learning disability can be a very confusing and emotional time for parents. Whilst some may be given a specific diagnosis, others may be told their child has global developmental delay, or in some cases may never receive a specific diagnosis at all.

Schools have a number of stages of increasing support for children with special educational needs. The first two stages are School Action and School Action Plus. The stage depends on the child's individual learning needs.

According to the January 2013 school census 21.3% (13,567) of children attending East Sussex Schools and Academies had Special Educational Needs: 3.6% (2,319) had a Statement of Special Educational Need; 6% (3,798) were at stage School Action Plus and 11.7% (7,450) School Action. Table 3.1 provides the breakdown in terms of primary, secondary and special schools.

There is a declining trend for congenital anomalies nationally. In 2010 (the latest available data) about 121 babies were born with congenital anomalies in East Sussex. Nationally the major cause of congenital abnormality is congenital heart defects (59/10,000) followed by chromosomal abnormalities (40.2/10,000). Congenital anomaly rates are likely to be higher than reported as most cardiac anomalies are diagnosed later in infancy and childhood.

Table3.1: Special Educational Needs (SEN) in East Sussex Schools and Academies: January 2013

	SEN provision				
	School Action	**School Action Plus**	**Statement of SEN**	**Total Number SEN**	**% SEN**
Primary school	4103	2239	816	7158	19.9%
Secondary school	3344	1543	657	5544	20.6%
Special school	<5	<20	846	865	100.0%
All local authority schools	7450	3798	2319	13567	21.3%

Source data: School Census January 2013

Note: some data suppressed to maintain confidentiality

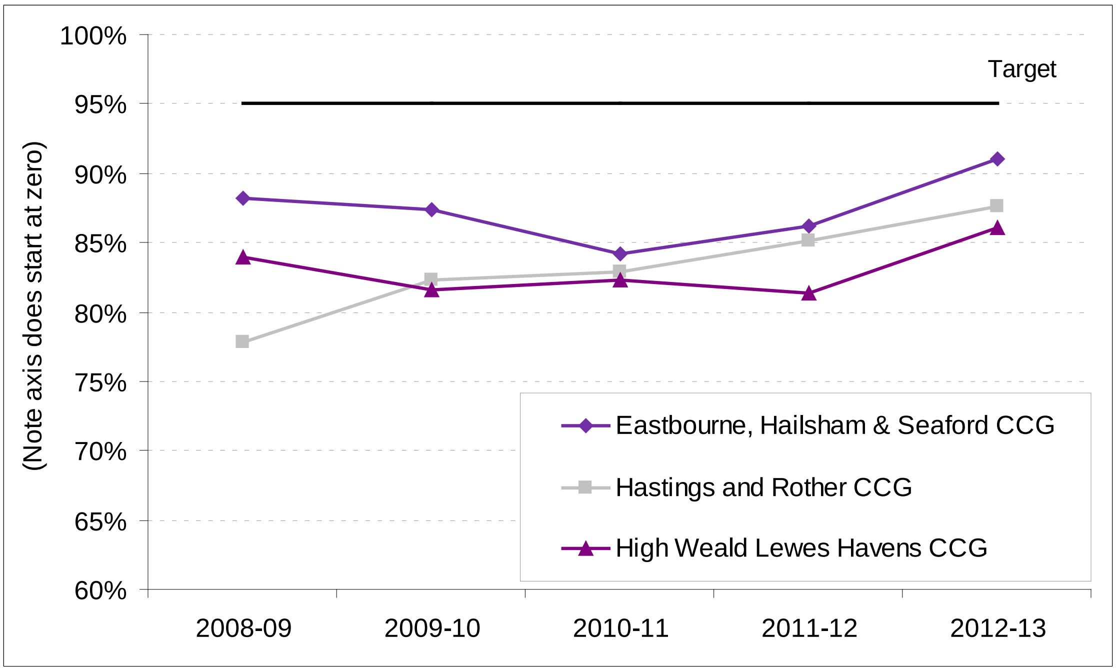
In the January 2013 school census there were 2,319 children with a Statement of Educational Need maintained by East Sussex County Council; of whom 4% (112) were under 5s. In the calendar year 2012, there were 410 Statements of SEN issued by East Sussex for the first time 26% (106) of which were for under 5s.

In 2014 the stages of support for children with SEN will be replaced by the new Education Health Care Plan. This will provide a simpler single assessment process for children from birth to 25 years and enable parents to buy in specialist and disabled care. East Sussex is a pathfinder for the new system with over 300 students receiving services.

3.4 Key facts and figures: infant immunisation and vaccination

Immunisation is the most important way of protecting babies and children from some illnesses. Complications, including deaths, from vaccine preventable diseases such as measles, whooping cough, meningococcal serogroup C and tetanus have been greatly reduced since the implementation of the routine childhood immunisation programme.

Figure 3.5 Percentage of children who have been immunised for measles, mumps and rubella (MMR) by their 5th birthday



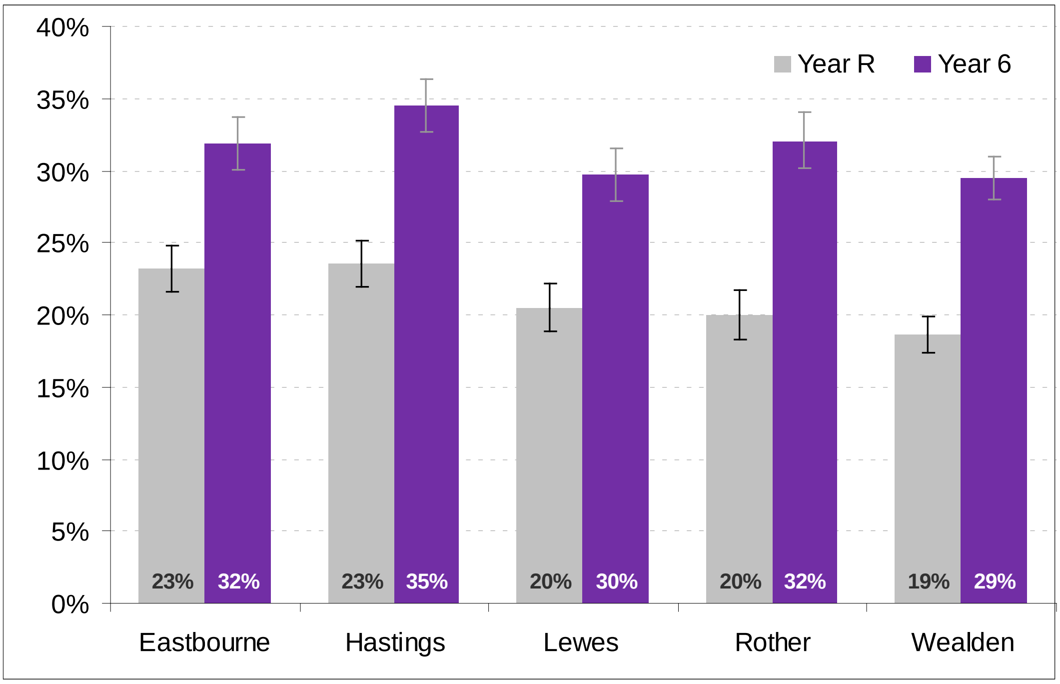
Source: East Sussex Child Health Information Systems

Whilst vaccination rates in East Sussex are generally better than the national average, uptake rates for MMR at 5 years still fall short of the national target of 95%, the level required to prevent disease outbreaks (herd immunity). Rates are highest in Eastbourne Hailsham and Seaford CCG and lowest in High Weald Lewes Havens CCG.

3.5 Key facts and figures: healthy weight during childhood

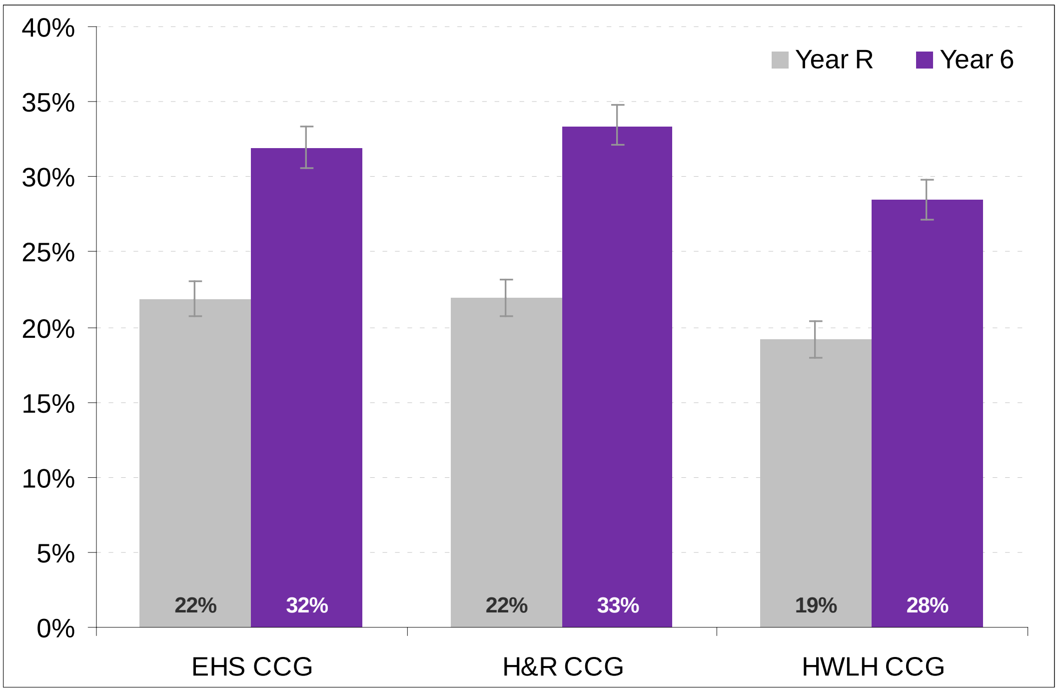
The World Health Organisation has declared childhood obesity to be one of the most serious global public health challenges for the 21st century. Obese children and adolescents are at an increased risk of developing various health problems, and are also more likely to become obese adults.

Figure 3.6a Prevalence of overweight and obese children by local authority and year group with 95% confidence intervals, 2009/10 to 2011/12



Source: East Sussex JSNA, Local Briefing - East Sussex National Child Measurement Programme 2011/12, October 2012
www.eastsussexjsna.org.uk/briefings

Figure 3.6b: Prevalence of overweight and obese children by clinical commissioning group and year group with 95% confidence intervals, 2009/10 to 2011/12



Source: East Sussex JSNA, Local Briefing - East Sussex National Child Measurement Programme 2011/12, October 2012 www.eastsussexjsna.org.uk/briefings

The National Child Measurement Programme annually measures the height and weight of English school children in reception year and year 6 to calculate the percentage who are overweight and obese. In East Sussex in the 2011/12 school year 97% of reception age children and 90% of year 6 children took part.

Nationally, obesity prevalence increases between Reception Year and Year 6 which is also the case in East Sussex. In Reception the prevalence of overweight and obesity are highest in Hastings and Eastbourne areas, and in Year 6 they are highest in Hastings, Rother and Eastbourne.

Across the East Sussex CCGs prevalence of overweight and obesity are lower in High Weald Lewes Havens CCG compared to Hastings & Rother

There is a clear link between deprivation and obesity for both Reception and Year 6. The percentage of pupils who are obese in the most deprived areas is almost double that of the least deprived (based on national IMD 2010 quintiles).

Recommendation: commissioners and multi-agency partnerships delivering in this area should review current commissioning plans and strategies against evidence recommendations laid out in Appendix 1. Where gaps or weaknesses are identified interventions for implementation should be prioritised using criteria outlined in Chapter 2.

References:

1. National Institute for Health and Clinical Excellence (NICE) 2010. Quitting smoking in pregnancy and following childbirth NICE public health guidance 26 www.nice.org.uk

Safe, resilient and secure parenting for all children and young people

Chapter 4: Safe, resilient and secure parenting for all children and young people

Focus on

4.1 Interventions to support parents who are struggling
4.2 Quality training as an intervention for those who work with vulnerable families
4.3 Effective parenting interventions to support children/young people
4.4 Interventions to reduce the number of young people entering the criminal justice system
4.5 Interventions to improve outcomes for children in families supported by social care services

Public Health Outcome Framework indicators relevant to this key area and their East Sussex rating in comparison to the England average, November 2013

Public Health Outcome Indicator	Comparison to England
1.01 Children in poverty	Significantly better
1.03 Pupil absence	Significantly worse
1.04 i First time entrants to the youth justice system	Significantly better
1.05 16-18 year olds not in education employment or training	Significantly worse
2.04 Under 18 conceptions	Worse

4.1 Key facts and figures: supporting parents

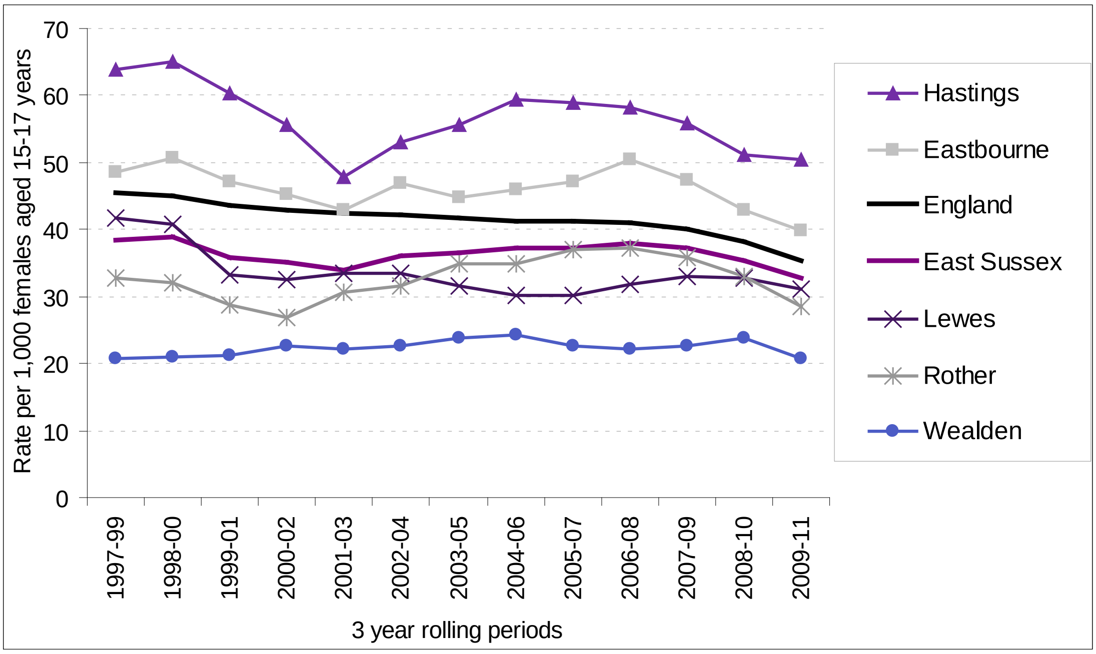
Families with low incomes are more likely to live in deprived neighbourhoods with poorer housing, higher rates of crime, poorer air quality, lack of green spaces for children to play and more risks to safety from traffic all of which impact on their health.

Many families are struggling to bring up their children in difficult personal and life circumstances.

Around one in five (18.7%) children in East Sussex are living in poverty with almost a six fold difference in the number of children in urban areas compared with rural areas. The wards with the highest numbers are Hampden Park and Langney. The ward with the highest percentage of children living in poverty is in Central St Leonards (50%).

Teenage pregnancy and early motherhood are associated with poorer health and social outcomes both for mothers and children. Socio-economic disadvantage can also be a cause of teenage parenthood as well as a consequence.

Figure 4.1: Under 18 conceptions for East Sussex local authorities, rate per 1,000, 1997 to 2011



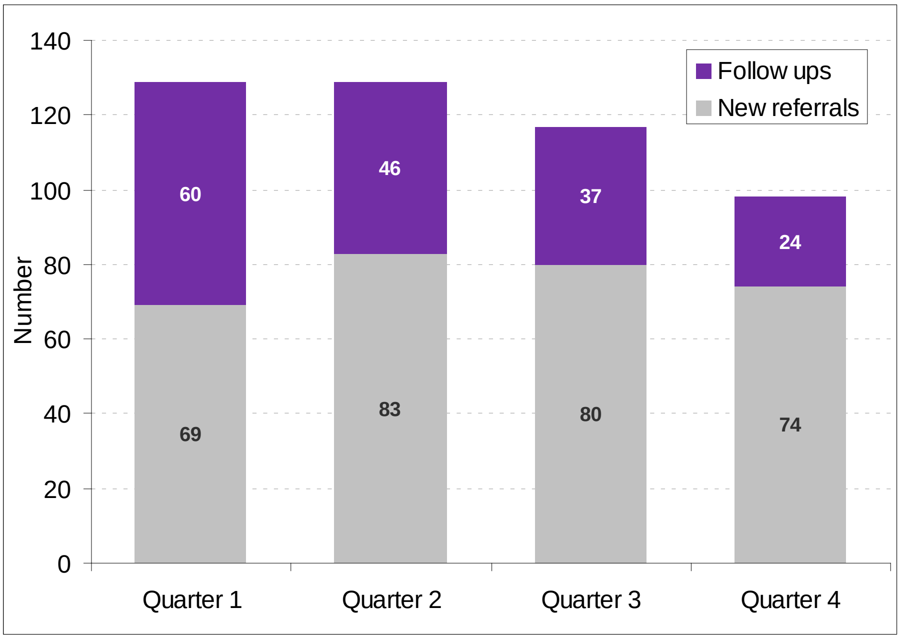
Source: Office for National Statistics

The teenage pregnancy rate in East Sussex is generally declining and is lower than the England average. Rates are highest in Hastings and Eastbourne and lowest in Wealden.

There is good evidence that postnatal depression affects the mother-infant relationship and children's cognitive and emotional development. Depression and anxiety are the most common mental health problems in pregnancy affecting 10-15 in every 100 women, although women also experience a range of other mental health problems during pregnancy. In 2012 there were 5,422 births to East Sussex women, around 550-800 of whom will have developed postnatal depression.

The East Sussex perinatal mental health service provides a service to women who develop mental health problems related to pregnancy, those with postnatal mental illness and those with pre existing psychiatric disorder. Provision continues until the first year of the baby's life. As well as taking referrals for women with moderate to severe mental health problems, the service provides advice and information, training and signposting for health professionals working with women with less severe presentation. The aim is to improve outcomes for women and prevent future crises which may affect parenting and have long term effects on their children.

Figure 4.2: Referral to East Sussex specialist perinatal mental health service 2012/13 by quarter



Source: East Sussex Healthcare NHS Trust

Figure 4.2 shows that in 2012/13 there were a total of 473 referrals to the perinatal mental health service, of which 306 were new referrals and 167 follow-up visits. The majority of new referrals are for depression and anxiety, with midwives and GPs being the main sources of referrals.

Those with less severe mental health problems are cared for by the Health Visiting Service or referred for community-based counselling. It is estimated that the latter service receives around 120 referrals per annum and provides both individual and group sessions.

4.2 Key facts and figures: working with vulnerable families

The Government's three-year Troubled Families Programme offers incentives to encourage local authorities, and their partners, to 'turn around' (achieve lasting change with) troubled families. Troubled families are characterised by there being no adult in the family working, children not being in school and family members being involved in crime and anti-social behaviour.

East Sussex County Council has a clear commitment to invest in the Children's Workforce through comprehensive training and other development opportunities, supporting staff to change the way they work, achieve greater confidence in keeping children safe and intervene with families more effectively.

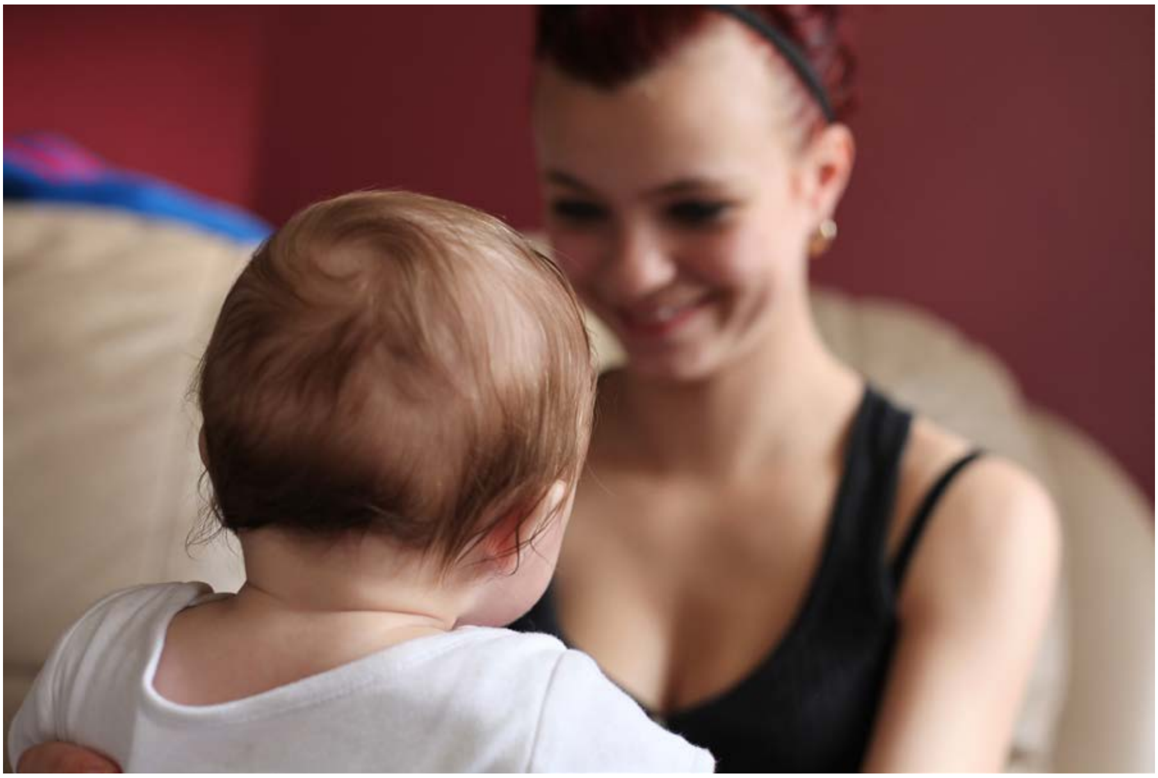
The national Troubled Families Programme rated East Sussex County Council 'green' at the end of the first year having already achieved 90% of its three year target for identification of troubled families and 83% of its target for engaging with troubled families. At the time of assessment 17 services/school clusters were offering Keywork to families and new services have since joined the programme. Keyworkers are now being introduced more widely into Early Help services as part of the THRIVE programme.

4.3 Key facts and figures: effective parenting

The Health Visitor Implementation Plan sets out the need for both universal provision and targeted help and support. In East Sussex around 1,450 families and 2,400 children were in receipt of targeted early help from the Health Visiting Service in each quarter of 2012/13. Of these, around 850 families and 1,000 children received Universal Plus provision and 600 families and 1,400 children received Universal Partnership Plus provision.

Under Universal Plus, health visitors provide a rapid response to families when there is a need for specific expert help, for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting.

Under Universal Partnership Plus**,** health visitors provide families and children with ongoing support and access to a range of local services to help them deal with more complex issues over a period of time. These include services from Sure Start Children's Centres, other community services including charities and, where appropriate, the



The Family Nurse Partnership is an evidence-based preventive programme for vulnerable young first time mothers and their families offering intensive and structured home visiting from early pregnancy until the child is 2 years old.

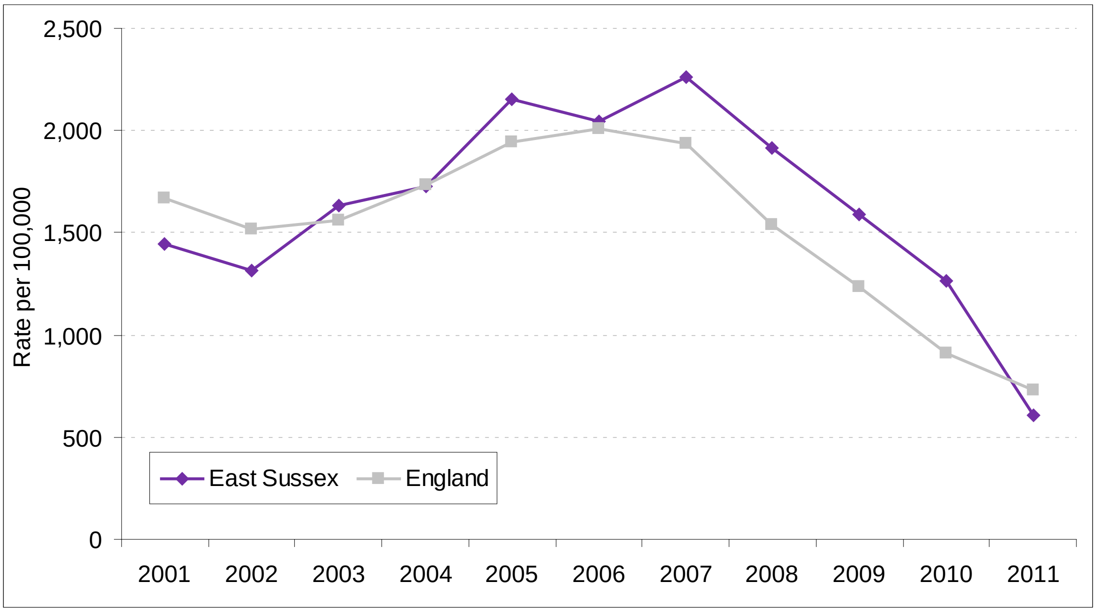
All first time mothers who are 19 years old and younger at conception are eligible for the East Sussex Family Nurse Partnership Programme. The programme has a caseload capacity of 266 clients: 123 for the East and 143 for the West of the county. At the end of June 2013 the programme was at 76% capacity in the East and 84% capacity in the West.

Research shows that good-quality early years education benefits children in the long term, particularly the most disadvantaged. It enhances children's all round cognitive, language and social development. In East Sussex 96% of 3 year olds and 98% of 4 year olds take up Early Years Educational Entitlement, similar to England.

4.4 Key facts and figures: young people entering the criminal justice system

The main aim of the youth justice system is to prevent youth offending. The effectiveness of the criminal justice system is therefore partly judged on its progress in reducing the number of young people entering the system for the first time. Justice agencies have worked to reduce the numbers through voluntary interventions targeted at those considered to be at risk of offending, and also by responding to minor offending in a more informal way. Figure 4.3 shows there have been substantial reductions in the number of first-time entrants in East Sussex since 2007, which is in line with the national picture.

Figure 4.3: Juveniles (10-17 year olds) receiving their first reprimand, warning or conviction, rate per 100,000 population, 2001 to 2011



Source: Ministry of Justice and Office for National Statistics

4.5 Key facts and figures: children in families supported by social care service

Generally children in care have poorer outcomes than the wider population particularly in relation to educational achievement, homelessness and mental health.

Looked after children are over-represented within the youth criminal justice system. Recent analysis of the experiences of 15–18-year-olds in prison found that around a third of the young people surveyed (30%) said they had been looked after by a local authority at some point.[1]

At the end of March 2013 there were 596 looked after children in East Sussex - a reduction on the previous year's 618 - of which 71% were placed with foster carers.

The ESCC THRIVE programme focuses on improving early help and prevention services, as well as social work practice and systems, to achieve better outcomes for children and families. It was introduced in response to the rising demand and cost of children's social care services and has involved a major change in the way children's services are delivered. Early indications suggest that the investment in early help is reducing the demand for social care intervention, and more purposeful work from social workers is impacting positively on social care spend across a number of budgets. The first year saw a 21% increase in the number of families offered a targeted preventative family support service, a 45% reduction in referrals to Children's Social Care services, and 100 fewer children and young people requiring statutory Child Protection Plans.

Recommendation: commissioners and multi-agency partnerships delivering in this area should review current commissioning plans and strategies against evidence recommendations laid out in Appendix 2. Where gaps or weaknesses are identified interventions for implementation should be prioritised using criteria outlined in Chapter 2.

References

1. Murray R. Children and Young People in custody 2011-12. HM Inspector of Prisons/Youth Justice Board. http://www.justice.gov.uk/news/press-releases/hmi-prisons/children-and-young-people-in-custody-a-fall-in-numbers,-but-little-change-otherwise

Enabling people of all ages to live healthy lives and have healthy lifestyles

Chapter 5: Enabling people of all ages to live healthy lives and have healthy lifestyles

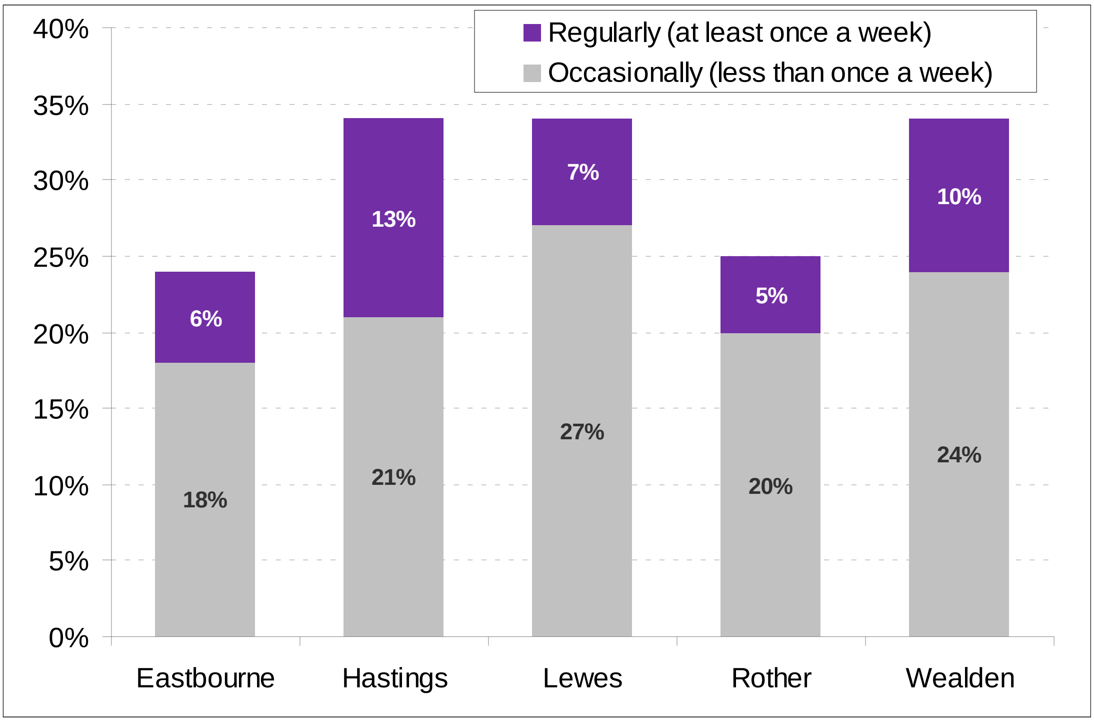
Focus on:
5.1 Interventions to reduce the number of young people/adults drinking alcohol at a high risk level
5.2 Interventions to lower rates of smoking amongst young people/adults
5.3 Interventions to support primary prevention of smoking in children/young adults
5.4 Interventions to support people to change behaviour (all ages)
5.5 Interventions to promote physical activity (all ages)
5.6 Interventions to promote healthy eating (all ages)

Public Health Outcome Framework indicators relevant to this key area and their East Sussex rating in comparison to the England average, November 2013

Public Health Outcome Indicator		Comparison to England
1.16	Utilisation of outdoor space for exercise/health reasons	Significantly better
2.14	Smoking prevalence – adults (over 18s)	Better
2.22	Take up of NHS Health Check Programme by those eligible	
	i health check offered	Significantly worse
	ii health check take up	Significantly better

5.1 Key facts and figures: young people and adults drinking alcohol at high risk level

Figure 5.1a: Frequency with which 14-15 year old pupils describe how often they drink alcohol, 2012



Source: East Sussex JSNA, The 2012 East Sussex health related behaviour survey of year 10 pupils, January 2013
www.eastsussexjsna.org.uk/evidencelinks/evidence

Figure 5.1b: Change in percentage of drinkers who are increasing risk and higher risk drinkers, 1992 and 2011

Source: East Sussex JSNA, Health and Lifestyle in East Sussex 1992-2011, January 2012
www.eastsussexjsna.org.uk/evidencelinks/evidence

What is increasing and higher risk drinking?
Increasing risk drinkers are at an increasing risk of alcohol-related illness. They are defined as:

- men who regularly drink more than 3 to 4 units a day but less than the higher risk levels
- women who regularly drink more than 2 to 3 units a day but less than the higher risk levels

Higher risk drinkers have a high risk of alcohol-related illness. They are defined as:

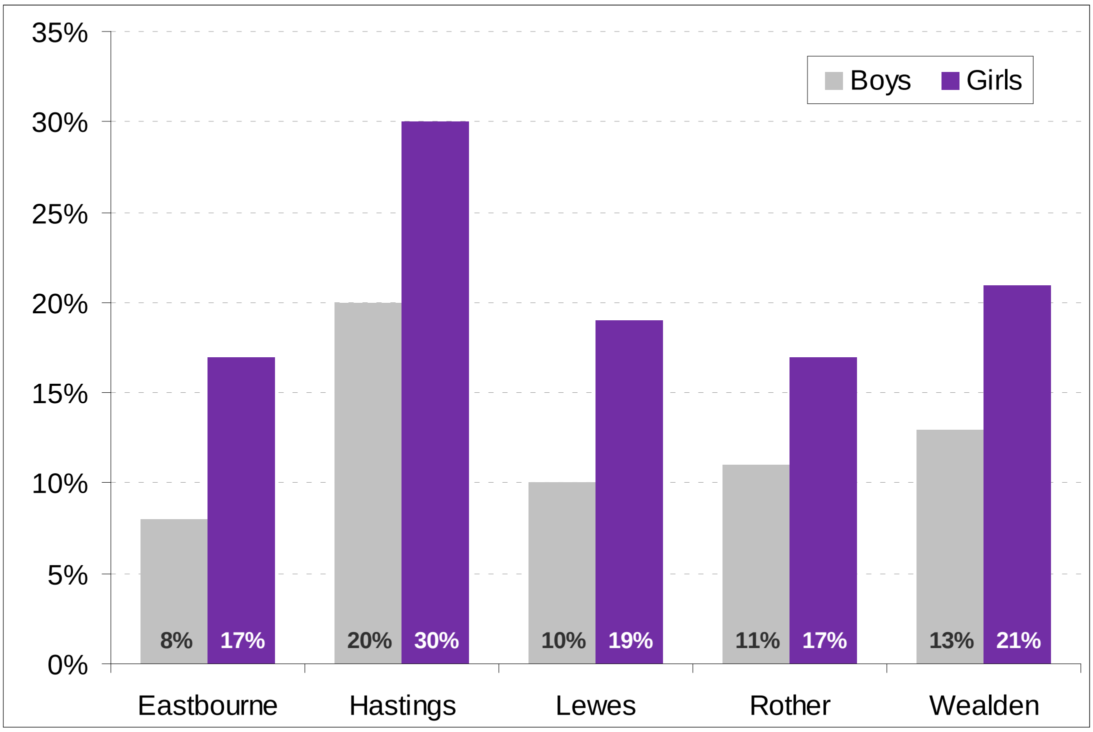
- men who regularly drink more than 8 units a day or more than 50 units of alcohol per week
- women who regularly drink more than 6 units a day or more than 35 units of alcohol per week.

In a recent survey of drinking habits in young people between a quarter and a third of 14-15 year olds said they drank alcohol occasionally or regularly, for young people drinking alcohol at any level can be harmful to health.

The proportion of adults drinking at increasing risk levels has significantly increased in recent year across East Sussex (Fig. 5.1b), this is due to a significant increase in Eastbourne. People who drink at these levels have a greater risk of developing conditions such as reduced fertility, high blood pressure, some cancers and heart disease.

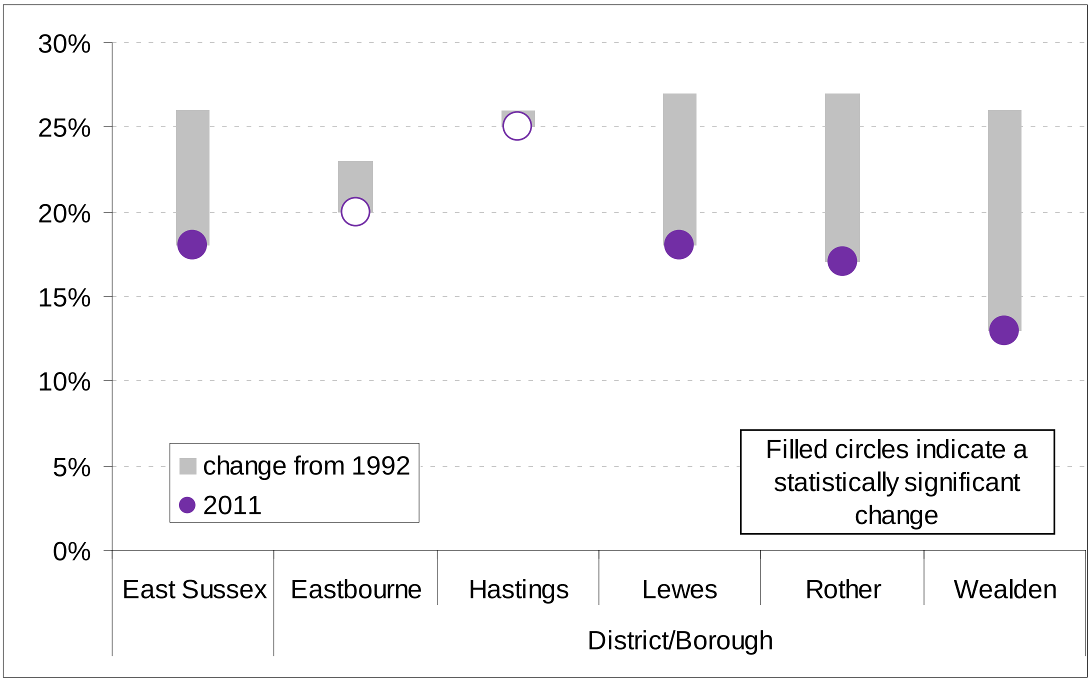
5.2 Key facts and figures: smoking amongst young people and adults

Figure 5.2a: Percentage of 14-15 year old pupils who describe themselves as occasional or regular smokers, 2012



Source: East Sussex JSNA, The 2012 East Sussex health related behaviour survey of year 10 pupils, January 2013
www.eastsussexjsna.org.uk/evidencelinks/evidence

Figure 5.2b: Change in percentage of smokers, 1992 and 2011



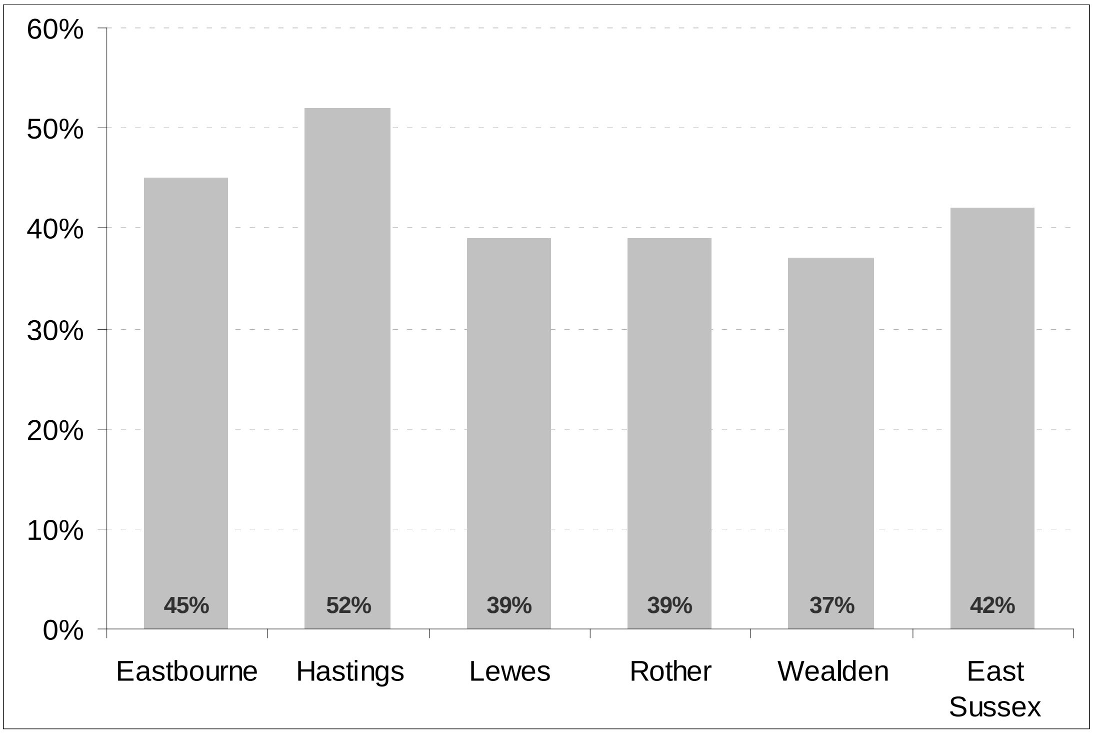
Source: East Sussex JSNA, Health and Lifestyle in East Sussex 1992-2011, January 2012
www.eastsussexjsna.org.uk/evidencelinks/evidence

The proportion of young people who say that they are occasional or regular smokers remains worryingly high across the county and in some areas almost 1/3 (30%) of girls say that they smoke occasionally or regularly.

In line with national trends smoking rates for adults across East Sussex as a whole have decreased in recent years. However in some areas despite more than 20 years of tobacco control activity rates remain virtually the same as they were in 1992.

5.3 Key facts and figures: primary prevention of smoking in children and young adults

Figure 5.3 Percentage of 14-15 year old pupils answering that at least one person smokes on most days indoors at home



Source: East Sussex JSNA, The 2012 East Sussex health related behaviour survey of year 10 pupils, January 2013
www.eastsussexjsna.org.uk/evidencelinks/evidence

Between 37% and 52% of 14-15 year olds in East Sussex live in a home where someone smokes inside the home on most days

Young people whose parents smoke are more likely to take up smoking themselves. In addition exposure to second hand tobacco smoke is associated with an increased risk of poorer health outcomes for children and young people.

5.4 Key facts and figures: supporting behaviour change (all ages)

Healthy Foundations is a lifestyle segmentation model which aims to ensure that all public health interventions are informed by our understanding of what motivates people and how these motivations are affected by their social and material circumstances. It classifies people according to their attitudes to life and health, demographic characteristics and their health-related behaviours. The Segmentation Model consists of five core motivational segments: Health Conscious Realists; Balanced Compensators; Live for Todays; Hedonistic Immortals; and Unconfident Fatalists.

Health Conscious Realists (HCR)	
What are they like	**Profile**
They are motivated people who feel in control of their lives and their health. They generally feel good about themselves, but have more internally focused aspirations to better themselves, learn more and have good relationships, rather than just aspiring to looking good. They tend not to take risks and take a longer term view of life, and that applies to their health too. Their health is very important to them and they feel that a healthy lifestyle is easy to achieve and enjoyable. They also take a realistic view of their health: of all the segments they are the least fatalistic about their health, and don't think they are any more or less likely than other people to get ill.	• Female bias in this segment • They are more likely to live in less deprived areas but significant numbers do live in deprived areas • Segment with an older than average age (47 compared to 43 years for the study sample)
	Behaviours • Display positive health behaviours • Highly motivated • In control of their lives and their health • Low prevalence of smoking and drug use • Eat healthily

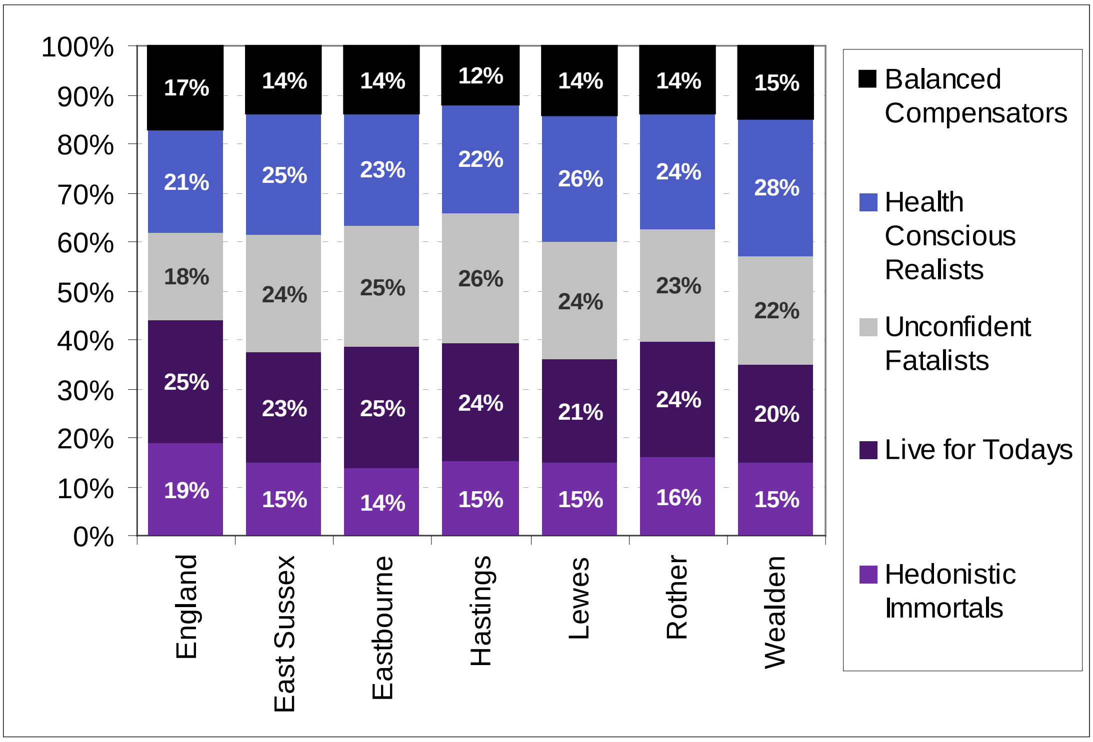
Balanced Compensators (BC)	
What are they like	**Profile**
They are positive and like to look and feel good about themselves. They get some pleasure from taking risks. However, they don't take risks with health. Health is very important to them, and something they feel in control of. A healthy lifestyle is generally easy and enjoyable. They are not fatalists when it comes to health and understand that their actions impact on their health both now and in the future. If they do take some health risks, they will use compensatory mechanisms to make up for this, such as going for a run in the morning having eaten a big meal or drunk too much the night before.	• Stronger male bias within this segment • Highest proportion of people in full time work • Segment with a slightly younger than average age (41 compared to 43 years for the study sample) **Behaviours** • Generally positive health behaviours • Exercise regularly • Eat healthily • Low prevalence of smoking and drug use

Live for Todays (LFT)	
What are they like	**Profile**
They definitely like to "live for today" and take a short term view of life. They believe that whatever they do is unlikely to have an impact on their health, so what's the point? They tend to believe in fate, both where their health is concerned, but also for other things in life. They value their health but believe that leading a healthy lifestyle doesn't sound like much fun, and think it would be difficult. They don't think they are any more likely than anyone else to get ill in the future. They tend to live in deprived areas which gets them down and they don't feel that good about themselves, but feel more positive about life than the "Unconfident Fatalists". They are the segment who are most resistant to change and don't acknowledge that their health needs to change, unlike the "Unconfident Fatalists".	• Tend to live in more deprived areas • Segment average age (42 compared to 43 years for the study sample)
	Behaviours • Exhibit fairly poor health behaviours • Hold short-term view of life • Fatalistic about life • More likely to smoke and drink heavily • Little concern for their future wellbeing

Hedonistic Immortals (HI)	
What are they like They are people who want to get the most from life. They do not mind taking risks – as this is part of leading a full life. They feel good about themselves and are not that motivated by material wealth or possessions. They know that their health is important to avoid getting ill in the future, but feel pretty positive about their own health at the moment and don't think they will be getting ill any time soon. Maybe because of that they do not really value their health right now. They do not have a problem with leading a healthy lifestyle: it would be fairly easy and enjoyable to do so, and they certainly intend to live healthily. However they feel that anything which is enjoyable, such as smoking and drinking, cannot be all bad.	**Profile** • Segment with a younger average age • More likely to come from less deprived areas • Segment with a younger than average age (36 compared to 43 years for the study sample)
	Behaviours • Motivated by enjoyment and taking risks • Display lack of concern for their health and wellbeing • Most likely to drink heavily • Higher-than-average incidence of drug taking

Unconfident Fatalists (UF)	
What are they like Overall, they feel fairly negative about things, and don't feel good about themselves. A significant proportion feel depressed. They feel that a healthy lifestyle would not be easy or in their control. Generally they don't feel in control of their health anyway. They are quite fatalistic about health and think that they are more likely than other people of the same age to get ill. Their current lifestyles are not that healthy, and their health isn't currently as good as it could be. They know their health is bad, and that they should do something about it, but they are de-motivated.	**Profile** • Segment with an older average age (47 compared to 43 years for the study sample) • Tend to live in more deprived areas • Least likely to be in paid work • More likely to be retired
	Behaviours • Exhibit the most negative health behaviours • Hold negative perceptions of a healthy lifestyle • Often fatalistic about their own health

Figure 5.4: Percentage of the adult population by Healthy Foundations segmentation, 2011



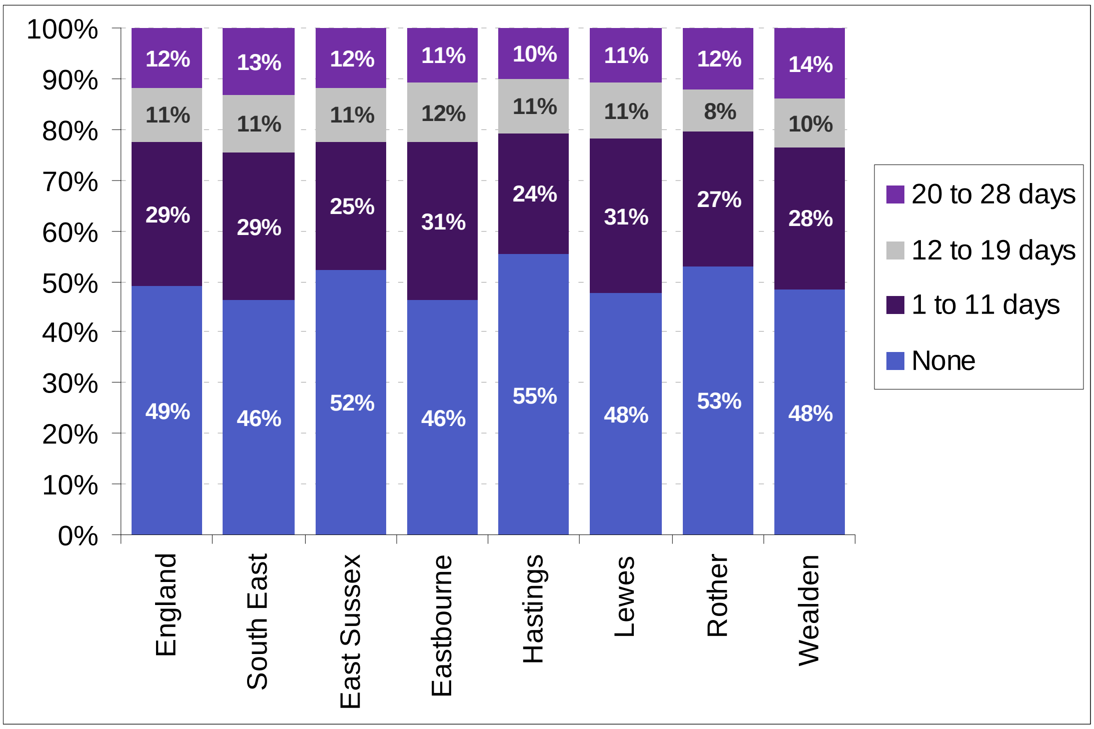
Source: East Sussex JSNA, Health and Lifestyle in East Sussex 1992-2011, January 2012
www.eastsussexjsna.org.uk/evidencelinks/evidence

Understanding motivational and communication preferences in the population can help to target support and services. Healthy Foundations segmentation of East Sussex show that we have a significantly higher proportion of ‘unconfident fatalists’, people who may find it more difficult to make behaviour changes and need more intensive support to do this than the England average. Hastings has an even higher proportion of ‘unconfident fatalists’ than East Sussex.

5.5 Key facts and figures: physical activity

East Sussex has higher proportion of adults reporting that they did no sport or active recreation in the past month than the England and South East averages.

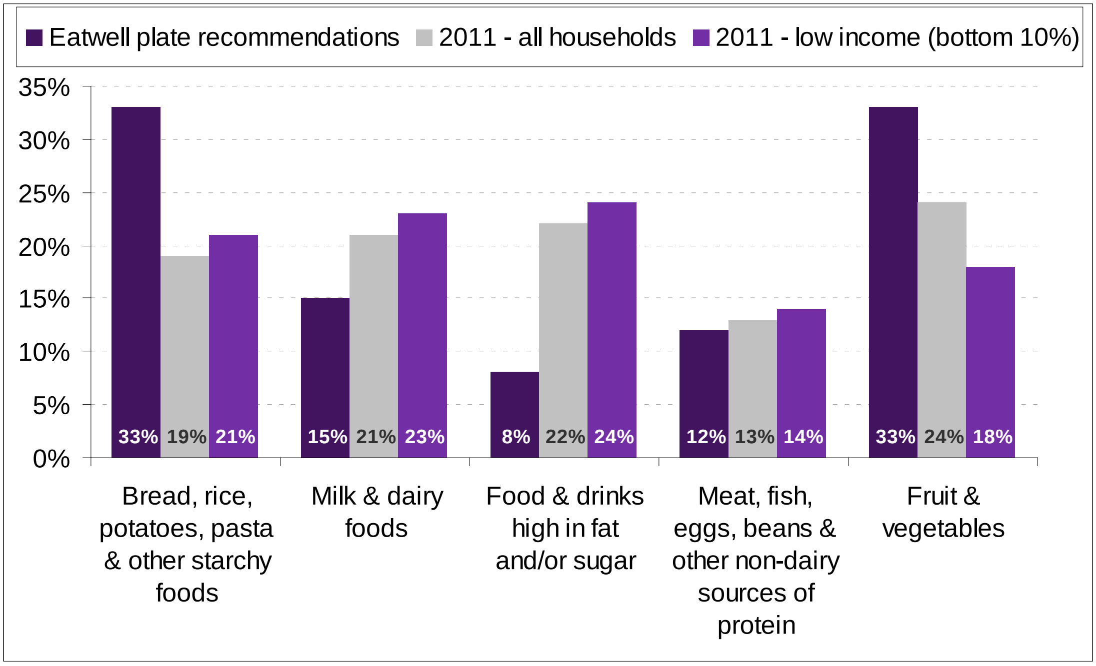
Figure 5.5: Days of adult participation in sport and active recreation in the last 28 days, 2010/12



Source: Source: Local Sport Profile Tool from Sport England based on Active People Survey Data
http://www.sportengland.org/our-work/local-work/local-government/local-sport-profile/

5.6 Key facts and figures: healthy eating (all ages)

Figure 5.6: Eatwell plate comparison for low income and all households in England, 2011

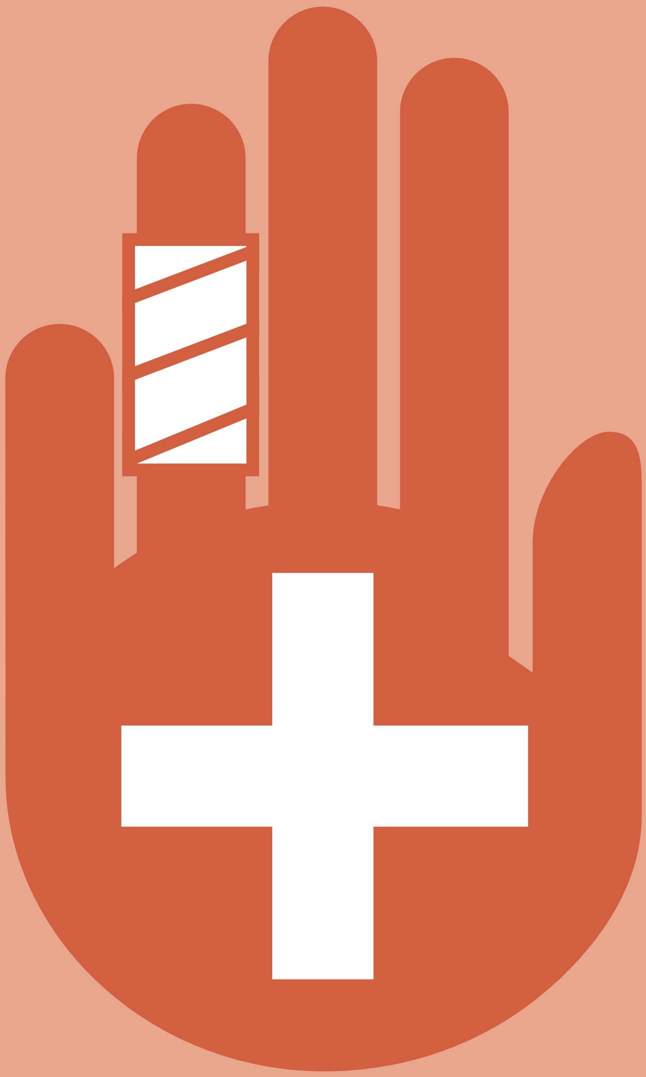


Source: Family Food 2011, Department for Environment, Food and Rural Affairs
www.gov.uk/government/publications/family-food-2011

The eatwell plate describes the proportions of food from the different food groups that adults are recommended to eat to achieve a healthy and balanced diet. Nationally most households are not eating close to the eatwell plate. Low income households tend to buy much less fruit and vegetables and much more food and drinks high in fat and/or sugar.

Recommendation: commissioners and multi-agency partnerships delivering in this area should review current commissioning plans and strategies against evidence recommendations laid out in Appendix 3. Where gaps or weaknesses are identified, interventions for implementation should be prioritised using criteria outlined in Chapter 2.

Preventing and reducing falls, accidents and injuries



Chapter 6: Preventing and reducing falls, accidents and injuries

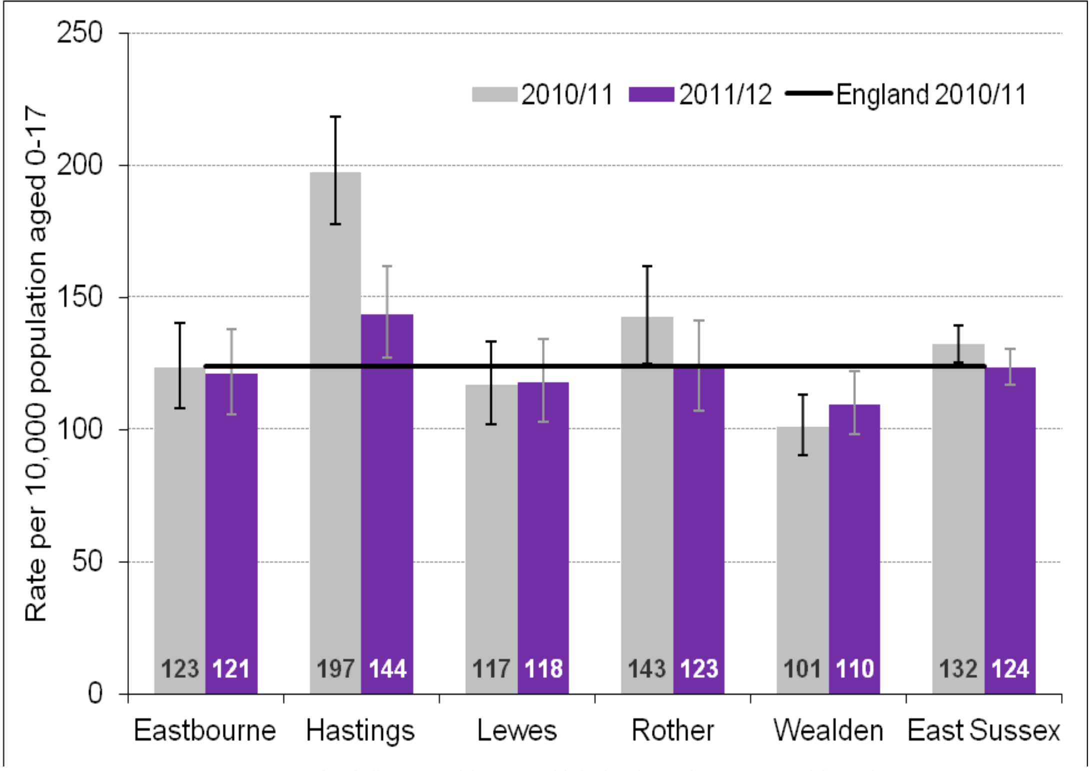
	Focus on
6.1	Interventions to prevent falls, accidents and injuries amongst children and young people
6.2	Interventions to prevent falls, accidents and injuries (adults)
6.3	Interventions to prevent falls, accidents and injuries (older people)
6.4	Integration of services to manage falls, accidents & injuries (older people)
6.5	Interventions to prevent road traffic injuries

Public Health Outcome Framework indicators relevant to this key area and their East Sussex rating in comparison to the England Average, November 2013

Public Health Outcome Indicator		Comparison to England
1.10	Killed and seriously injured casualties on roads	Significantly worse
2.24	Injuries due to falls in people aged 65 and over	
i	Female	Significantly better
i	Male	Significantly better
i	All persons	Significantly better
ii	aged 65-79	Significantly better
iii	aged 80+	Better
4.14	Hip fractures in people aged 65 and over	
i	All persons	Better
ii	aged 65-79	Better
iii	aged 80+	Better

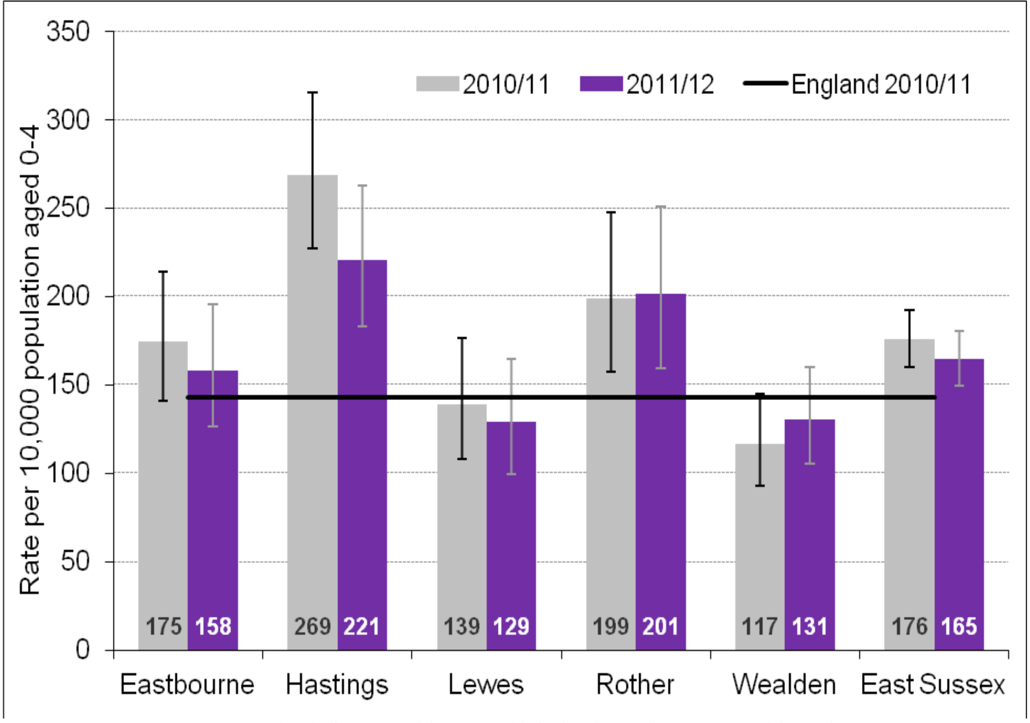
6.1 Key facts and figures: preventing falls, accidents and injuries amongst children and young people

Figure 6.1a: Emergency hospital admissions caused by unintentional and deliberate injuries to under 18s, rate per 10,000 population with 95% confidence intervals, 2010/11 and 2011/12



Source: East Sussex JSNA, Local Briefing - Accidents and injuries in under 18 year olds, July 2012
www.eastsussexjsna.org.uk/briefings

Figure 6.1b: Emergency hospital admissions caused by unintentional and deliberate injuries to 0-4 year olds, rate per 10,000 population with 95% confidence intervals, 2010/11 and 2011/12



Source: East Sussex JSNA, Local Briefing - Accidents and injuries in under 18 year olds, July 2012
www.eastsussexjsna.org.uk/briefings

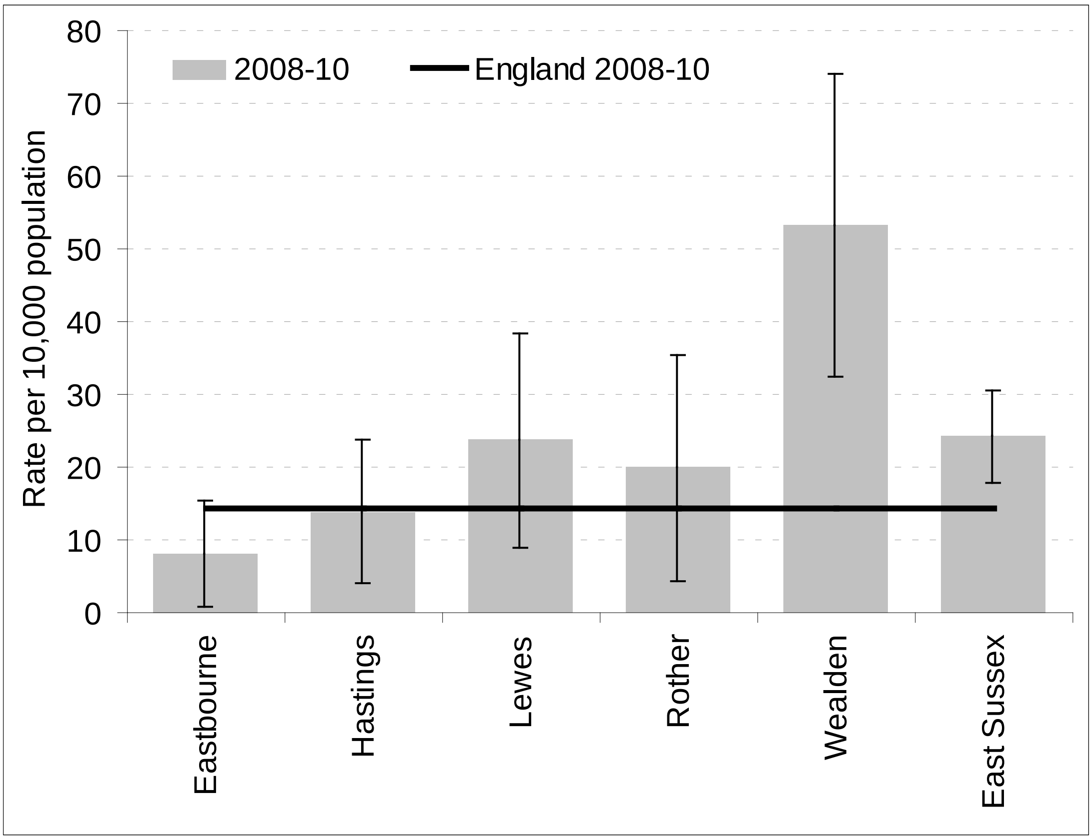
The rate of admissions to hospital in children and young people under 18 years as a result of accidental injury and deliberate harm is significantly higher than the national average in Hastings. For children under four years, East Sussex as a whole and Hastings and Rother have significantly higher rates than England.

6.2 Key facts and figures: preventing falls, accidents and injuries amongst adults

The National Injury Profiles provides a basket of indicators relating to injuries such as land transport injuries, falls, intentional injuries e.g. suicide and self harm, the consequence of injury, such as hospital admissions, injuries by age and mortality from injuries.

Of the 42 indicators in the injury profiles East Sussex is significantly worse than England for 18 indicators including hospital admissions for injuries in young people, land transport injuries, A&E attendances due to injury, hospital admissions due to fall injury (all ages), and hospital admissions due to burns. There is variation across the county with Hastings being significantly worse than the England average for 25 of the 42 indicators, and Wealden being significantly worse for land transport injury (7 of the 9 land transport injury targets).

Figure 6.2: Years of life lost due to land transport injuries, rate per 10,000 population with 95% confidence intervals, 2008-2010



Source: National Injury Profiles, Public Health England, , accessed July 2013
www.eastsussexjsna.org.uk/profiles/Injury

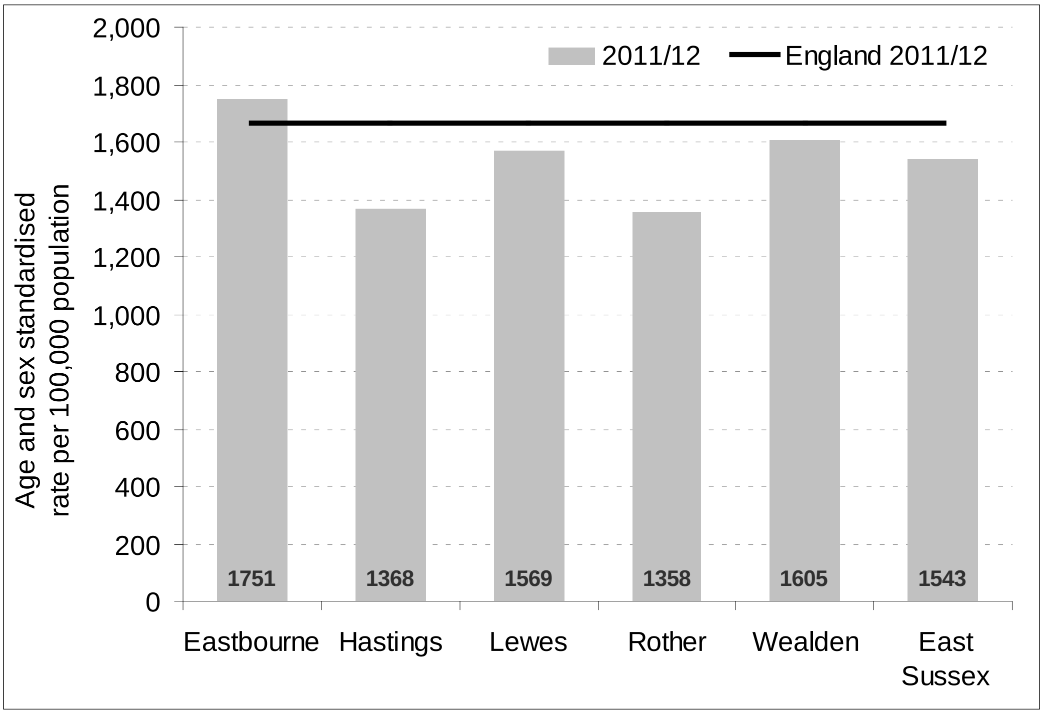
East Sussex as a whole and Wealden District have significantly higher Years of Life Lost due to land transport injuries than the England average.

Years of Life Lost provides a summary measure of premature mortality. Years of Life Lost is the years of potential life lost due to premature deaths. It takes into account the age at which deaths occur, giving greater weight to deaths at a younger age and lower weight to

6.3 Key facts and figures: preventing falls, accidents and injuries amongst older people

The overall rate of admissions due to falls for persons aged 65 years and over is lower than the England average. However there is variation across the county with the lowest rates in Hastings and Rother and the highest rates in Eastbourne, where rates are higher than the England average. Although rates of falls in East Sussex are slightly lower than the UK as a whole, given the size of the older population in East Sussex falls present a significant issue for health and social care services locally.

Figure 6.3: Emergency hospital admissions due to falls injuries for persons aged 65 years and over, rate per 100,000, 2011/12



Source: Local East Sussex SUS extracts, East Sussex Public Health Intelligence Team

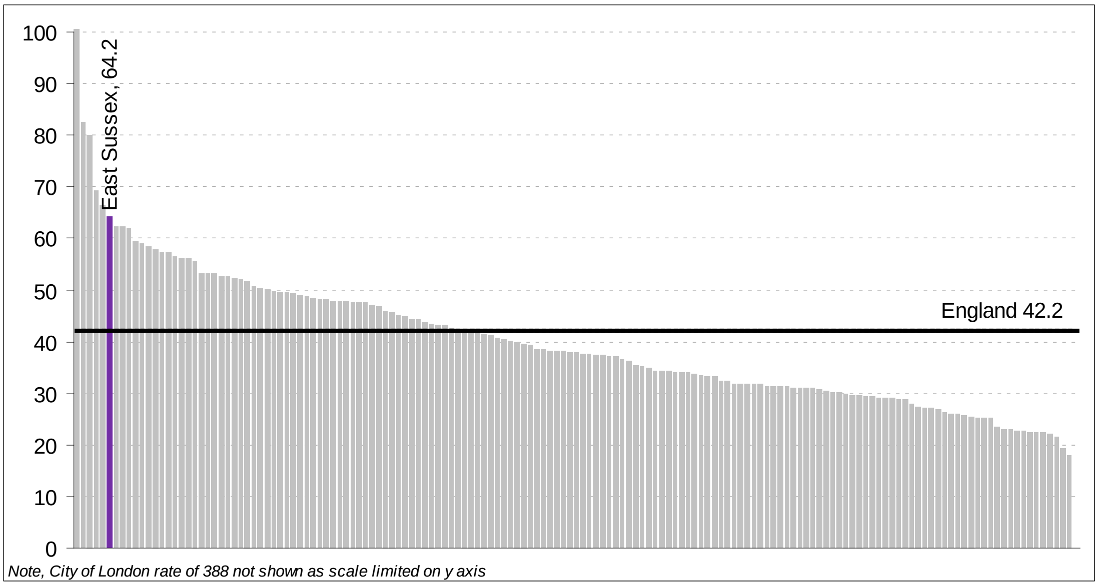
Age standardised rates for emergency admissions due to falls for persons aged 75 years and over show that the rates are nearly twice as high in Eastbourne, Lewes and Wealden than in Hastings and Rother.

6.4 Key facts and figures: managing falls, accidents and injuries in older people

Mortality from fractured neck of femur has been decreasing since 2005/6 at the East Sussex level, in line with national trends. However given the ageing population in East Sussex rehabilitation services for people recovering from falls, to maintain mobility and prevent future falls, remain important. In 2010/11 there were 61 patients in East Sussex who died within 30 days of having an emergency admission to hospital due to a fractured hip.

6.5 Key facts and figures: road traffic accidents

Figure 6.4: People reported killed or seriously injured on the roads by upper tier local authority, rate per 100,000 resident population, 2009-2011

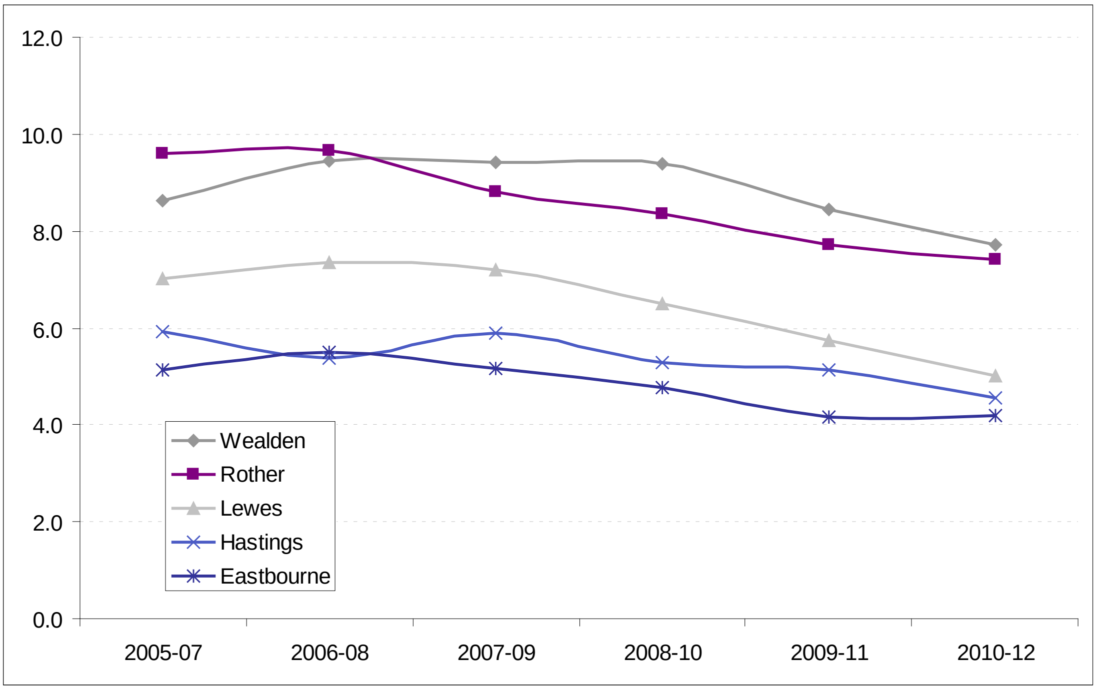


Note, City of London rate of 388 not shown as scale limited on y axis

Source: Public Health outcomes Framework, Public Health England
www.eastsussexjsna.org.uk/overviews/PHOF

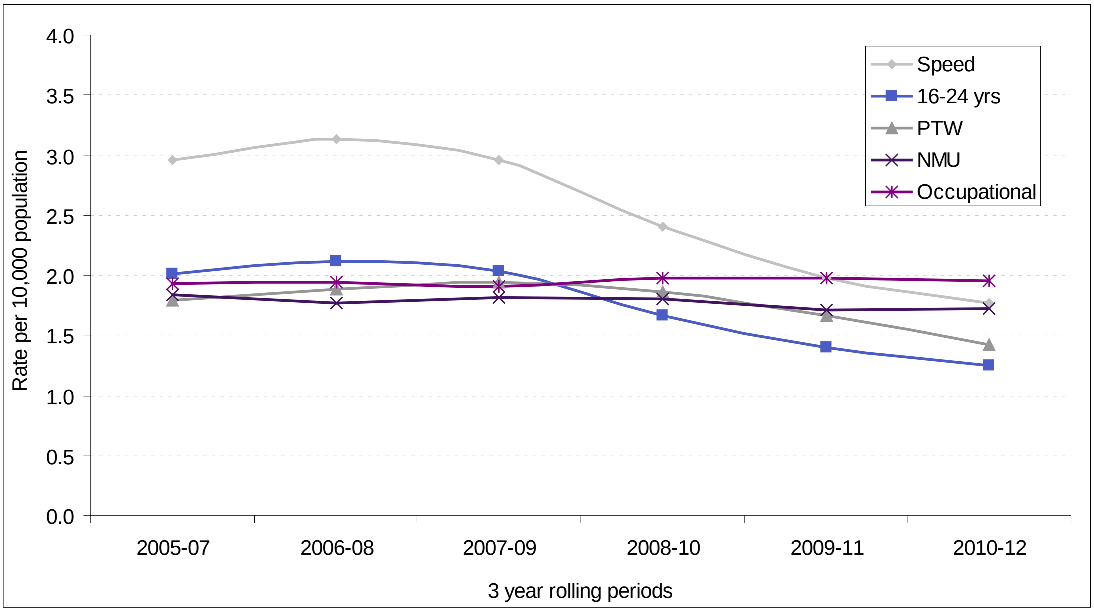
Although rates of people killed or seriously injured on the roads is reducing year on year in line with the national trend East Sussex has the fifth highest killed or seriously injured rate of any upper tier local authority in England.

Figure 6.5a: Killed and seriously injured on East Sussex roads, by district and borough, 3 year rolling average, rate per 10,000 population



Source: Sussex Safer Roads Partnership

Figure 6.5b: Killed and seriously injured on East Sussex roads, by priority groups, 3 year rolling average, rate per 10,000 population



Source: Sussex Safer Roads Partnership

Rates of people killed and seriously injured on the roads of East Sussex and for each of the district and boroughs appear to be reducing over time. Highest rates are seen in the most rural districts of the county.

Figure 6.5b shows killed and seriously injured rates for each of the East Sussex priority areas (speed, 16-24 year olds, powered two wheel vehicles (PTW), non motorised users (NMU) and occupational drivers). Rates appear to be reducing for all groups other than occupational drivers and non motorised users, with the most marked reduction seen in killed and seriously injured rates where speed is recorded as a factor.

Recommendation: commissioners and multi-agency partnerships delivering in this area should review current commissioning plans and strategies against evidence recommendations laid out in Appendix 4. Where gaps or weaknesses are identified interventions for implementation should be prioritised using criteria outlined in Chapter 2.

Enabling people to manage and maintain their mental health and wellbeing

Chapter 7: Enabling people to manage and maintain their mental health and wellbeing

Focus on:
7.1 Interventions to promote early identification, diagnosis, support and treatment of mental health conditions (all ages)
7.2 Interventions to promote community based mental health services and support (all ages)
7.3 Interventions to promote utilisation of comprehensive care plans for people with severe mental health needs (all ages)
7.4 Interventions to reduce the incidents of self-harm and suicide (all ages)
7.5 Interventions to improve the physical health of people with mental health conditions (all ages)
7.6 Interventions to promote better mental health outcomes and quality of life for carers (all ages)

Public Health Outcome Framework indicators relevant to this key area and their East Sussex rating in comparison to the England average, November 2013

Public Health Outcome Indicator			Comparison to England
1.06	ii	Adults in contact with secondary mental health services who live in stable and appropriate accommodation	Worse
2.23		Self-reported well-being	
	i	people with a low satisfaction score	Worse
	ii	people with a low worthwhile score	Worse
	iii	people with a low happiness score	Better
	iv	people with a high anxiety score	Better
4.10		Suicide rate (provisional)	Significantly worse

7.1 Key facts and figures: early identification, diagnosis, support and treatment

Nearly a quarter (23%) of the total burden of disease in the UK is attributable to mental disorder. This compares to 16% for cardiovascular disease and 16% for cancer.

The annual cost of mental disorder in England is estimated at £105 billion. By comparison the total costs of obesity is £16 billion a year and £31 billion for cardiovascular disease.

It has been estimated that one in six adults (16.7%) has a mental health problem at any given time. This would be equivalent to 70,500 persons in East Sussex.[1]

- 25% of older adults have depression requiring intervention.
- Dementia affects 20% of people aged over 80.

By 2026, the number of people in England who experience a mental disorder is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million. However, this does not take account of the current economic climate which is likely to increase prevalence.

Some mental disorders arise early in the life course:

- 40% of young people experience at least one mental disorder by age 16
- 50% of lifetime mental illness (except dementia) arises by age 14
- 75% of lifetime mental illness arises by the mid-20’s.

One in five (20%) children (aged 17 and below) experience mental health problem in any given year. This is equivalent to 20,900 children in East Sussex.[2, 3]

Some groups have a higher risk of mental disorder and poor wellbeing (Table 7.1). It is important to target these groups with prevention and promote interventions to prevent further widening of the inequality they already experience.

Table 7.1: Risk factors for child and adolescent mental disorder

Group	Expected prevalence of mental disorders
Looked after children	45%
Children with special educational need requiring statutory assessment	44%
Children with learning disability	36%
Children absent from school more than 15 days in previous term	
emotional disorder	17%
conduct disorder	14%
hyperkinetic disorder	11%
Children from households with no working parent	20%
Children from household reference person in routine occupational group	15%
Children of parents with no educational qualifications	17%
Children from weekly household income <£100	16%
Children living in less prosperous/mixed areas	15%
Children in stepfamilies	14%
Children from lone parent families	16%

Source: Joint Commissioning Panel for Mental Health – Guidance for commissioning mental health services

Parents of children with a mental health illness

- 51% of parents of a child with conduct disorder have an emotional disorder; 18% have a severe emotional disorder
- 48% of parents of children with emotional disorder have an emotional disorder.

Mental disorder in childhood and adolescence is associated with:

- poorer health, poorer social skills and lower levels of educational attainment
- higher risk of self-harm and suicide
- higher levels of health risk behaviour including smoking, alcohol consumption and drug misuse
- higher rates of antisocial and offending behaviour and violence.

Mental disorder in childhood leads to poorer outcomes and inequalities in adulthood, such as:

- higher levels of unemployment and lower earnings
- higher risk of crime and violence
- higher risk of adult mental disorder

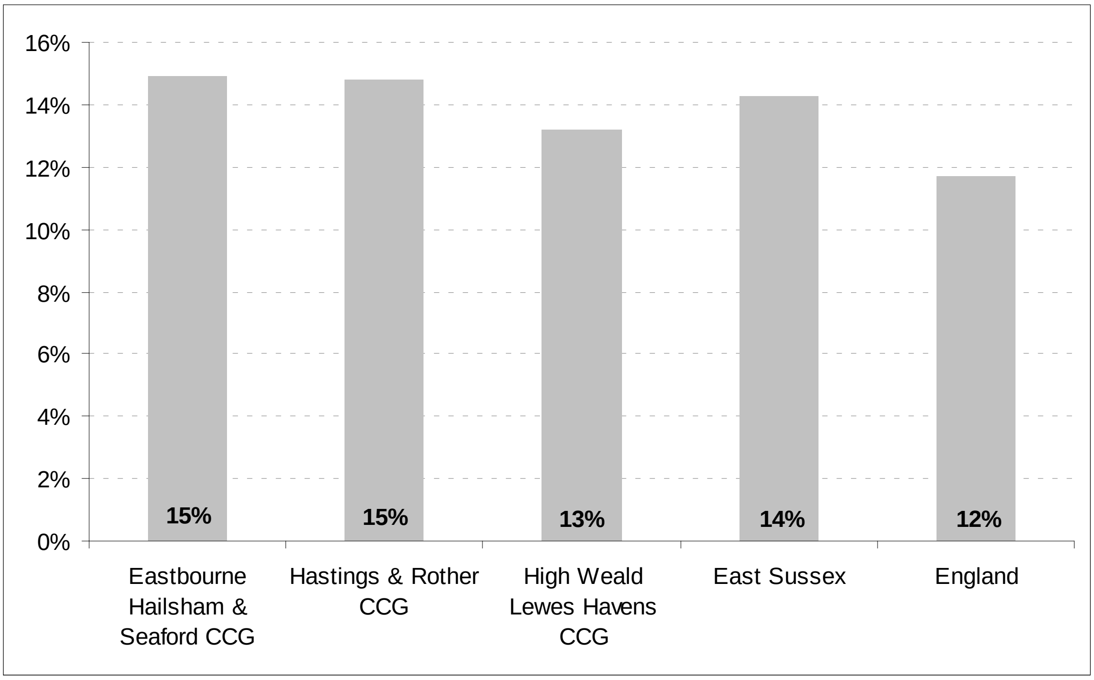
7.2 Key facts and figures: community based mental health services and support

Community mental health services support or treat people with mental health needs in the community, instead of a hospital setting. The goal of community mental health services often includes much more than simply providing outpatient psychiatric treatment.

Demand for community mental health services is high. A high percentage of patients registered with GPs in East Sussex have depression. Figure 7.1 shows incidence by CCG area. Overall 61,909 people in East Sussex are identified on GPs registers as having depression, although not all of these people will be in touch with community mental health services.

In England in 2010/11 3% of adults used hospital or community mental health services.

Figure 7.1 GP reported incidence of depression, Clinical Commissioning Groups, 2011/12



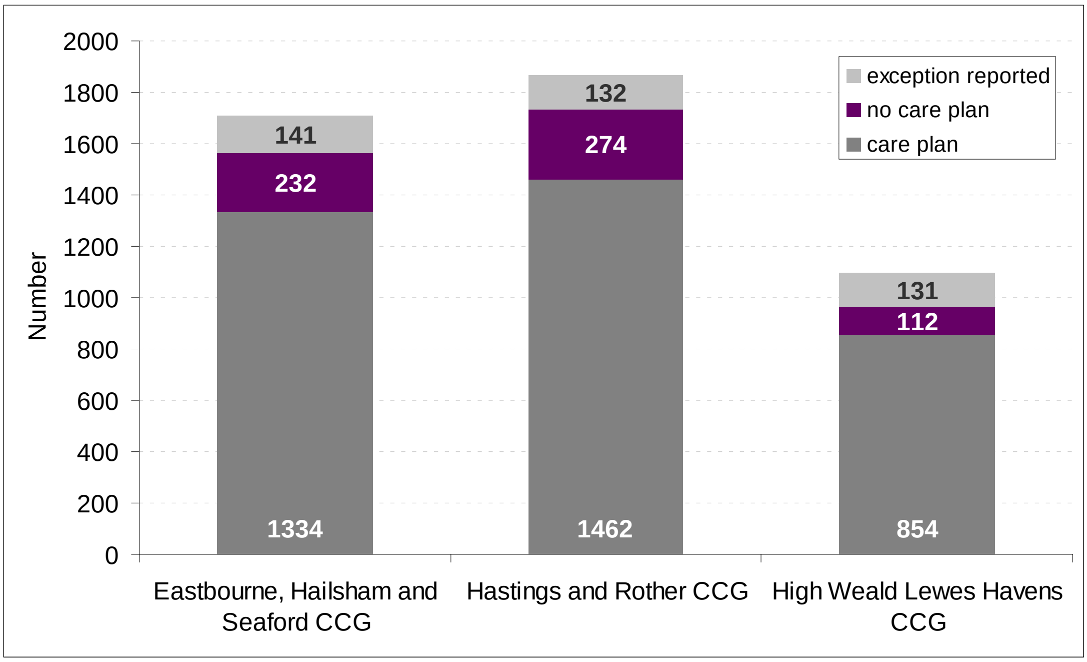
Source: Quality Outcomes Framework 2011/12, East Sussex JSNA scorecard 4.9 and Health & Social Care Information Centre
www.eastsussexjsna.org.uk/scorecards/2013nhsview
www.hscic.gov.uk/qof

7.3 Key facts and figures: comprehensive care plans for people with severe mental health needs

A high number of people in East Sussex require comprehensive care plans relating to severe mental health needs. There are 4,075 patients registered with GPs with mental health disorders, approximately 1% of General Practice lists, similar to England.

In High Weald Lewes Havens CCG 88% of patients on mental health registers have a comprehensive care plan, in Eastbourne, Hailsham and Seaford CCG it is 85% and in Hastings and Rother CCG it is 84%.

Figure 7.2: GP reported number of patients on mental health registers by care plan status Clinical Commissioning Groups, 2011/12

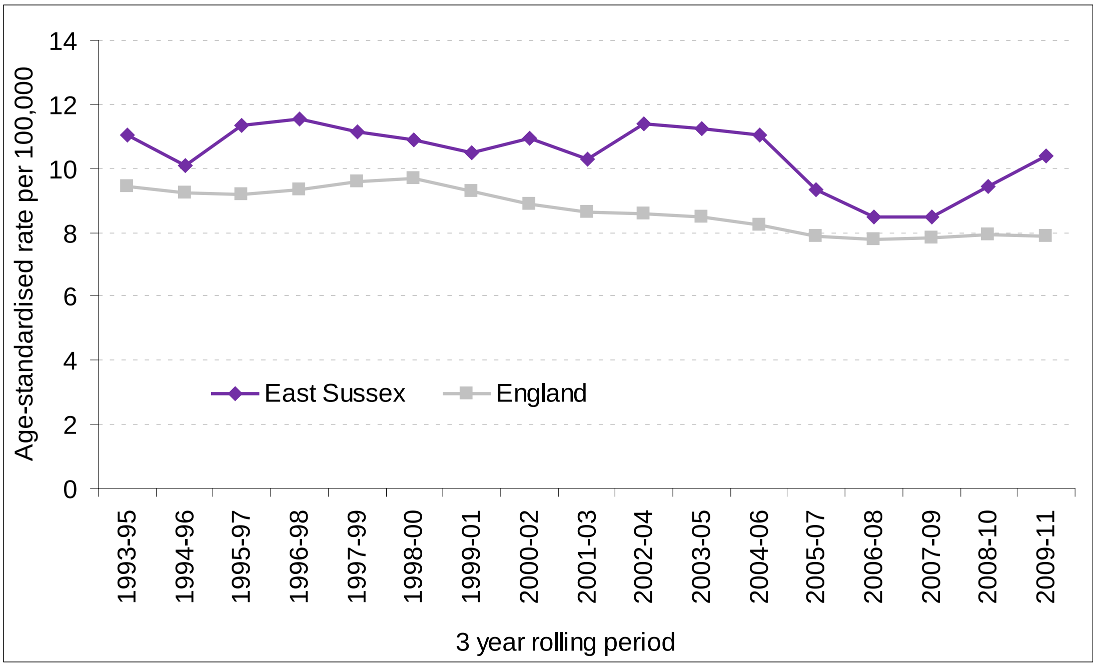


Source: Quality Outcomes Framework 2011/12,
www.hscic.gov.uk/qof

7.4 Key facts and figures: self-harm and suicide

The suicide rate in East Sussex is significantly worse than the rate for England as a whole and has been so for many years. Since 2007/09 the rate has been increasing.

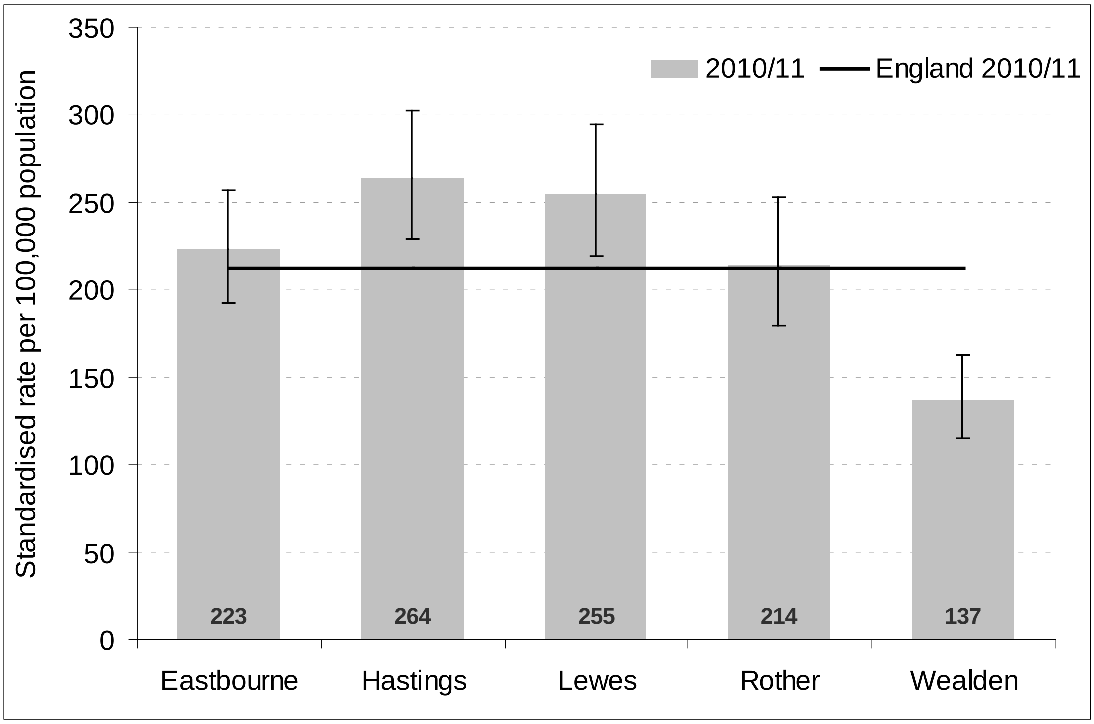
Figure 7.3: Mortality from suicide and injury undetermined



Source: Compendium of Population Health Indicators, Health & Social Care Information Centre
www.indicators.ic.nhs.uk/webview/

Emergency hospital admissions for intentional self-harm are the same or higher than national rates in Eastbourne, Hastings, Lewes, Rother and across East Sussex as a whole. In Hastings and Lewes the rates are significantly worse than England.

Figure 7.4: Emergency hospital admissions due to self harm, rate per 100,000 with 95% confidence intervals, 2010/11



Source: Health profiles 2012, Public Health England
www.eastsussexjsna.org.uk/profiles/health.aspx

7.5 Key facts and figures: physical health of people with mental health conditions

Obese people have a 55% increased risk of developing depression and depressed persons have a 58% increased risk of becoming obese.[5]

Nearly half (46%) of people with mental health problems have other medical long-term conditions.

Smoking is twice as common among people with mental disorders.[6]

Overall, people with mental disorders are more likely to engage in unhealthy lifestyles and some drug treatments have side-effects such as weight gain. Hence these people are more prone to poor physical health as compared with the general population[4].

Mental disorder during adulthood is associated with other health and social problems, such as:

- higher risk of homelessness;
- higher unemployment;
- increased suicide and self-harm level;
- increased health risk behaviours, including poor diet, and less exercise;
- higher prevalence of smoking, drug and alcohol misuse;
- increased risk of physical illness
  - depression is associated with an increased risk of coronary heart disease and diabetes;
- reduced life expectancy
  - depression is associated with a 50% increased mortality from all disease and reduced life expectancy of around 11 years in men and 7years for women;
  - Schizophrenia is associated with increased mortality from all diseases and a reduced life expectancy of around 21 years for men and 16 years for women.

7.6 Key facts and figures: better mental health outcomes and quality of life for carers

A carer is a person of any age, adult or child, who provides unpaid support to a partner, child, relative or friend who cannot manage to live independently or whose health would deteriorate without help. This could be due to frailty, disability or a serious health condition, mental ill health or substance misuse.

More than 60% of people will become a carer in their lifetime.

Being a carer comes at a physical and psychological cost:

- Up to 40% of carers experience psychological distress or depression.
- Carers have an increased rate of physical health problems e.g. providing high levels of care is associated with a 23% higher risk of stroke.
- Older carers who report 'strain' have a 63% higher likelihood of death in a year period than non carers or carers not reporting strain.
- Carers are at increased risk of mental disorder which affects their ability to care.

In a local survey of carers needs; all the respondents said that they had experienced some stress during the last 12 months as a result of their caring role and about half of them said that they were very stressed all of the time.

The 2011 Census identified 59,409 persons in East Sussex providing unpaid care, with a third of these providing care for 20 or more hours per week.

Recommendation: commissioners and multi-agency partnerships delivering in this area should review current commissioning plans and strategies against evidence recommendations laid out in Appendix 5. Where gaps or weaknesses are identified interventions for implementation should be prioritised using criteria outlined in Chapter 2.

References

1. NHS Information Centre (2009). Adult psychiatric morbidity in England, 2007: results of a household survey. London: NHS Information Centre.
2. National CAMHS Support Service (2012): Better Mental Health Outcomes for Children and Young People.
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6. Smoking and Mental Health: A Joint Report by the Royal College of Physicians and the Royal College of Psychiatrists, 2013. Luppino F.S., et al. (2010). Overweight, obesity, and depression: a systematic review and meta-analysis of longitudinal studies. Archives of General Psychiatry, 67(3):220-9.

Supporting those with special educational needs, disabilities and long term conditions

Chapter 8: Supporting those with special educational needs, disabilities and long term conditions

	Focus on
8.1	Interventions to support person centred care in the community for people with special educational needs
8.2	Interventions to support person centred care in the community for people with disabilities
8.3	Interventions to support person centred care in the community for people with long term conditions
8.4	Interventions to support self-management for people with long term conditions
8.5	Interventions to promote better physical health outcomes and quality of life for carers (all ages)
8.6	Integrated services as an intervention to avoid inappropriate attendance at A&E/admissions/bed days

Public Health Outcome Framework indicators relevant to this key area and their East Sussex rating in comparison to the England Average, November 2013

Public Health Outcome Indicator			Comparison to England
2.17	Recorded diabetes		Significantly better
2.20	Cancer screening coverage		
	i	Breast cancer	Significantly worse
	ii	Cancer screening coverage - cervical cancer	Significantly better
2.21	vii	Access to non-cancer screening programmes - diabetic retinopathy	Worse
4.03		Mortality rate from causes considered preventable (provisional)	Significantly better
Under 75 mortality rate from			
4.04	i	all cardiovascular diseases (provisional)	Significantly better
	ii	cardiovascular diseases considered preventable (provisional)	Significantly better
4.05	i	cancer (provisional)	Better
	ii	cancer considered preventable (provisional)	Better
4.06	i	liver disease (provisional)	Better
	ii	liver disease considered preventable (provisional)	Significantly better
4.07	i	respiratory disease (provisional)	Significantly better
	ii	respiratory disease considered preventable (provisional)	Significantly better
4.11	Emergency readmissions within 30 days of discharge from hospital		
		Persons	Better
		Female	Better
		Male	Better
4.12	Preventable sight loss		
	i	age related macular degeneration (AMD)	Significantly worse
	ii	Preventable sight loss - glaucoma	Significantly worse
	iii	Preventable sight loss - diabetic eye disease	Significantly worse
	iv	Preventable sight loss - sight loss certifications	Significantly worse

8.1 Key facts and figures: people with special educational needs

In East Sussex 13,567 children had an identified special educational need in 2013. Seventeen percent (2,319) had a Statement of Educational Need.

It is estimated that there are 4,600 people with autism in East Sussex: 1,769 people with autism are aged 19 years or under and 2,803 aged 20 years or over. 577 pupils in East Sussex maintained primary and secondary schools have special educational needs relating to the autistic spectrum.

There are low levels of employment among those diagnosed with autism, only 15% of working age adults are in employment.

A recent national inquiry into the premature deaths of people with learning disabilities showed that on average men and women with learning difficulties died 13 and 20 years younger than the general population respectively. Forty three percent of deaths of people with learning difficulties were unexpected and 42% of deaths were thought to be premature. [2]

Based on the national rates, it is estimated that there were about 50 infants aged 2 years and below with learning disabilities in East Sussex in 2011.

In 2011/12 approximately 2,200 adults in the county were recorded in GP QOF registers as having learning difficulties[3].

8.2 Key facts and figures: people with disabilities

In East Sussex 16,363 (5.4%) of working age people are claiming Disability Living Allowance.

Table 8.1 shows the number of people with different disabilities in East Sussex and projections over a ten year period. It shows that an estimated 19 % of the population of the county have a disability and by 2022 this figure is predicted to rise to 20%.

Table: 8.1 Disability projections policy-based, East Sussex all people aged 10+, 2012-2022.

Type	2012		2022		Change	
	Number	%	Number	%	Number	% point change
Overall disability	88,400	19	97,700	20	9,300	1.3
Higher severity disability	26,800	6	30,000	6	3,200	0.5
Lower severity disability	61,600	13	67,700	14	6,100	0.8
Locomotor disability	65,700	14	73,000	15	7,300	1.1
Personal care disability	34,500	7	37,900	8	3,400	0.4
Hearing disability	24,400	5	27,200	6	2,800	0.4
Sight disability	12,200	3	13,500	3	1,300	0.1

Source: East Sussex in Figures
www.eastsussexjsna.org.uk/esif

8.3 Key facts and figures: people with long term conditions

Long term conditions, such as high blood pressure, cardiovascular diseases, diabetes and chronic obstructive pulmonary disease, are more prevalent in older age groups and numbers are forecast to increase. Table 8.2 shows numbers of patients on disease registers.

Table: 8.2 GP reported chronic disease registers by care plan status Clinical Commissioning Groups, 2011/12

Long term condition	East Sussex	EHS CCG	H&R CCG	HWLH CCG
Hypertension	87499	32336	31367	23796
CHD	21331	8315	7604	5412
Heart Failure	4599	1679	1779	1141
Atrial Fibrillation	11741	4751	3862	3128
Diabetes (17+)	24620	8824	8906	6890
COPD	10287	3769	4026	2492
Asthma	32867	12259	10973	9635

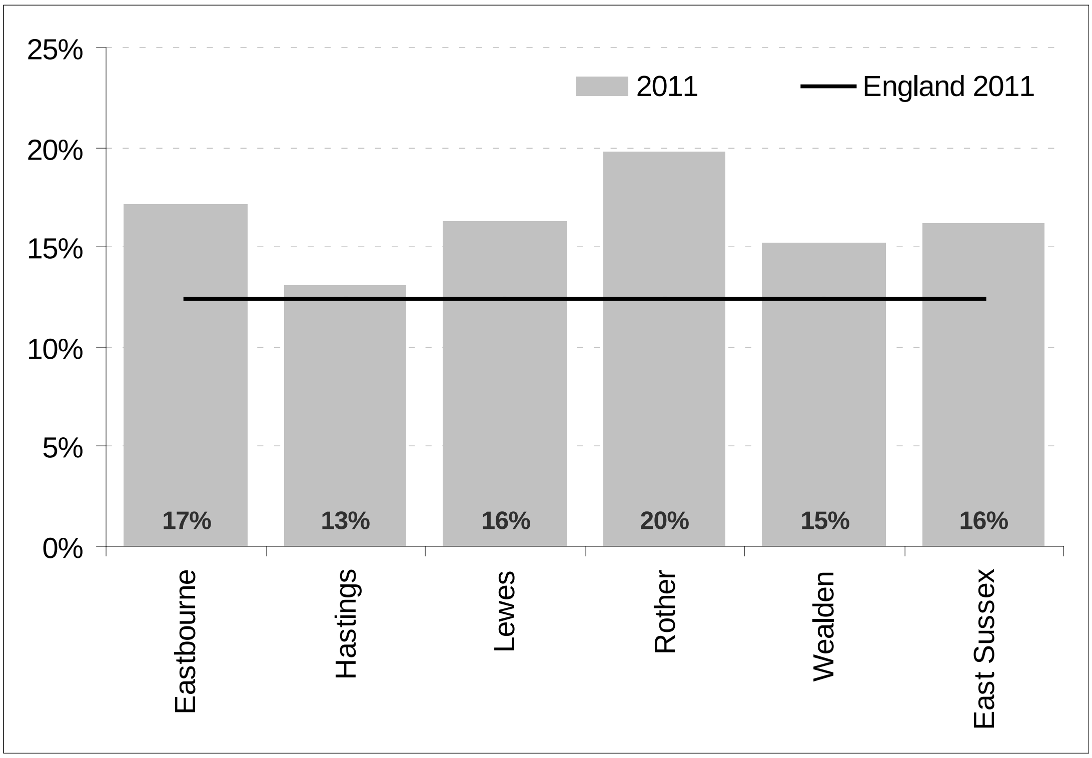
Source: Health & Social Care Information Centre

Using prevalence models to identify gaps between the expected number of patients on disease registers and the actual number of patients on disease registers, indicates that more needs to be done to identify patients who have disease but are not known to services and therefore not receiving the

8.4 Key facts and figures: self-management for people with long term conditions

Supporting self-management is an important objective. There are high numbers of older people living on their own in East Sussex and many have particular support needs in self-management of long-term health conditions.

Figure 8.1: One person households for persons aged 65 years and over, 2011 Census



Source: East Sussex in Figures
www.eastsussexjsna.org.uk/esif

8.5 Key facts and figures: better physical outcomes and quality of life for carers

The 2011 Census identified 59,409 persons in East Sussex providing unpaid care, with a third of these providing care for 20 or more hours per week.

- 16% of adult carers had a disability affecting their ability to carry out day-to-day activities.
- 12% of adult carers described their general health as ‘bad’ or ‘very bad’.
- Of those adult carers who were unable to continue in their caring role, 78% stopped due to a ‘problem with their own health’.
- 40% of adult carers had to cancel a personal visit to the doctor, dentist or hospital in the preceding 12 months due to their caring role.

8.6 Key facts and figures: integrated services

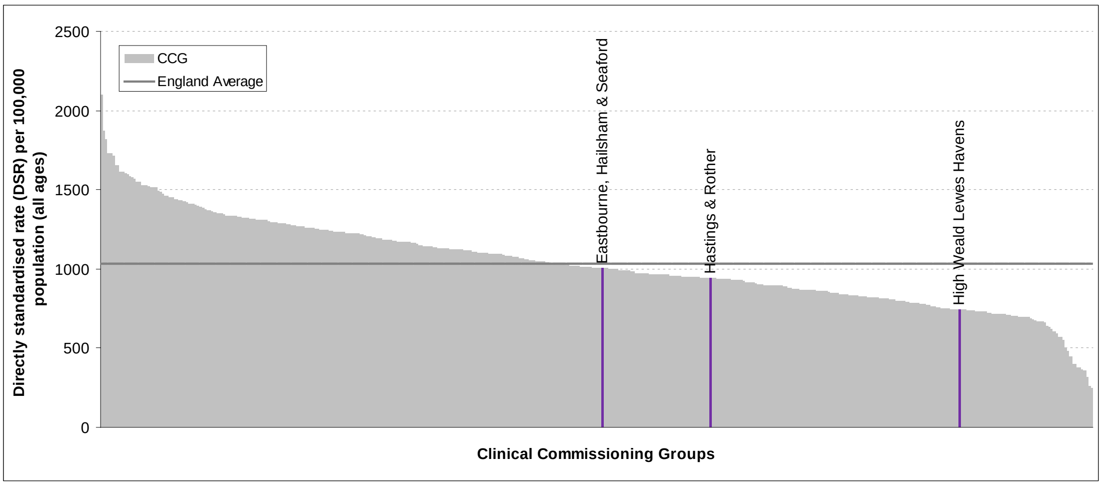
The ageing population and increased prevalence of long term conditions requires a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self care, more consistent standards of primary care and care that is well co-ordinated and integrated.

Ambulatory care-sensitive conditions are chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admissions through active management, such as vaccination, better self-management, disease or case management or lifestyle interventions.

According to The King’s Fund estimates, emergency admissions for ambulatory care-sensitive conditions could be reduced by between 8 and 18% simply by tackling variations in care and spreading existing good practice. This would result in savings of between £96 million and £238 million nationally.[4]

Taking into account the age profile of the East Sussex population the rates of emergency admissions across the county are at, or below, the England average.

Figure 8.2: Emergency admissions for acute conditions* that should not usually require hospital admission, rate per 100,000 population, 2010/11 to 2011/12



* Emergency admissions to hospital of persons with acute conditions (ear/nose/throat infections, kidney/urinary tract infections, heart failure) usually managed in primary care.

Source: Health Health and Social Care Information Centre
www.indicators.ic.nhs.uk

Due to the relatively high numbers of older people in East Sussex, when emergency hospital admissions are ranked by numbers of admissions, as contrasted to ranking by the rate of admissions – the ranking gets worse for clinical commissioning group areas in East Sussex. The lowest ranked CCG has the highest number of admissions. The table below shows these two sets of rankings.

Table: 8.3 Emergency admissions for acute conditions that should not usually require hospital admission, rate per 100,000 population, 2010/11 to 2011/12

Clinical Commissioning Group	DSR*	Rank	Crude rate**	Rank
Eastbourne, Hailsham & Seaford	1,005	214	1,217	88
Hastings & Rother	944	260	1,046	169
High Weald Lewes Havens	744	366	806	325
England average	1,034		1,001	

*Directly age Standardised Rate per 100,000 population
**Crude rate per 100,000 population
Rank is out of 422 CCGs in England (1 = highest rate)
Source: Health and Social Care Information Centre, www.indicators.ic.nhs.uk

Recommendation: commissioners and multi-agency partnerships delivering in this area should review current commissioning plans and strategies against evidence recommendations laid out in Appendix 6. Where gaps or weaknesses are identified interventions for implementation should be prioritised using criteria outlined in Chapter 2.

References

1. Comprehensive Needs Assessment on Adults with Autism in East Sussex 2011.
2. Reference: Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Russ L ; CIPOLD: Confidential Inquiry into Premature Deaths of People with Learning Disabilities, 2013, University of Bristol.
3. Eric Emerson et al. 2011. People with Learning Disabilities in England. Learning Disability Observatory, UK.
4. The King's Fund (2012) Emergency hospital admissions for ambulatory care-sensitive conditions identifying the potential for reductions – data briefing. http://www.kingsfund.org.uk

High quality and choice of end of life care

Chapter 9: High quality and choice of end of life care

Focus on

9.1 Interventions to increase the number of people identified as approaching end of life

9.2 Interventions to increase the number of people identified as approaching end of life with advanced care plans

9.3 Interventions to promote the number of people dying in their preferred place of care & reduce the number dying in hospital

9.4 Interventions to promote end of life care staff training

9.5 Interventions to support people who are bereaved

There are around 6,000 deaths per year in East Sussex. Around 2,200 per year in the Eastbourne, Hailsham and Seaford CCG area; 2,300 in the Hastings and Rother CCG area; and, around 1,500 per year in the High Weald Lewes Havens CCG area.

9.1 Key facts and figures: people identified as approaching end of life

People are approaching the end of life when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions;
- general frailty and coexisting conditions that mean they are expected to die within 12 months;
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition; and
- Life threatening acute conditions caused by sudden catastrophic events.

In 2011/12 there were 1170 people on GP palliative care registers across East Sussex, an increase of 40% on the 2010/11 figure of 835. The increase can be explained by better recording in general practice. However, it also demonstrates significant demand.

Table: 9.1: Number of patients recorded on GP reported palliative care registers, Clinical Commissioning Groups 2010/11 and 2011/12

Clinical Commissioning Group	2010/11	2011/12
Eastbourne Hailsham Seaford	342	404
Hastings & Rother	279	465
High Weald Lewes Havens	214	301

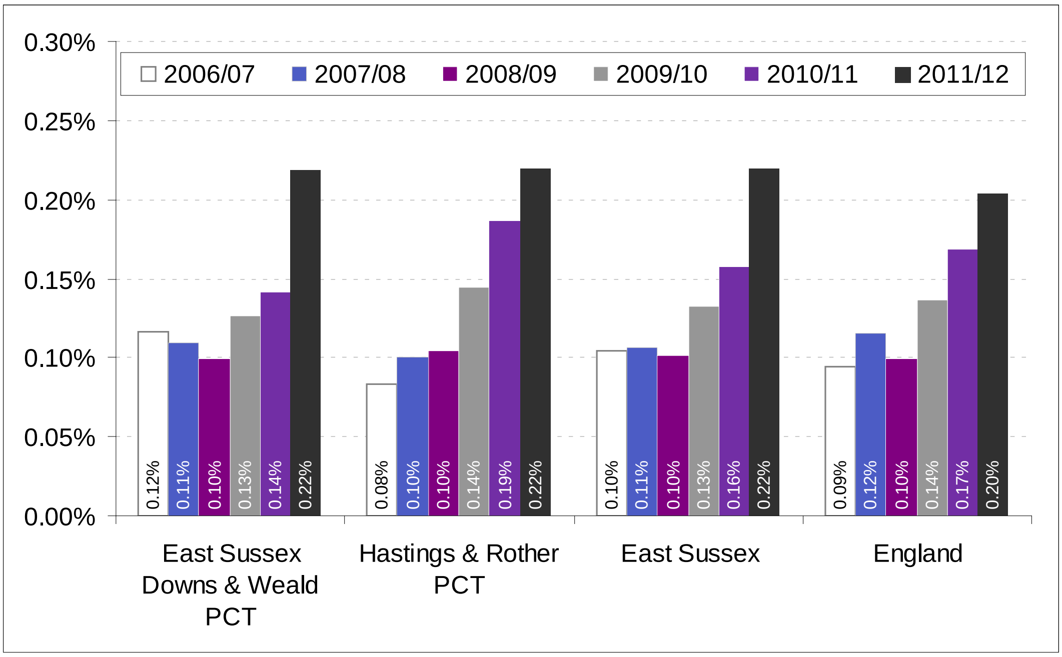
Source: Quality Outcomes Framework 2011/12, Health & Social Care Information Centre
www.hscic.gov.uk/qof

9.2 Key facts and figures: advanced care plans

Advanced care planning is a process of discussion between an individual and their care providers to make clear a person's wishes. Carers, family and friends may also be involved.

Figure 9.1 illustrates the increasing numbers of patients on GP palliative registers requiring end of life care, an indication of increasing need for advanced care plans.

Figure 9.1: GP reported palliative care registers, proportion of patients on palliative care register, Primary Care Trusts, 2006/07 to 2011/12



Source: Quality Outcomes Framework 2011/12, Health & Social Care Information Centre
www.hscic.gov.uk/qof

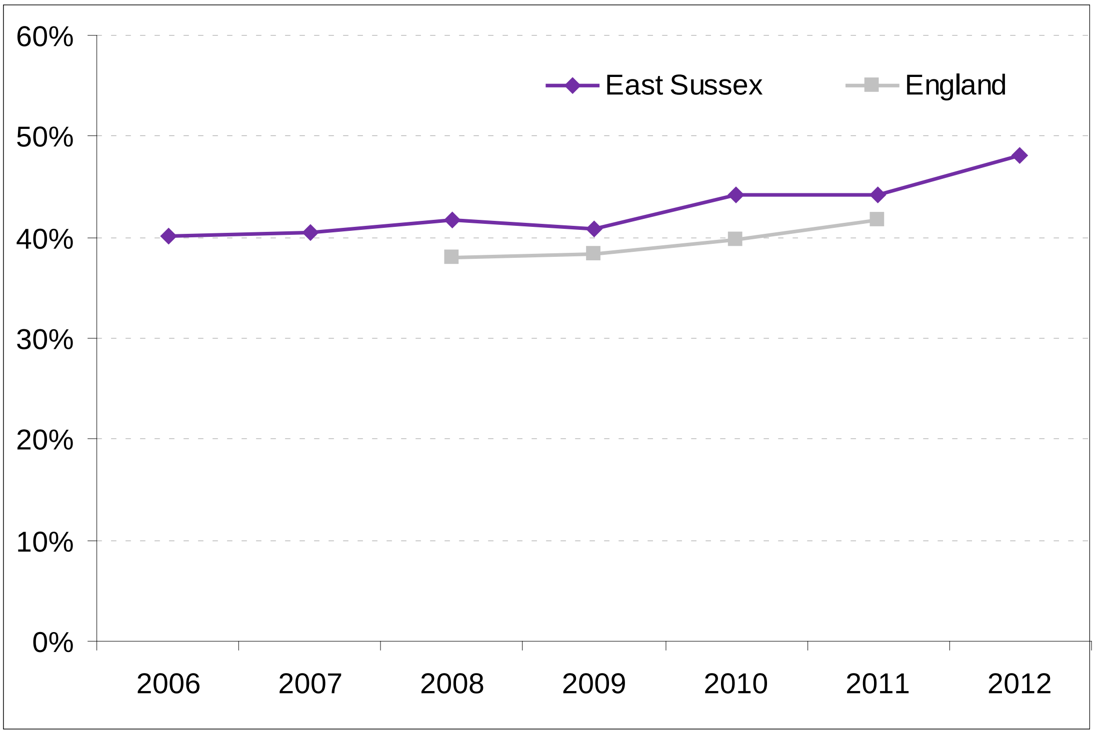
9.3 Key facts and figures: people dying in their preferred place of care

For people identified as approaching end of life, place of death is an important quality measure. The majority of people would prefer to die in their usual place of residence if circumstances allowed.

In 2012, 48% of deaths for East Sussex residents were in their usual place of residence and 43% of deaths were in hospital. In Hastings and Rother CCG 45% of deaths were in the usual place of residence and the percentages were 51% for Eastbourne, Hailsham and Seaford CCG and 48% for High Weald Lewes and Havens CCG.

Figure 9.2 shows an improvement in this indicator in both East Sussex and England.

Figure 9.2: Percentage of deaths at usual residence, 2006 to 2012



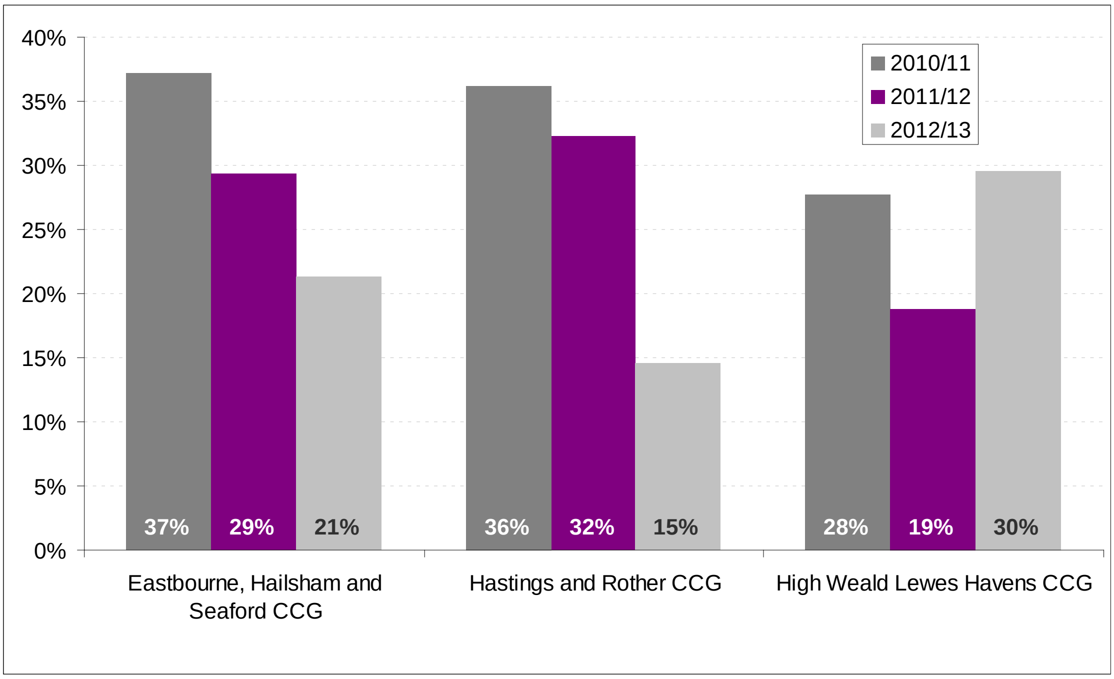
Source: Death registrations, Office for National Statistics

9.4 Key facts and figures: staff training and end of life care

Care of the dying requires not only substantial technical knowledge and clinical skill in assessing and adapting care to an individual's rapidly changing needs, but above all it needs excellent communication skills. These are an essential competence for doctors and nurses, and yet clinicians are sometimes particularly poor at dealing with discussions about a person's impending death. Unless there has been good communication between staff and relatives or carers, unnecessary misunderstandings can arise. For example, cessation of routine observations of temperature, blood pressure and pulse may appear as though routine nursing care has stopped. To many relatives, an unexplained cessation of observations means there is a lack of care. Evidence suggests some hospital doctors, no matter how senior, sometimes see communication as time consuming and an optional extra, rather than at the heart of effective care. This is very disturbing.[1]

A significant percentage of palliative care hospital admissions end in death in hospital (Figure 9.3).

Figure 9.3: Percentage of palliative care hospital admissions that ended in death by CCG, 2010/11 to 2012/13



Source: Local East Sussex SUS extracts, East Sussex Public Health Intelligence Team

9.5 Key facts and figures: supporting people who are bereaved

Bereavement is often shocking and has a huge impact on people's lives. As there are 6,000 deaths per year in East Sussex, the pain of bereavement is experienced by many people. For some groups, additional support may be required.

Bereavement support may not be limited to immediately after death, but may be required on a longer term basis and, in some cases, may begin before death.

Recommendation: commissioners and multi-agency partnerships delivering in this area should review current commissioning plans and strategies against evidence recommendations laid out in Appendix 7. Where gaps or weaknesses are identified interventions for implementation should be prioritised using criteria outlined in Chapter 2.

References

1. Parry *et al* (2013) Rapid evidence review: pathways for the dying phase in end of life care and their key components. Sue Ryder Care Centre for the Study of Supportive, Palliative and End of Life Care, National End of Life Programme and University of Nottingham. https://www.gov.uk/government/publications/review-of-liverpool-care-pathway-for-dying-patients

APPENDIX 1

THE BEST POSSIBLE START FOR ALL BABIES AND YOUNG CHILDREN

The objective of this section is to make evidenced based recommendations that support commissioners with a robust basis for decision making.

Recommendations are based on evidence from systematic reviews and meta-analyses. Scoring of recommendations is based on the SIGN methodology as set out in Chapter 2. Recommendations graded ‘A’ are based on the highest quality evidence and those graded ‘D’ the lowest. These reviews were carried out at a specific point in time and we acknowledge there are further caveats commissioners must take into consideration:

- NICE guidance is being updated on a continuous cycle, and some of the evidence presented here may not have been reviewed by NICE at this time. Commissioners need to ensure interventions do not conflict with current NICE guidance.

- East Sussex CCGs operate a ‘Low Priorities Procedures’ process. Whereby some procedures are not ordinarily commissioned and requests for treatment are referred to an ‘individual treatment panel’. It is important to recognise that the agreed processes should be followed for these interventions.

- Locally, new pathways to treatment for patients for a wide range of conditions are being developed by GPs, commissioners and secondary care clinicians. It is important to ensure agreed treatment pathways are followed.

It is recommended that commissioners review the entire evidence base set out in the evidence review for this priority area, but that service planning focuses on those issues highlighted by this recommendations section.

RECOMMENDATION NUMBERS LISTED ARE THOSE FROM THE FULL EVIDENCE REVIEW FOR THIS PRIORITY AREA. FULL EVIDENCE REVIEWS ARE AVAILABLE ON THE EAST SUSSEX JOINT STRATEGIC NEEDS ASSESSMENT WEBSITE WWW.EASTSUSSEXJSNA.ORG.UK.

2.2 Recommendations for interventions to support smoking cessation during pregnancy

This evidence review recommends:

Intervention	**Grade**
Smoking cessation interventions	
Promote:	
2.2.1 the 5 A's (Ask, Advise, Assess, Assist, Arrange)	A
2.2.2 cognitive behaviour therapy, motivational interviewing and structured self-help and support from NHS stop smoking services	A
2.2.3 smoking cessation programs in all maternity care settings.	A
2.2.4 telephone counselling as an intervention to help pregnant women stop smoking.	A
2.2.5 the provision of incentives to quit; this has been effective in other countries in helping women who are pregnant to quit smoking (research is required to see whether it would work in UK).	A
2.2.6 interventions to increase smoking cessation among the partners of pregnant women.	A
2.2.7 group therapy.	
Midwives	
Ensure midwives:	
2.2.8 identify pregnant women who smoke through discussion and the use of CO tests.	A
2.2.9 provide information in a variety of formats to pregnant women who smoke about the risks to the unborn child of smoking when pregnant, and the hazards of exposure to second-hand smoke for both mother and baby.	A
2.2.10 refer all pregnant women who smoke, have stopped smoking within the last 2 weeks, or have a CO reading of 7 parts per million or above to NHS Stop Smoking Services and are given the NHS Pregnancy Smoking Helpline number and local number when available.	A
2.2.11 check if referral was taken up at the next appointment and, if not, offer another referral to NHS stop smoking services	A
2.2.12 identify if anyone in the household smokes and, if so, suggest they contact the NHS stop smoking services.	A
2.2.13 who deliver intensive stop-smoking interventions are trained to the same standard as NHS stop-smoking advisers.	A
Health and support services	
2.2.14 Ensure those responsible for providing health and support services for pregnant women identify pregnant women who smoke; provide information about the risks of smoking; refer them to NHS Stop Smoking Services; give the NHS Pregnancy Smoking Helpline number and local number when available.	A
Stop smoking services	

Ensure NHS stop smoking services:	
2.2.15 telephone all women who have been referred for help, and attempt to see those who cannot be contacted by telephone.	A
2.2.16 address any factors which prevent the women from using smoking cessation services.	A
2.2.17 provide structured self-help materials.	A
2.2.18 send information on smoking and pregnancy to those who opt out during the initial telephone call.	A
2.2.19 are delivered in an impartial, sensitive, client-centred manner; they should take into account factors such as age, ethnicity, culture and language.	A
2.2.20 are tailored to meet individual needs and take place at times and in locations that make them easily accessible.	A
2.2.21 collaborate with the family nurse partnership pilot and other outreach schemes to identify additional opportunities for providing intensive and on-going support, and work in partnership with agencies that support women who have complex social and emotional needs.	A
2.2.22 identify partners that smoke and provide clear advice about the danger that other people’s tobacco smoke poses to the pregnant woman and to the baby – before and after birth.	A
2.2.23 recommend not smoking around the pregnant woman, mother or baby including not smoking in the house or car.	A
2.2.24 offer partners who smoke help to stop using a multi-component intervention that comprises three or more elements and multiple contacts.	A
2.2.25 choose an appropriate medication for the partner that seems most likely to succeed.	A
2.2.26 discuss the risks and benefits of NRT with pregnant women who smoke, particularly those who do not wish to accept other help from NHS Stop Smoking Services; use only if smoking cessation without NRT fails.	A

Community	
2.2.27 Promote strategies in the wider community to reduce social inequalities.	
2.2.29 Support population-wide strategies for smoking control to reduce the initiation of smoking by young people	A

This evidence review does not recommend:

Intervention	**Grade**
2.2.30 Giving pregnant women feedback on the effects of smoking on the unborn child and on their own health.	A
2.2.31 intensive counselling over brief counselling sessions.	A
2.2.33 Interventions involving additional group sessions during pregnancy.	A
2.2.34 smoking cessation materials without the direct input of health professionals, counsellors or group support.	A

2.3 Recommendations for interventions to support breastfeeding initiation and continuation

This evidence review recommends:

Intervention	**Grade**
Ensure:	

2.3.2 there is a written, audited and well-publicised breastfeeding policy that includes training for staff and support for staff who may be breastfeeding; a health professional responsible for implementing this policy should be identified.	A
2.3.3 all relevant healthcare professionals have demonstrated competency and sufficient on-going clinical experience in supporting breastfeeding women, including a sound understanding of the physiology of lactation, neonatal metabolic adaptation and the ability to communicate this to parents.	A
2.3.4 all healthcare providers have a written breastfeeding policy that is communicated to all staff and parents, each provider should identify a lead healthcare professional responsible for implementing this policy.	A
2.3.5 healthcare professionals have sufficient time to give support to a woman and baby during initiation and continuation of breastfeeding.	A
2.3.6 health professionals are trained as part of a coordinated programme of interventions across different settings to increase breastfeeding rates.	A
2.3.7 health professionals who provide information and advice to breastfeeding mothers have the required knowledge and skills.	A
2.3.8 support workers receive training in breastfeeding management from someone with the relevant skills and experience before they start working with breastfeeding mothers.	A
2.3.10 midwives and health visitors provide pregnant women and their partners with breastfeeding information, education and support on an individual or group basis; this should be provided by someone trained in breastfeeding management and should be delivered in a setting and style that best meets the woman's needs.	A
2.3.11 new mothers are contacted directly within 48 hours of their transfer home (or within 48 hours of a home birth).	A
2.3.12 new mothers are offered on-going support according to their individual needs.	A
2.3.13 GPs, obstetricians and midwives encourage breastfeeding during individual antenatal consultations; they should pay particular attention to the needs of women who are least likely to breastfeed (e.g. young women, those who have low educational achievement and those from disadvantaged groups).	A
2.3.14 a midwife or health visitor trained in breastfeeding management provides informal group sessions in the last trimester of pregnancy on how to breastfeed effectively by covering feeding position and how to attach the baby correctly.	A
2.3.15 that midwives or health visitors check that a mother can demonstrate how to position and attach the baby to the breast and can identify signs that the baby is feeding well before she leaves hospital (or before the midwife leaves the mother after a home birth).	A
2.3.16 that midwives or health visitors provide breastfeeding support at home and record all advice in the mother's hand-held records.	A
2.3.17 that midwives or health visitors advise mothers that a healthy diet is important for everyone and that they do not need to modify their diet to breastfeed.	A
2.3.18 nurses deliver early postpartum support to initiate breastfeeding.	B
2.3.19 that midwives or health visitors do not provide written materials in isolation but use them to reinforce face-to-face advice about breastfeeding.	A
2.3.20 midwives, health visitors, paediatric nurses, nurses working in special-care baby units, and nursery nurses show all breastfeeding mothers how to hand-express breast milk and advise mothers on how expressed milk can be stored and subsequently prepared.	A
2.3.9 education and information is provided to pregnant women on how to breastfeed, followed by proactive support during the postnatal period	A
Promote:	

2.3.1 a multifaceted approach or a coordinated programme of interventions across different settings to increase breastfeeding rates.	A
2.3.21 the UNICEF/WHO Baby Friendly Hospital Initiative (BFI) training to improve breastfeeding duration.	B
2.3.22 structured breastfeeding programmes in acute maternity care settings to improve breastfeeding initiation.	A
2.3.23 all forms of extra support to improve breastfeeding initiation, duration or exclusivity.	A
2.3.24 face-to-face support among healthy breastfeeding mothers with healthy term babies.	A
2.3.25 peer counselling interventions (alone or in combination with a health professional) to improve breastfeeding initiation, duration or exclusivity.	B
2.3.26 interventions that aim to increase maternal self-efficacy.	B
2.3.27 breastfeeding education and support, spanning from antenatal to postnatal period and involving women’s social network (including women’s partners or mothers).	B
2.3.28 educational interventions with hands-on activities and role playing to enhance maternal self-efficacy.	B
2.3.29 breastfeeding promotion programs delivered via the internet.	B
2.3.30 breastfeeding specific clinic appointments to improve breastfeeding initiation, duration or exclusivity.	B
2.3.31 group prenatal education to improve breastfeeding initiation, duration or exclusivity.	B
2.3.32 interventions for minority women that include: group prenatal breastfeeding education, breastfeeding specific clinic appointments, peer counselling interventions and nutrition programs for women, infants and children.	B
2.3.33 professional support interventions spanning from pregnancy to the intrapartum period and throughout the postnatal period.	B
Adolescent mothers	
2.3.34 Ensure adolescent mothers receive:	B
• practical and tangible assistance from nurses;	
• practical help when initiating breastfeeding;	
• emotional support (convey empathy, trust, and concern);	
• network support.	
Neonatal	
Promote:	
2.3.35 close, continuing skin-to-skin contact between mother and infant for infants in neonatal units to promote breastfeeding/breast milk feeding	B
2.3.36 multifaceted interventions for infants in neonatal units to improve breastfeeding rates.	B
Formula milk	
Ensure:	
2.3.37 that all parents and carers who are giving their babies formula feed are offered appropriate and tailored advice on formula feeding.	A
2.3.38 that formula milk is not given to breastfed babies unless medically indicated. Commercial packs containing formula milk or advertisements	A

for formula should not be distributed.	
2.3.39 breastfeeding women are offered skilled support in preventing, identifying and treating breastfeeding concerns (including nipple pain, engorgement, mastitis, Inverted nipples, tongue tie, sleepy baby).	A

This evidence review does not recommend:

Intervention	Grade
2.3.40 support only offered if women seek help.	A
2.3.41 postpartum professional support delivered by nurses was found to be the least effective intervention type.	B
2.3.42 written breastfeeding education materials as a stand-alone intervention.	A

2.4 Recommendations for interventions to support parents of babies with special educational needs/disabilities

This evidence review recommends:

Intervention	Grade
Commissioners and Managers	
Ensure:	
2.4.1 the social and emotional wellbeing of under-5s is assessed as part of the joint strategic needs assessment; this includes vulnerable children and their families.	A
2.4.3 vulnerable children at risk of developing (or who are already showing signs of) social and emotional and behavioural problems are identified as early as possible by universal children and family services	A
2.4.4 children and families with multiple needs have access to specialist services, including child safeguarding and mental health services.	A
2.4.2 the promotion of integrated commissioning of universal and targeted services for children aged under 5.	A
Tools	
2.4.5 Promote population-based models as a way of determining need and ensuring resources and services are effectively distributed.	A
Local Authority	
Ensure:	
2.4.6 local authority scrutiny committees for health and wellbeing review delivery of plans and programmes designed to improve the social and emotional wellbeing of vulnerable children aged under 5.	A
2.4.7 family welfare, housing, voluntary services, the police and others who are in contact with a vulnerable child and their family are aware of factors that pose a risk to the child's social and emotional wellbeing and raise any concerns they have with the family GP or health visitor.	A
2.4.8 Support children's services in ensuring that all vulnerable children can benefit from high quality childcare outside the home on a part or full-	A

time basis and can take up their entitlement to early childhood education, where appropriate.	

Health Visitors or Midwives	
Ensure:	
2.4.9 health professionals in antenatal and postnatal services, school nurses and early year’s practitioners identify factors that may pose a risk to a child's social and emotional wellbeing.	A
2.4.10 a trained nurse visits families in need of additional support a set number of times over a sustained period of time, sufficient to establish trust and help make positive changes.	A
2.4.11 during the home visit the nurse focuses on, where possible, developing the father–child relationship as part of an approach that involves the whole family.	A
2.4.12 they regularly check the parents' level of involvement in the intensive home visiting programme.	A
2.4.13 they explain to parents that home visits aim to promote the healthy development of the child. Taking into consideration the parents' first language and sensitivities to a wide range of attitudes, expectations and approaches in relation to parenting.	A
2.4.14 they enable both parents to fully participate in home visits, by taking into account their domestic and working priorities and commitments.	A
2.4.15 they work in partnership with other early year’s practitioners to ensure families receive coordinated support.	A
2.4.16 they promote evidence-based interventions to improve maternal sensitivity and mother–infant attachment.	A
2.4.17 they encourage parents to participate in other services delivered by children's centres and as part of the Healthy Child Programme.	A

Child care and Early Years Services	
2.4.18 Ensure that child care and education services:	A
• offer flexible attendance times, so that parents or carers can take up education, training or employment opportunities.	
• address any barriers that may hinder participation by vulnerable children such as geographical access, the cost of transport or a sense of discrimination and stigma.	
• are run by well-trained qualified staff, including graduates and qualified teachers.	
• based on an ethos of openness and inclusion.	

Managers and providers of child care and Early Years Services	
Ensure:	
2.4.19 services enable all vulnerable children to benefit from high quality services which aim to enhance their social and emotional wellbeing and build their capacity to learn.	A
2.4.20 services	A
• provide a structured, daily schedule comprising a balance of adult-led and child initiated activities	
• ensure parents and other family members are fully involved	
• ensure the indoor and outdoor environment is spacious and well maintained.	

2.4.21 a process is in place to systematically involve parents and families in reviewing services and suggesting how they can be improved.	A
2.4.22 they are systematic and persistent in their efforts to encourage vulnerable parents to use Early Years Services.	A
2.4.23 use outreach methods to maintain or improve the participation of vulnerable parents and children in programmes and activities.	A
2.4.24 work with community and voluntary organisations to help vulnerable parents who may find it difficult to use health and Early Years Services.	A

Parents and children	
Ensure:	
2.4.25 parents who lack confidence or who are isolated, receive particular encouragement.	A
2.4.26 parents are included in psychological therapies that reduce pain in children with painful conditions.	A
2.4.27 parents are included in CBT programmes focussed on improving the primary symptom complaints	A
Promote:	
2.4.28 problem solving therapy delivered to parents to improve parent problem solving skills and parent mental health.	A
2.4.29 group-based parenting programmes.	A

Parents of babies with special educational needs/disabilities	
Promote:	
2.4.30 parenting and stress management interventions for parents of children with developmental disabilities.	B
2.4.31 early intervention programmes for children from birth to nine years who have a physical disability.	C
2.4.32 parent training as a centre piece for interventions geared toward children with intellectual disability (ID).	B
2.4.34 parent training for the parents of children with Attention Deficit Hyperactivity Disorder (ADHD) aged 5 to 18 years.	B
2.4.33 Ensure: developmental disabilities are paired with instructions and teaching occurring at school or through early intensive behavioural intervention programs.	B

This evidence review does not recommend:	
Intervention	**Grade**
2.4.35 Psychological therapies that include parents in most outcome domains of functioning, for a large number of common chronic illnesses in children.	A

2.5 Recommendations for interventions to improve rates of infant immunisation and vaccination

This evidence review recommends:

Intervention	**Grade**

Reminder/recall systems	
Promote:	
2.5.1 interventions that incorporate tailored invitations for immunisation and reminder/recall systems followed up by telephone or text message.	A
2.5.2 patient reminder and recall in the following order (1) Person-to-person telephone reminders (2) Letter reminders (3) Postcard reminders.	A
Home visits	
Promote:	
2.5.3 home-visit interventions that consist of a healthcare professional or trained community support worker visiting parents in their homes to discuss immunisation, and offering to give their children vaccinations there and then (or arrange a convenient time in the future).	A
2.5.4 a home vaccination service targeted at children not up-to-date with immunisation schedule.	B
2.5.5 home visits for groups that may not use primary care services, for example, travellers or asylum seekers.	A
Knowledge and education	
Ensure children aged under 19 years and their parents:	
2.5.6 are provided with tailored information, advice and support to ensure they know about the recommended routine childhood vaccinations and the benefits and risks.	A
2.5.7 have an opportunity to discuss any concerns they might have about immunisation. This could either be in person or by telephone and could involve a GP, community paediatrician, health visitor, school nurse or practice nurse.	A
2.5.8 are provided with accurate, up-to-date information in a variety of formats on the benefits of immunisation against vaccine-preventable infections. This should be tailored for different communities and groups.	A
2.5.10 Ensure: health professionals have enough time to discuss immunisation.	C
2.5.9 Promote interventions that encourage parents to base their decisions less on emotional variables, such as anticipated responsibility or regret, and to assess the benefits and risks of immunising on the basis of scientific evidence.	B
School	
Encourage:	
2.5.11 head teachers to ask about immunisation status on school entry.	C
2.5.12 school nursing teams to work with GP practices and schools to check the vaccination status of children and young people when they transfer to a new school or college.	A
2.5.14 schools to become venues for vaccinating local children.	A
2.5.13 Ensure school nursing teams explain to parents of children and young people that are not up-to-date with their vaccinations, why immunisation is important.	A
2.5.15 Promote vaccination requirements for child care, school, and college attendance.	B

Hospital-based opportunistic immunisation	
2.5.16 Promote opportunistic immunisation of children in accident and emergency departments, or during a hospital admission.	A
Multi-component	
2.5.17 Promote targeted multi-component community-based interventions.	B
Monitoring and feedback of vaccination status	
Ensure:	
2.5.18 vaccination status of all children aged under 19 is checked at every appropriate opportunity.	A
2.5.19 GP practices have a structured, systematic method for recording, maintaining and transferring accurate information on the vaccination status of all children aged less than 19.	A
2.5.20 private providers are encouraged and enabled to give the relevant GP practice details of all vaccinations administered to children and young people, so they can be recorded in the appropriate information system.	A
2.5.21 the databases for recording children and young people's immunisation status is regularly updated and maintained	A
2.5.22 the Healthy Child Team checks the immunisation record of each child aged up to 5 years. They should carry out this check when the child joins a day nursery, nursery school, playgroup, children's centre or when they start primary school. The check should be carried out in conjunction with childcare or education staff and the parents.	A
2.5.23 Promote: audit and feedback of children and young people's immunisation status and vaccination coverage.	B
Health professionals	
Ensure:	
2.5.24 there is an identified healthcare professional in every GP practice who is responsible – and provides leadership – for the local childhood immunisation programme.	A
2.5.25 all immunisation services staff are appropriately trained.	A
2.5.26 health professionals who deliver vaccinations have received training that complies with the national minimum standard for immunisation training.	A
2.5.27 health professionals working with children and young people have the appropriate knowledge and skills to give advice on the benefits and risks of immunisation.	A
2.5.28 staff are appropriately trained to document vaccinations accurately in the correct records.	A
2.5.30 all staff involved in immunisation services for children aged under 19 have access to the 'Green book'.	A
Access and capacity of immunisation programmes **Ensure:**	

2.5.31 good access to immunisation services by extending clinic times, ensuring children and young people are seen promptly and by making sure clinics are child and family friendly.	A
2.5.32 that enough immunisation appointments are available so that all local children under the age of 19 can receive the recommended vaccinations on time.	A
2.5.33 that the age composition of the practice population is monitored so that there is enough capacity to provide timely immunisations.	A
2.5.34 good access to immunisation services for those with transport, language or communication difficulties, and physical or learning disabilities.	A
2.5.29 Promote: registered nurses, physician assistants, and medical assistants to independently screen patients, identify opportunities for immunisation, and administer vaccines under physician supervision.	B

Hepatitis B	
Ensure:	
2.5.37 there is an identified person responsible for coordinating the local hepatitis B vaccination programme.	A
2.5.38 babies born to hepatitis B-positive mothers are given a first dose of the vaccine promptly, whether they are delivered in hospital or at home. They should then receive all other recommended doses, a blood test to check for infection and, where appropriate, hepatitis B immunoglobulin, in line with the ‘Green book’.	A

This evidence review does not recommend:	
Intervention	**Grade**
2.5.39 Client/family incentives (or disincentives) at increasing uptake of immunisations in children of low-income families.	B

2.6 Recommendations for interventions to achieve healthy weight during childhood (addressing obese and underweight children)

This evidence review recommends:

Intervention	**Grade**
Commissioning	
Encourage:	
2.6.1 commissioners to develop a coordinated approach to the prevention of obesity.	
2.6.6 clinical commissioning groups to identify an obesity or public health lead to work with the public health team on joint approaches to tackling obesity.	A
2.6.2 Raise awareness of the health problems caused by obesity and the benefits of being a healthier weight among partners and the public.	
2.6.3 Provide training to meet the needs of staff and volunteers.	
2.6.4 Influence the wider determinants of health that encourage physical activity.	A
2.6.5 Ensure commissioners and organisations promote, through the health and wellbeing board, a coherent, community-wide, multi-agency approach is in place to address obesity prevention and management.	A
2.6.7 Support the identification of a senior council member to be a champion for children and young people’s physical activity.	A

Community engagement	
Encourage:	
2.6.8 community engagement and capacity-building methods to identify, train, and provide resources to networks of local people, champions and advocates who have the potential to co-produce action on obesity as part of an integrated health and wellbeing strategy.	A
2.6.9 coordinators and community engagement workers to jointly plan how they will work with population groups, or in geographic areas, with high levels of obesity.	A
Training	
Ensure:	
2.6.10 frontline staff set aside dedicated time to deliver specific aspects of the obesity agenda and receive training to improve their understanding of the needs of the local community and improve their practical implementation skills.	A
2.6.11 health professionals have the appropriate knowledge and skills to give advice on the nutritional needs of women and the importance of a balanced diet before, during and after pregnancy.	A
2.6.12 health professionals are trained in strategies for changing people’s eating behaviour, particularly by offering practical, food-based advice.	A
2.6.13 health professionals discuss the woman’s diet and eating habits early in pregnancy.	A
Healthy eating interventions	
Encourage:	
2.6.14 health professionals to inform pregnant women with a pre-pregnancy body mass index (BMI) over 30, and those who have a baby or who may become pregnant with a BMI over 30, about the increased risks this poses to themselves and their babies and encourage them to lose weight before becoming pregnant or after pregnancy.	A
2.6.16 commissioning agencies, local authorities, and public health nutritionists and dieticians to provide support (both practical and financial) to develop and maintain community-based initiatives which aim to make a balanced diet more accessible to families with children under 5 years on a low income. Examples include: food cooperatives, ‘cook and eat’ clubs, ‘weaning parties’ and ‘baby cafes’.	A
2.6.15 Ensure all people working with infants and pre-school children up to the age of 5 years implement a food policy which takes a ‘whole settings’ approach to healthy eating. They should encourage children to handle and taste a wide range of foods that make up a healthy diet	A
Physical activity	
Ensure:	
2.6.17 Children and young people’s plans, joint strategic needs assessments, local development and planning frameworks, sustainable community plans and strategies all explicitly address the need for children and young people to be physically active.	A
2.6.18 there is a coordinated local strategy to increase physical activity among children and young people, their families and carers.	A
2.6.19 physical activity initiatives aimed at children and young people are regularly evaluated.	A
Support:	

2.6.20 provision of places and facilities (both indoors and outdoors) where children and young people feel safe to take part in physical activities.	A
2.6.22 physical activity programmes for all ages of children that ensure children have the opportunity to explore a range of physical activities to help them identify those they can enjoy by themselves and those they can do with friends and family.	A
2.6.21 Encourage: employers or supervisors of people who provide programmes or opportunities for children and young people aged 18 and under to be physically active to ensure staff and volunteers have the skills, including interpersonal skills, to design, plan and deliver physical activity sessions including active play sessions, that meet children and young people's different needs and abilities. Those leading activities should make them enjoyable.	A

Parent involvement	
2.6.23 Support interventions combining general parenting components with lifestyle components.	B

This evidence review does not recommend:

Intervention	**Grade**
2.6.24 programs offering additional support during pregnancy. Additional support was defined as some form of emotional support and information or advice or both, either in home visits or during clinic appointments, and could include tangible assistance to clinic appointments, assistance with care of other children at home.	A

APPENDIX 2

SAFE, RESILIENT AND SECURE PARENTING FOR ALL CHILDREN AND YOUNG PEOPLE

The objective of this section is to make evidenced based recommendations that support commissioners with a robust basis for decision making.

Recommendations are based on evidence from systematic reviews and meta-analyses. Scoring of recommendations is based on the SIGN methodology as set out in Chapter 2. Recommendations graded ‘A’ are based on the highest quality evidence and those graded ‘D’ the lowest. These reviews were carried out at a specific point in time and we acknowledge there are further caveats commissioners must take into consideration:

- NICE guidance is being updated on a continuous cycle, and some of the evidence presented here may not have been reviewed by NICE at this time. Commissioners need to ensure interventions do not conflict with current NICE guidance.

- East Sussex CCGs operate a ‘Low Priorities Procedures’ process. Whereby some procedures are not ordinarily commissioned and requests for treatment are referred to an ‘individual treatment panel’. It is important to recognise that the agreed processes should be followed for these interventions.

- Locally, new pathways to treatment for patients for a wide range of conditions are being developed by GPs, commissioners and secondary care clinicians. It is important to ensure agreed treatment pathways are followed.

It is recommended that commissioners review the entire evidence base set out in the evidence review for this priority area, but that service planning focuses on those issues highlighted by this recommendations section.

RECOMMENDATION NUMBERS LISTED ARE THOSE FROM THE FULL EVIDENCE REVIEW FOR THIS PRIORITY AREA. FULL EVIDENCE REVIEWS ARE AVAILABLE ON THE EAST SUSSEX JOINT STRATEGIC NEEDS ASSESSMENT WEBSITE WWW.EASTSUSSEXJSNA.ORG.UK.

2.2 Recommendations for interventions to support parents who are struggling

This evidence review recommends:

Intervention	Grade
Commissioners and planners	
2.2.1 Ensure commissioners and planners target vulnerable children aged less than 5 years and their parents to address health inequalities.	A
Health and Early Years Professionals	
Ensure:	
2.2.2 health and Early Years professionals develop trusting relationships with vulnerable families and adopt a non-judgmental approach, while focusing on the child’s needs.	A
2.2.3 health professionals in antenatal and postnatal services identify factors that may pose a risk to a child’s social and emotional wellbeing.	A
Home visits	
2.2.4 Ensure an appropriately trained health visitor or midwife offers a series of intensive home visits to parents assessed to be in need of additional support over a sustained period of time (sufficient to establish trust and help make positive changes). It should be ensured both parents can fully participate in home visits.	A
2.2.5 Promote a set curriculum for home visits which aims to achieve specified goals in relation to:	A
• maternal sensitivity (how sensitive the mother is to her child’s needs);	
• the mother–child relationship;	
• home learning (including speech, language and communication skills);	
• parenting skills and practice.	
2.2.6 Ensure health visitors or midwives regularly check the parents’ level of involvement in the intensive home visiting programme.	A
2.2.7 Ensure health visitors or midwives explain to parents that home visits aim to promote the healthy development of the child.	A
Interventions that improve parenting and the mental health and well-being of children	
Promote:	
2.2.8 the following low cost universal programmes to improve parenting and the mental health and well-being of children: skin-to-skin contact at birth, Kangaroo care, abdominal massage in pregnancy, media-based parenting programmes.	A
2.2.10 slightly higher cost universal programmes to improve parenting and the mental health and well-being of children: developmental guidance, anticipatory guidance, infant massage.	A
2.2.13 problem solving therapy delivered to parents to improve parent problem solving skills and parent mental health.	A
2.2.12 Ensure health visitors and midwives consider evidence-based interventions, such as baby massage and video interaction guidance, to	A

improve maternal sensitivity and mother–infant attachment.	
High-risk groups	
2.2.14 Promote the following targeted programmes for high-risk groups to improve parenting and the mental health and well-being of children:	A
• Psychosocial interventions offering emotional and practical support for the prevention of post-natal depression.	
• Treatment for post-natal depression using cognitive behavioural approaches, interpersonal therapy or non-directive counselling.	
• Long-term multicomponent home visiting programmes starting antenatally, offering both support for parenting and support for parents particularly for teenage parents.	
• Short-sensitivity focused interventions including parent–infant interaction guidance training for high-risk infants.	
• Manualized group based and one-to-one parenting programmes addressing behaviour management and parent–child relationships.	
Parents of children with developmental disabilities	
2.2.15 Promote multiple component interventions addressing both parent well-being and behavioural parent training over interventions that offer either behavioural parent training or cognitive behavioural training alone for parents of children with developmental disabilities.	B
Father and other family members	
Ensure:	
2.2.16 that a nurse, where possible, focuses on developing the father–child relationship as part of an approach that involves the whole family. This includes getting the father involved in any curriculum activities.	A
2.2.17 health visitors or midwives try to involve other family members, if appropriate and acceptable to the parents.	A
2.2.18 Promote parenting and stress management interventions for fathers, for parents of children with developmental disabilities	B
Group based	
2.2.19 Promote group-based parenting programmes to improve the short-term psychosocial wellbeing of parents.	A
Psychological therapies	
2.2.20 Promote the inclusion of parents in psychological therapies that reduce pain in children with painful conditions.	A
Other support services	
Ensure:	
2.2.21 health and early years practitioners use outreach methods to maintain or improve the participation of vulnerable parents and children in programmes and activities.	A
2.2.22 health visitors and midwives encourage parents to participate in other services delivered by children’s centres and as part of the Healthy	A

Child programme.	
2.2.23 health and Early Years practitioners are systematic and persistent in their efforts to encourage vulnerable parents to use early year's services through:	A
• targeted publicity campaigns;	
• making contact by using key workers and referral partners;	
• encouraging other parents to help get them involved;	
• sending out repeat invitations;	
• using local community venues, such as places of worship and play centres to encourage them to participate;	
• addressing any concerns about discrimination and stigma home visits by family support worker;.	
2.2.24 health visitors and midwives work in partnership with other Early Years practitioners to coordinated family support.	A
2.2.25 health and Early Years practitioners are clear about their responsibility for improving the social and emotional wellbeing of vulnerable children and their families.	A
2.2.26 health and Early Years practitioners work with community and voluntary organisations to help vulnerable parents who may find it difficult to use health and early years services.	A

Reviewing and improving	
Ensure:	
2.2.27 health and Early Years providers have a process in place to systematically involve parents and families in reviewing services and suggesting how they can be improved. Vulnerable parents and families should be asked about their needs and concerns and experiences.	A
2.2.28 managers of intensive home-visiting programmes conduct regular audits to provide consistency and quality of delivery.	A

This evidence review does not recommend:

Intervention	**Grade**
2.2.30 Psychological therapies that include parents in most outcome domains of functioning, for a large number of common chronic illnesses in children.	A

2.3 Recommendations for quality training as an intervention for those who work with vulnerable families

This evidence review recommends:

Intervention	**Grade**
Work force training focused on delivering effective programmes and interventions to support vulnerable families	
Promote evidence based programmes that include:	
2.3.4 skin-to-skin contact at birth; kangaroo care; abdominal massage in pregnancy and media-based parenting programmes	A
2.3.5 developmental guidance, anticipatory guidance and infant massage.	A

Promote targeted programmes:	
2.3.6 to improve parenting and the mental health and well-being of children to high risk groups that include psychosocial interventions offering emotional and practical support for the prevention of post-natal depression.	A
2.3.7 for high risk women to treat post-natal depression that include CBT, interpersonal therapy or non-directive counselling.	A
2.3.8 with long-term multicomponent home visiting programmes for high risk groups starting antenatally, offering both support for parenting and support for parents, particularly for teenage parents.	A
2.3.9 targeted short-sensitivity focused interventions including parent–infant interaction guidance training for high-risk infants.	A
2.3.10 with manualized group based and one-to-one parenting programmes, high risk groups addressing behaviour management and parent–child relationships.	A
Ensure:	
2.3.1 a skilled workforce is established to deliver evidence based interventions to improve parenting and the mental health and well-being of children.	A
2.3.2 the relevant workforce is trained to support disabled parents and parents with additional support needs.	B
2.3.11 disabled parents and parents with additional support needs, including those who are currently using services, are involved in the development of protocols, in training, and in the monitoring of their implementation.	B
2.3.3 Support policies and programmes that promote parenting for improving mental health.	A

Quality staff training to deliver effective integrated support to vulnerable families	
Promote staff training:	
2.3.12 to support disabled parents across all levels of personnel in relevant agencies to maintain sustainable, good practice	B
2.3.13 supporting integrated services and ensuring effective communication between professional groups within teams.	B
2.3.14 on role awareness to support integrated services.	B
2.3.15 including partnership working and interprofessional working to support integrated services.	B

Quality staff training to support and train parents of children with complex health needs	
Ensure:	
2.3.16 that parents of children with complex health care needs are appropriately trained by nursing or medical staff to undertake the specialist care giving tasks they will be undertaking; parental competence in these tasks must be assessed prior to hospital discharge to ensure the child's health is not placed at risk.	B
2.3.17 parents of children with complex health care needs receive training given by nursing or medical staff that addresses the socio-emotional effects as well as medical procedures involved.	B

Training school staff and carers caring for children with complex health care needs	
Local authorities need to ensure that:	

2.3.18 staff of schools offering specialist child care for children with complex needs receive quality training, policies, support and supervision.	B
2.3.19 carers who offer short-break to children with complex needs receive quality training, policies, support and supervision.	B
Quality staff training interventions to support disabled parents and parents with additional support needs	
Ensure:	
2.3.20 mainstream services and specialist adults' and children's services specifically address the needs of families where a parent is disabled or has additional support needs associated with illness or substance misuse.	B
2.3.21 disabled parents with learning difficulties receive practical services that are supportive, respectful and considerate, and include information, advice and advocacy, and counselling.	B
Quality staff training to deliver effective evidence based practice to vulnerable families	
2.3.23 Promote continual professional development to a postgraduate level to support the use and production of evidence in the social care workforce, as well as promoting a research culture.	C
Ensure:	
2.3.22 evidence based research for the social care workforce is available to support evidence-informed practice.	B
2.3.24 the teaching of evidence-based practice skills includes practical application and critical reflection in order for clinical decision-making to be fully contextualised.	C
2.3.25 gaps in the skills of applying evidence-based knowledge are addressed.	C
2.3.26 gaps in knowledge and skills for evidence-based practice are clearly identified and a rolling programme for addressing these is developed in the workplace.	B
Quality staff training to deliver effective support to socially disadvantaged people with long term conditions, e.g. diabetes.	
2.3.27 Promote education interventions to improve diabetes care in socially disadvantaged populations that include the cultural tailoring of the interventions, one-on-one interventions and community educators leading the intervention.	B

This evidence review does not recommend:

Intervention	**Grade**
2.3.28 Psychological debriefing after birth and universal approaches to prevention of postnatal depression.	B

2.4 Recommendations for effective parenting interventions to support children/ young people

This evidence review recommends:

Intervention	**Grade**
Parenting interventions to support children/ young people	

Promote:	
2.4.1 parenting interventions within the home as part of a multi-faceted intervention to improve a range of child (and often maternal health) outcomes.	A
2.4.2 the following programmes to improve parenting and the mental health and well-being of children:	A
• Low cost universal: skin-to-skin contact at birth, kangaroo care, abdominal massage in pregnancy, media-based parenting programmes.	
• Slightly higher cost universal: developmental guidance, anticipatory guidance, infant massage.	
2.4.3 further research into the following promising interventions to improve parenting and the mental health and well-being of children in families:	B
• Antenatal education focusing on transition to parenthood and emotional and attachment issues and programmes to support parenting of fathers.	
• In families experiencing attachment difficulties and where there is a risk of abuse: parent–infant psychotherapy and infant led psychotherapy.	
• In families which physical abuse has occurred—intensive, multicomponent, multi-systemic family support approaches and cognitive behavioural-based parenting programmes.	
• In which emotional abuse has occurred—parent–infant psychotherapy; and where anger management is also an issue— group-based behavioural parent training with additional anger management components.	
• Where sexual abuse has occurred—CBT for the non-abusing parents; abused children can also benefit.	
• Where parents abuse drugs: multicomponent programmes targeting affect regulation, parental mood and views of self as a parent, drug use and parenting skills delivered on a one to one basis.	
2.4.4 Increasing positive parent-child interactions and emotional communication skills; teaching parents to use time out and the importance of parenting consistency; requiring parents to practice new skills with their children during parent training sessions.	B
2.4.5 Ensure the following key factors are taken into consideration when attempting to positively engage parents in parenting programmes:	B
• Parents to acknowledge that there is a problem.	
• The seriousness of the consequences of conduct disorder to be understood.	
• Knowledge and skills related to handling children’s behaviour to be gained.	
• Control and confidence in one’s ability to parent effectively to be acquired.	
• Parents need to receive non-judgemental support from professionals in the process of gaining new knowledge, skills and understanding, and help with implementing parenting skills; parents need peer support.	
• Parents need for their own needs to be recognized.	
• Mothers need for support from their spouse/partner.	
Teenage parenting interventions	
2.4.6 Promote parenting programmes for teenage parents to improve a number of aspects of parent-child interaction both in the short- and long-term.	B

Self-help parenting interventions	
Promote self-help:	
2.4.7 parenting intervention programmes in improving child behaviour, over the short and longer term.	A
2.4.8 delivery of self-help parenting intervention programmes via bibliotherapy and multimedia	B
2.4.10 within primary healthcare settings via community nurses and health visitors, for use with children with early-onset conduct problems.	B
2.4.11 as part of a stepped-care approach to treatment, where it may be used as the most basic and least intrusive level of intervention for families on waiting lists within specialist clinical services.	B
Group based interventions	
Promote:	
2.4.13 group based parenting programmes to allow parents to gain acceptance and support from other parents in the group	B
2.4.14 cognitive-behavioural group-based parenting.	B
Intervention for parents in transition to parenthood	
Promote:	
2.4.16 parenting-focused interventions for expectant and new parents.	B
2.4.17 interventions lasting 3 to 6 months to promote positive parenting and social development of the child.	B
2.4.18 interventions encouraging effective parenting in the transition to parenthood with an after-birth component to aid cognitive development.	B
Booster interventions	
2.4.19 Promote booster interventions compared to initial intervention only.	B
Father involvement	
Ensure:	
2.4.20 fathers participate in parenting programmes by taking the following barriers into account: lack of awareness, work commitments, female-orientated services, lack of organisational support and concerns over programme content.	B
2.4.21 participation in parenting programmes by actively promoting services to fathers rather than parents, offering alternative forms of provision, prioritise fathers within organisations and take different cultural and ethnic perspectives into account.	B
Health and social care provider’s interventions	
2.4.22 Ensure there is a skilled workforce.	A
2.4.23 Promote interventions delivered person-to-person and designed to modify parenting skills by targeting parents and other caregivers.	B

High risk groups	
Promote:	
2.4.24 the following targeted programmes for high-risk groups to improve parenting and the mental health and well-being of children:	A
• Psychosocial interventions offering emotional and practical support for the prevention of post-natal depression.	
• Treatment for post-natal depression using cognitive behavioural approaches, interpersonal therapy or non-directive counselling.	
• Long-term multicomponent home visiting programmes starting antenatally, offering both support for parenting and support for parents particularly for teenage parents.	
• Short-sensitivity focused interventions including parent–infant interaction guidance training for high-risk infants.	
• Manualized group based and one-to-one parenting programmes addressing behaviour management and parent–child relationships.	
2.4.25 health and social care provider home visiting programmes to 'at risk' families.	B

Long term benefits	
2.4.26 Promote parenting programmes that share an emphasis on active parental involvement and on developing skills in social competence, self-regulation and parenting to help prevent substance misuse in children <18 years.	B

This evidence review does not recommend:

Intervention	**Grade**
2.4.27 the role of parenting programmes in the primary prevention of mental health problems (there is currently insufficient evidence to reach any firm conclusions).	C
2.4.28 self-help for families that have additional risk factors, such as single parenthood, low income and maternal depression.	C
2.4.29 interventions promoting effective parenting in the transition to parenthood.	B
2.4.30 teaching parents problem solving; teaching parents to promote children's cognitive, academic, or social skills; and providing other additional services.	B
2.4.31 psychological debriefing after birth and universal approaches to prevention of postnatal depression.	B

2.6 Recommendations for interventions to reduce the number of young people entering the criminal justice system

This evidence review recommends:

Intervention	**Grade**
Parent-training or education	
Promote:	
2.6.1 group-based parent-training/education programmes in the management of children with conduct disorders.	A
2.6.3 behavioural and cognitive-behavioural group-based parenting interventions to improve child conduct problems, parental mental health and parenting skills in the short term (effective and cost-effective).	A

2.6.2 Ensure that all parent-training/education programmes	A
• are structured and have a curriculum informed by principles of social- learning theory;	
• include relationship-enhancing strategies;	
• offer a sufficient number of sessions, with an optimum of 8–12;	
• enable parents to identify their own parenting objectives;	
• incorporate role-play during sessions, as well as homework to be undertaken between sessions, to achieve generalisation of newly rehearsed behaviours to the home situation;	
• are delivered by appropriately trained and skilled facilitators who are supervised, have access to necessary ongoing professional development, and are able to engage in a productive therapeutic alliance with parents;	
• adhere to the programme developer’s manual and employ all of the necessary materials.	
Working with people with antisocial personality disorder	
Ensure:	
2.6.4 that when a diagnosis of antisocial personality disorder is made, the implications of it is discussed with the person, the family or carers where appropriate, and relevant staff.	A
• Acknowledge the issues around stigma and exclusion.	
• Emphasise that the diagnosis does not limit access to a range of appropriate treatments for comorbid mental health disorders.	
• Provide information on and clarify the respective roles of the healthcare, social care and criminal justice services.	
• Consider consulting with a relevant specialist.	
• Motivate them to attend and engage with treatment.	
• Establish regular one-to-one meetings to review progress.	
2.6.5 all staff working with people with antisocial personality disorder are familiar with the 'Ten essential shared capabilities: a framework for the whole of the mental health practice' and have a knowledge and awareness of antisocial personality disorder that facilitates effective working with service users, families or carers, and colleagues.	A
2.6.6 all staff have skills appropriate to the nature and level of contact with service users.	A
2.6.7 staff providing psychosocial or pharmacological interventions for the treatment or prevention of antisocial personality disorder are competent and properly qualified and supervised, and that they adhere closely to the structure and duration of the interventions as set out in the relevant treatment manuals.	A
2.6.8 staff supervision is built into the routine working of the service.	A
Continuity of health and social care	
Ensure:	
2.6.9 the disruption to therapeutic interventions is minimised for people with antisocial personality disorder by:	A
• initial planning and delivery of treatment, transfers from institutional to community settings take into account the need to continue treatment;	

• avoiding unnecessary transfer of care between institutions whenever possible during an intervention.	
2.6.10 people with antisocial personality disorder are not excluded from any health or social care service because of their diagnosis or history of antisocial or offending behaviour.	A
2.6.11 people with antisocial personality disorder are offered treatment for any comorbid disorders in line with recommendations in the relevant NICE clinical guideline, where available.	A
Family involvement interventions	
Ensure the person with antisocial personality disorder are asked directly if they want their family or carers to be involved in their care, and, subject to the person's consent and rights to confidentiality by:	A
• encouraging families or carers to be involved;	
• ensuring that the involvement of families or carers does not lead to a withdrawal of, or lack of access to, services;	
• informing families or carers about local support groups for families or carers.	
2.6.12 Ensure that when identifying vulnerable parents, care is taken not to intensify stigma associated with the intervention or increase the child's problems by labelling them as antisocial or problematic.	A
Working with people with conduct problems	
2.6.13 Promote cognitive problem-solving skills training for children aged 8 years and older with conduct problems if:	A
• the child's family is unwilling or unable to engage with a parent-training programme;	
• additional factors, such as callous and unemotional traits in the child, may reduce the likelihood of the child benefiting from parent-training programmes alone.	
2.6.14 Ensure social problem-solving skills training is conducted in groups over a period of 10–16 weeks. Training should focus typically on strategies to enable the child to:	A
• modify and expand their interpersonal appraisal processes;	
• develop a more sophisticated understanding of beliefs and desires in others;	
• improve their capacity to regulate their emotional responses.	
Child and adolescent mental health services	
2.6.15 Ensure child and adolescent mental health services establish robust methods to identify children at risk of developing conduct problems, integrated when possible with the established local assessment system. These should focus on identifying vulnerable parents including:	A
• parents with other mental health problems, or with significant drug or alcohol problems;	
• mothers younger than 18 years, particularly those with a history of maltreatment in childhood;	
• parents with a history of residential care;	
• parents with significant previous or current contact with the criminal justice system.	

Primary and secondary care services	
2.6.16 Ensure staff involved in the assessment of antisocial personality disorder in secondary and specialist services use structured assessment methods whenever possible to increase the validity of the assessment.	A
2.6.17 Promote tertiary-level interventions over primary- or secondary-level interventions to prevent youth violence.	B

Risk management strategy	
Ensure:	
2.6.18 when staff assess the risk of violence they take a detailed history of violence	A
2.6.19 staff consider a referral to forensic services where there is:	A
• current violence or threat that suggests immediate risk or disruption to the operation of the service;	
• a history of serious violence, including predatory offending or targeting of children or other vulnerable people.	
2.6.20 healthcare professionals in forensic or specialist personality disorder services consider, as part of a structured clinical assessment, routine use of a standardised measure of the severity of antisocial personality disorder and a formal assessment tool to develop a risk management strategy.	A
2.6.21 Probation services develop a comprehensive multi-agency risk management plan for people with antisocial personality disorder who are considered to be of high risk.	A

Interventions to support individuals with psychopathy or dangerous and severe personality disorder	
2.6.22 Consider cognitive and behavioural interventions to support individuals with psychopathy or dangerous and severe personality disorder.	A

Psychological interventions	
2.6.23 Support the provision of the following psychosocial Interventions for maladaptive aggression in youth:	A
• Provide or assist the family in obtaining evidence-based parent and child skills training during all phases of care.	
• Engage the child and family in taking an active role in implementing psychosocial strategies and help them to maintain consistency.	
• Initial medication treatment should target the underlying disorder(s).	
• When available, follow evidence-based guidelines for the primary disorder.	

Cognitive and behavioural interventions	
2.6.24 For individuals with antisocial personality disorder, including those with substance misuse problems, in community and mental health services, consider offering group-based cognitive and behavioural interventions, to address impulsivity problems, interpersonal difficulties and antisocial behaviour.	A
2.6.25 For young offenders aged 17 years or younger with a history of offending behaviour who are in institutional care, offer group-based cognitive and behavioural interventions aimed at young offenders and that are focused on reducing offending and other antisocial behaviour.	A

School-based interventions	
2.6.26 Promote universal school-based programs to prevent or reduce violent behaviour.	A

Inter-agency working	
2.6.27 Ensure that there are clear pathways for people with antisocial personality disorder.	A
2.6.28 Establish antisocial personality disorder networks, where possible linked to other personality disorder networks.	A

Nurse practitioner interventions	
2.6.29 Promote strategies already employed by nurse practitioners to promote the development of healthy families which can contribute greatly to reducing the problem of youth violence.	B

Multidimensional treatment foster care	
2.6.30 Promote multidimensional treatment foster care for young people aged between 12 and 17 years with conduct problems at risk of being placed in long-term out-of-home care.	A

This evidence review does not recommend:

Intervention	Grade
2.6.31 individual-based parent-training/education programmes in the management of children (aged 12 years or younger or with a developmental age of 12 years or younger) with conduct disorders.	A
2.6.32 additional interventions targeted specifically at the parents of children with conduct problems (such as interventions for parental, marital or interpersonal problems) alongside parent-training programmes.	A

2.7 Recommendations for interventions to improve outcomes for children in families supported by social care services

This evidence review recommends:

Intervention	Grade
Leadership and partnership	
2.7.1 Create strong leadership and strategic partnerships to develop a vision and a corporate parenting strategy that focuses on effective partnership and multi-agency working	A
Ensure:	
2.7.2 senior managers in partner agencies provide strong, visible leadership to raise aspirations and attainment, and promote joint working.	A
2.7.4 local strategic plans adhere to national guidance.	A
2.7.5 the joint strategic needs assessment process is a central component in assessing the needs of looked-after children and young people.	A

Plans and strategies	
2.7.6 Prioritise the needs of looked after children.	A
2.7.7 Create strong leadership and strategic partnerships to develop a vision and a corporate parenting strategy that addresses health and educational inequalities for looked-after children and young people.	A
2.7.8 Ensure local plans and strategies for children and young people's health and wellbeing fully reflect the needs of looked-after children, young people and care leavers.	A

Commissioners	
2.7.9 Encourage authorities to work together in local partnerships when commissioning services to offer greater choice and quality of services.	A
2.7.10 Commission services that enhance the quality of life of the child or young person by promoting and supporting their relationships with others.	A
2.7.12 Jointly commission services dedicated to promoting the mental health and emotional wellbeing of children and young people who are looked after or are moving to independent living.	A
Ensure services:	
2.7.11 dedicated to looked-after children and young people are integrated, preferably on the same site, and have expert resources to address physical and emotional health needs.	A
2.7.13 commissioned for looked-after children and young people are informed by: the views of children and young people; national evidence, guidance and performance data; the local corporate parenting strategy; local knowledge and experts; local audits; the joint strategic needs assessment; local plans and strategies for children and young people's health and wellbeing.	A

Regulation of services caring for children in families supported by social care services	
2.7.14 Regulate services by auditing, monitoring and inspecting local authorities, providers of health services and key partners to ensure local partnerships communicate effectively with one another.	A
2.7.15 Inspect services for care leavers and adopt the standards developed by the National Leaving Care Advisory Service.	A

Needs of children in families supported by social care services	
2.7.16 Support professional collaboration on complex casework including multi-agency team working.	A
2.7.17 Ensure services have local authority children's specialists, dedicated health and mental health professionals, and education specialists including experienced practitioners who are trained and supported to work with multi-agency networks on complex casework.	A

Needs of children and young people entering secure accommodation or custody	
Ensure:	
2.7.18 looked-after children and young people entering secure accommodation or custody have their physical, developmental and mental health needs assessed by a paediatrician, or suitably qualified professional with input from the dedicated multi-agency mental health service.	A
2.7.19 recommendations from assessments are included in the care plan or pathway plan.	A

Placing children	
2.7.20 Develop a strategy to identify suitable placements and interventions for looked-after children and young people.	A
2.7.21 Use current information to make decisions about placement changes.	A
Needs of babies and young children from families supported by social care services when making placements	
Ensure:	
2.7.22 there are specialist services for babies and young children.	A
2.7.23 comprehensive and sensitive assessment processes and access to services are in place to identify the needs of babies and young children as early as possible.	A
Information	
2.7.24 Assess the health needs of looked-after children and young people.	A
2.7.25 Introduce protocols that address information-sharing processes that include legal and confidentiality issues, to assist health information flows between health and social care.	A
2.7.26 Ensure that policies and activities are in place to allow each child or young person to explore their personal identity, including their life story.	A
2.7.27 Promote continued contact with former carers, siblings or family members personally valued by the child or young person where this is felt to be in their best interests.	A
Diversity	
2.7.28 Appoint a diversity champion and ensure everyone understands diversity issues. Provide all professionals and managers with specialist training, resources and access to expertise.	A
2.7.29 Network and share good practice with other local authorities with a similar profile of looked-after children and young people.	A
Needs of asylum-seeking children and young people who are looked after	
Provide:	
2.7.30 expertise relating to unaccompanied asylum-seeking children and young people who are looked after.	A
2.7.31 support and training to foster parents and residential staff to ensure they have a good understanding of the particular issues affecting unaccompanied asylum-seeking children and young people who are looked after.	A
Ensure staff receive high-quality, core training from trainers with specialist knowledge and expertise about the complex needs of children	
2.7.32 Ensure foster and residential carers receive high-quality, core training from trainers with specialist knowledge and expertise. Adapt the training to local needs.	A

2.7.33 Ensure foster carers and their families, including carers who are family or friends, receive high quality ongoing support packages that are based on the approach set out in the core training recommendation.	A
Looked-after children and young people who are in further and higher education.	
2.7.34 Support looked-after young people in further and higher education.	A
2.7.35 Involve designated teachers for looked-after children and young people.	A
Independent living	
2.7.36 Provide leaving-care services; supporting the preparation for the transition to adulthood and moving to independent living.	A
Kinship care for children and young people	
2.7.37 Support the practice of treating kinship care as a viable out-of-home placement option for children removed from the home for maltreatment.	B
Interventions to improve outcomes for visually impaired children	
2.7.38 Support families of newly diagnosed children with information, especially about educational and social services, and emotional support from professionals, informal and formal social networks, and support groups.	B
Pharmacotherapy interventions	
2.7.39 Support the best practice training guidelines for mental health in child welfare relating to pharmacotherapy.	B
2.7.40 Provide youth and families with ongoing information on the diagnosed mental health disorder, effective treatment options, and managing life with the condition.	B
Nurse family partnership interventions	
2.7.41 Consider promoting the Family Nurse Partnership.	C
Early prevention interventions	
2.7.42 Promote early prevention programs for families with young children at risk for physical child abuse and neglect.	C
Multicomponent parenting interventions	
2.7.43 Target parents and the parent-child interaction context in home-based settings during early childhood. Target families of higher risk children.	C

APPENDIX 3

ENABLING PEOPLE OF ALL AGES TO LIVE HEALTHY LIVES AND HAVE HEALTHY LIFESTYLES

The objective of this section is to make evidenced based recommendations that support commissioners with a robust basis for decision making.

Recommendations are based on evidence from systematic reviews and meta-analyses. Scoring of recommendations is based on the SIGN methodology as set out in Chapter 2. Recommendations graded ‘A’ are based on the highest quality evidence and those graded ‘D’ the lowest. These reviews were carried out at a specific point in time and we acknowledge there are further caveats commissioners must take into consideration:

- NICE guidance is being updated on a continuous cycle, and some of the evidence presented here may not have been reviewed by NICE at this time. Commissioners need to ensure interventions do not conflict with current NICE guidance.

- East Sussex CCGs operate a ‘Low Priorities Procedures’ process. Whereby some procedures are not ordinarily commissioned and requests for treatment are referred to an ‘individual treatment panel’. It is important to recognise that the agreed processes should be followed for these interventions.

- Locally, new pathways to treatment for patients for a wide range of conditions are being developed by GPs, commissioners and secondary care clinicians. It is important to ensure agreed treatment pathways are followed.

It is recommended that commissioners review the entire evidence base set out in the evidence review for this priority area, but that service planning focuses on those issues highlighted by this recommendations section.

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2.2 Recommendations for interventions to reduce the number of young people/adults drinking alcohol at a high risk level

This evidence review recommends:

Intervention		**Grade**
2.2.1	Commissioners should maintain and develop partnerships to monitor and evaluate alcohol reduction partnership working and incorporate good practice into planning.	A
2.2.3	Include formal evaluation within the commissioning framework so that alcohol interventions and treatment are routinely evaluated and followed up.	A
Ensure:		
2.2.2	a local joint alcohol needs assessment is carried out in accordance with 'World Class Commissioning' and ' Signs for improvement', that locally defined integrated care pathways for alcohol treatment are reviewed.	A
2.2.4	alcohol education is tailored for different age groups and takes different learning needs into account.	A
2.2.13	there are appropriate referral systems to specialist treatment for anyone who is dependent on alcohol.	A
2.2.14	there are sufficient resources to ensure all alcohol intervention providers have appropriately trained professionals who can provide strategic direction, governance structures and supervision to those providing screening and brief interventions for alcohol reduction.	A
2.2.19	there are appropriate referral pathways to child and adolescent mental health services, social care or to young people's alcohol services for treatment, as appropriate and available. For young people at a significant risk of alcohol-related harm, consider referral.	A
2.2.5	education programmes to reduce the number of young people drinking alcohol at a high risk level are integrated into to the school curriculum and knowledge attitudes and skills training included.	A B
Promote:		
2.2.6	education programmes that begin early in childhood; combine a school-based curriculum intervention with parent education, which target a range of problem behaviours including alcohol use.	A
2.2.7	partnerships to support alcohol education in schools as part of the education curricula. Engage with parents, children and young people about initiatives to reduce alcohol use and to involve them in those initiatives.	A
2.2.8	a 'whole school' approach to alcohol, in line with DCSF guidance. It should involve staff, parents and pupils and cover everything from policy development and the school environment to the professional development of staff.	A
2.2.10	brief interventions delivered by appropriately trained staff to children and young people in schools who are thought to be drinking harmful amounts of alcohol and/or make a direct referral to external services.	A
2.2.11	brief interventions with the adolescent and a parent.	B
2.2.16	audit in primary care to identify hazardous and harmful drinking.	B
2.2.17	alcohol screening as an integral part of practice. Where screening everyone is not feasible or practicable, NHS professionals should focus on groups that may be at an increased risk of harm from alcohol.	A
2.2.18	alcohol screening questions that are sensitive to people's culture and faith and tailored to their needs.	A

2.2.9	Follow best practice on child protection, consent and confidentiality. Where appropriate, involve parents or carers in the consultation and any referral to external services for children and young people in schools who are thought to be drinking harmful amounts of alcohol.	A
Consider:		
2.2.12	delivering brief interventions to heavy alcohol users admitted to general hospital wards.	A B
2.2.15	providing E-self-help alcohol awareness/reduction interventions without professional contact.	B
2.2.20	reviewing policies on pricing to reduce the affordability of alcohol.	A

This evidence review does not recommend:

Intervention		**Grade**
2.2.21	intensive brief interventions over less intensive interventions.	B
2.2.22	longer counselling over brief intervention.	B

2.3 Recommendations for interventions to lower rates of smoking amongst young people/adults

This evidence review recommends:

Intervention		**Grade**
2.3.1	Review of smoking cessation policies and practices at strategic and provider level.	A
Ensure:		
2.3.2	smoking cessation advice and support is available in community, primary and secondary care settings for everyone who smokes.	A
2.3.5	health professionals have monitoring systems set up to ensure they have access to information on the current smoking status of their patients.	A
2.3.6	all those offering smoking cessation services are offering one or more interventions that have been proven to be effective.	A
2.3.8	smoking cessation support and treatment is delivered only by staff who have received training that complies with the 'Standards for Training in Smoking Cessation Treatments'.	A
2.3.11	all health professions have access to smoking cessation training.	A
2.3.3	local policy makers and commissioners should target hard to reach and deprived communities including minority ethnic groups, paying particular attention to their needs.	A
2.3.4	reduction interventions can be carried out using self-help materials or aided by behavioural support, and can be carried out with the aid of pre-quit NRT.	A
Promote:		
2.3.7	interventions that offer either advice to stop smoking or assistance with stopping, including text messaging.	A
2.3.12	high intensity behavioural interventions in conjunction with nicotine replacement therapy that begins during a hospital stay and includes	A

	at least one month of supportive contact after discharge.	
2.3.14	interventions that combine pharmacotherapy and behavioural support.	A
2.3.15	intervening with older smokers.	B
Encourage:		
2.3.9	primary care professionals to advise all patients who smoke to quit when they attend a consultation. Those who want to stop should be offered a referral to an intensive support service. If they are unwilling or unable to accept this referral they should be offered pharmacotherapy in line with NICE guidance.	A
2.3.10	other health professionals, such as hospital clinicians, pharmacists and dentists and community workers to refer people who smoke to an intensive support service.	A
2.3.13	employers to develop a smoking cessation policy in collaboration with staff and their representatives as one element of an overall smoke-free workplace policy	A

This evidence review does not recommend:

Intervention		**Grade**
2.3.16	There is not strong evidence from indirect comparisons that offering more intensive behavioural support was associated with larger treatment effects.	A

2.4 Recommendations for interventions to support primary prevention of smoking in children/ young adults

This evidence review recommends:

Intervention		**Grade**
Ensure:		
2.4.1	smoking prevention interventions in schools and other educational establishments are part of a local tobacco control strategy.	A
2.4.2	schools and other educational establishments deliver evidence-based smoking prevention interventions.	A
2.4.10	interventions to prevent the uptake of smoking as part of PSHE are linked to the whole-school or organisation-wide smoke-free policy and involve children and young people in their design.	A
2.4.11	head teachers, school governors, public health commissioners, teacher training bodies and providers of continuing professional development work in partnership and provide training for all staff who will be involved in smoking prevention work.	A
2.4.4	interventions are integrated into the curriculum, PSHE education and work associated with healthy further education and healthy schools status.	A
Promote:		
2.4.3	smoke free policies consistent with regional and national tobacco control strategies.	A
2.4.8	interventions that are culturally sensitive and begun in early adolescence when susceptibility to smoking is highest.	C

2.4.13	national, regional or local mass-media campaigns to prevent the uptake of smoking among young people under 18.	A
2.4.16	community multi-sectorial interventions to reduce smoking rates among children and youth.	B

2.4.5	Work with local partners involved in smoking prevention and cessation activities to deliver interventions.	A
Local authorities and trading standards bodies:		
2.4.6	should work with other agencies to identify areas where under-age tobacco sales are a particular problem.	A
2.4.7	should ensure retailers are aware of legislation prohibiting under-age tobacco sales and support better enforcement of existing tobacco sales legislation and ensure enforcement efforts are sustained.	A
Encourage:		
2.4.9	head teachers, school governors, teachers, support staff and others who work with primary and secondary schools and further education colleges to develop a whole-school or organisation-wide smoke free policy in consultation with young people and staff.	A
2.4.12	parents and carers to become involved, in school based smoking prevention initiatives.	A
2.4.14	Effective practice, including effective local and regional media messages, should be shared locally, regionally and nationally.	A
2.4.15	Use process and outcome measures to ensure campaigns are being delivered correctly and effectively.	A

This evidence review does not recommend:

Intervention		**Grade**
2.4.17	Media campaigns delivered in conjunction with or supported by the tobacco industry.	A

2.5 Recommendations for interventions to support people to change behaviour

This evidence review recommends:

Intervention		**Grade**
2.5.1	Deliver population-level policies, interventions and programmes tailored to change specific, health-related behaviours. These should be based on information gathered about the context, needs and behaviours of the target population.	A
Ensure:		
2.5.2	population-level interventions and programmes aiming to change behaviour are consistent with those delivered to individuals and communities.	A
2.5.5	fair and equitable access to education and training, to enable practitioners and volunteers who help people to change their health-related behaviour to develop their skills and competencies.	A
2.5.8	that, wherever possible, the following elements of behaviour change interventions and programmes are evaluated using appropriate process or outcome measures: effectiveness; acceptability; feasibility; equity and safety.	A
2.5.2	population-level interventions and programmes aiming to change behaviour are consistent with those delivered to individuals and communities.	A

2.5.3	Work in partnership with individuals, communities, organisations and populations to plan interventions and programmes to change health-related behaviour.	A
2.5.4	Provide training and support for those involved in changing people's health-related behaviour so that they can develop the full range of competencies required.	A
2.5.6	Equip practitioners with the necessary competencies and skills to support behaviour change, using evidence-based tools.	A
2.5.7	Evaluate all behaviour change interventions and programmes, either locally or as part of a larger project. Wherever possible, evaluation should include an economic component.	A
2.5.9	Promote health behaviours that include physician advice or individual counselling, and workplace and school-based activities.	A
2.5.10	Consider mass media campaigns and legislative interventions to promote changing health behaviours.	A
2.5.11	Take into account the local and national context and working in partnership with recipients when planning interventions and programmes aimed at changing behaviour.	A
Prioritise behaviour change interventions and programmes:		
2.5.12	developed in collaboration with the target population, community or group and take account of lay wisdom about barriers and change.	A
2.5.13	using key life stages or times when people are more likely to be open to change such as pregnancy, starting or leaving school and entering or leaving the workforce.	A

2.6 Recommendations for interventions to promote physical activity

This evidence review recommends:

Intervention		**Grade**
Ensure:		
2.6.1	the joint strategic needs assessment, the joint health and wellbeing strategy and other local needs assessments and strategies take into account opportunities to increase walking and cycling and also consider how impediments to walking and cycling can be addressed.	A
2.6.6	walking and cycling projects are evaluated, including their impact on health inequalities.	A
Promote:		
2.6.2	coordinated, cross-sector working and ensure NICE's recommendations on physical activity and the environment are implemented.	A
2.6.3	multi-component physical activity school and community programmes for children and young people.	A B
2.6.4	physical activity sessions for children and young people are led by staff or volunteers who have achieved the relevant sector standards/ qualifications for working with children and have the skills to design, plan and deliver sessions.	A
2.6.13	community based interventions in increasing physical activity in socio-economically disadvantaged communities.	B
2.6.8	an exercise referral scheme that directs someone to a service offering an assessment of need, development of a tailored physical activity programme, monitoring of progress and a follow-up.	A

2.6.5	Offer high level support from the health sector for walking and cycling.	A
2.6.7	Address the needs of hard to reach and disadvantaged communities, including minority ethnic groups, when developing service infrastructures to promote physical activity.	A
Commissioners:		
2.6.9	work with public health to foster an integrated approach to local commissioning that supports a long term system-wide health and wellbeing strategy.	A
2.6.10	fund both targeted and universal services that can help people achieve or maintain a healthy weight.	A
2.6.11	introduce and monitor an organisation-wide programme that encourages and supports staff and, where appropriate, service users, to be physically active.	A
2.6.12	raise awareness of the importance of physical activity for children and young people that includes: ensuring there is a coordinated local strategy; ensuring physical activity initiatives aimed at children and young people are regularly evaluated; identifying a senior council member to be a champion for children and young people's physical activity.	A

2.7 Recommendations for interventions to promote healthy eating

This evidence review recommends:
Commissioners

Intervention		**Grade**
2.7.1	Focus on all of the following areas:	A
	• raising awareness of the health problems caused by obesity and the benefits of being a healthier weight;	
	• training to meet the needs of staff and volunteers;	
	• influencing the wider determinants of health;	
	• aiming activities at both adults and children in a broad range of settings;	
	• providing lifestyle weight management services for adults, children and families;	
	• providing clinical services for treating obesity.	
2.7.2	Working with public health teams to foster an integrated approach to local commissioning supporting a long-term (beyond 5 years) system-wide health and wellbeing strategy.	A
2.7.8	Ensure all monitoring and evaluation considers the impact of strategies, policies and activities on inequalities in obesity and related health issues.	A
2.7.5	Preventing and managing obesity is a priority for action, at both strategic and delivery levels, through community interventions, policies and objectives.	A
2.7.6	Engage with the local community, to identify environmental barriers to physical activity and healthy eating.	A

Strategic leadership

Intervention		Grade
2.7.3	Ensure through the health and wellbeing board a coherent, community-wide, multi-agency approach is in place to address obesity prevention and management. Activities should be integrated within the joint health and wellbeing strategy and broader regeneration and environmental strategies.	A
2.7.4	Health and wellbeing boards, supported by directors of public health, should ensure JSNAs address the prevention and management of obesity. They should ensure JSNAs consider the full range of factors that may influence weight, consider inequalities and the social determinants of obesity, consider local evidence on obesity.	A
2.7.7	Public health teams should ensure commissioners understand the demographics of their local area, and consider local insight on the motivations and characteristics of subgroups within local communities that may impact on obesity levels.	A
2.7.9	Consider extending effective programmes or services, recommissioning effective small-scale projects and commissioning small-scale projects or prototypes that fill a gap in provision.	A

APPENDIX 4

PREVENTING AND REDUCING FALLS, ACCIDENTS AND INJURIES

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- Locally, new pathways to treatment for patients for a wide range of conditions are being developed by GPs, commissioners and secondary care clinicians. It is important to ensure agreed treatment pathways are followed.

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2.2 Interventions to prevent falls, accidents and injuries amongst children and young people

Intervention		Grade
2.2.1	Incorporate unintentional injury prevention into local strategies and policies.	A
Establish:		
2.2.2	robust local strategies and policies to prevent falls accidents and injuries amongst children and young people.	A
2.2.3	partnership working across a range of organisations.	A
2.2.4	high quality professional and voluntary staff training including establishing reliable communication pathways.	A
2.2.5	Identify households at risk, prioritising households at greatest risk for home safety assessments, supply and installation of home safety equipment.	A
Ensure:		
2.2.6	home visits to conduct safety assessments include the installation of the necessary safety equipment.	A
2.2.8	community engagement, education and involvement to prevent falls, accidents and injuries amongst children and young people.	A
2.2.9	professionals and facilitators who have on-going relationships with families are encouraged to deliver safety home safety messages.	A
2.2.7	Include home safety education, with the provision of safety equipment. Interventions providing free or low cost home safety equipment and free installation are more effective.	A
2.2.10	Target interventions to high risk populations to optimise cost-effectiveness.	D

This evidence review does not recommend:

Intervention		Grade
2.2.11	home safety interventions varied by social group.	B
2.2.12	intervention features found to be barriers related to home injury prevention interventions for pre-school children (5 years and under) include: complex interventions, cultural, socio-economic, physical and behavioural barriers and deliverer constraints.	B

Recommendations for interventions to prevent falls, accidents and injuries (adults)

Intervention		Grade
Promote:		
2.3.1	physical activity interventions.	B
2.3.4	exercise programmes to prevent self-reported back problems in working age adults.	A
2.3.2	alcohol reduction initiatives to prevent falls.	B
2.3.3	the use of mouth guards among previously injured athletes (adolescents and adults, elite and recreational players) and consider promoting ankle braces to prevent further injuries (adults).	B B

This evidence review does not recommend:

Intervention		Grade
2.3.5	injury prevention interventions.	C
2.3.6	the following programmes in preventing self-reported back problems for working age adults: education alone; shoe inserts, and programs for reducing lifting.	A

Recommendations for interventions to prevent falls, accidents and injuries (elderly)

This evidence review recommends:

Intervention		Grade
Multi-factorial:		
2.4.1	risk assessments for elderly people with recurrent falls, including medication review.	A
2.4.2	interventions should be offered to high risk elderly people groups following treatment for falls.	A B B
2.4.3	Elderly people who have received treatment in hospital following a fall should be offered a home hazard assessment and safety intervention/modifications in conjunction with follow-up.	A A
2.4.4	Falls prevention programmes for elderly people living in the community, including home-based exercise programmes.	A A
2.4.5	Consider promoting Vitamin D supplements to elderly patients at risk.	A B B B
2.4.6	Health professionals should be encouraged to routinely ask elderly people whether they have fallen in the past year.	A
2.4.7	Individuals at risk of falling, and their carers, should be offered information orally and in writing.	A
2.4.8	All healthcare professionals dealing with patients known to be at risk of falling should develop and maintain basic professional competence in falls assessment and prevention.	A
2.4.9	Single interventions (such as the Otago Exercise Programme) targeted at high-risk groups can prevent the greatest number of falls at the lowest incremental costs.	B

Integration of services to manage falls, accidents and injuries (elderly)

This evidence review recommends:

Intervention		Grade
2.5.1	elderly patients with hip fractures should be offered an integrated multidisciplinary rehabilitation program specifically designed with the specific aim of regaining sufficient function to return to their pre-fracture living arrangements.	A B
	Include early integrated multidisciplinary care for:	
2.5.2	daily geriatric care to reduce hospital mortality and medical complications in elderly patients with hip fractures.	A B
2.5.3	early integrated multidisciplinary care specifically designed for geriatric patients during hospital admission.	A B
2.5.4	Integrate hip-fracture care pathways.	B
Promote:		
2.5.5	integrated early mobilisation, early discharge and on-going home-based rehabilitation.	A B B
2.5.6	integrated extended outpatient rehabilitation for elderly patients with hip fracture.	A
2.5.7	education interventions to prevent future falls, exercise and balance training in ambulatory patients, and the education and treatment of osteoporosis as secondary prevention strategies for hip fracture.	B B
2.5.8	Appoint a dedicated coordinator to promote prevention, support the integration of the multidisciplinary team and to act as the link between the patient and medical teams.	B B
2.5.9	Coordinator-based systems to facilitate bone mineral density testing, osteoporosis education and care in patients following a fragility fracture.	B
2.5.10	Ensure fragility fractures are monitored by utilising an access fracture registry and a database.	B

Interventions to prevent road traffic injuries

Intervention		Grade
2.6.1	Coordinated partnership working between health professionals, school staff, police and local highways authorities to promote changes to the road environment to prevent road traffic injuries.	A
2.6.2	Ensure pedestrians, cyclists and users of other modes of transport that involve physical activity are given priority when developing or maintaining streets and roads i.e. reallocating road space; restricting motor vehicle access; introducing traffic-calming; creating safe routes to schools; supporting the modification of the built environment.	A A
2.6.3	Authorities should work with other partners to introduce engineering measures to reduce speed as part of a broad strategy to prevent	A

	injuries and the risk of injuries.	B
2.6.6	Review data regarding attendances at emergency departments and minor injuries units to prevent unintentional injuries among the under-15s.	B
2.6.7	Implement multi-component prevention programs in conjunction with community mobilization to reduce alcohol-related crashes.	B
2.6.9	Support well-executed mass media campaigns to promote reduction in alcohol impaired driving and alcohol-related crashes.	B
Promote:		
2.6.4	purpose-built bicycle only facilities (e.g. bike routes, bike lanes, bike paths, cycle tracks at roundabouts) to reduce the risk of crashes and injuries.	A
2.6.5	unintentional injury prevention activities aimed at people under the age of 15.	B B
2.6.8	adequate street lighting and high visibility safety clothing and equipment to improve detection and recognition for cyclists and walkers.	B B
2.6.12	cycle helmet education interventions in schools and healthcare centres to young and older children.	A
2.6.10	education to parents and carers of young children to ensure they use car seats or booster seats appropriate to the child’s age and height and weight.	B

This evidence review does not recommend

Intervention		Grade
2.6.13	Guard rails, crash cushions, and interventions to reduce vehicle speeds.	B

APPENDIX 5

ENABLING PEOPLE TO MANAGE AND MAINTAIN THEIR MENTAL HEALTH AND WELLBEING

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2.2 Recommendations for interventions to promote early identification, diagnosis, support and treatment of mental health conditions (all ages)

This evidence review recommends:

Intervention		**Grade**
Identification and assessment		
Ensure:		
2.2.1	when assessing a person with a suspected common mental health disorder, staff consider using:	A
	• a diagnostic or problem identification tool or algorithm;	
	• a validated measure relevant to the disorder or problem being assessed.	
2.2.2	if identification questions indicate a possible common mental health disorder, a practitioner who is competent to perform a mental health assessment reviews the person's mental state and associated functional, interpersonal and social difficulties.	A
2.2.3	when working with people with significant language or communication difficulties staff consider using the Distress Thermometer and/or ask a family member or carer about the person's symptoms to identify a possible common mental health disorder.	A
2.2.4	all staff carrying out assessment of suspected common mental health disorders are competent to perform an assessment of the presenting problem in line with the service setting in which they work.	A
2.2.5	if the presentation and history of a common mental health disorder is of recent onset it is suggested that it may be mild and self-limiting and consider providing psycho-education and active monitoring before providing or referring for further assessment or treatment.	A
Treatment		
2.2.11	Promote the following evidence based interventions:	B
	• assertive community treatment for people with severe mental disorders;	
	• crisis intervention for people with severe mental illnesses;	
	• music therapy for schizophrenia or schizophrenia-like illnesses;	
	• psycho-education for schizophrenia.	
Ensure:		
2.2.6	when discussing treatment options with a person with a common mental health disorder the wider factors that may impact on the treatment options are considered.	A
2.2.7	additional supportive information is provided when discussing treatment options for people with a common mental health disorder.	A
2.2.8	staff take account of patient preference when choosing evidence-based treatments.	A
2.2.9	staff follow the stepped-care approach, usually offering or referring for the least intrusive, most effective intervention first.	A
2.2.10	if a person with a common mental health disorder needs social, educational or vocational support, staff consider: informing them about self-help groups, or support groups and other local and national resources, or befriending or a rehabilitation programme or educational and employment support services	A
2.2.6	when discussing treatment options with a person with a common mental health disorder, the wider factors that may impact on the	A

	treatment options are considered.	
Treatment - anxiety and depression symptoms		
2.2.12	Ensure that people with persistent sub-threshold depressive symptoms are offered one or more low-intensity interventions.	A
Promote:		
2.2.13	primary care depression screening and care management programs with staff assistance, such as case management or mental health specialist involvement, to increase depression response and remission.	B
2.2.14	close monitoring of all adult patients who initiate antidepressant treatment, particularly those younger than 30 years, to ensure optimal treatment and improved safety.	B
Treatment - learning disability		
2.2.15	Ensure that for people with a common mental health disorder and a mild learning disability or mild cognitive impairment, are where possible, referred for the same interventions relevant to people with the same common mental health disorder.	A
Developing local care pathways		
Ensure:		
2.2.16	managers and commissioners collaborate to develop local care pathways that promote access to services for people with common mental health disorders.	A
2.2.17	local care pathways are developed to promote implementation of key principles of good care.	A
2.2.18	that the development, management and evaluation of local care pathways lies with a designated leadership team, which should include primary and secondary care clinicians, managers and commissioners.	A
2.2.22	that the local care pathway has protocols for users with other professionals (including GPs) including:	A
	• sharing and communicating information with people with common mental health disorders, and where appropriate families and carers, about their care;	
	• sharing and communicating information about the care of service;	
	• communicating information between the services provided within the pathway;	
	• communicating information to services outside the pathway.	
2.2.23	local care pathways have robust systems for outcome measurement in place, which should be used to inform all involved in a pathway about its effectiveness. Ensure information is provided about mental health services and interventions that constitute the local care pathway.	A
Promote:		
2.2.19	local care pathways with a stepped-care model of service delivery.	A
2.2.20	pathways that offer prompt assessments and interventions that are appropriately adapted to the cultural, gender, age and communication needs of people with common mental health disorders and keep to a minimum the number of assessments needed	A

	to access interventions.	
2.2.21	pathways that minimise the need for transition between different services or providers, allowing services to be built around the pathway not the pathway around the services.	A
Access and uptake of services		
2.2.24	Promote access to services and increase the uptake of interventions by:	A
	• ensuring systems are in place to provide for the overall coordination and continuity of care of people with common mental health disorders.	
	• designating a healthcare professional to oversee the whole period of care (usually a GP in primary care settings).	
2.2.25	Ensure services for people with common mental health disorders are provided in a variety of settings and use an assessment of local needs as a basis for the structure and distribution of services.	A
2.2.26	Provide all information about mental health services in a range of languages and formats (visual, verbal and aural) and ensure that it is available from a range of settings throughout the whole community.	A
Older adults with mental health conditions		
Promote:		
2.2.27	psychosocial interventions for older adults to improve quality of life and positive mental health	B
2.2.28	social activities interventions to improve positive mental health, life satisfaction and quality of life and reduce depressive symptoms.	B
2.2.29	interventions lasting more than three months over shorter interventions.	B
2.2.30	Consider meaningful social activities, tailored to the older individual's abilities and preferences	B
High risk people with mental health conditions		
2.2.31	Ensure assessors of mental health disorders always ask people directly about suicidal ideation and intent. If there is a risk of self-harm or suicide:	A
	• assess whether the person has adequate social support and is aware of sources of help;	
	• arrange help appropriate to the level of risk;	
	• advise the person to seek further help if the situation deteriorates;	
	• ensure that if a person with a common mental health disorder, in particular depression, is assessed to be at risk of suicide	
	then take into account toxicity in overdose, if a drug is prescribed, and potential interaction with other prescribed medication; if necessary, limit the amount of drug(s) available;	
	• consider increasing the level of support, such as more frequent direct or telephone contacts;	
	• consider referral to specialist mental health services.	
2.2.39	Ensure, if a person with a common mental health disorder presents considerable and immediate risk to themselves or others, they	A

	are referred urgently to emergency services or specialist mental health services.	

Psychosis with mental health conditions		
Promote		
2.2.40	early intervention services over standard care for people with early psychosis.	B
2.2.41	family interventions services for people with early psychosis.	B

School interventions for people with mental health conditions		
2.2.42	Promote school based interventions with the following characteristics:	B
	• teaching skills focusing on positive mental health;	
	• balancing universal and targeted approaches;	
	• starting early with the youngest children and continuing with older ones;	
	• operating for a lengthy period of time and embedding work within a multi-model/whole-school approach.	
2.2.43	Ensure school based interventions are completely and accurately implemented.	B

This evidence review does not recommend:

	Intervention	**Grade**
2.2.44	routine antidepressants for people with persistent sub threshold depressive symptoms or mild depression,	A
2.2.45	depression screening programs without substantial staff-assisted depression care supports.	B

2.3 Recommendations for interventions to promote community based mental-health services and support (all ages)

This evidence review recommends:

Intervention		**Grade**
Community treatment Interventions		
Promote		
2.3.1	community mental health team management over non-team standard care.	B
2.3.4	interventions to aid adults with serious mental illness in community integration and normative life roles, such as:	B
	• social skills training;	
	• life skills and instrumental activities of daily living training;	
	• neurocognitive training paired with skills training in the areas of work;	
	• social participation, and instrumental activities of daily living;	
	• client-centred interventions.	
2.3.2	For assertive community treatment, promote community treatment that uses a team approach with small case loads.	B

Intensive case management interventions		
Promote intensive case management:		
2.3.5	interventions to improve outcomes for people with severe mental illnesses.	A
2.3.7	for people with severe mental illnesses who are in the sub-group of those with a high level of hospitalisation (about 4 days/month in past 2 years).	A
2.3.6	over standard care to reduce hospitalisation, increase retention in care and Improve social functioning.	A
Collaborative care interventions		
Promote collaborative care:		
2.3.8	for adult patients with depression and anxiety.	A
2.3.10	interventions providing a supportive network of professionals and peers for patients with depression, especially at the primary care level.	A
Crisis interventions		
Promote care based on crisis intervention:		
2.3.11	with or without an ongoing home care package to treat people with serious mental illnesses.	B
2.3.12	based on crisis intervention principles over standard care.	B
Outreach interventions		
2.3.13	Promote multidisciplinary working within assertive outreach services.	B
2.3.14	Ensure practitioners within assertive outreach services receive sufficient training and managerial and clinical supervision.	B
Low-income urban youth		
Promote:		
2.3.15	community-based mental health and behavioural interventions that focus on the environment for low-income urban youth.	B
2.3.16	programs that focus on the youth plus one or more environmental targets or environmental targets alone.	B

This evidence review does not recommend:

	Intervention	**Grade**
2.3.17	compulsory community treatment.	B
2.3.18	youth only interventions in community-based mental health; and Behavioural programs for low-Income urban youth.	B

2.4 Recommendations for interventions to promote utilisation of comprehensive care plans for people with severe mental health needs (all ages)

This evidence review recommends:

	Intervention	Grade
Collaborative care interventions		
2.4.1	Collaborative care system to include:	A
	• collaboration between a GP and at least one other healthcare professional;	
	• the use of a structured management protocol or guidelines;	
	• scheduling regular follow-up appointments;	
	• a system or mechanism to facilitate and enhance inter-professional communication regarding the care plan.	
2.4.2	Collaborative chronic care models across a wide variety of care settings to provide a robust clinical and policy framework for care integration and to improve mental and physical outcomes for individuals with mental disorder.	B
Organisational structure and strategy interventions		
2.4.3	Ensure organisational structures and strategies, such as rewards systems, are aligned to allow teams to function and training is provided to enable healthcare professionals to gain the knowledge and skills required for effective team working.	B
Patient self-care interventions		
Ensure:		
2.4.4	clear, comprehensible information and support for self care in adult mental health is provided.	A
2.4.5	needs-oriented continuity of care is provided for people with mental illness.	B
2.4.6	personal continuity of care is provided to avoid fragmented therapeutic relationships in complex mental health care provision.	B
Health Professional interventions		
2.4.7	Ensure health professionals review the needs of families and carers and offer an assessment of their caring, physical and mental health needs if one has not been offered previously.	A
2.4.8	Promote practice-based inter-professional collaboration (IPC) interventions to improve healthcare processes and outcomes	B
Care and crisis plans		
Ensure service users:		
2.4.9	are fully involved and active in the design and delivery of care plans, and that any documents created in collaboration are signed by the health and social care professionals and service users. A copy of the care plan should be provided for the service user and a review date should be agreed.	A

2.4.10	who may be at risk of crisis are offered a crisis plan. The crisis plan should be developed by the service user and their care coordinator, which should be respected and implemented, and incorporated into the care plan. The crisis plan should include:	A
	• possible early warning signs of a crisis and coping strategies;	
	• support available to help prevent hospitalisation;	
	• where the person would like to be admitted in the event of hospitalisation;	
	• the practical needs of the service user if they are admitted to hospital;	
	• details of advance statements and advance decisions;	
	• whether and the degree to which families or carers are involved;	
	• information about 24-hour access to services and named contacts;	
	• named contacts.	
2.4.11	routinely have access to their care plan and care record, including electronic versions. Care records should contain a section in which the service user can document their views and preferences, and any differences of opinion with health and social care professionals.	A
2.4.12	help to develop any advance statements and advance decisions for their care plans and that copies of the care plan are held by the service user and in primary and secondary care records.	A
2.4.13	are provided with effective and empathic packages of care and that they offer informal means of communication as well as formal interventions to assist and encourage families.	B
Ensure:		
2.4.14	health professionals get adequate training to work with informal carers and in particular with culturally diverse families.	B.
2.4.15	families are included in treatment and decision-making.	B
2.4.16	Promote a covenant between mental health services and the people who depend on services, to clarify what professionals and others expect of family carers in respect of their relative, with a starting point being that carers give ongoing support, and practitioners engage supportively and empathetically with carers.	B
Mental health services interventions		
Ensure:		
2.4.17	mental health service providers strive to involve family carers in the construction and provision of services and make it easier to access these services.	B
2.4.18	clear principles are published to guide information sharing between mental health services and carers that take account of confidentiality, consent and the needs of family carers.	B
2.4.19	Promote the implementation of discharge interventions in mental health care to reduce hospital stays and improve patient's adherence to aftercare as well as symptomatic impairment.	B

Primary care interventions		
2.4.20	Promote the following interventions in primary care settings:	B
	• collaborative mental health care for case review meetings in primary care settings;	
	• regular review of mutual patients by primary care staff and visiting psychiatrist;	
	• coordination of all care planning and management by occupational therapists;	
	• collaboration of primary care staff with accommodation staff .	
Community care interventions		
2.4.21	Use diverse media to communicate with community care service users, including letters, phone calls, emails or text messages according to the service user’s preference.	A
2.4.22	Ensure that care plans are developed jointly with community care service user, and include activities that:	A
	• address social inclusion such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants;	
	• provide support to help the service users realise the plan;	
	• provide the service user with an up-to-date written copy of the care plan, and agree a suitable time to review it.	
Depression		
Ensure:		
2.4.23	people with depression have the option to develop advance decisions and advance statements for their care plan and copies of the care plan are placed in primary and secondary care records along with copies given to the person and to their family or carer, if the person agrees.	A
2.4.25	teams working with people with depression develop comprehensive multidisciplinary care plans in collaboration with the individual with depression (and their family or carer with permission). The care plan should: identify clearly the roles and responsibilities of all health and social care professionals involved; develop a crisis plan that identifies potential triggers that could lead to a crisis and strategies to manage such triggers; be shared with the GP and the person with depression and other relevant people involved in the person's care.	A
Promote:		
2.4.27	care management with the following features: patient education and self-management; monitoring of depressive symptoms and treatment adherence; decision support for medication management; a patient registry and mental health supervision of care managers.	B
2.4.28	collaborative care interventions for depression in older people.	B
Children and young people with depression		
Ensure:		

2.4.29	that children and young people with depression have the opportunity to make informed decisions about their care and treatment following the Department of Health's reference guide to consent for examination or treatment (2001).	A
2.4.30	unless specifically excluded by the child or young person, parent(s) or carer(s) have the opportunity to be involved in decisions about the child or young person's care and treatment. The parent(s) and carer(s) should also be provided with the information and support they need.	A
2.4.31	information is provided to the patient and their parent(s) and carer(s) at an appropriate time and age-appropriate manor.	A
2.4.32	healthcare professionals involved in the treatment of children or young people with depression take time to build a supportive and collaborative relationship with both the patient and the family or carers.	A
2.4.33	healthcare professionals make all efforts necessary to engage the child or young person and their parent(s) or carer(s) in treatment decisions to enable meaningful and properly informed consent before treatment is initiated.	A
2.4.34	families and carers are informed of self-help groups and support groups and are encouraged to participate in such programmes where appropriate.	A
Psychosis and substance misuse		
Ensure:		
2.4.35	written and verbal information is offered to families, carers or significant others appropriate to their level of understanding about the nature and treatment of psychosis and substance misuse, including how they can help to support the person. Written information should be available in the appropriate language or, for those who cannot use written text, in an accessible format (audio or video).	A
2.4.36	advance decisions and advance statements are honoured wherever possible.	A
2.4.37	healthcare professionals in primary care and secondary care mental health services, and in specialist substance misuse services, work collaboratively with voluntary sector organisations.	A
2.4.38	protocols are developed between organisations for routine and crisis care.	A
2.4.39	when healthcare professionals asses adults and young people with psychosis and coexisting substance misuse, they seek corroborative evidence from families, carers or significant others where this is possible and permission is given to review any changes in the person's use of substances. This should include changes in: the way the use of substances affects the person over time, patterns of use, mental and physical state, circumstances and treatment. Share the summary with the person and record it in their care plan.	A
2.4.41	adults and young people with psychosis and coexisting substance misuse are offered evidence-based treatments for both conditions.	A
2.4.42	That when people with psychosis and coexisting substance misuse are discharged from an inpatient mental health service, that they have:	A
	• an identified care coordinator;	
	• a care plan that includes a consideration of needs associated with both their psychosis and their substance misuse;	
	• been informed of the risks of overdose if they start reusing substances, especially opioids that have been reduced or	

	discontinued during the inpatient stay.	
2.4.40	when developing a care plan for an adult or young person with psychosis and coexisting substance misuse the complex and individual relationships between substance misuse, psychotic symptoms, emotional state, behaviour and the person's social context are considered.	A

Children and young people with psychosis		
Ensure:		
2.4.43	a care plan is developed with the parents or carers of younger children, or jointly with the young person and their parents or carers, as soon as possible after the diagnosis of psychosis which includes activities promoting physical health and social inclusion.	A
2.4.44	all children and young people with a first presentation of sustained psychotic symptoms (lasting 4 weeks or more) are urgently referred to a specialist mental health service, either CAMHS (up to 17 years) or an early intervention in psychosis service (14 years or over), which includes a consultant psychiatrist with training in child and adolescent mental health.	A
2.4.45	that if a child or young person is at risk of crisis, a crisis plan is developed with the parents or carers of younger children, or jointly with the young person and their parents or carers, and with their care coordinator.	A
2.4.46	that when a child or young person with a diagnosis of psychosis or schizophrenia presents with a suspected relapse and is still receiving treatment, primary healthcare professionals refer to the crisis section of the care plan and consider referral to the key clinician or care coordinator identified in the crisis plan.	A
2.4.47	daytime activities of children and young people with psychosis or schizophrenia are routinely recorded in their care plans, including educational and occupational outcomes.	A

Schizophrenia comprehensive care plans		
Ensure:		
2.4.48 2.4.55	people with schizophrenia have a comprehensive bio-psychosocial assessment prior to the development of the care plan. The assessment should provide an understanding of the presenting problems of the service user within the context of their life, both past and present, and should facilitate the development of a care plan that addresses a broad range of client needs beyond symptom reduction.	A
2.4.49	co-morbid conditions are identified, including substance misuse or physical illness.	A
2.4.50	that following a full needs assessment, a comprehensive care plan is implemented whenever a schizophrenia diagnosis is suspected. Where a diagnosis has been reached, it should be fully explained and discussed with the service user (and with the carer where appropriate).	A
2.4.51	effective communication of care plans: following a clear structure, writing in understandable language and preferably typed, provides a crucial contribution to the successful delivery of management strategies.	A
2.4.52	issues of consent are appropriately addressed throughout the care pathway. Professionals must be fully aware of all appropriate legislation, particularly the Mental Health Act (HMSO, 2007) and the Mental Capacity Act (HMSO, 2005).	A

2.4.53	advance decisions and advance statements are developed collaboratively with people with schizophrenia. Record decisions and statements and include copies in the care plan in primary and secondary care. Give copies to the service user and their care coordinator, and their carer if the service user agrees.	A
2.4.54	that when a person with schizophrenia is planning on moving out of area, their current secondary care provider contacts the new secondary and primary care providers, and sends them the current care plan.	A
2.4.56	a crisis plan is included in the care plan, based on a full risk assessment.	A
2.4.57	all teams providing services for people with schizophrenia offer social, group and physical activities (including in inpatient settings) and record arrangements in their care plan.	A
2.4.58	staff routinely record the daytime activities of people with schizophrenia in their care plans, including occupational outcomes.	A
Generalized anxiety disorder comprehensive care plans		
Ensure:		
2.4.59	persons with Generalized Anxiety Disorder (GAD) receive a specialist assessment of needs and risks	A
2.4.60	that a comprehensive care plan is developed in collaboration with the person with Generalized Anxiety Disorder that addresses needs, risks and functional impairment and has a clear treatment plan.	A
Bipolar disorder comprehensive care plans		
Ensure:		
2.4.61	advance directives covering both mental and physical healthcare are developed collaboratively by people with bipolar disorder and healthcare professionals. These directives should be documented in care plans, and copies given to the person with bipolar disorder, and to his or her care coordinator and GP.	A
2.4.62	primary care clinicians refer patients with suspected bipolar disorder for a specialist mental health assessment and for the development of a care plan, where either of the following are present:	A
	• periods of overactive, disinherited behaviour lasting at least 4 days with or without periods of depression;	
	• three or more recurrent depressive episodes in the context of a history of overactive, disinhibited behaviour.	
2.4.63	primary care clinicians urgently refer patients with mania or severe depression who are a danger to themselves or other people to specialist mental health services.	A
2.4.65	parents or carers of children with bipolar disorder are involved in developing care plans so that they can give informed consent, support the psychological goals of treatment, and help treatment adherence.	A
2.4.64	Promote crisis resolution for people with bipolar disorder carried out by home treatment teams managing crises at home/in the community and/or supporting early discharge from hospital.	A

2.5 Recommendations for interventions to improve the physical health of people with mental health conditions (all ages)

This evidence review recommends:

Intervention		**Grade**
Health behaviour interventions		
Promote:		
2.5.1	health behaviour interventions to improve the physical health and general health of individuals diagnosed with a serious mental illness.	B
2.5.2	integration of health promotion interventions targeting physical activity and eating habits into the daily care of people with severe mental disorders.	B
2.5.3	behavioural interventions in outpatients to effectively prevent and reduced antipsychotic-associated weight gain.	B
2.5.4	the following to reduce antipsychotic-induced weight gain: adjunctive non-pharmacological interventions, either individual or group; cognitive-behavioural therapy and nutritional counselling.	B
Activity interventions		
2.5.5	Promote physical activity interventions for people with severe mental disorders. This results in positive effects on: metabolic outcomes, physical fitness, health-related behaviour and mental health.	B
Ensure:		
2.5.6	physical therapists take into account the emotional (negative symptoms, self-esteem, self-efficacy, and stress) and physiological (cardio-metabolic parameters) components of mental illness when offering physical activity interventions.	B
2.5.7	physical activity stimulus is adapted to the individual's physical fitness level and that any side effects of antipsychotic medications are considered.	B
Treatment interventions		
Management of patients with mood disorders and co-morbid metabolic disorders: Promote:		
2.5.8	non-pharmacological weight-management interventions as a priority, particularly during the early stages of antipsychotic treatment.	B
2.5.9	pharmacological approaches for excess weight are metformin and topiramate, with emerging evidence for liraglutide and modafinil.	B
2.5.10	cognitive-behavioural therapy as well as topiramate, zonisamide, and in select cases selective serotonin reuptake inhibitors, for those with binge eating disorder.	B
2.5.11	cognitive-behavioural interventions and anti-diabetic, antilipidemic, and antihypertensive treatments. for those with co-morbid metabolic disorders, including dysglycemia, dyslipidemia, and hypertension.	B
2.5.12	for patients with diabetes: diabetes education that incorporates diet and exercise components, as well as addressing challenges	B

	such as cognition, motivation, and weight gain that may result from antipsychotics.	
2.5.13	Ensure those individuals with major depressive disorder and bipolar disorder are routinely screened for risk factors that increase risk for metabolic syndrome.	B
Mental health nurses		
2.5.14	Promote a change in the culture of mental health service provision to allow the role of the mental health nurse to include the physical health needs of people with serious mental illness.	B
Ensure mental health nurses:		
2.5.15	have a positive attitude to help make changes in their role and engage patients in change.	B
2.5.16	have the right support and training to help improve the physical health needs of people with serious mental illness.	B
Interventions for children and young people with psychosis and schizophrenia		
Ensure:		
2.5.17	primary care registers are developed and used to monitor the physical and mental health of children and young people with psychosis or schizophrenia.	A
2.5.18	GPs and other primary healthcare professionals monitor the physical health of children and young people with psychosis or schizophrenia at least once a year.	A
2.5.19	children and young people with psychosis or schizophrenia who smoke or who have high blood pressure, raised lipid levels or increased waist measurement are identified at the earliest opportunity and monitored for the emergence of cardiovascular disease and diabetes.	A
2.5.20	children and young people with psychosis or schizophrenia who have diabetes and/or cardiovascular disease are treated in primary care.	A
2.5.21	healthcare professionals in secondary care make sure (as part of the care programme approach) that children and young people with psychosis or schizophrenia receive physical healthcare from primary care while continuing to maintain responsibility for monitoring and managing any side effects of antipsychotic medication.	A
Preventive interventions		
2.5.22	Promote preventive approaches as they have the potential to be more effective, acceptable, cost-efficient and beneficial.	B

This evidence review does not recommend:

Intervention		**Grade**
2.5.23	inpatient settings.	B

2.6 Recommendations for interventions to reduce the incidents of self-harm and suicide (all ages)

This evidence review recommends:

Intervention		**Grade**
Planning services to reduce the incidents of self-harm and suicide		
Ensure:		
2.6.1	joint planning of the configuration and delivery of integrated physical and mental healthcare services within emergency departments for people who self-harm, including emergency departments, commissioners , local mental health services, local service users and carers.	A
2.6.2	joint planning of the configuration and delivery of integrated physical and mental healthcare services within emergency departments for children and young people who self-harm, including emergency departments catering for children and young people under 16 years of age, commissioners , local children's mental health services, local service users and carers.	A
2.6.3	people who self-harm are involved in the commissioning, planning and evaluation of services.	A
2.6.4	consider integration of mental health professionals into the emergency department, to improve the psychosocial assessment and initial treatment for people who self-harm, and provide routine and regular training to non-mental-health professionals working in the emergency department.	A
2.6.5	emergency department and local mental health services should jointly plan effective liaison psychiatric services available 24 hours a day.	A
2.6.25	mental health services, including community mental health teams and liaison psychiatry teams are responsible for the routine assessment and the longer-term treatment and management of self-harm. In children and young people this should be the responsibility of tier 2 and 3 child and adolescent mental health services (CAMHS).	A
Interventions to reduce the incidents of self-harm and suicide		
2.6.6	Promote effective suicide prevention interventions, including: training general practitioners to recognise and treat depression and suicidality; improving accessibility of care for at-risk people; and restricting access to means of suicide.	A
Respect, understanding and choice for people who have self-harmed		
Ensure:		
2.6.7	people who have self-harmed are treated with the same care, respect and privacy as any patient.	A
2.6.8	all staff undertaking care of those who self-harm have regular clinical supervision in which the emotional impact upon staff members is discussed and understood.	A
2.6.9	people who have self-harmed are offered the choice of male or female staff for both assessment and treatment.	A
2.6.11	Provide people who self-harm with full information about the different treatment options available.	A

Consent and confidentiality		
2.6.12	Health and social care professionals who work with people who self-harm should be trained to: understand consent and confidentiality and apply the principles of the Mental Capacity Act (2005) and Mental Health Act (1983; amended 1995 and 2007); assess mental capacity; and make decisions about when treatment and care can be given without consent.	A
2.6.13	Health and social care professionals who have contact with children and young people who self-harm should be trained to understand the different roles and uses of the Mental Capacity Act (2005), the Mental Health Act (1983; amended 1995 and 2007) and the Children Act (1989; amended 2004) in the context of children and young people who self-harm.	A

Risk assessments to reduce the incidents of self-harm and suicide		
Ensure:		
2.6.14 2.6.15	all people who have self-harmed are offered an assessment of needs, which should be comprehensive and include evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment.	A
2.6.16	that when assessing the risk of repetition of self-harm or risk of suicide, identify and agree with the person who self-harms the specific risks for them.	A
2.6.17	social and health policy, and interventions relating to prevention of suicide, should focus not only on individual psychiatric factors (high risk, low prevalence) but also the potential effects of interventions relating to broader socio economic factors (low risk, high prevalence).	B

Treatment and care to reduce the incidents of self-harm and suicide		
2.6.18	Ensure people who have self-harmed are offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.	A
2.6.19	Summarise the key areas of needs and risks identified in the assessment and use them to develop a care plan and a risk management plan in conjunction with the person who self-harms and their family, carers or significant others if this is agreed with the person. Provide printed copies for the service user and share them with the GP.	A
2.6.20	Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms.	A
2.6.26	Ensure people who self-harm, and their families, carers and significant others where this is agreed with the person, have access to information about the short-term management of self-harm.	A
2.6.27	Consider offering 3 to 12 sessions of a psychological intervention specifically structured for people who self-harm.	A

Risk management plans		
Ensure:		
2.6.21	a risk management plan is a clearly identifiable part of the care plan.	A
2.6.22	the risk management plan is consistent with the long-term treatment strategy.	A

2.6.23	a person who self-harms is informed of the limits of confidentiality and that information in the care and risk plan may be shared with other professionals.	A
2.6.24	the risk management plan is updated regularly for people who continue to be at risk of further self-harm. Monitor changes in risk and specific associated factors for the service user, and evaluate the impact of treatment strategies over time.	A

Harm reduction		
2.6.28	Strategies aimed at harm reduction reinforce existing coping strategies and develop new strategies as an alternative to self-harm.	A
2.6.29	Treat associated mental health conditions by providing psychological, pharmacological and psychosocial interventions as appropriate.	A
2.6.30	Ensure health professionals take into account the toxicity of the prescribed drugs in overdose when prescribing drugs to people who self-harm for associated mental health conditions.	A

Referral, admission, and discharge to reduce the incidents of self-harm and suicide Ensure:		
2.6.31	that referral, treatment and discharge following self-harm is based on the overall assessment of needs and risk.	A
2.6.32	referral for further treatment and help is based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and is not determined solely on the basis of having self-harmed.	A
2.6.33	the referral for further assessment and/or treatment is based upon a comprehensive psychosocial assessment, and aims to treat a person's underlying problems or particular diagnosis rather than simply treating self-harming behaviour.	A

Managing endings and supporting transitions to reduce the incidents of self-harm and suicide		
2.6.34	Anticipate that for people who self-harm, the ending of treatment, services or relationships, as well as transitions from one service to another, can provoke strong feelings and increase the risk of self-harm.	A
2.6.35	Child and adolescent mental health services and adult health and social care professionals should work collaboratively to minimise any potential negative effect of transferring young people from child and adolescent mental health services to adult services.	A

Consent, mental capacity and mental ill health to reduce the incidents of self-harm and suicide		
2.6.36	Ensure issues of consent, mental capacity and mental ill health in the assessment and treatment of people who self-harm is understood and addressed by all healthcare professionals involved in the care of this group.	A

Staff interventions to reduce the incidents of self-harm and suicide		
2.6.37	All healthcare practitioners involved in the assessment and treatment of people who self-harm should ensure that the care they offer addresses, as a priority, the fact that the experience of care for people who self-harm is often unacceptable.	A

2.6.38	Promote high quality care from health and social care professionals working with people who self-harm.	A

Staff training and supervision interventions to reduce the incidents of self-harm and suicide		
Promote:		
2.6.39	dedicated training to all staff that come into contact with people who self-harm to improve both their understanding of self-harm and the treatment and care they provide.	A
2.6.40	effective collaboration of all local health organisations as essential to develop properly integrated services.	A
Ensure:		
2.6.42	ambulance staff are trained in the assessment and early management of self-harm. Training should particularly address the different methods of self-harm and the appropriate treatments, the likely effects if untreated, and issues of consent and mental capacity, as these apply both to adults, and to children and young people.	A
2.6.43	children’s and young people's triage nurses are trained in the assessment and early management of mental health problems and, in particular, in the assessment and early management of children and young people who have self-harmed.	A
2.6.44	staff who have emergency contact with children and young people who have self-harmed should be adequately trained to assess mental capacity in children of different ages and to understand how issues of mental capacity and consent apply to this group. They should also have access at all times to specialist advice about these issues.	A
2.6.45	health and social care professionals who work with people who self-harm, including children and young people, are trained in the assessment, treatment and management of self-harm, and educated about the stigma, discrimination and the need to avoid judgemental attitudes.	A
2.6.46	health and social care professionals who provide training about self-harm, involve people who self-harm in the planning and delivery of training; ensure that the training specifically aims to improve the quality and experience of care for people who self-harm; assess the effectiveness of training using service-user feedback as an outcome.	A

Primary care interventions to reduce the incidents of self-harm and suicide		
Promote:		
2.6.47	the important role primary care has in the assessment and treatment of people who self-harm.	A
2.6.52	cooperative working when people who self-harm are receiving treatment or care in primary care and secondary care. In these circumstances, primary health and social care professionals should attend care programme approach (CPA) meetings.	A
Ensure:		
2.6.48	that when an individual presents in primary care following an episode of self-harm, healthcare professionals urgently establish the likely physical risk, and the person's emotional and mental state, in an atmosphere of respect and understanding.	A
2.6.49	that if urgent referral to an emergency department is not considered necessary, a risk and needs assessment is undertaken to assess the case for urgent referral to secondary mental health services.	A
2.6.50	that service users who are considered at risk of self-poisoning, healthcare professionals prescribe, whenever possible, drugs which are least dangerous in overdose, and prescribe fewer tablets at any one time.	A

2.6.51	Ensure that primary healthcare professionals are aware that, if a person presents in primary care with a history of self-harm and a risk of repetition, they should consider referring them to community mental health services for assessment. If they are under 18 years, should consider referring them to child and adolescent mental health services for assessment.	A
Ambulance service interventions to reduce the incidents of self-harm and suicide		
2.6.53	Support ambulance staff's important role in the assessment and early treatment of self-harm through effective collaboration with other professional groups.	A
Emergency department interventions to reduce the incidents of self-harm and suicide		
Ensure:		
2.6.54	emergency department staff have the knowledge and skills to assess risk and emotional, mental and physical state quickly, as well as skills to encourage people who have self-harmed to stay for further psychosocial assessment.	A
2.6.56	people who have self-harmed and presented to services but wish to leave before psychosocial assessment has been undertaken, and in whom diminished capacity and/or the presence of a significant mental illness is established, are referred for urgent mental health assessment. Appropriate measures should also be taken to prevent the individuals leaving the service.	A
2.6.54	emergency department staff have the knowledge and skills to assess risk and emotional, mental and physical state quickly, as well as skills to encourage people who have self-harmed to stay for further psychosocial assessment.	A
Support and advice interventions		
2.6.57	Promote support and advice for people who repeatedly self-harm.	A
2.6.58	Ensure service users who repeatedly self-poison, and their carers where appropriate, are offered advice about the risks of self-poisoning.	A
2.6.59	Ensure people who repeatedly self-harm by self-inflicting superficial injuries receive advice regarding self-management of superficial injuries, harm minimisation techniques, alternative coping strategies and how best to deal with scarring.	A
Interventions for relatives or carers		
Ensure:		
2.6.60	people who self-harm are allowed, if they wish, to be accompanied by a family member, friend or advocate during assessment and treatment. However, for the initial psychosocial assessment, the interview should take place with the service user alone to maintain confidentiality.	A
2.6.61	healthcare professionals provide emotional support and help if necessary to the relatives/carers of people who have self-harmed, as they may also be experiencing high levels of distress and anxiety.	A
Children and young people (under 16 years)		
Ensure:		
2.6.62	children and young people under 16 years of age who have self-harmed are triaged, assessed and treated by appropriately	A

	trained children's nurses and doctors in a separate children's area of emergency departments.	
2.6.63	children, young people and adults from black and minority ethnic groups who self-harm have the same access to services as other people who self-harm based on clinical need and that services are culturally appropriate.	A
2.6.64	that when language is a barrier to accessing or engaging with services for people who self-harm, they are provided with: information in their preferred language and in an accessible format; psychological or other interventions, where needed, in their preferred language; and independent interpreters.	A
2.6.65	all child and adolescent mental health services (CAMHS) professionals who work with children and young people who self-harm, consider whether the child's or young person's needs should be assessed according to local safeguarding procedures.	A
2.6.66	there are correct procedures in place for when children or young people who self-harm are referred to CAMHS under local safeguarding procedures:	A
	• Use a multi-agency approach, including social care and education, to ensure that different perspectives on the child's life are considered.	
	• Consider using the common assessment framework.	
	• If serious concerns are identified, develop a child protection plan.	
2.6.67	Review information available locally on websites and ensure it is evidence based.	B
Older people (older than 65 years) interventions		
Ensure:		
2.6.68 2.6.71	all people older than 65 years of age who have self-harmed are assessed by mental healthcare practitioners experienced in the assessment of older people who self-harm. Assessment should follow the same principles as for younger adults who self-harm, but should also pay particular attention to the potential presence of depression, cognitive impairment and physical ill health, and should include a full assessment of their social and home situation.	A
2.6.69	acts of self-harm in people older than 65 years of age are regarded as evidence of suicidal intent until proven otherwise.	A
2.6.70	Given the high risks amongst older adults who have self-harmed, consideration should be given to admission for mental health risk and needs assessment, and time given to monitor changes in mental state and levels of risk.	A
2.6.72	Consider using telecommunications to reach vulnerable older adults, and evaluate the effects of means restriction and physicians education on elderly suicide.	B
Interventions for people with learning disabilities to reduce the incidents of self-harm and suicide		
2.6.73	Ensure people with a mild learning disability who self-harm have access to the same age-appropriate services as other people.	A

Community mental health services Interventions to reduce the incidents of self-harm and suicide		
2.6.74.	Offer an integrated and comprehensive psychosocial assessment of needs and risks to understand and engage people who self-harm and to initiate a therapeutic relationship	A

This evidence review does not recommend:

Intervention		**Grade**
2.7.75	risk categorization of individual psychiatric inpatients.	B
2.7.76	school-based programmes to prevent suicide among adolescents.	B
2.7.77	universal school education programmes to prevent youth suicide.	C

2.7 Recommendations for interventions to promote better mental health outcomes and quality of life for carers (all ages)

This evidence review recommends:

Intervention		**Grade**
Commissioners		
2.7.2	Commissioners should ensure sufficient capacity to meet the distinct needs of this group.	A

Provider organisations		
Ensure:		
2.7.3	provider organisations nominate a lead to oversee the development and implementation of services that specifically focus on the needs of families and carers.	A
2.7.4	carers are offered a separate assessment and respond positively when a carer asks for one.	A
2.7.6	organisation teams ‘signpost’ all family members and carers to local and national sources of information, advice and practical support, including sources of emotional and psychological support	A
2.7.8	organisation teams provide families and carers with a clear indication of the personnel they might contact in relation to a range of needs.	A

Support interventions		
Ensure		
2.7.10	family members and carers are offered the opportunity for their needs for support and information to be assessed separately from those of patients. Cultural and ethnic preferences on family involvement should be taken into account.	A
2.7.11	family members and carers are made aware of, and have easy access to, sources of local information, advice and support designed to meet their own needs.	A
2.7.12	families and carers have access to professionals capable of providing confidential emotional support .	A

2.7.14	practitioners enquire about the concerns of caregivers and consider that they may benefit from additional support.	A
2.7.16	the following factors are considered when providing support groups for carers: theoretical models, session length and session intensity.	B
2.7.10	family members and carers are offered the opportunity for their needs for support and information to be assessed separately from those of patients. Cultural and ethnic preferences on family involvement should be taken into account.	A

2.7.15	Promote support groups for carers to improve carer’s psychological well-being, depression, burden and social outcomes.	B

Involve carers in discussions about patient treatment		
2.7.18	Ensure that whenever possible and appropriate, family members and carers are invited to accompany patients during clinical encounters and are involved in discussions about treatment and care, in accordance with the patient’s wishes.	A

Multi-component interventions		
Promote:		
2.7.20	fully developed multi-component interventions that encompass a diversity of services for carers.	B
2.7.21	networked ICT interventions that are multifaceted with elements of networked peer support to moderately improve carer stress and depression	B
2.7.22	combined intervention programmes for people with dementia living at home and their caregivers.	B
2.7.23	multi-component interventions for caregivers of people with dementia to reduce the risk of institutionalization.	B

Bereavement support interventions		
Ensure:		
2.7.25	family members and carers who are bereaved are, in the first instance, encouraged to use existing support systems.	A
2.7.26	providers of specialist bereavement support work closely with other care providers (both statutory and voluntary) to make sure that carers and family members can access services when needed.	A
2.7.28	provider organisations are equipped to offer the first component of bereavement support and have strategies in place to access the other components.	A
2.7.31	a leaflet is made available to families and carers around the time of the bereavement. Ideally, this should be developed locally, agreed by those involved in the provision of bereavement services, and include information on anticipated feelings and how to access local and national services.	A
2.7.32	specialist bereavement services are sufficiently resourced to enable them to contribute to the preparation and ongoing support of health and social care professionals in relation to this aspect of care.	A
2.7.33	those who offer bereavement services that include volunteer support workers, should ensure mechanisms for recruiting, training, supervising and managing volunteers are in place.	A
2.7.27	Promote the development and implementation of a three-component model of bereavement support to ensure that people’s	A

	individual needs are addressed through variety in service provision.	

Interventions for health and social care professionals		
Ensure:		
2.7.34	health and social care professionals that provide day-to-day care to patients also assess and address the needs of family members and carers on an ongoing basis.	A
2.7.35	a system is established to allow family members and carers to have regular opportunities to discuss particular concerns.	A

Interventions involving other families and carers		
2.7.38	Ensure that providers set up arrangements for families and carers to meet other families and carers who have experienced similar situations, if wished. These services are ideally provided in partnership with the voluntary sector.	A
Interventions for different ethnicities and cultures		
2.7.39	Ensure that the needs of family members from different ethnic populations, including differences in language, religious practice and culture, are considered.	A

APPENDIX 6

SUPPORTING THOSE WITH SPECIAL EDUCATOINAL NEEDS, DISABILITIES AND LONG TERM CONDITIONS

The objective of this section is to make evidenced based recommendations that support commissioners with a robust basis for decision making.

Recommendations are based on evidence from systematic reviews and meta-analyses. Scoring of recommendations is based on the SIGN methodology as set out in Chapter 2. Recommendations graded ‘A’ are based on the highest quality evidence and those graded ‘D’ the lowest. These reviews were carried out at a specific point in time and we acknowledge there are further caveats commissioners must take into consideration:

- NICE guidance is being updated on a continuous cycle, and some of the evidence presented here may not have been reviewed by NICE at this time. Commissioners need to ensure interventions do not conflict with current NICE guidance.

- East Sussex CCGs operate a ‘Low Priorities Procedures’ process. Whereby some procedures are not ordinarily commissioned and requests for treatment are referred to an ‘individual treatment panel’. It is important to recognise that the agreed processes should be followed for these interventions.

- Locally, new pathways to treatment for patients for a wide range of conditions are being developed by GPs, commissioners and secondary care clinicians. It is important to ensure agreed treatment pathways are followed.

It is recommended that commissioners review the entire evidence base set out in the evidence review for this priority area, but that service planning focuses on those issues highlighted by this recommendations section.

RECOMMENDATION NUMBERS LISTED ARE THOSE FROM THE FULL EVIDENCE REVIEW FOR THIS PRIORITY AREA. FULL EVIDENCE REVIEWS ARE AVAILABLE ON THE EAST SUSSEX JOINT STRATEGIC NEEDS ASSESSMENT WEBSITE WWW.EASTSUSSEXJSNA.ORG.UK.

2.2 Recommendations for interventions to support person centred care in the community for people with special educational needs

This evidence review recommends:

Intervention		**Grade**
Local autism strategy group		
Ensure:		
2.2.1	the group is set up, with managerial, commissioner and clinical representation from child health and mental health services, education, social care, parent and carer service users, and the voluntary sector.	A
2.2.2	a lead professional is appointed to be responsible for the local autism pathway for recognition, referral and diagnosis of children and young people.	A
2.2.3	local autism strategy groups' aims include:	A
	• improving the early recognition of autism by raising awareness of the signs and symptoms of autism through multi-agency training;	
	• supporting the smooth transition to adult services for young people going through the diagnostic pathway;	
	• ensuring data collection and audit of the pathway takes place.	
2.2.22	the local autism multi-agency strategy group includes representation from managers, commissioners and clinicians from adult services, including mental health, learning disability, primary healthcare, social care, housing, educational and employment services, the criminal justice system and the third sector. There should be meaningful representation from people with autism and their families, partners and carers.	A
Autism team		
Ensure:		
2.2.4	in each area a multidisciplinary group (the autism team) is set up with the following core members: paediatrician and/or child and adolescent psychiatrist, speech and language therapist and clinical and/or educational psychologist.	A
2.2.5	the autism team either includes or has regular access to the following professionals if they are not already in the team:	A
	• paediatrician or paediatric neurologist	
	• child and adolescent psychiatrist	
	• educational psychologist	
	• clinical psychologist	
	• occupational therapist.	
2.2.6	the autism team have the skills and competencies to	A
	• carry out an autism diagnostic assessment	
	• communicate with children and young people with suspected or known autism, and with their parents and carers, and sensitively share the diagnosis with them.	

2.2.7	autism team members:	A
	• provide advice to professionals about whether to refer children and young people for autism diagnostic assessments	
	• decide on the assessment needs of those referred or when referral to another service will be needed	
	• carry out the autism diagnostic assessment	
	• share the outcome of the autism diagnostic assessment with parents and carers, and with children and young people if appropriate	
	• with parent or carer consent, and if appropriate, the consent of the child or young person, share information from the autism diagnostic assessment directly with relevant service	
	• Offer information to children, young people and parents and carers about appropriate services and support	
2.2.8	there is a single point of referral for access to the autism team.	A
2.2.9	the autism team have the skills (or have access to professionals that have the skills) needed to carry out an autism diagnostic assessment, for children and young people with special circumstances including:	A
	• coexisting conditions such as severe visual and hearing impairments, motor disorders including cerebral palsy, severe intellectual disability, complex language disorders or complex mental health disorders.	
	• looked-after children and young people.	
2.2.10	that, if young people present at the time of transition to adult services, the autism team should consider carrying out the autism diagnostic assessment jointly with the adult autism team, regardless of the young person's intellectual ability.	A
2.2.11	all staff working with adults with autism:	A
	• work in partnership with adults with autism and, where appropriate, with their families, partners and carers. Offer support and care respectfully;	
	• take time to build a trusting, supportive, empathic and non-judgemental relationship as an essential part of care;	
	• have an understanding of the nature, development and course of autism;	
	• have an understanding of the impact on personal, social, educational and occupational functioning;	
	• have an understanding of the impact of the social and physical environment.	
2.2.16	that in all settings the physical environment in which adults with autism are assessed, supported and cared for is taken into account, including any factors that may trigger challenging behaviour. If necessary make adjustments or adaptations to the:	A
	• amount of personal space given (at least an arm's length);	
	• setting using visual supports (for example, use labels with words or symbols to provide visual cues about expected behaviour);	
	• colour of walls and furnishings (avoid patterns and use low-arousal colours such as cream);	
	• lighting (reduce fluorescent lighting, use blackout curtains or advise use of dark glasses or increase natural light);	
	• noise levels (reduce external sounds or advise use of earplugs or ear defenders).	
Adults with autism		
Ensure health and social care professionals providing care and support for adults with autism:		

2.2.12	have a broad understanding of the:	A
	• nature, development and course of autism;	
	• impact on personal, social, educational and occupational functioning;	
	• impact of, and interaction with, the social and physical environment impact on, and interaction with, other coexisting mental and physical disorders and their management;	
	• potential discrepancy between intellectual functioning as measured by IQ and adaptive functioning as reflected, for example, by difficulties in planning and performing activities of daily living including education or employment;	
2.2.13	• aim to foster the person's autonomy, promote active participation in decisions about care and support self-management;	A
	• maintain continuity of individual relationships wherever possible;	
	• ensure that comprehensive information about the nature of, and interventions and services for, their difficulties is available in an appropriate language or format (including various visual, verbal and aural, easy-read, and different colour and font formats);	
	• consider whether the person may benefit from access to a trained advocate.	
2.2.14	ensure that families, partners and carers:	A
	• are easily identifiable (for example, by producing or wearing appropriate identification) and approachable; clearly communicate their role and function;	
	• address the person using the name and title they prefer; clearly explain any clinical language and check that the person with autism understands what is being said;	
	• take into account communication needs, including those arising from a learning disability, sight or hearing problems or language difficulties, and provide communication aids or independent interpreters (someone who does not have a personal relationship with the person with autism) if required.	
2.2.15	ensure that families, partners and carers are:	A
	• familiar with recognised local and national sources (organisations and websites) of information and/or support for people with autism;	
	• able to discuss and advise on how to access and engage with these resources.	
Ensure adults with autism:		
2.2.17	are encouraged to participate in self-help or support groups or have access one-to-one support, and provide support so that they can attend meetings and engage in activities.	A
2.2.18	who have caring responsibilities receive support to access the full range of mental and physical health and social care services, including:	A
	• specific information, advice and support to parents about their parenting role, including parent training if needed, by professionals experienced in the care of adults and children with autism;	
	• social support, such as childcare, to enable them to attend appointments, groups and therapy sessions, and to access	

	education and employment.	
Families, partners or carers of adults with autism		
Ensure:		
2.2.19	that if a person with autism wants their family, partner or carer(s) to be involved, encourage this involvement and:	A
	• negotiate between the person with autism and their family, partner or carer(s) about confidentiality and sharing of information on an ongoing basis;	
	• explain how families, partners and carers can help support the person with autism and help with care plans;	
	• make sure that no services are withdrawn because of involvement of the family, partner or carer(s), unless this has been clearly agreed with both the person with autism and their family, partner or carer(s).	
2.2.20	all families, partners and carer(s) (whether or not the person wants them to be involved in their care) have verbal and written information about:	A
	• autism and its management;	
	• local support groups and services specifically for families, partners and carers;	
	• their right to a formal carer's assessment of their own physical and mental health needs, and how to access this.	
2.2.21	that if a person with autism does not want their family, partners or carer(s) to be involved in their care, the family, partner or carer(s) is given verbal and written information about who they can contact if they are concerned about the person's care.	A
2.2.19	that if a person with autism wants their family, partner or carer(s) to be involved, this involvement is encouraged and	A
2.2.24	that a specialist community-based multidisciplinary team for adults with autism (the specialist autism team) is established with the following members:	A
	• clinical psychologists	
	• nurses	
	• occupational therapists	
	• psychiatrists	
	• social workers	
	• speech and language therapists	
	• support staff (e.g. staff supporting access to housing, educational and employment services, financial advice, and personal and community safety skills).	
2.2.25	that the specialist autism team have a key role in the delivery and coordination of:	A
	• specialist diagnostic and assessment services;	
	• specialist care and interventions;	
	• advice and training to other health and social care professionals on the diagnosis, assessment, care and interventions for adults with autism (as not all may be in the care of a specialist team);	

	• support in accessing, and maintaining contact with, housing, educational and employment services;	
	• support to families, partners and carers where appropriate;	
	• care and interventions for adults with autism living in specialist residential accommodation;	
	• training, support and consultation for staff who care for adults with autism in residential and community settings.	

Interventions for adults with autism		
Ensure when discussing and deciding on interventions:		
2.2.26	that the following are considered:	A
	• patient’s experience of, and response to, previous interventions;	
	• the nature and severity of autism;	
	• the extent of associated functional impairment arising from the autism, a learning disability or a mental or physical disorder;	
	• the presence of any social or personal factors that may have a role in the development or maintenance of any identified problem(s);	
	• the presence, nature, severity and duration of any coexisting disorders;	
	• the identification of predisposing and possible precipitating factors that could lead to crises if not addressed.	
2.2.27	that the following are taken into account:	A
	• the increased propensity for elevated anxiety about decision-making in people with autism;	
	• greater risk of altered sensitivity and unpredictable responses to medication;	
	• environment, for example whether it is suitably adapted for people with autism;	
	• presence and nature of hyper or hypo-sensory sensitivities and how these might impact on the delivery of the intervention;	
	• nature of support needed to access interventions.	
2.2.28	information is provided about:	A
	• the nature, content and duration of any proposed intervention;	
	• the acceptability and tolerability of any proposed intervention;	
	• possible interactions with any current interventions and possible side effects;	
2.2.29	that for any intervention used in adults with autism, there is a regular review of:	A
	• the benefits of the intervention, where feasible using a formal rating of the target behaviour(s);	
	• any adverse events;	
	• adherence to the intervention.	
Promote:		
2.2.30	psychosocial interventions focused on life skills for adults with autism of all ranges of intellectual ability, who need help with activities of daily living, consider a structured and predictable training programme based on behavioural principles.	A

2.2.31	additional research into tele-practice as a promising service delivery approach in the treatment of individuals with autism spectrum disorders (i.e. autism, Asperger’s or PDD-NOS).	B
Local care pathways		
Ensure:		
2.2.32	local care pathways are developed to promote implementation of key principles of good care, and are:	A
	• negotiable, workable and understandable for adults with autism, their families, partners and carers, and professionals;	
	• accessible and acceptable to all people in need of the services;	
	• responsive to the needs of adults with autism their families, partners and carers;	
	• integrated;	
	• outcome focused.	
2.2.33	autism strategy groups are responsible for developing, managing and evaluating the local care pathways. The group should appoint a lead professional responsible for the local autism care pathway.	A
2.2.34	access to services for all adults with autism, including:	A
	• people with coexisting physical and mental disorders (including substance misuse);	
	• women;	
	• people with learning disabilities;	
	• older people;	
	• people from black and minority ethnic groups;	
	• transgender people;	
	• homeless people;	
	• people from the traveller community;	
	• people in the criminal justice system;	
	• parents with autism.	
2.2.35	information about local care pathways, given to adults with autism and their families, partners and carers:	A
	• takes into account the person's knowledge and understanding of autism and its care and management	
	• is appropriate to the communities using the pathway.	
2.2.36	local care pathways promote a range of evidence-based interventions at each step in the pathway and support adults with autism in their choice of interventions.	A
2.2.37	local care pathways respond promptly and effectively to the changing needs of populations served by the pathways.	A
2.2.38	an integrated programme of care across all care settings.	A
2.2.39	that there is a single point of referral (including self-referral) to specialist services for adults with autism.	A

Residential care		
Ensure residential care:		
2.2.40	is usually provided in small, local community-based units (of no more than six people and with well-supported single person accommodation). The environment should be structured to support and maintain a collaborative approach between the person with autism and their family, partner or carer(s) for the development and maintenance of interpersonal and community living skills.	A
2.2.41	environments include activities that are:	A
	• structured and purposeful;	
	• designed to promote integration with the local community and use of local amenities;	
	• clearly timetabled with daily, weekly and sequential programmes that promote choice and autonomy.	
2.2.42	environments have:	A
	• designated areas for different activities that provide visual cues about expected behaviour;	
	• adaptations to the physical environment for people with hyper and/or hypo-sensory sensitivities;	
	• inside and outside spaces where the person with autism can be alone.	
2.2.43	staff:	A
	• understand the principles and attitudes underpinning the effective delivery of residential care for adults with autism;	
	• are trained in assessing and supporting the needs of adults with autism;	
	• are consistent, predictable, yet flexible to allow change and choice;	
	• are committed to involving families, partners and carers.	
Identifying health needs		
Ensure:		
2.2.45	staff are aware of the barriers people with learning disabilities face to access health care including: problems with communication, inadequate facilities, rigid procedures and lack of appropriate interpersonal skills among mainstream health care professionals in caring for these patients.	B
2.2.46	that third parties do not obstruct access to health care.	B
Promote:		
2.2.44	the following interventions to improve access to health care:	A
	• a communication aid	
	• a prompt card to support general practitioners,	
	• health checks programmes and walk-in clinics.	
2.2.47	health checks to identify previously unrecognised health needs in people with intellectual disabilities.	B

Ethnicity		
2.2.49	Ensure that people with mental health problems from different ethnic backgrounds have access to mental health services.	B

Staff		
2.2.50	Ensure that staff serving clients with intellectual disabilities receive training to improve clinical practice in the following formats:	B
	• The combination of in-service with coaching-on-the-job.	
	• In-service formats should use multiple techniques and verbal feedback.	
	• Coaching-on-the-job formats, verbal feedback should be part of the program, as well as praise and correction. To maximize effectiveness, program developers should carefully prepare training goals, training format, and training techniques, which will yield a profit for clinical practice.	

Living environment		
2.2.51	Support the use of dispersed housing over clustered housing for adults with intellectual disability to improve the majority of quality indicators studied.	B
2.2.52	Promote deinstitutionalisation and community living for people with intellectual disability.	B

2.3 Recommendations for interventions to support person centred care in the community for people with disabilities

This evidence review recommends:

Intervention		**Grade**
Cerebral palsy		
Ensure:		
2.3.1	adults with cerebral palsy are provided with knowledge and understanding to enhance the decision-making processes about their health.	B
2.3.2	psychosocial issues of concern for adults ageing with cerebral palsy are addressed.	B
2.3.3	support for the following five key elements to achieve a positive transition to adult-centred health care for cerebral palsy and spina bifida:	B
	• preparation	
	• flexible timing	
	• care coordination	
	• transition clinic visits	
	• interested adult-centred health care providers.	

Multiple sclerosis		
Promote:		
2.3.4	multidisciplinary rehabilitation programmes to improve the experience of people with multiple sclerosis in terms of activity and participation. Regular evaluation and assessment of these persons for rehabilitation is recommended.	B
2.3.5	inpatient multidisciplinary rehabilitation to produce short-term gains at the levels of activity (disability) and participation for patients with multiple sclerosis.	A
2.3.6	outpatient and home-based rehabilitation programmes for patients with multiple sclerosis to achieve short-term improvements in symptoms and disability with high intensity programmes.	B
2.3.7	low intensity programmes conducted over a longer period to achieve longer-term gains in quality of life.	A

Physical activity		
Promote:		
2.3.8	physical activity for youth with developmental disabilities.	A
2.3.9	participation in group exercise programs, treadmill training, or therapeutic riding/hippo-therapy for children and adolescents with developmental disabilities to achieve health benefits.	A
2.3.11	physical exercise therapy to gain a positive effect on mobility and physical functioning.	B
2.3.12	progressive resistance strength training as an effective intervention to reduce physical disability in older adults.	B
Ensure:		
2.3.13	therapists start with low intensity progressive resistance strength training and slowly progress the intensity to moderate or high to accommodate the clinical population.	B
2.3.14	progressive resistance strength training exercise frequency is two to three times a week and lasts for at least 6 weeks after the target intensity is reached.	B
2.3.15	therapists apply one of two strategies to increase the effect of progressive resistance strength training:	B
2.3.16	that during progressive resistance strength training therapists monitor possible adverse events cautiously and adjust the programme accordingly.	B

Tele-counselling		
Promote:		
2.3.17	tele-counselling as an effective treatment modality for adults adjusting to a physical disability.	B

Home environment		
Promote:		
2.3.18	interventions that improve home environments to enhance functional ability outcomes.	B

Children and young people with special care health needs		
Ensure:		
2.3.19	that a system of services for children and youth with special health care needs has the following critical characteristics:	B
	• coordination of child and family services;	
	• effective communication among providers and the family;	
	• family partnership in care provision	
	• flexibility.	
Promote:		
2.3.20	changes at the macro level of society to implement a community-based system of services for children and youth with special health care needs.	B
2.3.21	changes at the micro level of society to implement a community-based system of services for children and youth with special health care needs.	B
2.3.22	early intervention for children from birth to nine years who have a physical disability.	B
Musculoskeletal pain disorders		
Promote:		
2.3.23	educational strategy addressing neurophysiology and neurobiology of pain for chronic musculoskeletal pain disorders, to achieve a positive effect on pain, disability, catastrophization, and physical performance.	B
Deafness		
Promote:		
2.3.24	unilateral cochlear implantation as safe and effective for adults and children.	B

2.4 Recommendations for interventions to support self-management for people with long term conditions

This evidence review recommends

Intervention		**Grade**
Employees on long-term sickness absence		
2.4.1	Ensure employers identify someone who is suitably trained and impartial to undertake initial enquiries with the relevant employees to: determine the reason for the sickness and their prognosis for returning to work and if they have any perceived (or actual) barriers to returning to work (including the need for workplace adjustments) decide on the options for returning to work and jointly agree what, if any, action is required to prepare for this.	A

2.4.2	If following initial enquiries action is required, then identify:	A
	• whether or not a detailed assessment is needed to determine what interventions and services are required and to develop a return-to-work plan;	
	• whether or not a case worker/s is needed to coordinate a detailed assessment, deliver any proposed interventions or produce a return-to-work plan;	
	• If it is necessary for a case worker to be appointed;	
	• where necessary for employers to arrange for a referral to relevant specialists or services.	A
2.4.3	Coordinate and support the delivery of any planned health, occupational or rehabilitation interventions or services and any return-to-work plan developed following initial enquiries or the detailed assessment. People who have a poor prognosis for returning to work are likely to benefit most from more 'intensive' interventions and services; those with a good prognosis are likely to benefit from 'light' or less intense interventions and services.	A
2.4.4	Ensure employers appoint a case worker/s to coordinate referral for, and delivery of, any required interventions and services. This includes delivery of the return-to-work plan.	A
2.4.5	Ensure employees are consulted and jointly agree all planned health, occupational or rehabilitation interventions or services and the return-to-work plan	A
2.4.6	Encourage employees to contact their GP or occupational health service for further advice and support as needed.	A
2.4.7	Ensure psychological interventions and services are evidence-based. Also ensure they are delivered by suitably trained and experienced practitioners.	A
Promote:		
2.4.8	evidence-based psychological interventions to help people to develop problem solving and coping strategies. The aim is to overcome any barriers they have to returning to work and to support them to return. Examples which have been proven to be effective for certain groups and conditions include:	A
	• women with musculoskeletal pain: CBT in small groups (involving 5– 6 people), with one-to-one telephone follow-up;	
	• men and women with stress-related conditions: CBT and contact with the employer	
	• men and women experiencing low back pain: CBT in small groups (involving 5–6 people) combined with one-to-one sessions of behavioural graded activity and liaison with the workplace to discuss a return-to-work plan	
	• men and women with psychological or musculoskeletal problems: solution	
	• focused group sessions -men and women with whiplash injuries: progressive goal attainment programmes combined with physiotherapy or multimodal programmes	
2.4.9	multi-disciplinary back management programme to help employees with this condition return to work.	A
Unemployed people claiming incapacity benefit		
Promote:		
2.4.10	the commissioning of an integrated programme to help claimants enter or return to work (paid or unpaid).	A

Patient centred care		
Promote :		
2.4.13	the key principles of patient-centred care:	B
	• Explore patient “cognitions” (what they think, believe and expect and their confidence about their disease management).	
	• Explore the social supports, social and family influences and physical environment in which people live.	
	• Apply the principles of behaviour change.	
	• Work with teams of healthcare providers, community agencies and support groups.	
2.4.11	shared management of an illness between patient and doctor - especially for chronic problems such as diabetes, asthma and arthritis.	B
2.4.12	patient education programs integrated into patient-centred care over programs delivered independently of primary-care professionals.	B
Information technology for chronic illness care		
Promote:		
2.4.14	the following chronic illness care information technology components: Connection to an electronic medical record, computerised prompts, population management (including reports and feedback), specialised decision support, electronic scheduling, and personal health records. Barriers identified included costs, data privacy and security concerns, and failure to consider workflow.	B
2.4.15	informatics strategies to improve care for chronic illness. Software to implement these strategies should be developed, and rigorously evaluated within the context of organisational efforts to improve care.	B
2.4.16	Ensure that informatics to improve care for chronic illness is: patient-centred, focused on improving outcomes, and provide support for illness self-management. Ensure that outcomes are: routinely assessed, provided to clinicians during the clinical encounter, and used for population-based care management.	B
2.4.17	Promote implementation of interactive, sequential, disorder-specific treatment pathways to quickly provide clinicians with patient clinical status, treatment history, and decision support.	B
2.4.18	Promote interventions that contain at least 1 chronic care model (CCM) element to improve clinical outcomes and processes of care, and to a lesser extent, quality of life for patients with chronic illnesses.	B
Psychosocial interventions involving family members		
2.4.19	Promote psychosocial interventions involving family members in the treatment of chronic physical diseases to improve health outcomes for both the patient and his/her family. Family involvement resulted in significantly better health than standard treatment for all outcomes. Overall, the effects were not large, but they were broad, significant and stable over a long period of time.	B
2.4.20	Ensure that future interventions that aim to improve chronic illness outcomes emphasize increased family use of attentive coping	B

	techniques and family support for the patient's autonomous motivation.	
2.4.21	Promote family emphasis on self-reliance and personal achievement, family cohesion, and attentive responses to symptoms to achieve better patient outcomes.	B
Exercise interventions		
Promote:		
	exercise interventions to reduce depressive symptoms among patients with a chronic illness. Patients with depressive symptoms indicative of mild-to-moderate depression and for whom exercise training improves function-related outcomes achieve the largest antidepressant effects.	B
Pharmacist-provided direct patient		
Promote:		
2.4.22	pharmacist-provided direct patient care to achieve favourable effects across various patient outcomes, health care settings, and disease states.	B
2.4.23	the incorporation of pharmacists as health care team members.	B
Nurse-led interventions		
Promote:		
2.4.24	education programmes delivered by specialist nurses to improve the assessment and documentation of acute and chronic pain.	B
2.4.25	educational interventions and the use of protocols by specialist nurses to improve patients' understanding of their condition and improve pain control.	B
2.4.26	acute pain teams, led by nurses, to reduce pain intensity.	B
Integrated care		
Promote:		
2.4.27	integrated care	B
Outreach		
Promote:		
2.4.28	specialist multifaceted outreach intervention involving collaboration with primary care, education or other services.	B
Critical illness and intensive care		
Promote:		

2.4.30	multidisciplinary physical rehabilitation, initiated early and continuing throughout the intensive care unit care stay.	B
2.4.31	the following to reduce the long term complications of critical care: preventing hypoglycaemia for depression; limit use of sedation for post-traumatic stress disorder, delirium prevention and hypoglycaemia prevention for cognitive complications (including memory, attention and executive function); handbook for self-guided rehabilitation for quality of life.	B
Dementia		
Ensure:		
2.4.32	health and social care staff aim to promote and maintain the independence, including mobility, of people with dementia. Promote care plans that address activities of daily living.	A
2.4.33	people with mild-to-moderate dementia of all types are given the opportunity to participate in a structured group cognitive stimulation programme.	A
2.4.34	consideration is given to providing access to interventions tailored to the person's preferences, skills and abilities.	A
2.4.35	that if language or acquired language impairment is a barrier to accessing or understanding services, treatment and care, health and social care professionals provides the person with dementia and/or their carer with information in the preferred language and/or in an accessible format.	A
2.4.36	health and social care managers coordinate and integrate working across all agencies involved in the treatment and care of people with dementia and their carers, including jointly agreeing written policies and procedures. Joint planning should include local service users and carers in order to highlight and address problems specific to each locality.	A
Depression		
Ensure:		
2.4.37	that for all known and suspected presentations of depression: assessment, support, psycho-education, active monitoring and referral for further assessment and interventions.	A
Promote:		
2.4.38	low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions for persistent sub threshold depressive symptoms or mild to moderate depression.	A
2.4.39	for moderate and severe depression: medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions for persistent sub threshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions:	A
2.4.40	medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multi-professional and inpatient care for severe and complex depression or people with risk to life or severe self-neglect.	A
Epilepsy		
2.4.41	Promote psychological interventions (relaxation, cognitive behaviour therapy, biofeedback).	A

Rheumatoid arthritis		
Ensure:		
2.4.42	ongoing access to a multidisciplinary team.	A
2.4.43	people with RA have access to specialist physiotherapy.	A
2.4.44	people with RA have access to specialist occupational therapy, with periodic review if they have difficulties with any of their everyday activities, or problems with hand function.	A
2.4.45	Promote psychological interventions (for example, relaxation, stress management and cognitive coping skills) to help people with RA adjust to living with their condition.	A
2.4.46	Ensure all people with RA and foot problems have access to a podiatrist for assessment and periodic review of their foot health needs. Ensure that functional insoles and therapeutic footwear is available for all people with RA if indicated.	A
2.4.47	Ensure people with satisfactorily controlled established RA are offered review appointments at a frequency and location suitable to their needs. In addition, make sure they:	A
	• have access to additional visits for disease flares;	
	• know when and how to get rapid access to specialist care; and	
	• have ongoing drug monitoring.	

Occupational therapy to support self-management		
Promote:		
2.4.48	comprehensive occupational therapy for elderly people and people with stroke or rheumatoid arthritis to promote increasing functional abilities, improve quality of life and improve social participation.	B

People with multi-morbidity		
Promote:		
2.4.49	access to case management services to achieve positive impact on the patient, the carer and the healthcare staff, particularly the GP.	B

2.5 Recommendations for interventions to support self-management for people with long term conditions

This evidence review recommends:

Intervention		**Grade**
Self management		
Promote:		
2.5.1	self-management support for chronic conditions that is integrated into routine health care.	B
2.5.2	the following evidence-based principles to improve patient self-management and/or health outcomes:	B

	• brief targeted assessment;	
	• evidence-based information to guide shared decision-making;	
	• use of a non-judgmental approach;	
	• collaborative priority and goal setting;	
	• collaborative problem solving;	
	• self-management support by diverse providers;	
	• self-management interventions delivered by diverse formats;	
	• patient self-efficacy;	
	• active follow up;	
	• guideline-based case management for selected patients;	
	• linkages to evidence-based community programs;	
	• Multifaceted interventions.	
Ensure:		
2.5.3	core skills of self-management such as self-efficacy building, goal-setting, action-planning, problem-solving and self-tailoring are taught and emphasized throughout the programs.	B
2.5.4	measures of managing pain and disability such as relaxation, exercise, rational use of medication, and physician– patient communication are well organised and effectively delivered.	B
2.5.5	methods such as mailing, telephone and internet are considered to deliver self-management interventions.	B
2.5.6	the enhancement of standard care with: reminders, disease monitoring and management, and education through cell phone voice and short message services to help improve health outcomes and care processes for both patients and providers.	B
2.5.7	interactive Health Communication Applications (IHCAs) for people with chronic disease, to improve user knowledge, improve users feeling of support and possibly improve behavioural and clinical outcomes compared to non-users.	B
Healthcare provider		
2.5.8	Ensure healthcare providers facilitate self-management by coordinating self-management activities, by recognising that different self-management processes vary in importance to patients over time, and by having ongoing communication with patients and providers to create appropriate self-management plans.	B
Lay led self-management		
2.5.9	Promote education programmes for people with chronic conditions to achieve short-term improvements in participants' self-efficacy, self-rated health, cognitive symptom management, and frequency of aerobic exercise.	A

Self-management of pain		
2.5.10	Promote the following self-management programs for older adults with chronic pain: Arthritis Foundation Self-Help Program (AFSHP), yoga, massage therapy, Tai Chi, and music therapy.	B
Exercise interventions		
2.5.11	Promote exercise in the management of both chronic low back pain and osteoarthritis.	B
2.5.12	Ensure that exercise, supported by advice and education, is at the core of self-management strategies for chronic low back pain and osteoarthritis.	B
Arthritis		
Promote:		
2.5.13	both patient education and exercise for patients with knee osteoarthritis to achieve a modest, yet clinically important, influence on patients' well-being.	B
2.5.14	exercise regimes to achieve improvements in physical health (by self-report and direct measures) and in overall impact of osteoarthritis (OA).	B
2.5.15	self-management as a safe, community-based and effective way for patients with arthritis to manage pain and disability. Ensure that core skills of self-management are delivered using multiple approaches.	B
2.5.16	self-management programs for adult patients with arthritis to achieve small to moderate effects in improving pain and disability at the long-term level.	B
2.5.17	self-management programs for osteoarthritis to achieve small improvements in pain and function.	B
Diabetes		
Promote:		
2.5.18	diabetes self-management training programs to improve patients’ quality of life.	B
2.5.19	individual patient education for people with type 2 diabetes mellitus to improve glycaemic control.	B
2.5.20	chronic disease self-management programmes for elderly people with diabetes mellitus or hypertension to achieve clinically important benefits.	B
COPD		
2.5.21	Promote regular practice od pursed lip breathing as an effective self- management strategy for individuals with chronic obstructive pulmonary disease (COPD) to improve their dyspnoea.	B

Musculoskeletal pain		
2.5.22	Promote educational programs for patients with back pain in an occupational setting in combination with an exercise program.	B

Kidney disease		
Promote:		
2.5.23	multi-component structured educational interventions to improve pre-dialysis and dialysis care.	B
2.5.24	effective frameworks to develop, implement, and evaluate educational interventions that target patients with early stages of chronic kidney disease.	B

Mental health disorders		
2.5.25	Promote the Monthly Medication Journal as a tool to promote day-to-day functioning, perceptions of quality of life, severity of illness, and use of clinical services for individuals with mental disorders.	B

Anticoagulation therapy		
2.5.26	Promote self-monitoring to improve the quality of oral anticoagulation therapy.	A

Epilepsy		
2.5.27	Promote self-management for adults with epilepsy.	B

Calendar blister packaging		
2.5.28	Promote calendar blister packaging, in combination with education and reminder strategies, to improve medication adherence.	B

2.6 Recommendations for interventions to promote better physical health outcomes and quality of life for carers (all ages)

This evidence review recommends:

Intervention		Grade
Commissioners		
2.6.1	Ensure a range of information, support (including practical help and respite arrangements) and bereavement services are in place to meet the spectrum of need. They will need to work with statutory and voluntary health and social care agencies to achieve this.	A

Provider		
2.6.2	Nominate a lead to oversee the development and implementation of services that specifically focus on the needs of families and carers.	A
2.6.3	Assess and address the needs of family members and carers on an ongoing basis. Teams should establish a system to ensure	A

	family members and carers have regular opportunities to discuss particular concerns.	
2.6.4	Where carers are providing a substantial amount of care on a regular basis, providers should ensure they are offered a separate assessment, or respond positively when a carer asks for one, in accordance with The Carers (Recognition and Services) Act 1954.	A
2.6.5	Ensure all family members and carers are offered information on a variety of topics, from a simple ‘who’s who’ of professionals to more detailed accounts of cancer, its treatment and consequences and services available locally.	A
2.6.6	Ensure teams provide families and carers with a clear indication of the personnel they might contact in relation to a range of needs.	A
2.6.7	Promote support groups for family members and carers, either professionally or peer-led.	A
2.6.8	Ensure awareness of the needs of family members from different ethnic populations, including differences in language, religious practice and culture, is necessary within a multi-cultural society.	A
2.6.9	Ensure teams have access to reference guides on the cultural differences surrounding a diagnosis of cancer, death and dying, and that information on accessing interpreters, relevant health advocates (where available) and faith leaders is readily accessible.	A

Carer stress/anxiety/depression		
Promote:		
2.6.10	the development of standardised guidelines that address caregiver assessment, education, and resources.	B
2.6.11	the identification of "caregiver champions" in practice settings.	B
2.6.12	provision of referrals to established support organisations for caregivers.	B
2.6.14	collaboration among care-giving, professional, and cancer-related organisations to advocate policy and practice changes for family caregivers.	B

2.6.15	Ensure families coping with bipolar disorder benefit from family interventions to support caregivers' ability to manage stress and regulate their moods, even when the patient is not available for treatment.	C
2.6.16	Be aware that psychological morbidity, such as symptoms of depression or anxiety, as well as caregiver strain or burden, is associated with reports of decreased physical health.	B

Carers support and counselling Ensure:		
2.6.17	family members and carers are made aware of, and have easy access to, sources of local information, advice and support designed to meet their own needs.	A
2.6.18	family members and carers who are bereaved are, in the first instance, encouraged to use existing support systems. Where these prove insufficient, or it is predicted that those involved are likely to experience difficult grief reactions, there should be access to additional help and support.	A
Promote:		
2.6.19	provision of referrals to established support organisations for caregivers.	B
2.6.20	counselling and support preserved self-rated health (SRH) in vulnerable caregivers.	B

2.6.21	enhanced counselling in vulnerable caregivers. Enhanced counselling and support consists of six sessions of individual and family counselling, support group participation, and continuous availability of ad-hoc telephone counselling.	B
2.6.22	enhanced caregivers' social support in vulnerable caregivers, fostering more benign appraisals of stressors, and reducing depressive symptoms in order to yield indirect health benefits.	B
Carers information and advice		
2.6.23	Ensure family members and carers are made aware of, and have easy access to, sources of local information, advice and support designed to meet their own needs.	A
Respite for carers		
Promote:		
2.6.24	respite care for frail elderly people to improve carers mental or physical health.	B
Family		
2.6.25	Ensure that families coping with bipolar disorder are offered family interventions to manage stress and regulate their moods, even when the patient is not available for treatment.	C
2.6.26	Consider Family-Focused Treatment-Health Promoting Intervention (FFT-HPI) to reduce caregiver depressive symptoms and health risk behaviour among caregivers of patients with bipolar disorder.	C
Joint working		
2.6.27	Providers of specialist bereavement support should work closely with other care providers (both statutory and voluntary) to ensure carers and family members can access services when needed.	A
2.6.28	Promote collaboration among care-giving, professional, and cancer-related organisations to advocate policy and practice changes for family caregivers.	B
Training for carers-self care/problem-solving		
Promote:		
2.6.29	structured, multi-component skills training interventions in racially and ethnically diverse caregivers of people with dementia that is targeted at caregiver’s self-care behaviours.	B
2.6.30	the Resources for Enhancing Alzheimer's Caregiver Health (REACH) intervention, to improve self-rated health, sleep quality, physical and emotional health, in caregivers.	B
2.6.31	problem-solving training provided in the home to alleviate distress and decrease dysfunctional problem-solving styles among family caregivers of persons with traumatic brain injuries (TBI).	C

Carer gender/ age/ethnicity		
Be aware there is evidence that:		
2.6.32	female and male caregivers do not differ in the use of informal and formal support.	C
2.6.33	higher age, lower socioeconomic status, and lower levels of informal support are related to poorer caregiver health.	B
2.6.34	all groups of ethnic minority caregivers report worse physical health than white groups. (US study).	B
2.6.35	ethnic minority caregivers provided more care than white caregivers and had stronger filial obligations beliefs than white caregivers. (US study).	B

2.7 Recommendations for integrated services as an intervention to avoid inappropriate attendance at A&E/admissions/bed days

This evidence review recommends:

Intervention		Grade
Policy makers should:		
2.7.1	consider the impact of socio-economic deprivation and other socio-demographic factors when designing policy around admission rates	B
2.7.3	encourage commissioners to implement evidence-based interventions for avoidable admissions, and to evaluate their impact in the local context.	B
2.7.4	the impact of socio-economic deprivation and other socio-demographic factors when designing policy around admission rates.	B
2.7.5	aim to increase self-management among people with long- term conditions where there is evidence of benefit.	B
2.7.6	consider the impact of socio-economic deprivation and other socio-demographic factors when designing policy around admission rates.	B
2.7.2	Commissioners and providers should aim to increase self-management among people with long-term conditions where there is evidence of benefit.	B

Commissioners should consider:		
2.7.8	the impact of local out-of-hours primary care arrangements on avoidable admissions alongside primary care providers.	B
2.7.9	implementing multidisciplinary interventions and telemonitoring for patients with heart failure.	B
2.7.10	implementing hospital at home.	B
2.7.11	implementing assertive case management for people with mental health illnesses.	B
2.7.12	closer integration of primary and social care, and should evaluate the outcomes of any new interventions.	B
2.7.13	closer integration of primary and secondary care and should evaluate the outcomes of any new intervention	B

Commissioners need to:		
2.7.7	be clear about which admissions they consider to be avoidable, what proportion of these admissions are avoidable, and how	B

	these admissions should be coded and measured.	
2.7.14	be clear about which admissions they consider to be avoidable, what proportion of these admissions are avoidable, and how these admissions should be coded and measured.	B
2.7.15	implement evidence-based interventions as follows:	B
	• multidisciplinary interventions and tele-monitoring for patients with heart failure;	
	• assertive case management for patients with mental health problems;.	
	• hospital at home;	
	• closer integration of primary and secondary care;	
	• conduct early senior review in A&E;	
	• implement structured discharge planning (providers only);	
	• continue to implement acute assessment units, but consider the overall impact on number of admissions;	
	• aim to increase self-management among people with long-term conditions where there is evidence of benefit;	
2.7.16	disinvest in programmes where there is robust evidence that they have little or no effect.	B
2.7.17	evaluate all new interventions, as even those that have proved beneficial in other settings may not be transferable to the local population.	B
Service providers should consider:		
2.7.18	early senior review in A&E.	B
2.7.19	structured discharge planning.	B
2.7.20	Providers and commissioners should continue to implement acute assessment units, but should consider the overall impact on number of admissions.	B
Primary care should:		
2.7.21	increase continuity of care with a GP.	B
2.7.22	provide GP continuity of care.	B
2.7.23	provide diabetes clinics.	B
2.7.24	review the quality of local, out-of-hours primary care arrangements on avoidable admissions.	B
2.7.25	consider closer integration of primary and social care.	B
2.7.26	consider closer integration of primary and secondary care.	B
Effective interventions to reduce admissions and re-admissions		
Promote:		
2.7.27		B

	• continuity of care with a GP;	
	• hospital at home as an alternative to admission;	
	• assertive case management in mental health;	
	• self-management;	
	• early senior review in A&E;	
	• multidisciplinary interventions and tele-monitoring in heart failure;	
	• integration of primary and secondary care;	
	• structured discharge planning;	
	• personalised health care programmes.	

Personalised health care programmes		
Promote:		
2.7.29	integrated teams that work in the patient's home and incorporate elements of comprehensive geriatric assessment, care planning, disease management and health promotion.	B
2.7.30	interventions that include home care components. These include patient education on specific issues, close follow-up, home monitoring, adjustment of medication and regular communication with clinical experts.	B
2.7.31	interventions that incorporate geriatric management supported with home care post discharge to prevent hospital readmissions in elderly patients.	B

Telecare		
Promote:		
2.7.32	interventions that include automated vital signs monitoring and telephone follow-up by nurses.	B
2.7.33	Telemedicine to support patients with heart failure.	B
2.7.34	Telemedicine interventions for heart disease, diabetes, hypertension and older people.	B
2.7.35	interventions to improve care for frail elderly people and people with chronic conditions.	B

Factors that impact on inappropriate attendance at A&E/admissions/bed days		
2.7.36	When planning services to reduce inappropriate admissions be aware that:	B
	• those who live in urban areas have higher rates of emergency hospital admission than those in rural areas;	
	• higher levels of morbidity in a population are associated with higher levels of emergency admission;	
	• admission rates are also correlated with chronic illness;	
	• age is a risk factor for emergency hospital admission, with babies or very young children and older people being at higher risk;	

	• people from lower socio-economic groups are at higher risk of avoidable emergency admissions.	
Integrated health and social care services		
Promote:		
2.7.37	integration of primary and social care.	B
2.7.38	integrated health and social care teams, working with people in their own homes.	B
Integrated case management		
Promote:		
2.7.39	assertive case management for patients with mental health problems.	B
2.7.41	intensive case management for people with severe mental illness when hospital use is high.	B
2.7.42	patient advocacy case management in frail elderly patients.	B
Hospital at home services		
Promote:		
	hospital at home services where appropriate.	B
Accident and emergency		
2.7.43	Promote early review by a senior clinician in the emergency department.	B
2.7.44	Consider promoting GPs working in the emergency department to reduce inappropriate admissions, consideration should be made regarding cost-effectiveness.	B
Integrated primary and secondary care services		
Promote:		
2.7.45	the integration of primary and secondary care.	B
Integrated dementia services		
2.7.46	Consider alternatives to an acute hospital admission for those people with dementia, e.g. respite care or home care.	B
Improved out-of- hours services		
Promote:		
2.7.47	quality out-of hours services.	B

Integrated disease management and care pathways		
Promote:		
2.7.48	integrated use of disease management interventions for asthma and COPD.	B
2.7.49	integrated care pathways for disease management.	B

Specialist heart-failure services		
Promote:		
2.7.50	specialist clinics for heart failure patients, which include clinic appointments and monitoring over a 12 month period.	A
2.7.51	case management type interventions led by a heart failure specialist nurse to reduce congestive cardiac failure related readmissions after 12 months follow up, all cause readmissions and all-cause mortality.	A
2.7.52	multidisciplinary interventions to reduce congestive cardiac failure and all cause readmissions.	B

Integrated community services		
Promote:		
2.7.53	the visiting of acutely at risk populations e.g. failure to thrive infants, heart failure patients.	B

Exercise and rehabilitation services		
Promote:		
2.7.54	pulmonary rehabilitation as a highly effective and safe intervention in patients who have recently suffered an exacerbation of COPD.	B
2.7.55	exercise based cardiac rehabilitation for coronary heart disease.	B

Specialist outreach integrated services		
Promote:		
2.7.56	especially when delivered as part of a multifaceted intervention to improve access, outcomes and service use.	B
2.7.57	to facilitate engagement between specialists and primary care practitioners. Interaction is greatest when outreach is part of a complex multifaceted intervention which involves case-conferences, joint consultations, seminars and education sessions, other health professionals or other care enhancements.	B
2.7.58	as part of more complex multifaceted interventions involving collaboration with primary care, education or other services.	B

Supported discharge services for the management of acute stroke		
Promote:		
2.7.59	early supported discharge services to allow patients to return home from hospital earlier than usual and receive more rehabilitation in the familiar environment of their own home. Early supported discharge services are provided by teams of therapists, nurses and	A

	doctors.	
2.7.60	early supported discharge services because patients are more likely to be independent and living at home six months after stroke than those who received conventional services.	A
Comprehensive geriatric assessment		
Promote:		
2.7.61	evidence that comprehensive geriatric assessment increases patients’ likelihood of being alive and in their own homes after an emergency admission to hospital.	A
2.7.62	as routine part of inpatient care in older patients.	A
2.7.63	to support all frail elderly patients admitted to hospital as an emergency. Compliance with best practice should be audited across healthcare providers, and the provision of geriatric services needs reviewed.	A
This evidence review does not recommend:		
2.7.64	the following:	B
	• pharmacist home-based medication review;	
	• intermediate care;	
	• community-based case management (generic conditions);	
	• early discharge to hospital at home on readmissions;	
	• nurse-led interventions pre- and post-discharge for patients with chronic obstructive pulmonary disease.	
2.7.65	therapy based rehabilitation targeted towards stroke patients living at home.	B

APPENDIX 7

HIGH QUALITY AND CHOICE OF END OF LIFE CARE

The objective of this section is to make evidenced based recommendations that support commissioners with a robust basis for decision making.

Recommendations are based on evidence from systematic reviews and meta-analyses. Scoring of recommendations is based on the SIGN methodology as set out in Chapter 2. Recommendations graded ‘A’ are based on the highest quality evidence and those graded ‘D’ the lowest. These reviews were carried out at a specific point in time and we acknowledge there are further caveats commissioners must take into consideration:

- NICE guidance is being updated on a continuous cycle, and some of the evidence presented here may not have been reviewed by NICE at this time. Commissioners need to ensure interventions do not conflict with current NICE guidance.

- East Sussex CCGs operate a ‘Low Priorities Procedures’ process. Whereby some procedures are not ordinarily commissioned and requests for treatment are referred to an ‘individual treatment panel’. It is important to recognise that the agreed processes should be followed for these interventions.

- Locally, new pathways to treatment for patients for a wide range of conditions are being developed by GPs, commissioners and secondary care clinicians. It is important to ensure agreed treatment pathways are followed.

It is recommended that commissioners review the entire evidence base set out in the evidence review for this priority area, but that service planning focuses on those issues highlighted by this recommendations section.

RECOMMENDATION NUMBERS LISTED ARE THOSE FROM THE FULL EVIDENCE REVIEW FOR THIS PRIORITY AREA. FULL EVIDENCE REVIEWS ARE AVAILABLE ON THE EAST SUSSEX JOINT STRATEGIC NEEDS ASSESSMENT WEBSITE WWW.EASTSUSSEXJSNA.ORG.UK.

2.2 Recommendations for interventions to increase the number of people identified as approaching end of life

This evidence review recommends:

Intervention		Grade
Commissioner		
2.2.1	Promote and commission services that identify people approaching the end of life in a timely way and have the capability to record identification.	A
2.2.2	Ensure people approaching the end of their life are identified at the right time to receive care and support to meet their needs and preferences.	A
Service provider		
2.2.3	Service providers should ensure that systems are in place to identify people approaching the end of life in a timely way.	A
Health and social care professional		
2.2.4	Encourage health and social care professionals to identify people approaching the end of life in a timely way.	A
2.2.5	Ensure clinicians caring for patients with terminal cancer are aware of their tendency to overestimate survival, as it may affect patients' prospects for achieving a good death.	B
Decision support tools for assisting clinicians with timely identification		
Encourage:		
2.2.6	clinicians to use decision support tools with timely identification of people approaching the end of life.	B
2.2.7	health professionals to identify those patients who may be nearing the end of life.	B
Care Register		
2.2.8	Promote evidence based strategies to include more patients on the palliative care register	C
2.2.9	Consider using the question: "Would you be surprised if this patient were to die in the next year/months/weeks?". If it would not be a surprise, what could be done to be prepared just in case this occurred?	C
2.2.10	Consider using prognostic indicator guidance to increase the chance of predicting patients approaching the end of life , e.g. the revised Prognostic Indicator Guidance (RCGP website).	B
2.2.11	Encourage health professionals to use the RADboud indicators for PAlliative Care Needs (RADPAC) to identify patients with CHF, COPD, or cancer in need of palliative care.	B
Prognostic indicators for assisting clinicians		
Encourage:		

2.2.13	health professionals to review prognostic indicators of their patients with non-cancer long term conditions, including poor performance status; advanced age; malnutrition; comorbid illness; increasing organ dysfunction; hospitalisation for acute decompensation, in order to identify those who are approaching the last year of their life.	B
2.2.14	health professionals to review prognostic indicators of their patients with non-cancer long term conditions especially dementia, congestive heart failure and chronic obstructive pulmonary disorder, in order to identify those who are approaching the last year of their life.	B
2.2.15	clinicians to use Clinical Prediction of Survival (CPS) in combination with other prognostic factors or scores to improve the accuracy of their predictions.	A
2.2.16	health professionals to review prognostic indicators of their patients with cancer. Performance status is one of the most significant survival predictors in advanced cancer. The Karnofsky Performance Status (KPS) and the Eastern Cooperative Oncology Group (ECOG) scales, both have good reliability and validity.	B
2.2.17	health professionals to include the additional prognostic value of health-related quality of life data to that of socio-demographic and clinical factors, to improve estimation of survival probabilities for patients with cancer.	A

Identifying people approaching end of life		
Encourage:	health professionals to review prognostic indicators to identify those patients with a median survival of 6 months or less for:	
2.2.18	congestive heart failure	B
2.2.19	chronic obstructive pulmonary disease	B
2.2.20	dementia	B
2.2.21	geriatric failure to thrive	B
2.2.22	hepatic disease	B
2.2.23	renal disease	B
2.2.24	geriatric patients in care homes who are failing to thrive.	C

2.3 Recommendations for interventions to increase the number of people identified as approaching end of life with advanced care plans

This evidence review recommends:

Intervention		**Grade**
Commissioners and service providers		
Ensure:		
2.3.1	once people have been identified as approaching the end of life, they receive a prompt initial holistic assessment.	A
2.3.4	people approaching the end of life have the opportunity to discuss their needs and preferences. This includes the opportunity to develop and review a care plan detailing their preferences for current and future support and treatment.	A
2.3.5	comprehensive holistic assessments for advance care planning are multidisciplinary and have input from both health and social care professionals, as well as other appropriate support services.	A

2.3.6	assessments encompass all aspects of end of life care, taking into account the preferences of the person approaching the end of life, and their family and carers.	A
2.3.8	patients' individual needs are assessed.	A
2.3.9	patients do not receive unnecessary repeated assessments from different professionals aiming to elicit similar information.	A
2.3.2 2.3.3	Systems are in place to enable comprehensive holistic assessments to be carried out with people identified as approaching the end of life, in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.	A
2.3.7	provider organisations employ health and social care professionals that have received training in assessing patients' and carers' needs.	A
Structured assessments		
Ensure:		
2.3.10	structured assessments are undertaken at key points in the patient pathway with locally agreed format and mechanisms for sharing the data among the multidisciplinary team. Findings should be discussed at multidisciplinary team meetings.	A
2.3.11	the structured assessment is an on-going process that is updated throughout the course of a patient's illness.	A
2.3.12	all patients with advanced cancer have their physical, psychological, social and spiritual needs, and their preferences for the nature and location of care assessed on a regular basis.	A
2.3.13	assessments are made by health care professionals who have received further education and training in palliative care	A
Advanced care plans		
Promote:		
2.3.14	key components of best practice in supporting community palliative care advance care planning, including:	A
	• agreed identification criteria and a management plan discussed within the multidisciplinary team;	
	• patients and their carers are regularly assessed using agreed assessment tools;	
	• anticipated needs are noted, planned for and addressed;	
	• patient and carer needs are communicated within the team and to specialist colleagues, as appropriate;	
	• preferred place of care and place of death are discussed and noted, and measures taken to comply, where possible;	
	• co-ordination of care is orchestrated by a named person in a GP practice team;	
	• relevant information is passed to those providing care out of hours, and anticipated prescribed drugs left in the home;	
	• a protocol for care in the dying phase is followed, such as the Liverpool Care Pathway for the Dying Patient or the Welsh Integrated Care Pathway for the last two days of life;	
	• carers are educated, enabled and supported, which includes the provision of specific information, financial advice and bereavement care;	
	• audit, reflective practice, development of practice protocols and targeted learning are encouraged as part of personal,	

	practice and provider organisation development plans.	
2.3.31	simple patient-directed educational interventions to support the completion rate of advance directives.	B
2.3.32	direct counselling to support the completion rate of advance directives.	B
2.3.33	clinician-initiated discussion to support the completion rate of an advance directive.	B
2.3.34	direct patient–healthcare professional interactions over multiple visits to support the completion rate of advance directives.	B
2.3.35	combined written and verbal educational to support the completion rate of advance directives in clinic outpatients and hospitalised elderly.	A
2.3.36	a combination of informative material and repeated conversations over clinical visits to support the completion rate of advance directives.	A
2.3.37	interactive informative interventions to support the completion rate of advance directives.	B
2.3.38	multiple sessions of direct interaction between patients and health care professionals to support the completion rate of advance directives.	B
2.3.39	interaction with a knowledgeable person to support the completion rate of advance directives.	B
2.3.40	the availability of a person who can answer questions and assist with advance directive completion to support the completion rate of advance directives.	B
2.3.41	communications where participants had the opportunity to ask questions and/or receive assistance completing advanced directive forms to support completion rates.	B
2.3.42	opportunities for group interaction to intensify the discussion and question and answer process to support the completion rate of advance directives.	B
2.3.43	interventions that include repeated contacts or stimuli toward advance directive completion.	B
2.3.44	two or more home care visits by the community health nurse to improve completion rates.	B
2.3.14	key components of best practice in supporting community palliative care advance care planning.	A

Advanced care planning communication		
Ensure:		
2.3.15	communication about prognosis is included as an essential aspect of effective advance care planning and that it is documented effectively.	B
2.3.17	caregivers of palliative patients have information and support needs, especially prognostic and disease-related information needs.	B
2.3.19	information is provided using plain language and the patient’s understanding of the information that has been conveyed is checked.	B
Promote:		
2.3.16	discussion about prognosis and advance care planning within one month of a patient’s new diagnosis of advanced cancer	B
2.3.18	advanced care planning communication strategies that include the following:	B

	• facilitate the establishment of a close rapport with the patient;	
	• identify the patient’s information preferences;	
	• ensure comprehension of key knowledge and information;	
	• address the patient’s emotions in a supportive fashion;	
	• elicit the patient’s key concerns	
	• involve the patient in the treatment plan.	
2.3.20	provision of information verbally regarding advanced directives over multiple sessions.	A
Sentinel events		
2.3.21	Ensure there are minimal standards for when advance care planning should be discussed in cancer patients including at diagnosis of cancer, before an expected death from cancer, and other sentinel events.	B
Health professional communications		
Promote:		
2.3.22	patient-physician communication techniques to improve the frequency of advance directive completion.	B
2.3.23	educational interventions for physicians to increase the ability of physicians to elicit patient preferences.	B
2.3.24	palliative care/coordinated care intervention to improve completion of advance directives for patients.	B
2.3.25	oncologists being encouraged to be open with patients about prognosis and be comfortable addressing sensitive issues such as future goals of care in the context of their patient’s disease.	B
2.3.26	multi-component social work-based intervention that includes counselling by social workers specifically trained in communication skills, capacity assessment, and advance care planning improved documentation of patients’ wishes regarding common life-sustaining treatments.	B
Involvement of palliative care team		
2.3.27	Promote the inclusion of a palliative care team as part of the multi-disciplinary team early after the diagnosis of cancer as opposed to waiting until severe symptoms emerge may aid in the adjustment process. However, ultimately the timing should be guided by each individual’s preferences.	B
Identification of people with cognitive impairment		
Promote:		
2.3.28	advance care planning to reduce inappropriate hospital admissions and health-care costs for people with cognitive impairment and dementia.	B
2.3.30	advance care planning being carried out before mental capacity is lost. Advance care planning allows a patient to discuss and write down their preferences for care, so that if, in future, they cannot make decisions their wishes are known.	C

2.3.29	Ensure advance care planning is carried out in the earlier stages of the illness before capacity is lost, after which seek proxy views to facilitate best interest decision-making.	C

Transfer interventions		
Promote:		
2.3.48	a standardised patient transfer form to assist with the communication of advance directives and medication lists.	B
2.3.49	pharmacist-led review of medication lists to identify omitted or indicated medications on transfer of medication lists and advance directives.	B

This evidence review does not recommend:

Intervention		**Grade**
2.3.50	passive education of patients using written materials (without direct counselling) in the primary care setting.	B
2.3.52	education without the ability to ask questions.	B
2.3.53	didactic interventions.	B
2.3.54	the addition of video instruction when compared to the effectiveness of written materials.	B

2.4 Recommendations for interventions to promote the number of people dying in their preferred place of care and reduce the number dying in hospital

This evidence review recommends:

Intervention		**Grade**
Integrated care pathways		
2.4.1	People approaching the end of life should receive care that is aligned to their needs and preferences that include an increased length of time spent in preferred place of care during the last year of life.	B
2.4.2	People approaching the end of life should have a reduction in unscheduled care hospital admissions leading to death in hospital (where death in hospital is against their stated preference).	B
2.4.4	Promoting an integrated approach to provision of services is fundamental to the delivery of high-quality care to people approaching the end of life and their families and carers.	B
Ensure:		
2.4.3	services are commissioned from and coordinated across all relevant agencies, including specialist palliative care, and encompass the whole end-of-life care pathway.	B
2.4.5	people approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night, and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.	B
2.4.6	people approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective	B

	urgent care appropriate to their needs and preferences.	
2.4.7	people approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.	B
2.4.8	social care workers have the knowledge, skills and attitudes necessary to be competent to provide high-quality care and support for people approaching the end of life and their families and carers.	B
2.4.9	generalist and specialist services providing care for people approaching the end of life and their families and carers have a multidisciplinary workforce sufficient in number and skill mix to provide high-quality care and support.	B
Training and support of health professionals		
2.4.10	Promote training for health professionals to ensure they are empowered, enabled and supported to achieve the delivery of effective end of life care.	B
Responsive interventions		
Ensure:		
2.4.11	responsive mechanisms are implemented within each locality to ensure that medical and nursing services are available for patients with advanced cancer on a 24-hour, seven days a week basis, and that equipment can be provided without undue delay. Those providing generalist medical and nursing services should have access to specialist advice at all times.	B
2.4.12	primary care teams institute mechanisms to assess needs of patients with advanced cancer, and that the information is communicated within the team and with other professionals as appropriate.	B
2.4.14	an appropriate range and volume of specialist palliative care services to meet the needs of the local population, based on local calculations. These services should, as a minimum, include specialist palliative care in-patient facilities and hospital and community teams.	B
2.4.15	specialist palliative care advice is available on a 24 hour, seven days a week basis. Community teams should be able to provide support to patients in their own homes, community hospitals and care homes.	B
2.4.16	each multidisciplinary team or service implements processes for effective inter-professional communication within teams and between them and other service providers with whom the patient has contact. Mechanisms should be developed to promote continuity of care.	B
2.4.18	patients and carers have easy access to a range of high quality information materials about cancer and cancer services. These materials should be free at the point of delivery and patients should be offered appropriate help to understand them within the context of their own circumstances.	B
2.4.19	explicit partnership arrangements are agreed between local health and social care services and the voluntary sector to ensure that the needs of patients with cancer and their carers are met in a timely fashion and that different components of social support are accessible from all locations.	B
2.4.21	provider organisations identify staff who may benefit from training and should facilitate their participation in training and on-going development. Individual practitioners should ensure they have the knowledge and skills required for the roles they	B

	undertake.	
Promote:		
2.4.13	access to, and availability of, specialist palliative care services.	B
2.4.17	responsive mechanisms to ensure the views of patients and carers are taken into account in developing and evaluating cancer and palliative care services.	B
2.4.20	the nomination of a lead person to oversee the development and implementation of services that specifically focus on the needs of families and carers during the patient’s life and in bereavement, and which reflect cultural sensitivities.	B

End of life home care		
Promote:		
2.4.22	end of life home care to enable more people to die at home compared with those receiving usual care.	A
2.4.23	support by district nurses to offer additional help to care givers looking after the patients especially with night nursing.	B

Factors linked to people dying in their home		
Promote:		
2.4.24	actions to enable people to die at home: empowerment of families, public education, home based models of care, assessment of risk, and training of practitioners in palliative care.	B
2.4.25	social support, healthcare inputs, from services and programs and healthcare provider contact, and patient preferences.	B

Rural interventions		
Ensure:		
2.4.26	rural end-of-life services are integrated into rural hospitals and all other health care organisations.	B
2.4.27	family caregivers from rural areas are provided with more information and support, particularly in the form of home-based nursing care.	B
2.4.29	people living in rural areas have access to specialised palliative care and home care.	B
2.4.28	promote continuing education and for improved support of rural care providers.	B

Nurse led follow-up interventions		
Promote:		
2.4.30	nurse-led follow-up; patient-initiated or telephone follow-up could be practical alternatives to conventional care.	B
2.4.31	nurse-led follow-up actions to support patients with cancer that include: an initial care plan; provision of adequate patient	B

	education and information; provision of sufficient time and encouragement for patients to raise questions and concerns; provision of psychological support; tests and examinations not to be conducted purely for reassurance; provision of contact details of a key person whom patients can contact when needed and informed choice for patients about attendance for scheduled appointments or only attending when problems or symptoms arise.	

Hospice care delivered at home		
Promote:		
2.4.32	hospice care delivered at home, in nursing homes and in dedicated hospice facilities.	B
2.4.33	hospice services to ensure increased likelihood of effective pain management and of death not occurring in hospital.	B

Supporting carers		
Promote:		
2.4.34	support for informal carers as they are central to the achievement of end of life care and death at home.	B
2.4.39	access to professional advice to increase carers’ confidence in their ability to undertake practical aspects of home-based care.	B
2.4.40	nurses and other health providers to assist home-based carers by providing them with information and skills-training necessary to facilitate home-based care.	B
Ensure informal carers:		
2.4.37	have access to practically focused information from health professionals.	B
2.4.38	are offered opportunities to learn about practical nursing skills.	B
Receive information about:		
2.4.41	• medication and pain management.	B
2.4.42	• physical symptoms and comfort, including management of weakness and fatigue, nausea and vomiting, mouth ulcers, oedema; wound and skin care; symptom recognition and prevention of dehydration.	B
2.4.44	• personal hygiene and elimination - bathing, cutting toe nails and dressing; bowel management; coping with incontinence; changing a catheter.	B
2.4.45	• positioning - patient ambulation, lifting and handling, sorting pillows.	B
2.4.46	• awareness of, availability, access, optimal positioning and use of technical equipment.	B
2.4.47	• local support - access to night services or 24-hour support; signposting to local resources and/or agency help.	B
2.4.48	• emergency measures recognising signs of imminent death; knowledge of emergency measures and provision of emergency contacts.	B
2.4.35	Ensure older carers’ needs are addressed.	B

2.5 Recommendations for interventions to promote end of life care staff training

This evidence review recommends:

Intervention		**Grade**
Provider		
2.5.1	All health and social care professionals receive training in assessing patients' and carers' needs. These professionals have a responsibility to ensure they have received such training before undertaking assessments.	A
2.5.2	Promote communication skills training programmes on the introduction of palliative care.	A
Curricular interventions		
Promote:		
2.5.3	a palliative care curriculum with a multifaceted approach, incorporating a variety of intentional strategies to address the multiple competencies required.	B
2.5.4	communication skills in palliative care utilising simulated patients in a short 2-hour session or a full-day workshop.	B
2.5.5	a modular approach to End of Life education.	B
2.5.6	a multifaceted approach with focus on individual competencies to meet all of educational requirements of postgraduate learners in end-of-life care.	B
Intensive care unit staff training		
2.5.9	Promote increased collaboration and communication between health professionals in order to achieve more appropriate care and increased physician/nurse satisfaction.	B
Ensure:		
2.5.7	critical care physicians are competent in family-centred end-of-life communication.	B
2.5.8	all intensive care unit professionals receive adequate support and appropriate end-of-life education.	B
2.5.10	there is sufficient time and space made available for professional conversations and reflection about care, use of joint grand rounds, patient care seminars, and inter-professional dialogues can increase understanding and desire to have interdisciplinary end-of-life care.	B
2.5.11	nurses' role in end-of-life decision making is valued and included.	B
Palliative care nurse training		
Promote:		
2.5.12	transfer of communication skills training to practice by clinical supervision.	C
2.5.13	a combination of communication skills training and managing death education to improve skills outcomes.	C
2.5.14	palliative care courses that address general care and mental healthcare as well.	C

2.5.15	a mixture of didactical methods and a combination of multiple themes delivered over a period of several weeks. As well as ensuring the training is integrated with practical experiences.	B
Medical undergraduate training		
2.5.17	Development of more academic departments of palliative care would facilitate palliative care teaching.	B
2.5.19	Use of small groups for problem based learning.	B
Promote:		
2.5.20	inclusion of multidisciplinary teaching.	B
2.5.21	involvement of all team members along with the patient and family in the teaching.	B
2.5.22	integration of teaching and combination of disciplines and principles throughout the curriculum.	B
2.5.23	fostering of reflective learning.	B
2.5.24	inclusion of ethical and legal issues of relevance to end of life care.	B
Ensure:		
2.5.18	knowledge and essential core information is taught.	B
2.5.25	students acquire effective mechanisms to deal with the professional and personal pressures of this aspect of their work.	B
Specific oncology training		
Promote:		
2.5.26	specialist training for oncologists. Physicians can be trained to meet better core challenges during the transition to palliative care through developed concise communications skills training called COM-ON-p.	B
2.5.27	COM-ON-p communication skills training. A COM-ON-p communication skill training has been well accepted; oncologists rated COM-ON-p as highly practical, relevant, and of high personal benefit.	B
E-learning interventions		
Promote:		
2.5.28	palliative care education using e-learning platforms.	B
2.5.29	E-mailed fast facts and concepts as an educational intervention that increases intern medical knowledge and self-reported preparedness in symptom management skills.	B
Communications skills training		
Promote:		
2.5.30	three day communication skills courses to train nurses in end of life care.	B
2.5.32	nurses’ communication skills training, to improve patient satisfaction with nurses’ communication.	B

This evidence review does not recommend:

Intervention		Grade
2.5.33	E-mailed fast facts and communication skills or learner satisfaction with palliative care concepts assists in preparedness in education.	B

2.6 Recommendations for interventions to support people who are bereaved

This evidence review recommends:

Intervention		Grade
Models of bereavement support		
2.6.1	2004 NICE guidance recommends that a three-component model of bereavement support should be developed and implemented in each Cancer Network to ensure that people's individual needs are addressed through variety in service provision. Cancer Networks should take account of the standards for bereavement care developed by the National Bereavement Consortium. The components should be flexible and accessible when needed around the time of bereavement.	A
	Component 1: Grief is normal after bereavement and most people manage without professional intervention. All bereaved people should be offered information about the experience of bereavement and how to access other forms of support.	
	Component 2: Some people may require a more formal opportunity to review and reflect on their loss experience, but this does not necessarily have to involve professionals. Volunteer bereavement support workers/befrienders, self-help groups, faith groups and community groups will provide much of the support at this level.	
	Component 3: A minority of people will require specialist interventions. This will involve mental health services, psychological support services, specialist counselling/psychotherapy services, specialist palliative care services and general bereavement services, and will include provision for meeting the specialist needs of bereaved children and young people (being developed as part of the National Service Framework on children and not covered here).	
Commissioners		
2.6.2	Promote commissioning services for people closely affected by a death that include sensitive communication and provision for immediate and ongoing bereavement, emotional and spiritual support appropriate to their needs and preferences.	A
2.6.3	Commissioners, working through Cancer Networks, should ensure that a range of information, support (including practical help and respite arrangements) and bereavement services are in place to meet the spectrum of need. They will need to work with statutory and voluntary health and social care agencies to achieve this. While not necessarily separate from many of the services provided to patients (indeed, most will be fully integrated), commissioners should ensure sufficient capacity to meet the distinct needs of this group.	A
Provider		
2.6.4	Service providers should ensure that systems are in place for people closely affected by a death that include sensitive communication and provision for immediate and ongoing bereavement, emotional and spiritual support appropriate to their	A

	needs and preferences.	
2.6.5	Ensure families and carers have access to professionals capable of providing confidential emotional support and, if there is variance between the needs, choices and judgements of a family member or carer and those of the patient, the professional is independent of normal services offered to the patient.	A
2.6.6	Providers of specialist bereavement support should work closely with other care providers (both statutory and voluntary) to ensure carers and family members can access services when needed.	A
2.6.7	Ensure a nominated lead to oversee the development and implementation of services that specifically focus on the needs of families and carers.	A
2.6.8	Organisations should be equipped to offer the first component of bereavement support and have strategies in place to access the other components. Services should be accessible from all settings.	A
2.6.9	Provide an information leaflet including information on anticipated feelings and how to access local and national services and made available to families and carers around the time of the bereavement. Ideally, this should be developed locally, agreed by those involved in the provision of bereavement services.	A
2.6.10	Providers should ensure all staff working with people who are dying have access to a range of opportunities to address concerns and explore the difference between personal and professional responses to loss. This might involve a number of processes, such as clinical supervision and one-to-one and group support.	A
Health and social care workers		
2.6.11	Health and social care workers should communicate sensitively with people closely affected by a death and offer them immediate and ongoing bereavement, emotional and spiritual support appropriate to their needs and preferences.	A
2.6.12	Health and social care professionals involved in providing day-to-day care to patients should assess and address the needs of family members and carers on an ongoing basis. Teams should establish a system to ensure family members and carers have regular opportunities to discuss particular concerns.	A
2.6.13	Health and social care professionals involved in delivering care in the terminal phase of illness should assess individual and family coping ability, stress levels, available support and actual and potential needs with respect to the anticipated or actual bereavement.	A
2.6.14	Teams should ensure that all family members and carers are offered information on a variety of topics, from a simple ‘who’s who’ of professionals to more detailed accounts of cancer, its treatment and consequences and services available locally. They should be ‘signposted’ to local and national sources of information, advice and practical support, including sources of emotional and psychological support. Services for carers and families should be listed in the directories developed at Cancer Network level.	A
Specialist bereavement services		
2.6.16	Specialist bereavement services should be sufficiently resourced to enable them to contribute to the preparation and ongoing support of health and social care professionals in relation to this aspect of care.	A

2.6.17	Those who offer bereavement services that include volunteer support workers should ensure mechanisms for recruiting, training, supervising and managing volunteers are in place. It is desirable that the workforce reflects the gender, age distribution and ethnicity of the clients they serve.	A
Cancer Network		
2.6.18	Cancer Network-wide protocols should be developed to inform the level of bereavement support offered and the need for follow up and specialist referral, particularly for those at risk of complicated grief reactions.	A
2.6.19	Ensure all health care professionals involved in the delivery of supportive and palliative care services have access to basic training in understanding and meeting the needs of families and carers.	A
Family and carers		
Ensure:		
2.6.21	people closely affected by a death are communicated with in a sensitive way and are offered immediate and ongoing bereavement, emotional and spiritual support appropriate to their needs and preferences.	A
2.6.22	families and carers of people who have died suddenly or in an unexpected way, as well as those who were expecting the death, have access to information and support appropriate to their circumstances.	A
2.6.23	people closely affected by a death have access to support within an appropriate physical environment that facilitates sensitive communication.	A
2.6.24	family members and carers are offered the opportunity for their needs for support and information to be assessed separately from those of patients. Cultural and ethnic preferences on family involvement should be taken into account.	A
2.6.25	family members and carers are invited to accompany patients during clinical encounters and are involved in discussions about treatment and care, in accordance with the patient’s wishes.	A
2.6.26	family members and carers are made aware of, and have easy access to, sources of local information, advice and support designed to meet their own needs.	A
2.6.27	family members and carers who are bereaved are, in the first instance encouraged to use existing support systems. Where these prove insufficient, or it is predicted that those involved are likely to experience difficult grief reactions, there should be access to additional help and support.	A
2.6.28	where carers are providing a substantial amount of care on a regular basis, providers offer a separate assessment or respond positively when a carer asks for one.	A
Ongoing support		
2.6.29	Ensure bereavement support is not limited to immediately after death, but that there is provision for it to be available on a longer-term basis and, in some cases bereavement support may begin before death.	A

Information		
2.6.30	Promote a stepped approach to emotional and bereavement support, which could include but is not limited to:	A
	• information about local support services	
	• practical support such as advice on arranging a funeral, information on who to inform of a death, help with contacting other family members and information on what to do with equipment and medication	
	• general emotional and bereavement support, such as supportive conversations with generalist health and social care workers or support from the voluntary, community sectors	
	• referral to more specialist support from trained bereavement counsellors or mental health workers.	
2.6.31	Ensure relatives of patients who are dying in the ICU are provided with a brochure on bereavement and using a proactive communication strategy that includes longer conferences and more time for family members to talk may lessen the burden of bereavement.	B
2.6.32	Ensure people closely affected by a death have access to all support within an appropriate physical environment that facilitates sensitive communication.	A

Cultural and spiritual interventions		
Ensure:		
2.6.33	bereaved people are offered support at the time of death that is culturally and spiritually appropriate, immediate, and available shortly afterwards.	A
2.6.34	awareness of the needs of different ethnic populations, including differences in language, religious practice and culture. Providers should ensure teams have access to reference guides on the cultural differences surrounding a diagnosis of cancer, death and dying, and that information on accessing interpreters, relevant health advocates (where available) and faith leaders is readily accessible.	A

Children and teenager interventions		
2.6.35	Ensure patients with young children or teenagers are offered information by health and social care professionals providing day-to-day care on how to encourage the sharing of fears and concerns. Age-appropriate resources should be available to support this process.	A
Promote:		
2.6.36	support groups for family members and carers, either professionally or peer-led, to meet other families and carers who have experienced similar situations. These services are ideally provided in partnership with the voluntary sector.	A
2.6.37	family bereavement programmes to reduce mental health problems of bereaved youths and their parents.	B

Complex support interventions to support complicated grief		
2.6.38	Ensure there is provision for family members and carers who will require care and support from a health or social care	A

	professional capable of dealing with complex family situations. Providers should ensure they have access to individuals and teams with the requisite skills and knowledge to offer social support, spiritual support, specialist palliative care or psychological support services. Criteria and routes for referral should be agreed between different services.	
2.6.39	Promote treatment interventions that effectively diminish complicated grief symptoms.	B
Carers who are close to being bereaved		
2.6.41	Ensure that teams have the ability to offer information and training on practical issues to carers who are looking after patients requiring extra help with activities of daily living or approaching the terminal stage of illness. This might include manual handling, managing distressing symptoms and dealing with incontinence and other body fluids. As death approaches, they should also be given information about what to expect and what to do after the death.	A
Neo-natal and peri-natal support to parents		
Promote:		
2.6.42	support to families and facilitation of emotional adjustment following the death of a child.	B
2.6.43	support to families and facilitation of emotional adjustment following the death of a baby.	B
2.6.44	Ensure hospital nurses, and doctors support perinatal loss sensitively and increase parental choice about timing and location of delivery and postpartum care, encourage parental contact with the deceased infant, and facilitate provision of photos and memorabilia.	B
Carers of people with dementia		
2.6.45	Ensure there is adequate support for carers of people with dementia.	B
Promote:		
2.6.46	pre-loss interventions to support Alzheimer’s care-givers' post-loss adjustment following the death of their care recipient, tailored to the individual depending on the initial clinical presentation.	B
2.6.47	Resources for Enhancing Alzheimer’s Care-giver Health (REACH) Programme for Bereaved Care-givers.	B
Primary care staff interventions		
2.6.48	Ensure GPs and district nurses receive adequate end-of-life training.	C
Psychotherapeutic support		
2.6.49	Consider promoting psychotherapeutic interventions for bereaved persons that are exclusively targeted at grievers displaying marked difficulties adapting to loss.	B

Parenting interventions		
2.6.50	Consider promoting a family bereavement programme on effective parenting.	B

This evidence review does not recommend:

Intervention		**Grade**
2.6.51	Preventive interventions for diminishing complicated grief symptoms	B

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